

1988

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Recommended Citation

Joram Graf Haber, *The Freedom to be Psychotic*, 2 *J.L. & Health* 157 (1987-1988)

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The Freedom to be Psychotic?

Joram Graf Haber*

I. Introduction

Recent surveys indicate that approximately one-third of the nation's homeless are mentally ill.¹ Although the total number of homeless Americans is in dispute, ranging anywhere from 350,000² to 3 million,³ the number of chronic mental patients is easier to determine. The National Institute of Mental Health estimates that 2.4 million Americans should be classified as chronically mentally ill and that approximately 1.5 million of these individuals presently live "in the community."⁴ This broad category includes those who live in half-way houses, those who live with their families or by themselves in rooming houses or cheap hotels, those who have been referred for short-term stays in the psychiatric wards of local hospitals, and those who simply live in the streets.

Given these alarming statistics, the question that faces the mental health profession is what, if anything, should be done about them. Historically, society's solution has been to treat such people with or without their consent.⁵ This practice, however, has come under attack since it raises grave moral and legal questions. Does society, with the help of psychiatrists, have the right to deprive an individual of freedom because of alleged mental illness? If so, on what grounds? Because freedom is a fundamental value in Anglo-American society, the practice of coercively treating mentally ill patients has been viewed with great suspicion.

Louis McGarry and Paul Chodoff have noted that part of the concern with involuntary commitment is the fact that in the last quarter of the nineteenth century and the first half of the twentieth century, mental hospitals had become vast warehouses for human beings without hope.⁶ Typically, these in-

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This paper was delivered at the 38th Institute on Hospital and Community Psychiatry, San Diego, California, October 26-30, 1986.

¹Morgenthau and Agrest, *Abandoned*, NEWSWEEK, Jan. 6, 1986, at 14 (hereinafter Morgenthau and Agrest).

²*Id.*

³*Id.*

⁴*Id.*

⁵See Musto, *A Historical Perspective*, in PSYCHIATRIC ETHICS 24 (S. Bloch and P. Chodoff eds. 1981).

⁶McGarry and Chodoff, *The Ethics of Involuntary Hospitalization*, in PSYCHIATRIC ETHICS, *supra* note 5, at 201.

stitutions were located in rural settings far from the patients' communities of origin. Such hospitals existed throughout America where almost 600,000 patients had been gathered by the mid-fifties.⁷ These patients were ruled over by superintendents who, while for the most part benevolent, possessed great authority over their patients' lives.

In recent years, the pendulum has swung away from the sprawling and isolated state hospitals due, in part, to the extraordinary changes in the care and treatment of the institutionalized mentally ill. Among the factors contributing to these changes have been the advent of anti-psychotic medications, the growth of in-patient psychiatric wards in general hospitals, and the open-door rather than the locked-ward policy of the past.⁸

Nevertheless, the large mental hospitals are still with us and so is the warehousing of the mentally ill. This had become a major factor in the upsurge of civil libertarian activism of the late sixties and early seventies. Activists made these hospitals a prime target and attacked them, particularly through class actions, in the United States Courts.⁹ What resulted was a massive emptying of state hospitals, forcing chronic seriously ill patients into the community to be supported by a network of community centers which John F. Kennedy signed into legislation in 1963.¹⁰

If involuntary commitment is problematic because it deprives patients of their civil liberties, deinstitutionalization has proved ineffective. One reason for this is the fact that the nation reneged on its promise to provide the kind of community-based mental health care that chronic patients desperately need. Another reason is that psychiatrists must work within a framework of freedom which, I will argue, is morally suspect.

The following will examine both involuntary commitment and deinstitutionalization, as well as some recent and rather novel proposals that have been championed by those who advocate neither. I refer here to the so-called "Ulysses Contract" as well as to "mandatory out-patient treatment." My concern is primarily with the moral and legal aspects of these practices and to that end will focus on more conceptual matters. I will conclude by defending a concept of freedom which does greater justice to patients' needs than does the one currently employed.

