

# The Ethics of Advocacy for the Mentally Ill: Philosophic and Ethnographic Considerations

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## I. INTRODUCTION: ON THE NOTION OF JUSTICE AND ETHICS IN LAW AND PSYCHOLOGY<sup>1</sup>

The field of law and psychology emerged in the late 1960s with an avowed commitment to justice.<sup>2</sup> This emphasis on justice was a deliberate attempt to make the forensic domain “relevant” by “challeng[ing] and transform[ing] a prevailing ‘judicial common sense’ that had been used to keep the disenfranchised down so long”.<sup>3</sup> The medicolegal<sup>4</sup> field, with its identified “ultimate

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1. Portions of this introductory section are taken from Bruce A. Arrigo, *Back to the Future: The Place of Justice in Forensic Psychological Research and Practice*, 1 J. FORENSIC PSYCHOL. PRAC. 1-7 (2001) (original citations omitted).

2. See Dennis Fox, *Psychology and Law: Justice Diverted*, in *CRITICAL PSYCHOLOGY* 217, 217-18 (Dennis Fox & Isaac Prilleltensky eds., 1997) [hereinafter Fox, *Psychology and Law*]; Dennis R. Fox, Psycholegal Scholarship’s Contribution to False Consciousness About Injustice, 23 *LAW & HUM. BEHAV.* 9, 9-10 (1999) [hereinafter Fox, *False Consciousness*]; Craig Haney, *Psychology and Legal Change: The Impact of a Decade*, 17 *LAW & HUM. BEHAV.* 371, 375 (1993); Gary B. Melton, *Realism in Psychology and Humanism in Law: Psycholegal Studies at Nebraska*, 69 *NEB. L. REV.* 251, 259 (1990).

3. Haney, *supra* note 2, at 375. Tapp and Levine state:

purpose" [o]f promot[ing] justice and assess[ing] the role of law in achieving a just social order"<sup>5</sup> was institutionalized with the 1968 founding of the American Psychology-Law Society (APLS).<sup>6</sup> Unfortunately for the early pioneers of the APLS movement, the centrality of justice in psychological research mostly remain[s] diverted.<sup>7</sup>

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Today, in far too many research settings, psycholegal scholarship focuses on a limited and narrowly construed collection of topics.<sup>8</sup> [For example,] jury behavior, eyewitness testimony, sex

The explosion of law has done more than promote justice. It has clarified that the law is a mobility belt not solely for the "rights-deprived" but also for the "relevance-deprived." Psychologists had begun to experience frustration, futility, and doubt in the late 1960's and early 1970's, a period of insecurity for both science and society. . . . As a result some psychologists chose to act on or in the most potent "rule" or "norm" institution in the social structure—the law.

June Louin Tapp & Felice J. Levine, *Epilogue for Psychology and Law*, in *LAW, JUSTICE, AND THE INDIVIDUAL IN SOCIETY: PSYCHOLOGICAL AND LEGAL ISSUES* 363, 363 (June Louin Tapp & Felice J. Levine eds., 1977).

We note further that this concern for justice, as developed in the law-psychology domain, parallels the genesis of critical criminology. For a detailed analysis of critical criminology in relation to social justice, see *SOCIAL JUSTICE/CRIMINAL JUSTICE: THE MATURATION OF CRITICAL THEORY IN LAW, CRIME, AND DEVIANCE* (Bruce A. Arrigo ed., 1999). To date, as best as we can discern, no systematic assessment on the relationship between these two movements has thus far been undertaken. A number of striking similarities are discernible as evidenced by this Article's thesis and exposition.

4. Throughout this Article, the word "clinicolegal" is used interchangeably with "medico-legal." These descriptors refer to the joint and overlapping effects of the psychiatric and legal communities, as well as the mental health and justice systems. See Bruce A. Arrigo, *Civil Confinement, Semiotics and Discourse on Difference: An Historical Critique of the Sign of Paternalism*, in *FLUX, COMPLEXITY, AND ILLUSION* 23 n.6 (Roberta Kevelson ed., 1993). These effects often include the exercise of "expert" decision-making impacting the lives of disordered citizens. See *id.*

5. June Louin Tapp & Felice J. Levine, *Reflections and Redirections*, in *LAW, JUSTICE, AND THE INDIVIDUAL IN SOCIETY: PSYCHOLOGICAL AND LEGAL ISSUES* 3, 5 (June Louin Tapp & Felice J. Levine eds., 1977).

6. Fox, *False Consciousness*, *supra* note 2, at 9-10.

7. See Fox, *Psychology and Law*, *supra* note 2, at 218-19. Critics of mainstream psycholegal scholarship assert that despite contributions from critical legal studies, feminist jurisprudence, postmodern inquiry, and the like, scant attention has been given to "law's potential downside even as [forensic researchers] examined discretionary factors in legal decision-making and proposed relatively minor institutional reforms." Fox, *False Consciousness*, *supra* note 2, at 10. Other commentators suggest that the law-psychology field remains constituted by practitioners who "still have blinders on when they look at the law and the legal system." Gary B. Melton, *President's Column*, 11 *AM. PSYCHOL.-L. SOC'Y NEWS* 1, 1 (1991). These are blinders that signal "an abandoning of a sense of mission—the mission of legal change." Haney, *supra* note 2, at 378-79.

8. See, e.g., Mark A. Small, *Legal Psychology and Therapeutic Jurisprudence*, 37 *ST. LOUIS U. L.J.* 675, 687 (1993); James R.P. Ogloff, *Introduction*, in *LAW AND PSYCHOLOGY: THE BROADENING OF THE DISCIPLINE* 1, 2 (1992); D.K. Kagehiro & W.S. Laufer, *HANDBOOK OF*

offender treatment, and expert witness studies[,] while certainly interesting . . . , seldom, if ever, explore prospects for broad-based social or political change,<sup>9</sup> or examine opportunities for advancing the interests of citizen rights and/or collective justice.<sup>10</sup> Despite these shortcomings, the forensic field is, at its core, about justice.<sup>11</sup> This means that questions concerning psychological practices, and the manner in which people are socially, politically, economically, and philosophically affected by them require careful and considerable scrutiny.<sup>12</sup>

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PSYCHOLOGY AND LAW at xi (D.K. Kagehiro & W.S. Laufer eds., 1992); Michael J. Saks, *The Law Does Not Live by Eyewitness Testimony Alone*, 10 LAW & HUM. BEHAV. 279, 279 (1986); Ronald Roesch, *Creating Change in the Legal System: Contributions from Community Psychology*, 19 LAW & HUM. BEHAV. 325, 328-29 (1995); Richard L. Weiner, *Introduction: Law and Psychology—Beyond Mental Health and Legal Procedure*, 37 ST. LOUIS U. L.J. 499, 499-500 (1993). For example, Dennis Fox contends that, with an emphasis on justice, the law-psychology field has rarely posed several relevant questions regarding the human condition and human social behavior previously ignored or dismissed by the discipline. Fox, *False Consciousness*, *supra* note 2, at 10. He ponders:

How does the law ensure the maintenance of societal inequality and power imbalances? When does law provide the appearance of justice without the reality? Does the lack of consensus about how to define justice mean we cannot attack injustice? To what extent does reliance on law deflect attention from other solutions to societal problems?

