Legal Implications of Behavior Modification Programs*

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Introduction

Although it has probably never been tried in psychiatric practice, the use of the phrase "behavior modification" in a word association test[1] would probably evoke a range of responses covering the entire gamut of emotions. Projecting further, it is likely that the use of the phrase "legal regulation and intervention" in such a test given to practitioners of behavior modification would elicit even more emotional and anxious replies.[1A] Significantly, the disparity of (and volatility of) reactions to the above phrases is so great that even the apparently-simple issue of defining "behavior modification" has resulted in major, analytical discussions.[2] Any consideration, then, of the legal implications raised by use of behavior modification programs must come to grips – at the outset – with the serious problem of *definability* of the terms in question.

Whatever "behavior modification" may or may not mean to the psychiatrist or psychologist, it has been used – in the context of a legal survey – to include programs running the gamut from psycho-surgery to biofeedback to shock-generating devices to token economies to encounter groups.[3] Although some of these are specifically excluded from a recent operative definition proposed by officials of the National Institute of Mental Health,[4] the fact remains that all of the procedures listed – along with countless others – have been so classified. Thus, when public attention is focused on egregious examples of "treatment" (occasionally nothing more than Orwellianly labeled punishment), specifically including certain noxious aversive therapies, e.g.,[5] it is insufficient for a practitioner of behavior modification to say "That's really not behavior mod – they're just calling it that." Regardless of whether or not the outraged practitioner is right, programs with far-reaching implications are being labeled behavior modification programs, a factor which itself makes judicial scrutiny all the more inevitable and necessary.[6]

Because of the wide scope of programs involved, serious questions are being raised as to the constitutionality of many procedures and "therapies," specifically those involving aversive techniques or negative reinforcement,[7] on both substantive and procedural levels. The responses to such questions, as alluded to above, range from, "This is a scientific question, not a legal one, so courts should stay out," to "All programs should be abolished." To say that neither extreme contributes to a reasoned debate might appear to belabor the obvious, but probably needs to be repeated.

Similarly, when Director of the Federal Bureau of Prisons Norman Carlson says (as he did at a recent convention of the American Academy of Psychiatry and the Law) that the START[8] prison program would not have received the adverse criticism it did had it been called an "experiment in control" rather than a "behavior modification" program,[8A] he bypasses the true issue – a title alone will neither insulate a program from judicial scrutiny nor focus unwarranted attention upon it.[9] Rather, the inquiry should be focused

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upon what substantive and procedural rights persons in insitutional behavior modification programs have, and what kinds of behavior or actions might violate those rights.

I. Substantive Rights

All persons – including those who participate in behavior modification programs voluntarily or involuntarily – have the constitutional right to be free from cruel and unusual punishment, a right often characterized as "freedom from harm."[10] Although traditionally this right has been found in the context of jail or prison cases,[11] it has been applied specifically to mental hospitals[12] and to facilities for the retarded,[13] on the theory that an even higher duty is owed to persons in non-penal or non-incarceratory settings.[14]

Among the rights owed (based on a composite Eighth Amendment/Fourteenth Amendment argument) are a "tolerable living environment,"[15] protection from physical harm,[16] correction of conditions which violate "basic standards of human decency,"[17] and the "necessary elements of basic hygiene."[18] Mental patients are owed a therapeutic, not a punitive, confinement, [19] and have the right to be secure in the privacy of their own bodies against invasion by the State except where necessary to support a compelling State interest.[20]

In protection of this right, courts will thus look at programs (*whatever* their titles) beyond their alleged guise to determine whether constitutional rights are being violated. For example, the Eighth Circuit Court of Appeals has held that the non-consensual subjection of patients to the use of apormorphine (a morphine-based drug which induces vomiting) as part of an "aversive conditioning program" violated the "cruel and unusual punishment" clause of the Eighth Amendment.[21] Similarly, it has been held that the non-consensual use of succinylcholine (a drug causing temporary paralysis and the inability to breathe), if proven, could raise "serious constitutional questions respecting cruel and unusual punishment or impermissible tinkering with mental processes."[22]

Finally, in an analogous setting, a Federal court has held that confinement of prisoners in segregation for sixteen months (in response to their refusal to participate in prison work) similarly constituted cruel and unusual punishment.[23] Cases such as these clearly establish broad outlines which can be seen as a harbinger of how courts in the future will decide similar complaints.[24]

In another context, it has been held that an involuntarily committed patient could not give truly informed and voluntary consent[25] to experimental psychosurgery which would violate that patient's right to freedom of thought or to control his own "mental processes."[26] This right was found to stem from the right to privacy,[27] a fundamental right previously found by the United States Supreme Court.[28] The implications of such a decision regarding any program designed to modify a person's behavior (especially when it is embarked upon against the person's will) are clear.[29]

