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Recent Developments in Behavior Modification

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Comment

Recent Developments in Behavior Modification

> There are many varieties of "behavior modification" and many different formulations, but they all agree on the essential point: behavior can be changed by changing the conditions of which it is a function.[1]
>
> —B.F. Skinner

I. INTRODUCTION

Behavior modification traditionally has been defined as "the systematic application of proven principles of conditioning and learning in the remediation of human problems."[2] To more fully understand this definition, it is best to begin by examining some of the recognized psychological principles of conditioning and learning. Although there are many learning theory modes upon which behavior modification techniques may be based, the three major modes are modeling, classical conditioning, and operant conditioning.[3]

The modeling mode is based on observation. In theory, the probability of a subject demonstrating a particular behavior will be increased if the subject observes that behavior in another person. For example, a child is more likely to enjoy playing the piano if she observes her parent happily playing the piano.

In classical conditioning, an unconditioned stimulus which automatically elicits a particular behavior is frequently paired with a conditioned stimulus which does not automatically elicit that response. After one or more pairings, the conditioned stimulus alone will elicit the same response. For example, when the Russian physiologist Ivan Pavlov paired meat powder (unconditioned stim-

1. B.F. SKINNER, BEYOND FREEDOM AND DIGNITY 150 (1971).
2. Milan & McKee, BEHAVIOR MODIFICATION: PRINCIPLES AND APPLICATIONS IN CORRECTIONS (Oct. 1973), *reprinted in* STAFF OF SUBCOMM. ON CONSTITUTIONAL RIGHTS, SENATE COMM. ON THE JUDICIARY, 93D CONG., 2D SESS., INDIVIDUAL RIGHTS AND THE FEDERAL RULE IN BEHAVIOR MODIFICATION 459,461 (Comm. Print 1974) [Hereinafter cited as THE FEDERAL ROLE]. For an in depth discussion of the psychological principles involved in behavior modification, *see, e.g.*, A. BANDURA, PRINCIPLES OF BEHAVIOR MODIFICATION (1969); G. MARTIN & J. PEAR, BEHAVIOR MODIFICATION: WHAT IT IS AND HOW TO DO IT (1978).
3. *See generally* sources cited note 2 *supra*.

ulus) with the sound of a metronome (conditioned stimulus), dogs were eventually conditioned to salivate solely upon hearing the metronome.[4]

The third and most frequently used mode of behavior modification is operant conditioning. In operant conditioning, behavior responses are learned or unlearned as a function of their consequences. Unlike classical conditioning, these responses are not automatically elicited, but, rather, are voluntarily emitted by the person.[5] Under this learning theory mode, the three main consequences or contingencies of behavior are reinforcement (reward), punishment, and extinction. Reinforcers may be primary (food, water, sex) or secondary (praise, gold stars, money).[6] When a reinforcer is a consequence of specific behavior, that behavior is more likely to occur again in the future. For instance, when a child opens a cookie jar and finds cookies, he is more likely to open it again in the future because he was rewarded the first time. When punishment follows a particular behavior, that behavior is less likely to occur again. For instance, when the child opens a cookie jar and finds a snake inside, he is less likely to open it again in the future. Extinction occurs when a reinforcement is withheld from a response resulting in a decrease of repeated behavior. In the above example, if the child opens up a cookie jar and finds no cookies, he is less likely to open the jar in the future.[7]

Prior to the middle of the 1970s, little had been written on the constitutionality of using certain behavior modification techniques on institutionalized persons.[8] In 1976, one article stated, "[b]ecause new cases are continuously being litigated, the juridicial information provided in this paper will soon need to be updated."[9] Therefore, the purpose of this comment is to bring the evolving "law of behavior modification" up-to-date by an examination of recently decided federal opinions.[10]

This comment will explore recent developments in the law con-

4. *See generally* sources cited note 2 *supra*.
5. *See generally* sources cited note 2 *supra*.
6. *See* notes 157-58 & accompanying text *infra*.
7. Whitman, *Behavior Modification: Introduction and Implications*, 24 DEPAUL L. REV. 949, 954-56 (1975).
8. The culmination of these legal and psychological writings are included in a bibliography found at 13 AM. CRIM. L. REV. 101 (1975).
9. Budd & Baer, *Behavior Modification and the Law: Implications of Recent Judicial Decisions*, 4 J. PSYCH. & L. 171, 173 (1976).
10. For an informative source for the federal government's role in behavior modification up to 1974, *see* THE FEDERAL ROLE, *supra* note 2.

    For a discussion of the legal trends in the law of behavior modification up to 1975, *see generally* R. MARTIN, LEGAL CHALLENGES TO BEHAVIOR MODIFICATION (1975). The author summarizes some of the earlier cases having implications for the application of behavior modification techniques. *Id.* at 169-79.

cerning certain behavior modification practices in mental health and penal institutions. The practices which will be explored include the use of drugs, seclusion, physical restraints, token economies, therapeutic labor, psychosurgery, and electric shock. With the exception of psychosurgery, which is included here because it too causes behavior changes, all these practices may be used contingently as reinforcements or punishments to modify behavior in mental patients, prison inmates, or school children. Discussed herein are the constitutional limitations of these behavior modification techniques as they have evolved in recent years.

II. DRUGS

In the broadest sense, it might be said that behavior modification occurs whenever drugs are administered to a person for the purpose of changing the subject's behavior. Television commercials tell us that as a consequence of taking aspirin, we are less tense and irritable. The psychologist, however, would limit the scope of behavior modification by use of drugs to those situations where a drug is administered contingently for a desired response.[11] For example, a prison inmate might have a bad habit of dumping his food tray on the floor. Each time this contingency occurs, the warden might respond by injecting the inmate with a drug designed to induce vomiting. In time, the inmate will refrain from engaging in such behavior for fear of further injections. It is obvious that the use of such aversive reaction drugs can be very effective in modifying certain types of behavior.[12] But the use of drugs for such a purpose has been severely curtailed in light of various constitutional considerations identified in recent federal court cases. In the following review of cases, it should be understood that the holdings and standards set forth presumably apply to the use of drugs whether or not they are used contingently for behavior modification purposes.

A. First and Eighth Amendments

One of the first cases to have implications for the relatively recent legal awareness of behavior modification was *Winters v. Miller*.[13] *Winters* held that a physician, by forcing medication on a practicing Christian Scientist who had been admitted involuntarily

11. *See* Budd & Baer, *supra* note 9, at 222.
12. Whether or not used contingently, drugs are widely used for treating undesirable behavior in institutionalized persons. *See, e.g.*, Bomstein, *The Forcible Administration of Drugs to Prisoners and Mental Patients*, 9 CLEARINGHOUSE REV. 379, 379-80 (1975); Comment, *Forced Drug Medication of Involuntarily Committed Mental Patients*, 20 ST. LOUIS U. L.J. 100, 112 (1975).
13. 446 F.2d 65, 67 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971).

to the hospital, had violated the patient's first amendment right of religious freedom. The Court recognized a valid claim for damages under section 1983,[14] in part because no court had ever found the plaintiff to be mentally incompetent (although she was probably mentally ill).[15] The court found no evidence that medication given against plaintiff's continued objection would advance any social interest. Without an overriding secular interest, such as the state interest in public health and welfare,[16] the court would not allow any infringement upon the free exercise of the plaintiff's religion.[17]

In addition to these first amendment considerations, it has also been held that the compulsory use of tranquilizers on inmates and mental patients may violate the eighth amendment's prohibition against cruel and unusual punishment. For example, the Seventh Circuit has held that the staff at a boys training school could not give juveniles tranquilizers intramuscularly without first attempting treatment methods other than drugs, and obtaining proper medical supervision and prescription.[18] In a prior case the Seventh Circuit had also affirmed that tranquilizing drugs could not be given to juvenile delinquents "for purposes of mere control or punishment."[19] Similarly, a federal district court held, in part, that retarded residents of a state mental hospital could not be given excessive amounts of tranquilizers when administered for behavi-

14. 42 U.S.C. § 1983 (1976).

15. 446 F.2d at 68. It is the law in New York that a mentally ill person who has not been judicially declared incompetent may sue or be sued in the same manner as any competent person. *See, e.g.*, Sengstack v. Sengstack, 4 N.Y.2d 502, 151 N.E.2d 887, 176 N.Y.S.2d 337 (1958). Elsewhere, it is well settled that the law will presume every person to be fully competent until sufficient proof to the contrary is shown. *See, e.g.*, Simmons First Nat'l Bank v. Luzader, 246 Ark. 302, 438 S.W.2d 25 (1969); In re MacCrellish, 167 Cal. 711, 141 P. 257 (1914); Walton v. Malcolm, 264 Ill. 389, 106 N.E. 211 (1914); Speer v. Speer, 146 Iowa 6, 123 N.W. 176 (1909); Rose v. Rose, 298 Ky. 404, 182 S.W.2d 977 (1944); First Christian Church v. McReynolds, 194 Or. 68, 241 P.2d 135 (1952).

16. *See* Jacobson v. Massachusetts, 197 U.S. 11 (1905), wherein the Supreme Court held that compulsory vaccinations to prevent the spread of smallpox were permissible because they were based on a health interest sufficient to override free exercise of religion.

17. 466 F.2d at 68-70.

18. Nelson v. Heyne, 491 F.2d 352, 357 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974). In support of the argument that the use of tranquilizing drugs is punishment, the *Nelson* court heard expert testimony that tranquilizers administered intramuscularly to the juveniles could cause "the collapse of the cardiovascular system, the closing of a patient's throat with consequent asphyxiation, a depressant effect on the production of bone marrow, jaundice from an affected liver, and drowsiness, hemotological disorders, sore throat and ocular changes." 491 F.2d at 357.

19. Wilson v. Coughlin, 472 F.2d 100, 102 (7th Cir. 1973).

orial control, rather than for therapy.[20] In finding that the residents' rights under the eighth and fourteenth amendments were violated, the court suggested that insufficient staffing and self-protection of residents are impermissable reasons for the excessive use of tranquilizers.[21]

B. Constitutional Guidelines

Constitutional standards for the use of drugs in mental institutions were developed by the federal district court in *Wyatt v. Stickney*,[22] which, apparently, were intended to apply whether or not drugs are used contingently for behavior modification. The standards that indicate: (1) Patients have a right to avoid unneeded or excessive medication; (2) medication cannot be given without the written order of a physician who shall not prescribe medication for more than thirty days at a time; (3) the delivery of each dosage must be recorded, and in the case of the mentally retarded, the effects of medication and any behaviorial changes shall be recorded; and (4) the physician must review each patient's drug regimen weekly. The court also stated that "[m]edication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the patient's treatment program".[23] An apparent inconsistency exists in this statement because a "patient's treatment program" may include the use of behavior modification as "punishment."[24] Although this conflict remains unresolved, the court's language suggests that the *Wyatt* standard forbids, without consent, the use of drugs as a behavior modification punishment in a mental patient's treatment program.

In 1973, the Eighth Circuit developed guidelines for drug use within penal institutions. In *Knecht v. Gillman*,[25] mentally ill prisoners sought to enjoin the staff of an Iowa institution from injecting prisoners with the drug apomorphine. The apomorphine, which induces vomiting for up to an hour,[26] was given for such minor infractions as oversleeping, talking, swearing, lying, and for passing out cigarettes against orders. The Eighth Circuit held that

20. Welsch v. Likins, 373 F. Supp. 487, 503 (D. Minn. 1974), *aff'd in part and vacated in part*, 550 F.2d 1122 (8th Cir. 1977).
21. *Id.*
22. 344 F. Supp. 373, 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).
23. 344 F. Supp. at 380, 400.
24. *See generally* Burns, *Behavior Modification as a Punishment*, 22 AM. J. JURIS. 19 (1977).
25. 488 F.2d 1136 (8th Cir. 1973).
26. Temporary cardiovascular effects also were manifested by changes in the heart and blood pressure. *Id.* at 1137.

the use of apomorphine on nonconsenting inmates as an aversive behavior modification technique constituted cruel and unusual punishment.[27] The court's guidelines allowed apomorphine to be administered only if: (1) the inmate gives informed written consent[28] which is certified by the physician; (2) the inmate has an opportunity to revoke consent at any time; and (3) the drug is authorized by a physician and administered by the physician or a nurse only for modifying individual behavior actually observed by one of the professional staff.[29]

More recently, federal court decisions have refined the analysis of the permissible constitutional uses of drugs in penal or mental institutions and have recognized new constitutional questions. The most important and most pervasive result has been the recognition of the right to privacy[30] as the foundation for an inmate's or a mental patient's right to refuse medication.

