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UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
BOARD OF IMMIGRATION APPEALS

In the Matter of [redacted] Respondent. In Removal Proceedings	File No.: A[redacted]

REQUEST TO APPEAR AS AMICI CURIAE AND BRIEF OF AMICI CURIAE HARVARD LAW SCHOOL PROJECT ON DISABILITY, HARVARD IMMIGRATION AND REFUGEE CLINICAL PROGRAM, MENTAL HEALTH ADVOCACY SERVICES, INC., DISABILITY RIGHTS LEGAL CENTER, THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, INC., AND PROGRAM FOR TORTURE VICTIMS IN SUPPORT OF RESPONDENT

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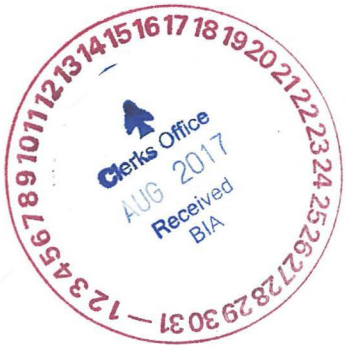

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

STATE CASES

TABLE OF AUTHORITIES
(continued)

Page(s)

ADMINISTRATIVE DECISIONS

FEDERAL REGULATIONS

OTHER AUTHORITIES

TABLE OF AUTHORITIES
(continued)

Page(s)

REQUEST TO APPEAR AS AMICI CURIAE

Amici curiae are nonprofit organizations devoted to protecting the rights of all people with disabilities. Accordingly, amici curiae share a vital interest in ensuring that people with disabilities are afforded the full protection of the law and that none are placed at risk due to misconceptions regarding the existence, influence, or consequences arising from disability, including mental illness. The continued practice of dubious methods of psychiatric treatment, which underlie the issues raised in this case, have been researched substantially by the community of mental health professionals, who have concluded that certain invasive acts lack a therapeutic purpose. Amici curiae respectfully request permission to submit this brief to present relevant and empirically based scientific evidence that demonstrates to the Board that mental health workers who continue to employ these retrogressive methods do so with the specific intent to cause severe pain and suffering.

The Harvard Law School Project on Disability ("HPOD") is the preeminent global disability rights law and policy center based in Cambridge, Massachusetts, engaging in academic research, providing rights-based technical support to civil society worldwide, advising governments and United Nations agencies, and promoting the effective implementation of the United Nations Convention on the Rights of Persons with Disabilities. HPOD has submitted amicus curiae and other third-party briefs in numerous disability rights cases before domestic and international adjudicative bodies, including the United States Supreme Court, the European Court of Human Rights, the Inter-American Court of Human Rights, and the highest adjudicative courts of many domestic jurisdictions.

The Harvard Immigration and Refugee Clinical Program ("HIRC") at Harvard Law School has been a leader in the field of refugee and asylum law for over 30 years. HIRC is dedicated to the representation of individuals applying for asylum, withholding of removal, and

protection under the Convention Against Torture ("CAT"), along with policy advocacy and appellate litigation. Clinic faculty have authored numerous publications on international law, refugee law, and CAT protection. HIRC has an interest in the appropriate application and development of U.S. asylum law, as well as law related to U.S. implementation of its obligations under the CAT, so that claims for asylum, withholding of removal, and CAT protection receive fair and full consideration.

Mental Health Advocacy Services, Inc. ("MHAS") is a non-profit law firm dedicated to serving the legal needs of those with mental health disabilities. MHAS's mission is to protect and advance the legal rights of children and adults with mental health disabilities to maximize autonomy, promote equality, and secure the resources these people need to thrive in the community.

Disability Rights Legal Center ("DRLC") is a non-profit legal organization that was founded in 1975 to represent and serve people with disabilities. Individuals with disabilities continue to struggle against ignorance, prejudice, insensitivity, and lack of legal protection in their endeavors to achieve fundamental dignity and respect. The DRLC assists people with disabilities in attaining the benefits, protections, and equal opportunities guaranteed to them under the Rehabilitation Act of 1973, the Americans with Disabilities Act, the IDEA, and other state and federal laws. Its mission is to champion the rights of people with disabilities through education, advocacy, and litigation. The DRLC is a recognized expert in the field of disability rights.

The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advance the rights of individuals with mental disabilities. The Center has engaged in litigation, policy advocacy, and public education to preserve the civil

rights of and promote equal opportunities for individuals with mental disabilities in institutional as well as community settings. It has litigated numerous cases concerning the rights of people with mental illness, including the right to refuse treatment by antipsychotic drugs.

Disability Rights Education and Defense Fund, Inc. ("DREDF") is a national disability civil rights law and policy organization dedicated to securing equal citizenship for Americans with disabilities. Since its founding in 1979, DREDF has pursued its mission through education, advocacy and law reform efforts. Nationally recognized for its expertise in the interpretation of federal disability civil rights laws, DREDF has consistently worked to promote the full integration of citizens with disabilities into the American mainstream, and to ensure that the civil rights of persons with disabilities are protected and advanced.

The Program for Torture Victims ("PTV") is a nonprofit organization dedicated to rebuilding the lives of torture survivors who have stood up for freedom, democracy, and dignity. The first organization of its kind in the country, PTV aims to alleviate the suffering and health consequences of state-sponsored torture, and has helped heal the wounds of thousands of survivors from over 70 countries by providing comprehensive medical, psychological, legal, and case management services.

For these reasons, amici curiae respectfully submit that it is in the public interest for the Board to consider this brief, and therefore respectfully request permission to appear as amici curiae. *See* 8 C.F.R. § 1292.1(d).

INTRODUCTION

It is highly likely that Mr. [redacted] will be institutionalized and tortured if he is returned to Mexico as a direct result of his mental illness. Specifically, Mr. [redacted] has schizophrenia, and the standard treatment in Mexico for schizophrenia is inpatient care in a mental institution. Patients confined in Mexican psychiatric institutions are routinely and

involuntarily subjected to practices that include (1) forced administration of mind-altering drugs for purposes of social control or punishment, (2) prolonged use of physical restraints for reasons unrelated to preventing imminent harm, (3) use of electro-convulsive therapy to control or punish patients, and (4) nonconsensual psychosurgery. These methods of alleged treatment have been widely repudiated by the international community of mental health professionals because they lack therapeutic justification and do not provide treatment. Instead, these methods' sole consequence is to inflict severe mental and physical pain and suffering, and thus constitute torture.

Yet in spite of the widespread condemnation of these practices evidenced in the record, *see* Exh. 6, Tabs J, H-O, the Immigration Judge stated that she could not find "any indications of health workers' specific intent to torture patients under their care" and could only "speculate" about whether health workers specifically intended to harm patients. I.J. Dec. at 4-5 (Apr. 21, 2017). The Immigration Judge decided that the prevalence of these practices in Mexican mental institutions resulted, instead, from a "misguided sense" that they are "medically necessary." *Id.* at 5.

In doing so, the Immigration Judge erred by myopically disregarding overwhelming evidence that these methods have no justification in modern mental health care. Mr. [redacted] claim that he will be tortured if he is removed to Mexico is not speculative. To the contrary, the objective facts in the record regarding the ongoing use of discredited forms of treatment in Mexican psychiatric institutions constitute clear evidence of specific intent to cause severe pain and suffering.

SUMMARY OF THE ARGUMENT

To secure protection under U.S. law implementing the CAT, an applicant must establish that he is more likely than not to be the victim of an act specifically intended to cause severe pain

or suffering. Circumstantial evidence of specific intent is sufficient to secure CAT protection under U.S. law, and certain abusive acts themselves may support an inference that an actor has the requisite intent. In the mental health context, these acts include forced administration of mind-altering drugs for purposes of social control or punishment, prolonged use of physical restraints, use of electro-convulsive therapy to control or punish patients, and nonconsensual psychosurgery.

Here, the record contains extensive evidence that mental health workers would subject Mr. [redacted] to these abusive acts if he were removed to Mexico. The Immigration Judge erred by failing to appropriately consider whether this evidence gives rise to an inference of specific intent, and instead demanding direct evidence regarding intent. Furthermore, the Immigration Judge improperly analogized this case to the Ninth Circuit's decision in *Villegas v. Mukasey*, 523 F.3d 984 (9th Cir. 2008), which rejected an inference of specific intent based merely on evidence regarding generalized "deplorable . . . conditions" in Mexican psychiatric institutions. Contrary to the Immigration Judge's characterization, this case involves specific evidence of invasive practices that are more likely than not to be perpetrated individually on Mr. [redacted] himself. Thus, this case is unlike *Villegas* and other cases involving maintenance of substandard conditions in prisons, mental institutions, or other governmental facilities. The failures by the Immigration Judge to adequately consider the evidence or to properly analyze case law constitute reversible error.

Finally, the Ninth Circuit has made clear that, where a government fails to remediate inhumane institutional conditions, adjudicators may properly infer a specific intent to cause severe pain and suffering. *See Ridore v. Holder*, 696 F.3d 907, 917 (9th Cir. 2012). Here, the evidence presented to the Immigration Judge shows that the Mexican authorities continue to rely

on psychiatric institutions to house individuals with mental illness, despite longstanding documentation of inhumane and invasive practices in these institutions. This refusal to adopt more humane and cost-effective forms of care reflects a conscious policy choice and supports the inference that the Mexican authorities, as a matter of policy, specifically intend to cause severe pain and suffering to psychiatric patients.

ARGUMENT

I. Specific Intent to Cause Severe Pain or Suffering May Properly Be Inferred from Evidence that Mental Health Workers Routinely and Involuntarily Subject Psychiatric Patients to Specific, Invasive Acts that Have Been Widely and Uniformly Repudiated in the Mental Health Profession

A. The requirement of specific intent can be met with reasonable inferences drawn from objective circumstantial evidence

An applicant for protection under U.S. law implementing the CAT must show an act that is "specifically intended to inflict severe pain or suffering." *Matter of J-E-*, 23 I&N Dec. 291, 300 (BIA 2002) (emphasis omitted); 8 C.F.R. § 1208.18(a)(5).[1] The actor need not have the specific intent to engage in torture *per se*; it is enough that the actor has specific intent to inflict severe pain or suffering. *See Auguste v. Ridge*, 395 F.3d 123, 145-46 (3d Cir. 2005). Here, in applying the specific intent requirement, the Immigration Judge disregarded the extensive circumstantial evidence in the record indicating that Mexican mental health workers have the requisite specific intent, and regarded anything other than direct evidence of specific intent as speculation. That was error. The Board should remand.

[1] The act also must have been "inflicted by or at the instigation of or with the consent or acquiescence" of a "person acting in an official capacity." 8 C.F.R. § 1208.18(a)(1). Here, the Immigration Judge correctly concluded that "the evidence in the record indicates that Mexican [mental] health workers acted in an official capacity for the purposes of determining eligibility for deferral of removal under the CAT." I.J. Dec. at 5 (Apr. 21, 2017).

Both in the context of U.S. law implementing the CAT and elsewhere, courts and commentators have recognized that specific intent can be shown without direct evidence of the perpetrators' state of mind; a "specific intent to do something" can be found from "inferences reasonably drawn" from circumstantial evidence. *United States v. Wilson*, 631 F.2d 118, 119 (9th Cir. 1980). The Committee Against Torture—the body established by the United Nations to monitor implementation of the CAT—has "explained that establishing intent and purpose does not involve a 'subjective inquiry into the motivations of the perpetrators.' Instead, it simply requires 'objective determinations under the circumstances.'" Hathaway et al., *Tortured Reasoning: The Intent to Torture Under International and Domestic Law*, 52 Va. J. Int'l L. 791, 802 (2012) (footnote omitted) (quoting U.N. Comm. Against Torture, *General Comment No. 2, Implementation of Article 2 by State Parties*, 9, U.N. Doc. CAT/C/GC/2 (Jan. 24, 2008)). Similarly, in prosecutions for specific-intent crimes, the courts have made clear that the requisite intent may be inferred from the sheer objective unreasonableness of a defendant's asserted good faith. *See, e.g.*, *Cheek v. United States*, 498 U.S. 192, 203-04 (1991) ("[T]he more unreasonable the asserted beliefs or misunderstandings are, the more likely the jury will consider them to be nothing more than simple disagreement with known legal duties . . . and will find that the Government has carried its burden").

