Rethinking Civil Commitment

The Radical Resources of the Ethics of Care

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Civil commitment is the legal process by which people with serious mental illnesses are hospitalized or required to receive treatment without their consent. Civil commitment has long been controversial, reflecting social values and goals in tension or outright conflict. In the United States, the fundamental political value of individual freedom is at odds with state-ordered involuntary confinement or treatment for mental illness. Even in cases where involuntary commitment is legally justified, concerns remain about limited resources for, and limited effectiveness of, the available care and treatment options for mental illness.

These basic tensions are amplified and complicated by a social and medical context in which care for serious mental illnesses is at best inconsistent. While mental health systems in the United States help many with serious mental illnesses get the treatment they need to maintain stability and improve their quality of life, for millions, the story is otherwise: Some people cannot access mental health treatment, and mental health care systems may fail or even cause harm. Lack of health insurance often limits available care; so does lack of capacity—in terms of numbers of providers and adequate mental health and substance abuse treatment facilities. For those who cannot access care, homelessness and imprisonment are two common results. Substandard treatment facilities[1] and the substitution of penal confinement for mental health treatment[2] also put mentally ill people at risk of physical and mental harm. Even medically and legally sanctioned interventions may fail to serve mentally ill people well by, for example, not recognizing the severity of drug side effects, or by taking advantage of patient vulnerabilities to involve them in risky research.[3] The sharply reduced life expectancy of people who have bipolar disorder or schizophrenia—15 or more years shorter than the general population[4]—is one sign of the magnitude of systemic gaps.

Given these many issues, the ethics of civil commitment for involuntary treatment, with or without confinement, needs to go beyond the traditional focus on individual freedom and the harms of government coercion; it should be expanded to ask questions such as, "To what form of treatment or institution is the person being committed?" and "When the person needs urgent care, is there a place for her to go?" Yet, public understanding and discussion of civil commitment and involuntary treatment tends to be sharply polarized, consistent with the adversarial legal process that pits individual freedom against the power of the state. Advocates for psychiatric human rights, some of whom oppose nearly all non-voluntary treatment for mental illness, point to the suffering of the mentally ill under what they call coercive legal and medical practices. Advocates for greater governmental authority and social resources for involuntary treatment emphasize the suffering of mentally ill persons who are left untreated and unable to care for themselves, as well as the risks to the public in cases where mentally ill persons are potentially dangerous to others.

The polarized public debate over involuntary treatment or confinement for mental illness reflects important shared assumptions of US constitutional law and popular political culture, where protection of individual freedom and the limitation of state power are primary concerns. Our analysis begins with an overview of the shared social values reflected in civil commitment

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[1] For discussions of treatment facilities, homelessness, and prisons, see, Kim Barker, "A Choice for Recovering Addicts: Relapse or Homelessness," *New York Times*, May 30, 2015, http://www.nytimes.com/2015/05/31/nyregion/three-quarter-housing-a-choice-for-recovering-addicts-or-homelessness.html and Prison Reentry Institute, Three Quarter Houses: The View from the Inside (New York: City University of New York, 2013), http://johnjayresearch.org/pri/files/2013/10/PRI-TQH-Report.pdf.

[2] For the relationship between mental health and prisons, see, E. Torrey et al., *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey* (Arlington, VA: Treatment Advocacy Center, 2014), http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

[3] See Carl Elliott, "Making a Killing," *Mother Jones* Sept-Oct (2010): 54-63.

[4] For the effect of mental health issues life on expectancy, see, E. Chesney et al., "Risks of All-Cause and Suicide Mortality in Mental Disorders: A Meta-Review," *World Psychiatry* 13 (2014): 153-60 and Casey Crump et al., "Comorbidities and Mortality in Persons with Schizophrenia: A Swedish National Cohort Study," *American Journal of Psychiatry* 170 (2009): 234-33, https://doi.org/10.1176/appi.ajp.2012.12050599.

DOI: 10.25335/M5/PPJ.1.1-4

law, showing how it has been shaped by an emphasis on protecting the freedom of autonomous individuals, where autonomy is understood in terms of independence and self-determination. We then offer an alternative way of thinking about the purposes and practices of civil commitment under an ethics of care, where the conceptual focus shifts from individual autonomy to a recognition of social interdependence and the moral value of caring relationships. An ethics of care opens new directions for civil commitment law, with effective care for those who have mental illness as a guiding standard.

Civil Commitment Under US Law and Politics

United States law and the political culture that influences it both reflect a powerful shared social value of individual freedom. This fundamental value shapes the conceptual understanding and limits the appropriate scope and purposes of governmental power over individuals—including civil commitment for involuntary confinement or treatment of the mentally ill. Three key issues are at stake and in tension in civil commitment cases: how to maintain respect for individual liberty and autonomy, concern for public safety, and providing appropriate and effective treatment for mentally ill patients whose capacity to make their own treatment choices is contested.

In the United States, procedures for involuntary commitment and treatment for mental illness are primarily governed by state law. In more serious cases, civil commitment involves involuntary inpatient treatment at a secure mental hospital, but alternatives include commitment to community-based facilities or outpatient mental health treatment programs. Statutory frameworks and policies, definitions of mental illness, and available treatment options vary widely across states. However, the power of state governments to enact and implement legislation is constrained by the United States Constitution. Thus, mental health and civil commitment laws in the United States are required to protect the constitutional rights and liberties of people who are mentally ill; the laws are subject to challenge and review by courts to determine whether they adequately do so.

Under influential precedents in US constitutional law, as well as in the popular imagination, physical confinement in a secure mental hospital or treatment facility has been characterized as a “massive curtailment of liberty.”[5] On this view, civil commitment is the effective equivalent of incarceration under a potentially indefinite sentence. Understood in this light, involuntary treatment for mental illness, whether in the form of forced medication or mandatory participation in either inpatient or outpatient treatment programs, directly conflicts with the fundamental values of individual freedom, autonomy, and self-determination. Because it involves such significant state-imposed restraints on liberty, civil commitment to involuntary confinement or treatment demands very strong legal justification. There must be an important and overriding governmental or social interest at stake, especially in cases where people who have mental illness are physically confined or required to take psychoactive medications without their consent.

Historically, involuntary civil commitment has served three general social purposes: protecting the public from dangerous persons, providing treatment for mental illness, and providing for the basic physical needs of those unable to care for themselves.[6] These purposes correspond to well-established powers of the state—the police power and *parens patriae*.

The police power is grounded in the authority and responsibility of the government to protect the public safety by preventing harm to citizens and their property or punishing the perpetrators of such harm. The primary purpose of the police power is to protect the rights and liberties of the wider public.

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[5] See Humphrey v. Cady, 405 US 504, 509 (1972).

[6] See Clifford D. Stromberg and Alan A. Stone, “A Model State Law on Civil Commitment of the Mentally Ill,” *Harvard Journal on Legislation* 20, no. 2 (1983): 273-396.

Civil commitment of individuals whose mental illness makes them potentially dangerous to others falls under the police power.

