LEGAL REGULATION OF APPLIED BEHAVIOR ANALYSIS IN MENTAL INSTITUTIONS AND PRISONS

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This Article has been prepared with two limited purposes in mind: first, to survey and synthesize in nontechnical language some of the relevant scientific and legal literature concerning applied behavior analysis for a mixed audience of lawyers, behaviorists, and representatives both of prisons and mental hospitals and of their inmates; second, to serve as a catalyst for a full discussion of the very difficult ethical and legal issues posed by the use of applied behavior analysis in closed institutions. In this connection, the reader should take note that many of the issues treated briefly here—for example, the theory of a constitutional right to mental privacy or the notion of capacity to consent—are sufficiently complex to have been discussed and to warrant discussion in individual scholarly articles. Given the very early stages of evolution of the law in this area, the reader is cautioned not to rely upon the conclusions reached and the recommendations propounded as definitive. Rather, this Article should be used as a starting point for what will hopefully become a more comprehensive and systematic exploration of the many issues raised by all of those who are concerned.

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INTRODUCTION

Traditionally, society and the courts have ignored both mental patients and prisoners during their institutional[1] confinement, attending

1. Throughout this Article, "mental institution" will be used to denote both facilities for the mentally ill and facilities for the mentally retarded. Although the institu-

only to issues of admission and release. For example, the decision whether an inmate would participate in a particular therapy or rehabilitation program was thought to be within the unfettered discretion of the administration.[2] But in recent years, public concern for the legal rights of mental patients and prisoners has dramatically increased and has been extended to all facets of the delivery of services.[3] Particular attention has been paid to the newly emerging concept of a right to treatment[4] and its obverse, the right to refuse treatment. Of late, there has

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tionalized mentally ill are often referred to as "patients" and the institutionalized mentally retarded as "residents," the terms "mental patients" and "residents" will be used interchangeably throughout this Article.

2. "It is widely assumed that the commitment of a person to a mental hospital, voluntary or involuntary, confers on the hospital administrators the authority to 'treat' him in whatever manner they deem appropriate." A. BROOKS, LAW PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 877 (1974). See also Whitree v. State, 56 Misc. 2d 693, 699, 290 N.Y.S.2d 486, 501 (Ct. Cl. 1968), stating in dictum: "We find that the reason for not using such drugs was that Whitree refused them. We consider such reason to be illogical, unprofessional, and not consonant with prevailing medical standards." In Rutherford v. Hutto, 377 F. Supp. 268, 272 (E.D. Ark. 1974), an illiterate prisoner complained that his forced attendance at school classes violated his constitutional rights. The court held:

> Granting the right of a state to try to rehabilitate the inmates of its penal institutions, the court does not think that it should necessarily be left up to an individual convict to determine whether or not he is to participate in a rehabilitative program such as the one involved here. . . . [A] state has the constitutional power to require a convict to participate in a rehabilitation program designed to benefit the convict.

3. *See* STAFF OF THE SUBCOMM. ON CONSTITUTIONAL RIGHTS OF THE SENATE COMM. ON THE JUDICIARY, 93D CONG., 2D SESS., INDIVIDUAL RIGHTS AND THE FEDERAL ROLE IN BEHAVIOR MODIFICATION 3 (1974) [hereinafter cited as INDIVIDUAL RIGHTS].

4. The constitutional right to treatment or release for involuntarily-committed mental patients has received an unusual amount of scholarly discussion and support. The first articulation of the right is found in Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960). Examples of the many law review articles published on this subject are: Goodman, *Right to Treatment: The Responsibility of the Courts*, 57 GEO. L.J. 680 (1969); Katz, *The Right to Treatment—An Enchanting Legal Fiction*, 36 U. CHI. L. REV. 755 (1969); Robitscher, *Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient*, 18 VILL. L. REV. 11 (1972); Note, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 YALE L.J. 87 (1967); Case Comment, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282 (1973). *See also* Brief for the Respondent, O'Connor v. Donaldson, No. 74-8 (U.S.S. Ct., petition for cert. filed July 25, 1974).

The constitutional right to treatment or release for the mentally ill and the mentally retarded has been recognized by both federal and state courts. *See, e.g.*, Donaldson v. O'Connor, 493 F.2d 507 (5th Cir.), *cert. granted*, 419 U.S. 894 (1974); Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974); Davis v. Watkins, Civil No. 73-205 (N.D. Ohio, Aug. 20, 1974); Wyatt v. Stickney, 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1972); Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973); Renelli v. Department of Mental Hygiene, 73 Misc. 2d 261, 340 N.Y.S.2d 498 (Sup. Ct. 1973).

One of the most perplexing questions now confronting mental health lawyers and professionals involves the issue of standards and especially the difficulty of developing standards which will ensure adequate and effective treatment outcomes. *See, e.g.*, Schwitzgebel, *The Right to Effective Mental Treatment*, 62 CALIF. L. REV. 936 (1974).

The right to rehabilitation for prisoners is less well established at present than the right to treatment for mental patients. Aware that criminal law statutes recognize deterrence, punishment, and the protection of society as well as rehabilitation and reform as legitimate purposes of criminal confinement, the few courts which have analyzed the right of prisoners to access to rehabilitative programs or treatment have addressed this issue solely in terms of the eighth amendment's protection against cruel and unusual pun-

been an increasing scrutiny of the imposition of potentially hazardous or intrusive "treatments" upon unwilling recipients and an attempt to delimit the conditions under which even an involuntarily-committed patient or a prisoner may refuse a particular treatment. Viewed in perspective, the recent concern about the abuse of behavior modification or applied behavior analysis,[5] which is intended to strengthen adap-

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ishment. *See* Smith v. Schneckloth, 414 F.2d 680 (9th Cir. 1969); Taylor v. Sterrett, 344 F. Supp. 411 (N.D. Tex. 1972); United States v. Wyandotte County, 343 F. Supp. 1189 (D. Kan. 1972); *cf.* Ledesma v. United States, 445 F.2d 1323 (5th Cir. 1971). While no court has yet held that the absence of rehabilitation facilities and services in itself constitutes cruel and unusual punishment, a few have held that absence of such services is a factor to be considered in determining whether the overall conditions of an institution constitute cruel and unusual punishment. Taylor v. Sterrett, *supra*; Jones v. Wittenberg, 323 F. Supp. 93 (N.D. Ohio 1971); Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970).

An affirmative right to treatment in the prison setting may also be based upon the concept of due process. While rehabilitation is not the sole purpose of incarceration, it has been widely recognized that rehabilitation is one of its several purposes and goals. *See, e.g.*, Pell v. Procunier, 417 U.S. 817, 823 (1974); United States v. Brown, 381 U.S. 437, 458 (1965); Williams v. New York, 337 U.S. 242, 248 (1949); Diamond v. Thompson, 364 F. Supp. 659, 667 (M.D. Ala. 1973); Benson v. United States, 332 F.2d 288, 292 (5th Cir. 1946). Even if the courts are unwilling to utilize due process for the development of an affirmative right of access to rehabilitative services, where the court finds that the prison environment exerts an essentially antirehabilitative effect on prisoners, thereby not only ignoring the rehabilitative function of incarceration but working against it, due process may provide a corrective vehicle.

While it is not possible within the scope of this Article to discuss the right to treatment further, it is important to note that the right to treatment and the right to refuse treatment are in no way mutually exclusive concepts. While the state may have an obligation to provide mental patients or prisoners with a reasonable opportunity to be cured or have their conditions improved so that they may be released from institutions, such persons may at the same time be protected by law or ethics from being obligated to accept a particular form of treatment which is unduly hazardous, intrusive, or experimental. Obviously, if a patient had a right to refuse every form of treatment offered by the state, the state's purpose in committing mental patients for treatment and prisoners for rehabilitation could be frustrated. Such refusal, however, could be deemed to be a waiver of whatever right to treatment or rehabilitation the state otherwise would have been obligated to provide. Additionally, it should be obvious that the state does not have an obligation to provide every mental patient or prisoner with the precise form of treatment or rehabilitation which such persons might desire. Unfortunately, it is impossible to say anything more definite about the interrelationship between the right to treatment and the right to refuse treatment at this time, since both concepts are at such early stages of their development.

5. Although behavior modification has had a precise and narrowly defined meaning in the past, *see* L. KRASNER & L. ULLMANN, CASE STUDIES IN BEHAVIOR MODIFICATION 1-2 (1965), the term, as used today, is so broad as to have lost much of its utility. Krasner and Ullmann use the term "behavior influence" to describe all of the ways in which human behavior is modified, changed or influenced and define "behavior modification" as a specific subcategory of behavior influencing procedures. *Id.* at 1 n.1. In popular usage, however, the terms behavior modification and behavior influence have become synonymous. As one observer notes:

> Nothing arouses the fears of prison inmates more than so-called "behavior modification" programs, and no wonder. Behavior modification is a catch-all term that can mean anything from brain surgery to a kind of "Clockwork Orange" mental conditioning; it usually includes drug experimentation, and in all too many cases it is aimed more nearly at producing docile prisoners than upright citizens.

N.Y. Times, Feb. 8, 1974, at 31, col. 5. *See also* INDIVIDUAL RIGHTS, *supra* note 4, at 1; Statement of Norman A. Carlson, Director of the Bureau of Prisons, *Before the Subcomm. on Courts, Civil Liberties, and the Administration of Justice of the House Comm. on the Judiciary*, 93d Cong., 2d Sess. 4 (1974) ("The problem in discussing 'behavior modification' is that the term is defined in a number of different ways. In its broadest sense, virtually every program in the Bureau of Prisons is designed to change or modify behavior.") For this reason, the term "applied behavior analysis" will be uti-

tive behavior and weaken maladaptive behavior by properly structuring the patient's or prisoner's physical and social environment, is an aspect of increasing public attention to the full range of potentially abusive treatment procedures. It is the right to refuse treatment—or to put it more precisely, the nature and extent of limitations upon the state's power to impose treatment procedures upon unwilling or incompetent persons—which is the subject of this discussion.

Section I of this Article provides a brief definition of applied behavior analysis, an overview of the reasons for the current assault on the use of behavioral procedures in closed institutions, and a discussion of the legal and ethical issues common to all therapies. The applied behavior analyst's statutory and common law duties as well as the possible legal bases for a constitutional duty to refrain from utilizing hazardous or intrusive behavioral procedures where a competent mental patient or prisoner withholds informed consent or where a procedure is not in the best interest of an incompetent patient or prisoner are described in the second section. Analysis litigation challenging nonbehavioral treatment programs will suggest the scrutiny to which behavioral programs may be subjected and relevant legal concepts such as waiver, permissible and compelling state interests, and the least restrictive alternative will be discussed. Section III explores five special problems which applied behavior analysts are likely to encounter in attempting to comply with the constitutional duty to refrain from utilizing hazardous or intrusive procedures except under special circumstances. The fourth section briefly describes and discusses the implications of a recent case setting procedural limitations on the imposition of behavioral programs.

Appendix I sets forth standards for the regulation of behavioral programs in mental institutions. An operating premise for this Article is that in at least some situations, behavioral programs will be genuinely desired and sought by persons who have trouble adjusting their behavior to required societal norms. Therefore, formulation of standards for the legal and ethical use of behavioral programs is necessary to allow consumers to benefit from such programs and to allow conscientious therapists to administer them with a sense of security, while at the same time providing protection against the misuse and abuse of behavioral procedures and possible violations of the client's[6] constitutional rights. Finally, Appendix II develops a hypothetical fact situation calling for

lized throughout this Article to denote the older and more delimited meaning of behavior modification and to describe the specific behavioral procedures which are the focus of inquiry.

6. Generally, applied behavior analysts refer to the recipients of treatment as clients.

the use of aversive conditioning in order to demonstrate how the proposed standards for the regulation of behavior modification would be practically applied.

I. APPLIED BEHAVIOR ANALYSIS

A. *Definition of Applied Behavior Analysis*

For the purposes of this discussion, applied behavior analysis will refer to the work of persons investigating processes of changing human behavior. These persons study clinical phenomena through operationally-defined and experimentally-manipulated variables; emphasize the effect of environmental stimulation in directing the individual's behavior; approach maladaptive behavior through a psychological or learning theory model rather than a medical or disease model, dealing directly with behavior rather than with underlying or disease factors that cause this behavior; and, utilize a model of social reinforcement under which it is recognized that other human beings are a source of meaningful stimuli that alter, direct, or maintain the individual's behavior.[7]

Applied behavior analysis includes many diverse approaches.[8] The principle underlying each approach is that behavior is primarily influenced by what follows it—its consequences—and that in order to change behavior, the consequences of that behavior should be altered. Applied behavior analysis inherently includes a systematic evaluation of the effectiveness of these alterations through observation and measurement. Applied behavior analysis, at least outside of institutions, involves a negotiated contractual agreement between therapist and patient, in which mutually agreeable goals and procedures are specified.[9] Arguably, the techniques of applied behavior analysis include positive reinforcement, token economy programs, shaping, modeling, aversive conditioning, overcorrection, extinction, and systematic desensitization.[10]

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7. *See* L. KRASNER & L. ULLMANN, *supra* note 5, at 1-2.

8. Although it will not be possible within the constraints of this Article to delineate the difference more carefully, the reader should be aware of the tension within the field of behaviorism between the strict determinists, who emphasize the influence of the environment over behavior, and those who build a recognition of man's self-directing capacities into their model of human behavior. *Compare, e.g.*, B. SKINNER, BEYOND FREEDOM AND DIGNITY (1971), *[and]* Rachlin, *Self-Control*, 2 BEHAVIORISM 94, 100-04 (1974), *with* Bandura, *Behavior Theory and the Models of Man*, 29 AM. PSYCHOLOGIST 859-69 (1974), *[and]* Wilson & Evans, The Therapist-Client Relationship in Behavior Therapy, in The Therapist's Contribution to Effective Psychotherapy: An Empirical Approach (A. Gurman & A. Razin eds.) (to be published in 1975). In present usage, the term applied behavior analyst is used most often to delineate those behaviorists of the first orientation and behavior therapists or persons with a "social learning" orientation to describe those of the second. In ordinary discourse, behavior analysis, behavior therapy, social learning, and behavior modification are all used more or less interchangeably.

9. S. Stolz, Behavior Modification: Definitions and Examples of Methods, May 20, 1974 (unpublished paper), on file in the *Arizona Law Review* office.

10. For brief definitions and descriptions of these behavioral procedures, see AM.

If inquiry is limited to applied behavior analysis as defined above, many of the behavior-influencing or behavior-controlling procedures which have attracted much public attention and indignation, such as psychosurgery, electronic stimulation of the brain, and injection of psychoactive drugs, are eliminated. Nevertheless, the procedures of applied behavior analysis, hereinafter referred to as behavioral procedures, share important ethical and legal issues with other behavior-influencing or controlling procedures.[11] Some behavioral procedures, such as aversive conditioning utilizing electric shock, isolation, and token economy programs involving deprivation of basic rights or privileges, already have been directly singled out for careful legal and ethical scrutiny.[12]

B. *Applied Behavior Analysis—A Subject of Public Controversy*

Highly intrusive and arguably hazardous "therapies" such as psychosurgery and electroconvulsive therapy have existed for years with relatively little public criticism and with virtually no scrutiny by the legal system. The question then is why applied behavior analysis has been singled out for so much current attention. There is no easy answer to this question, although a number of distinct but interrelated reasons have been offered.

There is a growing concern in our society over increasingly obvious intrusions upon and attempts to control thoughts, feelings, and actions.[13] Our society has long made systematic attempts to control human behavior. Examples of such efforts include propaganda, reli-

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PSYCHIATRIC ASS'N, TASK FORCE REP.: BEHAVIOR THERAPY IN PSYCHIATRY 7-22 (1973); Ayllon, *Behavior Modification in Institutional Settings*, 17 ARIZ. L. REV. 3, 4-9 (1975). For a brief definition of the behavioral procedures as well as the other procedures which comprise the universe of available treatment, see Kassirer, *Behavior Modification for Patients and Prisoners: Constitutional Ramifications of Enforced Therapy*, 2 J. PSYCHIATRY & L. 245 (1974); Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616 (1972).

11. Although this Article is written expressly for a conference on behavioral procedures, much of the legal analysis would apply equally to other modes of treatment.

12. *See* Clonce v. Richardson, 379 F. Supp. 338 (W.D. Mo. 1974); Wexler, *Token and Taboo: Behavior Modification, Token Economies, and the Law*, 61 CALIF. L. REV. 81 (1973). In all fairness, however, the exponents of applied behavior analysis appear to have an unusual concern for the ethical and legal implications of their work. One behavioralist has warned that: "The time has come for behavioral scientists to monitor their own activities, to recognize their legal and ethical implications, and to participate in resolving the ethical and moral dilemmas which are confronting the race of man." Roos, *Human Rights and Behavior Modification*, 12 MENTAL RETARDATION, June 1974, at 6. *See also* G. Davison & R. Stuart, Behavior Modification and Civil Liberties, June 14, 1974 (unpublished paper prepared for Biennial Conference of the American Civil Liberties Union), on file in the *Arizona Law Review* office. The National Conference on Behavior Modification in Closed Institutions, sponsored by the Behavioral Law Center, is an example of a profession consciously subjecting itself to rather rigorous scrutiny.

13. *See*, INDIVIDUAL RIGHTS, *supra* note 3, at iv.

gious proselytizing, advertising, and political campaigning.[14] But our lives are now being increasingly regulated through legislation in such areas as the economy and the environment, and a number of new technological developments are permitting smaller numbers of people to influence large segments of the population.[15] Authors such as B.F. Skinner,[16] Nicholas Kittrie,[17] Perry London,[18] and Philip J. Hilts[19] have identified elements of control in our society and have provoked analysis and reaction to the possibility of utopian control.

Applied behavior analysis is designed to alter behavior.[20] While establishment of such simple skills as tooth brushing or toileting is likely to remain noncontroversial, modification of complex behavioral repertoires, affecting changes in what might be described as attitudes or personality, may be criticized as curtailing freedom of choice and manipulating human character. Implicit in all behavior modification is the ethical issue of to what degree and under what circumstances the shaping of human behavior should be socially sanctioned.[21]

Another special source of concern about applied behavior analysis is that it originated in laboratory work with animals.[22] This concern stems from an apparently deep-seated aversion of human beings to the recognition that in some respects they are like other animals in responding predictably to various stimuli. Coupled with discomfort about the laboratory origins of behavior analysis are the public's equally anxious reactions to its objectives, its detached and mechanistic language, and the scientific nature of its procedures. This reaction

14. Roos, *supra* note 12, at 4; Stuart, *Notes on the Ethics of Behavior Research and Intervention*, in BEHAVIOR CHANGE: METHODOLOGY, CONCEPTS, AND PRACTICE 221 (L. Hammerlynch, L. Handy & E. Mash eds. 1973).

15. Of course, interactions of individuals are self-limiting in the sense that the actions of one constrain others in predictable ways and that all social organization requires some ordering. *See* A. BANDURA, PRINCIPLES OF BEHAVIOR MODIFICATION 81 (1969).

> Behavior therapists recognize that patterns of social influence reach into almost every quarter of our lives. They also realize that unless the process of this influence and its goals are made known, we will continually be subjected to covert manipulations which are planned by groups with vested interests. Drawing upon a scientific approach to the study of human behavior, behavior therapists hope to make valuable contributions to pluralism by generating a body of data describing the operation of influence processes and their consequences. Thus, if people are to make their own decisions about how to conduct their lives, is it not reasonable to provide as much knowledge as possible about how behavior is developed, maintained, and changed . . . .

G. Davison & R. Stuart, *supra* note 12, at 17-18.

16. B. SKINNER, *supra* note 8.

17. N. KITTRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY (1971).

18. P. LONDON, BEHAVIOR CONTROL (1969). *See also* V. FERKISS, TECHNOLOGICAL MAN: THE MYTH AND THE REALITY (1969).

19. P. HILTS, BEHAVIOR MODIFICATION (1974).

20. Roos, *supra* note 12, at 3.

21. *See, e.g.*, P. HILTS, *supra* note 19, at 220; P. LONDON, *supra* note 18, at 199-224; Roos, *supra* note 12, at 3.

22. G. Davison & R. Stuart, *supra* note 12, at 6-8.

is heightened by the growing aversion to the human costs of technology and the scientific revolution.[23]

Under the label of behavior modification, the procedures of applied behavior analysis have been publicly linked with a number of other organic therapies such as psychosurgery, electrical stimulation of the brain, and the administration of various phychoactive drugs which are potentially dangerous, highly intrusive, experimental, and of questionable appropriateness. Obviously, when behavior modification is used to refer only to the end product of the treatment—a change in behavior—it includes almost all therapeutic approaches. The public confusion between behavior modification as a specific procedure and behavior modification in this more general sense has caused all of the abuses of the psychosurgeons or the psychopharmacologists to be laid at the doorstep of applied behavior analysts. Moreover, a number of persons, often without training, who claim to be working in the tradition of applied behavior analysis have initiated behavioral programs which were highly abusive to institutional residents and violative of individual dignity and rights.[24]

Behavioral procedures are also attracting attention because they are highly visible and rapidly proliferating.[25] Having been scientifically tested in private clinics or university experimental settings, various behavioral procedures are beginning to spread throughout society. Token economy programs are now being used to teach bed making to large numbers of schizophrenics in public mental institutions, and contingency contracting is being used on children in classrooms and schools around the country.[26] Behavioral programs training parents for child raising and training couples for improving marital relationships have now been packaged for use in the home.

