REFLECTIONS ON THE LEGAL REGULATION OF BEHAVIOR MODIFICATION IN INSTITUTIONAL SETTINGS

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These remarks are intended more to highlight certain themes in Paul Friedman's article "Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons"[1] than they are intended to critique its principal thesis. A full-blown critique would be out of the question, for Friedman and I have attended so many meetings together recently that our intellectual behavior has obviously been shaped by similar forces! Indeed, Friedman's proposed standards derive largely from those developed for state retardation programs by the Florida Task Force on Behavioral Procedures, a task force on which we both served.

I agree with Friedman's central thesis that, as a matter of policy and quite possibly of constitutional law, the state lacks a sufficient interest to justify thrusting an intrusive behavioral procedure upon an unwilling competent person, but that competent persons should be able to consent to the use of such procedures. I agree, too, that in appropriate instances, the state, upon certain findings made by a Human Rights Committee, may disregard the supposed desire of an incompetent client and may apply a behavioral technique believed to be in the client's best interest. Since the entire legal scheme of regulation seems dependent upon the notions of competence and informed consent, those concepts are worthy of highlighting.

Competence and Informed Consent

It is often said that informed consent is unobtainable in an institutional setting, largely, though by no means exclusively, because the lure of release from the institution is so overpowering that any con-

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1. 17 ARIZ. L. REV. 39 (1975).

sent given must be deemed to be coerced.[2] It is important to recognize, however, that neither law nor philosophy views every pressure to select a particular option as coercion. In law, for example, conditions of probation or parole must be voluntarily assumed in order to be enforceable, and pleas of guilty must be given voluntarily if they are to be upheld. Yet, the law upholds reasonable probation and parole conditions as voluntary, and similarly upholds plea bargains, even though the avoidance or reduction of incarceration is the supreme motivating force underlying those agreements. Thus, the law does not employ the concept of coercion to condemn pressure per se. Rather, coercion is employed as a normative concept to condemn pressures regarded as unfair or unreasonable.[3]

In light of this, it would be improper to hold that a resident's strong desire for release by itself impermissibly coerces the resident into agreeing to behavioral procedures. Otherwise, the logical result would be that all therapy on involuntarily-institutionalized persons would, despite their expressed desires to submit to therapy, be deemed coerced and, therefore, either prohibited altogether or referred for approval to a surrogate decisionmaker. The surrogate in this situation would surely be no better equipped than the resident to decide whether to agree to the procedure.[4]

Indeed, to deem all such therapy to be impermissibly coerced, and thereby to preclude or severely restrict its use, may well constitute improper interference with what Friedman[5] calls the freedom of mentation[6] and with what I would include under the constitutional right

2. *See* Kaimowitz v. Michigan Dep't of Mental Health, 42 U.S.L.W. 2063 (C.A. 73-19434-AW, Civ. Ct. Wayne County, Mich., July 10, 1973).

3. *See* Wexler, *Foreword: Mental Health Law and the Movement Toward Voluntary Treatment*, 62 CALIF. L. REV. 671, 679 (1974). Philosophers have more explicitly recognized the normative content of the coercion concept. *See* V. Haksar, Civil Disobedience Threats and Offers 49-64, 1974 (unpublished paper), on file in the *Arizona Law Review* office. *But cf.* Nozick, *Coercion*, in PHILOSOPHY, SCIENCE, AND METHOD: ESSAYS IN HONOR OF ERNEST NAGEL 440 (S. Morgenbesser, P. Suppes & M. White eds. 1969).