⁷*Id.*

⁸*Id.*

⁹*Id.*

¹⁰See Morgenthau and Agrest, *supra* note 1.

II. *Liberty, Liberty-Limiting Principles, & Involuntary Commitment*

Prior to examining involuntary commitment, it will be useful to examine the concept of *liberty* or *freedom* as well as what has been referred to as *liberty limiting principles*.¹¹ In the history of philosophical and social thought, *liberty* has been used in two distinct senses.¹² In one sense, liberty refers to a condition characterized by the absence of coercion or constraint (*negative liberty*). In another sense, liberty refers to the possession of the means to achieve the objective one chooses of one's own volition (*positive liberty*). An individual is free in the first sense if he is not compelled to act as he would not himself choose to act, by the will of another, the state, or any other authority. An individual is free in the second sense if, in addition to the absence of coercion, he possesses the means or the power to achieve the objective he desires. A moment's reflection will show that it is negative liberty that has been central in the tradition of European individualism and liberalism.

However one defines liberty, it is obvious that liberty is a fundamental value, the infringement of which is cause for grave concern. But to say this is not to imply that liberty cannot be overridden. There are various grounds that have traditionally been thought to justify the infringement of liberty. Two of these are the so-called *harm principle* and the principle of paternalism.

The harm principle is the most widely accepted liberty-limiting principle.¹³ Under the terms of the principle, constraints on a person's liberty of action can be justified in order to prevent harm to others.¹⁴ Few will dispute that the law is within its proper bounds when it constrains individuals from performing acts which will seriously injure other persons. Laws which threaten thieves, murderers, or rapists with punishment, for example, are usually perceived as a necessary part of any social system. Individual acts of coercion whose intent is to prevent individuals from harming others are therefore considered morally permissible.

Paternalism, however, is a more complicated matter. Under the terms of the principle, constraints on a person's liberty of action can be justified in order to keep that person from harming himself, or in order to confer a benefit on him.¹⁵ Certainly, paternalistic interferences with a person's liberty are

¹¹See J. FEINBERG, *SOCIAL PHILOSOPHY* 20 (1973) (hereinafter J. FEINBERG).

¹²See I. BERLIN, *Two Concepts of Liberty*, in *FOUR ESSAYS ON LIBERTY* 118 (1970).

¹³Unless one is an anarchist, one must accept the legitimacy of the harm principle in circumscribing the liberty of another.

¹⁴See J. FEINBERG, *supra* note 11.

¹⁵*Id.* See also Dworkin, *Paternalism*, *MONIST*.

sometimes justified, such as when a parent forbids a child from engaging in dangerous activities. The problem, however, is whether such interferences are justified beyond these instances. Specifically, are paternalistic interferences morally justified where the person concerned is a mature adult? If so, under what conditions?

Neither are these principles the only ones that have been thought to justify the restriction of liberty. One might hold, for instance, that the restriction of one's liberty can be justified:

(1) to prevent behavior that causes shame, embarrassment, and discomfort to onlookers (the offense principle); (2) to benefit others, such as using human beings as research subjects if the research project promises some potentially great benefit to other members of society (the social welfare principle); (3) to prevent the impairment of institutional practices that are in the public interest (the public harm principle), etc.¹⁶

Many of these principles are highly problematic, but it is not my intention to canvass the arguments both for and against them. I wish to call attention only to the harm principle and principle of paternalism since these have been utilized by those who have been concerned with involuntary commitment.¹⁷

Generally speaking, involuntary commitment of the mentally ill to mental hospitals is legally justified on the following grounds. First, the individual must be in some way mentally disabled. This disability is variously described as "illness", "disease," "disorder," etc., depending on the wording of the relevant statute.¹⁸ While mental disability is a necessary condition for civil commitment, it is not a sufficient condition. Virtually all states require that there be one or more incapacitating conditions resulting from the mental disability.¹⁹

There appear to be five general categories of incapacitating conditions: (1) impaired judgment; (2) the need for hospitalization; (3) the need for care or treatment; (4) disablement; and (5) dangerousness to self or others.²⁰ Since

¹⁶See J. FEINBERG, *supra* note 11.