Further, the Second Circuit Court of Appeals has held that, even where the medical treatment was non-experimental in a non-emergency situation, an involuntarily detained patient had the right to refuse treatment on religious grounds,[30] a decision that has been extended administratively in at least one instance, to imply a right to refuse medication on the part of any patient not found to be judicially incompetent.[31] Such a decision may potentially have a significant impact on the implementation of certain behavior modification programs.[32]

And, in a case arising in a different setting, it has been held that patients in state psychiatric hospitals and residents of state schools for the retarded who are involved in work programs are deemed to be "employees" within the coverage of the Federal Fair Labor Standards Act[33] *even if* the work which they do is therapeutic, so long as the hospital derives "any consequential economic benefits" from that work.[34] Interestingly, the class of patients in this case includes "all patient-workers in non-Federal institutions

. . . who meet the statutory definition of employee;"[35] thus, although the decision's impact on token economy programs – which clearly do result in such "consequential economic benefits" to the institution[36] – has not yet been marked, it has been predicted that "token economy systems will soon find themselves subject to both legal and behavioral extinction."[37]

Finally, under the doctrine of the "right to the least restrictive alternative," although the government's purpose may be both legitimate and substantial, that purpose cannot be pursued by means that broadly stifle personal liberties when the end can be more narrowly achieved.[38] In other words, in a mental health setting, the Constitution requires an affirmative demonstration that no suitable less restrictive alternative exists prior to involuntary hospitalization,[39] a doctrine which similarly applies when a patient is in a more restrictive setting than is therapeutically necessary.[40] Such an interpretation can similarly be applied to the use of "hazardous or intrusive behavioral procedures."[41]

This litany of constitutional rights should pose meaningful and provocative questions for practitioners of behavior modification. Of course, as Paul Friedman has pointed out, "any basic constitutional right is waivable."[42] However, as Reed Martin has noted:

> [T]he legal challenge is here – and it is going to be with us in the future. It is now very much a part of the life of anyone who cares enough to enter the helping professions to try and change the behavior of another person.[43]

The practitioner of behavior modification must be aware of the potentialities and the dimensions of that challenge, and must be willing to confront the questions raised by cases such as those described above.[44]

II. Procedural Rights

In addition to those substantive rights outlined at Point I, above, persons subjected involuntarily to programs involving behavior modification also have protected *procedural* constitutional rights which are similarly, in certain circumstances, potentially subject to judicial scrutiny. Thus, before a prisoner could be transferred into the START program of the Federal Bureau of Prisons (an involuntary, segregated program in which inmates' rights to practice religion, possess reading matter, express opinions, and, in general, exercise First and Fourteenth Amendment liberty and due process rights were drastically curtailed, resulting in a significant change in their conditions of confinement),[45] a Federal District Court held that such a transfer could not be accomplished without minimal procedural due process safeguards, including the right to a hearing at which the transfers could be opposed.[46] Such a hearing would include the right to notice and the right of the individual to present his case to and to confront and cross-examine witnesses before a neutral hearing body.[47] Although procedures must be flexible within the demands of a particular situation,[48] their extent will depend on whether the recipients' interest in avoiding a loss outweighs the government's interest in summary decision.[49]

In a case such as START, involving as it does severe losses of constitutionally protected freedoms and activities, the circumstances will call for stringent procedural due process scrutiny.[50] Thus, Harvard Professor of Law and Psychiatry Alan Stone lists "behavior modification utilizing aversive therapy" as one of several treatments he would not allow without a prior judicial hearing.[51]

In addition to those issues involving court hearings, there will also be a careful examination of whether a patient could adequately consent to certain kinds of treatment. The court that held that an involuntarily detained mental patient could not give "informed and adequate consent" to experimental psychosurgery, for instance, premised its decision – to a significant extent – on the existence of an "inherently coercive atmosphere" in the institution where the patient was involuntarily hospitalized.[52] If, as

has been suggested, "civilly committed patients are especially susceptible to a situational duress,"[53] then any consent situation will be scrutinized with "special care"[54] – although consent standards have been suggested by both courts[55] and commentators,[56] they have been by no means universally accepted.[57] Yet, as the gaining of consent is "the first step in any behavior change program,"[58] it is an issue which must be considered by virtually all practitioners of behavior modification in institutional settings.[58A]

III. Some Observations

Albert Bandura has noted:

> The use of aversive methods is apt to be criticized as being if not anti-therapeutic then certainly anti-humanistic. But is it not far more humanitarian to offer the client *a choice of undergoing a brief, painful experience* to eliminate self-injurious behavior, or of enduring over many years the noxious, and often irreversible, consequences that will inevitably result if his behavior remains unaltered?[59]

There are, however, several serious problems with this approach. First, it is premised on the supposition that the participant is "offer[ed] . . . a choice"[60] to participate. Clearly, this is often not so in institutional settings.[61] In addition, the techniques employed often go far beyond the "brief, painful experience"[62] referred to by Bandura into the realm of cruel punishments.[63] Finally, of course, the Bandura position implies that each person's behavior *should be* altered, suggesting that each participant's behavior *is* "noxious" and "self-injurious."[64] Given the well-known inabilities of psychiatrists to accurately predict dangerousness,[65] this conclusion need not follow.

Beyond this, it has been suggested in a Task Force Report of the American Psychiatric Association that the moral issues facing behavior therapy are "the same problems [which] must be faced by all therapeutic approaches."[66] The presence of aversive conditioning in and the inability either to refuse or to sham participation in behavior modification programs, however, are sufficiently significant distinguishing characteristics to indicate that a rethinking of the APA approach is necessary.[67]

Thus, although Davison and Stuart have argued that the "record of responsibility" of behavior therapists is "at least the *equal*" of that other professions,[68] whether or not this is true, it misses the point: the Constitution requires a higher standard of behavior than one derived from the intra-professional comparisons. The United States Supreme Court, for instance, in the recent case of *O'Connor v. Donaldson*,[69] finally and forever put to rest the issue of justiciability of treatment questions, where it noted:

> Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present.[70]

Beyond this holding, the decisions discussed at length in Points I and II, above, clearly reflect a requirement that any behavior modification program must meet specific and stringent constitutional safeguards, both procedurally and substantively, on a case-by-case basis.[71] Indeed, the recent NIMH survey of behavior modification programs underlines the need for "appropriate safeguards" when aversive methods are used,[72] and highlights the special problems involved in prison programs.[73] Clearly, any response smacking of self-satisfaction is inappropriate.[74]

Scrutiny, thus, is, and will remain, a fact of life – it must be acknowledged, accepted and dealt with, in spite of what has been characterized as the "dangers of semantic obfuscation."[75] As Mr. Justice Brandeis noted nearly 50 years ago in his famous dissent

in the case of *Olmstead v. United States:*[76]

> . . . Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficient. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest danger to liberty lurks in insidious encroachments by men of zeal, well-meaning, but without understanding.[77]

His words are still most apt in this setting.

References

1. For a historical analysis of the use of word association tests, see Murphy and Kovach: Historical Introduction to Modern Psychology 165-167 (3d ed. 1972) (discussing the seminal work of Galton and Wundt). See also, Bemporad and Pinsker: Schizophrenia: The Manifest Symptomatology, in Arieta and Brody, eds., 3 American Handbook of Psychiatry: Adult Clinical Psychiatry, 524, 527, 531 (2d ed. 1974).

1A For a discussion of reactions to anxiety-eliciting material in another situation, see, *e.g.*, Bondewyns and Levis: Autonomic Reactivity of High and Low Ego-Strength Subjects to Repeated Anxiety Eliciting Scenes. 84 J. Abnormal Psychol 682 (1975).

2. Paul Friedman, a leading mental health rights' advocate, has stated flatly that "the term, as used today, is so broad as to have lost much of its utility," and substitutes "applied behavior research" as more appropriate terminology. Friedman: Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons. 17 Ariz L Rev 39, 42-43, n. 5 (1975) [hereinafter "Legal Regulation"] Similarly, the Institute for Behavioral Research – an independent research and educational organization – has circulated to a wide range of mental health professionals a tentative 175-word definition of "behavior modification" as part of a glossary it is developing "so specialists in the field can communicate with policymakers, specialists in other fields, and people in general." Parsons and Parsons: A Glossary of Behavioral Terms in Behavior Modification, unpaginated cover page and 3 (tentative draft, June 1975)

3. See generally, Behavior Modification Technology, in United States Senate Committee on the Judiciary, Staff Subcommittee on Constitutional Rights, 93d Congress, 2d Session, Individual Rights and the Federal Role in Behavior Modification 11-17 (1974) [hereinafter Individual Rights].

4. Stolz, Wienckowski and Brown: Behavior Modification: A Perspective on Critical Issues. 30 Am Psychologist 1027, 1029 (1975) (hereinafter "Perspective")

5. See *e.g.*, *Knecht v. Gillman*, 488 *F.* 2d 1136 (8 Cir. 1973); *Mackey v. Procunier*, 477 *F.* 2d 877 (9 Cir. 1973), both discussed in further detail below, at pp. 176-177.