The legal doctrine of *parens patriae* roughly translates as the "parental power" of the law or sovereign to act as a guardian to protect and care for citizens who are unable to recognize or act in their own best interests, such as children and the mentally ill.[7] Civil commitment for the purpose of providing treatment for mental illness is justified on this basis. But though the power of *parens patriae* might conceivably extend to the third social purpose of civil commitment (meeting the basic physical needs of mentally ill persons), the United States Supreme Court has not fully embraced this result. In the landmark 1975 case of *O'Connor v. Donaldson*, the Court ruled that "a finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement":

> In short, a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.[8]

O'Connor v. Donaldson significantly influenced the subsequent development of civil commitment law. The Supreme Court's reasoning that there is "no constitutional basis for confining [mentally ill] persons involuntarily if they are dangerous to no one and can live safely in freedom"[9] has led other courts and state legislatures to place primary focus on dangerousness as a legal requirement or justification for civil commitment. Currently, every state law allows for civil commitment or involuntary treatment for mental illness on the basis of dangerousness to self or others, or on a "substantial likelihood of serious harm."[10]

O'Connor v. Donaldson has also had significant legal and practical impacts for the treatment of mental illness. The Supreme Court concluded that indefinite involuntary commitment for "a simple regime of enforced custodial care" violated Donaldson's constitutional right to liberty.[11] The Court's reasoning implies that mentally ill people who are not dangerous to themselves or anyone else and have the capability to "survive safely in freedom" are better off free. If help is needed, they should look to "willing and responsible" family and friends. But this does not address what should happen in cases where a person suffering from mental illness or disability has no family or friends, or if these contacts are unable or unwilling to take responsibility for their care.

Some states responded to the *O'Connor* decision by crafting civil commitment statutes borrowing directly from the language of the Court's opinion. These statutes authorize involuntary commitment of mentally ill persons "unable to survive safely in freedom" (Louisiana) or "incapable of surviving alone or with the help of willing family and friends" (Florida). Thirty-five states allow involuntary commitment in cases where a person is unable to provide for their own essential personal needs—such as food, clothing, shelter, health, and safety—due to their mental illness. Many of these states also require that the inability to provide for essential personal needs puts the mentally ill person in danger of physical harm, or they treat the inability to provide for essential person needs as evidence of dangerousness to self.

The *O'Connor* case and the legislative responses that followed illustrate perennial tensions and conflicts in the conceptual frameworks of civil commitment law and policy. Though procedures vary from state to state, civil commitment cases are typically framed as adversarial contests, where individuals who have mental illness fight for their freedom and autonomy against the coercive power of the government to require treatment or confinement they do not desire or agree to for themselves. Similarly, states must prove more than just a diagnosis of mental illness to justify involuntary confinement or

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[7] See Mary L. Durham and John Q. La Fond, "The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment," *Yale Law & Policy Review* 3 (1985): 395-446.

[8] O'Connor v. Donaldson, 422 US 563 (1975).

[9] O'Connor v. Donaldson, 422 US 563, 575.

[10] See for example Tennessee Code 33-6-501.

[11] O'Connor v. Donaldson, 422 US 563, 575.

treatment. In nearly all cases, this requires evidence that a person who has mental illness is dangerous to themselves or others, or that they are at risk of serious harm or unable to meet their own basic needs due to mental illness. Under an adversarial framework, unless public safety or personal safety is at stake, the parental power of the state to require involuntary treatment or confinement must be strictly limited in order to safeguard individual freedom. Individual liberty and autonomy are taken as overriding, fundamental values to be defended against governmental interference.

Given the adversarial legal context that shapes civil commitment procedures, we are concerned that the needs for care and treatment of persons who have mental illness may often get lost in polarized ideological battles over the appropriate power of government and the provision of public resources to support mental health. We recognize that involuntary confinement or treatment is a very significant restriction of liberty, and agree that respecting and protecting the freedom and autonomy of persons who have mental illness is centrally important to affirming shared values of our political culture and to achieving ideals of social justice. However, we argue that an overriding focus on individual liberties and ideals of autonomy and self-determination (which may not be realistic or achievable for people experiencing mental illness) can lead to problematic outcomes in civil commitment cases. For many people who have mental illness, "living in freedom" means going without treatment—and in the worst cases, this freedom is, practically speaking, indistinguishable from neglect or lack of social support. This is the situation of many people who are both homeless and mentally ill, and many more who cannot find adequate or stable sources of treatment or housing and employment. These problems are reinforced and compounded by the lack of adequate funding and social resources for mental hospitals, inpatient or outpatient treatment facilities, or other support for the mentally ill and their families.

Individual freedom—including freedom from unjustified government intervention into important life decisions, such as whether to seek treatment for mental illness—is an important social value the law should protect. But what if the guiding purpose of civil commitment law were reframed to focus on ensuring appropriate care for individuals who have mental illness while still respecting their freedom and autonomy? An ethics of care provides analytical and conceptual resources for exploring what such a shift in perspective might mean in theory and practice.

Ethics of Care: Resource for Change

Story One

Maria moved out of state to live with her sister.[12] Maria had a long history of bipolar disorder, but in the preceding years she had worked part time, had adequate income to rent a small apartment, and had ongoing relationships with extended family and a church community. The move disrupted this equilibrium. She stopped taking medication, and she entered a delusional mania in which she wandered the streets convinced that she was wealthy and that her special connection to God guaranteed it. Maria rejected her sister's efforts to get help for her. Eventually, however, her behavior was disturbing enough to people in the area that she was committed to inpatient care without family involvement—or, at first, even knowledge. After two weeks, she was released against the extended family's arguments that she was not ready. When Maria eventually reappeared in her home state, extended family members were able to intervene despite her resistance. After prolonged in-patient treatment, during most of which she remained hostile to or with-

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[12] Story one is a fictionalized account of real events, intended to provide key points without revealing the identity of the individuals involved.

drawn from providers, family, and fellow patients, she again stabilized but was bankrupt and functioned at a lower level.

Story Two

Nicole experienced a relapse of her anorexia nervosa while studying abroad and was severely underweight.[13] Knowing she needed treatment, she sought it through her long-term psychiatrist. She was adamant, however, about not wanting to repeat the eating disorders program she had previously attended. The psychiatrist assured her that the program had greatly improved, so Nicole made an intake appointment, thinking she would join the revamped outpatient arm. At the intake appointment, the evaluating physician found that she was medically unstable and admitted her to a 72-hour hold. During the hold, Nicole met—for 5 minutes—with the doctor in charge of the program. Nicole explained that she was willing to stay until she was medically stable, but that she wanted to seek treatment elsewhere, as she was now convinced that the program had not changed. Nevertheless, the doctor initiated civil commitment proceedings. Nicole offered to complete the outpatient program despite her misgivings, and Nicole's parents, with whom she was close, tried to intervene, but the doctor would not change course. Taking an approach similar to the physician's, the court examiner's report of the pre-petition screening specified that Nicole denied needing treatment and that she lied about wanting treatment elsewhere. Eventually, Nicole was offered a stay of commitment with the contingency that she satisfactorily complete the hospital's outpatient program. During the 6 months of treatment, she completed her LSAT and was accepted into law school.