B. Certain abusive acts committed by mental health workers are circumstantial evidence of specific intent to inflict severe pain or suffering

Specific intent to inflict severe pain and suffering may be inferred from abusive acts themselves. *See Kang v. Att'y Gen. of the U.S.*, 611 F.3d 157, 167 (3d Cir. 2010) ("The acts themselves compel the conclusion that they were intended to inflict pain."). In the mental health context, certain treatment practices are so widely recognized as lacking therapeutic value, and so certain to cause severe pain and suffering, that their implementation evidences a specific intent

on the part of the perpetrator to cause severe pain and suffering. These practices include: (1) forced administration of mind-altering drugs for purposes of social control or punishment, (2) routine and prolonged use of physical restraints other than to prevent imminent harm, (3) administration of electro-convulsive therapy to control or punish patients, and (4) nonconsensual psychosurgery. For example, the World Health Organization ("WHO") and International Committee of the Red Cross ("ICRC") consider the "abusive use of seclusion, restraints and medication, and non-consensual . . . medical experimentation" to be torture or cruel, inhuman, and degrading treatment. World Health Org. & Int'l Comm. of the Red Cross, *Information Sheet: Mental Health and Prisons* 4, *available at* www.who.int/mental_health/policy/mh_in_prison.pdf. And Juan Méndez, formerly the United Nations Special Rapporteur on Torture, has called for an absolute ban on "all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs . . . for both long- and short-term application." Exh. 6, Tab K at 229[2]; *see also* U.N. Comm. on the Rights of Persons with Disabilities, *General Comment No. 1*, ¶ 42, U.N. Doc. CRPD/C/GC/1 (stating that forced psychiatric treatment is an infringement of the right to freedom from torture).

The institutional context in which mental health workers engage in these practices offers further evidence of a specific intent to inflict severe pain or suffering.[3] The involuntary

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[2] Portions of Exhibit 6, referenced throughout this brief, contain multiple sets of page numbering. Citations in this brief refer to the page numbering that is handwritten in the bottom margin.

[3] The National Center on Disability has observed that the "medical model" of disabilities, "which views people with disabilities as needing to be cured," has "involved the involuntary institutionalization of individuals based upon a dubious psychiatric diagnosis, enforced confinement on locked wards in a control-oriented regime with limited freedoms conditioned upon compliance with the rules of the facility, as well as 'treatment' which may be unwanted, most frequently the administration of powerful psychotropic drugs or controversial electroshock

confinement of patients to psychiatric institutions renders them powerless and therefore vulnerable to the specific, invasive acts mentioned above. By its very nature, torture "presupposes a situation of powerlessness of the victim." Nowak, *Challenges to the Absolute Nature of the Prohibition of Torture and Ill-Treatment*, 23 Netherlands Q. Hum. Rts. 674, 678 (2005). Consequently, Manfred Nowak, another former Special Rapporteur on Torture, has used powerlessness as a distinguishing criterion between acts of torture and acts of cruel, inhuman, and degrading treatment, calling it "the most important criteria of [the torture] definition that is not explicitly written in the Convention[.]" Nowak, *Torture: Perspective from UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment*, 7 Nat'l Taiwan U.L. Rev. 466, 471 (2012); Exh. 6, Tab O at 353 (citing Nowak & McArthur, *The United Nations Convention Against Torture: A Commentary* 77 (2008)).

In sum, mental health professionals know that practices such as forced administration of mind-altering drugs, prolonged use of physical restraints, nonconsensual administration of electro-convulsive therapy, and nonconsensual psychosurgery can rise to the level of torture. Accordingly, a mental health worker's engaging in these practices for nontherapeutic purposes, such as to control or punish patients, shows specific intent. The Immigration Judge erred by ignoring this probative evidence of intent. The Board should reverse the Immigration Judge's finding that Mr. [redacted] failed to meet his burden of showing specific intent.

'therapy.'" Nat'l Council on Disability, *Assisted Suicide: A Disability Perspective* § IV.B (Mar. 24, 1997), *available at* https://ncd.gov/publications/1997/03241997#4b6. This model is delivered "often in its most egregious form[] in mental health treatment facilities." *Id.*

1. Administering or threatening to administer mind-altering drugs for non-therapeutic purposes supports an inference of specific intent to cause severe pain or suffering

Mind-altering or psychotropic drugs are highly invasive and can cause significant and irreversible harm. *See, e.g.*, *Washington v. Harper*, 494 U.S. 210, 229 (1990) (observing that antipsychotic drugs "can have serious, even fatal, side effects" and cataloguing potential side effects). The regulations implementing the CAT therefore expressly recognize that mental harm resulting from "[t]he administration or application, or threatened administration or application, of mind altering substances or other procedures calculated to disrupt profoundly the senses or the personality" constitutes torture. 8 C.F.R. § 1208.18(a)(4)(ii).

International norms tightly regulate the administration of medication, including psychotropic drugs, to persons with mental illness. For example, the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care ("U.N. Mental Illness Principles") permit medication to "be given to a patient only for therapeutic or diagnostic purposes" and prohibit its use "as a punishment or for the convenience of others." Principle 10, U.N. Doc. A/RES/46/119 (1991); *see also Harper*, 494 U.S. at 241 (Stevens, J., concurring in part and dissenting in part) ("Forced administration of antipsychotic medication may not be used as a form of punishment."). The U.N. Mental Illness Principles also generally require that an "independent authority" review any treatment given without the patient's consent to determine that is in the patient's "best interest," and that all treatment "be immediately recorded in the patient's medical records." *Id.* Principle 11(6)(b)-(c), Principle 10.

In light of these well-established principles, when health workers administer psychotropic drugs non-consensually and without any procedural safeguards, such as documenting clinical necessity, it is reasonable to infer that they do so *not* for a therapeutic purpose, but rather to cause severe pain and suffering. Indeed, other Immigration Judges have recognized that the

administration of psychotropic drugs in Mexican psychiatric institutions can support an inference that they are administered with the specific intent to cause severe pain and suffering, where the "evidence show[ed] that the actual motivation of staff is to control and alter the behavior and personalities of the patients." *Matter of X-*, at 3 (Immig. Ct. Apr. 22, 2013) (attached hereto as Exhibit A).

Here, the record contains substantial evidence indicating that Mr. [redacted] would be subject to nonconsensual administration of psychotropic drugs for the purpose of sedation or punishment if he were removed to Mexico. In 2015, Disability Rights International ("DRI") reported that Mexican "institutions chemically restrain the people in their care by overmedicating. They heavily sedate the people in their care in order to control their behavior, rather than providing therapy or rehabilitation." Exh. 6, Tab M at 251. DRI also reported that medication "is administered indiscriminately" and "without adequate supervision." *Id.* DRI found that "[i]n some cases, [medications] are prescribed without the consultation of a psychiatrist." *Id.*

The Immigration Judge improperly dismissed this evidence as merely speculative and failed to consider it for its probative value. Viewed reasonably, mental health workers' unsupervised, indiscriminate, and nonconsensual administration of mind-altering drugs supports an inference that these drugs were administered with the specific intent to cause severe pain and suffering. The Immigration Judge's refusal to draw this reasonable inference constitutes reversible error.

2. Using or threatening to use restraints or seclusion supports an inference of specific intent to cause severe pain or suffering

Likewise constituting reversible error is the Immigration Judge's refusal to draw reasonable inferences from evidence indicating that Mr. [redacted] would be subject to

the prolonged use of physical restraints if he were removed to Mexico. The use of physical restraints for a proscribed purpose is a paradigmatic example of torture; the Senate Committee Report on the ratification of the CAT specifically cited "tying up . . . in positions that cause extreme pain" as an example of torture. S. Exec. Rep. No. 101-30, at 14 (1990). The prolonged use of restraints in a psychiatric setting serves no therapeutic purpose. The Supreme Court has recognized that "[p]hysical restraints are effective only in the short term, and can have serious physical side effects." *Harper*, 494 U.S. at 226. This understanding is consistent with international norms. These norms generally prohibit the use of physical restraints (or involuntary seclusion), except when "it is the only means available to prevent immediate or imminent harm to the patient or others." Principle 11(11), U.N. Doc. A/RES/46/119. Mr. Nowak, the former Special Rapporteur on Torture, has stated that "there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment." Nowak, *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/63/175, ¶ 55 (July 28, 2008).

In light of this long-held understanding that prolonged restraints serve no therapeutic purpose, it is reasonable to infer from mental health workers' use of these restraints a specific intent to cause severe pain and suffering. The Board itself has found that "[t]he placement of a person in long-term restraints over a life-time can meet the intent requirement [of the CAT] because staff knowingly places a person in this condition." *Matter of E-M-*, at 4 (BIA Sept. 5, 2014) (unpublished) (Exh. 6, Tab X at 728). And, in the same case noted in section II.B.1, *supra*, another Immigration Judge found that the prolonged use of physical restraints in Mexican psychiatric institutions can support an inference that they are used with specific intent to cause severe pain and suffering. *See Matter of X-*, at 3 (attached hereto as Exhibit A).

Here, the record before the Immigration Judge contained significant evidence regarding the prolonged use of physical restraints to which Mr. [redacted] would likely be subjected in a Mexican psychiatric institution. DRI has reported that "prolonged use of physical restraints remains a common practice in Mexican custodial institutions." Exh. 6, Tab M at 248. At one institution, DRI "observed a young man tied to a wheelchair from head-to-toe so that he was not able to move any part of his body." Exh. 6, Tab O at 352. DRI observed the same individual similarly restrained approximately ten years earlier, and staff at the institution stated that he was "permanently held in a wheelchair." *Id.* at 352-53. At another institution, "one minor in custodial care remained restrained at all times, and . . . eight other people with disabilities were confined to their beds 'all the time.'" Furthermore, four people died while in restraints at this institution in the previous four years. Exh. 6, Tab M at 243-44.

The Immigration Judge failed to address this evidence, and she failed to explain why mental health workers' indiscriminate use of physical restraints for prolonged periods could not support an inference that these restraints would be used with the specific intent to cause severe pain and suffering. These failures constitute reversible error, just as the Immigration Judge's failure to address similar evidence constituted reversible error in *E-M-*.

3. Using or threatening to use electro-convulsive therapy to control or punish patients supports an inference of specific intent to cause severe pain and suffering

U.S. courts have long recognized that electro-convulsive therapy ("ECT") is highly invasive. *See, e.g., In re Conservatorship of Foster*, 547 N.W.2d 81, 88 (Minn. 1996) (observing "that electroshock therapy is one of the most intrusive forms of treatment") (internal quotation marks omitted). When ECT is administered without anesthetics or muscle relaxants and at high

levels of electrical current, it can result in "broken bones, broken or lost teeth, and . . . long term memory loss." Electroconvulsive Therapy, 1 Health L. Prac. Guide § 17:23 (2017).[4]

Here, the record before the Immigration Judge contained evidence that Mr. [redacted] would likely be subject to the nonconsensual use of ECT if he were removed to Mexico. *See* Tr. at 136-37 (Feb. 8, 2016). In its remand order, the Board specifically stated that "the Immigration Judge's conclusion does not appear to consider the expert testimony that electro-shock therapy and lobotomies have been used as forms of punishment and forms of discipline" and ordered additional fact-finding. B.I.A. Dec. at 3 (Nov. 30, 2016) (internal quotation marks omitted). In her subsequent decision, the Immigration Judge credited evidence that patients in Mexican psychiatric institutions "are often subjected to a range of abusive practices, such as . . . electroconvulsive therapy, to control and constrain their actions." I.J. Dec. at 5 (Apr. 21, 2017). Nevertheless, she again failed to adequately explain why this evidence did not support an inference that ECT was administered with the specific intent to cause severe pain and suffering. This failure constitutes reversible error.