6. As to the scope of the public controversy and the proliferation of programs, see Legal Regulation, note 2, above, at 45-48. For a review of the "phenomenal" growth of behavior modification use as reported in the literature, see generally, Grundner and Krasner: Behavior Modification: An Empirical Analysis of the State of the Art, 3 (tentative draft, June 1975).

7. See *e.g.*, Wexler: Token and Taboo: Behavior Modification, Token Economies, and the Law. 61 Calif L Rev 81 (1973), and sources cited at *id.*, n. 4.

8. "START" is an acronym for Special Treatment and Rehabilitative Training. For a full discussion of the program, see Comptroller General: Behavior Modification Programs: The Bureau of Prisons' Alternative to Long Term Segregation (August 5, 1975) (hereinafter "Bureau's Alternative"); see also, Individual Rights, note 3, above, at 234-272.

8A Director of Prisons Sees End of Medical Model in Criminology. Psychiatric News, X, 24 (Dec. 17, 1975), at 3, 22.

9. See, *e.g.*, for a list and description of behavior related projects funded by the Law Enforcement Assistance Administration, Individual Rights, note 3, above, at 394-420. Compare to the substance of those programs, the observation by Stolz *et al.* that a behavior modification program should alter an individual's behavior in the direction that, *"ideally,* he himself (or his agent) has chosen." Perspective, note 4, above (emphasis added)
For the view that "[P]sychiatric therapy in prisons is often indistinguishable from punishment," see Opton: Psychiatric Violence Against Prisoners: When Therapy is Punishment. 45 Miss L J 605, 643 (1974).

10. See U.S. Constitution, Amendment VIII. For a general discussion of the rights discussed in text accompanying notes 10-20, below, see Perlin: Rights of the Mentally Handicapped. 98 N J L J 1057, 1067 (1975).