Finally, applied behavior analysis is under such intense scrutiny because the objectives of a properly administered program are always explicitly and specifically defined.[27] Consequently, they are easily scrutinized and therefore more readily attacked than the relatively nebulous goals of other therapies. Moreover, applied behavior analysis claims to have a demonstrated effectiveness[28] which many other therapies have never been able to prove, and it claims to work with a speed and efficiency which have not before been demonstrated. In fact, while

23. *Id.* at 1.
24. *See* P. HILTS, *supra* note 19, at 52-54; Roos, *supra* note 12, at 5-6.
25. *See* T. Grundner, W. Krasner & H. Cohen, Behavior Modification: An Empirical Analysis of the "State of the Art," Oct. 1974, at 1 (unpublished paper), on file in the *Arizona Law Review* office.
26. *See* P. HILTS, *supra* note 19, at 35-63.
27. G. Davison & R. Stuart, *supra* note 12, at 3.
28. *See* P. HILTS, *supra* note 19, at 12.

the evidence demonstrating that many behavioral procedures are effective in controlled settings is impressive,[29] there is still a major difficulty in having behavior which is learned in controlled environments carry over or "generalize" to the various environments in the real world.[30] Thus, to some extent the proponents of behavior analysis themselves may have unnecessarily provoked public fears of control by giving an exaggerated impression of the present and potential effectiveness of behavior modification.[31] At the same time, the success of behavioral procedures within controlled settings has raised many ethical, social, and legal questions which have long been implicit in all therapies, but which have never before been felt with such a sense of urgency.

C. *Legal and Ethical Issues Raised by Applied Behavior Analysis and Other Therapies*

One may argue convincingly that the ethical and legal problems raised by applied behavior analysis are no different from those raised by other therapies. Psychoanalysis, transcendental meditation, encounter groups, or somatic treatments all inevitably influence, to a greater or lesser degree, the patient's value system as well as his specific symptoms. The goal of all therapies can be defined in terms of the patient's desire to achieve increased self-control over behavior or symptoms which he perceives as foreign to him. The aim of applied behavior analysis, which is similar to the aim of all freely-sought therapies, is to help the client clarify his behavioral objectives and then achieve these objectives.

Of course, if the client is hallucinatory, profoundly retarded, or very young, it is difficult to honor the principle that the client, rather

29. *See* T. Grundner, W. Krasner & H. Cohen, *supra* note 25. But note the finding that only 11.3 percent of the reported behavioral studies include follow-up data. *Id.* at 16.

30. *See* G. Davison & R. Stuart, *supra* note 12, at 4. Additionally, there is the problem that reported success rates may be skewed because "scientists do not report upon, nor do professionals [sic] journals normally print, findings that are NOT successful." T. Grundern, W. Krasner & H. Cohen, *supra* note 25, at 14. "In theory, showing that a procedure is not useful is almost as important as finding out that it is. If it does not work, why and under what conditions does it fail?" *Id.* at 16.

31. An example of this type of reporting is found in Roos, *supra* note 12, at 3: "Recent developments in behavior modification herald the beginning stages of scientific control of human behavior. We may soon develop a technology which would allow us to shape individual futures and, perhaps, which will give us some control over the destiny of our race."

See Stuart, *supra* note 14, at 231-32. Stuart suggests a guideline for which behaviors can and cannot ethically be controlled without the consent of the subject himself.

> In these situations, ethics is served only when the intervention procedure used clearly conforms to the prevailing custom, when the procedures and results are monitored by a third party, and when the target of behavior change is a "minimal goal." Minimal goals seek to strengthen behavior which is mandatory if the client is to preserve his rights as a citizen . . . . However, when the goals are "optimal," that is, when they go beyond the production of minimally required social behavior, client consent would seem to be mandatory.

than the behavior modifier, should select the goals of therapy. Thus, ethical considerations regarding personal choice are raised. These considerations become still more complicated when the individual's behavior is sufficiently uncontrollable or dangerous to justify involuntary confinement under either the criminal or civil law. In this latter situation, there may be conflicts between the individual's values and behavioral goals and those of the society which has committed him. The applied behavior analyst employed by a mental hospital or prison may be uncertain as to where his primary responsibilities lie—with a particular mental patient or prisoner, the administration of the institution which pays his salary,[32] or the community at large. These conflicts are not unique; they are essentially the same regardless of whether the therapist utilizes a behavioral approach or has some other orientation.

As applied behavior analysts correctly observe, their techniques do not differ in kind from those which have historically been used by parents and teachers. Parents and educators try to teach desirable behavior by using positive reinforcements such as smiles or verbal expressions of appreciation or grades. Similarly, parents typically rely upon aversive consequences such as punishment, timeout, for example, confining the child in his room and prohibiting him from playing with his peers, and cost-contingency, such as explicit or implicit withdrawal of affection or withholding the child's allowance, as effective means of shaping their child's behavior.[33] Behaviorists rightly note that those in our society who object to such behavior influencing techniques now that they are being made explicit are like the would be gentleman in Moliere's *La Bourgeois Gentilhomme* who discovers to his astonishment that "he has been speaking prose all the time."[34] As another commentator has put it, behavior modification is like sex—"everyone does it in one form or another."[35]

Of course, to say that applied behavior analysis does not present qualitatively different ethical and legal issues from other therapies, but only perhaps presents them more vividly, it not to suggest that these issues are either simple or unimportant. To the contrary, the present deep-felt concern with "behavior mod" suggests that careful scrutiny of the issues it presents is sorely needed and long overdue.

32. *See* Opton, *Psychiatric Violence Against Prisoners: When Therapy is Punishment*, 45 MISS. L.J. 605, 622-32 (1974).

33. Roos, *supra* note 12, at 4. The enforcement of our society's laws is achieved almost exclusively by a complex set of aversive consequences, including cost-contingency (fines), time-out (imprisonment), and punishment (social condemnation and capital punishment).

34. Moliere, *La Bourgeois Gentilhomme*, in THE MISER AND OTHER PLAYS 19 (Penguin Books 1953).

35. Letter from G. Terence Wilson to Paul Friedman, Feb. 26, 1975, *quoting* Len Ullman, on file in the *Arizona Law Review* office.

Since these issues are essentially similar to those raised by all behavior influencing therapies, it is appropriate that an analysis of ethical and legal limitations upon applied behavior analysis draw upon literature, litigation, and legislation relating to the broader range of therapies; and it is hoped that the conclusions reached regarding substantive and procedural standards for the regulation of applied behavior analysis in closed institutions will apply to other modes of treatment.

II. STATUTORY DUTIES, COMMON LAW DUTIES, AND THE CONSTITUTIONAL DUTY TO REFRAIN FROM UTILIZING HAZARDOUS OR INTRUSIVE BEHAVIORAL PROCEDURES EXCEPT UNDER SPECIAL CIRCUMSTANCES

The legal bases for the applied behavior analyst's duty to refrain from utilizing hazardous or intrusive behavioral procedures, where a competent prisoner or patient withholds informed consent or where the procedure is not in the best interest of an incompetent prisoner or patient, may be derived in whole or in part from the statutory law, the common law, and constitutional principles.[36]

A. *Statutory and Administrative Duties*

A primary source of legal obligations of applied behavior analysts and other therapists is state statutes and the administrative rules or regulations which are promulgated by or for individual institutions. Recently, a number of states have passed statutes which limit the imposition of certain treatment procedures by requiring the informed consent of mental patients or prisoners. The most frequently regulated procedures are psychosurgery, surgery, and electroconvulsive therapy.[37] Some states require informed consent prior to administration of experimental drugs and other experimental procedures,[38] and at least one

36. In writing this section, the author has relied heavily on research and analysis by colleagues at the Mental Health Law Project and the Center for Law and Social Policy, Washington, D.C. In particular, see the Post-Trial Brief of Amicus Curiae, American Orthopsychiatric Association in Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973).

37. *See* ALASKA STAT. § 47.30.130 (Cum. Supp. 1970) (consent required for surgery and psychiatric therapies); CAL. WELF. & INST'NS CODE §§ 5325(f) to -(g) (West Supp. 1974) (involuntarily detained patient has right to refuse psychosurgery, shock treatment, and lobotomy); CONN. GEN. STAT. ANN. § 17-206d (Cum. Supp. 1975) (no medical or surgical procedures, including electroshock therapy, may be performed without consent); MASS. GEN. LAWS ANN. ch. 123, § 23 (1972) (patient has right to refuse shock treatment and lobotomy); MICH. STAT. ANN. § 14.800(716) (1974) (consent required for nonemergency surgery and electroshock therapy); N.Y. MENTAL HYGIENE LAW § 15.03 (b)(4) (McKinney Supp. 1974-75) (consent required for surgery and shock treatment); N.C. GEN. STAT. § 122-55.6 (1974) (informed consent required for nonemergency surgery and electroshock treatment); TENN. CODE ANN. § 33-307 (Cum. Supp. 1974) (consent must be obtained prior to surgery); VT. STAT. ANN. tit. 18, § 7708 (1968) (consent required for surgery); WASH. REV. CODE ANN. § 71.05.370(7) (Supp. 1974) (involuntarily detained patient has right to refuse shock treatment and nonemergency surgery).

38. *See* GA. CODE ANN. § 88-502.3(a) (1971) (unless consent is given, no treat-

state flatly prohibits unnecessary or excessive medication with drugs.[39] Although no state statutes specifically require informed consent for behavioral procedures, at least some of these procedures can be considered experimental and therefore would seem to require informed consent. Moreover, since some behavioral procedures, such as severely depriving token economy programs[40] or aversive conditioning with electric shock, are arguably as intrusive or as painful as electroconvulsive therapy, it may be that these and other behavioral procedures will be regulated as legislators develop an increasing awareness of these procedures and of patients' and inmates' rights.

Administrative rules and regulations may provide a second source of duties for applied behavior analysts. At present, few such rules or regulations exist. The state of Florida, however, is considering adopting a detailed set of "Guidelines for the Use of Behavioral Procedures in State Programs for the Retarded."[41] These guidelines were formulated by a Joint Task Force assembled by the Florida Division of Retardation and the Department of Psychology of Florida State University in response to reported abuses in what was purported to be a behavioral program administered in a residential facility. The goal of this Task Force was "to provide the State of Florida, and other states that may wish to adopt it, a document outlining philosophy, procedures and safeguards recommended for use in the State's administration of behavioral programs."[42] It can be anticipated that other states will consider adopting these or other similar regulations to establish guidelines and standardized controls on behavioral procedures.

Since each state will have differing statutes, rules, and regulations concerning the use of behavioral procedures, it is impossible to generalize as to the limitations which may be imposed. It is clear, however, that there appears to be a trend toward increased regulation in this area. Thus, it is essential that the applied behavior analyst, as well as other therapists, look to the laws of their state and the administrative regulations governing individual facilities as part of the total task of assessing the legal duties and limitations which govern the treatment of prisoners and mental patients.

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ment which is not recognized as standard psychiatric treatment shall be given); N.Y. MENTAL HYGIENE LAW § 15.03(b)(4) (McKinney Supp. 1974-75) (consent required for experimental drugs or procedures); N.C. GEN. STAT. § 122.55.6 (1974) (treatment involving experimental drugs or procedures shall not be given without informed consent).

39. N.C. GEN. STAT. § 122-55.6 (1974).

40. *See* Ayllon, *supra* note 10, at 13-14, 17.

41. Preface to Task Force Rep., Florida Guidelines for the Use of Behavioral Procedures in State Programs for the Retarded, June 17, 1974 (to be published in monograph form by the National Association for Retarded Citizens), on file in the *Arizona Law Review* office.

42. *Id.*

B. *Common Law Duties*

The common law protects one of our most fundamental values—the inviolability of the individual. As explained by Judge Cardozo, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."[43] Under existing tort law, consent is the mechanism by which the client grants the therapist permission to invade his person for the purposes of treatment. The informed consent of the client is necessary to distinguish legally permissible medical intrusions from those which would subject a therapist to liability for an unauthorized "offensive touching" or the assault and battery of his client.[44] Unless the therapist's action is privileged, "[i]t is the settled rule that therapy not authorized by the patient may amount to a tort—a common law battery—by the physician."[45]

A finding that a therapist has violated his duty to respect a client's right to determine what shall be done with his own body does not depend upon whether the procedure is commonly accepted or experimental in nature,[46] whether there was any evil motive or intention on the part of the therapist,[47] or whether the procedure in question was performed properly or in a negligent manner.[48] For consent to a therapy or medical procedure to be valid, it must be competent, knowledgeable, and voluntary.[49] As explained in *Kaimowitz v. Michigan*

43. Schloendorff v. Society of N.Y. Hosps., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

44. Nolan v. Kechijian, 75 R.I. 165, 64 A.2d 866 (1949).

45. Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (1965), *modified on other grounds*, 2 Ariz. App. 607, 411 P.2d 45 (1966); J. KATZ, EXPERIMENTATION WITH HUMAN BEINGS 523 (1972), *reviewed*, Boyd, Book Review, 62 CALIF. L. REV. 300 (1974); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1969); Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967); Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533 (1970).

A discussion and thorough analysis of available remedies is beyond the scope of this Article, it should be noted, however, that monetary damages may not be the only remedy available to a successful tort plaintiff. Where the resulting harm of a threatened tort would be irreparable, injunctive relief may issue. See D. DOBBS, HANDBOOK ON THE LAW OF REMEDIES § 7.4 (1973). Thus, under certain circumstances, an aversive conditioning program might be enjoined. For a discussion of available remedies under non-tort theories, see discussion note 145 *infra*.

46. *See* Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063, 2063-64 (C.A. 72-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973) (partial report).

47. W. PROSSER, LAW OF TORTS § 9, at 36 (4th ed. 1971).

48. *Id.* § 9, at 35-36.

49. Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063, 2063-64 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973); Note, *supra* note 10, at 668. The regulation implementing the experimental sections of the Food, Drug and Cosmetic Act, 21 U.S.C. §§ 301-92 (1970), states: " 'Consent' means that the person involved has legal capacity to give consent, is so situated as to be able to exercise free power of choice, and is provided with a fair explanation of pertinent information concerning the [experiment]. . . ." 21 C.F.R. § 130.37(h) (1973).

Department of Mental Health:[50]

> The involuntarily detained mental patient must have legal capacity to give consent. He must be so situated as to be able to exercise free power of choice without any element of force, fraud, deceit, duress, overreaching, or other ulterior form of restraint or coercion. He must have sufficient knowledge and comprehension of the subject matter to enable him to make an understanding decision.[51]

The *Kaimowitz* court held that competency or, phrased differently, capacity to give consent requires the ability of the subject to "rationally understand the nature of the procedure, its risks and other relevant information."[52] This formulation is an analogue of the legal tests used to determine whether a person is competent to stand trial or to maintain his property.[53] The adoption of this test for informed consent is consistent with the legal trend which recognizes that many mental patients and most prisoners are competent for most purposes and which leaves their civil rights intact insofar as they are competent to exercise such rights.[54] The practical implementation of this standard, however, presents numerous difficulties.[55]

The second requirement is that the consent be knowledgeable. In battery actions, the amount of information which is necessary for a patient to make a knowing decision turns on the doctor's duty to disclose. Uninformed consent is tantamount to no consent at all.[56] In most jurisdictions, the doctor's duty to disclose information about a particular medical procedure is established by the generally accepted

50. 42 U.S.L.W. 2063 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973).

51. *Id.* (material not reported in U.S.L.W.) This standard was based upon the Nuremberg Code.

52. *Id.* at 2064.

53. *See* S. BRAKEL & R. ROCK, THE MENTALLY DISABLED AND THE LAW 303-14, 408-21 (1971).

54. *Id.* at 155-72. *See* Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973); Winters v. Miller, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971); Wyatt v. Stickney, 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Henry v. Ciccone, 315 F. Supp. 889 (W.D. Mo. 1970).

55. For a discussion of the difficulties in measuring competency and a review of various standards for competency, see text & notes 183-99, 161-79 *infra*.

56. Darrah v. Kite, 32 App. Div. 2d 208, 210-11, 301 N.Y.S.2d 286, 290 (1969). *See* Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (1965), *modified on other grounds*, 2 Ariz. App. 607, 411 P.2d 45 (1966); Fiorentino v. Wenger, 26 App. Div. 2d 693, 272 N.Y.S.2d 557 (1966), *rev'd in part*, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967). In contrast to a battery action, an informed consent action for negligence focuses exclusively on the knowledge component of the consent requirement and on the doctor's duty to inform the patient of collateral risks. The doctor may be held liable for a negligent failure to properly inform the patient. W. PROSSER, *supra* note 47, § 32, at 165. *See generally* Note, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754 (1970); Note, *supra* note 45. The battery plaintiff also must show that there is a causal relation between the failure to disclose and the specific injury that resulted from the occurrence of an undisclosed risk. Waltz & Scheuneman, *supra* note 45, at 646.

professional standards of practice in effect in the community.[57] In contrast, courts in some jurisdictions[58] and recent commentators[59] have stated that the doctor should disclose whatever information the patient reasonably needs to know in order to make an intelligent decision. With regard to experimental and dangerous procedures, these standards merge.[60] Customary practice in the medical community is to make every effort to provide as much information as possible about experimental procedures so that a patient can reasonably make an intelligent decision.[61]

Finally, a valid consent must be voluntary. The client should be able to decide freely whether he wishes to undergo the procedure. His decision should not be influenced through the intervention of any overt or indirect element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion.[62] While the voluntariness requirement can be stated simply, it too presents complex questions in actual application. Particularly troublesome are the potentially coercive effects of continued confinement.[63]

In concluding this brief summary of therapists' duties under the common law, it is important to note that there are privileges and immunities protecting a therapist against liability for using procedures without informed consent. The doctrine of privilege may protect a therapist from what would otherwise be deemed a tort.[64] When the doctrine applies,

> it signifies that the defendant has asked to further an interest of such social importance that [the interest] is entitled to protection, even at the expense of damage to the plaintiff. He is allowed free-

57. *See, e.g.*, Shetter v. Rochelle, 2 Ariz. App. 358, 370, 409 P.2d 74, 86 (1965), *modified on other grounds*, 2 Ariz. App. 607, 411 P.2d 45 (1966); Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955); *cf.* "Medical Malpractice Litigation: Partial Abrogation of the Locality Rule," 15 ARIZ. L. REV. 595, 840 (1973).

58. *See* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Getchell v. Mansfield, 260 Ore. 174, 489 P.2d 953 (1971).

59. Waltz & Scheuneman, *supra* note 45, at 635-38; Note, *supra* note 45, at 1559.

60. *See* Fiorentino v. Wenger, 26 App. Div. 2d 693, 272 N.Y.S.2d 557 (1966), *rev'd in part*, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

61. *E.g.*, AM. MEDICAL ASS'N DECLARATION OF HELSINKI AND ETHICAL GUIDELINES FOR CLINICAL INVESTIGATION (1966); *Am. Medical Ass'n Principles of Medical Ethics*, 132 J. AM. MEDICAL ASS'N 1090 (1946); Latimer, *Ethical and Legal Aspects of Medical Research on Human Beings*, 35 J. PUB. L. 467 (1954).

62. *See* Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063, 2064 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973). The precise meaning of the elements of voluntariness in the context of tort law and medical procedures has not been extensively explored in the cases. *See* Waltz & Scheuneman, *supra* note 45, at 643. The reason for this underdevelopment is probably that the patient subjected to involuntary treatment is rarely in a position to present a grievance to the courts.

63. For discussion of the problem of securing truly voluntary consent in institutions, see text & notes 201-15 *infra*.

64. W. PROSSER, *supra* note 47, § 16, at 98.

> dom of action because of his own interests, or those of the public require it, and social policy will best be served by permitting it.[65]

For example, consent is not required under tort law if there is an emergency,[66] action in this situation being considered privileged.[67] Thus, to the extent that statutes or judicial decisions sanction intervention by the therapist in certain circumstances, liability will not be imposed.[68]

In addition to privileges, traditional tort law also recognizes certain immunities to liability for tortious conduct. Under the common law, this immunity shields executive officials in high ranking positions as well as legislative and judicial officials.[69] Generally, their immunity is absolute so long as they are acting within the scope of their duties, even to the extent of protecting them against malicious actions.[70] The application of the immunity doctrine to subordinate state officials, although less absolute, has traditionally protected officials exercising discretionary judgment within the scope of their duties and often has provided full protection except in cases where the person alleging tortious conduct can prove actual malice.[71]

Moreover, many of the behavioral procedures which are utilized in mental institutions and prisons, such as positive reinforcement through smiles or verbal encouragement, do not involve a touching of the client. Hence, they would provide no liability for assault and battery. It should be noted, however, that tort theories which do not require physical contact could provide a means for imposing liability upon the applied behavior analyst. Although not previously applied in this context, such traditional torts as invasion of privacy[72] or intentional infliction of severe emotional distress[73] could provide grounds for a claim. Additionally, even where there may be no basis for a battery

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65. *Id.*

66. *See, e.g.*, Preston v. Hubbell, 87 Cal. App. 2d 53, 196 P.2d 113 (Ct. App. 1948); Delahunt v. Finton, 244 Mich. 226, 221 N.W. 168 (1928); Schloendorff v. Society of N.Y. Hosps., 211 N.Y. 125, 105 N.E. 92 (1914).

67. W. PROSSER, *supra* note 47, § 18, at 103.

68. For example, privileges protecting therapists and institutional employees from liability might be recognized in situations where an inmate is physically restrained for his own protection or the protection of other inmates. They also might be recognized in situations where physical contact is necessary to care for an incompetent patient. *See generally* W. PROSSER, *supra* note 47, § 16.

