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# Mental Health Treatment Refusal in Correctional Institutions: A Sociological and Legal Analysis

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*Recently, the courts have recognized the right to a minimum level of mental health treatment for individuals confined in both mental and correctional institutions, utilizing a different rationale for each system. As mental health administrators in state mental hospitals accepted that they were responsible for providing an increased level of mental health services, they were disappointed that courts had subsequently ruled that individuals in state hospitals had a right to refuse treatment. The purpose of this paper is to elaborate, sociologically and legally, upon treatment refusal in the correctional system since most of the attention on treatment refusal has focused on individuals in state mental hospitals and since the legal status of inmates in correctional systems is different. An analysis of the literature revealed that inmates in correctional institutions, similar to individuals in the state hospital system, have a limited constitutional right to refuse mental health treatment, and this right is unlimited when the treatment provided is considered by the courts to be in fact punishment.*

Within the last twenty years there has been a steady development of case laws supporting the right to treatment for persons confined primarily in mental institutions (*Johnson v. Solomon*, 1979; *Rouse v. Cameron*, 1966; *Scott v. Plante*, 1981; *State in the Interest of R.G.W.*, 1976; *Welsch v. Likins*, 1974), and some professionals have argued that, under appropriate circumstances, there is a right to mental health treatment for inmates confined in correctional institutions as well (Alexander, 1987b; Brenner & Galanti, 1985). As a result of this newly established right, institutions, both mental and correctional, had to strengthen their treatment services to inmates. About the time that significant changes were being made, there began the as-

sersion, much to the chagrin of mental health professionals, that institutional mental health recipients had the right to refuse treatment. Psychologists and psychiatrists lamented that it is impossible to have a right to treatment and at the same time also have the right to refuse treatment (Hassenfeld & Grumet, 1984). Yet, advocates for inmates insist that some mental health treatments (i.e., psychotropic drugs, psychosurgery, aversive therapy) cause irreversible bodily damages (Herr, Arons, & Wallace, 1983) or in the case of correctional inmates are in fact punishment in disguise. When this is the case, there is a right to refuse treatment. Given that there is a right to refuse treatment for individuals in state mental hospitals (Beis, 1984; Bonnie, 1982; Brant, 1984; Brotman, 1982; Hoge, Gutheil, & Kaplan, 1987; Norris, Carroll, & Watson, 1980; Plotin, 1978; R.M.R., 1981), there practically should be the right to refuse treatment for inmates in correctional institutions. The purpose of this paper is to explain the right to refuse mental health treatment for inmates confined in correctional institutions. Admittedly, case laws arising from the mental health and correctional fields tend to be separate and distinct bodies of law (Churgin, 1983). But the United States Supreme Court has indicated that felons do not automatically lose all of their rights, and the Constitution, albeit hesitantly, follows them behind the walls of the penitentiary (*Pell v. Procunier*, 1973). The elaboration of the right to refuse mental health treatment, defined here as that treatment which is designed to alter the behavior or mental functioning of a prisoner, will be done from both sociological and legal perspectives.

### The Right to Mental Health Treatment

Before discussing the right to refuse treatment in a correctional institution, there needs to be an illumination of how the right to treatment developed in the first place.

Recognition of the right to treatment was first announced in 1966 when Judge Bazelon ruled that a man institutionalized for four years in a mental hospital had a statutory and constitutional right to treatment (*Rouse v. Cameron*, 1966). Finding treatment in Alabama state mental hospitals superficial, Judge Johnson wrote that "to deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the

very fundamentals of due process" (*Johnson v. Solomon*, 1979, p. 279). One state court ruling in a case involving a juvenile that had implications for the mental health system stated that "when mental patients are committed for treatment purposes they *unquestionably* [emphasis added] have a constitutionally reinforced right to receive such individual treatment as will give each of them the realistic opportunity to be cured or to improve his or her mental condition" (*State in Interest of R.G.W.*, 1976, p. 1376). In these cases the courts were simply saying that if a person's liberty is taken away for the purposes of treatment, then that person had a constitutional right to treatment. Subsumed in this argument is the acknowledgement that a *quid pro quo tacit* agreement arises between the state and the individual. That is to say, the state takes something from the individual (his or her freedom) and thus owes to that individual something of value (treatment). When treatment is nonexistent, the person's constitutional right to due process has been violated.