11. See, *e.g.*, *Holt v. Sarver*, 442 *F.* 2d 304 (8 Cir. 1971); *Rhem v. Malcolm*, 507 *F.*.2d 333 (2 Cir. 1974).

12. *Rozecki v. Gaughan*, 459 *F.* 2d 6 (1 Cir. 1972)
13. *New York State Association for Retarded Children v. Rockefeller*, 357 *F. Supp.* 752, 764 (E.D. N.Y. 1973), supplemented *New York State Association for Retarded Children v. Carey*, 393 *F. Supp.* 715, 719 (E.D. N.Y. 1975)
14. *Lollis v. New York State Department of Social Services*, 322 *F. Supp.* 473 (S.D. N.Y. 1970), modified 328 *F. Supp.* 1115, 1118 (S.D. N.Y. 1971)
15. *Welsch v. Likins*,373 *F.Supp.* 487, 502-503 (D. Minn. 1974).
16. *Rhem v. Malcolm*, 371 *F. Supp.* 594, 628, (S.D. N.Y. 1974), aff'd 507 *F.* 2d 333 (2 Cir. 1974)
17. *Brenneman v. Madigan*, 343 *F. Supp.* 128, 133 (N.D. Cal. 1972)
18. *New York State Association for Retarded Children v. Rockefeller*, 357 *F.Supp.* 752, 765 (E.D. N.Y. 1973) supplemented *New York State Association for Retarded Children v. Carey*, 393 *F. Supp.* 715, 719 (E.D. N.Y. 1975)
19. *Kesselbrenner v. Anonymous*, 33 *N.Y.* 2d 161, 350 *N.E.S.* 2d 161, 350 *N.Y.S.* 2d 889, 892 (Ct. App. 1973)
20. *Roe v. Wade*, 410 *U.S.* 113, 153-156 (1973)
21. *Knecht v. Gillman*, 488 *F.* 2d 1136, 1140 (8 Cir. 1973). For a relevant analysis of *Knecht* warning that it might lull courts into relying on the "false confidence" of the Eighth Amendment protections, see Legal Regulation, note 2, above, at 62-65.
22. *Mackey v. Procunier*, 477 *F.* 2d 877, 878 (9 Cir. 1973)
23. *Adams v. Carlson*, 368 *F. Supp.* 1050 (E.D. Ill. 1973). A cynic might term this case the ultimate use of "time-out." See, *e.g.*, Perspective, note 4, above, at 1032, and Martin: Legal Challenges to Behavior Modification 85-86 (1975) (hereinafter Legal Challenges). *Cf.* the daily schedule of the START program, reproduced at Bureau's Alternative, note 8, above, at 15.
24. Accord: *Legal Challenges*, note 23, above, at 126-127. For a general discussion of the cases in question, see Behavior Modification and the Courts: The Legal Background, in Individual Rights, note 3, above, at 7-10.
25. For a discussion of consent, see pp. 177-8 below.
26. *Kaimowitz v. Michigan Department of Mental Health*, Civil No. 73-19434-AW, 42 *U.S.L.W.* 2063 (Mich. Cir. Ct. 1973), slip op. at 35, 39. *Kaimowitz* has been discussed extensively in leading legal publications. See, *e.g.*, Note, Kaimowitz v. Department of Mental Health: A Right to be Free From Experimental Psychosurgery. 54 B U L Rev 301 (1974); Note, Medical Treatment and Human Experimentation: Introducing Illegality, Fraud, Duress and Incapacity to the Doctrine of Informed Consent. 6 Rutgers-Camden L J 538 (1975); see generally, Comment, Informed Consent and the Mental Patient: California Recognizes a Mental Patient's Right to Refuse Psychosurgery and Shock Treatment. 15 Santa Clara L 725 (1975). For a lay view of psychosurgery, see, *e.g.*, Kesey: One Flew Over the Cuckoo's Nest, 268-271 (Signet ed. 1962).
27. *Kaimowitz v. Michigan Department of Mental Health*, Civil No. 73-19434-AW, 42 *U.S.L.W.* 2063 (Mich. Cir. Ct. 1973), slip op. at 39
28. See, *e.g.*, *Griswold v. Connecticut*, 381 *U.S.* 479 (1962).
Interestingly, the decision in *Mackey v. Procunier*, 477 *F.* 2d 877, 878, n. 3 (9 Cir. 1973), discussed at text accompanying note 22, above, similarly cited decisions by the United States Supreme Court dealing with abortion (*Roe v. Wade*, 410 *U.S.* 113 (1973)), dissemination of contraceptives (*Eisenstadt v. Baird*, 405 *U.S.* 438 (1972)), and possession of pornographic literature in one's own home (*Stanley v. Georgia*, 394 *U.S.* 557 (1969)) for the similar proposition that the constitutional right to privacy extends to a person's control over his or her own body.
29. Although it has been suggested that the phrase behavior modification "specifically excludes psychosurgery," Perspective, note 4, above, at 1029, as Martin points out, "physicians [involved in behavior modification projects] have continued to receive research grants [for psychosurgery], and research in this area will continue in the future." Legal Challenges, note 23, above, at 42
For a comprehensive analysis of the entire "human exploration process," see generally, Katz: Experimentation With Human Beings (1972). For an overview of issues raised by psychosurgery, see Brown, Wienckowski and Bivens: Psychosurgery: Perspective on a Current Issue (1974 reprint).
30. *Winters v. Miller*, 446 *F.* 2d 65, 70 (2 Cir. 1971)
31. New Jersey Attorney General's Opinion #M73-1142 (1974). *Cf.* N J S A 30:4-24.2(d) (1) (1975).
32. In the lead case of *Wyatt v. Stickney*, 325 *F.Supp.* 781 (M.D. Ala. 1971), 334 *F. Supp.* 1341 (M.D. Ala. 1971), 344 *F. Supp.* 373 (M.D. Ala. 1972), 344 *F. Supp.* 387, 407 (M.D. Ala. 1972), aff'd *sub. nom. Wyatt v. Aderholt*, 503 *F.* 2d 1305 (5 Cir. 1974), the court adopted "Minimum Constitutional Standards For Adequate Habilitation of the Mentally Retarded" (developed from recommendations submitted by plaintiffs, defendants and *amicus curiae*) which included the following:

> No resident shall be subjected to a behavior modification program designed to eliminate a particular pattern of behavior without proper certification by a physician that he has examined the resident in regard to behavior to be extinguished and finds that such behavior is not caused by a phsysical condition which could be corrected by appropriate medical

procedures.

No resident shall be subjected to a behavior modification program which attempts to extinguish socially appropriate behavior or to develop new behavior patterns when such behavior modifications serve only institutional conveniences.

The *Wyatt* decision is discussed in this regard in Legal Regulation, note 2, above, at 56-57.