*Id.*

9. See Dennis R. Fox, *Psychological Jurisprudence and Radical Social Change*, 48 AM. PSYCHOLOGIST 234, 234 (1993).

10. Gary B. Melton, *The Significance of Law in the Everyday Lives of Children and Families*, 22 GA. L. REV. 851, 851-52. See also Gary B. Melton, *The Law Is a Good Thing (Psychology Is, Too): Human Rights in Psychological Jurisprudence*, 16 LAW & HUM. BEHAV. 381, 395 (1992). Contributions from the therapeutic jurisprudence literature notwithstanding, some argue that these efforts largely assess how the state can function as a powerful instrument of control, coercion, and regulation in which psychology merely operates as the handmaiden of legal decision-making. Fox, *Psychology and Law*, *supra* note 2, at 218-19. But see NORMAN J. FINKEL, COMMONSENSE JUSTICE (1995) (discussing jury nullification). For examples of therapeutic jurisprudence literature see, LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1996); BRUCE J. WINICK, THERAPEUTIC JURISPRUDENCE APPLIED (1997); Michael M. Perlin et al., *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption?* 1 PSYCHOL. PUB. POL'Y & L. 80 (1995); Bruce A. Arrigo & Jeffrey J. Tasca, *Right to Refuse Treatment, Competency to Be Executed, and Therapeutic Jurisprudence: Toward a Systematic Analysis*, 23 LAW & PSYCHOL. REV. 1 (1999).

11. See BRUCE A. ARRIGO, INTRODUCTION TO FORENSIC PSYCHOLOGY at xvi (2000).

12. See *id.* There is something approximating a tradition of this sort within mental health law circles dating back, at least, to the antipsychiatry movement of the 1960s. Indeed, on the American front, Szasz's and Ennis' investigations of insanity and jurisprudence, see BRUCE J. ENNIS, PRISONERS OF PSYCHIATRY (1972); THOMAS S. SZAZ, LAW, LIBERTY AND PSYCHIATRY (1963); THOMAS SZAZ, INSANITY (1987) [hereinafter SZAZ, INSANITY]; Morse's analysis of "crazy behavior," morals, science, and liberty, see Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978); Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54 (1982); Stephen J. Morse, *Treating Crazy People Less Specially*, 90 W. VA. L. REV. 353 (1988); Isaac's and Armat's review of law and psychiatry's abandonment

One domain where law-psychology-justice research has yet to assess forensic intervention entails the ethics of advocacy for the mentally ill. Broadly speaking, the concept of "ethics" has increasingly assumed a more passive, perhaps trivialized, role within the various academic fields where it was recognized as a valuable dimension and a necessary condition for ensuring the humanity of people.<sup>13</sup> This is most troubling in the law-psychology domain.<sup>14</sup> To be clear, our relegation of ethics to its more pedagogical and sanitary status forfeits its very foundations; that is, it undercuts the significance of moral contemplation and the importance of justice in human social interaction. Modern science teaches us to understand the ethical sphere within the imposed, coercive confines of its jurisdiction.<sup>15</sup> That is to say, ethics is "built" upon an edifice, a structure of *abstractions* resting solely on the intangible underpinnings upon which it is posed.<sup>16</sup> What is "selected out" as defining ethical boundaries is that which can be reduced to the abstract.<sup>17</sup>

In the fourteenth century, William of Ockham proposed an economic principle that has indirectly come to influence the fabric of

of the mentally ill, see RAE JEAN ISSAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS* (1990); and Arrigo's critique of civil and criminal confinement law for the psychiatrically disordered, see BRUCE A. ARRIGO, *MADNESS, LANGUAGE, AND THE LAW* (1993) [hereinafter ARRIGO, *MADNESS*]; BRUCE A. ARRIGO, *THE CONTOURS OF PSYCHIATRIC JUSTICE* (1996) [hereinafter ARRIGO, *PSYCHIATRIC JUSTICE*]; are all exemplars of this perspective. For the radical/critical psychology movement more generally see CRITICAL PSYCHOLOGY, *supra* note 2; ISAAC PRILLELTSKY, *THE MORALS AND POLITICS OF PSYCHOLOGY* (1994).

13. In his review of how the journal *Law and Human Behavior* has addressed issues concerning law and psychology, Ogloff notes that in order for legal psychology to advance knowledge, researchers "must develop an understanding of 'why' some phenomen[a] in law exist. Thus, it is not enough to know *what* types of pretrial publicity affect jurors, for example, but *why* they react the way they do and *how* the media affects their decision-making. . . . [O]nce we understand the cause of phenomen[a], we can begin to learn how the law can be revised, when necessary, to better reflect the reality of human behavior." James R.P. Ogloff, *Law and Human Behavior: Reflecting Back and Looking Forward*, 23 *LAW & HUM. BEHAV.* 1, 3-4 (1999). Applying this to ethics, researchers must develop an understanding of why ethics in law exists. See *id.* If we understand this, then we can learn how the law of ethics can be revised to better reflect the reality of human behavior. See *id.*

14. For application of this phenomenon to the interest-balancing of mental health consumer rights see, ARRIGO, *PSYCHIATRIC JUSTICE*, *supra* note 12, at 78-79, 179-80.

15. See Bruce A. Arrigo, *New Directions in Crime, Law, and Social Change: On Psychoanalytic Semiotics, Chaos Theory, and Postmodern Ethics*, 33 *W. GA. C. STUD. SOC. SCI.* 115 (1995).