The ethics of care, which grew out of feminist work beginning in the 1980s,[14] provides ways to think differently about the social purposes and ethical goals of involuntary treatment of mental illness. Ethicists of care recognize interdependence as a critical fact of human life. Ethically, our mutual dependence requires caring for others, where caring is defined and exhibited in terms of caring emotions or attitudes, actions, and dispositions or virtues.[15] For care ethicists, a fundamental moral question is, "How can we establish and maintain caring relationships?" For the purposes of this paper, the issue is how to do so when one person involved has a serious mental illness.

Ethicists of care challenge a number of assumptions common in western political, legal, and ethical theories. Challenged assumptions include individualist conceptions of autonomy and agency, the idea that rationality grounds human dignity, and the notion that there is a sharp, ethically relevant, public/private divide. Unlike many ethical theories, an ethics of care recognizes the importance of emotions in informing moral thinking. Finally, in contrast to theories of ethics and justice that demand impartial application of universal rules or principles, an ethics of care requires taking context into account in determining which attitudes, actions, and dispositions exhibit caring.

Relational Autonomy

As discussed in the previous section, the ideal of autonomy is central to both liberty as understood in US law and political culture and to the logic of laws surrounding civil commitment. Thinking from the standpoint of an ethics of care challenges this ideal and the related concepts of liberty, autonomy, and freedom as generally interpreted in US constitutional law. The ethics of care contends that individuals are, as a matter of social fact, simply *not* independently autonomous, but instead rely on one another in profound and ethically significant ways. This insight stems from feminist recognitions of our dependence on others at various stages of life (e.g., childhood and frail old age) and our interdependence in families, communities, and wider society. Humans are not only interdependent when it comes to physical existence (most of us do not build our own transportation systems), but also

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[13] Story two is an abbreviated version of the autobiographical account Nicole Hamilton, MA, MEd, JD, and PhD candidate in philosophy gives in her unpublished paper, "Committing Epistemic Injustice by Silencing the Voices of Patients with Eating Disorders." It is offered here with the author's permission.

[14] See Carol Gilligan, *In a Different Voice* (Cambridge: Harvard UP, 1982) and Nel Noddings, *Caring: A Feminine Approach to Ethics and Moral Education*, 1984 (2nd ed. Los Angeles: U of California P, 2003).

[15] See Virginia Held, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford UP, 2006) and Eva F. Kittay, "The Ethics of Care, Dependence, and Disability," *Ratio Juris* 24 (2011): 49-58.

when it comes to our ways of thinking and communicating, our received values, and aspects of our personhood established through social reciprocities. Though specific choices and actions might appear to be ours alone, to a varying but significant extent they depend on the choices and actions of others.[16]

We are thus mutually reliant on a network of relationships: while we do, to some extent, choose our own good(s), we achieve them through social ties and support.[17] The full range of relationships has moral significance, from intimate family connections, to professional-client interactions such as those in the legal or medical systems, to the more abstract relations with compatriots and world citizens. Within a relationship, one has the opportunity at times to be a "cared for" and at times to be a "carer." Being cared for also comes with an obligation to reciprocate care as we discuss below under "Responsibility and Reciprocity." Very importantly in the context here, mutuality in caring relationships is significant for all people, including those who have identifiable dependencies.[18]

Because all relationships—intimate through abstract—have moral significance, the supposed public/private divide is not sharp. Yet, in expanding the ethics of care beyond its early focus on intimate relationships, ethicists have wrestled with how to take issues of justice, freedom, autonomy, and distant or abstract relationships into consideration.[19] It is clear under an ethics of care that a government does have a responsibility for individuals' welfare, but significant tension arises between the partiality of individualized caring and the impartiality (arguably) required for justice and fairness. Resource allocation is one concern: in honoring particular relationships, we may disadvantage other people. For example, it might seem best for a particular person with suicidal thoughts to have around-the-clock companionship and oversight. The expense, however, could be considered burdensome to taxpayers.[20] In addition, too much focus on individuals and contexts can establish problematic legal precedents. It may be ethically justified for a caring, attached family to "win" a civil commitment case and quite another matter for an uncaring, manipulative family to do so.

Blurring the public/private divide also confronts an assumption that US law and political culture take as given: state intervention in an individual's choices or actions infringes on liberty and autonomy—where autonomy is characterized in terms of individual rationality, independence, and (nearly) absolute freedom or liberty to choose beliefs or courses of action. Because of this view, the adversarial positioning between the state and anyone with whom it "interferes" persists even if government officials genuinely intend an intervention to be supportive. Thus, activist David Oaks, speaking against almost all civil commitment, argues, "the unjust deprivation of liberty itself is always harmful."[21]

In contrast, under a relational view of autonomy, beneficent state intervention becomes conceivable. By contextualizing—but recognizing—the values placed on rationality, independence, and liberty, the concept of relational autonomy opens the door to a less antagonistic relationship between individuals and the state. With that door open, one can wonder to what extent civil commitment to treatment or confinement could be a cooperative rather than an adversarial process. Using as models more participatory and collaborative legal approaches, such as mediation, family courts, and deliberative discussion, it might be possible to create teams of professionals, community members, family, and mentally ill persons who work together to facilitate care and treatment in an appropriate setting. Such alternative models, grounded on the concept of relational autonomy, would honor the various relationships between the people who have mental illness, their families, friends, and care givers, as well as mental health systems, government

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[16] European views of autonomy, which emphasize solidarity, dignity, integrity, and vulnerability, are closer to the concept of relational autonomy than the individualist concepts of autonomy prevalent in US legal and political culture. This paper focuses on the US context, so we acknowledge this point but set aside additional discussion of these comparisons. Thank you to Martin Gunderson for suggesting such a discussion.

[17] Rather than shifting to the idea of relational autonomy, might one retain a classical sense of autonomy but consider relationships as one of the goods to which one aspired? Our answer is no, for two reasons: first, doing so would not take adequate account of the necessity of relationships in achieving any good—including that of having relationships. Second, autonomy as classically conceived leaves out any obligation for "you" to have a relationship with "me"—that is, for you to reciprocate in ways that are contextually appropriate.

[18] See Anita Ho, "Relational Autonomy or Undue Pressure? Family's Role in Medical Decision-Making," *Scandinavian Journal of Caring Sciences* 22 (2008): 128-35; Sarah Lucia Hoagland, "Some Thoughts about Caring," in *Feminist Ethics*, edited by Claudia Card, 246-63 (Lawrence: UP of Kansas, 19910; Held, *Ethics of Care*; and Daniel Engster, *The Heart of Justice: Care Ethics and Political Theory* (Oxford: Oxford UP, 2007).

[19] See Held, *Ethics of Care* and *Justice and Care: Essential Readings in Feminist Ethics* (Boulder: Westview, 1995); Engster, *Heart of Justice*; Kittay, "Ethics of Care"; and Helena Olofsdotter Stensota, "Public Ethics of Care—A *General* Public Ethics," *Ethics and Social Welfare* 9 (2015): 183-200.

[20] In *Heart of Justice*, Engster suggests that expenses for government responsibility for care can be kept manageable by recognizing that self-care is a prominent responsibility as well. This suggestion helps counterbalance expenditures needed for individuals who temporarily or permanently lack the capacity for self-care because of their mental illness.