33. 29 *U.S.C.A.* 206 *et seq.*

34. *Souder v. Brennan*, 367 *F. Supp.* 808, 813 (D.D.C. 1973). Similarly, in *Wyatt v. Stickney*, 325 *F. Supp.* 781 (M.D. Ala. 1971), 334 *F. Supp.* 1341 (M.D. Ala 1971), 344 *F. Supp.* 373, 381 (M.D. Ala. 1972), 344 *F. Supp.* 387, 402 (M.D. Ala. 1972), aff'd *sub nom. Wyatt v. Aderholt*, 503 *F.* 2d 1305 (5 Cir. 1974), the court specified that patients in institutions for the mentally ill and residents in facilities for the mentally retarded could "voluntarily engage in therapeutic labor" if that work were an integrated part of the patient's treatment, adequately supervised, and compensated for in accordance with the Fair Labor Standards Act. See, for a general discussion, Perlin: The Right to Voluntary, Compensated, Therapeutic Work as Part of the Right to Treatment: A Theory in the Aftermath of *Souder*. 7 Seton Hall L Rev 298 (1976).

The question has also been forcefully raised that compulsory, non-compensated work programs might come within the Thirteenth Amendment's prohibition against "involuntary servitude." See, *e.g., Downs v. Department of Public Welfare*, 368 *F. Supp.* 454, 465 (E.D. Pa. 1973); see generally, Friedman: Thirteenth Amendment and Statutory Rights Concerning Work in Mental Institutions. 2 Legal Rights of the Mentally Handicapped 637, 647-649 (P.L.I. Ed. 1973).

Although certain sections of the Federal Minimum Wage Law (29 *U.S.C.A.* 203 (d), (s) (5), and (x) were declared unconstitutional as they apply to state patients in the United States Supreme Court's recent decision in the case of *National League of Cities v. Usery*, 44 U S L W 4974 (1976), that action did not specifically overrule *Souder*, nor did it attack the reasoning behind the *Souder* decision. In any event, *Souder*-type decisions might still be sustainable on a variety of grounds in addition to the Thirteenth Amendment, including, *inter alia*, state minimum wage laws, the right to treatment doctrine, and Section 504 of the Rehabilitation Act of 1973.

35. *Souder v. Brennan*, 367 *F. Supp.* 808, 813 (D.D.C. 1973)

36. For a survey of institutional settings in which token economy programs are employed, see Wexler, note 7, above, at nn. 16-17.

37. Wexler, note 7, above, at 92-97.

For the view, however, that "the apparent conflict . . . may not be as serious as feared," see Legal Regulation, note 2, above, at 75. For a response to *that* view, see Wexler: Reflections on the Legal Regulation of Behavior Modification in Institutional Settings. 17 Ariz L Rev 132, 138-139 (1975).

38. See, *e.g., Shelton v. Tucker*, 364 *U.S.* 479, 488 (1960).

39. See, *e.g., Lessard v. Schmidt*, 349 *F. Supp.* 1078, 1096 (E.D. Wis. 1972), vacated on other procedural grounds 414 *U.S.* 473 (1974), on remand 379 *F. Supp.* 1376, 1379 (E.D. Wis. 1974), vacated and remanded—*U.S.*—, 43 *U.S.L.W.* 3600 (1975); *Dixon v. Attorney General of Pennsylvania*, 325 *F. Supp.* 966, 974 (M.D. Pa. 1971); Chambers: Alternatives to Civil Commitment of the Mentally Ill: Practical Guide and Constitutional Imperatives. 70 Mich L Rev 1107, 1145 (1972).

40. See, *e.g., Singer v. State*, 63 *N.J.* 319, 323 (1973); *State v. Krol*, 68 *N.J.* 236, 257-258 (1975).

41. Legal Regulation, note 2, above, at 73.

It has similarly been suggested that "every therapeutic intervention should begin with the least intrusive procedure from which a positive outcome can reasonably be expected." Davison and Stuart: Behavior Therapy and Civil Liberties. 30 Am Psychologist 755, 759 (1975)

42. Legal Regulation, note 2, above, at 75. Any such waiver must be "[a] voluntary . . . knowing, intelligent act done with sufficient awareness of the relevant circumstances and likely consequences." *Brady v. United States*, 397 *U.S.* 742, 748 (1970).

The burden of proof in a waiver situation will be far more difficult to sustain, of course, in matters involving an institutionalized population than where the public at large is concerned. See generally, Note, 6 Rutgers-Camden L J, note 26, above.

43. Legal Challenges, note 23, above, at 10

44. In addition to those sources heretofore cited, see also, Bomstein: The Forcible Administration of Drugs to Prisoners and Mental Patients. 9 Clearinghouse Rev 379 (1975), and Gobert: Psychosurgery, Conditioning, and the Prisoner's Right to Refuse 'Rehabilitation,' 61 Va L Rev 155 (1975) (hereinafter Right to Refuse).