16. See ROLLO MAY, *THE DISCOVERY OF BEING* 52 (1983).

17. *Id.* Ethics in the law-psychology domain attempts to fit critical cases into abstract principles (e.g., the duty to warn vs. client confidentiality, mandated conditions for reporting child sexual abuse, the ethics of advocacy by psychologists). The dilemma, of course, is that many of the nuances, complexities, and differences among the cases constituting real, unpredictable life are concealed and reduced to how such subtleties satisfy an artificial, and often homogenous, notion of personal and civic conduct.

our ethical edifice. Ockham's Razor states that "entities are not to be multiplied beyond necessity."<sup>18</sup> In other words, what is simplest is best. Thus, an abstract rule *becomes* a rule because it is simple to follow—to obey. And, equally, our identification of those whose behavior conflicts with or otherwise transgresses our rules becomes less ambiguous and less subject to debate. Indeed, codification of rules intends absence of ambiguity and of individual decision-making.<sup>19</sup> Decisions are, instead, produced by a representative democracy—the select few who, by way of "expert" knowledge, are deemed competent and are bestowed the power to speak for (presumably on behalf of) other constituencies. Again, as we will argue below, this is particularly disturbing in the domain of psychology and law, where mental health systems users are routinely subjected to the expertise of clinicolegal decision brokers,<sup>20</sup> such as judges and psychiatrists, whose choices all too frequently activate transcarcerative<sup>21</sup> ends.

Those phenomena that are easily subjected to "degrees of control and analysis necessary for the formulation of abstract laws"<sup>22</sup> are codified in such a way as to demand control.<sup>23</sup> What is more amenable to the formulation of abstract laws than laws (or rules) themselves?<sup>24</sup> Such is the constitution of *ethical codes*. Many systems—including the mental health and legal apparatuses—have been constructed (codified)

18. Philotheus Boehner, *Introduction to OCKHAM, PHILOSOPHICAL WRITINGS* at ix, xxi (Philotheus Boehner ed. & trans., 1957).

19. Generally speaking, the notion that one's thoughts or a group's sentiments can eventually be penned presumes that there is some consensus on the form and content of one's convictions. In law, we describe this consensus in terms of "plain meaning" or "clear intent," with the belief that such decision-making functions much like a "science"—a legal science. See *Harvard Celebration Speeches*, 3 LAW Q. REV. 124 (1887) (Professor Langdell discussing law as a science). For a critical analysis of this approach from the realist and sociological jurisprudence tradition to legal semiotics and postmodern law see DRAGAN MILOVANOVIC, *A PRIMER IN THE SOCIOLOGY OF LAW*, pt. II, at 84 (2d. 1994).

20. Arrigo, *supra* note 4, at 23.

21. Transcarceration is the "repeated channeling of disordered defendants (subjects) through institutional regimes of discipline and coercion." Bruce A. Arrigo, *Transcarceration: Notes on a Psychoanalytically-Informed Theory of Social Practice in the Criminal Justice and Mental Health Systems*, 27 CRIME L. & SOC. CHANGE 31, 31 (1997). In the extreme (and in some cases notwithstanding the best of advocacy intentions), persons with psychiatric disorders become prisoners of confinement, meaning that they are repeatedly routed to and from the civil and criminal systems of institutional control (i.e., transcarcerated) with little opportunity to break free from this disciplinary cycle. See *id.* at 32; ENNIS, *supra* note 12, at 215-16.

22. KENNETH W. SPENCE, *BEHAVIOR THEORY AND CONDITIONING* 236 (1956).

23. DONALD BLACK, *THE BEHAVIOR OF LAW* 6-7 (1976).

24. Pound described this social control process in law as one that required the power "to influence the behavior of men through the pressure of their fellow men." ROSCOE POUND, *SOCIAL CONTROL THROUGH LAW* 49 (Archon Books 1968) (1942). For a sociolegal analysis of the social control perspective in law see ALAN HUNT, *EXPLORATIONS IN LAW AND SOCIETY* 40 (1993).

in terms of abstract laws that collectively comprise an intimidating structure, turning volitional subjects into impugned objects who succumb to the will of the code in unreflective, subjugated obedience.<sup>25</sup> Indeed, what person or group could, without fear of legal reprisal or sanctioned repercussion, brave the turbulent waters of defiance and resistance—that is, embrace individual reason without (potentially) forfeiting something meaningful in the process? We seek such an edifying structure in our impetuous escape from the anxiety of personal choice and responsibility. Rollo May refers to this as the “edifice complex.”<sup>26</sup> The “escape” is treated at length by Fromm in his work *Escape from Freedom*.<sup>27</sup>

What all this suggests is that we, as constituent practitioners and/or scholars in the world of humanism and of human rights, have acquiesced to an unreflective existence within the preconfigured borders of (ethical) codes laid before us by our ancestors.<sup>28</sup> This legacy does not imply that we, as individuals, necessarily have made a choice to escape from the freedom of responsibility. What it does, in fact, suggest is that we no longer enjoy the power to *make* such a choice. At some historical point, the representative powers that be concluded that it was in our best interest to be subjected to constraints on moral discretion. One can only assume that our predecessors were unable to find the possibility of such unbridled freedom liberating. Perhaps a select few made choices that were not in the best interests of their clients and/or communities; consequently, such decision-making power was withdrawn from *their/our* possession. The result, of

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25. See Bruce A. Arrigo, *Desire in the Psychiatric Courtroom: On Lacan and the Dialectics of Linguistic Oppression*, 16 CURRENT PERSP. SOC. THEORY 159, 160-61 (1996); Bruce A. Arrigo, *Toward a Theory of Punishment in the Psychiatric Courtroom: On Language, Law and Lacan*, 19 J. CRIME & JUST. 15, 16 (1996). Consider, for example, the manner in which the administrative hearing unfolds in which a determination is made about prospects for sustained institutional confinement for a psychiatrically disordered petitioner. Resistance to the established code of comportment or opposition to the “ethic” of clinicolegal communication (i.e., appropriate speech, thought, and behavior) can thwart any expectation of release from civil or criminal custody. See generally ARRIGO, MADNESS, *supra* note 12, at 135-40 (1993) (discussing how the law defines what is normal, based on the majority, which disadvantages the mentally ill because they do not fit into the norm).