[21] D. W. Oaks, "The Moral Imperative for Dialogue with Organizations of Survivors of Coerced Psychiatric Human Rights Violations," in *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects,* edited by T. W. Kallert, J. E. Mezzich, and J. Monahan (Hoboken: Wiley-Blackwell, 2011), 192.

agencies, and the courts. Under such a system, the concerns of Maria's and Nicole's families—arguing for and against involuntary treatment, respectively—could have been addressed, along with Maria's and Nicole's wishes and the advice of the care teams.

The concept of relational autonomy also suggests alternative ways of thinking about the agency of mentally ill persons. Under prevailing assumptions of current civil commitment law, either the mentally ill can "live safely in freedom" (in which case involuntary commitment to inpatient or outpatient treatment is not justifiable) or they are deemed incapable of rational agency (so that their freedom of choice and rights to self-determination may be overridden by the state). A relational approach to autonomy, in which individuals are assumed to be in interdependent relationships with others in the community, recognizes that agency varies relative to mental state and relative to social context—for everyone, not just for those with mental illness. This observation suggests that competence be judged in context. Individuals who have mental illnesses are socially situated in diverse ways, including variations in access to medical care, the legal systems in the counties in which they reside, their family structure[22] and the presence or absence of wider social networks. These and other factors determine the resources people have for self-care and being cared for and thus whether or not any state intervention is necessary. The goal would be for mentally ill persons to participate or collaborate in their care and treatment in a way that respects their contextualized capacities for agency. For example, to determine whether or not they are allowed to take their babies home, new mothers with psychosis may undergo in-patient parenting assessments.[23] Some assessments do not take into account the degree of women's social and family support. If relational autonomy, rather than individual autonomy, were the ideal, significant risks to the child could still be recognized, but recognizing the availability of support could also mean that more mothers with psychosis would be able to raise their own children. Similarly, Nicole's agency in seeking treatment of her own choice gains support from her parents. Even Maria, despite her temporary rejection of family and society, has more potential support available than a person who is consistently hostile or isolated. This contextualized approach applies sliding scales for competence and for actions chosen, in contrast with the current adversarial commitment process under which individuals are considered either completely self-determining or effectively reduced to wards of the state. Rather than implying interference or coercion on the part of the supporting communities, attention to context recognizes resources for support that may be overlooked under an individualist view of autonomy.

There are also practical issues with how caring relationships work for people who have particular forms of mental illness. Some mental illnesses, such as those involving paranoid delusions, interfere with establishing relationships. Again, however, the interference occurs on a sliding scale. It would be relatively easy to establish a relationship with a person whose insight into his delusions lets him understand that they do not apply to the world as perceived by others, as long as one recognized his competence. Forming a relationship with Maria would be more difficult when her delusions fully constituted her reality, and her hostility and distrust also pushed people away. For people like Maria, relationship—and with it, relational autonomy—might need to be aspirational, with other actions taking precedence for a time. A great deal of caution is needed around that judgment, however. Maria's distrust and hostility might well have roots in current or previous encounters with the medical or legal systems. Thus, acting consistently in ways that increase rather than decrease trust, respect, and kindness is important for long-term efforts to establish relationship. This point argues that caring cannot happen simply on the individual level: to be effective, it needs to be systemic.

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[22] The complexities of family structure raise multiple considerations. First, the concept of family could readily, under an ethics of care, extend beyond traditional legal definitions, given the many ways people care for each other in long-term and highly interdependent ways. See Mary Donnelly and Claire Murray, "The Role of Family in Mental Health Law: A Framework for Transformation," *Child and Family Law Quarterly* 25 (2013): 1-26. Second, as Anita Ho demonstrates, family relationships may be fraught: people who have mental illness occasionally put their families at risk of physical harm; families may threaten or abuse the ill family member, or may attempt to mandate involuntary treatment inappropriately. See Ho, "Relational Autonomy." Consideration of such specific interactions is what allows evaluation of family resources or needs.

[23] See M. V. Seeman, "Relational Ethics: When Mothers Suffer from Psychosis," *Archives of Women's Mental Health* 7 (2004): 201-10.

Dignity, Reframed

The ideal of individual autonomy rests on individuals' possessing both rationality and agency; as typically construed, these require mental and physical independence. As discussed in the previous section, from the perspective of the ethics of care, this ideal is inaccurate. It is also harmful in that it excludes people who lack mental or physical independence. In the context of civil commitment law, those who have serious-enough mental illness are perceived as lacking autonomy, which allows for overriding their expressed wishes. This is part of what occurred in Nicole's situation when the program psychiatrist insisted on civil commitment and the examiner wrote that she lied about her intentions. To complicate matters, even a relational view of autonomy does not rule out objectionable degrees of paternalism: the possibility remains that actions understood as caring by the courts could be disempowering paternalism in disguise.

The concept of dignity is supposed to help remedy this tension. In Kantian ethics and natural law theory, the dignity people intrinsically possess provides sufficient reason for treating people well.[24] But the traditions of dignity stemming from Aquinas and Kant, which have made their way into common US understanding, have historically tied dignity to rationality (not necessarily to agency).[25] This understanding of dignity therefore recapitulates the disempowerment of those whose rationality is impaired or impugned.

One response from an ethics of care perspective could be to set the concept of dignity aside: we owe each other care not for a second reason of "dignity," but simply because we require care ourselves.[26] "Dignity" in the traditions of Kant and Aquinas is also an absolutist principle, inconsistent with the particularism of the ethics of care. However, when reframed to be inclusive, the idea of dignity can serve practical purposes in the context of reforming involuntary treatment. Eva Kittay, for one, has revised the concept of dignity to express the dignity of her daughter, who has multiple disabilities, and to link it to the central insights of the ethics of care. Rather than rationality, she argues that dignity's source is "the ability of a being to give and receive care."[27] With such a revision, the concepts and practices of dignity can be applied to all people (and many nonhuman animals), not excepting those with mental or physical disabilities.

Leget adds to the reconstrual, pointing out that the term "dignity" is used in three ways: historically to point to the concept of dignity, historically also as a set of practices that honor dignity, and in recent times as a subjective feeling that can be supported or degraded by others. He argues that in insisting on care and reciprocity, the ethics of care recognizes the subjective feeling of having dignity. But he suggests that the other two uses are also needed—to point to the practices that uphold dignity and to provide an ideal that helps articulate ways in which practices fall short.

Nicole's and Maria's experiences show how the idea of dignity can help caregivers avoid undue paternalism. Neither consistently experienced dignity: Nicole felt disempowered; Maria followed orders from the medical and legal systems but felt coerced. With the concept of dignity in hand, caregivers could supplement the goal of developing relationships with the goal of supporting Nicole's and Maria's subjective senses of dignity. How to do this will be highly contextual. Maria made middle-class life choices for most of her 50 years. Because of her conventional sensibilities, releasing her from the hospital with no support to which to turn disrespected her dignity; she could easily have ended up in jail or on the streets. Honoring her dignity required a degree of paternalism. Nicole's dignity would have been better supported without paternalism, given that she sought treatment herself and had clear reasons to avoid the program she was in.

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[24] See C. Leget, "Analyzing Dignity: A Perspective from the Ethics of Care," *Medicine, Health Care, and Philosophy* 16 (2013): 945-952.

