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The Right Against Treatment: Behavoir Modification and the Involuntarily Committed

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RECENT DEVELOPMENTS

The Right Against Treatment: Behavior Modification and the Involuntarily Committed

In recent years there has been a readily observable trend to treat various types of formerly criminal behavior in terms of illness, the cause of which is to be sought in physical or psychological dysfunction rather than in terms of *mens rea*.[1] This trend has proceeded to such a degree that psychopaths, juveniles, alcoholics, and drug addicts—all formerly *criminals*—have now become *deviants*.[2] Although this shift from retribution and deterrence to therapy and rehabilitation has placed an emphasis on what might be broadly termed "treatment" rather than punishment, nevertheless, the modalities of the traditional penal system have in large measure been retained. For example, incarceration for long, often indeterminate periods of time and the employment of various "treatments" sometimes rather closely resemble solitary confinement and hard labor in their painful effects. The danger in this trend, of course, lies in the fact that the reclassification of many former crimes as illnesses has withdrawn them from the protection and safeguards which have been hammered out over the course of centuries in criminal law and has placed them under the ill-defined *parens patriae* function of the state—the paternal and therapeutic role derived from the notion of the benevolent sovereign as guardian of the people.[3]

Although the courts have already attempted to require mental hospitals to provide treatment for patients involuntarily committed,[4] advancements in the field of psychology—behavior control, drug therapy, conditioning and psychosurgery—have given rise to the question whether there is a right *against* treatment. The eighth amendment's prohibition against cruel and unusual punishment has served well in the criminal area to check the zeal

1. "The criminal law in the United States has been undergoing a process of divestment—a relinquishing of its jurisdiction over many of its traditional subjects and areas." N. KITTRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY 4 (1971).
2. *Id.* at 5.
3. *Id.*
4. Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966).

of correctional personnel and the so-called "hangin' judge,"[5] but since the landmark case of *Robinson v. California*,[6] the application of therapeutic techniques has been taken out of the "punishment" category and reclassified as "treatment," thus withdrawing it from eighth amendment protection. It would seem that the recognized technique of behavior modification,[7] for example, could be applied in all of its aspects as long as it could be justified as treatment. In other words, it would be permissible to "make a bank robber want to vomit every time he saw a bank, . . . an armed robber shudder every time he saw a gun."[8] Whether or not the state has the authority to so modify the behavior of an involuntarily confined mental patient has been recently litigated in *Knecht v. Gillman*.[9] This article will explore behavior modification as it is in fact practiced in our mental hospitals, the issue of whether there exists a right against such treatment, and, if so, the basis for its assertion.

Drug therapy, specifically apomorphine, was the technique of behavior modification used in the *Knecht* case. The effect of apomorphine is to induce a period of vomiting lasting from fifteen minutes to an hour.[10] Appellants, Gary Knecht and Ronald Stevenson, were confined at the Iowa Security Medical Facility (ISMF) where they were subjected to the apomorphine treatment which they alleged was without their consent and constituted cruel and unusual punishment in violation of the eighth amendment. The ISMF is "an institution for persons displaying evidence of mental illness or psychological disorders and requiring diagnostic services and treatment in a se-

5. "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. CONST. amend. VIII. Rudolph v. Alabama, 375 U.S. 889 (1963). *See* Gates v. Collier, 349 F. Supp. 881 (N.D. Miss. 1972); Jones v. Wittenberg, 323 F. Supp. 93 (N.D. Ohio 1971); Hamilton v. Schrio, 338 F. Supp. 1016 (E.D. La. 1970); Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970).

6. 370 U.S. 660 (1972).

7. Behavior modification can be defined as the training of an organism through punishment and reward to act in a specific way when confronted with a particular stimulus. For purposes of this article, the pertinent method is aversion therapy which employs negative reinforcement, *i.e.*, an unpleasant stimulus either associated with or consequent upon a particular behavior. The goal of this technique is to develop a connection between the behavior and the unpleasant stimulus, thus forcing the subject to cease the undesirable behavior. Anthony Burgess' novel, *A Clockwork Orange* (1962), provides an example of this technique. By repeatedly pairing an injection of a nausea-producing drug with pictures of violently aggressive behavior, Burgess' main character was conditioned to be overcome with extreme nausea every time he became involved in such behavior. *See generally* Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616, 627-31 (1972).