45. See note 8, above, and references cited therein.

46. *Clonce v. Richardson*, 379 *F. Supp.* 338, 348 (W.D. Mo. 1974). For a discussion of the implications of *Clonce*, see Right to Refuse, note 44, above, at 177.

47. See, *e.g., Goldberg v. Kelly*, 397 *U.S.* 254, 268-271 (1970); *Morrisey v. Brewer*, 408 *U.S.* 471, 488-489 (1972); *Gagnon v. Scarpelli*, 411 *U.S.* 788, 790-791 (1973).

48. *Morrisey v. Brewer*, 408 *U.S.* 471, 481 (1972)

49. *Goldberg v. Kelly*, 397 *U.S.* 254, 263 (1970)

50. See generally, *United States v. Carolene Products Co.*, 304 *U.S.* 144, 152, n. 4 (1938).
51. Stone: Mental Health and Law: A System in Transition 105 (1975). *Cf. N.J.S.A.* 30:4-24.2(d) (2) (1975).
52. *Kaimowitz v. Michigan Department of Mental Health*, Civil No. 73-19434-AW, 42 *U.S.L.W.* 2063 (Mich. Cir. Ct. 1973), slip op. at 31
53. Note, 6 Rutgers-Camden L J, note 26, above, at 553. Another commentator has pointed out that "the opportunities for coercion and constraint in mental hospitals are at least as great as those in prisons." Note, Kaimowitz v. Department of Mental Health: Involuntary Mental Patient Cannot Give Informed Consent to Experimental Psychosurgery. 4 N Y U Rev L & Soc Change 207, 215-216 (1974)
For an exhaustive analysis of the issues raised by *Kaimowitz*, and an examination of the doctrines traditionally employed to negate consent in a contractual setting (illegality, fraud, duress and incapacity), see Note, 6 Rutgers-Camden L J, note 26, above at 549-564.
54. Legal Regulation, note 2, above, at 83
55. *Knecht v. Gillman*, 488 *F.* 2d 1136 (8 Cir. 1973)
56. Legal Regulation, note 2, above, Appendix I, at 97-99
57. See also, Stone, note 51, above, at 97-106; Stern and Caftel: Legal Issues Involved in Using Women as Experimental Research Subjects, at 5 (Unpubl. mimeo 1975); Katz, note 29, above, at 523-725; Reubhausen and Brim: Privacy and Behavioral Research, 65 Col L Rev 1184 (1965).
58. Legal Challenges, note 23, above, at 25
58A See, *e.g.*, Cohn: Mental Patients Vague on Tests, Doctor Says, Washington Post, Dec. 13, 1975.
59. Bandura: Principles of Behavior Modification 87 (1969) (emphasis added).
60. *Ibid.*
61. See, *e.g.*, *Clonce v. Richardson*, 379 *F. Supp.* 338 (W.D. Mo. 1974).
For another approach similar to Bandura's, see Kazdin, *Behavior Modification in Applied Settings* 234 (1975) ("Applied work usually is conducted with individuals whose behaviors have been identified as problematic or ineffective in some way. The responses may include deficits or behavior which are not under socially accepted stimulus control").
62. Bandura, note 59, above
63. See, *e.g.*, *Knecht v. Gillman*, 488 *F.* 2d 1136, 1137 (8 Cir. 1973) (apomorphine could be given "for not getting up, for giving cigarettes against orders, for swearing, for talking, or for lying"). For a catalog of similar programs, see Schwitzgebel: Development and Legal Regulation of Coercive Behavior Modification Techniques With Offenders, 5-22 (1974 reprint).
64. Bandura, note 59, above. Gobert has noted that "[behavior] conditioning depend[s] upon the assumption of recidivism," an assumption which has "rarely been challenged." Right to Refuse, note 44, above, at 172
65. From the brief filed by the Division of Mental Health Advocacy (N.J.) as *amicus curiae* with the U.S. Supreme Court, Kremens v. Bartley, No. 75-1064, pending:
The evidence demonstrates that psychiatrists are no more significantly predictively accurate than non-psychiatrists (*e.g.*, lawyers). See Rappeport, Lassen, and Gruenwald: Evaluation and Follow-up of Hospital Patients who had Sanity Hearings, in Rappeport ed., Clinical Evaluation of the Dangerousness of the Mentally Ill 89 (1969) ("The comparison between court released and hospital released adjustment rates shows no significant difference in the predictive accuracy of either institution"), and Ennis and Litwack: Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Calif L Rev 693, 749 (1974) (no evidence found that a psychiatrist can predict dangerousness more accurately than a lawyer). In fact, a recent report prepared by the American Psychiatric Association concludes that "neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness.'" American Psychiatric Association, Clinical Aspects of the Violent Individual 28 (1975).
Of course, in the famous study of the so-called "Baxstrom patients" (those persons ordered released from New York's maximum security facilities for "insane criminals" following this Court's decision in *Baxstrom v. Herold*, 383 U.S. 107 (1966)), it was found that, of the 969 *Baxstrom* patients who had previously been statutorily incarcerated in maximum security facilities, within one year, only *seven* were recommitted to such a facility on a finding of dangerousness (although it had been predicted by hospital officials that nearly 250 would need that type security), and, of the 147 patients released to the community, only *one* had been arrested within that time period (for petty larceny). Hunt and Wiley: Operation Baxstrom After One Year, 124 Am J Psychiat 124 (1968), reprinted in Association of the Bar of the City of New York: Mental Illness, Due Process and the Criminal Defendant 224 (1968). The Baxstrom patients have received special behavioral scrutiny. See, *e.g.*, Steadman: Follow-up on Baxstrom Patients Returned to Hospitals for the Criminally Insane. 130 Am. J. Psychiat. 317 (1973); Steadman and Cocozza: Careers of the Criminally Insane (1974). For a more recent evaluation and survey of the relevant literature, see Steadman and Cocozza: We Can't Predict Who Is Dangerous. Psychology Today 32 (January 1975). See also, *e.g.*, Dershowitz: The Law of Dangerousness: Some Fictions About Predictions, 23