26. MAY, *supra* note 16, at 52.

27. ERICH FROMM, *ESCAPE FROM FREEDOM* (1941).

28. This willing abdication or obedient acquiescence, absent prudent speculation, is precisely what we draw attention to in this Article. Both critical legal and critical psychological inquiry necessitate that we examine more systematically the implicit assumptions and hidden values embedded in the choices that we make. The need for such careful discernment is particularly warranted when assessing the advocacy efforts undertaken on behalf of citizens with psychiatric disorders. For a more detailed philosophical investigation of the values at issue when advocating for mental health system users see Christopher R. Williams & Bruce A. Arrigo, *The Philosophy of the Gift and the Ethics of Advocacy: Critical Reflections on Forensic Mental Health Intervention*, 13 INT’L J. SEMIOTICS L. 215 (2000).

course, continues to be a circumscribed education in morality and justice.

To be sure, many of us regard ethics as the study of rules or codes of conduct that define professional choice and responsibility.<sup>29</sup> Regardless of how one may feel about the presence of such rules, we have, undoubtedly, lost touch with what ethics really is. We no longer deliberately regard ethics as that which embodies concepts such as good, right, virtue, freedom, choice, and the morality that constitutes an ethical mode of being. Perhaps we are aware that ethical rules or codes are presumably assembled upon such conceptual underpinnings, yet we frequently take this for granted: the recipe that has become ethics is merely “taught” to us. As a consequence, students and practitioners memorize selected ethical precepts that apply to their potential or actual areas of practice. What we often neglect, however, are the critical and philosophical bases upon which such rules are formed. In other words, there is a certain morality and a particular sense of justice that encompasses every rule that we are taught or, perhaps, are teaching. On too many occasions, we unreflectively abandon the theoretical (and ideological) explorations that must necessarily accompany such instruction.<sup>30</sup>

In its relationship to morality and justice, we contend that ethics is not something that should be taught. Rather, it is something that should be *explored*, something one comes to understand on one’s *own* terms. As Schopenhauer duly noted:

As the biggest library if it is in disorder is not as useful as a small but well-arranged one, so you may accumulate a vast amount of knowledge but it will be of far less value to you than a much smaller amount if you thought it over for yourself . . .<sup>31</sup>

When we experience knowledge—a knowledge that one must come to *personally*—only then can our decisions or choices be regarded as truly ethical. The distinction between the human being and the

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29. For example, see DONALD N. BERSOFF, *ETHICAL CONFLICTS IN PSYCHOLOGY* 1 (1995).

30. As one of five traditional branches of philosophy, the ethics we have in mind is a blend of both metaethics (the study of the meaning of ethical concepts) and normative or applied ethics (the study of specific ethical theories in relation to specific behaviors engaged in by individuals under particular conditions or circumstances, mindful of “professional” boundaries. JOYCELYN M. POLLOCK, *ETHICS IN CRIME AND JUSTICE: DILEMMA AND DECISIONS* 4-5 (2d ed. 1994). The metaethical principles we consider include ethical egoism, altruism, the “good” act, etc. The application of these principles is linked to advocacy efforts for persons with mental disorders, subject to civil confinement or other forms of institutionalization. See, e.g., Williams & Arrigo, *supra* note 28.

31. ARTHUR SCHOPENHAUER, *ESSAYS AND APHORISMS* 89 (R.J. Hollingdale trans., 1970).

automaton posing as human is found within this process of reflection and exploration.

Our intention in the present Article is to explore the various paths that influence the often unquestioned choices we are impelled by rule/law to make, and those we may, at times, ponder. An exploration of ethics necessarily encourages us to understand why we make the choices that we do. From our perspective, a choice that is based merely on custom, convention, rule, etc., is not an ethical choice at all. And, without choice, the humanity we claim to hold so dear in our professional pursuits not only disappears, it becomes nonexistent.

In this Article, we critically address several philosophical underpinnings of ethical decision-making that impact persons with psychiatric disorders. We focus our attention, however, upon an admittedly limited target area. Thus, we canvass a select number of significant issues that pose unique problems for humanity. The purpose of these excursions is that of reflection. In brief, we will speculatively examine: (1) the relationship between human rights and the law; (2) the relationship between mental illness and the law (i.e. the rights of the mentally ill); (3) the ethics of involuntary confinement (i.e., taking away and giving back rights to the mentally ill); (4) the ethics of advocating for the rights of the mentally ill;<sup>32</sup> and (5) the philosophical limits of ethical (mental health) advocacy.

Our conceptually animated comments will then be applied to several case studies where questions of advocacy uniquely impact the lives of different psychiatric citizens. While our remarks in this section can only be construed as provisional, the findings will disclose just how ethically vexing the notion of forensic advocacy for persons with mental disorders is. We will conclude by assessing the implications of our philosophic and ethnographic exploration for purposes of mental health law, psychological humanism, and critical inquiry.

## II. "HUMAN" RIGHTS AND THE LAW

In order to examine systematically the relationship between law-psychology-justice and forensic advocacy, the more general connection between the function of law and individual rights must be delineated.<sup>33</sup>

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32. We are mindful of the violence research (e.g., the MacArthur Studies) documenting how persons with severe and untreated mental illness are more dangerous than members of the general population, especially when the mentally ill suffer from command hallucinations and co-occurring substance use disorders. John Monahan, *Violence Prediction: The Past Twenty Years and the Next Twenty Years*, 23 CRIM. JUST. & BEHAV. 107 (1996). Our thesis, however, addresses the general condition in which advocacy and rights-claiming for the mentally ill take place.

33. By "function of law" we refer to how the law behaves; that is, the patterns of judicial



In short, as citizens of a larger society we are *dependent* upon the law for the rights we possess as human beings. Law codifies and proclaims those rights that attach to us as individuals, given our status as citizens.<sup>34</sup> The use of the word "possess" is intentional. It implies something that is always temporary; that is, something that can be taken away.<sup>35</sup> Further, it implies the presence of some definable, delimited "object" that an individual currently enjoys as her or his own. The word "right" itself has come to mean something that is *given* (as in a gift)<sup>36</sup> and, consequently, something that can just as readily and easily be taken away.<sup>37</sup> Thus, a right is certainly not a free-

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decision-making, legal thought, or statutory construction that constitute a system of predictable behavior, yielding social control. See BLACK, *supra* note 23, at 2; DONALD BLACK, *SOCIOLOGICAL JUSTICE* 8 (1989).