8. Singer, *Psychological Studies of Punishment*, 58 CALIF. L. REV. 405, 433 (1970).

9. 488 F.2d 1136 (8th Cir. 1973).

10. *Id.* at 1137.

curity setting."[11] Apomorphine was administered to patients with "behavior problems," which, according to testimony at the trial, consisted of not getting up, giving cigarettes against orders, talking, swearing, or lying.[12] Any other inmate or any staff member could report on these violations, and an intra-muscular injection of the drug would then be given by a nurse. It was not necessary that any nurse or doctor observe the misbehavior, and the specific authorization of a doctor was not required. The drug was administered in a room near the nurses' station which contained only a toilet.

Whether the appellants' consent was obtained prior to subjecting them to aversion therapy is not clear from the opinion. The court noted that the drug had been administered without consent a few times prior to appellants' experience, but went on to state that at the time of trial ISMF authorities required a signed consent form. The court, however, pointed out three objectional areas of the treatment: (1) the authorities did not permit the inmate to withdraw his consent once given; (2) the approval of a physician was not required prior to each injection; and (3) the drug was administered upon reports of fellow inmates.[13]

Treatment or Punishment?

Due to the fact that ISMF receives persons committed under civil statutes and persons committed prior to conviction, the court emphasized that the procedures employed at the institution must be non-penal in order to justify the incarceration of such persons and the compromise of their constitutional rights. Moreover, since the purpose of ISMF according to statute[14] is examination, diagnosis, and treatment, the institution would be in violation of state law were it to employ penal measures. The court concluded, therefore, that since the administration of drugs is treatment, the administration of apomorphine "can be justified *only* if it can be said to be treatment."[15] The

11. *Id.* at 1138. More specifically, "[t]he patients admitted to the facility may originate from the following sources:

1) residents of any institution under the jurisdiction of the department of social services;
2) commitments by the courts as mentally incompetent to stand trial under Chapter 783 of the Iowa Code;
3) referrals by the court for psychological diagnosis and recommendations as part of the pretrial or presentence procedure or determination of mental competency to stand trial;
4) mentally ill prisoners from the county and city jails for diagnosis, evaluation, or treatment.

Section 223.4, Code of Iowa, 1973." *Id.*

12. *Id.* at 1137.
13. *Id.* at 1138.
14. *See* note 11 *supra.*
15. 488 F.2d at 1138 (emphasis added).

court thus seemingly required a very strict criterion, namely, that *only* if apomorphine is treatment can it then be used at ISMF, a non-penal institution. Nevertheless, the court then proceeded to equivocate. If "it is not possible to say that the use of apomorphine is a recognized and acceptable medical practice in institutions such as ISMF,"[16] then it may be used provided the subject consents. The court retreated from its original criterion (that apomorphine *must* be treatment) to one where the use of apomorphine is possible as long as *it cannot definitely be said not to be treatment*, and as long as there are appropriate safeguards. The reason for this shift in emphasis is not clear from the opinion, but since the court later provided for the withdrawal of consent at any time, the discussion becomes merely academic. In effect, the court's definition of informed consent will probably result in the elimination of the use of apomorphine at ISMF.

From Punishment to Required Treatment

The *Knecht* case, perhaps the first court test of aversion therapy, comes at the end of a recent development in the law which began with the removal of deviants from the traditional criminal law process. Initially, this was seen as humane as, for example, the new definition of criminal insanity[17] formulated by Chief Judge Bazelon in 1954 which abandoned the century-old *M'Naghten* test.[18] Hailed as a liberal and enlightened decision at the time,[19] it ironically had the effect of giving psychiatric examination and diagnosis such legal force that many defendants found themselves incarcerated in mental institutions for indeterminate lengths of time with little hope of release. In *Robinson v. California*[20] the Supreme Court gave constitutional sanction to the removal of deviants from criminal law. In that case, the Court held that drug addiction (as distinguished from the possession, use, and sale of narcotics) was an illness and thus not punishable under

16. *Id.* The court noted the conflicting expert opinions on the medical acceptability of apomorphine therapy. Dr. Fox stated that "behavior modification by aversive stimuli is 'highly questionable technique' and that only a 20% to 50% success is claimed." He further testified that "its use is really punishment." Dr. Loeffelholz, on the other hand, testified that "there had been a 50% to 60% effect in modifying behavior by the use of apomorphine at ISMF." *Id.* at 1138.