Several of the new developments arose in *Pena v. New York State Division for Youth*,[31] a civil rights class action brought on behalf of boys housed within New York's Goshen Annex. Specifically, the plaintiffs, relying on the eighth and fourteenth amendments, challenged the use of thorazine and other tranquilizers to control excited behavior. The court appeared shocked to find that the staff at Goshen used thorazine as a punitive device when Goshen's regulations prohibited such drug use unless "no other means of restraint can prevent the child from harming himself."[32] The district court granted an injunction against the present

27. *Id.* at 1140. *See also* Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973), wherein a state prisoner brought a civil rights action alleging that a California medical facility's experimental use of the drug succinycholine without his consent constituted cruel and unusual punishment. The drug is characterized by its paralyzing effect which inhibits breathing. The court held that unconsented experimentation with the drug "raise[s] serious constitutional questions respecting cruel and unusual punishment or impermissible tinkering with the mental processes." *Id.* at 878.

28. The ability of an institutionalized subject to freely give informed consent to behavior therapy is questioned in Davison & Stuart, *Behavior Therapy and Civil Liberties*, 30 J. AM. PSYCH. 755, 762 (1975). For a complete discussion of the subject of informed consent, see Barnhart, Pinkerton & Roth, *Informed Consent to Organic Behavior Control*, 17 SANTA CLARA L. REV. 39 (1977).

29. 488 F.2d at 1140-41.

30. For a background to the legal development of the right to privacy concept, see A. WESTIN, PRIVACY AND FREEDOM (1967); Gavison, *Privacy and the Limits of Law*, 89 YALE L.J. 421 (1980); Prosser, *Privacy*, 48 CALIF. L. REV. 383 (1960); Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890); Annot., 43 L. Ed.2d 871 (1976 & Supp. 1980). In Nebraska, see Comment, *The Right to Privacy in Nebraska*, 13 CREIGHTON L. REV. 935 (1980); Note, *Tort Recovery for Invasion of Privacy*, 59 NEB. L. REV. 808 (1980).

31. 419 F. Supp. 203 (S.D.N.Y. 1976).

32. *Id.* at 210 (italics omitted).

method of drug administration, and established three guidelines, primarily medical in nature, for future drug procedure at Goshen.[33] First, thorazine may be used only as a part of an ongoing treatment plan approved and supervised by a physician.[34] To the extent that this tranquilizer should not be used as a punitive behavior modification device, the first guideline of *Pena* is consistent with the *Wyatt* standards.[35] However, the other guidelines established in *Pena* were new. The second guideline stated that a boy given thorazine shall be examined for possible adverse side effects within thirty minutes.[36] Third, the boy should be given the option of taking thorazine orally or by injection because injection has more dangerous physical and psychological effects.[37] These guidelines seem to be concerned with establishing policies to protect the patient's health, rather than to advance any clear constitutional interests.

C. The Four Constitutional Interests

Four constitutional interests were alluded to in *Scott v. Plante*.[38] Scott, who had been committed to New Jersey's Trenton State Hospital on a finding that he was insane when he allegedly murdered his grandmother, complained that he had been confined in violation of several constitutional rights. In response to Scott's involuntary medication claim, the court upheld his cause of action.[39] The court first based its decision upon Scott's first amendment right to autonomy of mental processes.[40] Second, in a nonemergency situation, Scott had due process rights to notice and a hearing prior to the administration of medication.[41] It was relevant that Scott was never adjudged incompetent nor incapable of giving

33. *Id.* at 211.
34. *Id.*
35. *See* notes 22-23 & accompanying text *supra*. Although it is not entirely clear under what circumstances drug use will be allowed, *Pena* expressly excludes punitive use of tranquilizers. The court said Goshen's administrator's would be allowed flexibility in establishing regulations subject to the courts guidelines and the future protection of the court if such flexibility was abused. 419 F. Supp. at 207-08.
36. 419 F. Supp. at 207-08.
37. *Id.* The court further noted that at trial, an expert testified that in a similar institutional environment, eight out of ten children who were given the choice between oral and hypodermic administration of drugs chose the former despite their disturbed state of mind at the time. *Id.*
38. 532 F.2d 939 (3d Cir. 1976).
39. *Id.* at 946-47. Reference was made to Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973), although *Mackey* was not explicitly based on the first amendment. *See* note 27 *supra*.
40. 532 F.2d at 946.
41. *Id.*

informed consent[42] which is similar to *Winter*,[43] although due process was not a ground used in that earlier case. Third, following *Knecht*,[44] the court recognized the issue of eighth amendment cruel and unusual punishment. Finally, the court noted the *possibility* that Scott's right to bodily privacy may be a valid ground to challenge the forced administration of medication.[45]

The four constitutional grounds against forced medication—freedom of mental processes, due process, cruel and unusual punishment, and a right to privacy—were dealt with more thoroughly in *Rennie v. Klein*.[46] A mental patient involuntarily confined in Ancora Psychiatric Hospital (a state institution) had been diagnosed as a paranoid schizophrenic who exhibited suicidal and homicidal behavior.[47] When Rennie became more homicidal and his general condition deteriorated, the attending psychiatrist obtained permission from the state attorney general to administer medication without his consent in order to prevent him "from harming other patients, staff and himself and to ameliorate his delusional thinking pattern."[48] The drug prolixin was chosen as the only drug which was both injectable and long-lasting. Although he had many side effects from the drug,[49] Rennie's overall condition and behavior improved markedly. Rennie brought action under section 1983[50] to enjoin the defendant psychiatrists and officials from forcibly administering the psychotropic drugs[51] in the absence of an emergency situation.

42. *Id.*
43. Winters v. Miller, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971). *See* notes 13-17 & accompanying text *supra*.
44. Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973). *See* notes 25-29 & accompanying text *supra*.
45. Scott v. Plante, 532 F.2d 939, 946-47 (3d Cir. 1976). *But see* Souder v. McGuire, 423 F. Supp. 830, 832 (M.D. Penn. 1976). The *Souder* court allowed an action against unconsented treatment with psychotropic drugs which have a painful or frightening effect, and based that decision both on cruel and unusual punishment doctrine and on right to privacy grounds.
46. 462 F. Supp. 1131 (D.N.J. 1978). The facts presented here are found at 1135, 1138-30. *See also* Note, *Rennie v. Klein: Constitutional Right of Privacy Protects a Mental Patient's Refusal of Psychotropic Medication*, 57 N.C. L. REV. 1481 (1979).
47. 462 F. Supp. at 1135. At one point in a series of releases and readmissions, Rennie had been readmitted for threatening to kill President Ford. *Id.*
48. *Id.* at 1139.
49. Short-term side effects from the use of psychotropic drugs commonly include "blurred vision, dry mouth and throat, constipation or diarrhea, palpitations, skin rashes, low blood pressure, faintness and fatigue." *Id.* at 1138.
50. 42 U.S.C. § 1983 (1976).
51. The *Rennie* court acknowledged the extensive use of psychotropic drugs: "In sum, psychotropic drugs are widely accepted in present psychiatric practice. . . . They are the treatment of choice for schizophrenics today." 462 F. Supp. at 1137. *See also* A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL

The *Rennie* court discussed the four recognized constitutional grounds at some length. First, no eighth amendment cruel and unusual punishment was found.[52] The court distinguished *Knecht* because the drug apomorphine had no proven therapeutic value; its use was not recognized standard medical practice; and the adverse effects of its use appeared unnecessarily harsh.[53] The court then distinguished *Nelson v. Heynes*,[54] *Pena v. New York State Division of Youth*,[55] and *Maskey v. Procunier*[56] because in those cases drugs were used improperly and for punishment rather than as part of an ongoing treatment program.[57] In *Rennie*, however, psychotropic drugs are recognized as effective; the side effects were not unnecessarily harsh in light of long term benefits; and the drugs were used in an ongoing treatment program at Ancora and not as punishment.[58]

Second, the *Rennie* court found that there was no first amendment interference with the right to free mental processes. The court held that "if forced medication is otherwise proper, the temporary dulling of the senses accompanying it does not give rise to the level of the first amendment violations found in *Kaimowitz*."[59]

The court also held that the right to refuse treatment,[60] a com-

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HEALTH SYSTEM 878 (1974); Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U. L. REV. 461, 474 (1974).

52. 462 F. Supp. at 1143.
53. *Id.*
54. 491 F.2d 352 (7th Cir.) *cert. denied*, 417 U.S. 976 (1974). *See* note 18 & accompanying text *supra*.
55. 419 F. Supp. 203 (S.D.N.Y. 1976). *See* text accompanying notes 31-37 *supra*.
56. 477 F.2d 877 (9th Cir. 1973). *See* note 27 *supra*.
57. 462 F. Supp. at 1143.
58. *Id.*
59. *Id.* at 1144. In Kaimowitz v. Dep't of Mental Health, Civ. No. 73-19434-AW (Cir. Ct. Wayne County, Mich., filed July 10, 1973), *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 510, *and* A. BROOKS, *supra* note 40, at 902, the first amendment rose to a much greater level of importance because the adverse effects of experimental psychosurgery on a patient would be irreversible and unpredictible. Effects included flattened emotional responses, lack of abstract reasoning ability, loss of capacity for new learning, general sedation and apathy, and impairment of memory. Kaimowitz v. Department of Mental Health, *reprinted in* FEDERAL ROLE, *supra* note 2, at 515, *and* A. BROOKS, *supra* note 40, at 909.

    In *Rennie*, it was significant to the court that Rennie had indicated his desire to be cured of his condition. 462 F. Supp. at 1144. But there is no question of Rennie's lack of a free volition in selecting the *method* of cure. Still, that desire to be cured must have appeared to the court to be a form of implied consent to the temporary dulling of the senses.
60. For background on a patient's right to refuse treatment, see Plotkin, *supra* note 51, at 461. For an appendix that gives a fairly recent state statutory survey of the rights of mental patients to refuse treatment, see *id.* at 504-25. *See also* Comment, *The Right Against Treatment: Behavior Modification and the Involuntarily Committed*, 23 CATH. U. L. REV. 774 (1974); Comment, *Advances*

ponent of the right to privacy, extends to mental patients in non-emergency situations. However, the court stated that Ancora had a duty to prevent danger to other patients and staff, and, as a result, Rennie "cannot both refuse his medication and be left free to inflict harm on others."[61] Finally, the court found that because Rennie had been provided extended hearings, he had received ample due process protection.[62] However, the court emphasized that should a drug program subject a patient to harsh side effects and possible permanent disability, the patient is entitled to a hearing with legal counsel and an outside psychiatrist.[63] If the patient cannot afford the consultants, the state must supply them.[64]

Although the *Rennie* court did not issue an injunction against the involuntary administration of protixin because its use had been terminated, it did list four factors that must be considered in determining whether injunctions should be issued in the future:[65] "(1) plaintiff's physical threat to patients and staff at the institution, (2) plaintiff's capacity to decide on his particular treatment, (3) whether any less restrictive treatments exist, and (4) the risk of permanent side effects from the proposed treatment."[66]

When *Rennie* was expanded into a class action,[67] the court then concluded that voluntary as well as involuntary patients at mental institutions have privacy rights, including the right to refuse treatments.[68] The court reasoned that the intrusiveness and long-term side effects of forced medication are sufficient grounds for recognition of the privacy right bar, regardless of the fact that the patient's commitment was voluntary.[69] However, these privacy rights were qualified by the court's four factors.[70]

There are a number of problems with the *Rennie* court's four factors for determining the propriety of forced medication on mental patients. First, a court should also consider the patient's physical threat to property and, even more so, to himself. Although there is much to be said for a person's control over his

in Mental Health: A Case for the Right to Refuse Treatment, 48 TEMP. L.Q. 354 (1975).