¹⁷The legal principle of the state's police power presupposes the moral legitimacy of the harm principle. The legal principle of *parens patriae* presupposes the moral legitimacy of paternalism.

¹⁸A. BROOKS, *LAW, PSYCHIATRY, AND THE MENTAL HEALTH SYSTEM* 675-726 (1974) (hereinafter A. BROOKS).

¹⁹*Id.*

²⁰*Id.*

an increasing number of states require a showing that the individual in question is either dangerous to himself or others (the fifth condition),²¹ it is this condition that needs to be examined.

The requirement that an individual must be dangerous to himself on account of a mental disability rests on the principle of paternalism. Legally, the principle is expressed in terms of the state's function as *parens patriae*. The dangerousness to self criterion is applied, by and large, to two types of cases. The first are potential suicides and the second includes those persons who, because of their incapacity, expose themselves to harm.²² Committing a person on the basis of this principle raises serious questions concerning the power of the state to protect an individual from himself, against his will, in relation to his right to make decisions that may threaten his health, safety, or life. Thomas Szasz, for one, contends that an individual has "an unqualified constitutional right to be dangerous to himself — whether it be to take up smoking, have an abortion, or commit suicide."²³

Central to Szasz' claim is that mental illness is a myth thereby implying that those individuals who contemplate suicide or who otherwise expose themselves to harm do so out of "problems with living."²⁴ The problems with this position are well documented and need not be explored here.²⁵ For purposes of this paper, it is assumed that the individuals referred to are dangerous to themselves precisely because of their existent mental illness. In either event, to involuntarily commit them does involve a deprivation of liberty and to that end is highly problematic.

The requirement that an individual must be dangerous to others because of a mental disability rests on the harm principle. Legally, the principle is expressed in terms of the police power of the state. It was indicated earlier that the harm principle is the most widely accepted liberty-limiting principle and so, *prima facie*, commitment on this standard is unproblematic. A closer look, however, reveals some serious difficulties. This may be illustrated by a comparison of civil commitment with criminal confinement. In both cases, the state decides that society will benefit from deprivation of the person's liberty. But criminal imprisonment is normally imposed *after* the defendant has committed or attempted a dangerous act.

²¹*Id.* at 677.

²²*Id.* at 699.

²³*Id.* at 702 (quoting Slovenko, *Civil Commitment In Perspective*, 20 J. PUB. L. 3, 23-26 (1971)).

²⁴See generally Szasz, *The Myth of Mental Illness*, 15 AM. PSYCHOLOGIST 113 (1960) (hereinafter Szasz).

²⁵See, e.g., Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976).

One explanation for the different treatment of mentally ill persons is the assumption that hospitalization of someone suffering from mental illness is likely to benefit that person even if he is not dangerous.²⁶ But if this is so, then it is not the harm principle that is being utilized but the principle of paternalism. And, as previously indicated, the principle of paternalism is more difficult to justify than the harm principle, or at least must be justified on different grounds.

Assuming the harm principle is being utilized, the legislature must still choose a standard of dangerousness for deciding if a person should remain at liberty. Defining dangerousness is no easy task. At a minimum, it calls for a determination both of what acts are dangerous and how probable it is that such acts will occur.

Traditionally, the term dangerousness has been broken down into four component elements: (1) magnitude of harm; (2) probability of harm; (3) frequency with which harm will occur; and (4) imminence of harm.²⁷ Add to this the types of harm that may occur (*e.g.*, to the person, property, public morals), and the task is further exacerbated.