In the matter of convicted offenders, the right to treatment is medically based. Courts have held that the denial of medical care to an inmate while imprisoned is a violation of the Eighth Amendment right to be free from cruel and unusual punishment (*Estelle v. Gamble*, 1976; *Medcalf v. State of Kansas*, 1970). Taking this lead, other courts have ruled that the right to medical care includes both physical and mental illnesses (*Bowring v. Godwin*, 1977; *Rogers v. Evans*, 1986; *Ruiz v. Estelle*, 1980). In a Texas case in which the entire prison system was held to be unconstitutional, a federal judge restated the right to minimally adequate mental health treatment in a prison setting and reaffirmed that "a prison inmate is entitled to psychological or psychiatric treatment if a physician or mental health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial" (*Ruiz v. Estelle*, 1980, p. 106).

### Sociological Discussion of The Right to Refuse Treatment

One of the essential concerns of sociology is social control. In its infancy, sociology understood social control as societal

responses for managing members of society. Later, sociology began to conceptualize social control more concisely as the control of deviant behaviors and the promotion of conformity (Conrad & Schneider, 1980). There is a consensus among most members of society that without social control, society will quickly disintegrate into chaos (Cockerham, 1981). Generally, the institutions that helped to maintain social control primarily were the family and the church. Scheff (1984), further, contended that social control operates internally and externally to mold individuals' behaviors, perceptions, thoughts, and feelings. Sanctions to nonconformists by social control agents for nonconformity are applied inconsistently and are sometimes negotiable. Scheff also said that societal reaction to deviance is usually in excess to what is actually needed. Sensitive to this framework, studies of crime, delinquency, and mental illness sought to explain deviancy but equally important sought to explain the societal reactions to deviancy. Consequently, dependent variables that measure the severity of societal response are of central interest to investigators.

From a sociological perspective, mental illness is viewed as a social status and not a disease. The evidence for this view comes from studies which have shown how prevalent the symptoms of mental illness are in the general community and how imprecise the defining symptoms are. Moreover, the status of being mentally ill is ascribed by the societal reaction and not really achieved by the person designated as mentally ill (Scheff, 1984; Shah, 1980). The issue of social control of the mentally ill perturbs some professionals because of the imprecision of psychiatric diagnosis. Physicians specializing in internal medicine can generally reach consensus on diagnosis of a heart attack, appendicitis, or kidney failure, but mental health problems do not present for psychiatrists a concrete set of symptoms for diagnosis that will lead to a consensus of what the problem is. Oftentimes, it is the subjective opinion of the psychiatrists that is the determining factor in labeling one as mentally ill (Cockerham, 1981). The Diagnostic and Statistical Manual (DSM), of course, has helped to eliminate some of the subjectivity in psychiatric diagnosis, but vagueness of symptoms is still a problem. For example, as a neophyte social work intern in a psychiatric

unit of a major teaching hospital in Houston, Texas for indigent citizens, the author observed a psychiatrist explaining to a medical student why a woman he had examined deserved a particular diagnosis. The psychiatrist, in accordance with the DSM III, emphasized one criterion in the diagnosis as impulsiveness, which was determined by family reports that the woman had recently gone shopping and bought ten dresses. However, affluent people frequently buy clothing in bundance. This is an example of why sociologists, such as Lemert and Becker, believe that the symptoms of mental illness are imprecise and vague.

Despite these imprecisions, Conrad and Schneider (1980) averred that "medicine, especially psychiatry, has replaced religion as the most powerful extralegal institution of social control" (p. 241). Medical social control seeks to minimize, eliminate, or normalize deviant behavior. If something is defined as a psychic illness, it automatically becomes within the province of psychiatry to cure regardless of the efficaciousness of its intervention. At the same time, Conrad and Schneider suggest that there are positive benefits to the medicalization of deviance, such as viewing alcoholism or mental illness humanitarially. However, they identified seven negative byproducts. These are: (1) dislocation of responsibility; (2) assumption of the moral neutrality of medicine; (3) domination of expert control; (4) medical social control; (5) individualization of social problems; (6) depoliticization of deviant behavior; and (7) exclusion of evil (Conrad & Schneider, 1980).