[4] Consequently, the WHO has stated that "[i]f ECT is used, it should only be administered after obtaining informed consent. And it should only be administered in modified form, i.e. with the use of anaesthesia and muscle relaxants." World Health Org., *WHO Resource Book on Mental Health, Human Rights and Legislation* 64 (2005), *available at* https://ec.europa.eu/health//sites/health/files/mental_health/docs/who_resource_book_en.pdf. Similarly, the European Committee for the Prevention of Torture ("CPT") has for over a decade held that unmodified ECT is unacceptable in modern psychiatric practice. "Apart from the risk of fractures and other untoward medical consequences, the process as such is degrading for both the patients and the staff concerned." European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *The CPT Standards* ¶ 39 (2006).

4. Using or threatening to use psychosurgery, such as lobotomies, supports an inference of specific intent to cause severe pain or suffering

Psychosurgery is "the most grotesquely intrusive form of" purported psychiatric treatment. *Bell v. Wayne Cty. Gen. Hosp.*, 384 F. Supp. 1085, 1102 (E.D. Mich. 1974). Its nonconsensual use has been widely discredited. In *Kaimowitz v. Michigan Department of Mental Health*, the court held that "an involuntarily detained mental patient may not consent to experimental psychosurgery." 1 Mental Disability L. Rep. 147, 152 (Cir. Ct. Wayne Cty., Mich. 1973) (attached hereto as Exhibit B). Similarly, the U.N. Mental Illness Principles categorically prohibit "[p]sychosurgery and other intrusive and irreversible treatments for mental illness . . . on a patient who is an involuntary patient in a mental health facility." Principle 14, U.N. Doc. A/RES/46/119.

In light of this longstanding repudiation of psychosurgery on involuntarily detained psychiatric patients as a legitimate method of treatment, it is reasonable to infer from its use a specific intent to cause severe pain and suffering. Here, the record contains evidence regarding the likelihood that Mr. [redacted] would be subject to nonconsensual psychosurgery. *See, e.g.*, Tr. at 136-37 (Feb. 8, 2016). As noted above, the Board specifically stated in its remand order that the Immigration Judge had failed to consider evidence that psychosurgery was used in Mexican psychiatric institutions as a form "of punishment and . . . discipline" and ordered additional fact-finding. B.I.A. Dec. at 3 (Nov. 30, 2016). In her subsequent decision, the Immigration Judge credited evidence that patients in Mexican psychiatric institutions are often subjected to lobotomies. *See* I.J. Dec. at 5 (Apr. 21, 2017). Nevertheless, she again failed to adequately explain why this evidence did not support an inference that psychosurgery was used with the specific intent to cause severe pain and suffering. This failure constitutes reversible error.

C. The evidence that Mr. [redacted] will be involuntarily subjected to specific, invasive acts makes this case different from cases involving alleged torture arising from substandard conditions

The Immigration Judge analogized this case to *Villegas*, and characterized the evidence here as merely describing "conditions" in Mexican mental institutions that, as in *Villegas*, resulted from "'historical gross negligence and misunderstanding of the nature of psychiatric illness.'" I.J. Dec. at 6 (Apr. 21, 2017) (quoting *Villegas*, 523 F.3d at 989). That comment reveals the Immigration Judge's manifestly flawed understanding of this case. Contrary to the Immigration Judge's characterization, this case—unlike *Villegas* and other cases involving maintenance of substandard conditions in prisons, mental institutions, or other governmental facilities—involves specific evidence of invasive practices that are more likely than not to be perpetrated individually on Mr. [redacted] himself.

The evidence of invasive acts that will likely be inflicted on Mr. [redacted] himself is significantly more individualized and significantly more extensive than the evidence in *Matter of J-E-*, *Villegas*, and similar cases in which the alleged torture consisted of confinement in substandard or deplorable conditions and the mere maintenance of those prison conditions was found inadequate to show specific intent. In *Matter of J-E-*, for example, the Board ruled over dissenting votes from six Members that "[a]lthough Haitian authorities . . . know[] that the detention facilities are substandard, there is no evidence that they are intentionally and deliberately creating and maintaining such prison conditions in order to inflict torture." *Matter of J-E-*, 23 I&N Dec. at 301. Likewise, in *Villegas*, the Ninth Circuit upheld the Board's denial of CAT relief where the only proffered evidence of specific intent consisted of "evidence show[ing] that Mexican mental patients are housed in terrible squalor" and "nothing indicate[d] that Mexican officials . . . created these conditions for the specific purpose of inflicting suffering

upon the patients." *Villegas*, 523 F.3d at 989. The evidence that has been presented here is not analogous to the evidence in *Matter of J-E-* and *Villegas*.

First, there are good reasons why an inference of specific intent from objective circumstances is more likely to be appropriate in a case like this one involving psychiatric confinement than in a case involving imprisonment. Involuntary institutionalization in a psychiatric facility should occur only for therapeutic purposes. *See generally Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999) ("Unjustified isolation . . . is properly regarded as discrimination based on disability."). Mental health workers (unlike prison guards) are part of a trained, science-based profession that operates under standards and guidelines such as those promulgated by the WHO and the World Psychiatric Association. Thus, it is reasonable to infer that mental health workers (1) are aware of professional norms that repudiate certain specific, invasive acts, and (2) have the specific intent to cause severe pain or suffering when they perform those acts for the purpose of punishment or control.

Second, whereas the squalid conditions in *Matter of J-E-* and *Villegas* were not individualized, and existed whether or not any particular person was housed in the facilities described there, the evidence in this case shows that Mexican mental health workers are highly likely to perform invasive procedures on Mr. [redacted] because of the nature of his illness.[5] These facts distinguish this case from *Matter of J-E-* and *Villegas* and render it far more analogous to *Jean-Pierre v. United States Attorney General*, 500 F.3d 1315 (11th Cir. 2007), in which the Eleventh Circuit vacated the Board's denial of relief under U.S. law implementing the

[5] As the Second Circuit has observed, "it might be that petitioners with certain histories, characteristics, or medical conditions are more likely to be targeted not only with . . . individual acts [of abuse] but also with particularly harsh conditions of confinement." *Pierre v. Gonzales*, 502 F.3d 109, 122 (2d Cir. 2007).

CAT where the evidence showed that the applicant "would be *individually* and *intentionally* singled out for harsh treatment" rather than merely "generalized mistreatment and some isolated instances of torture." *Id.* at 1324 (distinguishing *Matter of J-E-*); *see also Eneh v. Holder*, 601 F.3d 943, 948-49 (9th Cir. 2010) (distinguishing *Villegas* where the evidence showed that the applicant "would be intentionally tortured in Nigerian prisons because he has AIDS" rather than because "conditions in Nigerian prisons are torturous generally"). So too here, Mr. [redacted] claim is based not on the generally deplorable conditions inside Mexican psychiatric institutions, but on the likelihood that the Mexican mental health workers in Mexican psychiatric institutions will intentionally perform specific, invasive acts on *this particular person* in light of *his particular* condition.

II. The Mexican Government's Reliance on Psychiatric Institutions Despite Evidence of Abuses and International Censure Is a Conscious Policy Decision Evidencing Specific Intent to Cause Severe Pain and Suffering

In *Villegas*, the Ninth Circuit concluded that Mexican officials' "desire to improve" conditions at psychiatric institutions confirmed that those conditions did not evidence a specific "intent to inflict harm." *Villegas*, 523 F.3d at 989. Nearly a decade after *Villegas*, however, the "terrible squalor" in these institutions remains. The record here contains extensive evidence documenting the continuing inhumane conditions in Mexican psychiatric institutions. *See, e.g.*, Exh. 6, Tabs H, I, J, K, M, N, O. This record evidence is corroborated by recent reports concerning these institutions. For example, the State Department's 2016 Human Rights Report on Mexico observed that "[h]uman rights abuses in mental health institutions and care facilities," including "the use of physical and chemical restraints," "continued to be a problem." Bureau of Democracy, Human Rights and Labor, U.S. Dep't of State, *Mexico 2016 Human Rights Report* 25 (updated Apr. 7, 2017), *available at* https://www.state.gov/documents/organization/265812.pdf.

In the aftermath of *Villegas*, the Ninth Circuit has specifically recognized that evidence of deteriorating prison conditions could support an inference that those conditions were created with the intent to cause severe pain and suffering. *See Ridore*, 696 F.3d at 917. Here, the Mexican government's continued reliance on psychiatric institutions to house individuals with mental illness, despite longstanding documentation of the specific, invasive acts detailed above, cannot "be explained simply by a lack of resources to implement reforms." *Olivar v. Holder*, 540 F. App'x 584, 585 (9th Cir. 2013) (unpublished). For decades, community-based alternatives to institutional care have been shown to be more humane and more cost-effective. *See, e.g.*, U.S. Comm'n on Civil Rights, Clearinghouse Pub. No. 81, *Accommodating the Spectrum of Individual Abilities* 78 (Sept. 1983) (observing that "[v]irtually all the relevant literature documents that segregating handicapped people in large, impersonal institutions is the most expensive means of care"). Consequently, the persistence of these practices in psychiatric institutions is not the unfortunate result of "severe economic difficulties," as was the case in *Matter of J-E-*, 23 I&N Dec. at 301; *see also* Exh. 6, Tab O at 303 (indicating that, as of 2010, Mexico was making new investments in segregated institutional care, rather than community-based care). Rather, it reflects a conscious policy choice on the part of the Mexican government and, thus, gives rise to the inference that mental health workers in psychiatric institutions operated by or on behalf of the Mexican government specifically intend to cause severe pain and suffering to patients like Mr. [redacted] housed in these institutions.

CONCLUSION

The Board should sustain Mr. [redacted]'s appeal, and the case should be remanded for the Immigration Judge to consider the inferences that can reasonably be drawn from the objective circumstances presented here.

Dated: August 11, 2017

Respectfully submitted,

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[redacted]

PROOF OF SERVICE

On August 11, 2017, I, Cynthia Silvas, served a copy of the **Request to Appear as Amici Curiae and Brief of Amici Curiae Harvard Law School Project on Disability, Harvard Immigration and Refugee Clinical Program, Mental Health Advocacy Services, Inc., Disability Rights Legal Center, the Judge David L. Bazelon Center for Mental Health Law, Disability Rights Education and Defense Fund, Inc., and Program for Torture Victims in Support of Respondent** and any attached pages by first-class mail to the following addresses:

Department of Homeland Security
Office of the Chief Counsel
10400 Rancho Rd.
Adelanto, CA 92301

Amanda Schuft
Munmeeth K. Soni
Ambar Tovar
Immigrant Defenders Law Center
634 S. Spring St., 10th Floor
Los Angeles, CA 90014

Cynthia Silvas

August 11, 2017
Date

Exhibit A

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
UNITED STATES IMMIGRATION COURT
401 West A Street, Suite 800
San Diego, California 92101

File No.: [redacted]) Date: April 22, 2013
)
In the Matter of)
) **IN REMOVAL PROCEEDINGS**
[redacted])
)
Respondent)

ON BEHALF OF RESPONDENT:

Pro Se[1]

ON BEHALF OF DEPARTMENT OF HOMELAND SECURITY:

Kerri Calcador, Esquire
880 Front Street, Suite 2246
San Diego, California 92101

CHARGE: Section 237(a)(2)(A)(iii) of the Immigration and Nationality Act (Alien Convicted of an Aggravated Felony).