17. Durham v. United States, 214 F.2d 862 (D.C. Cir. 1954). "The rule . . . is simply that an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect." *Id.* at 874-75.

18. M'Naghten's Case, 10 Cl. & Fin. 200, 8 Eng. Rep. 718 (H.L. 1843). "[T]o establish a defense on the ground of insanity it must be clearly proved that . . . the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature or quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong." *Id.* at 722.

19. N. KITTRIE, *supra* note 1, at 46. *See* Fortas, *Implications of Durham's Case*, 113 AM. J. PSYCHIATRY 577 (1957).

20. 370 U.S. 660 (1962).

criminal law sanctions.[21] The Court based its decision on the eighth amendment's prohibition against "cruel and unusual punishments," which formerly had been applied only to prohibit punishment disproportionate to the offense.[22]

In time, however, the courts became increasingly aware of the vast power they had invested in the therapists by removing large numbers of former criminals not only from criminal law sanctions but also from criminal law due process protections. Consequently, the courts began to take steps to restrict the broad *parens patriae* powers of the state through due process guarantees. In the Supreme Court, the movement to protect those outside the traditional judicial process of criminal law occurred in the area of procedural due process. *In re Gault*,[23] for instance, accorded juveniles the minimal requirements of procedural due process. More recently, the Court in *Jackson v. Indiana*[24] moved to insure due process in commitment procedures by invalidating the commitment of a mentally retarded deaf mute on the basis of his incompetency to stand trial on a criminal offense. The Court held that such a person

> cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain [the capacity to stand trial] in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant.[25]

Lower federal courts have been active in the area of substantive due process. The District of Columbia Circuit, for example, the same court which decided *Durham*,[26] sought to insure that the involuntarily committed would not merely languish in mental hospitals for indeterminate periods, but would receive treatment. In *Rouse v. Cameron*,[27] that court found a right to treatment derived primarily from the 1964 Hospitalization of the Mentally Ill Act, but it also mentioned arguments for such a right based solely on constitutional guarantees. Since *Rouse*, one federal district court[28] has ex-

21. Since *Robinson*, efforts have been made to test the validity of criminal sanctions for chronic alcoholics. *See* Powell v. Texas, 392 U.S. 514 (1968); Easter v. District of Columbia 361 F.2d 50 (D.C. Cir. 1966); Driver v. Hinnant, 356 U.S. 66 (1962).

22. This principle was reiterated in Rudolph v. Alabama, 357 U.S. 889 (1963).

23. 387 U.S. 1 (1967).

24. 406 U.S. 715 (1972).

25. *Id.* at 738.

26. *See* note 17 *supra.*

27. 373 F.2d 451, 453 (D.C. Cir. 1966). *See* Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966); Note, *supra* note 7, at 641.

28. Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970). *See* Note, *supra* note 7, at 645.

panded the right to treatment into a right to rehabilitation which would apply to ordinary criminals as well as the mentally disturbed, and which would compel prison authorities to institute positive programs designed to return prisoners to normal life rather than merely confine them behind bars.

Cruel and Unusual Treatment?

It is in this context that the *Knecht* case attempted to improve on *Robinson* by extending eighth amendment protection to non-criminals and to parallel *Rouse* with a right *against* treatment. The *Knecht* analysis began with *Trop v. Dulles*[29] which the court saw as authority for the proposition that although apomorphine aversion therapy may be therapy, it nevertheless can be reviewed under eighth amendment standards. In *Trop*, the Supreme Court said that "even a clear legislative classification of a statute as 'nonpenal' would not alter the fundamental nature of a plainly penal statute."[30] Thus, the *Knecht* court denied the distinction between penal and non-penal which has in the past been used to justify such practices as involuntary sterilization, found to be constitutional in *Buck v. Bell*[31] and *Skinner v. Oklahoma*.[32] Professor Kittrie notes:

> The argument that involuntary sterilization constitutes "cruel and unusual" punishment has been . . . unfruitful. The courts have avoided the constitutional confrontation by characterizing the insane or feeble-minded as non-criminals and the operation as non-punitive. Since sterilization is designed for social improvement and not punishment, the courts hold, it is not subject to the limitations imposed upon criminal punishment.[33]

