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Legal Implications of Behavior Modification Programs*

MICHAEL L. PERLIN, ESQ. **

Introduction

Although it has probably never been tried in psychiatric practice, the use of the phrase "behavior modification" in a word association test would probably evoke a range of emotions. Projecting further, it is likely that the use of the phrase "legal regulation and intervention" in such a test given to practitioners of behavior modification would elicit even more emotional and anxious replies.1

Significantly, the disparity of (and volatility of) reactions to the above phrases is so great that even the apparently-simple issue of defining "behavior modification" has resulted in major, analytical discussions.2 Any consideration, then, of the legal implications raised by use of behavior modification programs must come to grips - at the outset - with the serious problem of definability of the terms in question.

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

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

Similarly, when Director of the Federal Bureau of Prisons Norman Carlson says (as he did at a recent convention of the American Academy of Psychiatry and the Law) that the START8 prison program would not have received the adverse criticism it did had it been called an "experiment in control" rather than a "behavior modification" program,9 he bypasses the true issue - a title alone will neither insulate a program from judicial scrutiny nor focus unwarranted attention upon it.10 Rather, the inquiry should be focused

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*Mr. Perlin's paper, as one might guess, is separate and apart from the preceding materials of the San Diego symposium on child custody.
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upon what substantive and procedural rights persons in institutional behavior modification programs have, and what kinds of behavior or actions might violate those rights.

I. Substantive Rights

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

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

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

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

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

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

And, in a case arising in a different setting, it has been held that patients in state psychiatric hospitals and residents of state schools for the retarded who are involuntarily involved in work programs are deemed to be "employees" within the coverage of the Federal Fair Labor Standards Act even if the work which they do is therapeutic, so long as the hospital derives "any consequential economic benefits" from that work. Interestingly, the class of patients in this case includes "all patient-workers in non-Federal institutions...who meet the statutory definition of employee." Thus, although the decision's impact on token economy programs—which clearly do result in such "consequential economic benefits" to the institutions—has not yet been marked, it has been predicted that "token economy systems will soon find themselves subject to both legal and behavioral extinction."

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

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

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

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

II. Procedural Rights

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

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

In addition to those issues involving court hearings, there will also be a careful examination of whether a patient school for the retarded and certain kinds of treatment. The court that held that an involuntarily detained mental patient could not give "informed and adequate consent" to experimental psychosurgery, for instance, premised its decision—to a significant extent—on the existence of an "inherently coercive atmosphere" in the institution where the patient was involuntarily hospitalized. If, as...
has been suggested, "civilly committed patients are especially susceptible to a situational duress," 73 then any consent situation will be scrutinized with "special care," although consent standards have been suggested by both courts 52 and commentators, 56 they have been by no means universally accepted. 57 Yet, as the giving of consent is "the first step in any behavior change program," 58 it is an issue which must be considered by virtually all practitioners of behavior modification in institutional settings. 58A.

III. Some Observations

Albert Bandura has noted:

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

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

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

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

Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present. 69

Beyond this holding, the decisions discussed at length in Points I and II, above, clearly reflect a requirement that any behavior modification program must meet specific and stringent constitutional safeguards, both procedurally and substantively, on a case-by-case basis. 70 Indeed, the recent NIMH survey of behavior modification programs underlines the need for "appropriate safeguards" when aversive methods are used 71 and highlights the special problems involved in prison programs. 72 Clearly, any response amounting to self-satisfaction is inappropriate. 73

Statutory, thus, is, and will remain, a fact of life—it must be acknowledged, accepted and dealt with, in spite of what has been characterized as the "dangers of semantic obfuscation." 74 As Mr. Justice Brandeis noted nearly 50 years ago in his famous dissent in the case of Olmstead v. United States: 75

... Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficial. Men born to freedom are naturally alert to repel invasion of their liberty by evi.indicated rulers. The greater danger to liberty lurks in insidious encroachments by men of zeal, well-meaning, but without understanding. 76

His words are still most apt in this setting.

References


2. P. Friedman, A leading mental health rights advocate, has stated that "the term, as used today, is broad as to have lost much of its utility," and substitutes "applied research" at more appropriate terminology. Friedman, Legal Regulation of Applied Behavioral Analysis in Mental Institutions and Prisons, 44 Am. L. Rev. 42-44, n. 3 (1970) (hereinafter "Legal Regulation"). Similarly, the Institute for Behavioral Research—an independent research and educational organization—has circulated a wide range of mental health professionals a tentative 1974 moral code for behavior modification as part of a symposium it is developing "to assist specialists in the field to communicate with policymakers, specialists in other fields, and people in general." Parsons and Parsons: A Glossary of Behavioral Terms in Behavior Modification, unpublished cover story and Executive Draft, June 1975.


5. See generally, Klett v. Goldman, 488 F.2d 1136 (6th Cir. 1973), Wigmore v. Ravner, 477 F.2d 877 (7th Cir. 1973), both discussed in further detail below, at pp. 176-177.