4. The surrogate may well be less equipped than the resident to determine whether there should be consent to the procedure. In the ordinary situation of substituted judgment, the client is incompetent to understand and assess alternatives, and the role of the surrogate is obvious: to substitute its competent and rational judgment for that of the incompetent and irrational client. When, however, the client is presumably competent but is confronted with the unpleasant choice of continued confinement if his mental condition remains unchanged or the possibility of release if he submits to an intrusive procedure which ameliorates his mental condition, his autonomy ought to be respected by permitting him to make the decision. The surrogate ought not be permitted to interfere with the client's choice and, in effect, perhaps mandate the continued confinement of the client. Of course, if a client is confronted not with the simple pressure that flows from his desire for release, but with unfair pressure, such as the prospect of punishment or the retaliatory withholding of privileges if consent is not given, a surrogate could take appropriate action to terminate the impermissible consequences. That, however, is not the present situation.

5. Friedman, *supra* note 1, at 58.

6. *Accord*, Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237, 255-56 (1974).

to privacy. Elsewhere, I have argued that the Supreme Court abortion cases,[7] which found the physician-patient decision regarding abortion to be constitutionally protected against noncompelling state interference, may well be extended to other physician-patient decisions, including consensual therapeutic procedures.[8] As with abortion, the courts could find state interference with such procedures unwarranted if interference or prohibition could lead to "the taxing of mental . . . health" and to a "distressful life and future."[9]

To comply with the various policies enumerated above, coercion ought to be defined, at least in part, in terms of unfair consequences rather than in terms of sheer pressure to avoid further incarceration. At least for openers, I would accept, as Friedman apparently does,[10] Dr. Goldiamond's interesting behavioral formulation of uncoerced consent.[11] Problems of informed consent and competence will have to be grappled with in the day-to-day administration of behavioral procedures. Two of the more troubling issues will be examined below.

1. *Minors.* Friedman's proposed standards specify that behavioral procedures may be employed on a competent minor if consent is obtained from the minor as well as from the parents.[12] If the minor is incompetent, the minor's consent is not required, but the approval of the parents and of the Human Rights Committee is a prerequisite to the utilization of specified procedures.[13] In both instances the consent of the parents is required, but, because the interests of the parent might be at odds with the best interests of the minor, in neither instance is their consent sufficient.

While I have no objection to such checks on parental abuse, I suspect the potential for conflict over the submission to behavioral procedures will differ considerably from the potential for conflict over institutionalization and sterilization, the two areas in which potential parent-child conflict has been recognized in litigation.[14] Parents may obviously attempt to use institutionalization to rid themselves of a troublesome child or may attempt to use sterilization to avoid the prospect of being burdened with supporting or caring for grandchildren.

7. Roe v. Wade, 410 U.S. 113 (1973); Doe v. Bolton, 410 U.S. 179 (1973).
8. Wexler, *supra* note 3, at 681-83.
9. Roe v. Wade, 410 U.S. 113, 153 (1973).
10. Friedman, *supra* note 1, at 86 n.214.
11. Goldiamond, *Toward a Constructional Approach to Social Problems: Ethical and Constitutional Issues Raised by Applied Behavior Analysis*, 2 BEHAVIORISM 1, 60 (1974).
12. Friedman, *supra* note 1, at 97.
13. *Id.* at 99.
14. Relf v. Weinberger, 372 F. Supp. 1196 (D.D.C. 1974) (sterilization); Saville v. Treadway, Civil No. 6969 (M.D. Tenn. Mar. 8, 1974) (institutionalization).

It is rather unlikely, however, that parents would volunteer their resident child for behavioral therapy unless they thought that the procedure would benefit the child.

Indeed, any possible conflict would probably flow in the other direction: parents truly bent on preventing their child's return to the family might be unwilling to consent to therapy that is in the child's best interest. Moreover, even truly concerned parents of retarded children often incorrectly view retardation as a rigid, inflexible condition and thus view their children as pitiful and hopeless. Accordingly, such parents are sometimes unwilling to subject their children to intrusive, but perhaps efficacious, behavioral procedures. To the extent that conflicts in this direction are genuine and operate to frustrate the right to treatment of minors, thought might be given to removing the requirement of parental consent as an absolute prerequisite to the use of behavioral procedures on minors.[15] Perhaps the approval of an independent Human Rights Committee should, under certain circumstances, be sufficient. At the least, the issue is probably deserving of debate and ventilation.