34. See, e.g., MILOVANOVIC, *supra* note 19. Critical sociolegal commentators (e.g., deconstructionists, critical race theorists, postmodernists, constitutive integrationists) have been especially persuasive along these lines, demonstrating how words, whether spoken or written, make possible one's identity, agency, being, and humanity. For a deconstructionist analysis see J.M. Balkin, *Deconstructive Practices and Legal Theory*, 96 *YALE L.J.* 743 (1987); DRUCILLA CORNELL, *BEYOND ACCOMMODATION* (Rowman & Littlefield Publishers, Inc. 1999) (1991). For a critical race theory analysis see RICHARD DELGADO, *THE RODRIGO CHRONICLES* (1995). For a postmodernist analysis see JUDITH BUTLER, *EXCITABLE SPEECH* (1997); DRAGAN MILOVANOVIC, *POSTMODERN CRIMINOLOGY* (1997). For a constitutive integrationist analysis see STUART HENRY & DRAGAN MILOVANOVIC, *CONSTITUTIVE CRIMINOLOGY* (1996); *CONSTITUTIVE CRIMINOLOGY AT WORK* (Stuart Henry & Dragan Milovanovic eds., 1999).

35. The function of law is not principally to invest in rules and procedures; rather, to ensure "governmental social control." BLACK, *supra* note 23, at 2. Law, then, operates as a "quantitative variable." *Id.* at 3. In other words, as Milovanovic observes, "law is measured in terms of how much mobilization of social control takes place in a particular instance." MILOVANOVIC, *supra* note 19, at 20. Black measures this legal mobilization by "the number and scope of prohibitions, obligations, and other standards to which people are subject, and by the rate of legislation, litigation, and adjudication [that correspondingly occurs]." BLACK, *supra* note 23, at 3. Thus, one's possession of rights is temporary, depending on the quantifiable mobilization of the law and legal actions, procedures, and processes that ensue.

36. See, e.g., Bruce A. Arrigo & Christopher R. Williams, *The (Im)possibility of Democratic Justice and the 'Gift' of the Majority: On Derrida, Deconstruction, and the Search for Equality*, 16 *J. CONTEMP. CRIM. JUST.* 321, 323-26 (2000). The right to representation can also be understood as a gift assigned to persons unable to speak on their own behalf. For more on the philosophy of the gift see *THE LOGIC OF THE GIFT* (Alan D. Schrift ed., 1997). For an analysis of rights for individuals with psychiatric disorders see ROBERT M. LEVY & LEONARD S. RUBENSTEIN, *THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES* (1996). For an integration of the logic of the gift of rights and the psychology of advocacy see Williams & Arrigo, *supra* note 28.

37. This is a reference to Derrida's deconstructionist notion on the (im)possibility of the gift (as a right) and, by extension, the (im)possibility of advocacy for mental health systems users. According to Derrida, in order for a gift to occur it must not be caught in the logic of gift-exchange. That is to say, the economy of reciprocity, of reappropriation, un-does the gift *qua* gift. Therefore, the value of any gift (material or nonmaterial in nature) must not be derived from its status as an object of exchange, lest the unadulterated virtue of the award (i.e., right) be destroyed. See JACQUES DERRIDA, *GIVEN TIME* 12-15 (Peggy Kamuf, trans., 1992) (1991); JOHN D. CAPUTO, *DECONSTRUCTION IN A NUTSHELL* 18-19 (John D. Caputo ed., 1997).

dom: there is always a certain boundary imposed upon one's right; that is, a limit to one's freedom. In other words, one does not have the freedom to do what one pleases with her or his right. One's right is defined, as are its margins, by an exogenous, legally demarcated morality into which one has no direct input.<sup>38</sup>

In this sense, rights are something that we are given by the law. Without the law, one has no rights, *per se* or *a priori*. One must look to (i.e. rely upon) the law for the very rights that allow us to be human, to behave as human beings.<sup>39</sup> One may ask: "Do we not enjoy certain rights merely by being human; that is, by being alive in this world?" To answer this query, one need only ask: "Are there rights that cannot be taken away?"<sup>40</sup> The answer is clearly no. In other words, the extent to which our rights can be taken from us when, for example, we abuse or misuse them, is the degree to which they are always rights provided to us by the law.

The contours of this debate were extensively investigated by 18th century French Enlightenment thinkers, including Charles-Louis Montesquieu, Francois Voltaire, and Jean-Jacques Rousseau among others.<sup>41</sup> The Enlightenment thinkers were active in protesting the essential lack of rights that the majority enjoyed. They argued for

For applications to mental health advocacy see Williams & Arrigo, *supra* note 28.

38. Another way to state this is that the law "hails" or "interpellates" the subject. For a discussion of "interpellation" see LOUIS ALTHUSSER, *LENIN AND PHILOSOPHY AND OTHER ESSAYS* 170-86 (Ben Brewster trans., 1971). As Hunt observes:

law constitutes or participates in the constitution of a terrain or field within which social relations are generated, reproduced, disputed and struggled over, the most important implication being that within such a field . . . the legal discourses in play both place limits of possibility on social action and impose specific forms of discursive possibility.

HUNT, *supra* note 24, at 293.

39. See, e.g., MILOVANOVIC, *supra* note 19. The rights of the mentally ill are one case in point. Although this constituency enjoys the right to treatment, the right to treatment refusal, the right to counsel, etc., questions persist about how these rights attach and the instrumental role the law assumes in securing, sustaining, legitimizing, or taking away such protections. For further discussion, see Christopher R. Williams, *Inside the Outside and Outside the Inside: Negative Fusion from the Margins of Humanity*, 23 *HUMAN. & SOC'Y* 70 (1999); Bruce A. Arrigo & Christopher R. Williams, *Chaos Theory and the Social Control Thesis: A Post-Foucauldien Analysis of Mental Illness and Involuntary Civil Confinement*, 26 *SOC. JUST.* 177 (1999); Arrigo & Williams, *supra* note 36; Williams & Arrigo, *supra* note 28.

40. Even constitutional scholars debate "the erosion" of liberty rights, fearing that these rights exist, in certain contexts or under particular conditions, be eliminated altogether. See, e.g., DAVID M. O'BRIEN, *STORM CENTER* (3d ed. 1993); JEFFREY A. SEGAL & HAROLD J. SPAETH, *THE SUPREME COURT AND THE ATTITUDINAL MODEL* (1993).