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

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

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


10. See, e.g., for a list and description of behavior related projects funded by the Law Enforcement Assistance Administration, Individual Rights, note 3, above, at 599-600. Compare to the substance of those programs, the observations by Sells et al. that a behavior modification program should alter an individual's behavior in the direction that, "Ideally, he be himself (or his agent) has chosen," perspective, note 4, above (emphasis added).


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The plaintiff shall be subjected to a behavior modification program designed to eliminate a particular pattern of behavior without proper certification by a physician that he has examined the resident in regard to behavior to be extinguished and finds that such behavior is not caused by a physical condition which could be corrected by appropriate medical procedures.

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

The question has been discussed in this regard in Legal Regulation, note 2, at 56–57.


The question has also been forcefully raised that compulsory, non-compensated work programs might come within the Thirteenth Amendment's prohibition against "involuntary servitude." See, e.g., Down v. Department of Public Welfare, 694 F. Supp. 434, 465 (E.D. Pa. 1987); see generally, Friedman: Thirteenth Amendment and Statutory Rights Concerning Work in Mental Institutions: 2 Legal Rights of the Mentally Handicapped 647–649 (P.L.I. Ill. 1973).

Although certain sections of the Federal Minimum Wage Law (29 U.S.C.A. 207 (d), (s), (x)) have declared unconstitutional as they apply to state patients in the United States Supreme Court's recent decision in the case of National League of Cities v. Usery, 447 U.S. 474 (1975), that action did not specifically preclude Sander, nor did it attack the reasonableness behind the Sander decision. In any event, Sander-type decisions might well be sustainable on a variety of grounds in addition to the Thirteenth Amendment, including, inter alia, state minimum wage laws, the right to quantum doctrine, and Section 504 of the Rehabilitation Act of 1973.


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

Wexler, note 7, above, at 92–97.

For Sander, see the "apparent conflict... may not be as serious as feared," see Legal Regulation, note 2, above, at 73. For a response to that view, see Wexler: Reflections on the Legal Regulation of Behavior Modification in Institutional Settings. 17 Ariz. L. Rev. 138, 139 (1975).


Legal Regulation, note 7, above, at 73.

It has similarly been suggested that "every therapeutic intervention should begin with the least intrusive means reasonably likely to be effective on a positive outcome rather than on an ulterior motive..." Davidson and Stuart: Behavior Therapy and Civil Liberties. 30 Am Psychologist 255, 259 (1975).

Legal Regulation, note 2, above, at 73. Any such waiver must be "a voluntary... knowing, intelligent act done with sufficient awareness of the relevant circumstances and likely consequences."" See, e.g., Doe v. States, 397 U.S. 271, 274 (1970). The burden of proof in a waiver situation will be far more difficult to sustain, of course, in matters involving an institutionalized population than where the public at large is concerned. See generally, Note: "Camden v. Camden L. above, note 26, above.

Legal Regulation, note 23, above, at 10.


See also, note 6, above. The court in note 6 did not specifically cite therein.


is in Ayd, ed., Medical, Go!diamond, Singling e.g., Psych & L 409 (1973); Wenk, Robison J 2d 396, 406, n. 10 (1975)

behavior modification programs that, in an institutional setting, they may be employed to facilitate the Institution's operation rather than to help the patient/innmate. Trouter and Warren: The Carrot, the Stick and the Stick. 105 Science News 180, 181 (1974) (quoting Bandura)

O'Connell v. Donaldson, 438, 479 (1927)

For an exhaustive analysis of the issues raised by Kaimowitz, and an examination of the decisions, internally employed to negate consent in a contract setting (fraud, duress, and inequality), see Note, 6 Rutgers-Camden J. L. note 26, at 563-564.

Legal Regulation, note 2, above, at 83.


Legal Regulation, note 2, above, Appendix, at 79-99.

See also, Stone, note 51, above, at 97-100; Stern and Caffel, Legal Issues Involved in Using Women as Experimental Research Subjects (1971); Katz, note 20, above, at 323-275; Restaurant and Brim, Privacy and Behavioral Research, 65 Col L Rev 1184 (1965).

Legal Challenges, note 23, above, at 25.


Miscellaneous: Child Patient's Right to Refuse, note 44, above, at 194-195

61. "Risks associated with the use of aversive techniques (because the client seeks outpatient treatment gives consent for the use of such procedures and usually may leave treatment at any time.)" Katz, note 61, above, at 238, indicates a basic lack of awareness of the scope of the problems referred to above.

For an alternative response, see Katz: Children, Privacy, and Nontherapeutic Experimentation, 45 Am J Orthopsychiat 802, 810 (1975) ("Since the social scientists themselves have failed to exercise the necessary self-control in . . . (individual) area of obtaining formal consent, it seems appropriate to suggest that the community act for itself and legislate for the protection of the privacy of children."). Cf. Legal Regulation, note 2, above, at 59-100.

Similarly, for a discussion of the need for professionally-developed standards in behavior modification programs (specifically including psychosurgery), see Shuman: Beoiravior Modification and the Criminal Defendent 224 (1968). The Bastronk patients have received special behavioral training. See, e.g., Steadman, Follow-up on Bastronk Patients Returned to Hospitals for the Criminally Insane, 120 Am J Psychiatric 317 (1972).}

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