2. *Determinations of Competence.* Under Friedman's proposed standards, intrusive behavioral procedures may be employed if the Human Rights Committee finds, presumably without reservation, that the client is competent and agrees to the procedure,[16] or if the committee finds, among other things, that the client is clearly incompetent and that the procedure is in his best interest.[17] Unfortunately, many cases will not fall easily within either the "clearly competent" or "clearly incompetent" category. The Human Rights Committee's handling of these borderline cases therefore poses difficulties worthy of discussion.

If the client expresses a genuine desire to undergo the procedure, the problem for the committee will not be substantial. Approval should be given upon a finding that less restrictive procedures are unsuitable and that the proposed procedure is in the client's best interest. Under such circumstances, the issue of competency need not be definitively resolved, for whatever its resolution, the treatment is proper. If the client is competent his desire will be respected. If he is incom-

15. If certain behavioral procedures are shown to be so efficacious that they stand on a par with standard medical procedures, parental refusal to consent to the behavioral procedures could be viewed as abuse, neglect, or incompetence and could lead to total or partial termination of the legal parent-child relationship, with parental decisionmaking authority being transferred to another body. *Cf.* Zaremski, *Blood Transfusions and Elective Surgery: A Custodial Function of an Ohio Juvenile Court*, 23 CLEV. ST. L. REV. 231 (1974).

16. Friedman, *supra* note 1, at 97.

17. *Id.* at 99.

petent, the committee's finding that the procedure is suitable and in the client's best interest will be sufficient.

A more complicated situation is presented if the client expresses an unwillingness to submit to the procedure. Under Friedman's standards, if the client is unequivocally competent, his refusal is to be given conclusive weight. If the client is incompetent, and if certain other conditions are met, his refusal may be disregarded by the committee. But if the competency question cannot be clearly resolved, the unanswered question is whether the client's desire should be respected or overridden. Since respect for the client's autonomy requires a presumption of competence which, in this situation, has not been negated, his wishes should be complied with.

Friedman's standards, as augmented by the foregoing discussion, may be set forth diagramatically. The diagram below represents the various possibilities of client competence and client preference and indicates whether, under the various combinations of circumstances and findings, the Human Rights Committee should approve or disapprove the use of a proposed intrusive behavioral procedure.[18]

FIGURE 1

Client Preference	*Client Competence* Yes	No	Unsure
Unstated	1 Disapprove	2 Qualified Approval	3 Disapprove
No	4 Disapprove	5 Qualified Approval	6 Disapprove
Yes	7 Approve	8 Qualified Approval	9. Qualified Approval

Friedman suggests that, throughout the committee proceedings, the client be represented by counsel or a lay advocate.[19] Apparently, counsel will assist competent clients in reaching a decision whether or not to undergo a proposed procedure. For incompetent clients, counsel will ensure that factors militating against the proposed procedure are

18. The shaded boxes represent factual or legal rarities or impossibilities. The term Qualified Approval means approval so long as the Human Rights Committee finds that less drastic procedures are unsuitable and that the proposed procedure is, in an anticipated cost-benefit sense, in the best interest of the client. If the committee is unable to find those additional conditions satisfied, the Qualified Approval would convert to a Disapproval. The term Unstated under the Client Preference category principally includes instances where the client, presumably because of his mental condition, is unable to form or communicate a clear and specific preference.

19. Friedman, *supra* note 1, at 100.

fully developed. If counsel is dissatisfied with the committee's decision, he can seek judicial review.[20]

This scheme assumes that client competence has already been determined. Yet the competence or incompetence of the client is one of the crucial open issues with which the committee must grapple. Thus, counsel's role, at least in certain instances, may be more complicated and less clear-cut than Friedman's scheme suggests. The committee and counsel should begin by presuming the client's competence. If competence is presumed, counsel should strive to achieve the stated preference of his client, whether it be for or against undergoing the proposed behavioral procedure. That goal is best achieved by counsel advocating a finding of competence, for if the client is found competent, his preference will stand.