69. *Id.* § 132, at 987-88.

70. *Id.* at 987; Comment, *Civil Liability of Subordinate State Officials Under the Federal Civil Rights Acts and the Doctrine of Official Immunity*, 44 CALIF. L. REV. 887, 888 (1956).

71. W. PROSSER, *supra* note 47, § 132, at 989; Comment, *supra* note 70, at 889. However, when a damage action is brought under the Civil Rights Act of 1871, 42 U.S.C. § 1983 (1970), for violation of constitutional rights under color of state law, the trend has been to severely abridge, if not eliminate, the doctrine of immunity and to require a defense of "good faith and probable cause." *See* discussion note 145 *infra*.

72. *See generally* W. PROSSER, *supra* note 47, § 117.

73. *See generally id.* § 12.

charge, liability could be imposed for any injuries caused by negligent treatment.[74]

While the doctrines of privilege or immunity may insulate the therapist from liability, it should be emphasized that the protection which they provide varies considerably from state to state. Moreover, in recent years the immunity accorded therapists has been seriously undercut by the enactment of statutory provisions imposing personal liability on those committing certain abuses in mental institutions.[75] This protective trend can be expected to continue, and it may even be extended to the prison context. While the absence of experience in the application of tort theories to total institutions precludes generalizations, potential bases for such claims exist, and the applied behavior analyst or other therapist should not presume that he is immune from liability.

C. *The Constitutional Duty*

One of the first indications that the procedures of applied behavior analysts would be subject to constitutional limitations came with the decision of the federal district court in *Wyatt v. Stickney*.[76] This was the first judicial opinion to impose limitations on applied behavior analysis per se, as distinguished from the broader range of therapies. In establishing a comprehensive set of standards for the right to treatment of the mentally retarded, the *Wyatt* court held that:

> Behavior modification programs involving the use of noxious or aversive stimuli shall be reviewed and approved by the institution's Human Rights Committee and shall be conducted only with the express and informed consent of the affected resident, if the resident is able to give such consent, and of his guardian or next of kin,

74. A separate tort exists for malpractice or negligence in using a therapeutic procedure. It is the duty of an attending physician to use reasonable skill and care for the safety and well-being of the patient. W. PROSSER, *supra* note 47, § 32, at 162. The duty is based on the physician-patient relationship, which is the result of a consensual transaction, and applies even if the service rendered is gratuitous or if the physician is employed by a third person. *Id.* An examination of the therapist's duties in applying a particular procedure, as distinguished from his duties in deciding whether to employ a procedure at all, is beyond the scope of this Article.

75. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-516(B) (1974); FLA. STAT. ANN. § 394.459(13) (Supp. 1975).

76. 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). *See also* discussion of Clonce v. Richardson, 379 F. Supp. 338 (W.D. Mo. 1974), text & notes 230-32 *infra*. For a discussion of the constitutional bases for the right to refuse certain forms of therapy or rehabilitation, see INDIVIDUAL RIGHTS, *supra* note 3; R.K. SCHWITZGEBEL, DEVELOPMENT AND LEGAL REGULATION OF COERCIVE BEHAVIOR MODIFICATION TECHNIQUES WITH OFFENDERS (DHEW Pub. No. (HSM) 73-9015, 1971); Kassirer, *supra* note 10; Moya & Achtenberg, *Behavior Modification: Legal Limitations on Methods and Goals*, 50 NOTRE DAME LAW. 230, 238-48 (1974); Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237, 253-307 (1974); Note, *supra* note 49, at 655-67.

> after opportunities for consultation with independent specialists and with legal counsel. Such behavior modification programs shall be conducted only under the supervision of and in the presence of a Qualified Mental Retardation Professional who has had proper training in such techniques.[77]

Although the *Wyatt* court granted confined mentally ill and mentally retarded patients in Alabama the right to refuse to participate in certain behavioral programs, the constitutional basis for its ruling was not indicated. Thus, this Article will explore possible constitutional bases which might limit the power of the state to impose behavioral procedures upon unwilling or incompetent prisoners or mental patients. Recent cases which may indicate the beginning of judicial recognition of the right to refuse treatment or rehabilitation will be discussed in connection with the particular constitutional provisions upon which they were primarily decided.[78]

1. *Provisions Which May Impose Limitations upon Enforced Therapy. (a) The right to physical and mental privacy and autonomy.* The right to privacy has received extensive comment in scholarly journals.[79] The concept was first enunciated in an article by Samuel Warren and Louis Brandeis which asserted that citizens of the body politic have a right "to be left alone." When Brandeis became a Supreme Court justice he took the opportunity to further the right to privacy in his now famous dissent in *Olmstead v. United States.*[80] Noting that "[a]dvances in the psychic and related sciences may bring means of exploring unexpressed beliefs, thoughts and emotions,"[81] he maintained that:

> The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. . . . They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most com-

77. 344 F. Supp. at 400 (emphasis added).

78. In addition to the cases described in this Article, the right to refuse drugs and electroconvulsive therapy is being challenged in several cases presently in litigation. *See, e.g.,* Souder v. McGuire, No. 74-2039 (3d Cir., appeal docketed Oct. 17, 1974) (drugs). In Doe v. Younger, C.A. No. 14407 (4th Dist. Cal. Ct. App., undated), plaintiffs are challenging recent California legislation regulating psychotherapy and electroconvulsive therapy. Excessive medication as a means for "controlling excited behavior" rather than as a part of an ongoing psychotherapy program, has already been held unconstitutional. Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974); Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974).

79. Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). *See generally* A. WESTIN, PRIVACY AND FREEDOM (1968); OFFICE OF SCIENCE AND TECHNOLOGY, PRIVACY AND BEHAVIORAL RESEARCH (1967); Fried, *Privacy*, 77 YALE L.J. 475 (1968); Pound, *Interests of Personality*, 28 HARV. L. REV. 343 (1915); Ruebhausen & Brim, *Privacy and Behavioral Research*, 65 COLUM. L. REV. 1184 (1965).

80. 277 U.S. 438 (1928).

81. *Id.* at 474 (Brandeis, J., dissenting).

> prehensive of rights and the right most valued of civilized men. To protect that right, every unjustifiable intrusion by the Government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment.[82]

This concept was greatly advanced by the later Supreme Court opinion, *Griswold v. Connecticut*,[83] in which the Court held that a Connecticut statute aimed at reducing illicit sexual conduct by prohibiting the use of contraceptives violated a right to marital privacy. Justice Douglas, writing for a plurality of the Court, held that various guarantees, such as the first amendment's right of association, the third amendment's prohibition against quartering soldiers in any house in peacetime, the fourth amendment's prohibition against unreasonable searches and seizures, the fifth amendment's protection against self-incrimination, and the ninth amendment's provision that the enumeration of certain rights in the Constitution does not deny or disparage others retained by the people, create "zones of privacy," one of which relates to marital conduct.[84] In the recent abortion decision, *Roe v. Wade*,[85] the Supreme Court reaffirmed the constitutional dimensions of privacy as a protected right "whether . . . founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action . . . or . . . in the Ninth Amendment's reservation of rights to the people."[86] In his concurring opinion, Justice Douglas stated that the concept of liberty includes: "*the autonomous control over the development and expresssion of one's intellect, interests, tastes, and personality.*"[87]

Closely related to the right to mental privacy is the right to mental autonomy, which has been conceptualized as an aspect of the first amendment's protection of free speech. If the first amendment protects the communication of ideas, it must necessarily protect as a fundamental right "a person's power to generate thought, ideas and mental activities—his freedom of mentation."[88] Support for this position also can be found in an early concurring opinion by Justice Brandeis in *Whitney v. California*: [89]

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82. *Id.* at 478 (Brandeis, J., dissenting).
83. 381 U.S. 479 (1965).
84. *Id.* at 484. In Eisenstadt v. Baird, 405 U.S. 438 (1972), the *Griswold* holding was extended to include the right of any individual, married or single, to be free from unwarranted invasions by the state in the area of contraception.
85. 410 U.S. 113 (1973).
86. *Id.* at 153.
87. *Id.* at 211 (Douglas, J., concurring).
88. Shapiro, *supra* note 76, at 255-56. *See also* Shapiro, *The Uses of Behavior Control Techniques: A Response*, 7 ISSUES IN CRIMINOLOGY 55, 68-78 (1972); Note, *supra* note 10, at 661-64.
89. 274 U.S. 357 (1927).

> Those who won our independence believed that the final end of the State was to make men free to develop their faculties; and that in its government the deliberative forces should prevail over the arbitrary. They believed that *freedom to think as you will* and to speak as you think are means indispensable to the discovery and spread of political truth . . . .[90]

The most directly relevant Supreme Court case for the establishment of both mental privacy and mental autonomy is *Stanley v. Georgia*,[91] in which the Supreme Court held that the first amendment limits the power of the state to control obscenity within private homes. According to Justice Marshall, "Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds. . . ."[92] Whatever the power of the state to control public dissemination of ideas inimical to the public morality, it cannot constitutionally premise legislation on the desirability of controlling a person's private thoughts."[93]

In at least two cases, *Kaimowitz v. Michigan Department of Mental Health*[94] and *Mackey v. Procunier*,[95] lower courts have recognized a right to mental privacy and autonomy which carries beyond the privacy of the home and into an institutional setting. In *Kaimowitz*, the patient—called "John Doe" to protect his identity—had been committed for 17 years as a criminal sexual psychopath. Doe had signed an informed consent form to become a subject in an experimental psychosurgery program aimed at ameliorating destructive behavior, and his participation in the experiment had been approved by two separate three-man review committees—a scientific review committee and a human rights review committee—which had approved the scientific worthiness of the study and had validated the consent obtained from Doe. Despite an apparently willing experimental subject, suit was filed by a legal assistance lawyer and the Medical Committee for Human Rights, on the grounds that the proposed experiment was in violation of public policy and the state and federal constitutions.[96]

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90. *Id.* at 375 (Brandeis, J., concurring) (emphasis added).

91. 394 U.S. 557 (1969). Although the thrust of *Stanley* is no doubt broader, the holding in that case is limited to the rights of a man "sitting alone in his own house, to decide what books he wished to read or films he wished to watch." *Id.* at 565.

92. *Id.*

93. *Id.* at 566.

94. 42 U.S.L.W. 2063 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973). For an exhaustive discussion of *Kaimowitz* and its ramifications, see Note, *Kaimowitz v. Department of Mental Health: A Right to Be Free from Experimental Psychosurgery*, 54 B.U.L. REV. 301 (1974).

95. 477 F.2d 877 (9th Cir. 1973).

96. During the course of this litigation, the court held that the criminal sexual psychopath statute under which Doe originally had been detained was unconstitutional, and accordingly, Doe was released. In addition, the publicity created by the lawsuit caused the Director of the Department of Mental Health to stop funds for the research project,

The *Kaimowitz* court explored several related, but separable, constitutionally-protected rights which could be violated by an intrusive procedure such as psychosurgery.[97] Of particular importance was the court's explicit recognition that the rights to mental privacy and autonomy play an important role in regulating the delivery of treatments, including behavioral procedures in mental institutions and prisons. Addressing first the right to mental autonomy, the judges explained:

> A person's mental processes, the communication of ideas, and the generation of ideas come within the ambit of the First Amendment. To the extent that the First Amendment protects the dissemination of ideas and the expression of thoughts, it equally must protect the individual's right to generate ideas. . . .
>
> Freedom of speech and expression, and the right of all men to disseminate ideas, popular or unpopular, are fundamental to ordered liberty. Government has no power or right to control men's minds, thoughts, and expressions. . . .
>
> For, if the First Amendment protects the freedom to express ideas, it necessarily follows that it must protect the freedom to generate ideas. Without the latter protection, the former is meaningless.[98]

Later, addressing the right to mental privacy, the *Kaimowitz* court stated:

> There is no privacy more deserving of constitutional protection than that of one's mind. . . .
>
> Intrusion into one's intellect, when one is involuntarily detained and subject to the control of institutional authorities, is an intrusion into one's constitutionally protected right of privacy. If one is not protected in his thoughts, behavior, personality and identity, then the right of privacy becomes meaningless.[99]

In *Mackey v. Procunier*,[100] the Ninth Circuit Court of Appeals expressed a similar view. Petitioner Mackey, who was a state prisoner in California, had consented to being sent to the California Medical Facility at Vacaville for the purpose of undergoing electroconvulsive therapy.[101] The Vacaville staff had allegedly been engaged in medical and psychiatric experimentation with aversive treat-

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and the investigators dropped their plans to pursue their research. Thus, the defendants argued that the matter was moot, but the court held that since there was nothing that would prevent the experimental program from being instituted in the future, the matter was still ripe for declaratory judgment.

97. See text accompanying notes 200-03 *infra*.
98. *Id.*
99. *Id.*
100. 477 F.2d 877 (9th Cir. 1973).
101. *Id.*

ment of criminal offenders, including the use of succinycholine, a breath-stopping and paralyzing "fright drug." The stated purpose of this experimentation was to ascertain whether, by evoking fright and inflicting pain accompanied by psychological suggestion, behavior patterns could be affected.[102]

Mackey alleged that while at Vacaville, without his consent and not as a part of the shock treatment to which he had consented, he was administered succinycholine. He charged the defendants with " 'deliberate and malicious intentional infliction of mental and emotional distress, causing plaintiff great pain of body and mind, resulting in a severe disturbance.' "[103] Reversing a lower court's dismissal of Mackey's complaint, the court of appeals asserted that: "[P]roof of [Mackey's allegations] could . . . raise serious constitutional questions respecting cruel and unusual punishment *or impermissible tinkering with the mental processes.*"[104]

(b) *The eighth amendment.* Another possible basis for limiting the power of the state to impose behavioral procedures upon unwilling or incompetent prisoners or mental patients is the eighth amendment's proscription of cruel and unusual punishment. Relying on the eighth amendment, the judiciary has prohibited some of the most offensive features of institutional life traditionally imposed upon prisoners. Under this amendment, prisoners have successfully attacked corporal punishment,[105] inadequate medical care,[106] solitary confinement,[107] guard assaults,[108] and institutional conditions in *toto*.[109]

Despite this record of judicial intervention, the reluctance of

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102. *Id.* at 878 n.1.
103. *Id.* at 877.
104. *Id.* (emphasis added).
105. *See* Wheeler v. Glass, 473 F.2d 983 (7th Cir. 1973); Jackson v. Bishop, 404 F.2d 571 (8th Cir. 1968).
106. *See* Runnels v. Rosendale, 499 F.2d 733 (9th Cir. 1974); Martinez v. Mancusi, 443 F.2d 921 (2d Cir. 1970), *cert. denied*, 401 U.S. 983 (1971). In *Runnels*, the court noted: "A constitutionally protected right to be secure in the privacy of one's own body against invasion by the state except where necessary to support a compelling state interest has been recognized," 499 F.2d at 735, and held:

> Allegations that prison medical personnel performed major surgical procedures upon the body of an inmate, without his consent and over his known objections, that were not required to preserve his life or further a compelling interest of imprisonment or prison security, may foreshadow proof of conduct violative of rights under the Fourteenth Amendment sufficient to justify judgment under the Civil Rights Act.

Id.
107. *See* LaReau v. MacDougall, 473 F.2d 974 (2d Cir. 1972), *cert. denied*, 414 U.S. 878 (1973); Wright v. McMann, 387 F.2d 519 (2d Cir. 1967); Landman v. Royster, 333 F. Supp. 621 (E.D. Va. 1971); Hancock v. Avery, 301 F. Supp. 786 (M.D. Tenn. 1969).
108. *See* Inmates of Attica Correctional Facility v. Rockefeller, 453 F.2d 12 (2d Cir. 1971); Tolbert v. Bragan, 451 F.2d 1020 (5th Cir. 1971).
109. *See* Gates v. Collier, 349 F. Supp. 881 (N.D. Miss. 1972), *aff'd*, 501 F.2d 1291 (5th Cir. 1974); Hamilton v. Schiro, 338 F. Supp. 1016 (E.D. La. 1970); Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970), *aff'd*, 442 F.2d 304 (8th Cir. 1971).

courts to employ the eighth amendment in the absence of particularly objectionable conditions may limit its applicability to many behavioral procedures. Prior decisions have restricted the cruel and unusual punishment ban to those conditions which are "barbarous" and "shocking to the conscience,"[110] and to "physical and mental abuse or corporal punishment of such base, inhumane, and barbaric proportions so as to shock and offend a court's sensibilities . . . ."[111] Still, as Justice Douglas noted recently in dissent: "The delineation of just what conditions constitute cruel and unusual punishment is not well defined. But we know . . . that the concept is not rigid but progressive; that it acquires meaning as the public becomes enlightened."[112] And as former Chief Justice Warren observed: "The words of the [Eighth] Amendment are not precise, and . . . their scope is not static. The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."[113]

With at least one exception,[114] most cruel and unusual punishment litigation involves prisoners. Nevertheless, a recent Eighth Circuit Court of Appeals decision, *Knecht v. Gillman*,[115] has indicated that the eighth amendment also may protect mental patients from certain forms of enforced "treatments" which have been imposed over their objection

110. *See* LaReau v. MacDougall, 473 F.2d 974, 978 (2d Cir. 1972), *cert. denied*, 414 U.S. 878 (1973).

111. Burns v. Swenson, 430 F.2d 771, 778 (8th Cir. 1970), *cert. denied*, 404 U.S. 1062 (1972). Past eighth amendment challenges to institutional conditions may provide precedent for limiting certain possible excesses in behavioral programs. First, judicial concern that institutional residents not be deprived of the "basic elements of hygiene," Novak v. Beto, 453 F.2d 661, 665 (5th Cir. 1971), might prevent a prison or a mental hospital from denying its occupants certain minimal needs, for example, as part of a token economy program.

Second, courts have objected to institutional conditions having possibly substantial adverse effects on a person's mental state. In LaReau v. MacDougall, 473 F.2d 974, 977 (2d Cir. 1972), *cert. denied*, 414 U.S. 878 (1973), the court found the placement of a prison inmate in a totally dark cell without the opportunity for human communication to be unconstitutional since the conditions were "threatening [the] inmate's sanity and severing his contacts with reality . . . ." 473 F.2d at 978. Clearly, similar deprivations as part of a behavior modification program would be proscribed.

Third, courts have expressed considerable concern over corporal punishment in an institutional context and have on occasion ordered its halt. *See* Wheeler v. Glass, 473 F.2d 983 (7th Cir. 1973); Jackson v. Bishop, 404 F.2d 571 (8th Cir. 1968); Landman v. Royster, 333 F. Supp. 621 (E.D. Va. 1971). The almost inevitable abuses arising from corporal punishment and the impossibility of regulating any systematic program have been noted. See Jackson v. Bishop, *supra* at 579. Given this past judicial concern, aversive therapy programs involving shocks or similar pain may be scrutinized with special care.

Finally, courts have proscribed institutional action or inaction that results in the aggravation of illness or injury or in the denial of necessary treatment for such disabilities. See cases cited note 106 *supra*. Forms of drug treatment or aversive therapy that exacerbate an institutional resident's physical or mental illnesses would appear to come within the above judicial proscriptions.

112. McLamore v. South Carolina, 409 U.S. 934, 935 (1972).

113. Trop v. Dulles, 356 U.S. 86, 101 (1956).

114. Wheeler v. Glass, 473 F.2d 983 (7th Cir. 1973) (binding of two institutionalized mentally retarded children in spread-eagled fashion for 77½ hours constituted violation of the eighth amendment).

115. 488 F.2d 1136 (8th Cir. 1973).

and which are really punishments in disguise.[116] In this regard, the eighth amendment might be more accurately viewed not as an independent basis for a right to refuse treatment, but rather as a foundation for a collateral right to refuse hazardous or intrusive procedures which are only ostensibly treatment. This is the determinative issue in any eighth amendment challenge since the proscription applies only to punishment and would not provide a basis for challenging bona fide treatment, however painful it might be.[117]

In *Knecht*, two residents of the Iowa Security Medical Facility [ISMF] sought to enjoin the use of apomorphine, a morphine base, vomiting-inducing drug, on nonconsenting residents. At ISMF, apomorphine was used as part of an aversive conditioning program[118] for patients with behavioral problems. Under the ISMF program, "the drug could be injected for such pieces of behavior as not getting up, for giving cigarettes against orders, for talking, for swearing, or for lying."[119] The patients at the facility who might be "treated" under this program included residents from any institution under the jurisdiction of the state department of social services, persons found to be mentally incompetent to stand trial, referrals by the court for psychological diagnosis or as part of the pretrial or presentence pro-

116. Arguably, the eighth amendment should be interpreted more liberally when applied to mental patients than when applied to prisoners. As stated in Furman v. Georgia, 408 U.S. 238 (1972):

> Men may punish for any number of reasons, but the one reason that punishment is . . . morally justifiable is that someone has broken the law. Thus, it can correctly be said that breaking the law is the *sine qua non* of punishment, or, in other words, that we only tolerate punishment as it is imposed on one who deviates from the norm established by the criminal law.

Id. at 342-43. Consequently, it may be argued that when measures which can be considered punitive are applied in hospitals to persons who have not broken or are not responsible for breaking the law, they should be subjected to more careful scrutiny and may more readily be considered cruel and unusual.