Turning to the correctional institution, Waldron stated that modern correctional organizations' two essential functions are treatment and custody or control. The custody or control function of a correctional institution refers to establishing secure housing, safety for the staff and inmates, and a controlled environment. To be sure, some treatment activities, such as classification, also serve a custody and control function. Imperative to the control function is the establishment of rules for inmates to follow. Waldron, in addition, wrote that "although most of these rules are legitimate requirements for maintaining control, in some prisons and jail situations they are also used as a means of repression and punishment in the mistaken belief that control demands complete regimentation in all areas of prison life"

(Waldron, 1984, p. 371). On the other hand, Nassi argued that despite the manifest goal by some states that imprisonment is in part for rehabilitation or treatment, the overriding goal is always the punishment of the offender. As a consequence, prison psychologists and psychiatrists compromise precepts derived from their professional training in order "to be consonant with the punitive function of the prison." Moreover, Nassi indicated that "to the extent that psychiatrists and psychologists adhere to the precepts of their profession, they will have to adjust these precepts to function in harmony with the physical and social environment of the prison. Alternatively, they may attempt to reconstitute the organization and redirect its goals so that they are more consonant with their belief system. However, to the extent that the individual adjusts to the prison regime and alters the professional orientation, this orientation may become so distorted that it does not even resemble the traditions of his discipline. It is in this way that treatment becomes indistinguishable from punishments, except by name" (Nassi, 1980 p. 327).

As a matter of fact, most inmates are diagnosed as having a character or personality disorder. Mental health professionals believe that these inmates have accepted values that are contrary to the dominant society. Generally, the inmates are hostile and suspicious and feel that there is nothing wrong with their behavior (Silber, 1980). By way of illustration, inmates from one Georgia prison, who probably were thought by psychologists to have personality disorders, refused at one time to participate in their treatment because the feeling was that the mental health unit was an instrument of the prison administration to wage psychological warfare against them. For some mental health officials this view may be evidence of paranoia, but the possibility exists also that this view may be accurate and represents one of the tools of institutional social control. Alternatively, it could be an illustration of conflict between institutional and inmates' goals. Halleck wrote insightfully about this conflict when he said:

The conflict between the interest of society and the interest of the individual offender can be illustrated most powerfully by considering the "political prisoner". Some men violate the law out of conscience or as part of a deliberate effort to change the society. If we "rehabilitated" these men and trained them to behave in a

manner which the mass of citizens might find desirable, we would be negating their freedom to dissent and depriving the society of one important channel for social change. Consider, for example, the impact on our society if our prisons had succeeded in rehabilitating such convicted offenders as Henry Thoreau, Eugene Debs, Martin Luther King, or Malcolm X. [To this list could be added the Honorable Elijah Muhammed who went to prison for refusing to serve in the armed services and later built the Nation of Islam and the Berrigan Brothers who were jailed for activities protesting the Vietnam War.] These examples dramatize that the issue of rehabilitation must be considered not only in terms of our capacity to change human behavior but also in terms of under what circumstances and to what extent we should be allowed to do so (Halleck, 1980, p. 337).

This represents an example of one of Conrad and Schneider's concerns that medical social control could facilitate the depoliticization of deviant behavior. Offenders, as a practical matter, are sent to prison as punishment for violating criminal statutes. Hence, the loss of liberty for a specific period is the prescribed punishment, and one could assert that any attempt to take away what one believes is beyond the statutory requirement (Vetter & Rieber, 1980) and an issue for litigation.

### Legality of The Right To Refuse Treatment

Sharipo (1974) theorized that the first Amendment to the United States Constitution "protects a person's power to generate thoughts, ideas, and mental activity." He called this protection a person's freedom of mentation and based it on the following analysis: (1) The First Amendment protects communication of virtually all kinds, whether in writing, verbal, pictorial or any symbolic form, and whether cognitive or emotive in nature; (2) Communication entails the transmission and reception of whatever is communicated; (3) Transmission and reception necessarily involve mentation on the part of both the person transmitting and the person receiving; (4) It is in fact impossible to distinguish in advance mentation which will be involved in or necessary to transmission and reception from mentation which will not; (5) If communication is to be protected, all mentation regardless of its potential involvement in transmission or rejec-