61. 462 F. Supp. at 1145.
62. *Id.* at 1147.
63. *Id.*
64. *Id.* at 1147-48.
65. *Id.* at 1148. The court also denied an injunction against the use of thorazine, which had been administered to Rennie involuntarily when his condition worsened. *Id.*
66. *Id.* at 1148.
67. Rennie's motion to enlarge his suit to a class was granted March 20, 1978. Rennie v. Klein, 476 F. Supp. 1294, 1297 (D.N.J. 1979).
68. *Id.* at 1307.
69. *Id.* at 1297, 1307.
70. *Id.* at 1308.

body, a mental patient often does not have knowing control over himself. Even if he does have knowing control, the state has an interest in protecting the patient from injuring himself, especially because the institution often must bear the costs of any self-inflicted injuries, whether permanent or otherwise. Second, if a patient is incapable of making treatment decisions, a court should consider the preferences of the patient's family or guardian. Third, no standards were given for what consideration or use of treatment forms which are less restrictive than drugs. In an emergency situation, medication may well be the less restrictive treatment, although in a non-emergency situation, it may be that other forms of behavior modification, such as room isolation, would be far less restrictive than drugs. Finally, although the risk of permanent side effects from drug treatment should be considered, a court should be cautioned not to limit itself to one source of medical information, especially in a day when medical knowledge advances at remarkable rates.

D. A Private Right of Action

While the original *Pena* decision was concerned with the rights of an involuntary mental patient, *Naughton v. Bevilacqua*[71] dealt with a private right of action for a patient voluntarily committed at the Rhode Island Institute of Mental Health. Timothy Naughton had been diagnosed as moderately retarded and afflicted with childhood schizophrenia, and tranquilizers were used at times to control his behavior. Although the Institute was informed that Timothy reacted negatively to tranquilizers of the phenothiazine family, from the time of his admission, Timothy had been treated with phenothiazines which sometimes caused him serious adverse reactions such as convulsive spasms and hemorrhaging.[72] A complaint for injunctive relief and damages was filed against the Director of the Institute, the administering physician, and the State of Rhode Island.

The *Naughton* court held that a cause of action had been stated under the Developmentally Disable Assistance and Bill of Rights Act, which gives disabled or retarded persons a "right to appropriate treatment, services and habilitation."[73] It was also decided that the Act was applicable when the drugs were given to Timothy, with knowledge of its harmful effects, solely for the purpose of controlling his behavior and without any habilitative effect.[74] Section

71. 458 F. Supp. 610 (D.R.I. 1978), *aff'd*, 605 F.2d 586 (1st Cir. 1979).
72. 458 F. Supp. at 613-14.
73. Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6010(1) (1975).
74. 458 F. Supp. at 614.

1983 was found to be an appropriate vehicle with which to redress such a violation of civil rights. In addition, the *Naughton* court also held that violations of this statutory right can be remedied through a *private* cause of action.[75] The legislative scheme and history was invoked to support this discovery of a private cause of action under section 1983 as well as the discovery of an implied cause of action. The court reasoned that a statutory remedy which addresses only the wrongs of an institution and ignores individual wrongs would be inconsistent with the Congress's principle desire which was to correct past neglect of individual rights.[76] However, this reasoning differs from the conclusions reached by the Fifth Circuit in *Wyatt v. Aderholt*,[77] which held that individual remedies (such as habeas corpus, medical malpractice, and tort actions) would not support state hospital residents' actions to establish institutional programs for developing and implementing individual treatment plans.[78]

75. *Id.* at 614-16.

76. *Id.* at 616-17.

77. 503 F.2d 1305, 1316 (5th Cir. 1974).

78. The court in *Wyatt* presented four reasons for its finding that individual suits by mental patients were inappropriate: (1) mental patients are likely to be unaware of their legal rights; (2) mental patients are likely to have limited access to legal help; (3) private suits may be costly and protracted thus deterring individual patients from bringing such actions; (4) private suits may produce distortions in therapeutic effects in that "a staff may tend to give especially good—or especially harsh—treatment to patients the staff expects or knows to be litigious." *Id.* at 1316. These reasons are dubious because mental patients, like children, can always have family members, guardians, or legal advisors periodically check their treatment through conversations with the patients or by examining progress reports. Also, the denial of individual suits does not square well with patients' right to individualized treatment.

An involuntarily-confined mental patient's constitutional right to treatment was found in O'Connor v. Donaldson, 493 F.2d 507, 520-21 (5th Cir. 1974), *vacated and remanded on other grounds*, 422 U.S. 563 (1975). The Supreme Court in *O'Connor* did not reach the constitutionality of a right to treatment, holding only that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." 422 U.S. at 576. Other cases upholding a mental patient's constitutional right to individualized treatment are: New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975); Davis v. Witkins, 384 F. Supp. 1196 (N.D. Ohio 1974); Welsh v. Likens, 373 F. Supp. 487 (D. Minn. 1974), *aff'd*, 550 F.2d 1122 (8th Cir. 1977); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala.), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). The class action in *Wyatt* was initially brought as one lawsuit. However, the District Court gave two formal opinions making a distinction between patients receiving treatment for mental illness (first citation) and patients receiving treat-

E. Emergency v. Non-Emergency Situations

A distinction between emergency and non-emergency situations was discussed in *Rogers v. Okin*,[79] a class action which challenged medication and seclusion policies at Boston State Hospital, a state institution for both voluntarily and involuntarily committed mentally ill patients. The staff used forced medication and involuntary seclusion in non-emergency situations, and had given unconsenting patients mind-altering psychotropic drugs which were known to cause adverse physical and neurological side effects.[80] The court held that a mental patient could be forcibly drugged in *emergency* situations where failure to do so would result in a substantial likelihood of harm to others.[81] However, in *non-emergency* situations both voluntary and involuntary mental patients possessed the right to refuse medication.[82] This right to refuse was based on the right to privacy in bodily integrity and on the first amendment right to control of the mind.[83] In dismissing the state's interest in forcible injections, the court stated what may be considered the central philosophy behind the recent federal cases:

> The only purpose, therefore, of forced medication, in a non-emergency, is to help the patient. The desire to help the patient is a laudable if not noble goal. But, a basic premise of the right to privacy is the freedom to decide whether we want to be helped, or whether we want to be left alone. It takes a grave set of circumstances to abrogate that right. That a non-emergency injection in the buttocks may be therapeutic does not constitute such a circumstance.[84]

This recent line of federal cases[85] thus consistently has upheld the proposition that the non-emergency use of drugs in non-emergency situations for the purpose of control or for punishment, rather than as part of an ongoing psychotherapeutic purposes, may violate the eighth amendment prohibition against cruel and unusual punishment, first amendment freedom of thought, due process rights, and the constitutional right to privacy. Furthermore, as the *Naughton* case indicates, private rights of action based on statutory provisions, may be available to remedy these constitu-

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ment for mental retardation (second citation). With limited exceptions, the District Court treats both classifications in a similiar manner.

The right to individualized treatment plans may also be conferred statutorily. *See, e.g.*, NEB. REV. STAT. § 83-1044 (Cum. Supp. 1980).

79. 478 F. Supp. 1342, 1352 (D. Mass. 1979).
80. *Id.* at 1359-60.
81. *Id.* at 1365-68.
82. *Id.* at 1367-68.
83. *Id. See also* notes 156-59 & accompanying text *infra*.
84. 478 U.S. at 1369.
85. For two recent state cases following the federal courts' lead in situations of forced medication, see *In re* K.K.B., 609 P.2d 747, 750-51 (Okla. 1980); *In re* Boyd, 403 A.2d 744, 752 (D.C. 1979).

tional violations.[86] The bottom line is that the involuntary administration of drugs is likely to be prohibited as a behavior modification contingency, at least where that contingency is punishment. The central theme in the drug cases is that the forced administration of drugs for punishment is too *intrusive* on bodily and mental integrity in the absence of an emergency. A different situation, one which has not been addressed by the courts, is where drugs are administered as reinforcements or rewards for positive behavior. Conceivably, a court might well find that drugs producing mild pleasant sensations have a legitimate place in the realm of therapy. A drug can hardly be intrusive where it is welcomed.

III. SECLUSION

One of the more common behavior modification devices is seclusion. Seclusion, also known as "time out," is a temporary removal of a person from positive reinforcement after the person has engaged in unacceptable behavior. Although this device can consist of merely separating the person from social interaction (such as the old grade school sanction of standing in a corner), seclusion may also involve placing the person in an isolated room for a period of time.[87]

In the prison setting, such an isolated room or "seclusion room" might consist of a stark darkened cell with no sanitary facilities other than a floor toilet. It has been held that prisoner's confinement in such a cell for five days constitutes cruel and unusual punishment where the offense is relatively minor, such as possession of a rope made from towels.[88] Enforced isolation and boredom have been considered permissible disciplinary measures, although they might not remain so if utilized for an extended period of time.[89]

86. Several states have recently enacted statutes regulating the institutional use of medication on mentally retarded or mentally ill persons. *See* ARK. STAT. ANN. § 59-1415 (Supp. 1979); CAL. WELF. & INST. CODE § 5325.1(c) (Deering 1979); COLO. REV. STAT. § 27-10.5-114(5) (Supp. 1979); CONN. GEN. STAT. ANN. §§ 17-206d(c), -206e(b) (West Supp. 1980); GA. CODE ANN. § 88-2503.5 (Supp. 1980); KAN. STAT. ANN. § 59-2928(6) (1976); LA. REV. STAT. ANN. § 28-171p (West Supp. 1980); MICH. COMP. LAWS ANN. § 330.1718 (1975); MONT. REV. CODES ANN. § 38-1319 (Supp. 1977); N.J. STAT. ANN. § 30:4-24-2d(1) (West Supp. 1980-81); WIS. STAT. ANN. § 51-61(h) (West Supp. 1980-81).

87. *See* G. MARTIN & J. PEAR, *supra* note 2, at 183.

88. La Reau v. MacDougal, 473 F.2d 974 (2d Cir. 1972), *cert. denied*, 414 U.S. 878 (1973).

89. 473 F.2d at 978. The court's conception in *La Reau* apparently was that prison punishment in a seculsion room must not be grossly disproportionate to the offense in order to comply with eighth amendment standards. *See* Weems v. United States, 217 U.S. 349, 367 (1910); Rummel v. Estelle, 568 F.2d 1193, 1195

A stronger stand has been taken against the use of seclusion rooms, in boy's training schools. The isolation of juveniles in cold, dark cells containing only a toilet and a mattress has been held to be cruel and unusual punishment[90] because the placement of juveniles in solitary confinement "may be psychologically damaging, anti-rehabilitative, and, at times inhumane."[91] In another case involving juvenile inmates, standards were set for the use of "dormitory confinement," defined as the placing of an inmate alone in a secured room in his dormitory.[92] The standards indicated that "time out" procedures may not be employed unless confinement is necessary to prevent harm to the inmate or others, to prevent the destruction of property, to prevent escape, or to restrain substantial disruptive behavior.[93]

Seclusion standards for mental patients were set out in detail in *Wyatt v. Stickney*.[94] The standards indicated that: (1) a mentally ill patient usually may not be placed in isolation unless in an emergency to prevent harm to himself or others, and a professional's written order explaining the reasons for isolation are required if there is no emergency; (2) emergency use of isolation is limited to a maximum of one hour, and the written order for non-emergency use is effectve for twenty-four hours; (3) while in emergency isolation, the patient must have his physical and psychological condition checked and charted each hour by qualified ward personnel; (4) the patient must have access to a restroom every hour and must be bathed every twelve hours.[95]

(5th Cir. 1978), *aff'd*, 445 U.S. 213 (1980); Jackson v. Bishop, 404 F.2d 571, 577-79 (8th Cir. 1968); Willoughby v. Phend, 301 F. Supp. 644, 646 (N.D. Ind. 1969); Holt v. Sarver, 300 F. Supp. 825, 827 (E.D. Ark. 1969).