Commitment of dangerous persons is also problematic given that the purpose of such a measure is to accord protection for society and not ensure treatment for the patient. Opponents of involuntary commitment object to the procedure for two reasons. With respect to the dangerousness to self criterion, individuals have the inalienable right to live as they choose however irrational such choice might be.²⁸ Paternalistic interferences are accordingly unjustified. With respect to the dangerousness to others criterion, critics argue that the concept of dangerousness is too nebulous to justify commitment and is inadequately applied in many instances.²⁹

It should be noted that opponents of civil commitment do not contest the legitimacy of the harm principle.³⁰ They object to its application for the reasons cited. They do not, however, accept paternalism.³¹ Many critics are

²⁶A. BROOKS, *supra* note 18, at 678 (quoting Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1289-91 (1966)).

²⁷*Id.* at 680.

²⁸The principle of autonomy (self-legislation) is fundamental to Anglo-American law and was articulated in *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E.92 (1914). Under the terms of this principle, it is the capacity for choice rather than what is chosen which gives man his dignity.

²⁹See A. BROOKS, *supra* note 18, at 680. See also Livermore, Malmquist, and Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 81-86 (1968).

³⁰See *supra* note 13.

³¹See generally Szasz, *supra* note 24.

fond of citing John Stuart Mill in opposition to this principle.³² In Mill's famous essay *On Liberty*, he states his anti-paternalism in writing:

(t)he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any member, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good either physical or moral, is not sufficient warrant (emphasis added).³³

So while Mill championed the harm principle, he vociferously objected to paternalism.

Underlying Mill's anti-paternalism was his great fear of the tendency toward the suppression of individual freedom that he saw growing in his day.³⁴ His belief was that the search for truth and happiness in society required an unfettered competition among different ideas and lifestyles.³⁵ He thus argued that so long as people do not interfere with the liberty of others, they should be allowed the right to be idiosyncratic and to live as they choose. Hence, it is in Mill's name that opponents of civil commitment voice their objection and defend the "freedom to be psychotic." Opponents of paternalism in the psychiatric setting are guilty of misreading Mill. This misreading hinges, to a large extent, on the concept of liberty which is anything but unequivocal.

III. *Deinstitutionalization*

In addition to the conceptual problems with involuntary commitment described above, there are practical objections centering on the inadequacy of mental health facilities, the abuse to which paternalism is sometimes put, etc. But for whatever reasons critics oppose involuntary commitment, the reform known as "deinstitutionalization" has become a reality as an alternative way of handling America's mentally ill.³⁶

³²See McGarry and Chodoff, *supra* note 6, at 203.

³³J. MILL, *ON LIBERTY* 13 (1956) (hereinafter J. MILL).

³⁴*Id.* at 1-5.

³⁵*Id.* Mill assumed that in a "free marketplace of ideas" where each individual would think and live as they choose, the truth would eventually emerge.

³⁶See Morgenthau and Agrest, *supra* note 1.

Deinstitutionalization refers to the hopeful goal of releasing most chronic mental patients from state-run asylums and returning them to the community.³⁷ This idea, begun in 1963 when John F. Kennedy signed into legislation a network of community centers to support deinstitutionalized patients nationwide,³⁸ has the virtue of leaving patients at liberty while at the same time providing needed care. The program was largely predicated on the therapeutic power of modern psychopharmacology.³⁹ Even chronic schizophrenics, it was believed, could be released to the community if they were taking their regular doses of tranquilizers or antipsychotic drugs.⁴⁰ But while the goal was and still is laudable, many are of the opinion that the program has failed.⁴¹

It is important, however, to see why it has failed. The residential population at state and county mental hospitals has dropped by nearly 450,000 since 1955.⁴² It is also true that up to 65% of the liberated mental patients have successfully adapted to outside life.⁴³ But for the rest — for hundreds of thousands of former inmates and younger mental patients for whom long-term institutional care has never been available — deinstitutionalization is considered a brutal hoax.⁴⁴

One reason deinstitutionalization has failed is that the government has fallen short of providing the kind of community-based mental health care that chronic patients need. To be sure, spending by state government on mental health programs seems adequate: in 1981, the most recent year for which figures are available, that spending totaled 6.2 billion dollars.⁴⁵ But the dollars have not followed the patients.