tion must therefore be protected. Having established the basis for the protection of mentation, Shapiro posited that as a corollary the next two propositions form a right to be free from coercive organic therapies: (6) Organic therapy intrusively alters or interferes with mentation; and (7) The First Amendment therefore protects persons against enforced alteration or interference with their mentation by coerced organic therapy. It appears that there has been some recognition of First Amendment violation when drugs are administered against an individual's will (Shavill, 1981; Torrey, 1983), and some court decisions have recognized a limited right to refuse treatment in the absence of an emergency (Brooks, 1980; Brotman, 1982).

Seeing it a little differently, Beyer theorized that individuals have two types of freedom—freedom to and freedom from. He believes, for example, that “freedom to tattoo one's body involves a freedom from state constraints upon tattooing; freedom from compulsory state tattoos involves a freedom to keep one's body untattooed. Yet there remains an important conceptual distinction between freedom to tattoo oneself if one wants and freedom from the state compelling one to be tattooed if one does not. Freedom to (tattoo oneself, have an abortion, smoke marijuana) may conveniently be called autonomy, freedom from (compulsory tattoos, police searches of the rectum, unwanted blood transfusions) may conveniently be called integrity. When one wants to tattoo oneself and the state will not let one, autonomy is abridged by a state constraint; when the state tattoos one against one's will, integrity is invaded by a state compulsion” (Beyer, 1980, p. 502).

Others have recognized the right to refuse treatment based on the longstanding practice of informed consent as a prerequisite to treatment. At common law, any medical procedure that is not consented to by a person is a battery. Broadening the concept of consent, the court established the principle of informed consent. Informed consent not only requires that a person consent to a medical procedure but the person must be given information on the possible risks and likely benefits. Additionally, the person must be told of alternative procedures, if any. The reason for these explanations to a person is to respect his or her right to autonomy or self-determination (Rodenhauser,

1984). Granted, a doctor possesses more knowledge than a lay person but the final treatment decision must lie with the individual (Annas, Glantz, & Katz, 1977; Rhoden, 1980; R.M.R., 1981). Everyone has a fundamental right to determine to be helped or left alone—the right to privacy (Middleton, 1980). Even if the person's death is impending, an individual still has the right to refuse treatment (Schwitzgebel, 1979).

Although most mental health professionals now concede that there is a right to refuse treatment in a state mental hospital, they know as a result of *Rennie v. Klein* and *Rogers v. Orkin* that this right is limited as it can be overridden with procedural safeguards in place. That means that the refusing patient must have an independent review, assessment of the risks and benefits, perhaps involvement of an advocacy group, and an appeal process (Parry, 1984).

The rationale for the right to refuse treatment is different depending if a person is institutionalized based on *parens patriae* (intervening for the protection of the individual) or police power (intervening for the protection of society). The state's authority to intervene under *parens patriae* assumes that the person is incompetent to give informed consent or refused treatment. In the absence of competency, the state can force treatment if it is believed to be in the best interest of the individual and if less restrictive therapies are unsuitable. On the other hand, persons institutionalized because of police powers are not assumed to be incompetent and their mere confinement neutralizes their threat to the community (Wexler, 1976). Therefore, a person who is competent to make treatment decisions who is institutionalized under police powers has a stronger basis for refusing treatment than one who has been institutionalized under *parens patriae* and is deemed incompetent. Unlike mental hospitals which have both individuals committed under *parens patriae* and police powers, all correctional inmates are institutionalized under police powers because they have been convicted of crimes against society.

### The Right To Refuse in a Correctional Setting

Most of the above discussions referred to individuals institutionalized in mental hospitals. However, there are implications

for inmates incarcerated in correctional institutions. In 1973 the United States Supreme Court affirmed that prisoners retain all rights enjoyed by free citizens except those necessarily lost as an incident of confinement (*Pell v. Procunier*, 1973). What is considered an incident of confinement is the recognition by the legal system of valid penal objectives of deterrence (specific and general), rehabilitation, and institutional security (*Pugh v. Locke*, 1971). As a result, rights which do not interfere or clash with these objectives are kept by inmates. As a specific example, a federal appeals court ruled the dual commitment procedure in New York state as illegal because a person convicted under a criminal statute was entitled to the same rights that a civilian enjoys (*Schuster v. Harold*, 1969).