J Legal Ed 24 (1971); Steadman: Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychiatry. 1 J Psych & L 409 (1973); Wenk, Robison and Smith: Can Violence Be Predicted? 18 Crime and Delinq. 393 (1972); Kozol, Boucher, and Garofola: The Diagnosis and Treatment of Dangerousness, 18 Crime & Delinq. 371 (1972); Dershowitz: Dangerousness as a Criterion for Confinement. 2 Bull Am Acad Psych & L 172 (1974).

66. American Psychiatric Association, Task Force Report: Behavior Therapy in Psychiatry 23 (1973)

67. See, *e.g.*, Right to Refuse, note 44, above, at 163-164, 180. Compare *e.g.*, Goldiamond: Singling Out Behavior Modification for Legal Regulation: Some Effects on Patient Care, Psychotherapy, and Research in General. 17 Ariz L Rev 105 (1975), to Clemons: Proposed Legal Regulation of Applied Behavior Analysis in Prisons: Consumer Issues and Concerns. 17 Ariz L Rev 127 (1975). Another problem raised specifically by behavior modification programs is that, in an institutional setting, they may be employed to facilitate the institution's operation rather than to help the patient/inmate. Trotter and Warren: The Carrot, the Stick and the Prisoner. 105 Science News 180, 181 (1974) (quoting Bandura)

68. Davison and Stuart, note 41, above, at 760 (emphasis added)

69. 422 *U.S.* 563, 45 *L. Ed.* 2d 396 (1975)

70. *O'Connor v. Donaldson*, 422 *U.S.* 563, 45 *L. Ed.* 2d 396, 406, n. 10 (1975)

71. Cobert, *e.g.*, has suggested a reverse scale of acceptability of technique (from psychosurgery to aversive conditioning to negative reinforcement to positive reinforcement where the reward is something to which the patient has a right). Right to Refuse, note 44, above, at 194-195

72. Perspective, note 4, above, at 1039

73. *Ibid.* at 1040

74. Thus, even Kazdin's observation that "ethical concerns have not been strongly voiced for outpatient application of aversive techniques . . . [because] the client who seeks outpatient treatment gives his consent for the use of such procedures and usually may leave treatment at any time," Kazdin, note 61, above, at 238, indicates a basic lack of awareness of the scope of the problems referred to above.

For an alternative response, see Katz: Children, Privacy, and Nontherapeutic Experimentation. 45 Am J Orthopsychiat 802, 810 (1975) ("Since the social scientists themselves have failed to exercise the necessary self-control in . . . [the] area [of obtaining formal consent], it seems appropriate to suggest that the community act for itself and legislate for the protection of the privacy right of children"). *Cf.* Legal Regulation, note 2, above, at 95-100.

Similarly, for a discussion of the need for professionally-developed standards in behavior modification programs (specifically including psychosurgery), see Shuman: The Emotional, Medical and Legal Reasons for the Special Concern About Psychosurgery, in Ayd, ed., Medical, Moral and Legal Issues in Mental Health Care 48, 79-80 (1974).

75. Right to Refuse, note 44, above, at 185, n. 149

76. 277 *U.S.* 438 (1927)

77. *Olmstead v. United States*, 227 *U.S.* 438, 479 (1927)