41. MONTESQUIEU, *THE SPIRIT OF LAWS* (Anne M. Cohler, et al. eds. & trans., 1989) (1740); JEAN JACQUES ROUSSEAU, *THE SOCIAL CONTRACT AND DISCOURSES* (G.D.H. Cole trans., 1950) (1762); VOLTAIRE, *LETTERS ON ENGLAND* (Leonard Tancock trans., 1980) (1743); VOLTAIRE, *CANDIDE, ZADIG AND SELECTED STORIES* (Donald M. Frame trans., 1961) (1759).

“natural rights”; that is, rights that *all* human beings were entitled to simply by being human.<sup>42</sup> Thus, they advocated, among other things, for the abolition of slavery<sup>43</sup> and for more humane treatment of criminals and other “objectionable” persons.<sup>44</sup> These same “human rights,” as we have discussed, are the rights that often conflict with law. It is the law which, metaphorically speaking, “strips” individuals of their natural rights at birth, only to subsequently *give* rights back to individuals in the form of legislatively defined privileges and protections (i.e. “gifts”). As Rousseau suggested, these rights were mere frauds, instruments of the powerful established as a means of maintaining *their* chosen way of life by deception.<sup>45</sup> We will return to this point later when discussing the *parens patriae* and police powers of the state in relation to the mentally ill. For now, however, we conclude by stating this section’s thesis: human beings engage in a *parasitic* relationship with the law. Further, the law is that which gives and takes away rights; it is the edifice to which we must turn to ensure that our rights are protected and sustained.

### III. THE MENTALLY ILL, RIGHTS, AND THE LAW

The mentally ill, as one citizen group in contemporary society, find that they are in an even more precarious position than the general population. Not only are they, similar to all other human beings, living under the rights provided to them by the law, but they also constitute a membership group that has had many of their (given) rights taken from them.<sup>46</sup> Thus, not only must they look to the law to uphold their rights as human beings (i.e. human rights), they must contest the law to reestablish those rights (i.e., given rights) that are appropriated from them.<sup>47</sup> In this sense, then, the mentally ill become twice-removed from a state of true human existence. Of course, one of the key dilemmas in this situation is that many mentally ill persons are not regarded as competent enough to represent themselves.<sup>48</sup> In

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42. For example, see MONTESQUIEU, *supra* note 41, at 6-7.

43. ROSSEAU, *supra* note 41, at 7-12; MONTESQUIEU, *supra* note 41, at 246.

44. See MONTESQUIEU, *supra* note 41, at 89-93.

45. See ROUSSEAU, *supra* note 41, at 41.

46. See LEVY & RUBENSTEIN, *supra* note 36, at 1-8. See also *e.g.*, RAEL JEAN ISAAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS* (1990); JOHN Q. LAFOND & MARY L. DURHAM, *BACK TO THE ASYLUM* (1992); MICHAEL L. PERLIN, *MENTAL DISABILITY LAW* (1999).

47. See LEVY & RUBENSTEIN, *supra* note 36, at 7-8.

48. See Fernando J. Gutierrez, *Who Is Watching Big Brother When Big Brother Is Watching Mental Health Professionals: A Call for the Evaluation of Mental Health Advocacy Programs*, 20 *LAW & PSYCH. REV.* 57, 95 (1996).

cases such as these, advocates are appointed to help champion the causes of mentally ill persons, or even to fight for them.<sup>49</sup>

The unique position of persons with mental illness, however, is one that is historically contingent. Indeed, their position with regard to rights and the law has changed over time.<sup>50</sup> While many would agree that the status of psychiatric citizens in society (particularly their treatment and legitimacy as human beings) has substantially improved over the course of history, this "progress" has not been without its impediments.<sup>51</sup> Similar to Nietzsche, we must question our premature celebration of a Darwinian definition of progress and the devolution of humanity that often accompanies such growth.<sup>52</sup> Consistent with our discussion on the individual's parasitic relation with the law, the changes that have improved the lives of persons experiencing psychiatric illness have been at the hands of the clinicolegal establishment and not prompted by "progressive" social awareness.<sup>53</sup> Thus, while mental health systems users have attained certain rights they did not previously enjoy, their dependence on the law for these rights has remained.<sup>54</sup> What we have, then, is a positive correlation between the

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49. See *id.* at 73. Marianne R. Woodside & Robbie H. Legg, *Patient Advocacy: A Mental Health Prospective*, 12 J. MENTAL HEALTH COUNSELING 38 (1990). The use of the term "advocate" includes mental disability lawyers, psychiatric social workers and nurses, activist psychologists, and concerned family members of the disordered citizen. Depending on the individual case and the particular situation, each of these advocates assumes the role of representing the perspective of the mental health systems user. See, e.g., LEVY & RUBENSTEIN, *supra* note 36; Woodside & Legg, *supra* note 49; Gutierrez, *supra* note 48.

50. See LEVY & RUBENSTEIN, *supra* note 36, at 1-4. See also, e.g., Joseph P. Morrissey & Howard H. Goldman, *Cycles of Reform in the Care of the Chronically Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 785 (1984); Joseph P. Morrissey & Howard H. Goldman, *Care and Treatment of the Mentally Ill in the United States: Historical Developments and Reforms*, 484 ANNALS AM. ACAD. POL. SOC. SCI. 12 (1986); LAFOND & DURHAM, *supra* note 46.

51. See LEVY & RUBENSTEIN, *supra* note 36, at 6; MICHAEL L. PERLIN, LAW AND MENTAL DISABILITY § 1.01 (1994) reprinted in MICHAEL PERLIN, MENTAL DISABILITY LAW 3-8 (1999).

52. See FRIEDRICH NIETZSCHE, THE WILL TO POWER 361-65 (Walter Kaufman ed. & Walter Kaufman & R.J. Hollingdale trans., 1968) (1901).

53. See ARRIGO, PSYCHIATRIC JUSTICE, *supra* note 12, at 21-22. For example, consider the manner in which the value of "paternalism" anchored and continues to underscore mental health law dynamics in the wake of the deinstitutionalization movement. Some commentators have referred to legal and psychiatric investments in the lives of persons with mental disorders as nothing short of "illness politics." See generally Bruce A. Arrigo, *Paternalism, Civil Commitment, and Illness Politics: Assessing the Current Debate and Outlining a Future Direction*, 7 J.L. & HEALTH 131, 135 (1993). For a more polemical account on the sociology of mental illness, see generally, SZASZ, INSANITY, *supra* note 12. Others have traced the value of paternalism in clinicolegal decision-making from a law and social science perspective, citing examples of systematic abandonment, or from a critical sociological perspective, demonstrating where and how the medicolegal system historically sustains its own entrenched interests at the expense of psychiatric citizens. See Arrigo, *supra* note 53, at 157-62; Arrigo, *supra* note 4, at 16-20.