90. Inmates of Boys' Training School v. Affleck, 346 F. Supp. 1354, 1366-67 (D.R.I. 1972).

91. *Id.* at 1372. Due to insufficient testimony on the distinction between segregation and solitary confinement and on when destructiveness occurs, the court in *Affleck* denied a preliminary injunction. However, the court did formulate minimum standards for the future use of seclusion, including requirements that juveniles each receive a room with sufficient reading light, sufficient clothing, bedding changes, and personal hygiene supplies. *Id.* at 1373.

92. Morales v. Turman, 364 F. Supp. 166, 177 (E.D. Tex. 1973).

93. *Id.* at 177-78. Additionally, dormitory confinement is not to last longer than fifty minutes. *Id.*

94. 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

95. 344 F. Supp. at 380. As to mentally ill patients, the court extended these same standards to physical restraints. With respect to mentally retarded patients, the *Wyatt* court responded:

> Seclusion, defined as the placement of a resident alone in a locked room, shall not be employed. Legitimate "time out" procedures may be utilized under close and direct professional supervision as a technique in behavior-shaping programs.

344 F. Supp. at 400. Since the court made a curious distinction between seclu-

The more recent line of cases dealing with seclusion tend to refine and clarify the standards governing its use. The greater emphasis is placed on the procedural due process rights of the subject. *Pena v. New York State Division of Youth*[96] concerned, in part, eighth and fourteenth amendment challenges to the use of isolation as a means of controlling the excited behavior of boys at Goshen Annex in New York. Although Goshen's own regulations prohibit room confinement as a means of punishment,[97] the staff often used hours of room confinement as punishment for disobeying staff instructions, failing to cooperate, or exhibiting a negative attitude. The court granted injunctive relief against using isolation as punishment.[98] In situations where isolation is used to prevent violent and threatening behavior, the court held that "except in the most extreme circumstances, no boy should be held in isolation for more than six hours, and the condition of isolated boys should be evaluated at least hourly by a visit from a staff member."[99] It appears that this six hour limitation on emergency isolation allows more flexibility than the one hour maximum imposed in *Wyatt*. The frequent evaluation visits should be sufficient to protect the subject's health.

In *Gary W. v. Louisiana*,[100] standards very similar to the *Wyatt* standards[101] were imposed on state institutions for mentally retarded, physically handicapped, and delinquent children. Although seclusion in a locked room was prohibited, legitimate "time out" procedures were found permissible.[102] Clarifying *Wyatt*, the court defined "time out" as including placement in an *unlocked* room where a staff member remains constantly nearby to supervise the child.[103] The standards differ from the *Wyatt* standards in that the period of non-emergency isolation is not to exceed twelve hours as opposed to twenty-four hours, and that bathroom facilities are to be available to the child "as needed" rather than once every hour.[104]

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sion and "time out," it must be concluded that "time out" may not involve the use of a locked isolated room and that it is limited to either moving the retarded pateint a short distance away or temporarily withdrawing social reinforcement.

96. 419 F. Supp. 203 (S.D.N.Y. 1976).
97. Room confinement was permitted only "where a child constitutes a serious and evident danger to himself or others." *Id.* at 210.
98. *Id.* at 210-11.
99. *Id.*
100. 437 F. Supp. 1209 (E.D. La. 1976).
101. *See* note 95 & accompanying text *supra*.
102. 437 F. Supp. at 1229.
103. *Id.*
104. *Id.* For a similar set of standards, see Evans v. Washington, 459 F. Supp. 483, 488 (D.D.C. 1978).

Due process considerations in connection with seclusion were recognized in *Eckerhart v. Hensley*,[105] in which treatment and conditions at Fulton State Hospital in Missouri were challenged by a class of involuntarily confined mental patients. In settling any doubts about the scope of seclusion practices covered by *Wyatt*, the court defined seclusion as "a means of restricting a patient by removing him from social contact and placing him in a locked room."[106] Although Fulton's policy prohibited the use of seclusion for disciplinary purposes, in practice it had been used for such infractions as fighting, mouthing off, walking off the ward, and refusing to mop up spilled coffee.[107] The court held that if Fulton should ever promulgate a new policy whereby seclusion is used as a form of discipline rather than for answering "a *medical* decision to seclude for some *therapeutic purpose*,"[108] then the institution must provide the minimum due process required by the Supreme Court in *Wolff v. McDonnell*.[109] These requirements included: (1) a written notice of the infraction prior to a hearing; (2) a written statement containing reasons for the disciplinary action; and (3) an opportunity to call witnesses and to present evidence on his own behalf.[110]

Analogous to the use of seclusion rooms in mental institutions and juvenile training schools is the use of cramped, solitary confinement cells as punishment for adult prisoners.[111] Recently, in *Hutto v. Finney*,[112] the Supreme Court upheld a district court order[113] setting a maximum limit of thirty days on the punitive use of solitary confinement in the Arkansas penal system. Although it acknowledged that confinement in an isolation cell is a form of punishment subject to eighth amendment scrutiny, the Court agreed

105. 475 F. Supp. 908 (D. Mo. 1979).
106. *Id.* at 926. At Fulton, a patient would be secluded in a ward sleeping room which usually contained only a bed. The patient could wear no clothes except underwear. *Id.*
107. *Id.* at 927-28 & 928 n.67.
108. *Id.* at 928 (emphasis in original).
109. 418 U.S. 539 (1974).
110. *Id.* at 563-72. *See also* Davis v. Balson, 461 F. Supp. 842, 878 (D. Ohio 1978) (in addition to these requirements, it recognized a mental patient's right to assistance from another resident or staff member if he is illiterate or the charges are complicated).
111. A prisoner's solitary confinement in a small, unlighted "Behavior Adjustment Unit" was not cruel and unusual punishment *per se*, even when the confinement was not administered as punishment for any specific conduct. But such use of a "Behavior Adjustment Unit" for administrative control purposes may be unconstitutional if confinement therein is excessively restrictive. Hoss v. Cuyler, 452 F. Supp. 256, 283-85 (E.D. Pa. 1978).
112. 437 U.S. 678 (1978).
113. Finney v. Hutto, 410 F. Supp. 251, 278 (E.D. Ark. 1976), *aff'd*, 437 U.S. 678 (1978).

with the district court that punitive isolation "is not necessarily unconstitutional, but it may be, depending on the duration of the confinement and the conditions thereof."[114] The district court found three conditions which constituted cruel and unusual punishment, and thus required a thirty day limit on the use of solitary confinement. The violative conditions included the practice of placing three or more inmates in an extremely small cell;[115] the practice of placing confined inmates on an unappetizing diet of "grue";[116] and the policy of indeterminate sentencing to the isolation cells.[117]

The thirty day limitation for solitary confinement in *Hutto* apparently applies only for confinement for punitive purposes and not for administrative purposes, such as segregating maximum security inmates who cannot be placed safely with the general prison population. Nebraska has made a similar distinction, statutorily, in its regulation of solitary confinement in prisons:

> No person in the adult division shall be placed in solitary confinement for *disciplinary reasons* for more than fifteen consecutive days, or more than thirty days out of any forty-five day period, except in cases of violence or attempted violence committed against another person or property when an additional period of isolation for disciplinary purposes is approved by the warden. This provision shall not apply to segregation or isolation of persons for purposes of *institutional control*.[118]

The Nebraska statute applies a higher standard of control over the punitive use of solitary confinement in prisons. Besides the shorter time limitation, the use of consecutive confinement presumably is limited in order to prevent abuse of accumulating punishments. This is an important consideration which the *Hutto* court failed to address.

When a state statute is the contolling standard for the use of seclusion or isolation in the mental institution setting, a question

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114. Hutto v. Finney, 437 U.S. 678, 685 (1978), *quoting* Finney v. Hutto, 410 F. Supp. at 275.

115. Obviously, when several violent inmates are placed together in very cramped quarters, the punitive effect is even greater than that of solitary confinement. For instance, in *Hutto*, the inmates literally had to fight over the bunk with the mattress. In any event, mattresses were removed during the day. Finney v. Hutto 410 F. Supp. at 276. It is difficult to imagine how these conditions could ever serve to reform the behavior of the inmates.

116. 437 U.S. 678, 686-87 (1978).

117. The commissioner of corrections was of the view that the maximum limit in solitary confinement should be 14 days. But the permissible period was extended by the district court to 30 days in light of its order to correct conditions as follows: no more than two inmates were to be placed in isolation cells in the absence of an emergency; the use of "grue" as food in the prison was to be eliminated; and the policy of indeterminate sentencing was to be abolished. *Id.* at 277-78.

118. NEB. REV. STAT. § 83-4,114 (Reissue 1976) (emphasis added).

may arise as to whether the statute is applicable in a given factual situation. This issue was recently confronted in *Rogers v. Okin*,[119] wherein mental patients charged that seclusion was being used in non-emergency situations for the purposes of treatment and punishment.[120] This was contrary to a Massachusetts statute which permitted seclusion to be used only in emergencies where there is an occurrence of, or a "serious threat of extreme violence, personal injury, or attempted suicide."[121] In the Austin Unit of the Boston State Hospital, the staff routinely used seclusion as a negative reinforcement[122] to modify patient behavior which they felt was undesirable, and the May Unit of the hospital followed a similar policy.[123] The records of both units revealed that seclusion was being employed as a behavior modification device.[124] The defendants conceded that the Massachusetts statute was controlling, but contended that their practices were permissible because seclusion protected the "private interests" of the patients by preventing them from going "out of control."[125]

The court was not persuaded by this view and found that seclu-

119. 478 F. Supp. 1342 (D. Mass. 1979).

120. *Id.* at 1371. *See also* Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295, 1306-07, 1328 (E.D. Pa. 1977), *modified*, 451 F. Supp. 233 (E.D. Pa. 1978), (seclusion was prohibited in a state institution when used for the convenience of an insufficiently sized staff).

121. MASS. ANN. LAWS ch. 123, § 21 (Michie/Law Co-op. Supp. 1980). Several other states have recently enacted statutes generally allowing the use of seclusion only in emergencies to protect the mental patient or others from harm. ARIZ. REV. STAT. ANN. § 36-513 (Supp. 1980-81); ARK. STAT. ANN. § 59-1415 (Supp. 1979-80); CAL. WELF. & INST. CODE § 5325.1(c) (Deering 1979); COLO. REV. STAT. § 27-10.5-114(5) (Supp. 1979); CONN. GEN. STAT. ANN. § 17-206e(a) (West Supp. 1980); GA. CODE ANN. § 88-2503.5 (Supp. 1980); ILL. ANN. STAT. ch. 91 1/2, § 2-109 (Smith-Hurd Supp. 1980); IND. CODE ANN. § 16-14-1.6-6 (Burns Supp. 1979); KAN. STAT. ANN. § 59-2928 (1976); KY. REV. STAT. ANN. §§ 202A.180(10), 202B.060(10) (Baldwin Cum. Supp. 1979); LA. REV. STAT. ANN. § 28:171E (West Supp. 1980); MICH. COMP. LAWS ANN. § 330.1742 (1975); MONT. REV. CODES ANN. § 38-1320 (Supp. 1977); N.J. STAT. ANN. § 30:4-24.2d(3) (West Supp. 1980-81); S.C. CODE § 44-23-1020 (1976); S.D. CODIFIED LAWS ANN. §§ 27A-12-6, 27B-8-5 (1976); TENN. CODE ANN. § 33-307 (Supp. 1980); WIS. STAT. ANN. § 51.61(i) (West Supp. 1980-81). *Cf.* NEB. REV. STAT. § 83-1066 (Reissue 1976) (patient has right to refuse treatment unless it is necessary to prevent injury to himself or others, or if it will substantially improve his or her mental health).

