

## Aversives, Fundamental Rights and The Courts

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The controversy over the use of aversive stimuli with developmentally disabled individuals has not been limited to academic debate within professional societies. Instead, because it involves a clash between public policy and individual rights, it inevitably has entangled the courts. Not surprisingly, the use of aversive procedures with developmentally disabled individuals has sparked inconsistent judicial decisions, especially when the issue is characterized as a question of treatment versus corporal punishment. This paper examines how the courts have dealt with the aversives controversy and concludes that the courtroom may not be the most appropriate, but for now is an acceptable forum for vindicating a disabled individual's right to effective treatment.

### INCOMPETENT INDIVIDUALS AND FUNDAMENTAL RIGHTS

Prior to examining the controversy, it is important to discuss the constitutional rights possessed by the developmentally disabled and how those rights are protected.

The fundamental freedoms guaranteed to all citizens of the United States by the Bill of Rights apply as well to developmentally disabled citizens. Mentally ill and developmentally disabled individuals do not lose their constitutional rights by reason of their handicapping condition (*Youngberg v. Romeo*, 1982). Recipients of mental health care are not only entitled to be treated as equal citizens, they are also entitled to the same freedom of choice attendant to that citizenship (*Superintendent of Belchertown v. Saikewicz*, 1977). With respect to treatment decisions, the law recognizes that freedom of choice includes not only the right

to choose from among available treatment procedures, but also the right of an individual to refuse treatment, even one that may be highly beneficial (*In re Quinlan*, 1976). The origin for this right to refuse treatment is contained in the medical model—specifically, the law of informed consent.

The doctrine of informed consent is well presented in a book entitled *Legal Rights and Mental Health Care*, by Herr, Arons, and Wallace (1983). Essentially, the law states that a patient must consent to any treatment, psychological or medical, which can be administered lawfully. There are three critical elements to a finding of informed consent: (a) It must be preceded by the disclosure of adequate information, (b) it must be voluntarily given, and (c) the consenting individual must be competent. The disclosure requirement insures that patients are given sufficient information on which to base their decision. All material risks and alternatives pertaining to the proposed treatment must be disclosed. Only upon full disclosure can a patient's consent be knowing and voluntary. Importantly, the law does not require a competent person's decisions to be wise. In ordinary life for example, people make many decisions which may not be in their best interests. We may overeat, smoke, and gamble away money (Herr et al., 1983). Society's respect for a person's right to be an individual allows such choices to be made. Our society is heterogeneous, comprised of individuals with different likes, dislikes, and values. The Bill of Rights was specifically drafted to protect individual autonomy and to ensure that minority values and beliefs are not trampled by the will of the majority. John Stuart Mill (1952) framed the concept thusly:

[T]he only purpose for which power can be rightly exercised over any member of a civilized community against his will, is to prevent harm to others. His own good, either physical or moral is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. (p. 271)

The law, therefore, does not prevent competent people from making personal decisions which others may consider irresponsible. In the medical area, a person has the right to refuse amputation of a gangrenous leg, even though death is the likely result. The law's requirement is not that the decision necessarily serve the patient's best interests but only that the person's ability to make that decision not be so impaired that it threatens his or her safety or welfare. This concept, known as competency, is a measure of one's ability to make an informed decision about one's own protection and welfare.

To be treated as equal citizens, developmentally disabled and mentally ill individuals also must decide what is best for their own protection and welfare. As platitudes, these principles are easily understood. A difficult problem in their application arises however when the developmentally disabled individual is also incompetent. By definition, that person is unable to exercise the same freedom of choice competent citizens can. The decision-making authority must be entrusted to a surrogate such as a guardian or conservator. But the power of the surrogate is not plenary. Decisions which affect a category of rights which are so fundamental and so personal are afforded special protection when incompetent individuals are involved. The most well-known of the fundamental rights in this special category is the "right to life." This right, the most precious of all, has been the center of controversy in cases involving the removal of individuals from life support systems. Another such right is that of procreation. A woman's decision whether or not to bear children is so intensely personal and private that special protections must be in place when the decision is exercised on behalf of an incompetent woman. A third fundamen-