117. One commentator urges that all psychiatric treatment in prisons be scrutinized with respect to the question, "Is it also punishment?" If the answer is yes, such treatment should be subject to the eighth amendment's limitations. Opton, *supra* note 32, at 607-09, 643. Dr. Opton has performed a valuable service in cataloging prison authorities' efforts to escape the eighth amendment's limitations by terming a procedure "therapy" when, in reality, it is punishment. But whether testing all therapies, or at least all therapies involving punishment, by the eighth amendment would help enhance the rights and autonomy of prisoners and mental patients is questionable. See text accompanying note 124 *infra*. Moreover, to apply eighth amendment tests to hazardous or intrusive treatments which are not punishments in disguise might raise serious theoretical problems. While therapy and punishment properly defined may overlap to some extent, each is a distinct concept. Some genuine behavioral procedures may employ punishment to help a client extinguish certain behaviors, and many therapies may involve a great deal of physical or psychological pain, for example, "rolfing" or psychoanalysis, respectively.

The theoretical issue here is whether a finding of an eighth amendment violation can be based simply on the objective *impact* of a particular procedure or whether there also must be some finding of an *intent* to punish. What should be noted is that if a pure impact test were used, procedures such as a standard appendectomy would be subject to eighth amendment scrutiny. For an attempt to set forth the criteria which distinguish painful treatments from punishments, see note 159 *infra*. *See also* notes 122-23 *infra*.

118. *See* Ayllon, *supra* note 10, at 7-8.

119. 488 F.2d at 1137.

cedure, and mentally ill prisoners.[120]

The *Knecht* court found administration of apomorphine, absent informed consent, to be cruel and unusual punishment.[121] The court refused to accept ISMF's assertions that providing apomorphine as part of a "treatment" program exempted it from eighth amendment consideration, noting that "the mere characterization of an act as 'treatment' does not insulate it from eighth amendment scrutiny."[122] The court then concluded that:

> Whether it is called "aversive stimuli" or punishment, the act of forcing someone to vomit for a fifteen minute period for committing some minor breach of the rules can only be regarded as cruel and unusual unless the treatment is being administered to a patient who knowingly and intelligently has consented to it. To hold otherwise would be to ignore what each of us has learned from sad experience—that vomiting (especially in the presence of others) is a painful and debilitating experience. The use of this unproven drug for this purpose on an involuntary basis, is, in our opinion, cruel and unusual punishment prohibited by the eighth amendment.[123]

From a practical point of view, challenges by mental patients and prisoners to enforced therapies would appear to be more likely to succeed on autonomy or privacy grounds than on an eighth amendment theory. Assuming that a proposed therapy or treatment impinges

120. *Id.* at 1138.
121. *Id.* at 1140.
122. *Id.* at 1139. As demonstrated by *Knecht*, the judiciary has shown a capacity to look behind the mask of therapy and recognize when an objectional practice is punishment. Similarly, in Trop v. Dulles, 356 U.S. 86 (1958), the Supreme Court refused to accept a legislature's conclusion that a statute was nonpenal and found the statute's nature sufficiently punitive to invoke eighth amendment scrutiny. Despite claims that treatment rather than punishment is involved, courts have attacked various drug programs because of their actual or potential conflict with the cruel and unusual punishment ban. *See* Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973); Nelson v. Heyne, 355 F. Supp. 451 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974). Similarly, confinement in a facility for "treatment" purposes has not prevented courts from finding objectionable conditions violative of the eighth amendment. *See* New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972); Inmates of the Boys Training School v. Affleck, 346 F. Supp. 1354 (D.R.I. 1972).
123. 488 F.2d at 1139-40. Although the result reached in *Knecht* was correct, the legal basis for the decision is questionable. The decision might be read to suggest that all therapies which are intrusive or painful should be measured against the eighth amendment, an improper rationale. *See* discussion note 117 *supra*. The holding in *Knecht*, however, can be read more narrowly. Since the administration of apomorphine in the Iowa Security Medical Facility [ISMF] program was for violation of specific rules, that is, was applied in a situation where punishment is normally imposed, the *Knecht* court could have assumed that the program was intended as punishment and then ruled, correctly, that it was cruel and unusual punishment despite the fact that it was labeled as a treatment program. Alternatively, the *Knecht* decision might have been based upon an implicit assumption that one of the important characteristics which distinguishes punishment from therapy is that punishment may be imposed without the informed consent of the subject. The fact that informed consent was not secured from the subjects of this "treatment" program might then have been relied upon by the court as evidence that the program was in fact punishment. The court might then have appropriately decided that this form of punishment was cruel and unusual.

upon the constitutional right to privacy or autonomous mentation, state imposition of such a therapy over the objection of a mental patient or prisoner is constitutionally limited—the treatment must be in furtherance of a compelling state interest and the infringement can be no more painful or intrusive than necessary to accomplish that goal.[124] Arguing that a particular procedure is more painful or intrusive than necessary would provide a broader range of protection than an allegation of cruel and unusual punishment, since the eighth amendment really proscribes only the most extreme abuses. One danger, therefore, with which advocates relying on eighth amendment theories should be concerned is that the regular evaluation of punitive therapies by the eighth amendment standard might lead judges to a false sense that they were taking all necessary steps to safeguard mental patients and prisoners. This false confidence in the eighth amendment protections could lead to a judicial disinterest in recognizing other right to refuse treatment theories which might ultimately provide a higher standard of protection.

(c) *Substantive due process.* The fourteenth amendment provides that no state shall "deprive any person of life, liberty or property, without due process of law," [125] and the fifth amendment provides similarly that no person shall "be deprived of life, liberty, or property, without due process of law."[126] This language has been construed by the courts to impose limitations both on the manner in which liberty and property interests may be denied by a state or the federal government—procedural due process[127]—and on the extent to which those interests may be denied—substantive due process. It is these latter, or substantive, limitations that, in and of themselves, may provide an independent constitutional basis for the right to refuse behavioral procedures.

In the past, the Supreme Court utilized substantive due process to assume the role of a superlegislature, invalidating state business regulations as violative of the liberty and property interests protected by due process.[128] This activist intervention by the Court in matters of government regulation was criticized by commentators,[129] and the

124. See text & notes 146-52 *infra.*
125. U.S. CONST. amend. XIV, § 1.
126. *Id.* amend. V.
127. For discussion of procedural due process limitations on the imposition of behavior treatment, see text & notes 224-32 *infra.*
128. *See, e.g.,* Adkins v. Children's Hosp., 261 U.S. 525 (1923); Coppage v. Kansas, 236 U.S. 1 (1915); Lochner v. New York, 198 U.S. 45 (1905).
129. *See* Brown, *Due Process of Law, Police Power, and the Supreme Court,* 40 HARV. L. REV. 943 (1927); Grant, *The Natural Law Background of Due Process,* 31 COLUM. L. REV. 56 (1931); Willis, *Due Process of Law Under the United States Constitution,* 74 U. PA. L. REV. 331 (1926).

Court's reliance on substantive due process subsequently declined.[130] Nevertheless, substantive due process rights continue to be relied on by the Court and may even be in the process of revitalization.[131]

Each recognized due process right has been, in some manner, derivative of the basic liberty or property interests protected by the due process clauses. The right of abortion, for example, derives directly from the liberty a female has in the status of her body.[132] And the right to treatment is the necessary justification for denying liberty by involuntary commitment.[133] Thus, in order to successfully challenge a proposed procedure on due process grounds, an institutional resident would have to show that imposition of the procedure would involve deprivation of a significant property or liberty interest. More particularly, denying patients such basics as food, beds, use of personal property, recreation and personal clothing would probably constitute deprivations of liberty and property within the meaning of due process.[134] As will be amplified below, precisely what due process requires when a person alleges that his protected liberty or property interests have been infringed depends on whether the particular interests are regarded as fundamental.[135]

(d) *Miscellaneous grounds.* While the constitutional guarantees of autonomy and privacy, protection from cruel and unusual punishment, and due process serve as the primary bases for a right to refuse certain behavioral procedures, other possible constitutional grounds are worthy of mention. It has been suggested that the use of behavioral procedures and organic therapies may, in certain instances, raise first amendment freedom of religion questions.[136] The Court of Appeals for the Second Circuit provided some support for this position in *Winters v. Miller.*[137] In *Winters,* mental hospital officials forced a practicing Christian Scientist to accept nonemergency treat-

130. *See* Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives,* 70 MICH. L. REV. 1107, 1147-49 (1972).

131. Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade,* 82 YALE L.J. 920 (1973); Tribe, *Foreword: Toward a Model of Roles in the Due Process of Life and Law, The Supreme Court, 1972 Term,* 87 HARV. L. REV. 1 (1973).

132. *See* Roe v. Wade, 410 U.S. 113 (1973).

133. *See, e.g.,* Donaldson v. O'Connor, 493 F.2d 507 (5th Cir.), *cert. granted,* 419 U.S. 894 (1974); Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971). *See also* Jackson v. Indiana, 406 U.S. 715 (1972) (invalidating deprivation of due process right to liberty caused by involuntary civil commitment where there was no showing that commitment was in furtherance of a state interest).

134. *See* Meyer v. Nebraska, 262 U.S. 390 (1923); Wyatt v. Stickney, 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub nom.,* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); *cf.* Board of Regents of State Colleges v. Roth, 408 U.S. 564 (1972); Dixon v. Alabama State Bd. of Higher Educ., 294 F.2d 150 (5th Cir.), *cert. denied,* 368 U.S. 930 (1961).

135. See text accompanying notes 146-52 *infra.*

136. *See* Kassirer, *supra* note 10, at 273-75.

137. 446 F.2d 65 (2d Cir.), *cert. denied,* 404 U.S. 985 (1971).

ment, an action that violated her religious beliefs. The defendant hospital officials asserted that their treatment obligation overrode the plaintiff's first amendment right to religious freedom.[138] The Second Circuit rejected the defendant's position and recognized the right of a competent patient to refuse treatment on first amendment grounds.[139] While *Winters* may provide a right to resist certain intrusive behavioral procedures, its application is, of course, a limited one because of its religious basis.

The nature and degree of deprivations in certain token economy programs[140] may be limited by several different constitutional provisions. Among the constitutionally-guaranteed rights which such programs may violate are the right to worship,[141] the right to send and receive correspondence and printed materials,[142] and the right of access to the courts.[143] Still other possible theoretical bases for a right to refuse treatment are the equal protection clause and the fourth amendment.[144] However, neither of these latter two approaches has yet been effectively raised in litigation.

2. *Rationale Supporting the Applied Behavior Analyst's Constitutional Duty to Refrain from Utilizing Hazardous or Intrusive Behavioral Procedures Except Under Special Circumstances.* Recognizing that constitutional rights may be affected by some behavioral procedures is only the beginning of an inquiry into the applied behavior analyst's duties in employing such procedures. Waiver—the constitutional counterpart of informed consent—and justifications for infringing constitutional rights also must be considered when determining whether and under what circumstances imposition of a particular behavioral procedure impermissibly violates the constitutional rights of a mental patient or prisoner, thereby imposing a duty of restraint upon the applied behavior analyst.[145]

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138. 446 F.2d at 68.
139. *Id.* at 70.
140. See, for example, the discussion of START, text & notes 230-32 *infra*.
141. *Cf.* Cooper v. Pate, 382 F.2d 518 (7th Cir. 1967).
142. *Cf.* Procunier v. Martinez, 416 U.S. 396 (1974).
143. *Cf.* Johnson v. Avery, 393 U.S. 483 (1969).
144. See Kassirer, *supra* note 10, at 268-70, 275-76.
145. Again, it is beyond the scope of this Article to address liability for violations of prisoner or patient's rights. The recent case of Donaldson v. O'Connor, 493 F.2d 507 (5th Cir.), *cert. granted*, 419 U.S. 894 (1974), however, has caused unnecessary consternation in professional circles and warrants brief consideration.

In *Donaldson*, the patient recovered $38,500 from two psychiatrists for violation of his constitutional right to treatment or release. The case was brought under the Civil Rights Act, 42 U.S.C. § 1983 (1970), which provides a private cause of action in damages for violations of individual constitutional rights by state officials acting under color of state law. Although the cause of action is for deprivation of constitutional rights, the Act provides that principles of tort law shall govern the determination of violations and remedies, including damages.

The *Donaldson* case has been reported in some professional publications as involving the unjust assessment of damages against mental health professionals who were try-

Where physical and mental privacy and autonomy are the basis for the right to refuse treatment, imposition of therapy, absent waiver of refusal, must be justified both as necessary to promote a compelling government purpose[146] and as no more restrictive than necessary to promote that purpose.[147] With a substantive due process challenge, much depends on whether the liberty and property interests to be denied would be deemed fundamental.[148] If those interests are not deemed fundamental under due process, then treatment must

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ing in good faith to do the best they could to treat patients in a grossly understaffed and underfinanced facility. *See* Brief for Am. Psychiatric Ass'n as Amicus Curiae at 37-49, O'Connor v. Donaldson, No. 74-8 (U.S.S. Ct., petition for cert. filed July 25, 1974); *APA Enters Florida Case to Defend Psychiatrist*, 9 PSYCHIATRIC NEWS, Oct. 16, 1974, at 1. *But see* Brief for Am. Ass'n on Mental Deficiency, Am. Federation of State, County, and Municipal Employees, Am. Orthopsychiatric Ass'n, Am. Psychological Ass'n, Joseph P. Kennedy, Jr. Foundation, Nat'l Ass'n for Mental Health, Nat'l Ass'n for Retarded Citizens, Nat'l Center for Law and the Handicapped, and Nat'l Society for Autistic Children as Amicus Curiae at 7-21, O'Connor v. Donaldson, *supra*. In this regard, the case has been poorly reported. In fact, the theory upon which the case was tried and decided by the jury was that the defendants had kept a nondangerous patient capable of caring for himself in the community involuntarily incarcerated for 14½ years, even though they knew that he was receiving no treatment and that his continued confinement under these circumstances was unlawful. The *Donaldson* jury expressly found that the defendant doctors had acted "maliciously, wantonly or oppressively" in blocking the plaintiff's release to responsible and interested friends and organizations. Donaldson v. O'Connor, 493 F.2d at 515-17, 531. Although the claim in *Donaldson* was for violation of a right to treatment or release rather than for violation of a right to refuse treatment, the legal principles relating to liability would be the same.

Under the federal civil rights act, only legislators and judges have absolute immunity. Pierson v. Ray, 386 U.S. 547, 553-55 (1967) (judges); Tenney v. Brandhove, 341 U.S. 367 (1951) (legislators). A qualified immunity, however, is available to officers or employees of the state executive branch who act reasonably and in good faith, even though their actions may violate the constitutional rights of others. *See, e.g.*, Scheuer v. Rhodes, 416 U.S. 232, 242-49 (1974); Pierson v. Ray, *supra* at 555-57. Thus, even where a patient is able to establish a violation of his constitutional right to refuse treatment, an applied behavior analyst or other therapist, assuming he is an officer or employee of the executive branch, would be able to defend against a claim for damages if he could establish that he had acted reasonably and in good faith.

146. *See, e.g.*, Wisconsin v. Yoder, 406 U.S. 205, 214-15, 221-29 (1972); Stanley v. Georgia, 394 U.S. 557, 563-68 (1969); Sherbert v. Verner, 374 U.S. 398, 403, 406-09 (1963); West Virginia State Bd. of Educ. v. Barnette, 319 U.S. 624, 639 (1943).

147. *See* Griswold v. Connecticut, 381 U.S. 479, 485 (1965); Sherbert v. Verner, 374 U.S. 398, 407 (1963); Shelton v. Tucker, 364 U.S. 479, 488 (1960).

148. Unfortunately, there is no certain test for determining when a due process liberty or property interest will be deemed fundamental. Most likely, basics such as food and a place to sleep would be deemed fundamental. *See* Wyatt v. Stickney, 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). Since the liberty and property interests denied for treatment purposes will vary from procedure to procedure, the strength of due process challenges will also vary from procedure to procedure. To the extent, however, that every behavioral procedure may be viewed as always infringing some fundamental liberty or property interest, the due process challenge to treatments may always be couched in terms of the assertion of some fundamental right. For example, the physical and mental autonomy arguably protected by the first amendment or the penumbras of the Bill of Rights may instead be deemed a fundamental liberty protected by due process. Since under this theory all behavioral procedures infringe at least mental autonomy, all challenges to treatment would be based on a denial of the right to mental autonomy.

Unlike the substantive due process rights of the past, *see* Tribe, *supra* note 131, several of the rights recently found residing in the due process clauses of the fifth and fourteenth amendments have been deemed fundamental by the Supreme Court. *See, e.g.*, Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632 (1974); Roe v. Wade, 410 U.S. 113 (1973); Aptheker v. Secretary of State, 378 U.S. 500 (1964).

be imposed if it is necessary to promote a legitimate or permissible government purpose and if the means employed reasonably further that purpose.[149] If the liberty and property interests are deemed fundamental, then treatment may be no more restrictive than is necessary to promote a government purpose which is at least legitimate;[150] however, it is not at present clear whether a legitimate government purpose will suffice or whether the purpose must be compelling. Many due process cases, including the most recent, indicate that the purpose need only be legitimate.[151] If merely a legitimate government purpose will suffice to override any due process interest, a challenge to treatment based solely on due process, whether or not in protection of fundamental interests, will be weaker than a right based on privacy and autonomy. In *Roe v. Wade*,[152] the abortion case, however, the Supreme Court held that a compelling state purpose was necessary to overcome a fundamental due process interest and employed a least restrictive alternative analysis.

When read together, the foregoing principles establish the applied behavior analyst's duty to refrain from utilizing hazardous or intrusive behavioral procedures without the informed consent of a competent client or against the best interests of an incompetent client. The principles of waiver, legitimate government purpose, compelling purpose, and least restrictive alternative will now be examined in more detail.

(a) *Waiver of constitutional rights.* Traditionally, courts have refused to recognize a person's right to agree to his own substantial injury. Time and again, courts have rejected efforts by defendants to raise the victim's consent as a defense to aggravated assault, battery, or mayhem.[153] By contrast, courts have regularly permitted persons to waive fundamental constitutional rights. For example, when a criminal defendant is allowed to plead guilty, the courts are sanctioning waiver of the fifth amendment right against self-incrimination, the sixth amendment right to a jury trial, and the due process right to confront one's accusers.[154]

Perhaps these apparently inconsistent reactions by the courts to

149. See Ely, *supra* note 131, at 941.
150. *See, e.g.*, Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632 (1974); Roe v. Wade, 410 U.S. 113 (1973); Aptheker v. Secretary of State, 378 U.S. 500 (1964).
151. *See* Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632 (1974); Aptheker v. Secretary of State, 378 U.S. 500 (1964).
152. 410 U.S. 113, 155, 163-64 (1973).
153. *See, e.g.*, People v. Samuels, 250 Cal. App. 2d 501, 58 Cal. Rptr. 439 (Ct. App. 1967), *cert. denied*, 390 U.S. 1024 (1968); Commonwealth v. Farrell, 322 Mass. 606, 78 N.E.2d 697 (1948); State v. Fransua, 85 N.M. 173, 510 P.2d 106 (1973).
154. *See* Brady v. United States, 397 U.S. 742, 748 (1970); Boykin v. Alabama, 395 U.S. 238, 243 (1969). *See also* Schneckloth v. Bustamonte, 412 U.S. 218 (1973) (allowing waiver of fourth amendment protection against unreasonable searches and seizures); Miranda v. Arizona, 384 U.S. 436, 478 (1966).

the waiver of different rights can be explained on the basis of public policy. In rejecting claims of consent as a defense to a charge arising from a physical assault, the courts have stressed the societal danger inherent in allowing violent acts and have prohibited such acts as tending to create a breach of the peace.[155] On the other hand, public interests may be significantly furthered where a knowing and voluntary waiver of constitutional rights occurs.[156] For a example, in *Brady v. United States*,[157] the Supreme Court noted that a number of state interests were furthered by the acceptance of a defendant's plea of guilty with a resultant waiver of constitutional rights. The plea allowed the state to more promptly impose and attain the objectives of punishment and to conserve the judicial and prosecutorial resources for those cases in which there was a substantial issue as to the defendant's guilt. In particular, in the area of behavioral procedures, state interests in the rehabilitation, independence, and productiveness of its citizens may be furthered. To the extent certain hazardous or intrusive procedures are useful for behavior modification, permitting waiver of due process rights or rights of privacy and autonomy may further those state interests. Indeed, the court in *Knecht* appears to have rested its decision in part on the assumption that there may be some value, either to the individual or to society, which is furthered by allowing a person to consent to an intrusive but potentially efficacious experimental treatment.[158] The protection against cruel and unusual punishment, however, would appear to be a constitutional guarantee which may not be waived.[159]

155. *See* State v. Fransua, 85 N.M. 173, 510 P.2d 106 (1973).

156. *See* Schneckloth v. Bustamonte, 412 U.S. 218 (1973) (noting that a search authorized by a valid consent may be the only means of obtaining important and reliable evidence and may convince the police that an arrest, with its possible stigma and embarrassment, is unnecessary or that a far more extensive search pursuant to a warrant is not justified); Miranda v. Arizona, 384 U.S. 436, 478 (1966) (confessions may play an important role in some convictions).

157. 397 U.S. 742 (1970).

158. Many experiments are performed on prisoners and civilly-committed mental patients not because they have special applicability to these groups, but because confinement helps to establish ideal laboratory conditions. Additionally, the use of prisoners in such experiments has both monetary and methodological advantages for the investigators. Given the low salaries paid in most prison industries, the experimenters need not pay prisoners salaries commensurate with those paid outsiders. In addition, the captive status of inmates allows the experimenter to maintain a significant degree of control during the course of the clinical test. *See* 39 Fed. Reg. 30648 (1974).