122. For the purposes of this comment, negative reinforcement is another term for punishment. *See* A. BANDURA, *supra* note 2, at 295.

123. 478 F. Supp. at 1373-74.

124. The behavior sought to be modified could not have reasonably constituted "a serious threat of extreme violence, personal injury, or attempted suicide" under the Massachusetts statute. For instance, patients in the May Unit were placed in seclusion for such infractions as engaging in sexual relations, refusing to take medication, walking nude in the day hall, refusing to stop talking loudly, and saying negative things about oneself. *Id.* at 1373-74.

125. *Id.* at 1374-75.

sion was being used routinely for treatment and not for emergency restraint.[126] The court granted injunctive relief to the plaintiffs under the Massachusetts statute.[127] The court then considered the constitutional issue in order to deal with plaintiffs' section 1983 claim for damages and held that the defendants had violated the patients' due process "liberty interest" under the fourteenth amendment.[128]

Recent federal court cases and state statutes clearly follow the lead of the principles formulated in *Wyatt*. Generally, the use of seclusion rooms in institutional settings is limited to emergency conditions in which seclusion is needed to prevent serious harm to the subject or to others. Constitutional safeguards in the form of procedural standards operate to protect the basic human rights of the subject where seclusion rooms are being used. While these standards may vary according to the jurisdiction, a central notion running throughout is that seclusion rooms are highly restrictive and, if used at all, they must be the least restrictive means[129] available to control subject behavior. On the other hand, mild "time out" techniques, such as ignoring the individual or directing him to another part of the room upon an exhibition of negative behavior, are not being regulated with as much severity as seclusion rooms. This type of "time out" is much less restrictive in terms of time and place, although it remains an effective means for modifying undersirable behavior in certain instances.[130] But where the individual who is subject to treatment exhibits criminal or highly destructive behavior, such "time out" devices may be too weak as a punishment to be of any value. In such instances seclusion rooms may be recognized as a proper behavior modification contingency.

IV. PHYSICAL RESTRAINTS

A behavior modification device similar to seclusion is the use of physical restraints as a contingency for unacceptable behavior. Physical restraints are generally thought to be mechanical devices, such as straps or chains, which bind the limbs of a person thereby rendering him immobile. Although physical restraints are arguably more effective in controlling unacceptable behavior than seclu-

126. *Id.* at 1374.

127. *Id.*

128. *Id.*

129. Wyatt v. Stickney, 344 F. Supp. at 379, 334 F. Supp. at 396. *See generally* Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 1100 (1977).

130. *See, e.g.*, Clark, Rowbury, Baer & Baer, *Timeout as a Punishing Stimulus in Continuous and Intermittent Schedules*, 6 J. APPLIED BEHAVIORAL ANALYSIS 443 (1973).

sion, a critical evaluation would reveal that their use is less desirable legally because a person's freedom of movement is more severely restricted. As the following cases illustrate, the courts have rigorously scrutinized the use of physical restraints as a behavior modification device. As such, the courts have provided greater protections of personal and constitutional rights to those individuals confronted by institutional use of physical restraints.

In *Landman v. Royster*,[131] the use of chains and handcuffs in a prisoner's cell was held to constitute a form of corporal punishment that is "constitutionally excessive" under the eighth amendment.[132] Because seclusion could be used to prevent a dangerous prisoner from harming persons and property, the court ruled that the use of such physical restraints is justified only when necessary to protect the prisoner from harming himself.[133] Even this use is not permissible until less restrictive means of control have been attempted. The court suggested that drug treatment or straitjackets are preferable alternatives.[134]

In the context of mental patients, it has also been held[135] that the fourteenth and eighth amendments proscribe the use of certain physical restraints for controlling behavior unless less restrictive means of control have failed.[136] The *Wyatt*[137] standards for mentally ill patients were exactly the same for physical restraints as for seclusion.[138] With respect to mentally retarded patients, the *Wyatt* standards indicated that physical restraints may be used

131. 333 F. Supp. 621 (E.D. Va. 1971).
132. *Id.* at 647.
133. *Id.* at 648. The court noted with irony the fact that permanent scars, lack of sleep, and prolonged physical pain were the results of the use of restraints in the case before it. *Id.* at 647-48.
134. *Id. See also* Lollis v. New York State Dep't of Social Serv., 322 F. Supp. 473, 484 (S.D.N.Y. 1970) (unnecessary or prolonged handcuffing or binding of feet might violate constitutional rights, but such restraints might be used for a short period upon a showing of a reasonable necessity for such action).
135. Welsch v. Likins, 373 F. Supp. 487, 503 (D. Minn. 1974), *aff'd in part and vacated in part*, 550 F.2d 1122 (8th Cir. 1977). The Welsch court noted that two justifications have been advanced for the use of physical restraints: self-protection of the patients and insufficient staffing. But state law may provide that the right to treatment requires a "qualified staff in sufficient numbers." Rone v. Fireman, 473 F. Supp. 92, 122 (N.D. Ohio 1979). Thus, it is possible that insufficient staffing may not justify the use of restraints in the treatment of mental patients.
136. *See also* Wheeler v. Glass, 473 F.2d 983, 984, 987 (7th Cir. 1973), which held that binding two mentally retarded youths to their beds in spread-eagle fashion for 77½ hours for allegedly engaging in a consensual homosexual act was cruel and unusual punishment under the eighth amendment. This was a case which clearly shocked the conscience.
137. Wyatt v. Stickney, 344 F. Supp. 373, 380 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).
138. *See* notes 71-72 & accompanying text *supra*.

only when absolutely necessary to prevent the patient from harming himself or others. Furthermore, physical restraints may be used only if they are the least restrictive means to accomplish their intended purpose. However, such purposes shall never include punishment, staff convenience, or a treatment substitute.[139]

The *Wyatt* case has spawned a recent trend of federal court decisions which place strict limitations on the use of physical restraints, usually because of the supposed dehumanizing and antitherapeutic effects upon persons. The factual situations probably weighed heavily in the courts' reformation of institutional usage of physical restraints. For example, in *Pena v. New York Division for Youth*,[140] physical restraints were often used on the children in the Goshen Annex for Boys for punishment, although the institution's regulations permitted physical restraints only where the child is uncontrollable and poses a serious danger to himself or others.[141] Children at the Goshen Annex had been bound with handcuffs and plastic straps for hours at a time. Often they were restrained with a device which connected their hands and feet together behind their backs and then left lying face down on the floor. Similarly, inmates were also bound to their beds.[142] The *Pena* court declared that the use of physical restraints at Goshen violated the eighth and fourteenth amendments and enjoined the defendants to follow their own regulations.[143] Additionally, the court ordered that physical restraints could not be used for more than thirty minutes (except for vehicular transportation of a dangerous individual), that hands and feet could never be tied together, and that an individual should never be bound to a bed or any other piece of furniture.[144]

It is interesting to note that the *Pena* court placed a maximum thirty minute limitation on the use of physical restraints, while in *Wyatt*, an order could be effective for up to twelve hours in the case of mentally retarded patients and up to twenty-four hours for

139. 344 F. Supp. at 401. The *Wyatt* standards further indicate that a qualified professional may order the use of physical restraints on a mentally retarded patient, but only for a period of 12 hours and only if the patient is examined every half hour. The restraints must not cause physical injury, and discomfort must be minimized. The patient must have an opportunity for motion and exercise for at least 10 minutes for every two hours of physical restraints. *Id.* This last standard is a bit puzzling: physical restraints can be used only if absolutely necessary to prevent harm to the patient or others, then it would seem logical that the patient probably should not be taken off the restraints until he or she poses no further likelihood of harm.

140. 419 F. Supp. 203 (S.D.N.Y. 1976).

141. *Id.* at 210.

142. *Id.* at 211.

143. *Id.* at 210-11.

144. *Id.* at 211.

mentally ill patients in non-emergency situations. It is unclear why juvenile offenders should have greater protection from physical restraints than mental patients, who are less culpable for their behavior and, therefore, less able to understand the reasons for and circumstances of their restraint. In addition, mental patients may also be juveniles, which creates a problem in reconciling and applying the *Wyatt* and *Pena* standards.

The *Wyatt*[145] physical restraints standards for the mentally retarded were followed in *Gary W. v. Louisiana*,[146] and were extended to institutionalized children who are mentally retarded, emotionally disturbed, physically handicapped, socially delinquent, or normal but abandoned. Like *Wyatt*, the court in *Gary W.* ordered that a child "shall be restrained only if alternative techniques have failed and only if such restraint imposes the least possible restriction consistent with its purpose."[147]

In *Halderman v. Pennhurst State School & Hospital*,[148] a class action against Pennhurst, a Pennsylvania institution for the mentally retarded, physical restraints were claimed to be justified by staff shortages. An extreme example was the case of an extremely self-destructive female Pennhurst resident who was placed in a physical restraint device for 651 hours in June, 1976, for 720 hours in August, for 674 hours in September, and for 647 hours in October. However, when occupational therapy was applied, the patient responded successfully, and became able to function without restraints for as much as four hours a day.[149] The court found that physical restraints can be harmful to the patients' bodies, noting specifically the case of one child who was strangled to death when tied to a chair in soft restraints.[150] The court ordered Pennhurst to employ physical restraints only as a part of an individual treat-

145. Wyatt v. Stickney, 344 F. Supp. at 401.

146. 437 F. Supp. 1209, 1213, 1229 (E.D. La. 1976).

147. *Id.* at 1229. As with most other techniques of behavior modification, physical restraints are subject to the "least restrictive alternative" doctrine. That doctrine states that "when government does have a legitimate communal goal to serve, it should act through means that curtail human freedom to no greater extent that is essential for securing the goal." D. Chambers, *Right to the Least Restrictive Alternative Setting for Treatment*, in 2 LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 991, 993 (B. Ennis & P. Friedman eds. 1973). The least restrictive alternative doctrine only recently has been extended to the mental health field. *See, e.g.*, Covington v. Harris, 419 F.2d 617, 623-25 (D.C. Cir. 1969); Lake v. Cameron, 364 F.2d 657, 661 (D.C. Cir. 1966); Wyatt v. Stickney, 344 F. Supp. 373, 379, (M.D. Ala.), 344 F. Supp. 387, 396 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). *See generally* Hoffman & Foust, *supra* note 130.

148. 446 F. Supp. 1295 (E.D. Pa. 1977).

149. *Id.* at 1307.

150. *Id.* at 1307 n.36.

ment plan, and "only when necessary to (1) prevent injury to self or others, or (2) promote normative body positioning and physical functioning."[151] Thus, contrary to earlier cases, the *Halderman* court was willing to permit the use of physical restraints in non-emergency settings where there is a *medical* determination of their necessity.[152]

Similarly, the court in *Evans v. Washington*[153] ordered that physical restraints could be used *only* when necessary to prevent injuries to the patient or others. Furthermore, the court stated explicitly that restraints could not be used for the convenience of the institution's staff.[154] This stricter set of restrictions on physical restraints if the prevailing view, at least as evidenced by recently enacted state statutes.[155] In most instances, therefore, the use of physical restraints as punishment or as a behavior modification contingency will be forbidden by law.