tal right that falls into this select category is the right to be free from bodily invasion. This right is of particular importance here since it is implicated whenever aversive procedures are used. The right to be free from bodily invasion is an outgrowth of the right of privacy and right of personal autonomy recognized by the United States Supreme Court in cases such as *Griswold v. Connecticut* (1965) (striking down laws prohibiting distribution of birth control devices) and *Roe v. Wade* (1973) (right of privacy permits a women to choose to terminate pregnancy). Both of these cases stand for the proposition that an individual has a constitutionally protected right to be left alone as well as a right to control what happens to his or her body. As long ago as 1891, the United States Supreme court stated in *Union Pacific Railway v. Botsford*:

No right is held more sacred or more closely guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others unless by clear and unquestionable authority of law. (p. 251)

The fundamental right to be free from bodily invasion in conjunction with the right to refuse treatment was the cornerstone for judicial decisions limiting a clinician's authority to administer antipsychotic medication to incompetent patients (*Rogers v. Okin*, 1979).

In treatment cases, where the rights involved are so fundamental they demand special protection, the law requires that the treatment procedure also be carefully scrutinized. When the procedure is deemed "extraordinary," that is, where it poses significant risks to the patient, has significant side effects, or is highly intrusive, most states have stripped the surrogate of the authority to consent on behalf of the ward (*Brophy v. New England Sinai Hospital, Inc.*, 1986). In some states, that power can be exercised by a clinical team (*In re Quinlan*, 1976). In the vast majority of jurisdictions however, the ability to consent is entrusted to the court alone (*Superintendent of Belchertown v. Saikewicz*, 1977). Accordingly, a guardian has no authority to sub-

mit the ward to involuntary sterilization, to terminate life support, or to give consent for the administration of anti-psychotic medication. A guardian's consent in those circumstances is meaningless. The underlying rationale is that the guardian, no matter how well intentioned, may tend to impose his or her own views upon the ward or to make a decision based on what the guardian feels is in the best interest of the ward. If so, the guardian would be utilizing an incorrect legal standard by not giving proper weight to the ward's individual preferences and values as well as to the ward's inalienable right to refuse a plan even if designed to promote his or her best interest. Indeed, the magnitude of the decisions involved—life, sterility, individual personality—demand that extreme care be taken and the possibility of mistake be eliminated. Where an "extraordinary" treatment procedure would have the effect of infringing upon fundamental personal rights such as the right to be free from bodily invasion, the law in most states provides that permission can only be granted by a court through a process known as substituted judgment (*Rogers v. Okin*, 1979). The court's role in these cases is not to determine what is in the best interest of the ward, but to attempt to substitute its judgment for that of the ward. Even if the ward's judgment would not have been in his or her best interest, it is the obligation of the court to give those wishes effect.

By transferring decision-making authority in this area to the courts, the law ensures that the ward's individual rights are properly protected. Prior to making its decision on a treatment procedure, the court typically is required to take into account the following factors (*Superintendent of Belchertown v. Saikewicz*, 1977): (a) the expressed preferences of the ward, if any; (b) the prognosis for the ward with treatment; (c) the prognosis for the ward without treatment; (d) side effects of the proposed treatment; (e) family background and guardian's wishes; and (f) the ward's religious beliefs.

As part of the required judicial process, separate attorneys represent the ward, the

ward's family, and the treatment facility. If indigent, the ward is entitled to court-appointed counsel. Typically, it is the function of the ward's attorney to advocate against any proposed treatment plan. In theory, a truly adversarial process, with the right of cross-examination preserved, allows the court to make the best determination of a ward's substituted judgment and to protect the incompetent ward's individual rights.