Although 63% of the nation's chronic mentally ill are at large in the community, two-thirds of all state and local mental health funding still goes to mental institutions that now house a fraction of their former inmate population.⁴⁶ The result is a staff-to-patient ratio that currently exceeds 1.5 to 1 in public and private hospitals nationwide.⁴⁷ In New York, for instance, from a

³⁷*Id.*

³⁸*Id.*

³⁹*Id.*

⁴⁰*Id.*

⁴¹See *infra* text accompanying notes 42-55.

⁴²Morgenthau and Agrest, *supra* note 1.

⁴³*Id.*

⁴⁴*Id.*

⁴⁵*Id.*

⁴⁶*Id.*

⁴⁷*Id.*

high of 93,000 resident mental patients in 1955, the hospital population has dropped to 20,000; yet not a single mental hospital has closed, and two-thirds of a 1.5 billion dollar budget (approximately \$990 million) is still spent on the sparsely inhabited hospitals at which most of New York's mentally ill are unwelcome.⁴⁸

Clearly, what is missing is effective community care. Though some 2,000 community centers are needed, only 700 have been built.⁴⁹ The result is that many of the chronically mentally ill are in the community, getting minimal treatment if any at all.

The second and perhaps most important reason deinstitutionalization has failed is, not unsurprisingly, the law's bias in favor of the rights of the mentally ill.⁵⁰ Because of the barriers to involuntary commitment,⁵¹ treatment has been difficult to obtain. To be sure, deinstitutionalized patients are referred for outpatient treatment, but get minimal support from mental health agencies.⁵² They eventually decompensate,⁵³ lose touch with their caseworkers, and get into trouble. This accounts for the so-called revolving door syndrome which mental health professionals often lament.⁵⁴

The obvious conclusion is that the system has failed, but the real issue is the law's bias in favor of the rights of the mentally ill. Given the presumption of liberty and the difficulties in applying liberty-limiting principles, psychiatrists are forced to work within a libertarian framework. Certainly, within this framework, the civil rights of mentally ill patients are protected. But as Donald Treffert has so eloquently put it, many of these patients are "dying with their rights on".⁵⁵

⁴⁸*Id.*

⁴⁹*Id.*

⁵⁰*Id.*

⁵¹Such barriers have been erected primarily by the American Civil Liberties Union.

⁵²Morganthau and Agrest, *supra* note 1.

⁵³*Id.*

⁵⁴*Id.*

⁵⁵Treffert, *Dying with Their Rights On*, 130 AM. J. PSYCHIATRY 1041 (1973). This slogan has become a rallying cry for those who support civil commitment practices.

IV. *Alternative Proposals*

A. *The Ulysses Contract*

An interesting alternative to involuntary commitment and deinstitutionalization is the so-called Ulysses Contract. Just as Ulysses instructed his crew to bind him to the masts before they sailed past the irresistible Sirens and to ignore his requests for release, so too, proponents of the Ulysses Contract suggest that certain patients, specifically those with recurrent but treatable mental disorders, be allowed to contract with their physicians during times of remission and to disregard certain instructions they might issue during relapse, such as refusing needed treatment.⁵⁶ By furnishing a means of consenting in advance to treatment for a disorder, and by waiving the right to refuse treatment when it is administered, the proposal would allow for requisite treatment without infringing on the patient's liberty rights.

Despite the attractiveness of the Ulysses Contract, it is not without its problems. First of all, there is a powerful legal tradition that stands opposed to the idea of people binding themselves in advance to lengthy periods of confinement.⁵⁷ The thirteenth amendment prohibits the enforcement of private agreements that limit physical freedom.⁵⁸ Thus, because of this, the Ulysses Contract might not pass constitutional muster.