There remains, however, the problem of enforcement of the law. As a practical matter, the protection afforded an incompetent, institutionalized individual is lost without the intervention of a conscious and zealous third party. A patient, bound hand and foot, is in no condition to bring his situation before a court of law. This is especially true of an insane or mentally retarded patient who is unlikely to know that his rights are being violated. For this reason, a relative, guardian, or other responsible person with no connec-

151. *Id.* at 1328.

152. *See also* Eckerhart v. Hensley, 475 F. Supp. 908, 927 (W.D. Mo. 1979), where the court held that the *medical* decision to use physical restraints and seclusions was proper under due process considerations only where there is sufficient documentation of the patient behavior to justify the use of physical restraints or seclusion.

153. 459 F. Supp. 483 (D.D.C. 1978).

154. *Id.* at 488.

155. *See* ARIZ. REV. STAT. ANN. § 36-513 (Supp. 1980-81); ARK. STAT. ANN. § 59-1415 (Supp. 1979); CAL. WELF. & INST. CODE § 5325.1(c) (Deering 1979); COLO. REV. STAT. § 27-10,5-114(7) (Supp. 1979); CONN. GEN. STAT. § 17-206e(a) (West Supp. 1980); GA. CODE ANN. § 88-2503.5 (Supp. 1980); IDAHO CODE § 66-345 (Supp. 1979), ILL. ANN. STAT. ch. 91 1/2, § 2-108 (Smith-Hurd Supp. 1980); IND. CODE ANN. § 16-14-1.6-6 (Burns Supp. 1979); KAN. STAT. ANN. § 59-2928 (1976); KY. REV. STAT. ANN. §§ 202A.180(10), 202B.060(10) (Baldwin Cum. Supp. 1979); LA. REV. STAT. ANN. § 28:171D (West Supp. 1980); ME. REV. STAT. ANN. tit. 34, § 2332-A (Supp. 1980-81); MASS. ANN. LAWS ch. 123, § 21 (Michie/Law Co-op. Supp. 1980); MICH. COMP. LAWS ANN. § 330.1740 (1975); MINN. STAT. ANN. § 253A.17 (West 1971); MONT. REV. CODES ANN. § 38-1320 (Supp. 1979); NEB. REV. STAT. § 83-356 (Cum. Supp. 1980); NEV. REV. STAT. § 433.484(7) (1975); N.J. STAT. ANN. § 30:4-24.2d(3) (West Supp. 1980-81); N.Y. MENTAL HYG. LAW § 33.04 (McKinney 1978); OR. REV. STAT. §§ 426.385(3), 427.031(4) (Supp. 1979); S.C. CODE § 44-23-1020 (1976); S.D. CODIFIED LAWS ANN. §§ 27A-12-6, 27B-8-5 (1976); TENN. CODE ANN. § 33-307 (Supp. 1980); VT. STAT. ANN. tit. 18, § 7704 (1968); WIS. STAT. ANN. § 5161(i) (West Supp. 1980-81); WYO. STAT. § 25-71 (1967).

tion to the institution should be required to periodically make unannounced checks on a patient's condition. Only such scrutiny can give meaning to the prohibition against using physical restraints as punishment.

V. TOKEN ECONOMIES AND THERAPEUTIC LABOR

A. Token Economies

Positive reinforcement (rewards) as a contingency to increase "good" behavior or decrease "bad" behavior is probably the least adversive behavior modification technique currently in use.[156] Positive reinforcement may be either primary or secondary. A primary reinforcer fulfills biological needs such as food, water, sex, or relief from pain. Secondary reinforcers, such as verbal praise, a pat on the back, gold stars or money,[157] are effective as a behavior changing reward because of its past assoication with primary reinforcers. Secondary reinforcers may be "tokens" which can be used to purchase primary reinforcers, such as candy or stockings.[158] The use of "token economies" in institutional settings can be very effective in shaping behavior.

Token economies have three defining characteristics. First, institutional authorities, using their value judgments, must designate desirable behaviors in which persons should engage. Second, there must be tokens, or mediums of exchange which persons receive then they engage in the desirable behaviors.[159] Third, there must be available those primary reinforcers that the persons want and which can be received in exchange for the token earned.[160]

The first formalized use of a token economy scheme in the Federal Bureau of Prisons began in 1965 when the CASE (Contingencies Applicable to Special Education) project was effectuated at the National Training School for Boys in Washington, D.C. CASE was a project designed to motivate delinquent youth to attend school. School attendance was encouraged by giving teenagers secondary reinforcers (called "cash") for achievement in school programs. The "cash" could be used to buy snacks or clothing or to participate in special game activities such as ping pong and pool.

156. THE FEDERAL ROLE, *supra* note 2, at 16.
157. Whitman, *Behavior Modification: Introduction and Implications*, 24 DEPAUL L. REV. 949, 955 (1975).
158. Wexler, *Token and Taboo: Behavior Modification, Token Economies, and the Law*, 61 CALIF. L. REV. 81, 83 (1973).
159. Tokens may be tangible or intangible and may include such things as metallic coins, poker chips, green stamps, or recorded points.
160. Milan & McKee, *Behavior Modification: Principles and Application in Corrections* (Oct. 1973), *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 459, 474-75.

The use of the token economy in the CASE project was considered "very successful both in increasing the amount of time the offenders spend in school and the amount of knowledge they gained."[161]

In an institution, such as an adolescent treatment center, it is easier to modify undesirable behavior with a token economy because the artificial environment is normally much less confortable than the outside living environment. Because basic privileges are so limited, there is a stronger motivation in an institution to earn a higher number of privileges. For example, in a token economy program funded by the Law Enforcement Assistance Administration (LEAA), adolescent subjects, by accumulating points for engaging in cooperative and desirable behavior, could earn extra privileges, which included any of the following: (1) five cigarettes a day; (2) regular meals; (3) a bed; (4) state clothes; (5) one or two hours of daily recreation; and (6) the privilege of participation in the program at all. But if a subject is uncooperative and exhibits undesirable behavior, he or she would be placed at a more coercive privilege level wherein the subject might have to: (1) sleep on a mattress on the floor; (2) wear night clothing only; (3) eat nutritious but unappetizing meals; (4) do boring tasks or calisthenics to receive reinforcement; (5) use the phone only in an emergency; and (6) communicate only with the staff.[162]

A due process question arises where institutionalized subjects begin a token economy program at a level of privileges less than that for the general institution population. In other words, can an artificial treatment environment be created by taking away basic privileges? The question was answered negatively in *Clonce v. Richardson*[163] which dealt with challenges to the START program at the Medical Center for Federal Prisoners at Springfield, Missouri. START (Special Treatment and Rehabilitative Training) was a program to modify the behavior of certain highly aggressive and assaultive inmates. Several privilege levels were established and as an inmate learned to better control his aggressive behavior, he could obtain more privileges. When the inmate could completely control his behavior he was returned to the regular prison environment. The START program succeeded for ten of the nineteen inmates who were involuntarily transferred to the program, which was thought to be a good success rate considering the

161. *Behavior Modification Programs in the Federal Bureau of Prisons: Oversight Hearing Before the Subcomm. on Courts, Civil Liberties and the Administration of Justice of the House Comm. of the Judiciary*, 93d Cong., 2d Sess. 4 (1974) (testimony of Norman Carlson, Director, Federal Bureau of Prisons, Dep't of Justice) [hereinafter cited as *1974 Oversight Hearing*].

162. THE FEDERAL ROLE, *supra* note 2, at 16-17, 358-71.

163. 379 F. Supp. 338 (W.D. Mo. 1974).

criminal backgrounds and extreme prison conduct of the inmates.[164]

In *Clonce*, the plaintiff inmates claimed that the beginning program level, where they were stripped of the most basic rights and privileges, was a form of cruel and unusual punishment. The inmates further alleged that the entire program deprived them of freedom of religion, freedom of expression, freedom from unwarranted search and seizure, and freedom from invasion of privacy.[165] The parties stipulated that START inmates were not allowed to attend religious services, or to acquire political and educational literature. In addition, they were subjected to constant surveillance, which included both body searches and cell searches. Finally, the inmates were housed in small, dimly lit cells. The court did not reach these claims since the Federal Bureau of Prisons discontinued the program, thereby rendering these issues moot.[166] However, *Clonce* did establish that if an inmate is transferred to a behavior modification program like START which involves a sufficient change in confinement conditions, then the inmate is entitled to the due process guarantees of notice, hearing, and an opportunity to challenge his inclusion in the program.[167]

Because the benign nature of token economies as a means of effecting behavior modification, the courts have said little with respect to the constitutional limitations on this form of treatment. Even in light of *Clonce*, if due process rights are protected, a little common sense may be all that is needed to forego constitutional scrutiny. So long as drastric privilege deprivations are not employed at the beginning program level or during the program, none of the problems recognized in *Clonce* need ever materialize.[168]

B. Therapeutic Labor

Within the institutional framework, token economies are often employed so that inmates or patients will learn to adequately per-

164. *1974 Oversight Hearing*, *supra* note 161, at 5-7. The START program was eventually terminated due to the small number of inmates who met the rigid criteria for the program and due to the disproportionate amount of manpower and resources necessary to keep the program in operation. *Id.*

165. 379 F. Supp. at 352.

166. *Id.*

167. *Id.* at 347-48, 352.

168. In Wexler, *supra* note 158, at 107-08, the author concluded that such drastic deprivations may soon subject token economy systems to "legal and behavior extinction." This prediction has not manifested itself in reality, and token economies appear to be a settled and permissive area in the law. For more on the techniques of the token economy, see T. AYLLON & N. AZRIN, THE TOKEN ECONOMY: A MOTIVATIONAL SYSTEM FOR THERAPY AND REHABILITATION (1968).

form institutional work assignments.[169] Job assignments themselves can be therapeutic by reducing apathy and alienation in an institution.[170] However, a problem can arise if an involuntarily committed patient is forced to perform institutional work assignments that have no therapeutic purpose and which are given solely to save labor costs for the institution. One court has held that the Constitution will not tolerate such a situation on the basis of the thirteenth amendment prohibition of involuntary servitude.[171]

The question of where to draw the line between therapautic and nontherapeutic labor was taken up in *Wyatt v. Stickney*,[172] where the *Wyatt* court took an absolutist approach and forbade all involuntary patient maintenance work assignments, whether therapeutic or not.[173] However, the court did allow voluntary patient maintenance work, regardless of any therapeutic value, where patients receive minimum wage compensation under the Fair Labor Standards Act (FLSA).[174] In addition, *Wyatt* also permitted certain therapeutic labor, such as requiring a patient to make his own bed, so long as the labor does not involve operation and maintenance of the institution.[175] *Wyatt* made no mention of the involuntary servitude rationale. Instead, the decision was presumably based on the rationale that uncompensated work is dehumanizing and a violation of the patient's right to treatment.[176]

Shortly after *Wyatt*, a suit was filed in *Souder v. Brennan*[177] to test the applicability of the FLSA to patient-workers in state facilities for the mentally ill and mentally retarded. In a far-reaching decision, the *Souder* court held that such patient-workers were considered "employees" within the meaning of the FLSA, even if the work they do is therapeutic, so long as the institution receives some consequential economic benefit.[178]