The substituted judgment model is designed to scrupulously guard against reckless infringement of individual rights. While courts have used the term "extraordinary" to describe the general category of treatment procedures which are subject to more intensive scrutiny, clearly not all procedures which fit within the definition receive such intensive review. While the administration of anti-psychotic medication is "extraordinary" requiring substituted judgment because of the intrusiveness and risk of serious side effects, substituted judgment has never been required for routine surgery despite similar characteristics. The explanation seems to lie in the degree to which the procedure has become "accepted" by society. Ever since the days when doctors used to leech patients to rid them of disease, society has accepted surgical intervention as a common, established procedure for providing necessary medical treatment. Although on occasion particular surgical procedures have been criticized as overused and unnecessary, there is no raging debate within the medical profession as to whether surgery in general is a professionally responsible method for treating patients. Likewise, no one would suggest that substituted judgment be obtained every time an infected tooth needs to be pulled from an incompetent patient's mouth. There again the procedure has achieved acceptance as routine. The same cannot be said for administration of anti-psychotic medication, sterilization, or for that matter aversives. Each of these procedures historically has generated widespread criticism. In looking at the nature of the aversives controversy, it is necessary first to examine its historical context.

### SOCIETY'S PROTECTIVE INSTINCTS AND THE USE OF AVERSIVES

Beginning in the 1960's, the civil rights movement sought to eliminate the repression of minorities and the politically powerless within society. Advocates on behalf of minorities and the handicapped fought vigorously to eliminate barriers which had the effect of preventing those groups from achieving equal status. The developmental disabilities civil rights movement of the 1960's and 1970's was intended to remedy the historical abuse of the handicapped. Initially, the focus was on institutionalized care. Fictionalized accounts such as *One Flew Over the Cuckoo's Nest* dramatized the plight of the mentally ill, while news exposes and documentaries such as *Willowbrook, A Report On How It Is And Why It Doesn't Have To Be That Way* and *Titicut Follies* underscored the need for reform. Advocacy organizations proposed widespread changes, and courts and state legislatures were swept up in the movement. In a series of cases culminating in the United States Supreme Court decision in *Youngberg v. Romeo* (1982), a constitutionally based right to minimally adequate treatment was established for the mentally ill and developmentally disabled.

Politicians too, reluctant to be labeled as insensitive to the needs of the handicapped, quickly enacted a series of protective measures. Indeed, many state legislatures, encouraged by the federal government, promulgated so-called bills of rights for the developmentally disabled. This legislation was devised to codify and expand the rights possessed by the disabled in order to ensure that past abuse would not be repeated. An example of such legislation is the Lanterman Developmental Disabilities Service Act passed in California in 1977. In the first section (4501) of the Act, the State of California acknowledges its "responsibility for its developmentally disabled citizens and its obligations to them which it must discharge." In the next sec-

tion (4502), the rights of the disabled are set forth:

- (a) A right to treatment and habilitation services. Treatment and habilitation services should foster the developmental potential of the person. Such services shall protect the personal liberty of the individual who shall be provided with the least restrictive conditions necessary to achieve the purposes of treatment.
- (b) A right to dignity, privacy, and humane care.
- (c) A right to participate in an appropriate program of publicly supported education, regardless of degree of handicap.
- (d) A right to prompt medical care and treatment.
- (e) A right to religious freedom and practice.
- (f) A right to social interaction and participation in community activities.
- (g) A right to physical exercise and recreational opportunities.
- (h) A right to be free from harm, including unnecessary physical restraint, or isolation, excessive medication, abuse, or neglect.
- (i) A right to be free from hazardous procedures.