[25] In more modern Catholic thought, dignity no longer depends on rationality: it is a gift from God. Human rationality does, as with Aquinas's natural law, imbue us with dignity because it allows us to pursue knowledge of God. But it is also innate in human organisms who are potentially rational, such as embryos, and in those who lack full rational capacity. However, a majority in the US rejects the consequences of this view—such as opposition to abortion—so the potential benefits of the broader view to people with disabilities have not been realized.

[26] See, for example, Engster, *Heart of Justice*.

[27] Kittay, "Ethics of Care," 52. Perhaps Kittay's argument could be expanded in scope to encompass the ability to give *or* receive care in order to mark the dignity of those who permanently or temporarily cannot give care.

Variation in how to support dignity, suggests Kittay, is as it should be, given that not all persons have full capacity for self-care. This variation also helps escape concerns that the concept of dignity is absolutist. The ethics of care, by embracing the importance of context, can hold contrasting degrees of paternalism in tension, prepared to resolve them case by case. According to Kittay, however, "Cooperative, respectful, attentive relations are…better alternatives than paternalistic responses toward those who depend on us in times of need."[28] Ensuring that individuals' dignity is honored by maximizing their involvement in defining their own needs and making their own care decisions significantly decreases the risk of indefensible paternalism.[29]

Effective Care

Under an ethics of care, care must aim at being effective—and ideally should *be* effective—in meeting the needs of the person cared for.[30] This stipulation adds a significant criterion by which to judge the justice of civil commitment: to be just, the program to which a person is committed should be effective. But several issues arise immediately from this claim: the meaning of "effective" varies by context; the "effectiveness" standard is difficult to meet, at present, for treatment of many mental illnesses; and how to ethically assess practical limits on providing effective care when it is unavailable.[31] The term "needs" is similarly ambiguous. Working through some of these considerations begins to develop a picture of the contexts in which an ethics of care can support any civil commitment to treatment or confinement and particularly the contexts in which it might support a "need-for-treatment" standard.

The pervasive difficulty treatment programs face meeting "effectiveness" standards has scientific and sociopolitical roots. Scientific and medical understanding of mental illness and its treatment is limited, and present treatments are counterproductive in some ways. For example, treatment with antipsychotics may reduce psychosis, but medications often lead to sedation, weight gain, type 2 diabetes, and/or tardive dyskinesia (a motion disorder most commonly affecting the face and tongue). In addition, research in the US on managing mental illness greatly emphasizes biological approaches,[32] despite the fact that people who have serious mental illnesses prefer psychosocial interventions such as help with housing stability and finding work.[33] Sociopolitically, the effectiveness of mental health care is restrained by resource limitations and by models of care that provide inadequate ongoing support. Adding to these problems is the inadequate supply of trained professionals in psychiatric or psychological care—not just psychiatrists and psychologists but police officers, social workers, psychiatric nurses, and other support personnel. In this setting, then, the ethics of care brings with it a demand for both additional research and for institutional reform, so that if individuals do require civil commitment to receive treatment for mental illness, the mandated care is effective.

Also importantly, "effectiveness" needs to be determined relative to goals and needs defined in ways that express the wishes of the cared-for individual as closely as possible: One is unlikely to establish a caring relationship by asserting needs or goals an individual denies. When people other than the cared-for individual define the terms, the words used can readily be used paternalistically or coercively. For example, a person with a mental illness can be perceived to "need" treatment in order to control their behavior, and "effective" treatment can be seen as that which controls the person's behavior as the observer sees fit. The fudging phrase "as closely as possible," of course, leads us into another vague area—but the general direction is clear—head toward meeting an individual's goals, not an observer's or a system's.[34]

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[28] Kittay, "Ethics of Care," 55.

[29] See ibid. and Stensota, "Public Ethics of Care."

[30] See Held, *Ethics of Care*.

[31] For example, sometimes no adequate symptom relief or method for social integration is available. This situation raises the issue of whether "custodial" care (that is, care aimed at safety and comfort rather than treatment) can be considered "effective" and be sanctioned by an ethics of care. As discussed above, the US Supreme Court's decision in *O'Connor v. Donaldson* held that involuntary commitment to "simple" custodial care is a violation of individual liberty. But an ethics of care, focused on contextual decision-making, raises the possibility that for some persons who are chronically mentally ill and unable to care for their own basic needs, custodial care might be "effective" in meeting those needs. Well performed, such care is not necessarily the equivalent of indefinite incarceration—it may support individuals and relieve pressure on society, families, and other care-givers. As such, it deserves consideration as a model of care for those who are chronically mentally ill and who are not capable of caring for themselves, and deserves recognition as an important social contribution by those who perform the labor. See Kittay, "Ethics of Care."

[32] See Thomas Insel, *The Anatomy of NIMH Funding* (Washington, D. C.: Government Printing Office, 2015), https://www.nimh.nih.gov/funding/funding-strategy-for-research-grants/the-anatomy-of-nimh-funding.shtml.

[33] See Frese et al., "Integrating Evidence-Based Practices and the Recovery Model," in *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice*, edited by Larry Davidson, Courtenay Harding, and LeRoy Spaniol (Boston: Boston Center for Psychiatric Rehabilitation, 2005), 375-90.

[34] Notably, the same general direction applies to treatment under a "recovery" model. According to Larry Davidson, "recovery refers to a person's right and ability to live a safe, dignified, and meaningful life in the community of his or her choice despite continuing disability associated with illness…this is the term, and the sense of recovery, that has been chosen and promoted by people living with mental illnesses." See Preface to *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice*, edited by Larry Davidson, Courtenay Harding, and LeRoy Spaniol (Boston: Boston Center for Psychiatric Rehabilitation, 2005), xxi. Although in principle the recovery model is widely adopted, in practice these goals do not necessarily align with the symptom relief emphasized in the medical system. The recovery model fits more comfortably with the ethics of care than does an overemphasis on symptom relief, because it asserts the priority of the individual's goals, rather than those of the system or of professionals.

If "needs" are defined in ways that express the wishes of the individual, and if the treatment to which a person is committed is "effective" according to standards relevant to that person, an ethics of care supports "need for treatment" standards for civil commitment. "Need for treatment" standards allow intervention before the crisis of imminent dangerousness to self or others, and can set a standard for function in society that is higher than "survival in freedom." Such a standard might have been useful for Maria. The medical/legal system in her sister's state deemed her not imminently dangerous to self or others and capable of "surviving," so professionals delayed in admitting her to care and released her from care before she recognized that her thinking was delusional. A "need for treatment" standard would have allowed earlier intervention, and likely for a longer period, given that she could not function sustainably in society on release. Earlier intervention might have helped her stabilize sooner, with less damage to her family, work, and church relationships (and to her bank account). It is, however, important to reiterate the "ifs." Maria's wishes to engage with family, work, and church could be inferred from her choices throughout most of her life: these are not choices all would make.[35] In contrast, Nicole understood and rejected the definition of "needs" offered by the program to which she was committed, so the shift to a "need for treatment" standard would not shift the ethical assessment of her experience. As for the other big "if"—that the care offered be effective by standards relevant to the person—practitioners have no choice but to do the best possible with resources available, but, under an ethics of care, they also need work toward improving the resources.