54. See ARRIGO, PSYCHIATRIC JUSTICE, *supra* note 12, at 22.

dependence of psychiatric citizens upon the law, and the enrichment of their lives (e.g., justiciable rights) as human beings. Again, this process makes sense only if we understand that such enrichment comes *through* or *by way of* the law.

Clearly, the reliance on the law for "rights claiming" by mentally ill persons has produced certain effects. For example, invoking the right to refuse treatment or to receive treatment represents a change in mental health law.<sup>55</sup> However, the assertion of each right requires one to approach the law.<sup>56</sup> That is to say, these are not rights that mental health systems users can simply "exercise" by act alone: they must find acceptance from the forces that constitute the law *before* acting. Typically, this entails an administrative hearing to determine whether the person is competently invoking her legally-sanctioned right.<sup>57</sup> Mentally "healthy" citizens have the power to act alone; that is, without direct permission from the law. It is assumed that psychologically well members of society are competent to make rational decisions regarding their actions and, thus, will often do so. Mentally "ill" persons, however, must seek permission from the legal apparatus to act.<sup>58</sup> Even then, they are often appointed a qualified overseer (i.e., an advocate) to champion their interests.<sup>59</sup>

Thus, in a sense, each time persons experiencing mental illness (or their representatives) engage the law, they strengthen and bolster their dependence on it and, further, become somewhat disempowered because of it. The law assumes more control over their lives and psychiatric consumers reinforce the preexisting medicolegal notion that they are incapable of advocating on their own behalf.<sup>60</sup> This, then, is the profound paradox mental health citizens confront: to endure without rights (as the law has taken them away), or seek rights from the law, which, in turn, fortifies the power of the law. As with most paradoxes, there is no simple solution. In fact, there may be no solution. Ethically speaking, however, what is important here is that we give adequate attention to the underlying, often hidden, consequences of

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55. See WINICK, *supra* note 10, at 362-64.

56. See *id.*

57. See generally JAMES A. HOLSTEIN, COURT-ORIENTED INSANITY (1993); CAROL A.B. WARREN, THE COURT OF LAST RESORT (1982).

58. See LEVY & RUBENSTEIN, *supra* note 36, at 284-321.

59. See *id.*

60. In critical criminological circles this process amounts to hegemony and reality construction. See MILOVANOVIC, *supra* note 19, at 149-50. The legitimacy of the clinicolegal system (and all of its ideological dimensions), becomes reified; that is, the medicolegal apparatus functions as the dominant arbiter of justice for the psychiatrically disordered through the unknowing consent of those who are governed by the very (confinement) system of which they are a part. See ARRIGO, MADNESS, *supra* note 12, at 137-40.

our actions and those of others—even when ostensibly acting in the best interest of subjugated and marginalized groups.

#### IV. THE ETHICS OF CONFINEMENT PRACTICES

When we speak of the rights of mental health citizens, we generally refer to those individuals who lost their rights (i.e., were involuntarily committed and subjected to the structural constraints of an institution). This loss of liberty is justified under two separate but inter-related mental health law doctrines: police power and *parens patriae* authority.<sup>61</sup> Each embodies underlying ethical assumptions that serve to rationalize the ensuing action or choice-making impacting the psychiatric citizen in question.<sup>62</sup> In Plato's *Republic*, the former of these "state interests" was alluded to in a discussion involving Socrates and Thrasymachus.<sup>63</sup>

*The Republic* begins with the concept of *dikaiosyne*, a term that embodies those conventions that one must respect in the interest of other people.<sup>64</sup> We can think of *dikaiosyne* as "morality." In other words, it is a term that signifies a certain morality that should be obeyed because the interests of others are at stake. Thrasymachus, however, claims that such "standards" in which moral conventions are embedded are in the interest of the powerful.<sup>65</sup> Morality, then, consists merely of rules imposed by the political powers that constitute a calculated attempt to preserve the advantage of the ruling class.<sup>66</sup> The rules can be manipulated by those creating them if their interest calls for it.<sup>67</sup> Thrasymachus's response exemplifies the present-day anti-theoretical concerns of the state regarding individuals with mental illness.

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61. LEVY & RUBENSTEIN, *supra* note 36, at 15. Manifestations of paternalism and *parens patriae* can be traced back to the colonial jurisprudential period of American history; some variations of these respective doctrines are visible today. For a thorough historical assessment of these overlapping and interdependent notions, see GERALD N. GROB, *MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875* (1973); GERALD N. GROB, *MENTAL ILLNESS AND AMERICAN SOCIETY 1875-1940* (1983); DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM* (1971); DAVID J. ROTHMAN, *CONSCIENCE AND CONVENIENCE* (1980); ANDREW SCULL, *SOCIAL ORDER/MENTAL DISORDER* (1989). For more of a legal history analysis see John E.B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367 (1983/1984); RALPH REISNER ET AL., *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* (3d ed. 1999).

62. See LEVY & RUBENSTEIN, *supra* note 36, at 16-17.

63. PLATO, *THE REPUBLIC OF PLATO* (A.D. Lindsay trans., 1957).

64. See generally PLATO, *THE REPUBLIC AND OTHER WORKS 19-40* (B. Jowett trans. 1973).

65. See PLATO, *supra* note 63, at 18, 25.

66. See *id.* at 8.

67. See *id.*

Thrasymachus argues that society's interests are thus not *his* interests.<sup>68</sup> In fact, *immorality* would be to one's advantage because the "just man always comes off worse than an unjust [man]."<sup>69</sup> In other words, the powerful (i.e., the unjust) gain advantage in every situation where the common person (i.e. the just) concedes to convention (conventions, of course, are codified in such a way as to be in the interests of the powerful).<sup>70</sup> Thus, the injustice that is suffered by the just man at the hands of the law will only encourage the continuance of the vicious cycle of injustice if one were to always obey.<sup>71</sup>

#### A. Taking Away the Human Rights of Persons with Mental Illness

In the context of our present concern, we can think of *dikaiosyne* as embodied in the law (i.e., in the law's treatment of the unique concerns of the mentally ill). We recognize that the law is informed by social notions of what is moral.<sup>72</sup> These conceptualizations of "good vs. bad" and "right vs. wrong" are, of course, based chiefly on Judeo-Christian teachings.<sup>73</sup> At some unspecified historical juncture, however, the law was no longer formed by morality; rather, morality was imposed upon society through the administration of the law.<sup>74</sup> Our conception of what one should or should not do increasingly refers to the edified morality that we have termed law. Again, this reference may be regarded as an "edifice complex"; that is, a tangled fixation on the law as an escape from the choices that confront us as human beings.<sup>75</sup>

With regard to confinement practices for persons with psychiatric disorders, the underlying concern is the best interest of the

68. See *id.*

69. *Id.* at 25.