The focus of protective legislation such as the Lanterman Act was to prevent a recurrence of past abuses, not to deny people with disabilities access to legitimate and accepted treatment procedures. From that viewpoint, the aversives controversy should not generate the controversy it has. Indeed, when competent individuals are involved, the issue of aversives hardly raises an eyebrow. Competent individuals certainly may consent, for instance, to a treatment regimen involving Antabuse, a drug which induces vomiting, in combating alcoholism. Others, in order to attempt to stop smoking are directed to wear a rubber band around their wrist which they can "flick" when the urge arises. The association of the momentary pain with the urge to smoke is intended to eliminate the habit altogether. It should follow, therefore, that if

competent people can consent to aversive procedures, then incompetent people, as equal citizens, have those same rights.

Yet the chasm between competence and incompetence is not so easily bridged. The respect we as a society have for self-determination becomes overridden by our protective instincts when the issue involves people who are unable to care for themselves. When a person is incompetent, less leeway is given in determining what is legitimate and accepted. What we have accepted as legitimate treatment when competent individuals are involved, we condemn when the same treatment is proposed for use with an incompetent individual. The explanation seems to lie in the unwavering respect we have for a competent individual's freedom of choice and an equally strong but erroneous belief that it is the obligation of society to shield incompetent individuals from treatments which the majority would not choose for themselves. The harsh reality is that aversives have not been accepted by the public at large as legitimate treatment procedures but instead are viewed as a form of abuse when administered to incompetent individuals. One reason for this perception stems from the poor job the field of psychology in general, and behavior analysis in particular, has done in legitimizing by scientific method the use of those procedures. Until the field of behavior analysis can speak with a unified voice regarding the acceptability of aversive procedures, it cannot expect courts, legislatures, and the general public to provide that legitimacy by default. To the non-professional, the use of aversives seems to be a vestige from the dark ages. Aversives are not seen as a form of treatment but as a form of corporal punishment. Indeed, opponents of the use of aversive procedures do not have to go very far in order to find support for this view. They need simply start in the field of behavior analysis. The name that behavior analysts use for aversive techniques—punishment—feeds into that belief. How can punishment be treatment? Punishment is, after

all, just that. Punishment means corporal punishment. It is *Cuckoo's Nest*, *Willowbrook*, and *Titicut Follies* all over again. It is what the developmental disabilities civil rights movement of the 1960's and 1970's was designed to remedy. It is that movement's very *raison d'etre*. Punishment is, as everyone "knows," tantamount to abuse.

A recent article which appeared in the *U.S. News & World Report* (1989), puts these misconceptions in sharper focus. Appearing under the headline "Punishing the Retarded," which, it should be noted, uses the word "punish" in its lay context, the article stated:

Parents and guardians of severely retarded children and adults who repeatedly bang their heads or otherwise harm themselves may soon be asked to let doctors and caretakers "punish" patients to alter their behavior. A recent panel of experts convened by the National Institutes of Health recommended "aversive" therapy, which could include pinches, mild shocks and whiffs of ammonia, so long as a guardian's consent is given and more-positive therapy such as stroking and gentle scolding is used as well. Many schools and institutions already practice aversive therapy, but it could become even more widespread now that the NIH panel has given it the O.K.

Nearly every major association that represents the retarded disagrees with the panel. "Constructive, not destructive, methods are just as effective," says Alan Abeson, executive director of the Association for Retarded Citizens (ARC). (p. 71)

As this article demonstrates, widespread condemnation of the use of aversive procedures exists among organizations which advocate on behalf of the developmentally disabled. The criticism is not limited to advocates, however. Professionals such as LaVigna and Donnellan (1986) provide formidable support for the anti-aversive movement. These advocates have generally been successful in convincing the general public that positive procedures are "effective" and aversives are therefore unnecessary, cruel, and barbaric. Part of the criticism stems from a perceived lack of effective controls on and standards for the implementation of aversive procedures. The fear exists that these procedures are employed wantonly and callously by clinicians when less intrusive procedures

would be just as effective. The failure of behavior analysts as a professional body to effectively counter the anti-aversives campaign has led policymakers astray. The NIH panel itself is an important step toward the professional legitimacy needed but it is only a beginning. So long as the field is splintered on the issue, policymakers will continue to react to public sentiment and legislatively limit effective treatment options under the guise of protecting the disabled. It is for that reason substituted judgment proceedings should be used as the one currently available means for vindicating treatment rights.