169. THE FEDERAL ROLE, *supra* note 2, at 378.
170. *Id.*
171. Jobson v. Henne, 355 F.2d 129, 132 n.3 (2d Cir. 1966). The court also stated that a patient can be required to participate in work assignments where they provide some therapeutic purpose. Without a therapeutic purpose, however, mere payment of compensation for forced labor will not remove work assignments from the thirteenth amendment prohibition. *Id.* at 132.
172. 344 F. Supp. 373, 381 (M.D. Ala.), 344 F. Supp. 387, 402-03 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt 503 F.2d 1305 (5th Cir. 1974).
173. 344 F. Supp. at 381; 344 F. Supp. at 402-03.
174. 29 U.S.C. § 206 (1976 & Supp. III 1979).
175. 344 F. Supp. at 381; 344 F. Supp. at 402.
176. 344 F. Supp. at 375.
177. 367 F. Supp. 808 (D.D.C. 1973).
178. *Id.* at 812-13. By requiring state institutions to pay the federal minimum wage even for therapeutic patient labor, *Souder* has caused some states to abolish all or nearly all work programs which would require compensation. *See* Perlin, *The Right to Voluntary, Compensated, Therapeutic Work as Part of the Right to Treatment: A New Theory in the Aftermath of Souder*, 7 SETON HALL

The effect of *Souder* was substantially limited by *Davis v. Balson*,[179] wherein inmates at the Lima State Hospital argued that the fourteenth amendment was violated by the failure to pay the federal minimum wage to all patients who perform work at the hospital. At one point, 305 inmates worked an average of four to eight hours per day in jobs necessary for proper administration of the hospital, and were paid an average of only ten to fifteen dollars per month. Work assignments were not necessarily based on therapeutic considerations and were generally assigned to serve administrative convenience.[180]

The *Davis* court did not address the federal minimum wage argument because it did not recognize *Souder* as a controlling authority. In explaining its position, the court stated that since the time *Souder* decided that patient workers were "employees" under the FLSA, the Supreme Court had invalidated those amendments to the FLSA which had extended the wage provisions to virtually all state employees.[181] Since this removed the underlying basis for applying the FLSA to patient "employees" of state mental institutions, the *Davis* court found no statutory right to compensation for patient labor.[182] The court did, however, recognize a constitutional right to adequate compensation based on the constitutional right to treatment.[183]

The court in *Davis* held that forced work assignments considered by professionals in the field to be countertherapeutic are violative of a patient's right to treatment.[184] Therefore, certain standards were required to ensure that a patient's right to treatment was honored.[185] These standards included that: (1) no com-

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L. REV. 298, 300 & n.15 (1976). The author argues that termination of work programs in state mental institutions violates a patient's right to treatment, right to the least restrictive treatment, right to freedom from harm, and right to earn a livelihood. *See id. passim*.

179. 461 F. Supp. 842 (N.D. Ohio 1978).

180. *Id.* at 850-51.

181. *Id.* at 851. *See* National League of Cities v. Usery, 426 U.S. 833, 852 (1976).

182. 461 F. Supp. at 851.

183. *Id.* at 851-52. *See* New York State Ass'n for Retarded Children., Inc. v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975); Davis v. Watkins, 384 F. Supp. 1196 (N.D. Ohio 1974); Welsh v. Likens, 373 F. Supp. 487 (D. Minn. 1974), *aff'd*, 550 F.2d 1122 (8th Cir. 1977); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala.), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

184. 461 F. Supp. at 852.

185. *Id.* The *Davis* court seemed very persuaded by the expert testimony of Dr. Walter Fox, M.D., who stated that forcing persons to perform menial tasks can damage their self-image. Dr. Fox also stated that "paying people for the value of work they do" is an "extremely important component in developing a positive attitude toward one's job." *Id.* at 852.

pensation need be given for requiring a patient to perform tasks of a personal housekeeping nature; (2) all work assignments must be based upon an individual patient's treatment needs and not upon the institution's maintenance needs; (3) all work assignments must be approved as a therapeutic activity by a qualified mental health professional responsible for the patient's treatment; (4) all work assignments must be supervised by a qualified staff member; (5) compensation must be given for all work assignments for which the institution would otherwise have to pay an employee; and (6) the patient wage rate shall be the amount that an ordinary employee would receive for performing the work, adjusted downward only if the patient's disability hinders performance.[186]

The labor standards developed in *Davis* appear to be more carefully conceived and more flexible than the *Wyatt* standards. Aside from the constituitonal, rather than statutory, ground for adequate wage reinforcement, an essential difference is that *Davis* permits even involuntary maintenance work by institutionalized patients so long as a therapeutic purpose is involved. This change from the absolute prohibition of involuntary maintenance work in *Wyatt* is beneficial both to the patient who can gain self-esteem from the treatment measure, and to the institution which can receive any services the patient is able to deliver, with wages adjusted according to ability. These practical and humanitarian considerations make the *Davis* standards a better guide for state regulation of therapeutic labor in institutions.[187] The chief effect of *Davis* is to greatly extend the use of therapeutic labor as a constructive behaviour modification device.

VI. PSYCHOSURGERY AND ELECTRIC SHOCK

A. Psychosurgery

Psychosurgery and electric shock are the two most extreme and controversial means to achieve behavior change in persons. Psychosurgery may be defined as the surgical removal or destruction of brain tissue or the cutting of brain tissue to disconnect one lobe of the brain from the other "with the primary intent of altering be-

186. *Id.* at 852-53. The court noted that because these standards were based on a patient's right to treatment, they were applicable to civilly as well as criminally committed persons. *Id.* at 853.

187. Recent statutes regulating patient labor include: KAN. STAT. ANN. § 59-2929(5) (1976); MONT. REV. CODES ANN. § 38-1318 (Supp. 1977); NEB. REV. STAT. § 83-1066(7) (Reissue 1976); N.Y. MENTAL HYG. LAW § 33.04 (McKinney 1978); OHIO REV. CODE ANN. §§ 5122.28, 5123.87 (Supp. 1979-80); OR. REV. STAT. §§ 426.385(1)(j), 427.031(1)(i) (Supp. 1979); S.C. CODE § 44-23-1060 (1976); WIS. STAT. ANN. § 51.61(b) (West Supp. 1980-81).

havior, thought, or mood."[188] Although not a behavior modification technique in the sense of a contingently administered stimulus seeking a desired response under learning theory principles,[189] psychosurgery is often aligned with other behavior modification techniques because the result of its use—a change in behavior—is the same. An essential difference is that psychosurgery can change behavior permanently and unpredictably.

Psychosurgery as a medical-surgical procedure[190] is unsettled, and it likewise exists in an unsettled, legal environment, although the argument has been advanced that regulation can stabilize the legal environment.[191] There is a dearth of case law concerning the constitutional limits of psychosurgery. Surprisingly, the landmark decision in this area is an unreported opinion, *Kaimowitz v. Department of Mental Health*,[192] which is recognized as the principal judicial pronouncement on experimental psychosurgery.[193]

In *Kaimowitz*, a civilly committed sexual psychopath had given initial written consent to submit to a state-funded medical experiment. The planned experiment was to compare the effects of the drug cyproterone acetate with psychosurgical destruction of a portion of the brain. The goal of the experiment was to determine which technique is more effective in controlling aggression in insti-

188. *Psychosurgery Report of the National Institute of Mental Health* (Jan. 21, 1974), *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 142.

189. *See* notes 2-7 & accompanying text *supra*.

190. Not long ago, a panel of scientific, clinical, legal, and ethical experts convened to study the current practice of psychosurgery. The panel recommended the following: "*Psychosurgery should be regarded as an experimental therapy at the present time*—As such, it should not be considered to be a form of therapy which can be made generally available to the public because of the peculiar nature of the procedure and of the problems with which it deals." *Psychosurgery Report of the National Institute of Mental Health* (Jan. 21, 1974), *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 144.

191. Peters & Lee, *Psychosurgery, A Case for Regulation*, 1978 DET. C.L. REV. 383, 410.

192. Civ. No. 73-19434-AW (Cir. Ct. Wayne County, Mich. filed July 10, 1973), *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 510, *and* A. BROOKS, *supra* note 51, at 902. *See also* Note, *Kaimowitz v. Department of Mental Health: A Right to Be Free from Experimental Psychosurgery?*, 54 B.U. L. REV. 301 (1974).

193. *See also* Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (1976), which involved challenges to amendments to a California statute concerning the regulation of psychosurgery and electric shock treatment. The court held, *inter alia*, that the amendments were unconstitutionally vague since the only prerequisite for treatment was that treatment must be critically needed for the welfare of the patient. *Id.* at 677-78, 129 Cal. Rptr. at 545. The court also held that the failure to provide for adequate notice of a hearing was a denial of procedural due process. *Id.* at 684-86, 129 Cal. Rptr. at 549-50. For a brief discussion of the other issues in *Aden*, see Comment, *Psychosurgery: The Rights of Patients*, 23 LOY. L. REV. 1007, 1012-14 (1977).

tutionalized males.[194] A third party challenged the validity of the experiment and the court held that an *involuntarily* committed mental patient does not have the legal capacity to give informed consent to destructive experimental psychosurgery.[195] The elements of informed consent—competency, knowledge, and voluntariness—cannot be ascertained with sufficient reliability to safeguard a patient's interest from such an invasive procedure as psychosurgery. Of the three elements of informed consent, the court gave the most attention to voluntariness. With respect to institutionalized persons, the court stated:

> Involuntarily confined mental patients live in an inherently coercive institutional environment. Indirect and subtle psychological coercion has a profound effect upon the patient population. Involuntarily confined patients cannot reason as equals with the doctors and administrators over whether they should undergo psychosurgery. They are not able to voluntarily give informed consent because of the inherent inequality of their position.[196]

It is interesting to note that the court specifically held that an involuntarily detained mental patient could give informed consent to accepted neurosurgical procedures, the implication being that psychosurgery was not yet an accepted neurosurgical procedure.[197]

The *Kaimowitz* court drew further support for its decision from the first amendment right of citizens to control their own "minds, thoughts, and expressions,"[198] and the right of privacy in bodily

194. Kaimowitz v. Department of Mental Health, *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 510-11, *and* A. BROOKS, *supra* note 51, at 902-03.

195. Kaimowitz v. Department of Mental Health, *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 517-20, *and* A. BROOKS, *supra* note 51, at 903. The three elements required for informed consent in *Kaimowitz* are briefly explained in Barnhart, Pinkerton & Roth, *Informed Consent to Organic Behavior Control*, 17 SANTA CLARA L. REV. 39 (1977):

> (1) *knowledge*—the adequacy of the information conveyed to the prospective treatment subject and his or her comprehension of this information;
> (2) *volition*—the circumstances allowing for freedom of choice; and
> (3) *competency*—the capacity to make rational or intelligent judgments.

Id. at 51 (footnotes omitted).

196. Kaimowitz v. Department of Mental Health, *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 519-20, *and* A. BROOKS, *supra* note 51, at 915.

197. Kaimowitz v. Department of Mental Health, *reprinted in* THE FEDERAL ROLE, *supra* note 68, at 523, *and* A. BROOKS, *supra* note 51, at 918. It appears that the court's decision was heavily influenced by the irreversible and intrusive effects of experimental psychosurgery. The court found that psychosurgery often leads "to the blunting of emotions, the deadening of memory, the reduction of affect, and limits the ability to generate new ideas." Kaimowitz v. Department of Mental Health, *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 522, *and* A. BROOKS, *supra* note 51, at 917.

198. Kaimowitz v. Department of Mental Health, *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 522, *and* A. BROOKS, *supra* note 51, at 917. The court agreed

and mental functions.[199] With respect to the asserted right of privacy in bodily functions, there is clear support from the Supreme Court.[200] From the recognition of bodily privacy, it follows that mental functions, such as thought, behavior, personality and identity, which lie at the core of one's individuality, are equally deserving of the protection afforded by the right of privacy.[201]

Federal involvement in the area of psychosurgery resulted in the passage of the National Research Service Award Act of 1974[202] which created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The commission was required to study the practice of psychosurgery in the United States and to make recommendations to the Secretary of the Department of Health, Education and Welfare of policies for the continued use of psychosurgery.[203] In 1977, the Commission issued its report[204] which reviewed the history of psychosurgery.[205] The report surveyed relevant issues, case law, and applicable legislation.[206] As a result of the Commission's studies and hearings,[207] eight recommendations were formulated by the Commission[208] on the use of psychosurgery.