APPLICATION: On Remand from the Board of Immigration Appeals

DECISION AND ORDER OF THE IMMIGRATION JUDGE

The respondent, a citizen of Mexico and a long-time lawful permanent resident of the United States, is removable from the United States as an alien convicted of an aggravated felony. (Decision and Order of the Immigration Judge, Aug. 2, 2011, at 1.) After lengthy removal proceedings, the Immigration Judge found that the only relief from removal for which the respondent is eligible is deferral of removal under the United Nations Convention against Torture ("CAT"). In a thorough and a well-reasoned decision authored on August 2, 2011, the Immigration Judge ordered the respondent removed but deferred his removal under CAT. (*Id.* at 3-4, 13.) The Department of Homeland Security ("DHS") timely appealed the Immigration Judge's grant of deferral of removal to the Board of Immigration Appeals ("BIA"). (Decision of the BIA, Jan. 14, 2013, at 1.) Although neither party requested that the case be remanded to the Court, the BIA decided to remand for further fact-finding on certain discrete issues.[2] (*Id.* at 3.)

These removal proceedings have been significantly influenced by the respondent's limited mental competency. The parties agree that the respondent suffers from certain mental illnesses and the

[1] The Immigration Judge handled the respondent's case in a detained setting. The respondent was unable to get counsel until the appeal where counsel graciously agreed to represent the respondent on a *pro bono* basis. This Court entered an Interim Order on March 8, 2013, and incorporates it fully into this final written decision. The Court thanks counsel for her assistance and will serve a courtesy copy of this Decision on counsel.

[2] As the respondent was released from DHS custody during the pendency of the appeal, upon remand this case was reassigned to the undersigned Immigration Judge on the nondetained docket.

Court has established safeguards, pursuant to *Matter of M-A-M-*, 25 I&N Dec. 474 (BIA 2011), to protect the respondent's rights in light of his demonstrated capacities. (*See* Decision of the Immigration Judge, 2-3; DHS Br. on Appeal; Resp't Br. on Appeal; Decision of the BIA, 2; Interim Order of the Immigration Judge, Mar. 8, 2013.) The respondent sought deferral of removal based on his fear that, if returned to Mexico, he will suffer torture on account of his mental illness. (Decision and Order of the Immigration Judge, 4-5.)

In her written decision, the Immigration Judge found that the respondent does suffer from mental illness and that, if returned to Mexico, he will be unemployed and homeless and without necessary psychiatric medications and mental health services outside of a psychiatric institution. (Decision and Order of the Immigration Judge, at12; *see also* Decision of the BIA, at 1.) The BIA "agree[d] with the Immigration Judge that it is more likely than not that the respondent will have contact with a psychiatric institution if returned to Mexico." (Decision of the BIA, 2.)

Upon review of the extensive documentary evidence in the record, the Immigration Judge held that the treatment the respondent is more likely than not to receive upon being returned to Mexico will constitute torture within the meaning of the CAT. (Decision and Order of the Immigration Judge, 12.) She based this conclusion upon the totality of the circumstances, including both the documented general conditions in psychiatric institutions in Mexico and specific practices within them, including lobotomies without informed patient consent, the improper administration of psychotropic drugs in a life-threatening manner, and the application of prolonged and indefinite physical restraints upon psychiatric patients. (*Id.*) The BIA parsed the Immigration Judge's analysis. To the extent that the Immigration Judge found that general conditions, although admittedly deplorable, constitute torture, the BIA reversed for lack of specific intent by the Mexican government. (Decision of the BIA, 2.) Additionally, to the extent that the Immigration Judge found it more likely than not that the respondent would be forced to undergo a lobotomy without proper consent, the BIA reversed the Immigration Judge. (*Id.* at 3.)

Recognizing "the respondent's history of self-mutilating behavior" and taking into account the undisturbed finding of the Immigration Judge that the respondent is more likely than not to be placed in a psychiatric institution upon being returned to Mexico, the BIA remanded the matter for this Court to determine whether, specifically, the "long term use of chemical and physical restraints constitutes torture." (*Id.*) The BIA also directed the Court to determine, if the Court finds that these practices do constitute torture, whether "torture is probable and the government likely will turn a blind eye to such treatment." (*Id.* at 3-4.)

Although the record in this matter is already extensive, the Court provided the parties with an opportunity to supplement the record before issuing this decision. (Interim Order of the Immigration Judge, Mar. 8, 2013.) The *amicus* did provide the Court with additional evidence to support the record, and the Court considered it along with the other evidence in the record in making its decision. Upon a thorough evaluation of all the evidence and after very careful consideration of the BIA remand Order, the Court concludes that the respondent has met his burden of proof for deferral of removal under the CAT.[3]

[3] The Court is mindful of the difficulties that a further in-person hearing might impose upon both the respondent, who would have to travel to San Diego, and the DHS. Neither party has requested an additional evidentiary hearing.

[redacted]

Torture is (1) any act by which severe pain or suffering, whether physical or mental, (2) is intentionally inflicted on a person, (3) for a proscribed purpose, including for any reason based on discrimination of any kind, (4) by or at the instigation of or with the acquiescence of a public official or other person acting in an official capacity. *See* 8 C.F.R. § 1208.18(a)(1). The Court notes the findings of Disability Rights International in its 2010 report, *Abandoned & Disappeared: Mexico's Segregation and Abuse of Children and Adults with Disabilities*, regarding the use of physical restraints and psychotropic drugs in Mexican mental institutions, and it adopts those findings as its own. (Exh. 7, at 11-13, 15-17, 39-40, 43-46.) Based on an analysis of the facts in this specific case, the Court finds that the long-term use of physical restraints and psychotropic drugs that the respondent would be required to endure if returned to Mexico today does constitute torture.

The evidence demonstrates that the long-term use of physical restraints and psychotropic drugs causes severe pain and suffering. Physical restraints cause severe physical pain and suffering and medical complications that can be life-threatening, and high levels of psychotropic drugs can result in severe physical damage and mental pain by disrupting the senses and personalities of mental health patients. (*Id.* at 11-13, 16-17, 39-40.) The evidence also demonstrates that the use of physical restraints and psychotropic drugs is specifically intended to inflict such pain and suffering. The dangerous and painful effects of using these forms of treatment and possible alternatives to them have long been known, but the use of both treatments is still widespread within Mexican mental institutions. (Exh. 5, at 284, 326-27; exh. 7, at 11, 16.) The staff at the mental institutions has made the conscious choice to use physical restraints and psychotropic drugs rather than other treatments that are less restrictive, less painful, and less dangerous to the patients' health, and have chosen to administer these treatments in a way that is dangerous to the patients' health. (Exh. 7, at 11-13, 15-16, 40.) The evidence further demonstrates that the use of these treatments is for the proscribed purpose of discrimination. Notwithstanding the incredible claim that these treatments are for medicinal purposes, the evidence shows that the actual motivation of staff is to control and alter the behavior and personalities of the patients. (*Id.* at 11, 13, 15-17, 40, 43.) The use of these methods is discrimination based on mental disability because the staff has chosen to use physical restraints and psychotropic drugs on the patients because of the patients' mental disabilities. (*See id.* at 45.) Finally, the evidence demonstrates that the Mexican government instigates the torture in some instances and acquiesces in the infliction of torture in others. Some Mexican mental institutions are government facilities and in those cases the torture is inflicted by the government itself. (*Id.* at 46.) In cases where the institutions are privately-run, the Mexican government has acquiesced in the torture of patients. The government has been on notice for more than ten years that physical restraints and psychotropic drugs are used in the mental institutions, and that the use of such treatments can have damaging and painful effects. (Exh. 5, at 284, 326-27; exh. 7, at viii.) Despite statements that it desires to make progress on these issues, the Mexican government has turned a blind eye to the continued use of these acts and almost no change has occurred. (Exh. 7, at viii.) Based upon that evidence and all the evidence of record, the Court holds that respondent has met his burden to show that the evidence establishes that the long-term use of physical restraints and psychotropic drugs constitutes torture in his case.

Furthermore, the Court finds that torture is probable. The BIA agreed with the Immigration Judge's conclusion that it is more likely than not that the respondent will be institutionalized if

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Additionally, the Court notes that, pursuant to the regulations, a security investigation is not required in order for the Court to grant deferral of removal under the CAT. *See* 8 C.F.R. § 1003.47.

returned to Mexico, and it accepted that the respondent has a history of self-mutilating behavior. (Decision of the BIA, 2.) As discussed above, the use of physical restraints and psychotropic drugs is widespread in Mexican mental institutions, especially in the cases of patients who are self-abusive like the respondent. Therefore, the Court finds that the respondent has met his burden to show that it is more likely than not that the respondent would be subject to these treatments that constitute torture if returned to Mexico. Accordingly, the respondent is entitled to deferral of removal pursuant to the Convention against Torture.

Pursuant to 8 C.F.R. § 1208.17(b), the Court notifies the respondent that his removal to Mexico shall be deferred until such time as the deferral is terminated. 8 C.F.R. § 1208.17(b)(1). The respondent is notified that deferral of removal (i) does not confer upon the respondent any lawful or permanent immigration status in the United States; (ii) will not necessarily result in the respondent being released from custody of the DHS if the respondent is subject to such custody; (iii) is effective only until terminated; and (iv) is subject to review and termination if the Immigration Judge determines that it is not likely that the respondent would be tortured in the country to which removal has been deferred, namely Mexico, or if the respondent requests that deferral be terminated. *Id.* The respondent is further informed that removal has been deferred only to Mexico, and that the respondent may be removed at any time to another country where he is not likely to be tortured. *Id.* § 1208.17(b)(2).

ORDER

IT IS ORDERED: that the respondent be removed from the United States to Mexico but that his removal to Mexico be deferred under the United Nations Convention Against Torture.

THE RESPONDENT IS FURTHER ADVISED: that his removal to Mexico shall be deferred until such time as the deferral is terminated. 8 C.F.R. § 1208.17(b)(1). The respondent is notified that deferral of removal (i) does not confer upon the respondent any lawful or permanent immigration status in the United States; (ii) will not necessarily result in the respondent being released from custody of the DHS if the respondent is subject to such custody; (iii) is effective only until terminated; and (iv) is subject to review and termination if the Immigration Judge determines that it is not likely that the respondent would be tortured in the country to which removal has been deferred, namely Mexico, or if the respondent requests that deferral be terminated. *Id.* The respondent is further informed that removal has been deferred only to Mexico, and that the respondent may be removed at any time to another country where he is not likely to be tortured. *Id.* § 1208.17(b)(2).

RICCO J. BARTOLOMEI
Immigration Judge

cc: The Respondent.
Ms. Calcador for the DHS.
Ms. Markovich (as *amicus curiae*).

Exhibit B

(§§404(a), (f), 601)

KAIMOWITZ v. DEPARTMENT OF MENTAL HEALTH FOR THE STATE OF MICHIGAN. No. 73-19434-AW (Mich. Cir. Ct., Wayne County, July 10, 1973)

This case came to this Court originally on a complaint for Writ of Habeas Corpus brought by Plaintiff Kaimowitz on behalf of John Doe and the Medical Committee for Human Rights, alleging that John Doe was being illegally detained in the Lafayette Clinic for the purpose of experimental psychosurgery.[1]

John Doe had been committed by the Kalamazoo County Circuit Court on January 11, 1955, to the Ionia State Hospital as a Criminal Sexual Psychopath, without a trial of criminal charges, under the terms of the then existing Criminal Sexual Psychopathic law.[2] He had been charged with the murder and subsequent rape of a student nurse at the Kalamazoo State Hospital while he was confined there as a mental patient.