### AVERSIVES IN THE COURTS

The state of the aversives controversy can be summed up as follows. Public opinion generally condemns aversive procedures while most responsible clinicians and guardians believe that the techniques are not only legitimate but necessary in certain cases to control serious self-destructive behaviors. Society's legitimate interest in protecting the developmentally disabled is pitted against the individual's right of access to treatments which may help improve his or her condition. Inevitably, this is the kind of dispute that is resolved in the courts. While courts can be engines of social change, they have no mandate to formulate public policy. Instead, it is the function of a court to resolve cases or controversies by applying the law to specific, unique fact patterns. It is important to note, however, that the vast majority of cases that have dealt with aversives do not attempt to define the term. Since many cases involve procedures such as water sprays, slaps, facial screening, and mechanical restraint, judges apparently have adopted an "I know it when I see it" approach. The only appellate opinion defining aversives which is occasionally also cited by other courts, is *Knecht v. Gillman* (1973). In *Knecht*, the court referred to aversive therapy as being based on Pavlovian conditioning. Citing *Singer* (1970), the Court further explained:

Pavlovian conditioning is based on the theory that when environmental stimuli or the kinetic stimuli

produced by the incipient movements of the punished act are made contiguous with punishment, they take on some of the aversive properties of the punishment itself. The next time the organism begins to act, particularly in the same environment, it produces stimuli which through classical conditioning have become aversive. It is these aversive stimuli which then prevent the act from occurring. (p. 423)

When the issue of aversives has reached the courts, it has generally involved two types of cases—consent cases and right to treatment cases. The consent cases follow a straightforward analysis. In most of those cases, aversives have been administered without obtaining proper consent. Many of these cases involve prisoners' rights. There, the state has attempted to forcibly change a prisoner's behavior by administering aversives against his or her will. In cases such as *Mackey v. Proconier* (1973), which involved the administration of a breath stopping fright drug to prisoners, courts uniformly have held that the absence of consent resulted in a violation of the constitutional prohibition against cruel and unusual punishment. This past term the United States Supreme Court decided *Washington v. Harper* (1990), a case with important ramifications in this area of the law. In that case, the state attempted to administer anti-psychotic medication against the will of a prisoner who had never been declared incompetent. The state argued that Harper's behavior is under control only when he is on the medication and that it has a compelling interest in maintaining order in its prisons as well as an obligation to ensure other prisoners' safety. Harper argued on the other hand that as a competent individual, he has the right to refuse the medication. The Supreme Court held that in the prison context only, so long as the state's proposed action was reasonably related to a legitimate penal objective—in that case prison security—it could overcome fundamental individual constitutional rights. Harper therefore established a boundary line for an individual's right to refuse treatment and articulated a different standard for criminal as opposed to civil commitment cases.

The other subset of "consent" cases

usually arises either where the clinician has administered aversive procedures without the consent of the guardian or where the treatment plan requires only the consent of the guardian and not approval by the court. In *Price v. Sheppard* (1976) for instance, electric shock treatments were being administered to an involuntarily committed incompetent minor against the wishes of the guardian. The court held that imposition of an intrusive and extraordinary treatment such as shock was not to be left to the sole discretion of medical and clinical personnel. However, the fact that the guardian opposed the procedures also was not dispositive. The court proceeded to follow the traditional substituted judgment model by requiring the treating institution to petition the court for consent to administer the treatment. In making the determination, the court balanced the need for the treatment against the intrusiveness based on the following factors: (a) the extent and duration of changes in behavior patterns and mental activity affected by the treatment, (b) the risks and side effects, (c) the experimental nature of the treatment, (d) acceptance by the professional community, (e) the extent of the intrusion and pain associated with it, and (f) the patient's ability to determine whether the treatment is desirable and/or the wishes of the guardian.