Initially, the right to refuse treatment emerged from the criminal justice system. Lawsuits initiated by individuals judged incompetent to stand trial, judged insane, and convicted under the general penal statutes reached the courts alleging that they were subjected to abusive "treatment" (Shobat, 1985). For example, an inmate of a New York prison system who accused the administration of being corrupt in 1941 was diagnosed as paranoid and transferred to the Dannemora State Hospital For The Criminally Insane for an unspecified period although he was close to serving his original sentence. In 1969, a federal court ruled in his favor and said in effect that his treatment had to end (Talbot & Kaplan, 1983).

Further, it is not uncommon for prison officials to use drugs as a means of social control. Mattocks and Jew researched aversive therapy on California prisoners in 1967 and wrote glowingly of its efficacy. They suggested that innumerable assaults, stabbings, self-mutilations, and suicidal attempts probably were reduced by the use of Anectine, a drug used in aversive treatment, and that 57 percent of the treated prisoners were able to get further treatment in a psychiatric unit or suitable for transfer to other prisons for "programming" (Mattocks & Jew, 1982). The court began to look at aversive therapy and found programs in California and Iowa in violation of the Eighth Amendment prohibition against cruel and unusual punishment (*Knecht v. Gillman*, 1973; *Mackey v. Procunier*, 1973; Shapiro, 1974). Labeling a practice treatment does not bar scrutiny to determine if it is

in violation of the Eighth Amendment prohibition against cruel and unusual punishment. It is the intent, the actual procedure, and the results that are important, not whether the state calls a practice treatment instead of punishment (Schwitzgebel, 1979). The court noted in the Iowa case that "whether it [the treatment] is called aversive stimuli or punishment, the act of forcing someone 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 has consented to it" (*Knecht v. Gillman*, 1973, p. 1140). Implied in this decision is the right to refuse treatment.

Correctional treatment which is designed to change the mind of thought processes of inmates can be rightfully refused as being violative of their right to free speech. Recent case laws have established the right to "mind freedom" and "privacy of the mind." There is a fundamental right of people to be secure in their private thoughts. Ordinarily, courts are reluctant to interfere with this right unless the state advances a compelling interest (Vetter & Rieber, 1980). Thus, the right of an individual to have, for instance, delusional thoughts is protected from alteration by the state. To comprehend this principle it is important to understand that many delusional thoughts are not harmful to the state or the individual. An inmate who believes he is Jesus or has thoughts, realistic or unrealistic, of grandeur is not threatening to institutional order, and it would be difficult for the state to persuasively argue that a compelling state interest exists in seeking to alter such thoughts.

In *Rummels v. Rosendale* the issue was a purely medical issue but had implication for mental health. In this case, Rummels was operated on for a hemorrhoidectomy against his will. The court ruled that "allegations that prison medical personnel performed major surgical procedures upon the body of an inmate, without his consent and over his known objection, that were not required to preserve his life or further a compelling interest of imprisonment or prison security, may foreshadow proof of conduct violative of rights under the Fourteenth Amendment sufficient to justify judgment under the Civil Rights Act" (*Rummels v. Rosendale*, 1974, p. 735). In a later case a man named

Scott was held incompetent to stand trial in 1954 and also was held to be mentally incompetent. Scott began habeas corpus action claiming that he was forced to take drugs and treatment against his will. The court suggested that in the absence of an emergency unconsented treatment of a drug that affects the mind is a tort and actionable under the Civil Rights Act of 1871 (*Scott v. Plante*, 1976).

Besides psychotropic drugs, the state possesses a wide array of medical tools, such as electrical stimulations of the brain by implantation of electrodes, psychosurgery, and organic conditioning techniques, with which to control the behavior of inmates in both correctional and mental institutions. Use of psychotropic drugs can alleviate the symptoms of mental illness, but the misuse of them, as well as the other interventions, foreshadows an abridgement of personal freedom for inmates (Shapiro, 1973).