So far, counsel's role is clear. Further, if the committee in the first prong of a presumably bifurcated decisionmaking process finds the client incompetent, counsel's role will remain clear and consistent so long as the client's stated preference was and is against submission to the therapy. In such a situation, counsel, during the second prong of the process, will try to elicit information establishing that the proposed procedure is not in the best interest of the client[21] or that less intrusive alternatives are available.[22] But if the client is found incompetent and yet states a preference for the proposed procedure, it will be difficult and awkward for counsel suddenly to shift gears, to ignore—indeed, oppose—the stated preference of the client, and to begin eliciting factors militating against committee approval of the proposed procedure.[23] Moreover, if the committee rules in favor of the procedure, counsel may further ignore the client's stated preference and challenge the decision in court.[24]

Perhaps the tension and awkwardness of this situation could be

20. *Id.*

21. The client's antagonistic feeling toward the procedure, or perhaps his anxiety over it, may constitute a significant factor to be thrown into the hopper of considerations relevant to gauging whether, in a cost-benefit sense, the proposed procedure is in the best interest of the client. By the same token, the client's strong feelings in favor of the procedure may be relevant, though not determinative, in finding the procedure to be in his best interest. *Cf.* Wexler, *Therapeutic Justice*, 57 MINN. L. REV. 289, 326 (1972).

22. The lawyer's role also will be relatively straightforward and uncomplicated in instances where the client is unable to state any preference for or against the proposed procedure. In such cases, the client will almost certainly be declared incompetent, and in eliciting factors against the use of the proposed procedure, counsel will not be urging a position in conflict with the client's stated preference.

23. It is possible, of course, that during the process of arguing that a procedure is not in the client's best interest or that less restrictive procedures are effective, counsel will discover a less restrictive procedure to which the behavior therapist and client will agree. This may alleviate the tension and eradicate any mistrust that the client would develop toward counsel.

24. Of course, counsel may also challenge in court the committee's finding of incompetence, and that course of action would be consistent with the client's stated preference.

eliminated by specifying that counsel argue against committee approval only in those instances where the client lacks a stated preference[25] or where the client's stated preference is in opposition to the proposed technique.[26] In situations where the client favors the proposed technique,[27] counsel could advocate the competence of the client during the first phase of committee decisionmaking and, win or lose at that stage, could advocate the client's stated preference during the second phase of the decisionmaking process. Another lawyer, perhaps serving as amicus to the committee, could, during the second phase, perform the role of fully informing the committee by eliciting information suggesting the impropriety of the proposed procedure,[28] and could even participate in all first-prong proceedings by developing facts which cast doubt on the competence of the client.

Absolute and Contingent Rights

It has been recognized that it may be constitutionally impermissible, or at least constitutionally difficult, to utilize the acquisition of certain items, activities, and events as reinforcers in a behavioral procedure such as a token economy.[29] Certain personal requirements are so basic that they should seemingly be afforded to institutionalized individuals as a matter of right.[30] For example, these absolute rights might include food and a suitable place to sleep. On the other hand, other aspects of institutional life may not be constitutionally guaranteed. Thus, acquisition of the latter may be made contingent on proper behavior. To the extent that absolute rights are broadly defined, there is a conflict between them and the need for contingent rights which are essential to effective behavior modification.