In 1972, Drs. Ernst Rodin and Jacques Gottlieb of the Lafayette Clinic, a facility of the Michigan Department of Mental Health, had filed a proposal "For the Study of Treatment of Uncontrollable Aggression."[3]

This was funded by the Legislature of the State of Michigan for the fiscal year 1972. After more than 17 years at the Ionia State Hospital, John Doe was transferred to the Lafayette Clinic in November of 1972 as a suitable research subject for the Clinic's study of uncontrollable aggression.

Under the terms of the study, 24 criminal sexual psychopaths in the State's mental health system were to be subjects of experiment. The experiment was to compare the effect of surgery on the amygdaloid portion of the limbic system of the brain with the effect of the drug cyproterone acetate on the male hormone flow. The comparison was intended to show which, if either, could be used in controlling aggression of males in an institutional setting, and to afford lasting permanent relief from such aggression to the patient.

Substantial difficulties were encountered in locating a suitable patient population for the surgical procedures and a matched control group for the treatment by the antiandrogen drug.[4] As a matter of fact, it was concluded that John Doe was the only known appropriate candidate available within the state mental health system for the surgical experiment.

John Doe signed an "informed consent" form to become an experimental subject prior to his transfer from the Ionia State Hospital.[5] He had obtained signatures from his parents giving consent for the experimental and innovative surgical procedures to be performed on his brain,[6] and two separate three-man review committees were established by Dr. Rodin to review the scientific worthiness of the study and the validity of the consent obtained from Doe.

The Scientific Review Committee, headed by Dr. Elliot Luby, approved of the procedure, and the Human Rights Review Committee, consisting of Ralph Slovenko, a Professor of Law and Psychiatry at Wayne State University, Monsignor Clifford Sawher, and Frank Morgan, a Certified Public Accountant, gave their approval to the procedure.

Even though no experimental subjects were found to be available in the state mental health system other than John Doe, Dr. Rodin prepared to proceed with the experiment on Doe, and depth electrodes were to be inserted into his brain on or about January 15, 1973.

Early in January, 1973, Plaintiff Kaimowitz became aware of the work being contemplated on John Doe and made his concern known to the Detroit Free Press. Considerable newspaper publicity ensued and this action was filed shortly thereafter.

With the rush of publicity on the filing of the original suit, funds for the research project were stopped by Dr. Gordon Yudashkin, Director of the Department of Mental Health, and the investigators, Drs. Gottlieb and Rodin, dropped their plans to pursue the research set out in the proposal. They reaffirmed at the trial, however, their belief in the scientific, medical and ethical soundness of the proposal.

Upon the request of counsel, a Three-Judge Court was empanelled, Judges D. O'Hair and George E. Bowles joining Judge Horace W. Gilmore. Dean Francis A. Allen and Prof. Robert A. Burt of the University of Michigan Law School were appointed as counsel for John Doe.

Approximately the same time Amicus Curiae, the American Orthopsychiatric Society, sought to enter the case with the right to offer testimony. This was granted by the Court.

Three ultimate issues were framed for consideration by the Court. The first related to the constitutionality of the detention of Doe. The full statement of the second and third questions, to which this Opinion is addressed, are set forth in the text below.

The first issue relating to the constitutionality of the detention of John Doe was considered by the Court, and on March 23, 1973, an Opinion was rendered by the Court holding the detention unconstitutional. Subsequently, after hearing testimony of John Doe's present condition, the Court directed his release.[7]

In the meantime, since it appeared unlikely that no project would go forward because of the withdrawal of approval by Dr. Yudashkin, the Court raised the question as to whether the rest of the case had become moot. All counsel, except counsel representing the Department of Mental Health, stated the matter was not moot, and that the basic issues involved were ripe for declaratory judgment. Counsel for the Department of Mental Health contended the matter was moot.

Full argument was had and the Court on March 15, 1973, rendered an oral Opinion holding that the matter was not moot and that the case should proceed as to the two framed issues for declaratory judgment. The court held that even though the original experimental program was terminated, there was nothing that would prevent it from being instituted again in the near future, and therefore the matter was ripe for declaratory judgment.[8]

The facts concerning the original experiment and the involvement of John Doe were to be considered by the Court as illustrative in determining whether legally adequate consent could be obtained from adults involuntarily confined in the state mental health system for experimental or innovative procedures on the brain to ameliorate behavior, and, if it could be, whether the State should allow such experimentation on human subjects to proceed.[9]

The two issues framed for decision in this declaratory judgment action are as follows:

1. After failure of established therapies, may an adult or a legally appointed guardian, if the adult is involuntarily detained, at a facility within the jurisdiction of the State Department of Mental Health give legally adequate consent to an innovative or experimental surgical procedure on the brain, if there is demonstrable physical abnormality of the brain, and the procedure is designed to ameliorate behavior, which is either personally tormenting to the patient, or so profoundly disruptive that the patient cannot safely live, or live with others?

2. If the answer to the above is yes, then it is legal in this State to undertake an innovative or experimental surgical procedure on the brain of an adult who is involuntarily detained at a facility within the jurisdiction of the State Department of Mental Health, if there is demonstrable physical abnormality of the

brain, and the procedure is designed to ameliorate behavior, which is either personally tormenting to the patient, or so profoundly disruptive that the patient cannot safely life, or live with others?

Throughout this Opinion, the Court will use the term psychosurgery to describe the proposed innovative or experimental surgical procedure defined in the questions for consideration by the Court.

At least two definitions of psychosurgery have been furnished to the Court. Dr. Bertram S. Brown, Director of the National Institute of Mental Health, defined the term as follows in his prepared statement before the United States Senate Subcommittee on Health of the Committee on Labor and Public Welfare on February 23, 1973:

> "Psychosurgery can best be defined as a surgical removal or destruction of brain tissue or the cutting of brain tissue to disconnect one part of the brain from another, with the intent of altering the behavior, even though there may be no direct evidence of structural disease or damage to the brain."

Dr. Peter Breggin, a witness at the trial, defined psychosurgery as the destruction of normal brain tissue for the control of emotions or behavior or the destruction of abnormal brain tissue for the control of emotions or behavior, where the abnormal tissue has not been shown to be the cause of the emotions or behavior in question.

The psychosurgery involved in this litigation is a sub-class, narrower than that defined by Dr. Brown. The proposed psychosurgery we are concerned with encompasses only experimental psychosurgery where there are demonstrable physical abnormalities in the brain.[10] Therefore, temporal lobectomy, an established therapy for relief of clearly diagnosed epilepsy is not involved, nor are accepted neurological surgical procedures, for example, operations for Parkinsonism, or operations for the removal of tumors or the relief of stroke.

We start with the indisputable medical fact that no significant activity in the brain occurs in isolation without correlated activity in other parts of the brain. As the level of complexity of human behavior increases, so does the degree of interaction and integration. Dr. Ayub Ommaya, a witness in the case, illustrated this through the phenomenon of vision. Pure visual sensation is one of the functions highly localized in the occiptal lobe of the back of the brain. However, vision in its broader sense, such as the ability to recognize a face, does not depend upon this area of the brain alone. It requires the integration of that small part of the brain with the rest of the brain. Memory mechanisms interact with the visual sensation to permit the recognition of the face. Dr. Ommaya pointed out that the more we know about brain function, the more we realize with certainty that many functions are highly integrated, even for relatively simple activity.

It is clear from the record in this case that the understanding of the limbic system of the brain and its function is very limited. Practically every witness and exhibit established how little is known of the relationship of the limbic system to human behavior, in the absence of some clearly defined clinical disease such as epilepsy. Drs. Mark, Sweet and Ervin have noted repeatedly the primitive state of our understanding of the amygdala for example, remarking that it is an area made up of nine to fourteen different nuclear structures, with many functions, some of which are competitive with others. They state that there are not even reliable guesses as to the functional location of some of the nuclei.[11]

The testimony showed that any physical intervention in the brain must always be approached with extreme caution. Brain surgery is always irreversible in the sense that any intrusion into the brain destroys the brain cells and such cells do not regenerate. Dr. Ommaya testified that in the absence of well defined pathological signs, such as blood clots pressing on the brain due to trauma, or tumor in the brain, brain surgery is viewed as a treatment of last resort.

The record in this case demonstrates that animal experimentation and nonintrusive human experimentation have not been exhausted in determining and studying brain function. Any experimentation on the human brain, especially when it involves an intrusive, irreversible procedure in a non-life-threatening situation, should be undertaken with extreme caution, and then only when answers cannot be obtained from animal experimentation and from non-intrusive human experimentation.

Psychosurgery should never be undertaken upon involuntarily committed populations, when there is a high-risk low-benefits ratio as demonstrated in this case. This is because of the impossibility of obtaining truly informed consent from such populations. The reasons such informed consent cannot be obtained are set forth in detail subsequently in this Opinion.

There is widespread concern about violence. Personal violence, whether in a domestic setting or reflected in street violence, tends to increase. Violence in group confrontations appears to have culminated in the late 60's but still invites study and suggested solutions. Violence, personal and group, has engaged the criminal law courts and the correctional systems, and has inspired the appointment of national commissions. The late President Lyndon B. Johnson convened a commission on violence under the chairmanship of Dr. Milton Eisenhower. It was a commission that had fifty consultants representing various fields of law, sociology, criminology, history, government, social psychiatry, and social psychology. Conspicuous by their absence were any professionals concerned with the human brain. It is not surprising, then, that of recent date, there has been theorizing as to violence and the brain, and just over two years ago, Frank Ervin, a psychiatrist, and Vernon H. Mark, a neurosurgeon, wrote *Violence and the Brain*[12] detailing the application of brain surgery to problems of violent behavior.

Problems of violence are not strangers to this Court. Over many years we have studied personal and group violence in a court context. Nor are we unconcerned about the tragedies growing out of personal or group confrontations. Deep-seated public concern begets an impatient desire for miracle solutions. And necessarily, we deal here not only with legal and medical issues, but with ethical and social issues as well.

Is brain function related to abnormal aggressive behavior? This, fundamentally, is what the case is about. But, one cannot segment or simplify that which is inherently complex. As Vernon H. Mark has written, "Moral values are social concerns, not medical ones, in any presently recognized sense.[13]

Violent behavior not associated with brain disease should not be dealt with surgically. At best, neurosurgery rightfully should concern itself with medical problems and not the behavior problems of a social etiology.

The Court does not in any way desire to impede medical progress. We are much concerned with violence and the possible effect of brain disease on violence. Much research on the brain is necessary and must be carried on, but when it takes the form of psychosurgery, it cannot be undertaken on involuntary detained populations. Other avenues of research must be utilized and developed.

Although extensive psychosurgery has been performed in the United States and throughout the world in recent years to attempt change of objectionable behavior, there is no medically recognized syndrome for aggression and objectionable behavior associated with the nonorganic brain abnormality.

The psychosurgery that has been done has in varying degrees blunted emotions and reduced spontaneous behavior. Dr. V. Balasubramanian, a leading psychosurgeon, has characterized psychosurgery as "sedative neurosurgery," a procedure by which patients are made quiet and manageable[14] The amygdalotomy, for example, has been used to calm hyperactive children, to make retarded children more manageable in institutions, to blunt the emotions of people with depression, and to attempt to make schizophrenics more manageable.[15]

As pointed out above, psychosurgery is clearly experimental, poses substantial danger to research subjects, and carries substantial unknown risks. There is no persuasive showing on this record that the type of psychosurgery we are concerned with would necessarily confer any substantial benefit on research

subjects or significantly increase the body of scientific knowledge by providing answers to problems of deviant behavior.