Employment in a responsible research project may also benefit particular prisoners. Participation in an experiment often offers a level of financial compensation, health care, physical amenities, and human contact absent from regular prison life. It can relieve the tedium of the prison routine and increase an inmate's self-respect. It also increases the likelihood of parole, based on medical and prison authorities' recommendations. *See* Hodges & Bean, *The Use of Prisoners for Medical Research*, 202 J. AM. MEDICAL ASS'N 177 (1967); McDonald, *Why Prisoners Volunteer to Be Experimental Subjects*, 202 J. AM. MEDICAL ASS'N 175 (1967). The regulation of experimentation is at present the subject of great public controversy. See authorities cited note 215 *infra*.

159. This proposition depends on the criteria employed for determining whether a given procedure is punishment or therapy. The intent of the person applying the procedure is certainly one factor, though probably not a sufficient factor. Physical of-

When a waiver of constitutional rights is at issue, courts have given special attention to the validity of the waiver.[160] As the Supreme Court has explained, "[w]aivers of constitutional rights not only must be voluntary but must be knowing, intelligent acts done with sufficient awareness of the relevant circumstances and likely consequences."[161] Waiver of a fundamental right and informed consent to a medical procedure therefore appear to involve essentially comparable standards.[162] A valid waiver, like a valid consent, must be knowing, voluntary, and competent.[163]

(b) *Legitimate and compelling governmental purposes.* As already indicated, constitutionally-protected interests may only be infringed for government purposes which are at least legitimate, and sometimes, depending on the nature of the interest protected, the government purpose must be compelling. Legitimate government purposes relevant to the imposition of treatment include the police power[164] pur-

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fensiveness or deprivation of things desired would probably be a second criterion. Even a combination of an actual intent to punish and an offensive procedure, however, would not necessarily define the procedure as punishment. Consider, for example, a normal appendectomy performed in the case of acute appendicitis by a sadistic surgeon who actually intends to punish his patient. In this case, the law would probably deem the procedure treatment rather than punishment despite the paintful impact of the procedures and the surgeon's punitive intent. Thus the recognized therapeutic nature of a procedure would be another criterion. On the other hand, where a hazardous or intrusive procedure of recognized therapeutic value is utilized against a patient's will, it might be deemed punishment, despite its recognized therapeutic value, depending on the surgeon's punitive intent. Thus, the lack of consent of the patient to a procedure would be another criterion of punishment.

The upshot of this discussion is that for a procedure to be considered punishment for eighth amendment purposes, it must first be physically offensive or depriving of things desired and imposed with an intent to punish. In addition, it must be either without recognized therapeutic value or with recognized therapeutic value but imposed without the patient's consent. In this latter instance, the patient's consent would remove the procedure from the category of punishment, making it unnecessary to say that he has waived his protection against cruel and unusual punishment. In the former instance, consent would not be permitted for the same reason one would not be permitted to consent to mayhem; consent would not serve any legitimate interest of either the subject or society.

160. *See* Boykin v. Alabama, 395 U.S. 238, 243 (1969); Miranda v. Arizona, 384 U.S. 436, 475-76 (1966).

161. Brady v. United States, 397 U.S. 742, 748 (1970).

162. For a discussion of the elements of informed consent, see text & notes 49-63 *supra.*

163. To be noted with some concern, however, is the apparent erosion in recent decisions of the voluntariness and knowledge components of a valid waiver. Brady v. United States, 397 U.S. 742 (1970), while permitting a guilty plea, recognized that the decision to waive constitutional rights when pleading guilty may result largely from pressures exerted by the state, for example, from the threat of a death penalty or other coercion. Similarly, in Schneckloth v. Bustamonte, 412 U.S. 218 (1973), the Supreme Court refused to require police officials to advise suspects of their constitutional right to refuse a warrantless search before obtaining consent to such a search, thereby allowing a person to unknowingly waive his fourth amendment protections.

164. The state's plenary power, the police power, allows it to make laws and regulations for the protection of the public health, safety, welfare, and morals. *See* Jacobson v. Massachusetts, 197 U.S. 11, 24-25 (1905). The primary justification for this power is the need to protect members of society from threats to their person or property. *Id.* Protection of society from the mentally handicapped who are dangerous is a traditional use of the police power. AM. BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 39 (S. Brakel and R. Rock eds. 1971).

pose in protecting society by confining harmful persons and the parens patriae[165] purpose in making decisions in the best interest of persons who are incapable of making decisions for themselves. Compelling purposes are those purposes which are legitimate and which, in the judicial mind, carry substantially greater weight than most other legitimate purposes. To date, no court has found a compelling state purpose justifying imposition of a treatment procedure infringing fundamental rights.[166] Nevertheless, there currently is no identifiable limitation precluding the courts from designating some purpose as sufficiently compelling to permit imposition of treatment.[167]

(c) *Least restrictive means.* A necessary corollary of the principle that government action infringing protected interests must be justified by legitimate or compelling government purposes is that the means chosen to promote the government interest must be at least reasonably related to that end.[168] As indicated, however, where fundamental rights are involved, the means must additionally be the least restrictive of the alternatives for achieving the government's end.

A classic expression of the doctrine of least restrictive alternative

165. The parens patriae power, is "inherent in the supreme power of every State . . . ." Late Corp. of the Church of Jesus Christ of Latter Day Saints v. United States, 136 U.S. 1, 57 (1890). Under English law, the King had the authority to act as "the general guardian of all infants, idiots, and lunatics." Hawaii v. Standard Oil Co., 405 U.S. 251, 257 (1972), *quoting* W. BLACKSTONE COMMENTARIES 47. In more modern times, "[t]he *parens patriae* doctrine has been used as the basis for state laws which protect the interests of minors, establish guardianships, and provide for the involuntary commitment of the mentally ill." *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1208-09 (1974) [hereinafter cited as *Developments—Civil Commitment*] But while the parens patriae power was historically premised on the presumed incapacity of minors and the actual incapacity of idiots and lunatics to make decisions about their own care and protection for themselves, recent discussions of the state's power to protect and care for the mentally handicapped have often left out considerations of incapacity with resulting lack of clarity concerning the proper limitations of the exercise of state power under this rationale. *Id.* It is important to bear in mind that not all mentally ill or mentally retarded persons, and certainly not most prisoners, are incompetent.

166. The court in Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063, 2064 (C.A. 72-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973), simply stated that the state had not demonstrated an interest sufficiently compelling to justify the intrusion.

167. It is plausible, for example, that a state's interests in the productivity of its citizens and their discharge of responsibilities could be deemed compelling. Another interest, that of preventing persons from becoming a charge on the state, such as by becoming permanently commited, is probably not sufficiently compelling to justify imposition of treatment procedures which infringe fundamental rights. *See* Runnels v. Rosendale, 499 F.2d 733 (9th Cir. 1974); Wyatt v. Stickney, 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970), *aff'd*, 442 F.2d 304 (8th Cir. 1971); *cf.* Shapiro v. Thompson, 394 U.S. 618 (1969) (state interest in protecting public treasury not sufficiently compelling to justify 1-year durational residence requirement for receipt of welfare benefits).

168. *See* Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 643 (1974); Jackson v. Indiana, 406 U.S. 715, 738 (1972). Thus, a mental patient or prisoner may use this legal principle to attack behavioral procedures for which there is no evidence of effectiveness. This legal attack would be available for many treatments now in use, ranging from group therapy to milieu therapy.

is found in *Shelton v. Tucker*.[169] There, the Supreme Court invalidated an Arkansas law requiring school teachers to list all organizations to which they belonged as violative of the first amendment right of free association since there were "less drastic means" for protecting the state's "legitimate and substantial" interest. The Court stated:

> In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.[170]

This principle has already been applied in the civil commitment context.[171] Application of the doctrine of the least restrictive alternative to attempts by the state to impose hazardous or intrusive behavioral procedures upon unwilling mental patients supports the view that competent mental patients have a right to refuse unnecessarily intrusive or hazardous procedures and that a right to refuse such procedures may be exercised on behalf of incompetent patients.

Where institutionalization is based upon the state's police power interest in confining persons who are harmful to others, imposition of treatment on a competent mental patient over his objection cannot be justified. The state's legitimate safety interest can be fully accomplished by confinement. To be sure, incarceration itself intrudes on

169. 364 U.S. 479 (1960).

170. *Id.* at 488. For a period corresponding with the alleged demise of substantive due process, the doctrine of the least restrictive alternative appeared to lose its vitality as the Supreme Court tended to affirm the legislative prerogative to use any rational means chosen to reach permissible state ends regardless of the asserted availability of less restrictive alternatives. But recently the doctrine has appeared to regain its vitality. It has been used to strike down encroachments on fundamental rights. Memorial Hosp. v. Maricopa County, 415 U.S. 250, 262-69 (1974) (right to travel); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639-46 (1974) (right to procreate); Dunn v. Blumstein, 405 U.S. 330, 342-43, 353 (1972) (right to vote); Aptheker v. Secretary of State, 378 U.S. 500, 512-14 (1964) (right to travel); Sherbert v. Verner, 374 U.S. 398, 407 (1963); (free exercise of religion).

It has been observed that "the principle that government should intrude as little as necessary into the lives of citizens" is presently treated less as an independent principle of constitutional law and more as "simply one of several useful tools available [to the justices] to accommodate important constitutional and legislative interests when they conflict." Chambers, *supra* note 130, at 1147. According to another commentator, the least restrictive alternative reasoning has recently been incorporated into due process and equal protection analysis, since

> when state action affects a fundamental interest, the due process and equal protection clauses require that the state's statutory scheme be necessary to achieve the state's goal. Least drastic means reasoning is used to test whether the state action is necessary; if a less burdensome alternative is available, the challenged action will be invalidated.

Developments—Civil Commitment, supra note 165, at 1246 n.238. Whether less drastic means reasoning is a "tool" or a principle with independent status is an issue which need not be resolved here.

171. Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969) (requiring the exploration of alternative placement prior to commitment to a particular institution); Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) (holding that the committing court not only had an obligation to consider the range of alternative courses of treatment but also to place the patient in the least restrictive of the alternative courses found suitable).

other constitutional rights, perhaps more so than the intrusion which would result from compelled treatment. But, the competent patient's refusal of treatment must be viewed as a waiver of those other constitutional rights, precluding the argument that treatment is less intrusive than commitment. While participation in a behavioral program could eliminate a mental patient's dangerous propensities and permit his earlier release, a competent patient's choice to preserve the integrity of his fundamental rights, the infringement of which is not absolutely necessary to the state's interest in protecting its citizens, should be respected. [172]

The doctrine of the least restrictive alternative also has important implications for incompetent patients whose treatment may be justified under a parens patriae rationale of making decisions in the best interest of persons incapable of making such decisions for themselves, including decisions calculated to enhance their dignity and productivity. Such persons may be subjected to hazardous or intrusive behavioral procedures without their consent. But before requiring incompetent persons to undergo such procedures, the state must demonstrate that such action is in the patient's best interest[173] and that the proposed procedure is no more intrusive[174] than necessary to accomplish the legitimate therapeutic or behavioral goal.

D. *Effect of Constitutional Limitations on Token Economy Programs*

Some very effective token economy programs used to rehabilitate chronically psychotic mental patients involve reinforcers which include a broad range of patient needs and privileges.[175] Under the decision in *Wyatt v. Stickney*,[176] however, patients are guaranteed, *inter alia*, a

172. This view has been expressed by other commentators in closely analogous areas:
> A police power commitment requires no finding of incapacity to make a treatment decision; instead, there must be a finding of diminished capacity to conform to the criminal law and a sufficient level of dangerousness to justify state intervention. Because there is no reason to distinguish police power patients from other competent individuals allowed by a state to make their own treatment decisions, such patients need not submit to unwanted therapy. Admittedly, these patients have a due process right to receive available treatment that would make their confinement less restrictive. However, they should not have to accept such therapy if they consider it more oppressive than the prospect of continued detention . . . .

Developments—Civil Commitment, supra note 165, at 1351. *See also* Shapiro, *supra* note 76, at 280-82.

173. The assumption here is that a competent patient will always act in his best interest; therefore, those charged with acting for an incompetent patient may act for the patient by permitting treatment when to do so would be in the patient's best interest. Essentially, permitting treatment when that would be in the incompetent patient's best interest is tantamount to vicarious informed consent, justified by the parens patriae doctrine. For a discussion of the concept of best interest, see text & note 216 *infra*.

174. For a discussion of criteria for measuring intrusiveness, see text & notes 222-23 *infra*.

175. Wexler, *supra* note 12, at 83-90.

176. 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt,

comfortable bed, privacy, nutritionally adequate meals, the right to have visitors, to attend religious services, to wear their own clothes, to exercise regularly, to be out of doors regularly, and to interact with members of the opposite sex.[177] As one commentator has noted: "The crux of the problem, from the viewpoint of behavior modification, is that the items and activities that are emerging as absolute rights are the very same items and activities that the behavioral psychologists would employ as reinforcers—that is, as 'contingent rights.'[178] . . . Thus, the usual target behaviors for token economies would be disallowed and the usual reinforcers will be legally unavailable."[179]

It is possible that in an effort to protect the basic rights of mental patients, society might deny applied behavior analysts the very reinforcers which might be needed to effectively treat chronic psychotics. Before deciding that there is an inevitable clash between a patient's or prisoner's civil rights and his therapeutic best interests, however, one would first have to ascertain whether nonbasic reinforcers might be found which would be equally effective in shaping the behavior of institutionalized patients. Even assuming that deprivation of basic reinforcers is necessary in some specific cases for a token economy program to be effective, the conflict between legal and therapeutic interests is by no means irresolvable. The basic rights promised to patients in the *Wyatt* decision would presumably be waivable under appropriate circumstances, just as any basic constitutional right is waivable.[180] Moreover, as already indicated, where a legitimate parens patriae justification exists, it may be appropriate for the state to waive certain basic rights on behalf of incompetent patients.[181] Thus, the apparent conflict between absolute and contingent rights which is presently of great concern to the applied behavior analysts may not be as serious as feared.[182]

III. Special Problems Which the Applied Behavior Analyst Will Encounter in Attempting to Implement the Duty to Refrain

A. *Determining Competency*

Most prisoners, except possibly those who are psychotic or severely retarded, are competent to make decisions about their treat-

503 F.2d 1305 (5th Cir. 1974). For a discussion of *Wyatt*, see text accompanying notes 76-77 *supra*.

177. 344 F. Supp. at 379-83; Wexler, *supra* note 12, at 94.

178. Wexler, *supra* note 12, at 93-94.

179. *Id.* at 94.

180. See text & notes 153-63 *supra*.

181. See text & notes 173-74 *supra*.

182. *See, e.g.*, Berwick & Morris, *Token Economies: Are They Doomed?* 5 Professional Psychology 434-39 (1974).

ment or rehabilitation. Moreover, it is now generally recognized that persons who are mentally handicapped may have impaired functioning in some areas but be perfectly functional and competent in others.[183] For example, the Second Circuit has noted:

> [T]he law is quite clear in New York that a finding of "mental illness" even by a judge or jury, and commitment to a hospital, does not raise even a presumption that the patient is "incompetent" or unable adequately to manage his own affairs. Absent a specific finding of incompetence, the mental patient retains the right to sue or defend in his own name, to sell or dispose of his property, to marry, draft a will, and, in general to manage his own affairs.[184]

Nevertheless, because the very nature of a total institution impairs a patient's capacity to make important decisions concerning his life, the issue of whether a prisoner or mental patient is competent to give consent is always a difficult one. For example, while recognizing that involuntarily-detained mental patients may have sufficient IQ's to intellectually comprehend their circumstances, the *Kaimowitz* court noted with concern that "the very nature of [a confined mental patient's] incarceration diminishes his capacity to consent . . . . He is particularly vulnerable as a result of his mental condition, his involuntarily [*sic*] confinement, and the effects of 'institutionalization.' "[185]

Defining capacity to consent is, along with defining voluntariness, one of the thorniest of all issues involved in the regulation of applied behavior analysis. As a general proposition, it may only be stated that capacity, like voluntariness, "is a requirement of variable demands."[186] Greater care must be taken when the proposed procedure is experimental, dangerous, or intrusive than when it is routine.

The goal in choosing a standard of competency is, on the one hand, to enhance self-autonomy and guard against paternalism and, on the other, to provide for vicarious judgment in the best interest of patients when necessary. As with so many of the difficult issues in

183. *See* Winters v. Miller, 446 F.2d 65, 68 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971); Henry v. Ciccone, 315 F. Supp. 889 (W.D. Mo. 1970).

184. Winters v. Miller, 446 F.2d 65, 68 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971).

185. Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063, 2064 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973). As the court explained the problem:

> The fact of institutional confinement has special force in undermining the capacity of the mental patient to make a competent decision on this issue, even though he is intellectually competent to do so. . . . Institutionalization tends to strip the individual of the support which permits him to maintain his sense of self worth and the value of his own physical and mental integrity. An involuntarily confined mental patient clearly has diminished capacity for making a decision . . . .

Id. (material not reported in U.S.L.W.). For exhaustive discussion of *Kaimowitz* and its ramifications, see Note, *supra* note 74, at 301.

186. 42 U.S.L.W. at 2063.

mental health law, there may be no ideal approach. Under too lax a standard of competency, persons will be allowed to act in ways which may be viewed as being contrary to their best interests. Under too strict a standard, the opportunity for self-determination may be undermined and personal integrity denigrated by the paternalism of the state. Horror story hypotheticals can be formulated to expose potential weaknesses in any standard of competency that has been proposed. The real question is under which standard will undesirable results be most effectively minimized. Unfortunately, very little attention has been devoted to this problem to date, and it is, therefore, possible only to identify some of the different standards of competency which have been used and to briefly discuss the likely effects of choosing one standard over another.

1. *Competency Defined as Reaching a Reasonable Result.* One approach to determining competency requires the reviewer to decide whether the result of the client's decision is one which a "reasonably competent man might have made."[187] Thus, "[p]ersons who, because of mental illness, would be likely to make decisions about their own interests which would result in substantial damage to their own mental or physical well-being," should be deemed incompetent.[188] This approach has been criticized as being extremely paternalistic and drawing a probably unsupportable distinction between the decision-making freedom of persons with physical illnesses and mental disabilities.[189] Under this standard, a mentally ill person who decides to forego a treatment despite a substantial risk to his mental well being might be labelled incompetent and thus denied his basic right to self-determination. Any determination of the reasonableness of a result is based on the balancing of complex factors and is likely to be subjective. Thus, adoption of this standard may result in a Catch-22 logic—any decision with which the reviewer of competency disagreed would provide a basis for labelling the client incompetent and for substituting the reviewer's opinion as to the best result for the client.

187. Green, *Proof of Mental Incompetency and the Unexpressed Major Premise*, 53 YALE L.J. 271, 306-07 (1944); Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288 (1966).

188. Note, *supra* note 187, at 1295. *See also* NAT'L INSTITUTE OF MENTAL HEALTH, DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL § 9(g)(2) (1952), *found in* AM. BAR FOUNDATION, *supra* note 164, at 457, 459. This section proposes involuntary commitment of patients who lack "sufficient insight or capacity to make responsible decisions with respect to hospitalization." The commentary to this section, however, indicates that the authorities are concerned only with the capacity of the individual. The issue is "whether he is *capable* of making a responsible, not necessarily a wise, decision . . . ." *Id.* at 469.

189. *See* Dix, *Hospitalization of the Mentally Ill in Wisconsin: A Need for a Reexamination*, 51 MARQ. L. REV. 1, 26-27 & n.79 (1967); Shapiro, *supra* note 76, at 288.

2. *Competency Defined as the Capacity to Reach a Decision Based on Rational Reasons.* Under this standard, competency is defined as the capacity to understand the nature of the behavioral procedure, to weigh the risks and benefits, and to reach a decision for rational reasons. This standard is most commonly advanced in scholarly writing.[190] While it is an improvement on the first proposed standard, it has its own difficulties. To be sure, this standard tends to protect against the paternalistic tendency to substitute the reviewer's decision for the client's by focusing on the client's overall patterns of thought rather than on the result of a particular decision.[191] Thus, the patient's total decisionmaking process is evaluated to determine if there is evidence of incoherent reasoning or eccentricities of emotion. The insolvable problem of any rationality test, however, is that it may express a value preference for a particular kind of thinking, the results of which have not been proved to be less valid than other modes of reasoning. As is commonly observed, the line between genius and madness is a thin one, and many sound decisions have been made on the basis of unconscious or preconscious thought or on the basis of what might be characterized as irrational or intuitive reasons. Arguably, any attempt to assess the quality of reasoning, as distinguished from the ability to decide at all, carries with it the danger that the reviewer of competency will substitute his own manner of thinking and value preferences for those of the client.

3. *Competency Defined as the Capacity to Make a Decision.* A minority of courts and scholarly commentators have suggested an approach to defining competency which would avoid the difficulties inherent in evaluating whether a person's thought processes are rational or irrational but which also would preclude the apparent consent of persons clearly out of touch with reality. Under this approach, so long as the client has a sufficient understanding of the nature of the procedure, its risks and benefits, and the possible alternatives, his decision, provided there is a decision, will be honored.[192] Of course, here again, the question of what constitutes sufficient understanding is highly subjective.

In re Yetter,[193] a decision by a Pennsylvania lower court, provides a good illustration of the application of this approach. Maida

190. *See, e.g.*, Dix, *supra* note 189, at 26; Postel, *Civil Commitment: A Functional Analysis*, 38 BROOKLYN L. REV. 1 (1971); Siegel, *The Justifications for Medical Commitment—Real or Illusory*, 6 WAKE FOREST L. REV. 21, 32-33 (1969), *Developments—Civil Commitment*, *supra* note 165, at 1217.