A second objection to the Ulysses Contract concerns an analogy made between it and the so-called living will, a future-oriented consent mechanism that has already gained wide acceptance.⁵⁹ Just as living wills allow persons, when competent, to extend their right to refuse medical treatment into a future period of incompetency by incorporating their wishes into a legally binding document,⁶⁰ so too, the argument goes, the Ulysses Contract should accomplish similar aims.

There is, however, a problem with the analogy. The living will's treatment directives become operative when its signer becomes incapable of expressing any present treatment preferences. Clearly, if a patient who had

⁵⁶See Dresser, *Bound to Treatment: The Ulysses Contract*, HASTINGS CENTER REP., June 1984, at 13 (hereinafter Dresser).

⁵⁷*Id.*

⁵⁸*Id.* The thirteenth amendment provides that "[n]either slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction." U.S. CONST. amend. XIII, §1.

⁵⁹To date, 35 states and the District of Columbia have living will laws. For an analysis of these laws, see SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF 1985 LIVING WILLS LAWS.

⁶⁰For an interesting discussion of the living will, see Haber, *The Living Will and the Directive to Provide Maximum Care: The Scope of Autonomy*, 90 CHEST 442 (1986).

written a living will was to change his preferences when competent, it would be immoral and unlawful to reject his present wishes in favor of his past wishes. In contrast, the Ulysses Contract would permit an individual's presently articulated treatment preferences to be overridden by a conflicting decision expressed in the past. Accordingly, the Ulysses Contract embodies, as does paternalism generally, a departure from the principle that an individual's present expression of choice is honored concerning matters of self-determination.⁶¹ It is therefore subject to the kind of problems it was originally designed to cure.

B. *Mandatory Outpatient Treatment*

Another proposal, and one that has been attracting increasing attention, is mandatory outpatient treatment.⁶² The American Psychiatric Association presently has a task force studying this proposal,⁶³ and the National Institute of Mental Health recently funded a survey of current approaches to it.⁶⁴ Very simply, the purpose of the proposal is to extend the state's civil commitment powers to compel patients to take their medications and continue contact with their therapists after discharge.⁶⁵ The proposal has the virtue of short-circuiting the revolving door syndrome, while being attractive to civil libertarians who see it as the least restrictive alternative to inpatient hospitalization.

Many states now have statutory provisions that appear to allow for mandatory outpatient treatment.⁶⁶ Surveys suggest, however, that these provisions are infrequently employed.⁶⁷ Perhaps the main reason for this is that statutes often use identical criteria to identify patients who are appropriate for inpatient commitment and those who can be required to receive outpatient care.⁶⁸ If those who can be committed on an outpatient basis are also

⁶¹Dresser, *supra* note 56.

⁶²See Appelbaum, *Outpatient Commitment: The Problems and the Promise*, 143 AM. J. PSYCHIATRY 1270 (1986).

⁶³*Id.*

⁶⁴*Id.*

⁶⁵*Id.*

⁶⁶*Id.*

⁶⁷*Id.*

⁶⁸*Id.*

those who can be committed on an inpatient basis, the former approach will rarely be used for fear of legal liability. Thus, because of this and other problems,⁶⁹ mandatory outpatient treatment is too new to evaluate properly.

V. *Philosophical Reflections*

However we evaluate the various proposals designed to treat the mentally ill, there is one fact that is clear: the medical perspective, with its imperative to treat, may be in opposition to the civil libertarian one, with its imperative to protect liberty rights. Construed this way, the battlelines are drawn between those who would treat patients involuntarily, and those who would defend liberty rights even if it meant the freedom to be psychotic.

The issue need not be construed this way, and an alternative construction is morally preferable.