The dangers of such surgery are undisputed. Though it may be urged, as did some of the witnesses in this case, that the incidents of morbidity and morality are low from the procedures, all agree dangers are involved, and the benefits to the patients are uncertain.

Absent a clearly defined medical syndrome, nothing pinpoints the exact location in the brain of the cause of undesirable behavior so as to enable a surgeon to make a lesion, remove that portion of the brain, and thus affect undesirable behavior.

Psychosurgery flattens emotional responses, leads to lack of abstract reasoning ability, leads to a loss of capacity for new learning and causes general sedation and apathy. It can lead to impairment of memory, and in some instances unexpected responses to psychosurgery are observed. It has been found, for example, that heightened rage reaction can follow surgical intervention on the amygdala, just as placidity can.[16]

It was unanimously agreed by all witnesses that psychosurgery does not, given the present state of the art, provide any assurance that a dangerously violent person can be restored to the community.[17]

Simply stated, on this record there is no scientific basis for establishing that the removal or destruction of an area of the limbic brain would have any direct therapeutic effect in controlling aggressivity or improving tormenting personal behavior absent the showing of a well defined clinical syndrome such as epilepsy.

To advance scientific knowledge, it is true that doctors may desire to experiment on human beings, but the need for scientific inquiry must be reconciled with the inviolability which our society provides for a person's mind and body. Under a free government, one of a person's greatest rights is the right to inviolability of his person, and it is axiomatic that this right necessarily forbids the physician or surgeon from violating, without permission, the bodily integrity of his patient.[18]

Generally, individuals are allowed free choice about whether to undergo experimental medical procedures. But the State has the power to modify this free choice concerning experimental medical procedures when it cannot be freely given, or when the result would be contrary to public policy. For example, it is obvious that a person may not consent to acts that will constitute murder, manslaughter, or mayhem upon himself.[19] In short, there are times when the State for good reason should withhold a person's ability to consent to certain medical procedures.

It is elementary tort law that consent is the mechanism by which the patient grants the physician the power to act, and which protects the patient against unauthorized invasions of his person. This requirement protects one of society's most fundamental values, the inviolability of the individual. An operation performed upon a patient without his informed consent is the tort of battery, and a doctor and a hospital have no right to impose compulsory medical treatment against the patient's will. These elementary statements of tort law need no citation.

Jay Katz, in his outstanding book "Experimentation with Human Beings" (Russell Sage Foundation, N.Y. (1972)) points out on page 523 that the concept of informed consent has been accepted as a cardinal principle for judging the propriety of research with human beings.

He points out that in the experimental setting, informed consent serves multiple purposes. He states (page 523 and 524):

> "... Most clearly, requiring informed consent serves society's desire to respect each individual's autonomy, and his right to make choices concerning his own life."
> "Second, providing a subject with information about an experiment will encourage him to be an active partner and the process may also increase the rationality of the experimentation process."
> "Thirdly, securing informed consent protects the experimentation process by encouraging the investigator to question the value of the proposed project and the adequacy of the measures he has taken to protect subjects, by reducing civil and criminal liability for nonnegligent injury to the subjects, and by diminishing adverse public reaction to an experiment."
> "Finally, informed consent may serve the function of increasing society's awareness about human research ..."

It is obvious that there must be close scrutiny of the adequacy of the consent when an experiment, as in this case, is dangerous, intrusive, irreversible, and of uncertain benefit to the patient and society.[20]

Counsel for Drs. Rodin and Gottlieb argues that anyone who has ever been treated by a doctor for any relatively serious illness is likely to acknowledge that a competent doctor can get almost any patient to consent to almost anything. Counsel claims this is true because patients do not want to make decisions about complex medical matters and because there is the general problem of avoiding decision making in stress situations, characteristic of all human beings.

He further argues that a patient is always under duress when hospitalized and that in a hospital or institutional setting there is no such thing as a volunteer. Dr. Ingelfinger in Volume 287, page 466 of the New England Journal of Medicine (August 31, 1972) states:

> "... The process of obtaining 'informed consent' with all its regulations and conditions, is no more than an elaborate ritual, a device that when the subject is uneducated and uncomprehending, confers no more than the semblance of propriety on human experimentation. The subject's only real protection, the public as well as the medical profession must recognize, depends on the conscience and compassion of the investigator and his peers."

Everything defendants' counsel argues militates against the obtaining of informed consent from involuntarily detained mental patients. If, as he agrees, truly informed consent cannot be given for regular surgical procedures by noninstitutionalized persons, then certainly an adequate informed consent cannot be given by the involuntarily detained mental patient.

We do not agree that a truly informed consent cannot be given for a regular surgical procedure by a patient, institutionalized or not. The law has long recognized that such valid consent can be given. But we do hold that informed consent cannot be given by an involuntarily detained mental patient for experimental psychosurgery for the reasons set forth below.

The Michigan Supreme Court has considered in a tort case the problems of experimentation with humans. In *Norter* v. *Koch*, 272 Mich. 273, 261 N.W. 762 (1935), the issue turned on whether the doctor had taken proper diagnostic steps before prescribing an experimental treatment for cancer. Discussing medical experimentation, the Court said at page 282:

> "We recognize the fact that if the general practice of medicine and surgery is to progress, there must be a certain amount of experimentation carried on; but such experiments must be done with the knowledge and consent of the patient or those responsible for him, *and must not vary too radically from the accepted method of procedure.*" (Emphasis added).

This means that the physician cannot experiment without restraint or restriction. He must consider first of all the welfare of his patient. This concept is universally accepted by the medical profession, the legal profession, and responsible persons who have thought and written on the matter.

Furthermore, he must weigh the risk of the patient against the benefit to be obtained by trying something new. The risk-benefit ratio is an important ratio in considering any experimental surgery upon a human being. The risk must always be

relatively low, in the non-life threatening situation to justify human experimentation.

Informed consent is a requirement of variable demands. Being certain that a patient has consented adequately to an operation, for example, is much more important when doctors are going to undertake an experimental, dangerous, and intrusive procedure than, for example, when they are going to remove an appendix. When a procedure is experimental, dangerous, and intrusive, special safeguards are necessary. The risk-benefit ratio must be carefully considered, and the question of consent thoroughly explored.

To be legally adequate, a subject's informed consent must be competent, knowing and voluntary.

In considering consent for experimentation, the ten principles known as the Nuremberg Code give guidance. They are found in the Judgment of the Court in *United States* v. *Karl Brandt*.[21]

> There the Court said:
> "... Certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:
> 1. The voluntary consent of the human subject is absolutely essential.
> This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration and purpose of the experiment; the methods and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.
> The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.
>
> "2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
>
> "3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.
>
> "4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
>
> "5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.
>
> "6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
>
> "7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.
>
> "8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
>
> "9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
>
> "10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject."

In the Nuremberg Judgment, the elements of what must guide us in decision are found. The involuntarily detained mental patient must have legal capacity to give consent. He must be so situated as to be able to exercise free power of choice, without any element of force, fraud, deceit, duress, overreaching, or other ulterior form of restraint or coercion. He must have sufficient knowledge and comprehension of the subject matter to enable him to make an understanding decision. The decision must be a totally voluntary one on his part.

We must first look to the competency of the involuntarily detained mental patient to consent. Competency requires the ability of the subject to understand rationally the nature of the procedure, its risks, and other relevant information. The standard governing required disclosures by a doctor is what a reasonable patient needs to know in order to make an intelligent decision. See Waltz and Schenneman, "Informed Consent Therapy," 64 Northwestern Law Review 628 (1969).[22]

Although an involuntarily detained mental patient may have a sufficient I.Q. to intellectually comprehend his circumstances (in Dr. Rodin's experiment, a person was required to have at least an I.Q. of 80), the very nature of his incarceration diminishes the capacity to consent to psychosurgery. He is particularly vulnerable as a result of his mental condition, the deprivation stemming from involuntary confinement, and the effects of the phenomenon of "institutionalization".

The very moving testimony of John Doe in the instant case establishes this beyond any doubt. The fact of institutional confinement has special force in undermining the capacity of the mental patient to make a competent decision on this issue, even though he be intellectually competent to do so. In the routine of institutional life, most decisions are made for patients. For example, John Doe testified how extraordinary it was for him to be approached by Dr. Yudashkin about the possible submission to psychosurgery, and how unusual it was to be consulted by a physician about his preference.

Institutionalization tends to strip the individual of the support which permits him to maintain his sense of self-worth and the value of his own physical and mental integrity. An involuntarily confined mental patient clearly has diminished capacity for making a decision about irreversible experimental psychosurgery.

Equally great problems are found when the involuntarily detained mental patient is incompetent, and consent is sought from a guardian or parent. Although guardian or parental consent may be legally adequate when arising out of traditional circumstances, it is legally ineffective in the psychosurgery situation. The guardian or parent cannot do that which the patient, absent a guardian, would be legally unable to do.

The second element of an informed consent is knowledge of the risk involved and the procedures to be undertaken. It was obvious from the record made in this case that the facts sur-

rounding experimental brain surgery are profoundly uncertain, and the lack of knowledge on the subject makes a knowledgeable consent to psychosurgery literally impossible.

We turn now to the third element of an informed consent, that of voluntariness. It is obvious that the most important thing to a large number of involuntarily detained mental patients incarcerated for an unknown length of time, is freedom.

The Nuremberg standards require that the experimental subjects be so situated as to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, overreaching, or other *ulterior form of constraint or coercion*. It is impossible for an involuntarily detained mental patient to be free of ulterior forms of restraint or coercion when his very release from the institution may depend upon his cooperating with the institutional authorities and giving consent to experimental surgery.

The privileges of an involuntarily detained patient and the rights he exercises in the institution are within the control of the institutional authorities. As was pointed out in the testimony of John Doe, such minor things as the right to have a lamp in his room, or the right to have ground privileges to go for a picnic with his family assumed major proportions. For 17 years he lived completely under the control of the hospital. Nearly every important aspect of his life was decided without any opportunity on his part to participate in the decision-making process.

The involuntarily detained mental patient is in an inherently coercive atmosphere even though no direct pressures may be placed upon him. He finds himself stripped of customary amenities and defenses. Free movement is restricted. He becomes a part of communal living subject to the control of the institutional authorities.

As pointed out in the testimony in this case, John Doe consented to this psychosurgery partly because of his effort to show the doctors in the hospital that he was a cooperative patient. Even Dr. Yudashkin, in his testimony, pointed out that involuntarily confined patients tend to tell their doctors what the patient thinks these people want to hear.

The inherently coercive atmosphere to which the involuntarily detained mental patient is subjected has bearing upon the voluntariness of his consent. This was pointed up graphically by Dr. Watson in his testimony (page 67, April 4). There he was asked if there was any significant difference between the kinds of coercion that exist in an open hospital setting and the kinds of coercion that exist on involuntarily detained patients in a state mental institution.

Dr. Watson answered in this way:

> "There is an enormous difference. My perception of the patients at Ionia is that they are willing almost to try anything to somehow or other improve their lot, which is — you know — not bad. It is just plain normal — you know — that kind of desire. Again, that pressure — again — I don't like to use the word 'coercion' because it implies a kind of deliberateness and that is not what we are talking about — the pressure to accede is perhaps the more accurate way, I think — the pressure is perhaps so severe that it probably ought to cause us to not be willing to permit experimentation that has questionable gain and high risk from the standpoint of the patient's posture, which is, you see, the formula that I mentioned we hashed out in our Human Use Committee."