191. Shapiro, *supra* note 76, at 311-13.

192. *See, e.g., In Re Yetter*, 62 D. & C. 2d 619 (C.P. Northampton County, Pa. 1973); Grannum v. Berard, 70 Wash. 2d 304, 422 P.2d 812 (1967); Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1366 (1974).

193. 62 D. & C. 2d 619 (C.P. Northampton County, Pa. 1973).

Yetter had been committed to Allentown State Hospital in 1971, and her diagnosis at that time was chronic undifferentiated schizophrenia. Subsequently, because Mrs. Yetter was discovered to have a breast discharge, the doctors recommended a surgical biopsy and any additional necessary corrective surgery. Mrs. Yetter refused the surgery because she was afraid of that type of operation, which she claimed had resulted in the death of her aunt. The caseworker indicated that at the time of the refusal, Mrs. Yetter was "lucid, rational, and appeared to understand that the possible consequences of her refusal included death."[194] The court described Mrs. Yetter's refusal as "informed" and "conscious of the consequences," and stated:

> The ordinary person's refusal to accept medical advice based upon fear is commonly known and while the refusal may be irrational and foolish to an outside observer, it cannot be said to be incompetent in order to permit the State to override the decision.
>
> . . . .
>
> . . . Upon reflection, balancing the risk involved in our refusal to act in favor of compulsory treatment against giving the greatest possible protection to the individual in furtherance of his own desires, we are unwilling now to overrule Mrs. Yetter's original irrational but competent decision.[195]

While the *Yetter* standard of competency would appear to be more objective and less likely to provoke disagreement in its application than a rationality standard, it is not without its own problems. There was, for example, evidence in the *Yetter* case that Mrs. Yetter's decision to forego corrective surgery was based not only on irrational reasons but also on fundamental misperceptions of reality. Mrs. Yetter justified her objections to surgery on the basis that her aunt had died following surgery for cancer. In fact, the aunt's death was unrelated to her cancer operation and occurred some 15 years after that operation.[196] Other evidence that Mrs. Yetter's reasoning had a delusional component came from her responses to questions by the court and counsel; she indicated that the proposed operation would interfere with her genital system, affect her ability to have children, and would prohibit a movie career.[197] At the time of these questions, Mrs. Yetter was 60 years of age. It might, therefore, have been decided that Mrs. Yetter was not competent even under this standard because she lacked sufficient understanding of the nature of the procedure, the risks and benefits, and the alternatives involved.

194. *Id.* at 621.
195. *Id.* at 624.
196. *Id.* at 622.
197. *Id.*

Clearly, if a client is psychotic or hallucinating and cannot assimilate information about a proposed procedure at all, he is incompetent to make a decision one way or the other. More difficult situations are presented where the client cannot accurately "hear" and weigh the pertinent information for delusional reasons. Consider, for example, the difference between the decision of a child molestor to reject proposed aversive conditioning on the ground that the pain of the proposed procedure is not, in his opinion, worth the possibility of a change in his behavior and the decision of a similarly situated person to refuse aversive conditioning based on a paranoid belief that all behavior modifiers are conspiring in a plot to kill him or that he has a little man inside him who is his true self and who would be fried by any electricity. What this and similar hypothetical comparisons point up is that we are dealing with a question which involves the balancing of complex factors and the delicate evaluation of personal preferences.[198] The task of framing an ideal standard for competency and studying its operational effectiveness is beyond the scope of this Article. The tentative approach recommended in the proposed standards set out in an Appendix to this Article[199] removes the rationality standard from the determination of competency since rationality per se is unduly restrictive. Instead, the standards define competency to consent as the ability to understand and knowingly act upon the information provided. Meaningful decisions concerning this or any other standard, however, can be made only through a careful empirical study of operational results.

B. *Determining Whether Consent in the Institutional Context Is Truly Voluntary and Competent*

After noting that a crucial element of informed consent is voluntariness, the *Kaimowitz*[200] court also gave an informative description of the great difficulty of eliciting a truly voluntary consent in an institutional setting:

198. An approach to defining competency which would obviate these problems would be to forego any inquiry into understanding at all, provided a client is able to hear the question of whether he is willing to consent to a particular therapy and to answer either yes or no. Barring some additional requirement of a causal connection, the response of a client who automatically said, "no, no, no," to any and all questions which he was asked would be a competent refusal. Even with a causal connection requirement, this standard would require the response of a client who could hear the information given, but whose hallucinations caused serious distortions in his thinking, to be honored. This very low standard for competency was adopted by the federal district court in Wyatt v. Aderholt, 368 F. Supp. 1383 (M.D. Ala. 1974), with regard to consent by the mentally retarded to sterilization. The court's order provided that even legally incompetent residents may not be sterilized unless they have "formed . . . a genuine desire to be sterilized." *Id.* at 1385.

199. See App. I, *infra* at 95.

200. 42 U.S.L.W. 2063 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973). For a discussion of *Kaimowitz*, see text & notes 94-99 *supra*.

> It is impossible for an involuntarily detained mental patient to be free of ulterior forms of restraint or coercion when his very release from the institution may depend upon his cooperating with the institutional authorities and giving consent to experimental surgery.
> The privileges of an involuntarily detained patient and the rights he exercises in the institution are within the control of the institutional authorities. As was pointed out in the testimony of John Doe, such minor things as the right to have a lamp in his room, or the right to have ground privileges to go for a picnic with his family assumed major proportions. For 17 years he lived completely under the control of the hospital. Nearly every important aspect of his life was decided without any opportunity on his part to participate in the decisionmaking process.
>
> . . . .
>
> Involuntarily confined mental patients live in an inherently coercive institutional environment. Indirect and subtle psychological coercion has profound effects upon the patient population. . . . They are not able to voluntarily give informed consent because of the inherent inequality in their positions.[201]

If the *Kaimowitz* court's analysis is read to mean that no involuntarily-confined patient may ever be subjected to any treatment since he can never give legally adequate consent, the thrust of normalization theory and the attempts of advocates of the mentally handicapped to restore to them the fullest possible degree of personal autonomy would be seriously undercut. Such a reading, however, would suggest a very unsophisticated understanding of the underlying issues of voluntariness, and a failure by the court to recognize that degrees of voluntariness exist in all situations, even those outside the confines of institutions. Read this way, the *Kaimowitz* decision would appear to assume that persons in the community always act with unimpaired voluntariness. Perhaps, they do in a very general sense; however, the husband or wife seeking private psychotherapy under pressure from a spouse who has threatened separation or divorce may actually act less

201. Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973) (material not reported in U.S.L.W.). The appropriateness of the court's observations about the difficulty of assuring the voluntariness of a decision made by an involuntarily-confined person was nicely illustrated by subsequent events in this very case. While he was confined in Ionia State Hospital, the patient involved in the case staunchly maintained that he genuinely and voluntarily desired to participate in the psychosurgery experiment. Two review committees pressed him on whether his decision was the result of coercion, and he convinced them that he genuinely desired to participate, even if he were released from Ionia. Nevertheless, after he was released from the institution and after the sexual psychopath statute justifying his commitment was held to be unconstitutional, he suddenly saw things very differently and withdrew all consent for the performance of the proposed experiment. *Id.* (material not reported in U.S.L.W.). Moreover, whether or not the hope of early freedom or improved conditions destroys decisionmaking capacity or constitutes duress, an explicit or implicit offer of such benefits by the state may amount to an unconstitutional condition for freedom or privileges. Shapiro, *supra* note 76, at 318.

voluntarily than a mental patient or prisoner agreeing to undertake psychotherapy. Clearly, involuntary confinement is only one of many variables, albeit a very important one, which can and do limit the voluntariness of a person's acts.

Fortunately, the *Kaimowitz* court does not appear to have intended to suggest that confined persons may never give a valid consent. As the court itself commented:

> We do not agree that a truly informed consent cannot be given for a regular surgical procedure by a patient, institutionalized or not. The law has long recognized that such valid consent can be given. But we do hold that informed consent cannot be given by an involuntarily detained mental patient for experimental psychosurgery . . . .[202]

The analytical framework employed by the court does not regard consent as an all or nothing concept. In deciding whether there has been voluntary consent in a particular factual setting, a number of factors must be balanced. Consent must be more carefully scrutinized if the right to be waived is constitutionally protected, if the procedure to be employed is dangerous, or if the nature of the setting in which consent is to be given undermines capacity and voluntariness.[203]

This is the approach which has been adopted by several federal courts which have scrutinized ostensibly voluntary decisions by mental patients to undergo sterilization,[204] aversive conditioning,[205] or to la-

202. Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063 (C.A. 73-19434-AW, Cir. Ct. Wayne County, Mich., July 10, 1973) (material not reported in U.S.L.W.).

203. As the *Kaimowitz* court stated:

> Informed consent is a requirement of variable demands. Being certain that a patient has consented adequately to an operation, for example, is much more important when doctors are going to undertake an experimental, dangerous, and intrusive procedure than, for example, when they are going to remove an appendix. When a procedure is experimental, dangerous, and intrusive, special safeguards are necessary. The risk-benefit ratio must be carefully considered, and the question of consent thoroughly explored.

Id. at 2063-64. The result reached in *Kaimowitz* is probably correct, but the opinion is very unclear on the issue of informed consent and probably confused the understanding of this important concept. As noted above, to the extent that it suggests that mental patients or prisoners may not be able to give consent to at least some procedures, it has potential for undermining their integrity and autonomy. What the *Kaimowitz* court was actually doing was making a basic social policy judgment that the potential harms of psychosurgery were so great and the potential benefits so small that involuntarily-confined mental patients, subject to especially strong coercion, should not be allowed to give consent to such a procedure. But to say that patients or prisoners should not be allowed, as a matter of social policy, to consent to certain procedures, or, to put it another way, to erect a ban on certain procedures in certain settings for social policy reasons is significantly different from saying that patients lack the ability to give a legally valid consent. Unfortunately, informed consent was the legal handle which the court utilized to accomplish an arguably worthy result at the cost of conceptual clarity and at the risk of undermining developing public notions that mental patients and prisoners are able to exercise autonomy and should be allowed to exercise autonomy to the fullest possible extent.

204. *See* Wyatt v. Aderholt, 368 F. Supp. 1383 (M.D. Ala. 1974); *cf.* Relf v. Weinberger, 372 F. Supp. 1196 (D.D.C. 1974).

205. *See* Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973).

bor without compensation in an institutional setting.[206] In such circumstances, and in acknowledgement of the inherently coercive pressures of an institution, the courts have scrutinized consent with special care, but have permitted residents to consent to procedures after ascertaining that reasonable efforts have been undertaken to ensure capacity and voluntariness.[207] These courts recognized the fallibility of consent in a total institutional setting. They also recognized, however, that to assume that institutionalized populations are incompetent to make any decisions affecting their lives would have serious consequences; it would erode the notion of personal autonomy and might well lead to a situation in which the state would invoke alleged incapacity to consent as justification for substituting its own judgment on a whole range of issues personally involving a patient or prisoner. Such a situation would not only involve bad therapy or rehabilitation fostering dependency and loss of self-control but also might involve an unconstitutional abridgment of the first, fifth, or fourteenth amendment rights of prisoners and mental patients.[208] Sound public policy requires that courts and legislators formulate standards for consent which balance the threat of coercion against the equally serious threat of paternalism.[209]

206. *See* Henry v. Ciccone, 315 F. Supp. 889 (W.D. Mo. 1970); Parks v. Ciccone, 281 F. Supp. 805 (W.D. Mo. 1968). In *Henry v. Ciccone*, the court denied an involuntary servitude claim only after it found that the patient knowingly and freely signed a form which "fully informed him of his right not to work . . . ." 315 F. Supp. at 891. The court further found that "inmates who do not sign the waiver are permitted all normal privileges and no punitive action is taken against them . . . and that the work agreement form is not binding . . . ." *Id.*

207. For example, in Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973), the Eighth Circuit laid down specific safeguards designed to ensure that consent to an aversive conditioning program for inmates with behavioral problems was truly voluntary. The action was brought by two residents of the Iowa Security Medical Facility who sought to enjoin the use of apomorphine on nonconsenting residents. For a further discussion of *Knecht*, see text & notes 115-23 *supra*. The court ordered that all treatment using apomorphine be enjoined unless a written consent was obtained from the inmate specifying the nature, purpose, and risks of the treatment; advising the inmate of his right to revoke his consent at any time; and, certifying by a physician that the inmate had read and understood the terms of the consent and that the inmate was mentally competent to understand the consent. While a step in the right direction, these standard procedures to ensure informed consent could certainly be improved. See App. I, *infra* at 97-99.

208. For a discussion of the constitutional rights of mental patients and prisoners, see text accompanying notes 76-144 *supra*.

209. One of the most interesting and difficult issues relating to voluntariness arises in the context of contingency contracting procedures. Simply explained these procedures are used for clients who express a wish to change certain deep-rooted behavior, such as excessive eating, drinking, or smoking or a sexual fetish, but who lack the "self control" to do so by themselves. In such procedures, various reinforcements are set forth in advance for participation in therapy. In the behavioral treatment of obesity, for example, applied behavior analysts have eliminated the notorious tendency of obese clients to drop out of on-going therapy programs by making a refundable deposit contingent upon attendance at group sessions. *See, e.g.*, Romanczyk, Tracey, Wilson & Thorpe, *Behavioral Techniques in the Treatment of Obesity: A Comparative Analysis*, in BEHAVIOR RESEARCH & THERAPY 629-40 (1973). In another variation on the same theme, applied behavior analysts often contract with clients to have post-dated checks sent off to the client's most disliked organization if therapeutic directives which have been mutually agreed upon are not followed. Boudin, *Contingency Contracting as a Therapeutic Tool in the Deceleration of Amphetamine Use*, 3 BEHAVIOR THERAPY 604,

The problem of securing a valid informed consent from institutionalized populations has been recognized by behaviorists as well as the courts,[210] and the meaning of informed consent has been consid-

604-08 (1972).

Applied behavior analysts argue with much persuasion that once clients have voluntarily agreed to enter into such a contract they should be legally required to see the behavioral procedure through, even if at a subsequent time the clients express the desire to dispense with the procedure in question. Such a requirement would appear to be most necessary in connection with procedures involving aversive stimuli. A client may very desperately wish to rid himself of an alcohol addiction or a sexual fetish and may therefore agree to a program involving aversive stimuli, but when it is time for the aversive stimulus—electric shock or a nausea-inducing drug, for example—to be applied, the client may suddenly see the matter in a very different perspective and vigorously attempt to withdraw his consent.

The essential dilemma here is that the time in the presence of the aversive stimuli which will ultimately make it possible to stop drinking or having perverse sexual fantasies is the very time at which the value of being able to stop seems lowest to the client. As soon as the aversive stimuli are removed, the value of not drinking or the wish to be free of the sexual fetish assumes its usual high place. The commitment to accept the consequences in this situation must be offered and accepted at a time when the value of not smoking or not drinking is high. The effect of the commitment is to reduce the client's choice—to *compel* him to give up his addiction. Rachlin, *supra* note 8, at 100-04. Perhaps the classic expression of this commitment strategy is Homer's recounting of how Odysseus arranged to have himself bound to the mast of his ship ahead of time so that when he sailed by the island of the Sirens, he could not be tempted by their dangerous enticements.

Seen from this perspective, the attempt of the court in Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973), to set forth specific safeguards to assure the voluntariness of resident consent to behavioral programs involving aversive stimuli is very important and controversial. In *Knecht*, the Eighth Circuit held as a matter of constitutional law that in order to ensure informed consent, an inmate must have "the right to terminate his consent at any time." Applied behavior analysis would argue that this approach might frustrate well-meaning attempts to utilize contingency contracting procedures involving aversive stimuli and would make it legally impossible for clients with self-control problems to adopt an effective "commitment" strategy. With regard to such procedures, applied behavior analysts also argue a contractual theory that once a client makes a valid "contract" to undergo such a procedure, and the applied behavior analyst goes to the trouble of designing an individualized program, they should have a right to compel the client to perform this part of the contract or at least to pay the designated forfeits.

This analysis grows out of discussion with Professor David B. Wexler and Dr. G. Terence Wilson. The problems associated with a rule of revocability have, for the past few years, been of particular interest to Professor Wexler. *See* Wexler, *Foreword: Mental Health Law and the Movement Toward Voluntary Treatment*, 62 CALIF. L. REV. 671, 688-91 (1974); Wexler, *Of Rights and Reinforcers*, 11 SAN DIEGO L. REV. 957, 970-71; Wexler, *Reflections on the Legal Regulation of Behavior Modification in Institutional Settings*, 17 ARIZ. L. REV. 132, 138-40 (1975); Wexler, *Therapeutic Justice*, 57 MINN. L. REV. 289, 330-31 (1972); Wexler, *supra* note 12, at 108 n.151.

210. Some exponents of applied behavior analysis challenge the applicability of the concept of informed consent to the treatment of institutionalized mental patients and prisoners. *See* R.K. Schwitzgebel, A Contractual Model for the Protection of the Rights of Institutionalized Patients, 1975 (unpublished paper). They argue that informed consent is a notion derived from the medical model of treatment. While it may be appropriate to a decision concerning therapy, it is not a relevant concept under a learning theory model of behavior change. The more appropriate model, it is argued, would be a contractual model in which the client and the therapist agree upon explicit goals and the means by which these goals will be achieved, each undertaking specified responsibilities in this regard. Adoption of the contractual model, however, would give only illusory relief to the therapist who believes that under this model the nagging problem of informed consent disappears. In the first place, courts have traditionally exercised their power to review and, on occasion, declare contracts void when the bargaining was not between parties of equal status or power or where one side was able to effectively coerce or influence the other into signing. A. CORBIN, CONTRACTS § 228 (1952). Courts have also held contracts which are based on fraud on inaccurate information to be voidable, *id.* §§ 6, 146, 228, and contracts made by minors or incompetents are voidable as a matter of public policy. *Id.* §§ 6, 146, 227. Thus, the issues of knowledge, competency, and voluntariness will be just as relevant under a contractual model of behavioral ther-

ered in the context of behavior therapy. One approach relies on the individuals' ability to learn behavioral principles and understand how environmental events can control their own behavior.[211] The hope is that as behavioral principles are more widely disseminated and understood by the public, the client population will become increasingly sophisticated about issues of control and will resist controls with which they are not in sympathy. It is recognized, however, that "until behavioral understanding is more widespread than it is at present, experimenters should be particularly sensitive to the manner in which they describe research and ask for the subject's cooperation. [Behaviorists] should help [their] subjects by making them aware of variables that may affect their decision."[212]

A third behaviorist would, however, go even further. Noting that possible remedies for exploitative use of psychological techniques are usually discussed in terms of individual safeguards and that increased knowledge about modes of influence is prescribed as the best defense to manipulation, he observes that awareness alone is insufficient.

> If protection against exploitation relies solely upon individual safeguards, people would continually be subjected to coercive pressures. Accordingly, they create institutional sanctions which set limits on the control of human behavior. The integrity of individuals is largely secured by societal safeguards that place restraints upon improper means and foster reciprocity through balancing of interests.[213]

One behaviorist has offered the following helpful definition of uncoerced consent in behavioral terms:

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apy as under a medical model. Finally, if the Constitution protects mentation and privacy against coercive intrusion by the state in at least some situations, then a necessary condition for use of such therapies by the state is the informed consent of the subject. Shapiro, *supra* note 76, at 307.

211. Stolz, Ethical Issues in Research on Behavior Therapy, Mar. 28, 1974 (unpublished paper presented at the First Drake Conference on Professional Issues in Behavior Analysis, Mar. 28-29, 1974, Des Moines, Iowa), on file in the *Arizona Law Review* office; *see* Davidson, *Countercontrol in Behavior Modification*, in BEHAVIOR CHANGE: METHODOLOGY, CONCEPTS, AND PRACTICE 153 (L. Hammerlynck, L. Handy & E. Mash eds. 1973) (arguing that "nearly everything we do in behavior modification requires the active cooperation of the client. This is especially true when the therapist cannot be present whenever the problematic behavior may occur, and/or when the therapist's presence cannot insure the forcing out of a particular response at any given time."). *See also* Freund, *Some Problems in the Treatment of Homosexuality*, in BEHAVIOR THERAPY AND THE NEUROSES (H. Eysenck ed. 1960). Freund's study found that markedly fewer homosexuals referred for therapy by the courts or coerced by relatives achieved changes in sexual orientation than patients who seemed to have come of their own accord.

212. Stoltz, *supra* note 211, at 12-13. *See also* NAT'L PRISON PROJECT, COMMENTS ON DHEW-NIH DRAFT AND REGULATIONS: PRISONERS (undated) (comments by Holland); Ulrich, *Behavior Control and Public Concern*, 17 PSYCHOLOGICAL RECORD 229-34 (1967).

213. Bandura, *supra* note 8, at 868. It is the discussion of just such institutional sanctions and restraints, of course, which is the purpose of the conference for which this Article is written.

We may now define contingencies of consent. The behaviors of the subject are on the left and the consequences provided are on the right. Aversive confinement is in parentheses because it may not be involved in non-penal institutions:

1. Ongoing program participation → Standard custodial consequences (and standard aversive confinement).
2. Program participation absent → Standard custodial consequences (and standard aversive confinement).

AND

3. Ongoing program participation → Program-specific consequences.
4. Program participation absent → No program-specific consequences.