Although there is no clear consensus of what rights are,⁷⁰ at the very least they are claims yielded by justified rules and principles.⁷¹ Rights come in different varieties. There are "moral" rights yielded by justified moral rules and principles,⁷² and there are "legal" rights justified by legal rules and principles. Although moral and legal rights often overlap, such as the ethico-legal right to life, there is no necessary connection between the two.⁷³ It is conceptually possible to have a moral right which is not a legal right and conversely, to have a legal right which is not a moral right. For instance, it may be thought that we have a moral right to health care; but we do not have a legal right to it. So too, while in this country we have a legal right to private ownership of property, it may be that we do not have a moral right to it (as is often argued, particularly in certain socialist countries).

We must, for the sake of conceptual clarity, distinguish between the moral and the legal. Although legal rights have greater authority behind them in the sense that disrespect for such rights have certain legal conse-

⁶⁹One such problem has to do with the state's authority to force a patient to accept treatment at risk of being involuntarily committed.

⁷⁰For an interesting discussion on what rights are, see RIGHTS (D. Lyons ed. 1979) (hereinafter D. Lyons).

⁷¹V. HELD, PROPERTY, PROFITS, AND ECONOMIC JUSTICE 3-4 (1980) (hereinafter V. HELD).

⁷²That moral rights differ from legal ones is axiomatic for moral philosophers. For the difference between them, see text accompanying note 73.

⁷³For an interesting discussion of the relationship between the two, see Hart, *Positivism and the Separation of Law and Morals*, 71 HARV. L. REV. 593 (1958).

quences, moral claims outweigh legal ones when a conflict arises between the two.⁷⁴ Consider, for instance, life in an unjust society such as apartheid South Africa. Although white people in this country have the legal right to live segregated from black people, black people's moral rights to live integrated among whites supersedes the former.⁷⁵ It follows that moral rights outweigh legal one in cases of conflict. If, therefore, it can be demonstrated that a psychotic patient has the moral right to relevant treatment, the fact that he cannot be legally treated should not disturb us.

Rights of any kind are generally construed to entail obligations.⁷⁶ For example, "Smith has a right to X" entails that others have an obligation to act in a certain manner with respect to Smith. In what manner others are obligated to act towards Smith is a question on which there is much disagreement.⁷⁷ In one sense, to say that "Smith has a right to X" implies that others should not interfere with Smith's legitimate enjoyment of X. Construed this way, rights are *warnings against interference*.⁷⁸ In another, to say that "Smith has a right to X," implies that others have an obligation to provide Smith with the means to acquire or use X. Construed this way, rights are *entitlements*.⁷⁹

It follows, to say that someone has a right to something leaves open the question of how we should construe such rights. If rights are construed as warnings against interference, then others are obligated not to interfere with that to which the holder has the right. If, however, rights are construed as entitlements, then others are obligated to provide the holder with the means and conditions to enable the holder to effect the right. It should also be added that neither of these constructions are mutually exclusive.⁸⁰ Sometimes we respect a person's rights when we leave that person alone, other times, we respect a person's rights when we enable that person to realize his aims.

Having said this, the question we must raise is how should we construe the right to be free which is at the heart of the freedom to be psychotic? From

⁷⁴See *infra* text accompanying note 75.

⁷⁵The truth of this claim is presupposed by the truth of ethical universalism, the theory that morality transcends time and place. Of course if ethical relativism were true (the theory that morality is a function of time and place), this claim would break down. For an interesting critique of ethical relativism, see W. STACE, *THE CONCEPT OF MORALS* (1962), A. BLOOM, *THE CLOSING OF THE AMERICAN MIND* (1987) (most recent attack on this theory).

⁷⁶See T. BEAUCHAMP AND L. WALTERS, *CONTEMPORARY ISSUES IN BIOETHICS* 36 (2d ed. 1982).

⁷⁷See D. LYONS, *supra* note 70.

⁷⁸See V. HELD, *supra* note 71.