Involuntarily confined mental patients live in an inherently coercive institutional environment. Indirect and subtle psychological coercion has profound effect upon the patient population. Involuntarily confined patients cannot reason as equals with the doctors and administrators over whether they should undergo psychosurgery. They are not able to voluntarily give informed consent because of the inherent inequality in their position.[23]

It has been argued by defendants that because 13 criminal sexual psychopaths in the Ionia State Hospital wrote a letter indicating they did not want to be subjects of the psychosurgery, that consent can be obtained and that the arguments about coercive pressure are not valid.

The Court does not feel that this necessarily follows. There is no showing of the circumstances under which the refusal of these thirteen patients was obtained, and there is no showing whatever that any effort was made to obtain the consent of these patients for such experimentation.

The fact that thirteen patients unilaterally wrote a letter saying they did not want to be subjects of psychosurgery is irrelevant to the question of whether they can consent to that which they are legally precluded from doing.

The law has always been meticulous in scrutinizing inequality in bargaining power and the possibility of undue influence in commercial fields and in the law of wills. It also has been most careful in excluding from criminal cases confessions where there was no clear showing of their completely voluntary nature after full understanding of the consequences. No lesser standard can apply to involuntarily detained mental patients.

The keystone to any intrusion upon the body of a person must be full, adequate and informed consent. The integrity of the individual must be protected from invasion into his body and personality not voluntarily agreed to. Consent is not an idle or symbolic act; it is a fundamental requirement for the protection of the individual's integrity.

We therefore conclude that involuntarily detained mental patients cannot give informed and adequate consent to experimental psychosurgical procedures on the brain.

The three basic elements of informed consent — competency, knowledge, and voluntariness — cannot be ascertained with a degree of reliability warranting resort to use of such an invasive procedure.[25]

To this point, the Court's central concern has primarily been the ability of an involuntarily detained mental patient to give a factually informed, legally adequate consent to psychosurgery. However, there are also compelling constitutional considerations that preclude the involuntarily detained mental patient from giving effective consent to this type of surgery.

We deal here with State action in view of the fact the question relates to involuntarily detained mental patients who are confined because of the action of the State.

Initially, we consider the application of the First Amendment to the problem before the Court, recognizing that when the State's interest is in conflict with the Federal Constitution, the State's interest, even though declared by statute or court rule, must give way. See *NAACP* v. *Button*, 371 U.S. 415 (1963) and *United Transportation Workers' Union* v. *State Bar of Michigan*, 401 U.S. 576 (1971).

A person's mental processes, the communication of ideas, and the generation of ideas, come within the ambit of the First Amendment. To the extent that the First Amendment protects the dissemination of ideas and the expression of thoughts, it equally must protect the individual's right to generate ideas.

As Justice Cardozo pointed out:

> "We are free only if we know, and so in proportion to our knowledge. There is no freedom without choice, and there is no choice without knowledge — or not that is illusory. Implicity, therefore, in the very notion of liberty is the liberty of the mind to absorb and to beget . . . The mind is in chains when it is without the opportunity to choose. One may argue, if one please, that opportunity to choose is more an evil than a good. One is guilty of a contradiction if one says that the opportunity can be denied, and liberty subsist. At the root of all liberty is the liberty to know . . .
> "Experimentation there may be in many things of deep concern, but not in setting boundaries to thought, for thought freely communicated is the indispensable condition of the intelligent experimentation, the one test of its validity.
> Cardozo, the *Paradoxes of Legal Science*, Colum-

bia University Lectures, reprinted in *Selected Writings of Benjamin Nathan Cardozo.*" (Fallon Publications (1947)), pages 317, and 318.

Justice Holmes expressed the basic theory of the First Amendment in *Abrams* v. *United States*, 250 U.S. 616, 630 (1919) when he said:

> "... The ultimate good desired is better reached by free trade in ideas — that the best test of truth is the power of the thought to get itself accepted in the competition of the market, and that truth is the only ground upon which their wishes safely can be carried out. That at any rate is the theory of our constitution ... We should be eternally vigilant against attempts to check expressions of opinions that we loathe and believe to be fraught with death, unless they so imminently threaten immediate interference with the lawful and pressing purpose of the law that an immediate check is required to save the country ..."

Justice Brandeis in *Whitney* v. *Cal.* 274 U.S. 357, 375 (1927), put it this way:

> "Those who won our independence believed that the final end of the State was to make men free to value their faculties; and that in its government the deliberative force should prevail over the arbitrary ... They believed that freedom to think as you will and to speak as you think are means indispensible to the discovery and spread of political truth; that without free speech and assembly discussion would be futile; that with them, discussion affords ordinarily adequate protection against the dissemination of noxious doctrine; that the greatest menace to freedom is an inert people; that public discussion is a political duty; and that this should be a fundamental principle of the American Government ..."

Thomas Emerson, a distinguished writer on the First Amendment, stated this in "Toward a General Theory of the First Amendment," 72 Yale Law Journal 877, 895 (1963):

> "The function of the legal process is not only to provide a means whereby a society shapes and controls the behavior of its individual members in the interests of the whole. It also supplies one of the principal methods by which a society controls itself, limiting its own powers in the interests of the individual. The role of the law here is to mark the guide and line between the sphere of social power, organized in the form of the state, and the area of private right. The legal problems involved in maintaining a system of free expression fall largely into this realm. In essence, legal support for such a society involves the protection of individual rights against interference or unwarranted control by the government. More specifically, the legal structure must provide:
> "1. Protection of the individual's right to freedom of expression against interference by the government in its efforts to achieve other social objectives or to advance its own interests ...
> "2. Restriction of the government in so far as the government itself participates in the system of expression.
> "All these requirements involve control over the state. The use of law to achieve this kind of control has been one of the central concerns of freedom-seeking societies over the ages. Legal recognition of individual rights, enforced through the legal processes, has become the core of free society."

In *Stanley* v. *Georgia*, 397, U.S. 557 (1969) the Supreme Court once again addressed the free dissemination of ideas. It said at page 565-66:

> "Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds ... Whatever the power of the state to control dissemination of ideas inimical to public morality, it cannot constitutionally promise legislation on the desirability of controlling a person's private thoughts."

Freedom of speech and expression, and the right of all men to disseminate ideas, popular or unpopular, are fundamental to ordered liberty. Government has no power or right to control man's minds, thoughts, and expressions. This is the command of the First Amendment. And we adhere to it in holding an involuntarily detained mental patient may not consent to experimental psychosurgery.

For, if the First Amendment protects the freedom to express ideas, it necessarily follows that it must protect the freedom to generate ideas. Without the latter protection, the former is meaningless.

Experimental psychosurgery, which is irreversible and intrusive, often leads to the blunting of emotions, the deadening of memory, and the reduction of affect, and limits the ability to generate new ideas. Its potential for injury to the creativity of the individual is great, and can impinge upon the right of the individual to be free from interference with his mental processes.

The State's interest in performing psychosurgery and the legal ability of the involuntarily *detained mental patient* to give consent must bow to the First Amendment, which protects the generation of free flow of ideas from unwarranted interference with one's mental process.

To allow an involuntarily detained mental patient to consent to the type of psychosurgery proposed in this case, and to permit the State to perform it, would be to condone State action in violation of basic First Amendment rights of such patients, because impairing the power to generate ideas inhibits the full dissemination of ideas.

There is no showing in this case that the State has met its burden of demonstrating such a compelling State interest in the use of experimental psychosurgery on involuntarily detained mental patients to overcome its proscription by the First Amendment of the United States Constitution.

In recent years, the Supreme Court of the United States has developed a constitutional concept of right of privacy, relying upon the First, Fifth and Fourteenth Amendments. It was found in the marital bed in *Griswold* v. *Conn.* 381 U.S. 479 (1962); in the right to view obscenity in the privacy of one's home in *Stanley* v. *Georgia*, 395 U.S. 557 (1969); and in the right of a woman to control her own body by determining whether she wishes to terminate a pregnancy in *Rowe* v. *Wade*, 41 L.W. 4213 (1973).

The concept was also recognized in the case of a prison inmate subjected to shock treatment and an experimental drug without his consent in *Mackey* v. *Procunier*, — F.2d —, 71-3062 (9th Circuit. April 16, 1973).

In that case, the 9th Circuit noted that the District Court had treated the action as a malpractice claim and had dismissed it. The 9th Circuit reversed, saying, inter alia:

> "It is asserted in memoranda that the staff at Vacaville is engaged in medical and psychiatric experimentation with 'aversion treatment' of criminal offenders including the use of succinycholine on fully conscious patients. It is emphasized the plaintiff was subject to experimentation without consent.
>
> "Proof of such matters could, in our judgment, raise serious constitutional questions respecting cruel and unusual punishment or *impermissible tinkering with the mental process.* (Citing Stanley among other cases) In our judgment it was error to dismiss the case without ascertaining at least the extent to which such charges can be sustained ..." (Emphasis added).

Much of the rationale for the developing constitutional concept of right to privacy is found in Justice Brandeis' famous

dissent in *Olmstead* v. *United States*, U.S. 438 (1928) at 478, where he said:

> "The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure, and satisfaction of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be left alone — the most comprehensive of rights and the right most valued by civilized men."

There is no privacy more deserving of constitutional projection than that of one's mind. As pointed out by the Court in *Huguez* v. *United States*, 406 F 2d 366 (1968), at page 382, footnote 84:

> "... Nor are the intimate internal areas of the physical habitation of mind and soul any less deserving of precious preservation from unwarranted and forcible intrusions than are the intimate internal areas of the physical habitation of wife and family. Is not the sanctity of the body even more important, and therefore, more to be honored in its protection than the sanctity of the home? ..."

Intrusion into one's intellect, when one is involuntarily detained and subject to the control of institutional authorities, is an intrusion into one's constitutionally protected right of privacy. If one is not protected in his thoughts, behavior, personality and identity, then the right of privacy becomes meaningless.[26]

Before a State can violate one's constitutionally protected right of privacy and obtain a valid consent for experimental psychosurgery on involuntarily detained mental patients, a compelling State interest must be shown. None has been shown here.

To hold that the right of privacy prevents law against dissemination of contraceptive material as in *Griswold* v. *Conn.* (supra), or the right to view obscenity in the privacy of one's home as in *Stanley* v. *Georgia* (supra), but that it does not extend to the physical intrusion in an experimental manner upon the brain of an involuntarily detained mental patient is to denigrate the right. In the hierachy of values, it is more important to protect one's mental processes than to protect even the privacy of the marital bed. To authorize an involuntarily detained mental patient to consent to experimental psychosurgery would be to fail to recognize and follow the mandates of the Supreme Court of the United States, which has constitutionally protected the privacy of body and mind.

Counsel for John Doe has argued persuasively that the use of the psychosurgery proposed in the instant case would constitute cruel and unusual punishment and should be barred under the Eighth Amendment. A determination of this issue is not necessary to decision, because of the many other legal and constitutional reasons for holding that the involuntarily detained mental patient may not give an informed and valid consent to experimental psychosurgery. We therefore do not pass on the issue of whether the psychosurgery proposed in this case constitutes cruel and unusual punishment within the meaning of the Eighth Amendment.

For the reasons given, we conclude that the answer to question number one posed for decision is no.

In reaching this conclusion, we emphasize two things.

First, the conclusion is based upon the state of knowledge as of the time of the writing of this Opinion. When the state of medical knowledge develops to the extent that the type of psychosurgical intervention proposed here becomes an accepted neurosurgical procedure and is no longer experimental, it is possible, with appropriate review mechanisms,[27] that involuntarily detained mental patients could consent to such an operation.

Second, we specifically hold that an involuntarily detained mental patient today can give adequate consent to accepted neurosurgical procedures.

In view of the fact we have answered the first question in the negative, it is not necessary to proceed to a consideration of the second question, although we cannot refrain from noting that had the answer to the first question been yes, serious constitutional problems would have arisen with reference to the second question.