Stated otherwise, the institution provides or eliminates no custodial (or confinement) consequences contingent on participation or nonparticipation in the program. What maintains participation is the delivery and nondelivery of consequences which derive from the program itself. The presence of this set of options defines a *noncoercive* situation.

. . . .

This method not only defines the options as noncoercive, but as involving full consent.[214]

214. Goldiamond, *Toward a Constructional Approach to Social Problems: Ethical and Constitutional Issues Raised by Applied Behavior Analysis*, 2 BEHAVIORISM 1-84 (1974).

Other behaviorists offer a proposal for securing consent which involves a hierarchy of protections responsive to the level of benefit to the client; level of risk; the validational status of the procedure to be used; and the extent to which the client can freely render informed consent. G. Davison & R. Stuart, *supra* note 12, at 15-16. This proposal can be diagramed as follows:

	LEVEL OF POTENTIAL BENEFIT TO SUBJECT	HIGH POTENTIAL BENEFIT TO SUBJECT		LOW POTENTIAL BENEFIT TO SUBJECT/HIGH POTENTIAL BENEFIT TO SOCIETY	
	NOVELTY OF PROCEDURE	ESTABLISHED	EXPERIMENTAL	ESTABLISHED	EXPERIMENTAL
LEVEL OF RISK	LIKELIHOOD OF FREE CONSENT				
Low Risk	Great Freedom	1	3	2	4
	Some Coercion	4	5	7	8
High Risk	Great Freedom	2	4	5	10
	Some Coercion	6	7	9	N/A

The above graph ranks the degree of consent which is required in relation to the variable factors. The number 1 signifies that the consent can be simply verbal. The number 10 signifies consent that must be witnessed and approved by an outside review panel.

The approach taken to formulating the protective standards later set forth in this Article is in harmony with that of the cases and commentators cited above. Informed consent is not treated as a unitary concept. The model invoked recognizes that coercive influences[215] and diminished capacity will depend upon the setting in which consent takes place and the nature of the procedure for which consent is requested. Just as a person may be competent for some purposes but not for others, the same person may be competent to consent to some procedures and not to others. The more coercive the pressures to which a person is subjected and the more potentially harmful, intrusive, or experimental are the procedures for which consent is requested, the stricter and more numerous must be the safeguards erected to protect the person from an unwarranted intrusion. Although none of the generally accepted applied behavior techniques appear to be so offensive as to require an absolute protective ban, some are potentially abusive and require the strictest control.

C. *Determining Best Interest*

The functional equivalent of consent by a competent patient is the notion that the treatment of an incompetent patient must be in his best interest. The idea that a procedure is in the client's best interest would require, at a minimum, that the benefits of the contemplated procedure clearly outweigh both the known harms and the possible risks or side effects. Ideally, there should be assurance that the proposed procedure is in fact efficacious; and that where the procedure is either intrusive or hazardous, less intrusive or less hazardous procedures have first been exhausted.

Since a best interest determination requires a balancing, it must be the outcome of a decisionmaking process and cannot be objectively

215. The danger of abuse of prisoners' rights is obvious. Most glaring is the possibility that the degrading and depressing aspects of prison life, combined with the lure of parole, will make a truly voluntary consent impossible. Given this inherent coercion, critics have called for a temporary or permanent ban on the use of prisoners for research. *See* Capron, *Medical Research in Prisons*, 1973 HASTINGS CENTER REP. 4.

While admitting the possibility of coercion, other critics have refused to call for an outright ban on such prison research and instead have urged greater supervision and control over the consent process. Among those proposing means for greater control are: Alberts & DeRiemer, *Connecticut "Watchdogs" Human Research Experiments*, 1973 AM. J. OF CORRECTION 40; Hodges & Bean, *supra* note 158, at 177. Rules promulgated by HEW on May 30, 1974 adopt such a regulatory position. *See* 39 Fed. Reg. 18914 (1974). On August 23, 1974, HEW proposed additional regulations providing more safeguards for vulnerable groups, such as prisoners and the mentally disabled. *See* 39 Fed. Reg. 30647 (1974).

A Commission for the Protection of Human Patients has been recently established by Congress and charged with identifying the basic ethical principles which should underlie research, developing guidelines accordingly, and making recommendations to the Secretary of HEW concerning administrative action. *See generally Human Experimentation Regulations: Too Little or Too Much?*, 3 FEDERATION OF AM. SCIENTISTS PROFESSIONAL BULL., Feb. 1975.

described. The numerous variables, such as intrusiveness, risk, potential harm, or side effects, the degree to which the procedure is established or experimental, and the efficacy of the treatment, cannot be fully quantified. For example, a relatively safe procedure may not be in a person's best interest if there are even safer and more efficacious procedures available to effect the same behavioral change; conversely, a highly risky or intrusive procedure may be in a client's best interest if the available alternatives are even more risky, more intrusive, or less effective.

Procedures which would normally be considered intolerable may be acceptable if they are successful in eliminating even less desirable conditions:

> It can be argued . . . that elimination of severe self-abusive behavior warrants the use of painful stimuli, since the damage to the subject is relatively milder and of much shorter duration. Again, these questions are ethical rather than empirical in nature and value judgments must be made in reaching decisions. The making of value judgments is inescapable in such cases, since deciding not to use aversive conditioning is itself a decision based on value considerations which can have major consequences for the subject. For example, without recourse to aversive conditioning, prevention of self-injury or possibly death may require indefinite use of restraint which can effectively totally curtail the individual's development and freedom of action.[216]

Consequently, one must carefully balance a wide variety of factors in determining whether a particular procedure is in the best interests of an incompetent patient.

D. *The Validity of Vicarious Parental Consent for Children*

Traditionally, minors have been presumed to be incompetent, and parents have given vicarious consent on their behalf for various

216. Roos, *supra* note 12, at 3. An interesting issue relating to best interest determinations is whether prior competent indications of a desire to undertake or refuse specific procedures by a now incompetent client should be honored. The theoretical issue underlying this question is whether the purpose of substitute judgment for incompetent clients is to make the decision which they themselves would have made were they competent or whether it is to make the decision that a reasonable man would make under all the circumstances known. Those commentators who have addressed this issue seem to agree that where the essential facts remain the same and where the prior decision was competent, it should be honored even though the client is now incompetent and others may feel that a reasonable man would have made a different decision. *See, e.g.*, Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity vs. The Preservation of Life*, 26 RUTGERS L. REV. 228 (1973); *Developments—Civil Commitment, supra* note 165, at 1218 n.95; Note, *An Adult's Right to Resist Blood Transfusions: A View Through John F. Kennedy Memorial Hospital v. Heston*, 47 NOTRE DAME LAW. 571 (1972). This issue is by no means academic since many mental disorders have the effect of intermittently causing their victims to become disoriented while leaving them completely lucid otherwise. *See Developments—Civil Commitment, supra* note 165, at 1217 n.91.

therapies and even for civil commitment. Recently, however, the assumption that parents always effectively represent the best interests of their children when giving such consent has been called into question.[217] With regard to civil commitment, for example, a New York federal court held that:

> There may be a fundamental conflict of interest between a parent who is ready to avoid the responsibility for caring for an abnormal child, and the best interests of the child. . . . A "voluntary admission" on the petition of the parents may quite properly be treated in the same category as an "involuntary admission," in the absence of evidence the child's interests have been fully considered.[218]

One commentator has observed that factors motivating parents to seek institutionalization of their children include the interest of other children in the family, the mental and physical frustration of the parents, economic strain resulting from caring for the child at home, the stigma of retardation, hostility resulting from the burdens of caring for the child, and the parents' success-oriented expectations of the child.[219]

At least one federal court has extended the questionability of parental consent from the civil commitment process to the intrusive surgical procedure of sterilization. In *Relf v. Weinberger*,[220] plaintiffs challenged the statutory authorization and constitutionality of regulations of the Department of Health, Education, and Welfare governing sterilizations under the programs funded by the Department of Public Health Services. The *Relf* court found uncontroverted evidence in the record that minors and other incompetents had been sterilized in a family planning program which Congress had intended to function on a purely voluntary basis. In order to ensure that sterilizations under the program were voluntary in the full sense of the term, the court found it necessary to enjoin or revise substantial portions of the regu-

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217. *See generally* J. GOLDSTEIN, A. FREUD & A. SOLNIT, BEYOND THE BEST INTERESTS OF THE CHILD (1973); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840 (1974).

218. New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752, 762 (E.D.N.Y. 1973) (citations omitted); *accord*, Saville v. Treadway, Civ. No. 6969 (M.D. Tenn., Mar. 8, 1974) ("possible conflicts of interest between a mentally retarded child and even a parent" render apparently "voluntary" commitments of mentally retarded children under the Tennessee statute constitutionally inadequate); *see* Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968); Horacek v. Exon, 357 F. Supp. 71 (D. Neb. 1973) (preliminary relief); Frazier v. Levi, 440 S.W.2d 393 (Tex. Civ. App. 1969); *cf.* Strunk v. Strunk, 445 S.W.2d 145 (Ky. Ct. App. 1969). *See generally* Ellis, *supra* note 217, at 844-50; Herr, *Retarded Children and the Law: Enforcing the Constitutional Rights of the Mentally Retarded*, 23 SYRACUSE L. REV. 995 (1972); Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 NOTRE DAME LAW. 133, 139-43 (1972).

219. Murdock, *supra* note 217, at 139-43.

220. 372 F. Supp. 1196 (D.D.C. 1974).

lations which had allowed the "voluntary" participation of minors and other incompetents.

An analysis of the revisions suggests that an institution utilizing constitutionally intrusive behavioral procedures on children would be advised to seek consent directly from the child as well as the parent.[221] Review of proposed procedures by a committee which would not have the possible conflict of interest problems of a parent would help protect against biased decisions. Some procedures, like sterilization, however, may be so intrusive and irreversible that they call for a per se rule enjoing their use until such time as a child becomes an adult and is capable of giving a legally valid consent.

E. *Determining Intrusiveness*

Not every behavioral procedure is sufficiently intrusive to require either waiver by competent patients or a best interest determination for incompetent patients. Where such a determination is required, however, there exists a need for criteria determining intrusiveness and a consensus about a hierarchy of alternative behavioral procedures based upon their intrusiveness. Without criteria for intrusiveness, for example, it is difficult to determine whether, in any given situation, psychoanalysis is more or less intrusive than aversive conditioning by electric shock.

One commentator has suggested the following six criteria for intrusiveness:

> (i) the extent to which the effects of the therapy upon mentation are reversible; (ii) the extent to which the resulting psychic state is "foreign," "abnormal" or "unnatural" for the person in question, rather than simply a restoration of his prior psychic state (this is closely related to the "magnitude" or "intensity" of the change); (iii) the rapidity with which the effects occur; (iv) the scope of the change in the total "ecology" of the mind's functions; (v) the extent to which one can resist acting in ways impelled by the psychic effects of the therapy; and (vi) the duration of the change.[222]

Even guided by these criteria of intrusiveness, deciding which treatments are more restrictive is largely a matter of subjective opinion and theoretical disposition. But the idea that some techniques may be viewed as more onerous than others and that they may be categorized may contribute to making the search for the least restrictive alternative less difficult.[223]

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221. *Id.* at 1204-05.
222. Shapiro *supra* note 76, at 262.
223. Another commentator has formulated a "coerciveness continuum" for various therapeutic techniques, ranking coerciveness according to three criteria: (1) the nature,

It is beyond the scope of this discussion to improve upon the important initial efforts made by these commentators. Ultimately, in order to make judgments about the client's right to refuse and determinations of best interest, the exponents of applied behavior analysis and other concerned individuals must systematically establish the range of specific behaviors which are presently sought to be promoted or extinguished. Then, for each specific behavior, they must list all the various techniques which are thought to promote or extinguish that behavior and must indicate for each procedure: (1) both its short and long-term effectiveness; (2) its intrusiveness upon the personal autonomy of the patient; (3) the harms and the probability of such harms resulting from its use; (4) how experimental, from a medical view, the use of the technique to promote or extinguish the specific behavior is; and (5) how the alternative procedures available to modify each specific behavior compare in terms of the above categories.

IV. PROCEDURAL LIMITATIONS ON IMPOSING TREATMENT—DUE PROCESS REVISITED

The primary focus of this Article has been the right to refuse treatment. Accordingly, primary emphasis has been placed on developing and analyzing the possible bases for the applied behavior analyst's duty to refrain from utilizing hazardous or intrusive behavioral procedures except under special circumstances. A discussion of applied behavior analysis in mental institutions and prisons would not be complete, however, without a brief discussion of procedural due process and the limitations which it may impose on the utilization of behavioral procedures.

Procedural due process requires that persons be given adequate notice, an opportunity to be heard, and other procedural protections where impending state action will deprive them of a significant property or liberty interest.[224] The fundamental question in each case is whether a deprivation without notice and an opportunity to be heard

extent, and duration of the primary and side effects of the technique; (2) the extent to which an "uncooperative" patient can avoid the effects of the technique; and (3) the extent of the physical intrusion. Note, *supra* note 10, at 619. This resulted in the following ranking of therapies from the least to the most intrusive: milieu therapy, psychotherapy, drug therapy, behavior modification, aversion therapy, electroconvulsive therapy, electronic stimulation of the brain, lobotomy, and stereotactic psychosurgery. *Id.* at 619-33. It might be questioned, however, whether behavior modification is amenable to such a ranking since it covers a small universe of different procedures, all of which have varying degrees of intrusiveness. Compare the proposed standards and procedures in Appendix I, *infra* at 95, which provide that different behavior modification techniques be ranked in three separate categories calling for different protective safeguards according to their differing degrees of intrusiveness.

224. *See, e.g.*, Wolff v. McDonnell, 418 U.S. 539 (1974); Fuentes v. Shevin, 407 U.S. 67 (1972); Goldberg v. Kelley, 397 U.S. 254 (1970).

violates traditional notions of fairness.[225] A determination that liberty or property interests protected by due process are being invaded, however, is only the beginning of the inquiry. The nature and extent of the procedural protections required will depend on the importance of the liberty or property interest involved and the nature of the proceedings.[226]

The due process rights of prisoners and mental patients have been the subject of acute controversy. In the past, courts have ordered hearings before patients were transferred to sections of a hospital with greater security and fewer privileges[227] or were returned to prison after receiving hospital treatment.[228] Courts also have accorded prisoners the right to a hearing before allowing changes in the conditions of confinement.[229]

Of particular interest in the behavior modification area is *Clonce v. Richardson*,[230] a recent right-to-refuse rehabilitation case resting on procedural due process grounds. The challenged program, Special Treatment and Rehabilitative Training [START], was developed at the Medical Center for Federal Prisoners at Springfield, Missouri, in September 1972. START was an involuntary program. Prisoners who were selected for placement in START were not notified that they were being considered for the program, nor were they granted an opportunity for a hearing at the time of their selection.

The stated purpose of START was to teach participants to adjust to the requirements demanded in a prison environment, rather than to make them better adapted to life in the community after release from prison. No prisoner was permitted to leave the START unit for the purpose of attending religious services, and Muslim petitioners were not provided with any opportunity to consult with or to seek guidance from a Muslim spiritual leader. START prisoners in the "orientation" phase, the lowest level of the program, were prohibited from possessing, reading, or otherwise using political and educational literature, religious materials, and political publications. They were denied the

225. *See, e.g.*, Duncan v. Louisiana, 391 U.S. 145 (1968); Gideon v. Wainwright, 372 U.S. 335 (1963); Palko v. Connecticut, 302 U.S. 319 (1937).

226. *See, e.g.*, Fuentes v. Shevin, 407 U.S. 67 (1972); Cafeteria & Restaurant Workers Local 473 v. McElroy, 367 U.S. 886 (1961); Hannah v. Larche, 363 U.S. 420 (1960).

227. Jones v. Robinson, 440 F.2d 249 (D.C. Cir. 1971).

228. Burchett v. Bower, 355 F. Supp. 1278 (D. Ariz. 1973).

229. Wolff v. McDonnell, 418 U.S. 539 (1974) (placement in punitive segregation); Schumate v. People, 373 F. Supp. 1166 (S.D.N.Y. 1974) (termination of work-release privileges); Cousins v. Oliver, 369 F. Supp. 553 (E.D. Va. 1974) (reclassification leading to reduced privileges); White v. Gillman, 360 F. Supp. 64 (S.D. Ia. 1973) (transfer to an institution of increased security); Park v. Thompson, 356 F. Supp. 783 (D. Hawaii 1973) (transfer to an out-of-state prison).

230. 379 F. Supp. 338 (W.D. Mo. 1974).

opportunity to view television and possess or utilize a radio. Their actions, including communications with others in the START program, were under continual surveillance for the purpose of determining the inmates' rate of progress.

The START program had several ingredients of a behavior modification system, including deprivation state, reinforcement arrangement, and a graded progression of criteria for reinforcement. The program operated as a form of a token economy designed to teach prisoners to live according to the rules of a penal institution by taking away all privileges and rights, and then offering to restore them in graduated steps as the prisoner "progressed."

On the merits, the court held that "a prisoner transferred into START or into a behavior modification program like START, which . . . involves a major change in the conditions of confinement is entitled, at a minimum, to the type of hearing required by the Supreme Court's opinion in Wolff v. McDonnell."[231] The *Wolff* Court had required prison officials to provide a hearing, written notice to a prisoner of his alleged violation, a written statement of findings of fact, and a right to call witnesses, all prior to the imposition of solitary confinement or the deprivation of good-time credits.[232]

Undoubtedly, *Clonce* foreshadows the application of procedural due process protections to prisoners and mental patients participating in other behavior modification programs. The limitations of the case's impact, however, should be noted. The START program involved extensive deprivations for lengthy periods and major changes in the conditions of confinement. Thus, it is unclear to what extent the requirements of *Wolff* would apply to most behavior modification programs. Further case law development will be necessary to define the scope of

231. *Id.* at 348.

232. The *Clonce* court declined to answer, on grounds of mootness, the questions whether a prisoner selected to participate in START had a right to freely withdraw without penalty and whether the START program, as designed and applied, violated protected constitutional rights such as freedom of religion, freedom of speech and association, the right to be free from unwarranted search and seizure, the right of privacy, and the prohibition against cruel and unusual punishment. The court's opinion, however, implicitly recognizes the nonfrivolity of these constitutional claims. Serious constitutional issues were clearly raised since

> [f]orced participation in S.T.A.R.T. was obviously designed to accomplish a modification of the participant's behavior and his general motivation. He was forced to submit to procedures designed to change his mental attitudes, reactions and processes. A prisoner may not have a constitutional right to prevent such experimentation but procedures specifically designed and implemented to change a man's mind and therefore his behavior in a manner substantially different from the conditions to which a prisoner is subjected in segregation reflects a major change in the conditions of confinement.

379 F. Supp. at 350. In context, the meaning of this somewhat ambiguous statement appears to be that the court did not have to reach the issue whether other constitutional rights were denied by the START program in order to hold that due process is violated if prisoners are transferred without a notice and hearing.

procedural protections required for various behavior modification programs. In this regard, a major concern of the standards proposed in this Article is the assurance of adequate procedural safeguards for mental patients prior to the imposition of behavioral treatments.

CONCLUSION

It is difficult at present to give precise advice to applied behavior analysts or other therapists as to the legal limitations on the use of behavioral or other procedures. The greater volume of legal precedent suggests an overly deferential respect by courts for the discretionary judgments of administrators and staff of mental institutions and prisons.[233] Nevertheless, one senses that newer and stricter notions of accountability are gaining acceptance. Cases such as *Kaimowitz, Knecht, Mackey,* and *Wyatt* suggest a new and more activist judicial scrutiny of enforced therapy. Consequently, although it may not be stated with certainty that the following proposed standards and procedures are constitutionally required at this time, it is fair to say that an applied behavior analyst or other therapist who complies with these standards will minimize the risk of costly and vexacious litigation. The following proposed standards and procedures should be acceptable because they comport with recommended standards for professional practice found in the literature and because similar approaches have not been deemed unduly cumbersome or restrictive by representative behavior analysts the author has had the opportunity to consult. But, whether such standards could be practically implemented is an issue which requires further debate and discussion.[234]

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233. *See* discussion note 3 *supra.*

234. This is, of course, precisely the subject for full discussion and debate at the conference for which this Article has been prepared.

These proposed standards draw upon and attempt to integrate several existing models. In large part, they grow out of the author's experience as a member of a Joint Task Force on Behavioral Procedures which was assembled by the Florida Division of Retardation and the Department of Psychology of Florida State University on June 17, 1974, after some incidents of alleged abuse involving behavioral programs in Florida's institutions. Much of the credit for Task Force recommendations concerning legal rights of the clients/residents in Florida's institutions belongs to Professor David Wexler, College of Law, University of Arizona, who was also a member of the Task Force. The final report of the Task Force, entitled Florida Guidelines for the Use of Behavioral Procedures in State Programs for the Retarded, is to be published shortly in monograph form by the National Association for Retarded Citizens. Another important model which was considered and often closely followed in developing these proposed standards was the proposed California standards. *See* Shapiro, *supra* note 76, at 339-46 (analyzing the California standards). *See also* Wyatt v. Aderholt, 368 F. Supp. 1383 (M.D. Ala. 1974) (standards regulating voluntary sterilization); Wyatt v. Aderholt, Civ. No. 3195-N (M.D. Ala., Interim Order issued Feb. 25, 1975) (standards regulating the administration of psychosurgery, aversive conditioning, and electroconvulsive therapy); G. Davison & R. Stuart, *supra* note 12; M. Wolf, D. Fixsen, & E. Phillips, Some Suggestions for Accountability Procedures for Behavior Modification Treatment Programs, June 3, 1974 (unpublished paper presented at NIMH Behavior Modification Seminar), on file in the *Arizona Law Review* office.