Responsibility and Reciprocity

Under an ethics of care, both individual caregivers and the wider society take on a share of responsibility toward caring for people who have mental illness. This responsibility to provide effective and appropriate care for others' needs is based on simple reciprocity for the care each person receives in various ways at various stages of life. Because of the need for taxpayer and/or medical insurance funding to provide the resources needed for care, the responsibility is borne, to some extent, by all citizens. Libertarian reasoning resists this assertion, arguing that it impinges on liberties and rights of those held responsible. But because the basic values of reciprocity and responsibility are widely shared, the ethics of care provides a strong counter to the view of liberty that allows citizens "freedom" to neglect those who have a mental illness.

On more personal levels, in contexts where families, friends, or professionals provide care for people who have mental or physical disabilities, three important criticisms have been raised against the reciprocal understanding of responsibility. The common thread is concern that some people with disabilities cannot reciprocate care, or cannot reciprocate fully. In these contexts, the critics argue one of the following: 1) too much responsibility is asked of caregivers; 2) too little responsibility is asked of cared-for people, or 3) too much responsibility is asked of cared-for people.

The concern that too much is asked of caregivers of disabled people—in the present context people who have serious mental illnesses—has several aspects. First is the risk that the caregiver will become subservient, given that caregivers are likely, at least at times, to give more care than they receive. This concern ties to a second: sexism, given that caregivers are often women.[36] Finally—either independently of or tied to the first two aspects of concern—there is the issue that caregivers in US society are often under-supported. This practical issue affects families who provide care when medical or social systems fail to aid mentally ill people; it also affects professionals who are asked to take on ever-higher caseloads.

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[35] This line of thinking can leave too much room for luck in what an individual has been able to experience and choose—that is, some people might *want* to have made choices that weren't available to them. This, too, is context that needs to be taken into account.

[36] See Held, *Ethics of Care* and Kittay, "Ethics of Care."

The ethics of care can address these concerns, but doing so demands reciprocity and responsibility at both personal and public levels. Because a person who has a mental illness cannot always (or sometimes ever) reciprocate care, families may have much responsibility. At a minimum, this situation risks overburdening the carers, but subservience is also a risk. Because of these risks, taken on by families through no fault of their own, basic reciprocity (giving all a turn to be cared for) suggests that other people or social systems must be in place to support the families with, for example, access to counseling or respite care. On the other hand, families may be ineffective or pushed aside (as in Maria's situation). In those cases, others—sometimes professionals, sometimes not—must be positioned to provide care.

The concern that too little responsibility is asked of cared-for people also has several facets. In the context of civil commitment, holding up mutual and reciprocal caring as an ideal presents a problem, as many patients with disabling mental illness can only partially reciprocate the care they receive from others—and some will not be able to do so at all. Yet, requiring too little responsibility of the person who has mental illness risks belittling them and their capabilities; taking control unnecessarily is a form of paternalism that risks dependence.[37] In the words of one individual who has a serious mental illness, "When the opportunity to risk or to fail is taken away from us by clinical paternalism, it is easy to fall into or stay in that comfortable role of being 'taken care of.'"[38] Finally, expecting too little of the cared-for can set up a divide between carers and cared-for that mimics the hierarchical stratification between competent and noncompetent or autonomous and nonautonomous under liberty-based views.

Conversely, the third criticism—that the ethics of care asks too much of people who have mental illness—argues that asking too much backfires by being ineffective (asking people to be responsible for actions they are incapable of taking), dangerous (in reducing oversight or assistance), or corrosive of trust (in leaving people with needs underserved). Donnelly and Murray raise a related concern: requiring too much might be construed as giving people who have a mental illness a responsibility to get well. Lawmakers, they suggest, could use this idea to enforce this responsibility through civil commitment to treatment or confinement. For this reason, Donnelly and Murray argue that the ethics of care should de-emphasize individual responsibility and emphasize relational autonomy and the vulnerability of mentally ill individuals. The state's role, then, would be to support structures and policies that enhance relational autonomy.

In response to both the second and third criticisms, context is key: an ethics of care, as we have seen, places moral reasoning in the context of particular persons, their social positions, and their relationships. Determining what is "too much" or "too little" to ask from any individual demands assessment of context. As discussed above, honoring relational autonomy and dignity entails maximizing individuals' roles in making decisions for themselves, while recognizing that people must take on responsibility on a sliding scale, according to the skills and capacities they do or do not possess. To determine what constitutes "too much" and "too little" responsibility, one must have a good sense of what the person's abilities are. For example, Nicole's and Maria's abilities differ significantly. But it will often not be easy to determine what actions avoid both paternalism and neglect.

Taking context into account also helps avoid the difficulty of stratification introduced by expecting too little.[39] Kittay and Baier point out that people clearly have different capacities to care for others and themselves. Pretending that they do not differ is the reasoning that sets up stratification. The pretense "works" in a broad middle range, where give and take occur in caring relationships without incident. But at the margins, differences in ability

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[37] 37. See Kittay, "Ethics of Care."

[38] 38. Katherine Storey, "A Critical Analysis of the Factors that Promote and Support Leadership and Advocacy for People with Lived Experience with Mental Health Problems or Illness" (PhD diss., The University of Western Ontario, 2011), 79.

[39] 39. See Kittay, "Ethics of Care." Here Kittay cites Annette C. Baier, "The Need for More than Justice," in *Justice and Care*, edited by Virginia Held (Boulder: Westview, 1995,) 47-60.

to reciprocate care are so obvious that people whose caring capacities are limited are judged to be ethically and legally non-autonomous. A contextualized approach replaces the dichotomous view: differences in ability are recognized as gradations rather than stratifications, and caring actions are chosen accordingly.

Finally, Donnelly's and Murray's concern about excess use of civil commitment was made in the context of civil commitment in the UK and Ireland. In the US, given the interpretations of freedom and autonomy typically employed here, asking "too much" responsibility is more typically an excuse for neglect than an excuse for more civil commitment—as in, "it's your responsibility, not the state's." Maria's quick release was typical of this attitude. While a concern that warrants attention, in our view it is not of great practical concern in the United States.

Conclusion

The ethics of care provides conceptual resources with potential to shift ethical and legal thinking about civil commitment for involuntary treatment of serious mental illness. Reconceiving autonomy as relational is one such resource. Relational understandings of autonomy recognize people's interdependence with each other, the varying degrees of agency people experience over time, and the significance of caring family and social support in achieving agency and autonomy. If civil commitment proceedings can recognize these factors, so that non-voluntary treatment accords with supporting the committed individual and others involved, intervention may be beneficent—even if it involves restrictions on individual liberty. However, to be supportive, civil commitment proceedings must respect individuals' dignity, particularly in following practices that respect each individual's subjective experience of being treated with dignity. Crucially, the treatment or confinement to which a person is civilly committed must be effective in order to be caring—and just. At present, this goal is often not met: the ethics of care requires that more attention be paid to developing and implementing effective care—and that "effective" be defined in ways that matter to individuals who have a mental illness. Finally, the concepts of responsibility and reciprocity emphasize that the care needed by people who have mental illnesses cannot be the responsibility of just a few—whether individual family members or specific institutions. Instead, the responsibility accrues to wider society to provide adequate funding and systems so that people who have mental illness are not neglected and those who care for them are not overburdened.