By scrutinizing the "fundamental nature" of the non-penal apomorphine treatment, the Eighth Circuit concluded:

> Whether it is called "aversive stimuli" or punishment, the act of forcing some one to vomit for a fifteen minute period for committing some minor breach of the rules can only be regarded as cruel and unusual unless the treatment is being administered to a patient who knowingly and intelligently consented to it.[34]

If, according to *Trop*, it is not whether a particular procedure is *called* treatment or punishment, but whether in the particular case such procedure may *by its nature* be considered cruel and unusual, then it is submitted that the

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29. 356 U.S. 86 (1958).
30. *Id.* at 95.
31. 274 U.S. 200 (1927).
32. 316 U.S. 535 (1942). The sterilization was actually disallowed, but on the grounds that the specific exemption of embezzlement from the class of felonies involving moral turpitude was an unreasonable classification and a denial of equal protection.
33. N. KITTRIE, *supra* note 1, at 319.
34. 488 F.2d at 1139-40.

very nature of involuntary sterilization is as much cruel and unusual punishment as apomorphine aversion therapy. Consequently, *Buck* and *Skinner* under the broader *Trop* test would probably be decided differently.

The exposure of all treatments to eighth amendment scrutiny raises the question of new standards. In *Trop*, the Court suggested that each case should be decided in the light of "the evolving standards of decency that mark the progress of a maturing society."[35] The vagueness of this standard is evident from the fact that most eighth amendment decisions since *Trop* have been on an ad hoc basis.[36] Furthermore, this standard is vulnerable to the behaviorists' claims that their techniques represent "the progress of a maturing society." What is needed is some other standard which provides more guidance but remains flexible enough to respond to advances in psychology. Psychological theories of motivation, specifically those of R.B. Cattell and A.H. Maslow, can shed some valuable light on this perplexing problem.

Hierarchy of Motivation

The theories of both Cattell and Maslow postulate a hierarchy of motivation, *i.e.*, they attempt to rank the instinctual forces in the human psyche according to their relative strengths, the most basic being the strongest. These instinctual forces are innate and hereditarily determined.

Cattell calls these instinctual forces "*ergs*" and characterizes each of them as inherent dynamic patterns. According to Dr. Stagner,

> Each erg or instinct has three attributes: the person tends to perceive more promptly certain classes of objects related to that erg; he tends to experience certain emotions in relation to these objects; and he starts on a course of action which ceases when a specific goal activity is achieved.[37]

The sexual erg, for example, would exhibit the following attributes: the perception of appropriate sex objects, sexual arousal as to these objects, and sexual effort resulting in some form of consummation. Cattell did not specify the exact number of human ergs, but he did work out a list of fourteen

35. 356 U.S. at 101.

36. The following have been found to be cruel and unusual punishment: the death penalty when applied arbitrarily, Furman v. Georgia, 408 U.S. 238 (1972); penal incarceration for status, Robinson v. California, 370 U.S. 660 (1962); civil commitment for status without treatment, Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); strip-rooms and solitary confinements, LaReau v. MacDougall, 473 F.2d 974 (2d Cir. 1972), *cert. denied*, 414 U.S. 878 (1973); tranquilizing drugs, Nelson v. Heyne, 355 F. Supp. 451 (N.D. Ind. 1972); corporeal punishment of prisoners, Jackson v. Bishop, 404 F.2d 571 (8th Cir. 1968).

37. R. STAGNER, PSYCHOLOGY OF PERSONALITY 301 (1961).

ranked according to relative strength.[38] He measured the relative strengths by noting "memory for words and pictures relating to the erg; galvanic skin response to such words or pictures; reported interest in the class of stimuli; reported time and money expenditures on a class of stimuli,"[39] etc. Cattell himself admitted that these classifications were only probable, but he did point out the following convincing criteria:

> (1) a similar pattern in mammals, especially primates, indicating a biological basis for the erg; (2) a universal pattern appearing in a wide diversity of cultures; (3) the pattern of attention, emotion, and response mentioned above, despite environmental variations; (4) an accompanying unlearned facial and visceral pattern of expression; (5) presence at birth; (6) powerlessness of training to eliminate this propensity.[40]