APPENDIX I

Proposed Standards and Procedures to Govern Applied Behavior Analysis in Mental Institutions[235]

I. *Declaration of Policy*

It is hereby recognized and declared that all persons involuntarily confined to mental institutions have a fundamental right to refuse behavioral procedures which intrude upon their first, eighth, and fourteenth amendment rights under the United States Constitution. This fundamental right requires that any person who has the capacity to give informed consent and who refuses certain behavioral procedures may not be compelled to undergo such procedures. In order to justify the use of these behavioral procedures upon a person who lacks the capacity for informed consent, the state must establish that such procedures would be in the best interest of the person and that all less onerous alternatives to the proposed procedure have been exhausted or would be ineffective. No behavioral procedure shall be applied without the prior approval of a Peer Review Committee and a Human Rights Committee.

II. *Peer Review Committee*

A. There shall be established a state-wide Peer Review Committee [PRC] which shall consist of three members, two of whom have demonstrated competence in applied behavior analysis, but with different theoretical orientations, and one of whom is a physician. The PRC shall be appointed by the governor, subject to approval by the state chapters of the National Association for Retarded Citizens [NARC] and the National Association for Mental Health [NAMH]. Members of this Committee shall serve 2-year staggered terms and shall be compensated at an appropriate level.

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235. Standards for the use of applied behavior analysis in prison are not set forth. The operation of behavioral programs in prisons creates even more difficult problems than the operation of such programs in mental institutions. Of concern is the likelihood of considerable abuse of behavioral programs by prison guards, *see, e.g.*, Clonce v. Richardson, 379 F. Supp. 338 (W.D. Mo. 1974); Hilts, *supra* note 19; Opton, *supra* note 32, and the possibility that prison officials may alter the goal of behavioral programs to one of shaping a prisoner's behavior to the institution's needs, rather than to one of enabling the prisoner to adapt his behavior to society. Such an alteration in behavioral objectives may actually have an antirehabilitative effect. *Id.*

One possible approach to avoiding such abuses would be to require that all hazardous and intrusive behavioral programs be operated outside the prison setting by independent professionals on a subcontract basis. A primary objective of such programs must remain that of enabling an inmate to better function upon return to society, rather than to conform to the "unreal" environment of the prison. A second alternative would be to prohibit hazardous and intrusive, or perhaps all, behavioral programs in prisons on the grounds that the real purposes of criminal confinement are deterrence and retribution and that behavioral programs in the context of criminal confinement have simply not proved effective. A final alternative would be to allow behavioral programs within prisons to be run under much the same safeguards proposed for mental institutions. The approach to regulating behavioral programs in prisons is a matter of utmost complexity and importance and will hopefully receive appropriate attention at the conference for which this Article has been written.

B. New behavioral programs or particular behavioral procedures which are specially designed for an individual or group of individuals and which are proposed for introduction in any facility shall first be submitted to the PRC for its approval. The PRC also shall review particular behavioral procedures upon request from the Human Rights Committee. Approval by the PRC shall be based on a finding that the procedure is effective for strengthening or weakening specified behaviors and that the design of the procedure is professionally sound. The PRC shall set forth all possible harms associated with the proposed procedure and the likelihood of occurrence of each harm. It also shall indicate whether there is a risk of unknown harms and the likelihood of their occurrence. The PRC also shall indicate whether there are less hazardous or intrusive procedures which would be effective to accomplish the stated behavioral objective. The PRC may disapprove the proposed procedure, approve it, or approve it with specified modifications, limitations, or restrictions.

C. The PRC shall keep a written record of the factors enumerated in paragraph (B) above and the reasons supporting these decisions.

III. *Human Rights Committee*

A. There shall be established a Human Rights Committee [HRC] for various regions in the state. Each HRC shall consist of five members unaffiliated with the Division of Mental Health or Mental Retardation, among whom shall be: an applied behavior analyst; a lawyer, preferably with experience in representing the mentally handicapped and versed in civil liberties; a representative of the consumers of behavioral services; and concerned members of the community. Members shall serve for 3-year staggered terms and shall be compensated at an appropriate level. Appointment to the HRC shall be by the governor, with the approval of the local chapters of the NARC and the NAMH. The HRC shall meet as necessary, but no less than once monthly.

B. The HRC shall receive and investigate complaints regarding behavioral programs lodged by clients, parents, staff, public officials, members of the press, or the public. The HRC also shall make periodic visits to the state's mental institutions and inspect their facilities and behavioral programs.

C. The HRC shall have responsibility for categorizing target behaviors and the procedures used to strengthen or weaken such behaviors according to the following scheme:

(1) Procedures not sufficiently hazardous or intrusive to raise constitutional issues and used to modify behaviors which are clearly for the benefit of the clients/residents and not primarily for the benefit or convenience of the institution.[236] Once initially approved by the HRC and the PRC, these

236. Examples would be the use of positive reinforcement involving reinforcers other than "basic" reinforcers such as regular meals or regular bedding to strengthen sensory awareness, self-help or mobility; or use of extinction to weaken self-mutilating or self-stimulating behaviors.

combinations of behaviors and the procedures used to strengthen or weaken them shall be regarded as reasonable and conventional and may be employed in accordance with proper professional standards, without further notification to or approval by the HRC.

(2) Procedures to strengthen or weaken behaviors specified under subparagraph (C)(1) above, which are somewhat more hazardous or intrusive but not sufficiently hazardous or intrusive to require full review under paragraph (D) below.[237] Subject to initial approval by the HRC, programs utilizing the procedures in this category shall be regarded as sometimes necessary and as relatively reasonable and conventional and may be employed to strengthen or weaken the target behaviors listed pursuant to subparagraph (C)(1) above when performed in accordance with proper professional standards without prior approval by the HRC, so long as both the PRC and the HRC are notified of the use of such procedures within a reasonable time, not to exceed 7 days after such use. The HRC shall monitor such procedures on a sampling basis.

D. The strengthening or weakening of any behaviors not listed pursuant to subparagraph (C)(1) above and the use of any procedures not specified under subparagraphs (C)(1) or (C)(2) above may be performed only after the HRC finds that the conditions set forth in subparagraphs (1)-(4) or (5) of this paragraph have been met and the PRC approves such performance.[238]

(1) That the client/resident has the capacity to consent to the particular procedure and has given a valid informed consent[239] or waiver in writing to the proposed procedure, and if the client/resident is a minor, that the parent or guardian of the client/resident also has given valid informed consent or waiver in writing. Informed consent requires a decision that is: (a) based upon an understanding of the nature and consequences of the procedure; (b) wholly voluntary and free from any coercion, overt or covert;[240] and, (c) given by a person competent to make such a decision.

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237. Examples would be brief timeout to weaken temper tantrums or educational fines for aggression toward fellow clients/residents.

238. Examples of procedures to strengthen or weaken behaviors which would be covered under this section would be aversive conditioning with electric shock to extinguish head banging in an autistic child and making a severely retarded nonverbal child's meals conditional upon learning language.

239. From the legal point of view, informed consent is required only for those procedures which intrude upon legally protected rights. From a policy point of view, however, the practice of disclosing relevant information about any procedure to a client/resident and securing the client's voluntary cooperation has a sound basis in both ethics and successful practice. *See*, M. Wolf, S. Fixsen & E. Phillips, *supra* note 234. Thus, administrators of behavioral programs would be wise to comply with this section for all behavioral programs.

240. One of the most difficult issues concerning voluntariness of consent is whether participation in a behavioral program by a mental patient or prisoner does not deserve to be a factor in decisions concerning the release or parole of such persons. In order to safeguard voluntariness, it is the position of these proposed standards that release or parole can never be made contingent upon participation in a behavioral program per se. This is not to say, of course, that if participation in a program alters the condition of a mental patient or prisoner so that, for example, a mental patient is no longer mentally ill or dangerous, the patient or prisoner should not be entitled to release on the basis

(2) For purposes of requirement (D)(1)(a), the applied behavior analyst shall communicate directly with the client/resident and clearly and explicitly provide all the following information:

(a) The nature and seriousness of the client's behavioral problem and the proposed specific objectives for the client;

(b) The nature of the proposed procedure to accomplish these objectives, its probable duration, and intensity;

(c) The likelihood of improvement or deterioration, temporary or permanent, without the administration of the proposed procedure;

(d) The likelihood and degree of improvement, remission, or control resulting from the administration of such procedure; the likelihood, nature, and extent of changes in and intrusions upon the person's personality and patterns of behavior and thought resulting from such procedure; and the degree to which these changes may be irreversible;

(e) The likelihood, nature, extent, and duration of side effects of the proposed procedure and how and to what extent they may be controlled, if at all;

(f) The uncertainty of the benefits and hazards of the proposed procedure;

(g) The reasonable alternative therapies or procedures available and an explanation why the specific procedure recommended has been chosen. These alternatives shall be described and explained to the client/resident in the same manner as the recommended procedure;

(h) Whether the proposed procedure is generally regarded as established procedure by applied behavior analysts or is considered experimental;

(i) A description of the procedure for termination of the treatment program prior to completion and clear notification whether consent or waiver may be withdrawn at anytime;

(j) The data gathering procedures which will be used to evaluate the program.

(3) For purposes of requirement(D)(1)(b), the client/resident must be informed orally and in writing that no benefits or penalties will be made contingent upon participation in the proposed program or agreement to undergo the proposed procedure. Specifically, there must be an explicit understanding by the client/resident that his consent is not a precondition for release from the institution, and his decision should not be made to obtain ap-

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of the actual change. The most difficult problems in this area arise with respect to prisoners, in that parole boards typically make decisions for parole based upon mere participation in behavioral and other programs rather than measurable change, thus putting undue pressure on prisoners who wish to assert their legal rights to refrain from participation in such programs. This practice is presently being challenged in Taylor v. Manson, C.A. No. H 75/37 (D. Conn., filed January 29, 1975), which attacks a parole board on behalf of prisoners who allege that their chances for early release will be prejudiced because of their refusal to participate in a behavioral program involving hypnotism and aversive conditioning for recidivist child molesters at Somers State Prison in Connecticut.

proval or avoid reprisals from the staff. Any individual having knowledge of implicit or explicit coercion of any client/resident shall immediately bring such information to the attention of the facility's HRC. Failure to do so shall be punishable as provided by law.

(4) For purposes of requirement (D)(1)(c), a person confined shall be deemed incapable of giving informed consent if such person cannot understand and knowingly act upon the information specified under provisions (D)(2)(a)-(j) above or if for any other reason he cannot manifest his consent. A client confined to a mental institution shall not be considered incompetent solely because of his institutionalization.

To aid the HRC in assessing the client's competency, the director of the facility or his designated representative shall prepare a written report evaluating the resident's understanding of the proposed procedure and describing the steps taken to inform the resident of the nature and consequences of the procedure.

(5) If the client/resident has been determined to be legally incompetent by a court of competent jurisdiction, or if the director or his designated representative cannot certify without reservation that the client/resident understands the nature and consequences of the proposed procedure, the procedure may not be used unless the parents, in the case of a minor, or the guardian, in the case of an adult incompetent, of the client/resident have given informed consent and the HRC is persuaded that: the procedure complies with generally accepted professional standards; less intrusive alternatives either have been exhausted without success or would be clearly ineffective; the benefits of the procedure clearly outweigh the harms; and, the procedure would be in the best interest of the client/resident. If in rendering a decision under this paragraph the HRC finds that a less restrictive alternative is insufficient only because of the lack of staff or funds, it shall immediately notify the director, the governor, the attorney general, and the chairmen of the appropriate legislative committees, including health and appropriations.[241]

E. Prior to approving procedures under paragraph (D) above, the HRC shall review appropriate medical, social, and psychological information concerning the client/resident and shall interview the client/resident and others who in its judgment have information pertinent to its determination. The HRC shall maintain written records of its determinations and the reasons therefor, with supporting documentation. The HRC shall file a written report in the office of the state attorney general at least bimonthly indicating the number and nature of procedures approved and disapproved, the reasons for approval or disapproval, and other relevant information, including follow-up evaluations of the success of the procedures utilized. The identity of the client/resident involved shall not be disclosed in these reports. The reports shall be available to the public if they are released by a competent client/

241. Note that this paragraph takes no position on whether the HRC should rule for or against a more restrictive procedure when it finds that the only bar to less drastic measures is inadequate resources.

resident or by the parent or guardian and the legal representative of an incompetent client/resident.

F. Clients/residents shall be assisted and represented throughout all the processes detailed above by legal counsel or by a lay advocate recommended by the local chapter of a concerned consumer group such as the local chapters of NAMH or NARC. Such counsel shall assist competent clients/residents in deciding whether to undergo proposed procedures and shall ensure for minor and incompetent clients/residents that all considerations militating against the proposed procedure have been fully explored and resolved. No such counsel shall be an officer, employee, or agent of the treating facility or have any other conflict of interest which would impair adequate representation. If such counsel believes the HRC has made a biased or mistaken decision based upon all the evidence, he shall appeal the decision to a state court of competent jurisdiction,[242] and the procedure shall not be utilized until and unless the court has given its approval.

242. Presumably, there is already jurisdiction for such an appeal since imposition of intrusive behavioral procedures without compliance with these provisions raises issues of violation of constitutional rights. Specific legislation providing for appeal from HRC and PRC decisions to the courts, however, would facilitate this review.

APPENDIX II

Sample Application of Suggested Standards and Procedures to a Hypothetical Situation[243]

Facts

At about 2½ years of age, Bob began to show mild and intermittent head tapping. The behavior gradually increased in intensity, and he was diagnosed as autistic at age 4. By the age of 7, when aversive conditioning was first considered, his head banging had reached the point where constant restraint was required. He would, if left unrestrained, beat himself at a rate of 5,000 times an hour. He is capable of splitting his head with one well-placed knee blow or knocking himself unconscious on the floor. Indeed, in the recent past he has had several trips to the hospital emergency room.

In past years, various drugs and various standard behavioral procedures, including withdrawal of attention, time-out, and reinforcement of other non-injurious behaviors, have all been tried without success. Under these circumstances, the staff recommends a program of aversive conditioning for Bob. They propose using a standard hand-held Sears & Roebuck inductorium to administer an electric shock for .5 seconds to his leg or arm each time he hits himself. The individualized treatment plan for Bob calls for data to be kept on the frequency of his self-injurious behavior and provides for the reinforcement of learning and social skills at the same time the self-injurious behavior is to be extinguished by shock.

Peer Review Committee

The PRC is called together to consider this case. The first question the Committee asks is whether there is evidence in the professional literature that the procedure proposed would be effective to extinguish Bob's self-injurious behavior. The committee recognizes that no one knows what causes self-injurious behavior. Some claim that it arises out of a need for increased stimulation, and others argue that it results from a need for greater attention. But the members of the PRC agree that there are ample reports in the professional literature which show that the use of electric shock to treat self-injurious behavior can be very effective.[244] On the basis of this review of the literature and their own personal familiarity with the

243. This hypothetical is based upon an actual case at the Psychological Clinic of Rutgers University. *See* S. Harris, Statement in Response to a Complaint Received by the Attorney General's Office by Unknown Parties With Respect to the Use of Reward-Punishment Treatment (undated) (unpublished paper in the Psychological Clinic of Rutgers University), on file in the *Arizona Law Review* office. The author has received assurance that this hypothetical may be used with the subject's consent.

244. *See, e.g.*, Lang & Melamed, *Avoidance Conditioning Therapy of an Infant with Chronic Ruminative Vomiting*, 74 J. ABNORMAL PSYCHOLOGY 1 (1969); Lovaas & Simmons, *Manipulation of Self Destruction in Three Retarded Children*, 2 J. APPLIED BEHAVIOR ANALYSIS 143 (1969); Risley, *The Effects and Side Effects of Punishing the Autistic Behaviors of a Deviant Child*, 1 J. APPLIED BEHAVIOR ANALYSIS 21 (1968).

techniques, the members of the PRC agree that the proposed procedure is likely to be effective and may be considered therapeutic rather than experimental at this time. Upon reviewing the history of the child and the alternative procedures which have been tried and have proved ineffective, the PRC also decides that there are no less intrusive procedures which have not been exhausted or which would likely be effective.

The PRC next reviews the literature for indications of harms or side-effects associated with the proposed procedure. The primary harm associated with the procedure is determined to be the infliction of a localized and brief, but painful, shock to the arm or leg.[245] But on the basis of its review of the professional literature and after special review by its physician member, the PRC decides that electric shock administered to a physically healthy patient under controlled conditions is harmless and produces no after effects. On the benefit side, the PRC notes first the obvious value of a procedure which promises to be efficacious in eliminating self-injurious behavior. Moreover, the committee notes reports in the literature that self-injurious children who received aversive conditioning have become more social and appeared more at ease with themselves.

As its final task, the PRC turns to the research design proposed for the procedure. The committee approves the general research design and notes with satisfaction: (1) that a baseline of the self-destructive behavior prior to treatment had been determined so that an objective record of the client's behavior could be maintained during and after treatment to help determine when the aversive procedures should be discontinued; (2) that the contemplated level of shock will be no higher than necessary but high enough to discourage possible adaption by Bob; and, (3) that the design for the procedure properly will call for positively reinforcing Bob with affection and attention and other appetitive reinforcers contingent upon his not hitting himself, at the same time as his self-injurious behavior is to be suppressed with shock. The PRC, however, notes one flaw in the research design. The design does not allow for the fact that there is "situation specificity" associated with the use of punishment. That is, although the client is taught to suppress his behavior in the presence of one adult, it does not necessarily follow that the behavior will not occur with other adults or in other settings. The PRC, therefore, exercises its option to approve the proposed program upon the condition that the procedure be modified to allow administration of shock by more than one person in more than one environment to ensure that Bob will learn to extinguish his self-injurious behavior not only in specific situations but in his life generally. The PRC's written findings are then passed to the Human Rights Committee.

The Human Rights Committee

At its regular monthly meeting, the HRC considers Bob's case. The members of the HRC agree that aversive conditioning is in the category of

245. *See* Lovaas & Simmons, *supra* note 244, at 149; Risley, *supra* note 244, at 25.

procedures which require most careful scrutiny under section III, paragraph (D) of the operative standards. Its first task, therefore, is to determine whether Bob has the capacity to consent to aversive conditioning and, if so, whether he has given a valid informed consent or waiver to the proposed procedure. After hearing from the mental health professional in charge of Bob's treatment and speaking with Bob himself, the members of the committee agree that Bob, who is autistic and a minor, is not legally competent to make a decision one way or the other on the proposed aversive procedure. The HRC then proceeds to determine: whether Bob's parents have given informed consent to the proposed procedure and to review for itself, according to its mandate; whether the procedure complies with previously adopted professional standards; whether less intrusive alternatives have either been exhausted without success or would be clearly ineffective; whether the benefits of the procedure clearly outweigh the risks; and whether the procedure would be in Bob's best interest.

The committee determines that Bob's parents have been fully informed about the nature and seriousness of Bob's behavioral problem and the specific objectives of aversive conditioning; that they understand the nature of aversive conditioning and its probable duration and intensity in Bob's case; that they are aware of the likelihood and nature of side effects, of alternative procedures, and of the reasons the procedure recommended was thought to be the best procedure; that they understand that the procedure is generally regarded as sound by applied behavior analysts and is not considered experimental; that they understand the kind of data which will be kept about Bob's behavior and are satisfied with the controls which are contemplated for this data; and that they have been apprised that their initial consent will not be binding should they decide in the process of treatment that aversive conditioning is not in Bob's best interest. Since there is no evidence to rebut the presumption of the parents' competence, and since the parents had been informed orally and in writing that no benefits or penalties will be made contingent upon their consent to the procedure, the HRC concludes that informed consent has been properly secured from the parents.

The HRC then reviews the record developed by the PRC and agrees that the proposed procedure complies with generally accepted professional standards and that less intrusive alternatives have either been exhausted without success or would be clearly ineffective.

Considering the possible and probable benefits and harms from this procedure as they have been articulated by the PRC, the HRC next proceeds to its weighing function. While the members of the HRC are, like most of us, reluctant to inflict pain upon other persons, they recognize that the psychologist in charge of Bob's treatment might, like other highly respected members of our society such as surgeons and dentists, be required to inflict pain in an attempt to promote the health of his client. After some discussion, the HRC decides that use of electric shock in the manner prescribed would be ethical and humane. Although this procedure will be briefly

painful to Bob, the committee determines that the duration of this pain will be relatively short and that the pain is clearly justified since the remaining alternatives are either further life-threatening self-injury or a possible lifetime of chemical or physical restraint. After weighing all of the known possible harms or side effects, which, apart from the relatively short pain of the shock itself, appear to be minimal relative to the promise of long-term freedom and improvement for Bob, the HRC unanimously agrees that the benefits of the procedure clearly outweigh the harms and that the procedure will be in Bob's best interest.

The counsel appointed by the HRC to assist in the deliberations by ensuring that all considerations militating against the proposed procedure have been fully explored and resolved is satisfied and therefore declines to appeal the HRC decision to the local court. The secretary of the HRC prepares minutes of these proceedings with supporting documentation so that the decision can be incorporated in the next bi-monthly written report which, with Bob's identity concealed and with his parents' consent, will be made available for public inspection if released.

The standards and procedures for review of aversive conditioning having been complied with, Bob's individual conditioning program is begun shortly thereafter.