These conclusions have strong practical implications. Because effective care requires continuity of care and support for many people—individuals who have a mental illness, their family and social support systems, and the people and institutions that provide professional care—the system must identify and implement practices that build trust. A likely starting place (partly because it is practiced in many venues already) is to consistently honor the dignity of people experiencing serious mental illness by facilitating their participation as far as possible in their own care and decision-making. Perhaps such consistent practices of trust, support, and caring could do much to reduce the need for involuntary treatment or confinement.

Other practical implications are primarily institutional. Legal institutions can reconceptualize civil commitment as a collaborative and contextualized process. Key features would be that people who have serious mental illness as well as their families and other supporters would work with legal advocates and medical experts toward appropriate and effective care and treatment. Models for such programs exist, including the participatory and collaborative legal approaches used in mediation, family courts, and deliberative discussion. In institutions involved in medical or social care, such as hospitals, community care facilities, residential facilities, and county social services, an ethics of care calls for resource allocation and staff support that allows professionals to engage in attentive and effective care.

Systemically, across most of the mental health system, the role of government in providing care must be delineated. Under an ethics of care, government, as a proxy for individual citizens' contributions, has a responsibility for individuals' welfare. Whether the welfare of people who have serious mental illness should be supported through providing housing, aiding families, funding community-care centers or hospitals, or other approaches is debatable. Because the ethics of care denies the moral significance of the public/private distinction, the choice depends on what is most effective and most caring—again with due attention to caring definitions of "effectiveness." But one clear priority for government is to fund research into multiple approaches that can guide institutional reform. Of course, the research has not yet been done, and the ethics of care does not yet guide the system. Given this, it may well be that radical departures from current practices of civil commitment for serious mental illness will, in the end, be the most caring.

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Caring While Respecting Moral Agency

A Public Holistic Response

Martin Gunderson

Susan Hawthorne and Amy Ihlan make a plausible case that the ethics of care can ease the tension between the liberty of persons with severe mental illness and the potential benefits of compulsory treatment. In addition, they show how the ethics of care can take account of the goals, abilities, and social context of persons with mental illness. As Hawthorne and Ihlan note, however, an emphasis on caring relationships raises the question of what the goal of care should be. They answer that the goal should be meeting the needs of the person cared for and that needs should be spelled out largely in terms of the person's wishes and goals. I believe this moves us in the right direction. My main concern is that mental illness can produce distorted wishes and goals that should be discounted. A severely depressed person's wish for death does not provide us with a reason to help the person die.

How do we determine which wishes and goals to take into account? I suggest the guiding principle is respect for the moral agency. People are moral agents to the extent they are able to form values, to formulate reasons for action, and to conform their behavior to those reasons and values. Hawthorne and Ihlan are right that people have more or less capacity to function as agents, and this is also true for moral agency.

Respecting moral agency provides caregivers with a strong, though defeasible, reason for allowing a person to participate in treatment decisions to the extent that the person can function as a moral agent. When moral agency is attenuated by mental illness, respect for moral agency provides caregivers with a strong reason to help the person regain full moral agency. In working out a specific treatment plan caregivers should consider the patient's wishes and goals insofar as they embody the person's long-term values as a moral agent. When the moral agency of a mentally ill person is completely absent and we do not know what the person's values are, respect for moral agency requires us to ask what a moral agent would most likely want us to do in the event of a complete loss of moral agency. Central to any reasonable answer to that question would be the restoration of his or her moral agency insofar as it is possible.

Respect for moral agency should not be viewed as an absolutist principle that is incompatible with the ethics of care. Respecting moral agency requires sensitivity to context and social relationships. It is also compatible with valuing relational autonomy. No one can function adequately as a moral agent without the help of others. In addition, respect for a person's moral agency provides a reason that can sometimes be overridden by the values and needs of others. After all, respect for moral agency requires us to take account of the moral agency of friends, family, and others who care for the mentally ill person. In the end, the guidance of principles such as respect for moral agency requires practical wisdom that is sensitive to context. The ethics of care gets this right, but it does not require us to abandon the guidance of principles such as respect for moral agency.

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Rethinking Civil Commitment

A Public Holistic Response

Jennifer Radden

Susan Hawthorne and Amy Ihlan offer us a persuasive thesis. By adopting and applying the tenets of care ethics, with its relational approach to autonomy and more contextualized, interpersonal interpretations of reality, they have demonstrated, many of the ills associated with US practices of civil commitment and involuntary treatment of those with mental disorder could be mitigated.

That these innovations could improve matters for the mentally ill, and that, as they say, the ethics of civil commitment for involuntary treatment *needs to go beyond* the traditional focus on individual freedom and the harms of government coercion, seems indisputable. Moreover, the urgency with which these authors seek to reform practices around the civil commitment and involuntary treatment of people at risk of harming or neglecting themselves due to disorder is indisputably appropriate. After centuries of objections voiced by those most immediately subject to them, these practices are today increasingly recognized to violate rights, not only those found the US Constitution, but more recently those proclaimed in the 2006 UN Convention on the Rights of Persons with Disabilities.

The misapprehensions attached to liberal individualism, emphasized here, are convincingly identified and challenged. Its misleading conception of individual autonomy, and model of the person emphasizing independence and self-determination, can and should be improved upon: there are conceptions of autonomy and responsibility better fitting our experience and our values. Far from resolving all our problems, these authors recognize, the appeal to care ethics fundamentals still leaves moral hazard around the degree of responsibility accorded to those with temporarily diminished capabilities; determining the "too much and too little" to ask of the person must always remain a difficult, context-sensitive, case-by-case decision. While conceding the advantages that come with more realistic and more desirable ideas about autonomy and the person, however, I want to urge against drawing an entirely sharp dichotomy between policy and practices guided by classical, liberal individualism and those guided by the feminist conceptions underlying care ethics. More can be said, I think, about the areas of agreement between these different, and in many ways quite contrary, sets of ideas.

As a preliminary, for example, it seems worth noting that from a broader historical perspective—training our lens on the last four or five hundred years, let's say—we can judge mental health care itself to resemble the care ethic these authors applaud. Even if the difference is in certain respects more in name than reality, those who are confined are sent to hospitals, *not prisons*, after all. However misguided or inadequate, they are offered help and care, not measures intended to be punitive. Moreover, much about their treatment, involving one-on-one exchange and individualized responses that emphasize the healing power of interpersonal relationship, exemplifies what we might expect from approaches guided by an ethics of care.

It is also possible to overstate the errors of individualism. There are many contexts in which to see the person as an isolated, independent individual is outright mistaken and ethically unwarranted, it is true. Yet our societal allegiance to valued conceptions of individual responsibility associated with praise and blame undeniably require us to maintain a kind of methodological individualism when it comes to human action. The person and she alone, we think, is rightly reproached (and sometimes punished) for past wrongdoing, and held to commitments made for the future. It is precisely because mental illness sometimes compromises that personal responsibility that there are protections and exceptions in law and policy such as are found in the insanity defense, and in these civil commitment (in contrast to penal), statutes. The moral category of personal responsibility, together with the methodological individualism on which it rests—while they may not have appropriate application in such cases—are mainstays of society. They cannot be forgotten in the rush to dismiss the many misapplications of individualism critiqued by feminist care ethics.