Maslow also proposed a hierarchy of motivations, but he differs from Cattell in two respects.[41] First, Maslow's hierarchy is based on *need*, with the corollary that the physiological needs must be satisfied before the "higher" needs even manifest themselves. Cattell's ergs were supposed to be present at all time, differing only in their degree of intensity. Second, Maslow's categories are very general and are thus more in keeping with the certitude of

38. Table 13.1
Cattell's List of "Ergs" Arranged in Order of Relative Strength

Erg	*Coleman and McRae's method**	*Cattell's method*
Mating	1	1
Self-assertion	6	2
Pugnacity	5	3
Repugnance	9	4
Appeal	Not included	5
Hunting	Not included	6
Laughter	Not included	7
Self-abasement	2	8
Construction	Not included	9
Flight	3	10
Curiosity	7	11
Protection	4	12
Gregariousness	8	13
Acquisition	10	14

* Colman and McRae, according to Cattell (1950), used the magnitude of the GSR [*Galvanic Skin Response*] to a variety of stimuli to obtain indices of strength of mobilization in these various areas. Cattell's ranking is a composite based on attention to and memory for activities, words, and pictures in each area.

SOURCE: Cattell (1950), p. 192. Reprinted by permission of McGraw-Hill Book Company, Inc.

Id. at 302.

39. *Id.* at 301.

40. *Id.* at 301-02.

41. *Id.* at 303.

his method. Maslow characterized his innately determined needs as "instinctoid" to distinguish them from instincts which are more specifically focused. There are five groups of basic needs: (1) the physiological needs; (2) the safety needs; (3) the belonging-love needs; (4) the need for esteem; (5) the need for self-actualization.[42] Each group of needs in ascending order must be fulfilled before the next group of needs makes its appearance. On the first level, the physical needs must be fulfilled before the second group (which include freedom from pain, discomfort, threat, and unfamiliar, disturbing stimuli) makes its appearance. When these are satiated in turn, they weaken and the third level appears. This level includes sex and its various derivatives (love, friendship, desire for children, acceptance in a group), which, when satisfied, yield to a desire for prestige, recognition, and fame. Finally, when all the others are relatively satisfied, man feels a need for self-actualization which Maslow has vaguely defined as "man's desire for self-fulfillment" or "the desire to become more and more what one is, to become everything that one is capable of becoming."[43]

Proposal: An Eighth Amendment Hierarchy

The crux of the motivational theories of both Cattell and Maslow is that human instincts or needs are hierarchical, *i.e.*, that some outweigh others in importance, even to the degree that satisfying some is a necessary precondition for the manifestation of others. This basic hierarchical principle may be an appropriate vehicle for a solution of eighth amendment standards of cruel and unusual punishment. The starting point of such a theory would have to be the inclusion of "treatment" under the domain of the eighth amendment. This would necessitate an abandonment of the *Buck* and *Skinner* decisions insofar as they distinguished punishment and treatment. Actually, this would not be a radical step given the *Trop* decision which directed the courts' attention to the nature of a supposedly non-penal statute.

Any therapy, therefore, would be reviewable according to eighth amendment standards. These standards would be based on a general need hierarchy, so that the more basic the need, the broader the constitutional protection. This need hierarchy would of necessity draw upon current psychological theory and common sense. Maslow's theory, for example, could be employed in such a way that all level one needs (the biogenic and homeostatic)[44] would have the broadest constitutional protection—a per se viola-

42. *Id.* Maslow also added (6), the desire to know and understand, and (7), the aesthetic needs. The kernel of his theory, however, involves the first five. The last two seemingly were added as an afterthought.

43. *Id.*

44. Homeostatic needs are those necessary to maintain equilibrium in bodily functions.

tion of the eighth amendment—while level two needs (safety) could be permissibly abridged with informed consent where practicable.[45] Although broad constitutional protection of level one needs is fairly straightforward (especially given the fact that level one needs are fairly easy to identify), level two needs, embracing freedom from pain, discomfort, threat, and unfamiliar, disturbing stimuli, are commonly infringed even in everyday life. What is meant in the treatment context, however, is the *unnecessary* infringement of this freedom, the result of a positive intent on the part of the authorities to cause pain, discomfort, etc., above and beyond the common and unavoidable unpleasantness which naturally arises from the hospital-prison setting. Incarceration itself is certainly a discomfort, but it is part of the very essence of a prison and thus takes on a "normality" within that limited context. A physical beating, on the contrary, would be an infringement of the need to be free from pain, discomfort, etc., even in a prison setting.[46] The use of apomorphine for aversion therapy purposes, without consent, would also be an infringement of the need to be free from unfamiliar, disturbing stimuli even in a mental hospital context. Of course, the problem then becomes one of fitting the disturbing stimuli (such as shock therapy routinely administered in mental hospitals) into this scheme since they presumably would not be permissible without consent. The solution may indeed lie in banning such therapies, but a middle ground may also be devised in terms of capacity for informed consent.[47]