Friedman contends that the conflict between absolute and contingent rights may not be as serious as is feared by some behavior modification practitioners.[31] He notes that competent patients may waive their rights, thus allowing such rights to be made available contingently.[32] He also notes that, with respect to incompetent patients, even constitutionally-guaranteed rights can be vicariously waived if the denial of those rights constitutes the least restrictive means of fur-

25. See Figure 1, *supra* at 136, boxes 1-3.
26. See *id.*, boxes 4-6.
27. See *id.*, boxes 7-9.
28. See *id.*, boxes 8-9.
29. *See* Wexler, *Token and Taboo: Behavior Modification, Token Economies, and the Law*, 61 CALIF. L. REV. 81, 92-97 (1973).
30. *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).
31. Friedman, *supra* note 1, at 75.
32. *Id.*

thering the patient's best interest.[33] Further elaboration of several of these points should indicate that while the conflict may be somewhat less than some behavioral practitioners fear, it may also be somewhat greater than Friedman assumes.

It is of course true that competent patients may waive their rights to basic items, activities, and benefits and submit to an intrusive behavioral procedure.[34] But it is also true that candidates for such behavioral procedures are often chronic patients who, while perhaps technically competent, are highly apathetic and dependent. Accordingly, they may be quite unwilling to waive the standard benefits of hospital life in order to embark upon an arduous program of self-improvement. Further, even if patients give initial consent, an emerging rule requires that clients be permitted to withdraw consent and terminate procedures at will.[35] While this free revocability principle may make sense in general, more discussion is in order concerning its applicability to behavioral procedures.

Of particular concern is the situation in which a competent client desires to attain certain target behavior but realizes that he lacks motivation for social learning. Accordingly, that client may agree to waive basic rights by entering a token economy where the items and events he has waived will be available only if earned through performance of target behaviors. A patient may waive a right to food or to a bed, but when that patient becomes hungry or tired and lacks the tokens to purchase a meal or a bed, revocation of the waiver would be, at that moment, the easiest way out of an uncomfortable situation. If the client may terminate consent and retrieve his right to these items or events at any time, the motivational force of the token economy might be sapped.[36] Thus, it may soon be necessary to discuss whether there should be certain situations in which a competent client may waive even the right of revocation. Of course, if a limited exception to revocability is contemplated, it also must be asked whether the exception could withstand the prospect of expansion by administrative abuse. In any event, under the free revocability rule, the waiver-of-rights approach to solving the absolute versus contingent right controversy will, for the above reasons, probably be unworkable in practice.

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33. *Id.*

34. *See, e.g.*, Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973); Wyatt v. Aderholt, 368 F. Supp. 1383 (M.D. Ala. 1974); Henry v. Ciccone, 315 F. Supp. 889 (W.D. Mo. 1970), *appeal dismissed*, 440 F.2d 1052 (8th Cir. 1971).

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

36. *See* Wexler, *supra* note 29, at 108 n.151; Wexler, *Of Rights and Reinforcers*, 11 SAN DIEGO L. REV. 957, 970-71 (1974).

Beyond infringement by waiver, it might be permissible with respect to nonconsenting competent patients to infringe constitutionally-guaranteed rights in order to satisfy a compelling state interest.[37] But the various basics guaranteed as constitutional rights in *Wyatt v. Stickney*,[38] unlike other constitutional rights, were cast by the court in terms of *minimum* constitutional standards. As such, they may fall without the ordinary ambit of constitutional balancing. Also, even if the *Wyatt* rights are viewed as ordinary constitutional rights susceptible to negation by balancing, legislative action may secure those basics as absolute guarantees. In that event, they will be given legislative status that exceeds their constitutional status, and it will be impermissible to convert them for therapeutic purposes into mere contingent reinforcers. Finally, even if protective legislation is not enacted and even if the *Wyatt*-type rights are regarded as ordinary constitutional rights, they, as with other constitutional rights, may be denied only if less restrictive means of attaining the state's compelling interest do not exist. But there is at the moment no clear indication that procedures involving massive deprivation of basic rights achieve therapeutic outcomes superior to alternative systems which do not approach that level of deprivation.[39]