Considerations such as these seem to me to clear the way for the possibility of giving individualism some, even if limited, credit, and to see a place for it within mental healthcare policy that is compatible with the policy proposals outlined by Hawthorne and Ihlan. Two brief examples will illustrate, although they are introduced not in a spirit of correction, so much as one of amplification. At the center of individualist conceptions of autonomy lies the ability to bind oneself in advance, to make plans, promises and commitments for future contingencies (even beyond the grave, in the case of last wills and testaments). In the healthcare setting, the living will is an important one of these, anticipating and controlling future health contingencies; it is mandated within some healthcare systems and widely employed in many countries, including the US. The psychiatric version of such contractual arrangements (sometimes known as a Ulysses contract), has been endorsed by proponents of liberal and libertarian ethics since the 1970s, and anecdotal evidence indicates that such contracts are employed informally in the clinical setting. But they have yet to be enshrined as public policy, which to the best of my knowledge has neither required, nor even advocated, psychiatric living wills. Yet that could, and perhaps should, change. Enough is known about the onset and incidence of various mental illnesses to expand the scope of the healthcare documents already in use. If it were based on interpersonal exchange and discussion with other stake-holders such as friends, family and likely care-givers, the practice of writing psychiatric wills could be agreeable to both care ethics and liberalism.

Another example, to which these authors draw our attention, involves the use of a conditional approach that acknowledges the individual's rational response to incentives. As policy, the system is associated with conditional release for those leaving closed institutions: release can be earned by adherence to norms (staying on meds, abstaining from drugs, etc.). The conditional approach is similarly employed informally in other settings, where the person is provided opportunities to earn privileges and freedoms. In the case described by Hawthorne and Ihlan, Nicole was offered a stay of commitment conditional on the completion of the hospital's outpatient program. Because they leave the individual free to comply or not, and show respect for his or her agency and ability to make rational commitments, agreements of this kind are central to the ideals of liberalism. Yet such an approach is entirely compatible with the tenets of care ethics.

Shared ground can then be found. Hawthorne and Ihlan recognize that rather than inimical to liberal policies and practices, theirs are revisions and proposals that can often be made to dovetail with them. I want to endorse their spirit of reconciliation.

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Rethinking Civil Commitment

Composers' Public Response

Susan Hawthorne
Amy Ihlan

We thank Martin Gunderson and Jennifer Radden for their supportive and insightful comments. Both appreciate the amendments an ethics of care can usefully offer to our practices of civil commitment; both also draw attention to areas of overlap with other ethics and views of rights and agency. We also wish to acknowledge that both reviewers provided comments on an earlier draft that helped us make significant improvements in the paper. For this we are very grateful.

In response to Gunderson's comments: we argue that under an ethics of care, effective treatment should aim to meet the needs of persons experiencing mental illness—and we agree with his observation that to the extent possible, "needs should be spelled out largely in terms of the person's own wishes and goals." Our analysis shows how prevailing assumptions about the rational agency of persons experiencing mental illness make this challenging. In civil commitment cases, agency is frequently considered in "all or nothing" terms. Either persons experiencing mental illness are assumed to be full-functioning autonomous agents who should not be confined or forced to receive treatment against their will—or they are deemed completely incapable of rational agency, so that their freedom of choice and rights to self-determination can be justifiably overridden by the state and their medical caregivers. We think the ethics of care points to a contextualized vision of agency informed by an alternative concept of relational autonomy—on this view, both autonomy and agency should be evaluated relative to mental state and social context, including interdependent relationships with others in community. Thus, it should not be assumed that persons experiencing mental illness and in need of care are able to live as fully autonomous agents capable of making their own treatment decisions. But we are also concerned about the potential for paternalism and violation of dignity if the needs of these persons for care and treatment are determined primarily or exclusively by the state, medical experts, or other caregivers. The goal, as we see it, is that persons experiencing mental illness should be able to participate and collaborate in their care and treatment in a way that respects their own individual contextualized capacity for agency.

But Gunderson notes his concern that "mental illness can produce distorted wishes and goals" that that should be "discounted" in determining effective care and treatment. He urges us to focus our analysis of agency more specifically on moral agency—which he defines as the ability "to form values, to formulate reasons for action, and to conform…behavior to those reasons and values." Gunderson argues that a "principle of respect for moral agency" should be used as a guiding principle for determining how to take the wishes and goals of the mentally ill into account in civil commitment and involuntary treatment decisions.

A principle of respect for moral agency might provide one helpful perspective to consider in determining what treatment is needed (and effective) under an ethics of care. However, Gunderson's concern about "distorted" wishes and goals that should be "discounted" in decision-making appears to rely on some of the same problematic assumptions about persons experiencing mental illness that an ethics of care and relational understandings of autonomy challenge. We argue that an ethics of care should push us to rethink our tendency to assume that values and reasons not in sync with those favored by legal or medical decision-makers are distorted by mental illness, and ought to be discounted. Sometimes this is the case, but sometimes it isn't.

At a minimum, we think some significant further work is needed on how respect for moral agency would work in practice—for example, how the capabilities necessary for moral agency (including the ability to form values, formulate reasons for action, and conform behavior accordingly)—should be evaluated in civil commitment proceedings under an ethics of care. Respect for moral agency could serve as a check against paternalism and a safeguard for the dignity of persons experiencing mental illness. But this would require setting aside assumptions and avoiding advance judgment that their desires or capabilities should be discounted or overridden. Even if a person lacks sufficient moral agency for full participation in treatment decisions, a principle of respect for moral agency would require other decision-makers to aim to understand and take seriously the goals and values of persons facing commitment or involuntary treatment.

This kind of understanding and respect is, we think, a part of caring for and about people experiencing mental illness. As Gunderson points out, it also provides another useful way of thinking about the purpose of effective treatments for mental illness under an ethics of care—to restore the agency (including moral agency) of persons to make their own decisions about how to live their lives.

Radden's comments amplify the idea that there are approaches to serious mental illness that can be supported from multiple ethical perspectives. Her overall concern is that we have "overstate[d] the errors of individualism," and that we would do well to recognize the strengths of liberalism in the context of serious mental illness. For Radden, these include an emphasis on personal responsibility and on rational commitments by individuals. On a practical basis, for example, these give grounding to increased use of "Ulysses contracts" as a form of psychiatric living will.

Parallel with our response to Gunderson—and, we think, in agreement with Radden—we concur that a liberal perspective can be an effective reminder of individuals' dignity and their ability to navigate their own lives and decisions. Indeed, there *is* shared ground here. However, we suggest that in the US context, change will require clear recognition of the areas where there is not overlap, so that civil commitment policies can shift away from the coercion/neglect dichotomy into which they have fallen. Radden's reminder of history points to the urgency of the problem, when she says that those with serious mental illness "are sent to hospitals, *not prisons*." Sadly, in the US, that is not the case—in the US, there are approximately ten times more people with serious mental illness in prison than in hospitals at any given time. Sharing the perspective that *that* is a problem is another point on which we expect we'd agree.