⁷⁹*Id.*

⁸⁰*Id.*

a legal perspective, the right to be free is a warning against interference.⁸¹ Thus, to assert one's legal right to liberty implies that others, particularly the government, are obligated not to interfere with one's actions, provided such actions are within the scope of the liberty limiting principles. What this right does not entail is that the government is obligated to provide the holder of this right with the means necessary for being at liberty. In a word, there are no *de jure* entitlements in American jurisprudence.⁸² It should be argued, however, that construing rights in this fashion violates certain canons of ethics with injurious consequences for the mentally ill homeless.⁸³ This Note defends the notion that the right to be free should be construed as an entitlement.

Considering the reference to Mill which critics of involuntary commitment often invoke, Mill construed the right to be free as a warning against interference.⁸⁴ The reason for this is that Mill feared the tyranny of the majority which he saw growing in his day.⁸⁵ It was Mill's contention that truth and happiness require an unrestricted competition among conflicting ideas and lifestyles. He thought that these would come about only if people remained free to experiment with different lifestyles and live as they deemed fit to live. When Mill spoke about the right to be free, however, he conceded, in an important and often overlooked paragraph,

(that) this . . . is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or womanhood. *Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury* (emphasis added).⁸⁶

It may be presumed that this last sentence includes those who are mentally ill.

⁸¹Entitlements have always been viewed as privileges, not rights, in Anglo-American law. Thus, for instance, education, welfare, and even police protection exist at the pleasure of the state and the abolishment of any of these would arguably not run afoul of the U.S. Constitution.

⁸²*Id.*

⁸³The right to health care is one such example, if such a right is in fact a moral right. For an interesting discussion on the question of whether health care is a moral right, see Arras and Jameton, *Medical Individualism and the Right to Health Care*, in *INTERVENTION AND REFLECTION: BASIC ISSUES IN MEDICAL ETHICS* 541 (R. Munson ed. 2d ed. 1983).

⁸⁴See *supra* note 33 and accompanying text.

⁸⁵See *supra* notes 34-35 and accompanying text.

⁸⁶J. MILL, *supra* note 33, at 13.

If this is Mill's position, the right to be free is a warning against interference, presupposing that, when free, people's rational (though idiosyncratic) lifestyles will work to the betterment of society.⁸⁷ Where, however, this presupposition is false,⁸⁸ then society has a legitimate interest in providing for those who cannot provide for themselves. In a word, freedom, as in freedom from interference, (negative freedom), makes sense only where people are free to live a life according to a self-designed plan, (positive freedom). If people are not free to live a life according to a self-designed plan, then the right to be free construed as a warning against interference breaks down in practical respects.

The mentally ill homeless are not free to live a life which is self-designed and rational, precisely because of their mental illness.⁸⁹ If this is so, then we do not respect their liberty rights by leaving them alone. Rather, we respect their liberty rights by providing them with the means to be free, *i.e.*, by treating them with the relevant therapy. In this sense, the freedom to be psychotic is not freedom in any responsible sense of the word.

The adversaries in the civil commitment debate often talk past each other.⁹⁰ Proponents of involuntary treatment have as a paradigm of the mentally ill patient an individual who, because of his mental illness, cannot care for himself, is dangerous to himself or others, etc.⁹¹ Opponents of involuntary treatment have as a paradigm a perfectly normal person who happens to have a mental illness appended to him.⁹² This explains why the two sides cannot get together (although it is the former view that is more defensible).

In conclusion, it is true, as Dr. Treffert has said, that America's mentally ill are dying with their rights on.⁹³ They are dying with their legal rights on but with their moral rights off.

⁸⁷See *supra* notes 34-35 and accompanying text.

⁸⁸The mentally ill, specifically.

⁸⁹Being mentally ill presupposed that an individual lacks just this ability.

⁹⁰See *infra* text accompanying note 91.

⁹¹Were this not true, they would be hard pressed to support this claim.

⁹²*Id.*

⁹³See *supra* note 55.