With respect to incompetent patients, problems are raised which are similar to those raised regarding nonconsenting competent patients. While incompetent patients may not waive rights, their rights may be vicariously waived, according to Friedman, if waiver would be in the patient's best interest and would be the least intrusive means to a therapeutic end.[40] Presumably, an incompetent patient's rights are also potentially subject to balancing. The minimal nature of basic rights, however, would make it difficult to contend that their denial is in the patient's best interest. Additionally, as with nonconsenting competent patients, the judicial characterization of these basics as minimal guarantees may remove those rights from the constitutional balancing process. Legislative action may also protect the basic rights of incompetents. Finally, even if basic rights may be balanced and are not legislatively protected, there is no clear indication that procedures denying basic rights are superior to systems not involving such deprivations.

The Problem of Prisoners

In his discussion of the use of intrusive behavioral procedures on

37. Friedman, *supra* note 1, at 68-69, 71-72.
38. 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). For discussion of *Wyatt*, see Friedman, *supra* note 1, at 56-57, 74-75.
39. *See* Wexler, *supra* note 29, at 104-09.
40. Friedman, *supra* note 1, at 99.

prisoners, Friedman suggests several possible avenues: permit the use of such procedures to the same extent as with mental patients, ban their use altogether, or permit their use if performed by independent professionals outside the prison setting.[41] A troubling prior question, however, is whether, when dealing with convicted criminals, the state has a compelling interest in reformation that is sufficient to thrust intrusive behavioral procedures on prisoners even over their competent objections.

The constitutional question is more difficult in the context of convicted criminals than it is with respect to mental patients. It has been contended that there exist compelling interests permitting imposition of intrusive procedures on prisoners but not on mere mental patients.[42] While most modern commentators would not view competent prisoners as standing in a legal position any weaker than competent mental patients,[43] the constitutional issue remains unresolved. Yet, even if it is assumed that it would not be constitutionally offensive to force treatment on unwilling competent prisoners, there are legal as well as policy reasons which favor respecting the autonomy of prisoners by providing intrusive treatment only after securing informed consent.

This result would be persuasively required if needed, in depth legal and empirical research were to support the following assumptions:

(1) When dealing with experimental techniques—at least those involving possible pain, privation, or risk—rather than with techniques of demonstrated efficacy, the informed consent of competent subjects should surely be a necessary condition to the utilization of the technique, even if it is of potential, but undemonstrated, therapeutic value. That is to say, there is no overriding state interest permitting forced experimentation with prisoners.

(2) In practice, the line between experimentation and therapy, particularly with respect to behavioral procedures and perhaps with all other therapeutic techniques, is extremely difficult to draw.

(3) To date, there is no known therapeutic technique which is demonstrably efficacious in rehabilitating prisoners,[44] especially when prisoners object to the reformative effort or technique.[45]

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41. *Id.* at 95 n.235.

42. R. SCHWITZGEBEL, DEVELOPMENT AND LEGAL REGULATION OF COERCIVE BEHAVIOR MODIFICATION TECHNIQUES WITH OFFENDERS 66 (1971).

43. *See* Morris, *The Future of Imprisonment: Toward a Punitive Philosophy*, 72 MICH. L. REV. 1161 (1974).

44. *See* CITIZENS' INQUIRY ON PAROLE AND CRIMINAL JUSTICE, INC., SUMMARY REPORT ON NEW YORK PAROLE 36 (Mar. 1974).

45. *See* Bandura, *Behavior Theory and The Models of Man*, 29 AM. PSYCHOLOGIST 859, 860-61 (1974).

If these assumptions are correct, then even if there were a constitutionally-recognized compelling state interest in the forced treatment of prisoners, the current absence of demonstrably efficacious procedures could lead to a successful substantive due process challenge to the proposed forcible administration of merely experimental procedures on the ground that the use of such techniques is not closely enough connected to the state's reformative goal.