The above proposal suffers from the deficiency of being inspired by the theories of Cattell and Maslow, which admittedly are *theories* and not based upon incontrovertible facts. Nevertheless, they are not entirely without supporting data and are probably no less certain than many psychological judgments. Furthermore, one need not depend upon the levels proposed by Maslow and Cattell in order to be convinced of the existence of a hierarchy of human needs in general. The recognition of a hierarchy of human needs and a determination from all the psychological data currently available could at least lead to a further determination of the broad outlines of what basic human needs deserve comprehensive protection, those which can only be abridged with consent of the subject, and those free from such procedural constraint. Such a step would be at least an attempt to introduce some viable standard in the confused realm of the eighth amendment where soli-

45. "Informed consent" will be discussed on pp. 784-85 *infra*.

46. The prison setting presents a problem for this proposal as long as the classical criminological theory is adhered to. If the criminal's incarceration is not seen by the state as the sole form of punishment imposed by his sentence, maximization of the unpleasantness and discomfort of prison life may be perceived as a desirable goal. Such a view would be incompatible with the proposed theory.

47. *See* p. 784 *infra*.

tary confinement has been found intolerably cruel under some circumstances while sterilization is at the same time countenanced.[48]

Informed Consent

The key factor which overcomes any eighth amendment objection in *Knecht* is consent,[49] and to insure a free and informed consent the court framed its remedy in terms of procedural safeguards. The court ruled that the subject's written consent must be obtained, that he may revoke it at any time, and that each apomorphine injection must be individually authorized by a doctor who was to rely on information based on the personal observation of staff members.[50] This directive would in effect prohibit apomorphine aversion therapy, since it is hard to imagine an inmate not withdrawing his consent after one hour-long session of vomiting. Indeed, the general question of informed consent from persons determined to be legally incompetent is at issue here. A catatonic schizophrenic, for example, who cannot give even the time of day, certainly cannot give informed consent. A severely paranoid person may be loathe to sign anything. This dilemma has often resulted in a justification for blanket *parens patriae* power over anyone legally committed.

However, the argument that legal commitment deprives a person of capacity to give informed consent is both dangerous and simplistic. The law has long recognized that a person may be incompetent for some purposes while perfectly capable for others. Competency to make a will, for instance, may exist simultaneously with incompetency to make a contract. It is necessary to determine from the ability of the person to communicate and

48. Buck v. Bell, 274 U.S. 200 (1927); LaReau v. MacDougall, 473 F.2d 974 (2d Cir. 1972), *cert. denied*, 414 U.S. 878 (1973).

49. 488 F.2d at 1140.

50. "In this case the trial court should enjoin the use of apomorphine in the treatment of inmates at the ISMF except when the following conditions are complied with:

1. A written consent must be obtained from the inmate specifying the nature of the treatment, a written description of the purpose, risks and effects of treatment, and advising the inmate of his right to terminate consent at any time. This consent must include a certification by a physician that the patient has read and understands all of the terms of the consent and that the inmate is mentally competent to understand fully all of the provisions thereof and give his consent thereto.
2. The consent may be revoked at any time after it is given and if an inmate orally expresses an intention to revoke it to any member of the staff, a revocation form shall be provided for his signature at once.
3. Each apomorphine injection shall be individually authorized by a doctor and be administered by a doctor, or by a nurse. It shall be authorized in each instance only upon information based on the personal observation of a member of the professional staff. Information from inmates or inmate aides of the observation of behavior in violation of an inmate's protocol shall not be sufficient to warrant such authorization." *Id.* at 10.

from the nature of his illness whether he is capable of giving informed consent.[51] If he is not, then resort should be made to a neutral decision-maker before treatment can begin. This sort of plan, of course, depends upon a good faith evaluation of the capacity to consent on the part of psychiatric experts. Psychiatrists who do not value human autonomy or who look upon any refusal of treatment as a product of mental illness could effectively frustrate the system.