The Commission's first four recommendations set out the basic requisites to psychosurgeries.[209] The final four recommendations

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that the law must provide "[p]rotection of the individual's right to freedom of expression against interference by the government in its efforts to achieve other social objectives or to advance its own interests." Kaimowitz v. Department of Mental Health, *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 521, *and* A. BROOKS, *supra* note 51, at 916-17 (*quoting* Emerson, *Toward A General Theory of the First Amendment*, 72 YALE L.J. 877, 895 (1963)). The court found no compelling state interest sufficient to override the patient's first amendment interest in mental processes.

199. Kaimowitz v. Department of Mental Health, *reprinted in* THE FEDERAL ROLE, *supra* note 2, at 522-23, *and* A. BROOKS, *supra* note 51, at 919-20.

200. *See, e.g.*, Roe v. Wade, 410 U.S. 113 (1973) (a woman's right to bodily privacy permits her decision to terminate pregnancy in its early stages); Stanley v. Georgia, 394 U.S. 557 (1969) (right to view obscenity in the home); Griswold v. Connecticut, 381 U.S. 479 (1965) (right of privacy prohibits laws against dissemination of contraceptives).

201. *See* Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616, 663 (1972).

202. 42 U.S.C. § 2891-1 (1974).

203. *Id.*

204. 42 Fed. Reg. 26318 (1977).

205. *Id.* at 26319-20.

206. *Id.* at 26320-23.

207. *Id.* at 26323-29.

208. *Id.* at 26329-32.

209. (1) That any psychosurgery proceedure should be performed only at an institution with an institutional review board (IRB) and only after such IRB has determined that (a) the surgeon is competent in the procedure, (b) the procedure is appropriate for the particular pa-

merely set out certain HEW follow-up procedures.[210] In summarizing its report, the commission stated:

> This report recommends the [*sic*] psychosurgery be used only to meet the health needs of individual patients, and then only under strict limitations and controls, with added safeguard where the patient is a prisoner, minor, or in a mental institution.[211]

Although the Commission's report is not law, it does conclude that the *Kaimowitz* approach might not apply today. New information in the field indicates that psychosurgery can be "less hazardous than previously thought and potentially of significant therapeutic value."[212] The Commission looked with favor upon Oregon's comprehensive legislation for the regulation of psychosurgery.[213] The Oregon model requires committee review of both the merits of the therapy and informed consent, permits psychosurgery on involuntarily committed patients, and recognizes guardian or proxy consent to psychosurgery of an incapacitated patient.[214]

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tient, (c) adequate pre- and post operative evaluations will be performed; and (d) the patient has given informed consent.

Id. at 26329-30. In (2), (3) and (4) the commission incorporates the requirements of recommendation (1) and imposes further conditions for the performance of psychosurgery on specific populations of patients whose capacity for self-determination may be limited by institutionalization, mental disability, involuntary confinement or immaturity. For specific provisions, see *id.* at 26330-31.

210. (5) Material concerning the nature, extent and outcomes of psychosurgical procedures should be compiled. Stringent provisions for the safeguard of privacy must be included as well.
(6) The secretary is encouraged to conduct studies and evaluate the safety and efficacy of specific procedures in relieving specific psychiatric symptoms and disorders.
(7) The secretary should impose strict sanctions, including the withholding of federal funds to insure compliance with the regulations implementing these recommendations.
(8) Congress should take appropriate action to assure implementation of regulations and to assure psychosurgery is not conducted or supported by Federal agencies unless such agencies are primarily concerned with health care or the conduct of biomedical and behavorial research.

Id. at 26331-32.

211. *Id.* at 26318.

212. *Id.* at 26323.

213. OR. REV. STAT. §§ 426.700 to .760 (Supp. 1979).

214. *Id.* In addition, it must appear that these conditions are met before the review board can deem a psychosurgery (or lobotomy) operation appropriate in a given case:
(a) All conventional therapies have been attempted;
(b) The criteria for selection of the patient have been met;
(c) The operation offers hope of saving life, reestablishing health or alleviating suffering; and
(d) All other viable alternative methods of treatment have been tried and have failed to produce satisfactory results.
OR. REV. STAT. § 426.720(3) (Supp. 1979). Compare this statute with psycho-

Because the Commission's report suggests that certain kinds of psychosurgery may be becoming medically acceptable as a treatment for extreme cases of behavior disorders, more regulation of the procedure will probably occur.[215] Like the relatively complete Oregon model, the statutes should make it clear that psychosurgery should not be used except as a last resort necessary to protect the patient's health and then only with adequate informed consent. Because of its extreme intrusiveness on the body and the mind, some legislators may well advocate that psychosurgery not be used as treatment in any circumstances. Certainly, because of the potential permanent adverse effects, such as those alluded to in *Kaimowitz*,[216] state lawmakers should consider all legal as well as ethical components of psychosurgery.[217] For instance, one question that must be asked is whether it is morally permissible for a psychosurgeon to invade the cavity of the mind and alter it as a dentist would fill a tooth. Direct tinkering with the brain is an invasion of the last bastion of human autonomy. If the sovereign is permitted to make such invasions, albeit in extreme cases, then nothing humans possess is sacred.

B. Electric Shock

Another extreme method used to change problem behavior in persons is the contingent application of electric shocks. Electric shock treatment, which is to be distinguished from electroconvulsive therapy,[218] can be a very adverse form of punishment, de-

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surgery regulation in other states. *See* ARK. STAT. ANN. § 59-1415 (Supp. 1979); CAL. WELF. & INST. CODE §§ 5325(g), 5326.95 (Deering 1979); CONN. GEN. STAT. ANN. § 17-206d(d) (West Supp. 1980); FLA. STAT. ANN. § 458.325 (West Supp. 1980); ILL. ANN. STAT. ch. 91 1/2, § 2-110 (Smith-Hurd Supp. 1980); KAN. STAT. ANN. § 59-2929(6) (1976); KY. REV. STAT. ANN. §§ 202A.180(7), 202B.060(7) (Baldwin Cum. Supp. 1979); LA. REV. STAT. ANN. § 28:171 0 (West Supp. 1980); MASS. CONN. LAWS ch. 123, § 23 (Michie/Law. Co-op. Supp. 1980); MONT. REV. CODES ANN. § 38-1322 (Supp. 1977); N.J. STAT. ANN. § 30:4-24.2d(2) (West Supp. 1980-81); OHIO REV. CODE ANN. §§ 5122.27.1(6), 5123.86(6) (Page Supp. 1979); S.C. CODE § 44-23-1010 (1976); WIS. STAT. ANN. § 51.61(k) (West Supp. 1980-81).

215. *See generally* Peters & Lee, *Psychosurgery: A Case for Regulation*, 1978 DET. C.L. REV. 383.

216. *See* notes 59 & 197 *supra*.

217. *See generally* Greenblatt, *The Ethics and Legality of Psychosurgery*, 22 N.Y.L. SCH. L. REV. 961 (1977).

218. Electroconvulsive therapy, which is not technically within the scope of behavior modification, is a method of inducing an epileptic-like seizure under the theory that it will reintegrate "the split personality of a schizophrenic." R. MARTIN, LEGAL CHALLENGES TO BEHAVIOR MODIFICATION 145 (1975). Electroconvulsive therapy can also be used to treat severe depression in a patient. Note, *Regulation of Electroconvulsive Therapy*, 75 MICH. L. REV. 363, 363 (1976).

pending of course upon the duration and intensity of the shock. Because of its potential for abuse, one would suspect that adequate safeguards for its use would have been formulated either judicially or legislatively. However, with the exception of a few state statutes,[219] the law on the subject is sparse.

The *Wyatt*[220] minimum constitutional standards for adequate rehabilitation of mentally retarded persons continue to prevail as the governing judicial authority in the area. The standards indicate that electric shock devices "shall only be used in extraordinary circumstances to prevent self-mutilation leading to repeated and possibly permanent physical damage to the resident and only after alternative techniques have failed."[221] The standards also require the patient's informed consent to treatment, and a committee's review and professional supervision of the treatment.[222]

Perhaps the main deficiency in the *Wyatt* standards for electric shock treatment is that there are no provisions for the maximum voltage allowed or the maximum time for which a shock can be administered. Although shocks are usually brief and low-level,[223] any regulation governing their application for behavior modification purposes should set a point beyond which individual rights are clearly implicated.

VII. CONCLUSION

In foreseeing the future of behavior modification, one could paint a gloomy picture indeed. One might imagine an Orwellian nightmare where the sovereign need only to apply carefully controlled psychological principles to shape the citizenry into a conforming, obedient, and unthinking society. Day-to-day conduct would be determined by a prepared program so that there would

219. Several states have recently enacted statutes regulating the use of electric shock treatment or electroconvulsive therapy. *See* ARK. STAT. ANN. § 59-1415 (Supp. 1979); CAL. WELF. & INST. CODE §§ 5325(g), 5326 to 5326.95 (Deering 1979); CONN. GEN. STAT. ANN. § 17-206d(d) (West Supp. 1980); FLA. STAT. ANN. § 458.325 (West Supp. 1980; ILL. ANN. STAT. ch. 91 1/2, § 2-110 (Smith-Hurd Supp. 1980); IOWA CODE ANN. § 229.23 (West Supp. 1980-81); KAN. STAT. ANN. § 59-2929(6) (1976); KY. REV. STAT. ANN. §§ 202A.180(7), 212B.060(7) (Baldwin Cum. Supp. 1979); LA. REV. STAT. ANN. § 28:171F (West Supp. 1980); MASS. ANN. LAWS ch. 123, § 23 (Michie/Law. Co-op. Supp. 1980); MICH. COMP. LAWS ANN. § 330.1716 (1975); MO. REV. STAT. § 202.213 (1978); N.J. STAT. ANN. § 30:4-24.2d(2) (West Supp. 1980-81); OHIO REV. CODE ANN. §§ 5122.27.1(2), 5123.86(2) (Page Supp. 1979); OR. REV. STAT. § 426.385(2) (Supp. 1979); S.C. CODE § 44-23-1010 (1976); WIS. STAT. ANN. § 51.61(k) (West Supp. 1980-81).

220. Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

221. 344 F. Supp. at 400-01.

222. *Id.* at 400-01.

223. Budd & Baer, *supra* note 9, at 217.

no longer be even an illusion of free will or free thought. Although this chilling scene is not impossible, a more likely prediction is that behavior modification principles will be responsibly used by profesionals possessing sound ethical standards. It is true that even the most ethical professional has periodic lapses in judgment. It is therefore necessary for the sovereign to recognize and vigorously protect the individual rights of the citizenry. The sovereign then would not control human behavior, but control the controllers.

To ensure the sound evolution of behavior modification, the law concerning the various techniques should be standardized. The law has reached the point where there are clear trends, especially as to the constitutional rights of patients in mental institutions, but a sense of uniformity is lacking. Now is the best time for a national committee to reinvestigate the use of behavior modification in light of recent legal developments. Such a committee should thoroughly examine the ethical issues. It should consider the legal issues and draw from the best of the federal case law and state statutes to create a model act which would guarantee rights to all individuals, not just institutionalized persons.

The *Wyatt* standards have provided a good starting point for an analysis of the issues; yet, because of the volatile state of the art, the law needs to be refined, particularly in the areas of procedural due process and right of privacy where there is still considerable uncertainty. The day is near when behavior modification techniques such as those discussed herein may unexpectedly confront each and every one of us in the educational, commercial, and even home settings. If we are to preserve the integrity of the mental processes, then it is essential that we act now to gather the pieces of the law of behavior modification and construct a stronger fortress against potentially abusive treatment.

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