Even if the suggested substantive due process right of competent prisoners to resist intrusive therapies simply reflects the momentary absence of effective rehabilitative techniques, it is not at all clear that anticipated scientific advances in therapeutic efficacy will necessarily undercut the right to resist. Scientific advances regarding therapeutic efficacy will come about only through experimentation, and the sort of prisoner experimentation that we are concerned with may, under the first assumption above, be performed only on volunteers. Further, under the third assumption, a subject's voluntary desire to change may be highly instrumental in the success of behavior modification efforts.[46] Consequently, future scientific claims of therapeutic efficacy, based upon experiments performed on prison volunteers, will be limited in their demonstrated efficacy to consenting prisoners, and would therefore remain experimental—and accordingly beyond the pale of coercive administration—with respect to nonconsenting prisoners.[47]

46. *See id.* Of course, the success of neurologically and biochemically based therapies such as psychosurgery and chemotherapy might depend less, or not at all, on the voluntary cooperation of the subjects. With behavioral procedures, however, the motivational element has been asserted as crucial. Without a thorough review of the psychological literature, it is difficult to determine whether claims that voluntary cooperation is part and parcel of successful behavior modification are scientifically grounded or whether they are made to blunt assertions that applied behavior analysts have at their disposal powerful techniques capable of altering the behavior of even unwilling subjects. Further, it may be that the therapeutic necessity of voluntary cooperation has never been a major focal point of scientific scrutiny by behavioral researchers. If the latter is the case, the law may have to rely on the conclusory assertion that voluntariness plays a key role in behavior modification, since research on the significance of voluntary cooperation will presumably be precluded, at least in this country, if we deem it improper to experiment on nonvolunteers in order to compare the therapeutic outcome of that group with a group of volunteers. Any thought of plugging the scientific void by performing motivational research in nations with fewer restrictions on experimentation will of course run into its own ethical and scientific problems: whether it is ethical to seek a laboratory that is not bound by high ethical standards, a question which should not really be open to much discussion, and whether research results obtained in such a foreign setting may be comfortably generalized to a population of nonconsenting American prisoners.

47. The application of the arguments in this section to mental patients, while permissible, is considerably more complex. First, as to mental patients, whether competent or incompetent, there may exist demonstrably efficacious behavioral techniques. Thus, assuming the existence of an overriding state interest, a substantive due process argument could not be made in opposition to the forced application of those techniques. Of course, to the extent that other techniques are not demonstrably efficacious, due process stands as a barrier to their application. It is, however, conceivable that techniques whose efficacy is undemonstrated may be applied in the best interest of willing and unwilling incompetent patients. In this manner, the efficacy of those techniques may ultimately be demonstrated. Moreover, to the extent that the effectiveness of such tech-

If this array of assumptions proves accurate, coerced treatment of prisoners may be barred, for any system which seeks to implement a purported constitutionally-authorized state interest in the coercive reformation of prisoners is likely to encounter several crippling snags. The constitutional risk need not be run, however, and the practical impediments can be avoided, if policymakers, perhaps exceeding minimal constitutional requirements, adopt a firm right of prisoners to resist intrusive treatment.[48]

niques is generalizable from incompetent to competent patients, there would be no due process bar to the application of those techniques to nonconsenting competent patients.

The foregoing results present a certain irony. It is more likely that state interests sufficient to allow coerced treatment will be recognized for prisoners than for patients. See text accompanying notes 42-43 *supra*. Thus, as to prisoners but not as to mental patients, the legitimate end requirement of due process might be satisfied. Yet, as to prisoners but not as to mental patients, the means may be insufficiently related to the end to satisfy due process.

48. The argument in this section was formulated by the author and others during a recent meeting of the American Psychological Association Commission on Behavior Modification. While several persons contributed to the formulation of the argument, it is advanced here for the purpose of discussion as the personal and tentative view of the author, does not represent a position of the Commission, and is not necessarily embraced by any other member of the Commission.