A much more troublesome series of cases are those involving right to treatment issues. Often these cases arise when aversives are clinically recommended but either state law specifically bans the use, or administrative agencies prohibit the treatment pursuant to corporal punishment proscriptions. These cases have all turned on the narrow issue of whether courts believe aversives to be a professionally accepted form of treatment. In cases where the court has answered the question affirmatively, it has been willing to authorize aversive procedures within strict guidelines.

The strongest appellate opinion against the use of aversives is *Kate' School v. Department of Health* (1979). There, California regulations banned the use of behavior modification techniques in-

volving the infliction of corporal punishment. In appealing its license revocation, Kate' School challenged the regulations on the basis that its use of aversives such as hand and calf slapping, restraining head movement by holding the chin or hair, cool showers, and withdrawal of food was not punishment but treatment. The Court of Appeals disagreed, calling the school's argument a theoretical distinction and a transparent attempt to relabel prohibited conduct with euphemisms.

Remarkably absent in the record is the necessary expert clinical testimony to support the position that the recommended treatment plan including aversives was professionally responsible. Based on this glaring failure of proof, the court apparently viewed the plan as an *ad hoc* experimental program which the State of California had authority to regulate. The court ruled that the state has a legitimate right to regulate intrusive and possibly hazardous forms of treatment for the mentally disordered. Conversely, the court also ruled that nothing gives a person the right to receive aversive therapies.

The *Kate' School* case is an unfortunate example of poor legal advocacy leading to a poor judicial decision. The court's premise—that aversives are not accepted forms of treatment—led to an inevitable result. If indeed the court's premise were correct, the decision would be totally defensible. No one has a right to receive treatment which does not meet accepted professional standards. For example, the government has every right to refuse cancer patients access to Laetrile since there is no competent medical evidence that the drug cures cancer. On the other hand, a disabled person cannot be deprived of equal access to accepted forms of treatment. In *Lelsz v. Kavanaugh* (1987), a federal court in Texas was presented with a variation of the *Kate' School* facts. There, aversives were used with clients at a state school but not in a professionally responsible manner. Expert testimony revealed that there was no evidence of the effectiveness of the procedures and no relationship between the choice of the procedures and the anal-

ysis of the cause of the clients' problems. The court, therefore, ruled that use of aversives under these circumstances crossed the line from treatment to corporal punishment.

A more constructive example of correct judicial analysis of aversives in a right to treatment context is the case of *Behavior Research Institute ("BRI"), et al. v. Leonard* (1986). There, a Massachusetts administrative agency attempted to close a school which offered a regimen of aversive procedures to autistic individuals on the grounds that the students were being abused. The *BRI* case was the first in which a court was asked to apply a strict substituted judgment analysis in an aversives case not involving electric shock. Moreover, the mistakes of the *Kate' School* case were not replicated. Counsel for the school seeking to administer the treatment, and the parents who supported it, presented a succession of nationally recognized experts in the field of behavior modification who testified that the particular procedures at issue were safe, effective, and professionally accepted. Although the Massachusetts agency opposed the use of the procedures, it produced no witnesses to contradict the expert testimony. The trial judge ultimately determined, after applying the substituted judgment criteria, that use of the aversive procedures was the least restrictive effective means to control the serious and potentially life-threatening behaviors exhibited by the *BRI* students. The court issued an injunction prohibiting the Massachusetts agency from interfering with the *BRI* treatment while at the same time imposing strict monitoring requirements on the institution in order to ensure that individuals' rights were safeguarded.