The United States Supreme Court examined the transfer of a Nebraska prisoner to a mental hospital and ruled that Vitek had a right to a hearing because of the substantial change in condition of a transfer to a mental hospital. The court wrote

"While a conviction and sentence extinguish an individual right to freedom from confinement for the term of his sentence, they do not authorize the state to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections. Here, the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections. . . . Although the state's interest in segregating and treating mentally ill patients is strong, the prisoner's interest in not being arbitrarily classified as mentally ill and subjected to unwelcomed treatment [emphasis added] is also powerful, and the risk of error in making the determinations . . . is substantial enough to warrant appropriate procedural safeguards against error" (*Vitek v. Jones*, 1979, p. 481).

While the court did not specifically say that Vitek had an absolute right to refuse treatment, there are fairly strong references that a prisoner could not be capriciously treated against his will.

For example, some of the procedural requirements for a Vitek hearing are the opportunity for the inmate to present witnesses in his or her behalf, to cross-examine state witnesses, and to have an independent decision maker. These safeguards suggest that an inmate has the right to refuse treatment that is not in his or her best interest. Having the right to challenge state witnesses and the right to an independent decision maker will stop unnecessary treatment decisions. Hence, there is a latent pronouncement of a right to refuse or reject treatment that is unwarranted in this decision.

Similarly, another federal court ruled that the Federal Bureau of Prison's START (Special Treatment and Rehabilitation Training) program was reviewable as possibly being violative of the Eighth Amendment prohibition against cruel and unusual punishment despite the assertion of the prison officials that the program was treatment. START consisted of placing problem inmates on a level system with just the bare essentials and allowing them to move up depending upon improved behavior. However, some critics charged that the initial level of deprivation was too low and unconstitutional. The issue became moot when the program was terminated and the court did not make a ruling (*Clone v. Richardson*, 1974). Like aversive therapy, the START program could be reasonably construed as being punishment and subject to the test of whether it was cruel and unusual punishment.

Similar to their counterparts in state mental hospitals, prisoners have a limited right to refuse treatment which can be overridden. For instance, at the Federal Medical Center at Rochester, prisoners who are transferred there for psychiatric treatment are sent back to their sending institutions if they refuse treatment. However, if it is determined that the prisoner is dangerous to himself or others, he can be forcibly treated following an adverse ruling from a hearing at the institution before a federal magistrate. In like manner, the Oak Park Heights Correctional Institution has a mental health unit that is responsible for treating all of the mentally ill male offenders in the Minnesota system. By statute, it has the authority to forcibly treat a psychotic inmate following a hearing before a judge (Alexander, 1987a). Hence, one can see similar types of safeguard procedures in the prison system that exist in the mental health system.

### Conclusion

The essential focus of this paper was the elaboration of the right to refuse mental health treatment in correctional institutions. This is an essential right given that the dominant penal philosophy is to punish offenders and given that medical technology may discover more effective behavior controlling drugs or innovations. It is quite easy for institutional treatment officials to stray, as some examples in this paper have shown, from their helping philosophy and adopt practices that are punishing. Perhaps, this is an inevitability given the environment of a total institution. It must be remembered that antipsychotic drugs, which sound helpful, do not cure mental illness and have serious side effects. The primary benefit of psychoactive drugs is to temporarily make a person more manageable, and they do not produce any permanent changes (Bartol & Bartol, 1986). Moreover, as major tranquilizers, they can be used as an effective means of social control in an institution. Churgin (1983) cited a study in his article which showed that inmates in one prison system were transferred to mental hospitals for being disruptive and not for being mentally ill. Occasionally, one hears snide references about the Soviet Union who reportedly put some of their dissidents in psychiatric hospitals as a means of stifling dissent. But the same type of practice can be done to citizens in the United States who are powerless and despised, like prison inmates are, if the right to refuse treatment is unavailable. Whenever something of a treatment nature is planned for an inmate, the following question needs to be asked "is it really for the inmate or is it for the institution"? While institutional social control is not per se opprobrious, it can be if allowed to go unchecked. The courts have offered some fairly sound guidelines spelling out when psychiatric or psychological treatment is indicated (*Ruiz v. Estelle*, 1980), and all are focused on the inmates' needs rather than institutional. Allowing inmates the limited right to refuse questionable therapies and drugs is necessary in order to protect against institutional abuses.

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