One final word. The Court thanks all counsel for the excellent, lawyer-like manner in which they have conducted themselves. Seldom, if ever, has any member of this panel presided over a case where the lawyers were so well-prepared and so helpful to Court.

The findings of this Opinion shall constitute the findings of fact and conclusions of law upon the issues framed pursuant to the provisions of G.C.R. (1963) 517.1.

A judgment embodying the findings of the Court in this Opinion may be presented.

[1] The name John Doe has been used through the proceedings to protect the true identity of the subject involved. After the institution of this action and during proceedings his true identity was revealed. His true name is Louis Smith. For the purpose of this Opinion, however, he will be referred to throughout as John Doe.

[2] C.L. 780.501 et seq. The statute under which he was committed was repealed by Public Act 143 of the Public Acts of 1968, effective August 1, 1968. He was detained thereafter under C.L. 330.35(b), which provided for further detention and release of criminal sexual psychopaths under the repealed statute. The Supreme Court also adopted an Administrative Order of October 20, 1969 (382 Mich. xxix) relating to criminal sexual psychopaths. A full discussion of these statutes is found in the court's earlier Opinion relating to the legality of detention of John Doe, filed in this cause on March 23, 1973.

[3] See Appendix to Opinion, Item 1. [Appendix omitted.]

[4] For criteria, see Appendix, Item 2. [Appendix omitted.]

[5] The complete "Informed Consent" form signed by John Doe is as follows:

"Since conventional treatment efforts over a period of several years have not enabled me to control my outbursts of rage and anti-social behavior, I submit an application to be a subject in a research project which may offer me a form of effective therapy. This therapy is based upon the idea that episodes of anti-social rage and sexuality might be triggered by a disturbance in certain portions of my brain. I understand that in order to be certain that a significant brain disturbance exists, which might relate to my anti-social behavior, an initial operation will have to be performed. This procedure consists of placing fine wires into my brain, which will record the electrical activity from those structures which play a part in anger and sexuality. These electrical waves can then be studied to determine the presence of an abnormality.

"In addition electrical stimulation with weak currents passed through these wires will be done in order to find out if one or several points in the brain can trigger my episodes of violence or unlawful sexuality. In other words, this stimulation may cause me to want to commit an aggressive or sexual act, but every effort will be made to have a sufficient number of people present to control me. If the brain disturbance is limited to a small area, I understand that the investigators will destroy this part of my brain with an electrical current. If the abnormality comes from a larger part of my brain, I agree that it should be surgically removed, if the doctors determine that it can be done so, without risk of side effects. Should the electrical activity from the part of my brain into which the wires have been placed reveal that there is no significant abnormality, the wires will simply be withdrawn.

"I realize that any operation on the brain carries a number of risks which may be slight but could be potentially serious. These risks include infection, bleeding, temporary or permanent weakness or paralysis of one or more of my legs or arms, difficulties with speech and thinking, as well as the ability to feel, touch, pain and temperature. Under extraordinary circumstances, it is also possible that I might not survive the operation.

"Fully aware of the risks detailed in the paragraphs above, I authorize the physicians of Lafayette Clinic and Providence Hospital to perform the procedures as outlined above."

October 27, 1972	/s/Louis M. Smith
Date	Signature
	/s/ Emily T. Smith/Harry L. Smith
Calvin Vanee	Signature of responsible
	relative or guardian

[6] There is some dispute in the record as to whether his parents gave consent for the innovative surgical procedures. They testify they gave consent only to the insertion of depth electrodes.

[7] The release was directed after the testimony of John Doe in open court and the testimony of Dr. Andrew S. Watson, who felt that John Doe could be safely released to society.

[8] On Thursday, March 15, 1973, after full argument, the Court held in an Opinion rendered from the bench that the matter was not moot, relying upon *United States v. Phosphate Export Association*, 393 U.S. 199. There the United States Supreme Court said:

"The test for mootness . . . is a stringent one. More voluntary cessation of allegedly illegal conduct does not moot a case; if it did, the courts would be compelled to 'leave the defendant . . . free to return to his old ways.' A case might become moot if subsequent events made it absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur."

The Court also relied upon *Milford v. People Community Hospital Authority*, 380 Mich. 49, where the Court said on page 55:

"The nature of the case is such that we are unlikely to again receive the question in the near future, and doctors and other people dealing with public hospital corporations cannot hope to have an answer to the questions raised unless we proceed to decision. For these reasons, we conclude the case is of sufficient importance to warrant our decision."

It should also be noted that Defendant, Department of Mental Health, sought an Order of Superintending Control for a Stay of Proceedings in the Court of Appeals on the ground the case was moot. On March 26, 1973, the Court of Appeals denied the Stay.

[9] As the trial proceeded, it was learned that John Doe himself withdrew his consent to such experimentation. This still did not render the proceeding moot because of the questions framed for declaratory judgment.

[10] On this point, Amicus Curiae Exhibit 4 is of great interest. This exhibit is a memo to Dr. Gottlieb from Dr. Rodin, dated August 9, 1972, reporting a visit Dr. Rodin made to Dr. Vernon H. Mark of the Neurological Research Foundation in Boston, one of the country's leading proponents of psychosurgery on noninstitutionalized patients. Dr. Rodin, in his Memo, stated:

"When I informed Dr. Mark of our project, namely, doing amygdalotomies on patients who do not have epilepsy, he became extremely concerned and stated we had no ethical right in so doing. This, of course, opened Pandora's box, because then I retorted that he was misleading us with his previously cited book and he had no right at all from a scientific point of view to state that in the human, aggression is accompanied by seizure discharges in the amygdala, because he is dealing with only patients who have susceptible brains, namely, temporal lobe epilepsy . . ."

"He stated categorically that as far as present evidence is concerned, one has no right to make lesions in a 'healthy brain' when the individual suffers from rage attacks only."

[11] Mark, Sweet and Ervin, *"The Affect of Amygdalotomy on Violent Behavior in Patients with Temporal Lobe Epilepsy,"* in Hitchcock, Ed. *Psycho-Surgery: Second International Conference* (Thomas Pub. 1972), 135 at 153.

[12] Mark and Ervin, *Violence and the Brain* (Harper and Row, 1970).

[13] Mark, "Brain Surgery in Aggressive Epileptics," The Hastings Center Report, Vol. 3, No. 1 (February, 1973).

[14] See Defendant's Exhibit 38, Sedative Neurosurgery by V. Balasubramaniam, R. S. Kanaka, P. V. Ramanuman, and B. Ramaurthi, 53 Journal of the Indian Medical Association, No. 8, page 377 (1969). In the conclusion, page 381, the writer said:

"The main purpose of this communication is to show that this new form of surgery called sedative neurosurgery is available for the treatment of certain groups of disorders. These disorders are primarily characterized by restlessness, low threshold for anger and violent or destructive tendencies.

"This operation aims at destruction of certain areas of the brain. These targets include the amygdaloid nuclei, the posteroventral nuclear group of the hypotalamus and the periaqueductal grey substance . . ."

"By operating on the areas one can make these patients quiet and manageable."

[15] The classical lobotomy of which thousands were performed in the 1940's and 1950's is very rarely used these days. The development of drug therapy pretty well did away with the classical lobotomy. Follow-up studies show that the lobotomy procedure was over used and caused a great deal of damage to the persons who were subjected to it. A general bleaching of the personality occurred and the operations were associated with loss of drive and concentration. Dr. Brown in his testimony before the United States Senate, supra, page 9, stated: "No responsible scientist today would condone a classical lobotomy operation."

[16] Sweet, Mark & Ervin found this to be true in experiments with monkeys. Other evidence indicated it is possible in human beings.

[17] Testimony in the case from Dr. Rodin, Dr. Lowinger, Dr. Breggin and Dr. Walter, all pointed up that it is very difficult to find the risks, deficits and benefits from psychosurgery because of the failure of the literature to provide adequate research information about research subjects before and after surgery.

[18] See the Language of the late Justice Cardozo in *Schleendorff v. Society of New York Hospitals*, 211 N.Y. 125, 105 N.E. 92, 93 (1914) where he said, "Every human being of adult years or sound mind has a right to determine what shall be done with his own body . . ."

[19] See "Experimentation on Human Beings," 22 Stanford Law Review 99 (1967); Kidd, "Limits of the Right of a Person to Consent to Experimentation Upon Himself," 117 Science 211 (1953).

[20] The principle is reflected in numerous statements of medical ethics. See the American Medical Association, "Principles of Medical Ethics, 132 JAMA 1090 (1946); American Medical Association "Ethical Guidelines for Clinical Investigation (1966); National Institute of World Medical Association, "Case of Ethics" (Declaration of Helsinki) reprinted in 2 British Medical Journal, 177 (1964). It is manifested in the code adopted by the United States Military Tribunam at Nuremberg which, at the time, was considered the most carefully developed precepts specifically drawn to meet the problems of human experimentation. See Lammer, "Ethical and Legal Aspects of Medical Research in Human Beings." J. Pub. L. 467, 487 (1954).

[21] *Trial of War Criminals before the Nuremberg Military Tribunals.* Volume 1 and 2, "The Medical Case," Washington, D.C.; U.S. Government Printing Office (1948) reprinted in 'Experimentation with Human Beings,' by Katz, (Russel Sage Foundation) (1972) pg. 305.

[22] In Ballentine's Law Dictionary (Second Edition) (1948) competency is equated with capacity and capacity is defined as "a person's ability to understand the nature and effect of the act in which he is engaged and the business in which he is transacting".

[23] It should be emphasized that once John Doe was released in this case and returned to the community he withdrew all consent to the performance of the proposed experiment. His withdrawal of consent under these circumstances should be compared with his response on January 12, 1973, to questions placed to him by Prof. Slovenko, one of the members of the Human Rights Committee. These answers are part of exhibit 22 and were given after extensive publicity about this case, and while John Doe was in Lafayette Clinic waiting the implantation of depth electrodes. The significant questions and answers are as follows:

1. Would you seek psychosurgery if you were not confined in an institution?
   A. Yes, if after testing this showed it would be of help.
2. Do you believe that psychosurgery is a way to obtain your release from the institution?
   A. No, but it would be a step in obtaining my release. It is like any other therapy or program to help persons to function again.
3. Would you seek psychosurgery if there were other ways to obtain your release?
   A. Yes. If psychosurgery were the only means of helping my physical problem after a period of testing.

[24] See, for example, *Miranda v. Arizona*, 384 U.S. 436 (1966) and *Escobedo v. Illinois*, 378 U.S. 478 (1964).

Prof. Paul Freund of the Harvard Law School has expressed the following opinion:

"I suggest . . . that (prison) experiments should not involve any promise of parole or of commutation of sentence; this would be what is called in the law of confessions undue influence or duress through promise of reward, which can be as effective in overbearing the will as threats of harm. Nor should there be a pressure to conform within the prison generated by the pattern of rejecting parole applications of those who do not participate . . ." P. A. Freund, "Ethical Problems in Human Experimentation," New England Journal of Medicine, Volume 273 (1965) pages 687-92.

[25] It should be noted that Dr. Vernon H. Mark, a leading psychosurgeon, states that psychosurgery should not be performed on prisoners who are epileptic because of the problem of obtaining adequate consent. He states in "Brain Surgery in Aggressive Epileptics", the Hastings Center Report, Vol. 3, No. 1 (February, 1972): "Prison inmates suffering from epilepsy should receive only medical treatment; surgical therapy should not be carried out because of the difficulty in obtaining truly informed consent."

[26] See note: 45 So. Cal. L.R. 616, 663 (1972).

[27] For example, see Guidelines of the Department of Health, Education and Welfare, A C Exhibit 17.