While virtually all the reported court cases involving aversives and developmentally disabled individuals have arisen in the context of public or private residential institutions, recently two Michigan cases have addressed the issue in a public school setting. *In re Northville Public Schools and Wayne-Westland Public Schools* (1990) involved a mentally retarded fifteen year old boy with

cerebral palsy who had engaged in self-injurious behavior since he was two years old. His behavioral program required wearing a helmet and face guard and constant restraint. An electrical shock device known as SIBIS (Self-Injurious Behavior Inhibiting System) had proven successful during clinical trials in greatly reducing his and others' self-injurious behavior (Linscheid, Iwata, Ricketts, Williams, & Griffin, 1990). The Michigan school district, however, refused to permit SIBIS in the public schools on the grounds that its use would violate a local policy against use of contingent electric shock as well as a Michigan state statute prohibiting corporal punishment. The statute defined any procedure which inflicted pain as constituting corporal punishment. As an alternative, the school proposed continuing with the prior program which, in at least one internal memorandum, a school district official admitted would not be effective.

After a lengthy administrative hearing, the hearing officer allowed the school district one year to improve the boy's condition using a new non-aversive program. If the district were not successful—which was defined as a 90% reduction in self-injurious behavior and a fading of the use of restraints—the hearing officer would entertain a request for SIBIS. With respect to Michigan law, the hearing officer ruled that neither the corporal punishment statute nor the local policy could prohibit SIBIS if it were the most appropriate treatment since federal law, namely the Education for All Handicapped Children Act (1975), was superior to state law. The federal act mandates that handicapped children have access to appropriate available treatments.

A second Michigan case, *Van Duser v. Intermediate School Board of the Intermediate School District of the County of Genesee* (1989), also involved authorization for SIBIS. The case was settled before a formal judicial opinion was rendered when the school district agreed that SIBIS was a medical device and so long as it was prescribed by a physician, it did not fall within the Michigan statute. As part of the settlement, the school district



also agreed to implement an early intervention program aimed at identifying other school children who were currently exhibiting, or were at risk of developing, self-injurious behavior (Landau, 1990).

Once again, the key in these Michigan cases was a recognition of the aversive procedure as a legitimate, accepted form of treatment. Once that hurdle was surpassed, state statutes that would ordinarily serve as insurmountable obstacles were deemed inapplicable in the face of an individual's paramount right to legitimate, effective forms of treatment. Moreover, although the *Northville Public School* case did not utilize a formal substituted judgment proceeding, the decisional framework employed by the hearing officer encompassed most of the substituted judgment elements. The final result—putting SIBIS on hold temporarily while a new less intrusive behavioral program is attempted—struck a reasonable and constitutionally sound balance by insuring that less restrictive procedures are exhausted before more restrictive ones are used.

### CONCLUSION

Several years ago, a state mental health official predicted that “the era of use of judicial procedures on behalf of the disenfranchised in our health system has just begun” (Greenblatt, 1974, p. 452). There is no question that the prediction was accurate. Courts have been dragged into the aversives controversy by default and they will continue to be involved at least until the field of behavior analysis can resolve the controversy internally. Courts certainly are poorly equipped to make clinical decisions. Nevertheless, the court's responsibility to adjudicate disputes and to protect individual rights has inextricably bound it to the controversy. While the controversy continues, the ultimate decision on the use of aversive procedures cannot be left to state legislatures and administrative agencies. So long as opponents of aversives successfully persuade others that aversives are functionally equivalent to Laetrile, they will control the outcome of the debate.

The unacceptable result will be that a class of severely disabled individuals will be denied access to effective treatment options.

The use of aversive procedures must be authorized on a case by case basis taking into account the unique clinical needs of the individual. Substituted judgment proceedings are currently the most effective means for achieving the appropriate balance between individual rights and societal interests. By focusing on the particular needs of the individual, the court is able to protect fundamental rights while assuring that effective treatment is provided. At the same time, clinicians who advocate the judicious use of aversive procedures can break free of the bonds of restrictive state laws and regulations that do not reflect the advanced thinking in scientific fields such as behavior analysis.

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