The Right to Privacy

A constitutional right to privacy, although not mentioned in the *Knecht* case, may provide an additional argument against involuntary subjection to behavior therapy. *Griswold v. Connecticut*[52] found such a right in the "penumbras" of the first, third, fourth and fifth amendments, as well as in the ninth, specifically with regard to the "marital bed." *Stanley v. Georgia*[53] asserted a right to be free from "unwanted governmental intrusions into one's privacy" with regard to mere possession of obscene matter. This right to be let alone or the general right to privacy may appropriately be applied to prohibit non-consensual behavior therapy.

A first amendment right to generate ideas was recently found to protect an involuntarily confined mental patient from psychosurgery in *Kaimonitz v. Michigan Department of Mental Health*.[54] Basing its argument on a right to privacy and citing *Griswold, Stanley,* and *Roe v. Wade*,[55] the court said:

> Intrusion into one's intellect, when one is involuntarily detained and subject to the control of institutional authorities, is an intrusion into one's constitutionally protected right of privacy. If one is not protected in his thoughts, behavior, personality and identity, then the right of privacy becomes meaningless.[56]

Of course, the drastic nature of psychosurgery with its literal intrusion into the brain lends itself more readily to the *Kaimonitz* analysis than does behavior therapy. When a drug such as apomorphine is used, although there is an intrusion in the form of an injection, the actual change in the subject's intellect is a normal reaction to a stimulus, similar to a child's learning to respect fire after having once been burned; apomorphine does not in and of itself change the subject's physical makeup. This effect is common to

51. By allowing the appellants to bring suit, the *Knecht* court impliedly recognized the principle that a determination of legal incompetency was not necessarily a determination of incapacity in all areas.
52. 381 U.S. 479 (1965).
53. 394 U.S. 557 (1968).
54. 42 U.S.L.W. 2063 (1973).
55. 410 U.S. 113 (1973).
56. 42 U.S.L.W. at 2064.

other prison disciplinary measures such as solitary confinement which seek to change an inmate's behavior by means of aversive stimuli. Thus, any argument in terms of a right of privacy aimed at apomorphine therapy would run the risk of embracing traditional punishments as well. Surely, prison itself is fashioned to be a denial of privacy. A right of privacy argument would seem to have more promise in the context of preservation of *bodily integrity* from drastic measures.

Conclusion

In the face of the ever-increasing power of the social engineers, a right *against* treatment has begun to emerge parallel to a previously formulated right *to* treatment.[57] The *Knecht* case employed the eighth amendment's prohibition of cruel and unusual punishment to protect an inmate from non-consensual behavior modification. To do so, it was necessary to include treatment within the meaning of "punishment," a departure from the semantic distinction which had protected such practices as sterilization from eighth amendment scrutiny. Authority for this step was seemingly provided by *Trop*, yet *Buck* has not been overruled. A definitive solution, therefore, would be for the Supreme Court clearly to apply the eighth amendment to all so-called "treatments" inflicted upon those involuntarily committed to mental institutions. Such a decision would lay a firm foundation for a judicial evolution of a right against treatment protected by a flexible, yet comprehensible eighth amendment standard. Contemporary psychological theory has much to contribute to the articulation of this standard. The theories of Cattell and Maslow, for instance, provide an amenable framework in postulating a hierarchy of human needs. If courts were to judge "cruel and unusual" according to three ranges on a hierarchy of need in which the most basic human needs would be given per se protection, the next range conditional protection (*i.e.* informed consent) and a third range in which the state would be given broad discretion in exercising the *parens patriae* power, then considerable progress would be made over the present ad hoc "evolving standard of decency" test.

The judicial acceptance of a three-range hierarchy of human need standard, however, necessitates a simultaneous acceptance of an elaborated notion of informed consent. Unless there is a basic commitment to the recognition of human autonomy even among those legally incompetent, the second range would be absorbed into the first by conditioning capacity to consent upon a determination of legal competence. Safeguards must be established so that only those persons who are actually incapable of giving consent would

57. *See* pp. 777-79 *supra.*