70. See *id.*

71. See *id.*

72. See POLLOCK, *supra* note 30, at 81. For some detailed and targeted philosophical comments along these lines see John Stuart Mill, *Utilitarianism*, in UTILITARIANISM, LIBERTY, AND REPRESENTATIVE GOVERNMENT (E.P. Dutton & Co., Inc. 1951) (1863); IMMANUEL KANT, FOUNDATIONS OF THE METAPHYSICS OF MORALS WITH CRITICAL ESSAY (Robert Paul Wolf ed. & Lewis White Beck trans., 1969) (1785); JOHN RAWLS, A THEORY OF JUSTICE (1971).

73. See POLLOCK, *supra* note 30, at 14-18. It is often difficult to discern how ethics and morals are distinct, though overlapping, concepts. Generally speaking, however, morality refers to conduct that is judged as good or not good (i.e., moral or immoral), and ethics refers to the assessment of what is defined as good or bad conduct. *Id.* at 4; VINCENT BARRY, APPLYING ETHICS: A TEXT WITH READINGS 5 (2d ed. 1985). These distinctions can be traced to religious (and philosophical) convictions about human behavior. See, e.g., KANT, *supra* note 72; Mill, *supra* note 72. For a recent analysis of how such terms apply to the study of crime and justice issues, see POLLOCK, *supra* note 30.

74. See POLLOCK, *supra* note 30, at 5-8.

75. See MAY, *supra* note 16, at 52.

community versus the best interest of the individual.<sup>76</sup> By Thrasymachus's own assertion—and we have no reason to believe that it is not, to some degree, present in contemporary society—we must regard “community interest” as being defined by those *re-presenting* the community's concerns.<sup>77</sup> Community standards, then, under the facade of the “convention” of morality, can be manipulated by way of the law.<sup>78</sup> That is to say, those mentally healthy individuals looking out for their own interests and fitting the nonmentally healthy (i.e., ill) into a social framework relegitimize their own status while subjecting citizens with psychiatric disorders to a marginalized and often criminalized existence.<sup>79</sup>

This social framework, however, often (historically) implies a concern for the interests of the community at the expense of the interests of psychiatric citizens.<sup>80</sup> To be sure, the celebrated perspective that regards persons with mental illness as “dangerous,” “undesirable,” “deviant,” “monstrous,” “diseased,” “demonic,” etc., would naturally incline the community to establish as their particularized interest the containment and control of those persons identified as outsiders.<sup>81</sup> That is to say, community interests in this context have traditionally been concerned with keeping the mentally ill *away from* the mentally healthy.<sup>82</sup> Frequently, these community interests have been motivated by fear and ignorance.<sup>83</sup> Society's persistent perception of mental health citizens as dangerous has encouraged the state to implement police power clauses that allow for the involuntary confinement of psychiatric consumers: persons thought to be a danger to the

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76. Arrigo, *supra* note 53, at 132.

77. See PLATO, *supra* note 63, at 45.

78. See *id.*

79. See H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483, 485 (1998). This marginalizing framework *conceives and produces* the “mentally ill offender.” In other words, the manner in which legal and psychiatric agents think about, know, and describe psychiatric consumers is *already* encoded with a marginalizing and alienating logic, rendering such citizens deviant-minded, disease-prone, and dangerous-oriented “outsiders.” See Bruce A. Arrigo, *The Logic of Identity and the Politics of Justice: Establishing a Right to Community Based Treatment for the Institutionalized Mentally Disabled*, 18 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 1, 23-28 (1992) [hereinafter Arrigo, *Logic of Identity*]. For a more philosophically animated investigation of how mental health systems users are criminalized, relying on relevant ethnographic data see Bruce A. Arrigo, *Transcarceration: A Constitutive Ethnography of Mentally Ill Offenders*, 85 PRISON J. (forthcoming 2001) [hereinafter Arrigo, *Transcarceration*].

80. See Arrigo, *Logic of Identity*, *supra* note 79, at 12.

81. See Williams, *supra* note 39.

82. See Arrigo, *Logic of Identity*, *supra* note 79, at 11-12.

83. See *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1200 (1974).



community.<sup>84</sup> The reality for the community, however, is that, in general, persons experiencing psychiatric disorders are *no more* dangerous than the healthy and competent members of the community.<sup>85</sup> Indeed, it may be said that the supposed "rational" decisions of the mentally healthy can be far more irrational, injurious, and, thus, dangerous, than the choices made by their presumably ill and incompetent counterparts.<sup>86</sup> As Thrasymachus professed, the "just" are often led to suffer injustices by conforming to the codified form of "justice" engendered by the political.<sup>87</sup>

A similar injustice to the mentally ill is enacted by the *parens patriae* power of the state. While such power is afforded the state on the assumption that involuntary confinement is, at times, in the best interest of the individual,<sup>88</sup> undoubtedly there is a historical element of morality attached to it.<sup>89</sup> Many of those involuntarily confined "for their own benefit" are persons whose chosen standard of living differs markedly from that of the community. Indeed, these are persons whose existential *choices* are vastly inconsistent with traditionally held ways of being, for example, the homeless mentally ill population.<sup>90</sup> The literature concerning *parens patriae* provides ample evidence of the confinement of individuals whose only "crime" was difference.<sup>91</sup> Again, we must ask ourselves: Does the best interest of the individual truly receive suitable consideration, or does the interest of the community (i.e. those maintaining a position of political power) receive inordinate attention?

We submit that in both cases (the state's police power and *parens patriae* authority), *dikaiosyne* exists as law imposed upon members of the community, and, under present conditions, is not necessarily in the interest of all people. Embedded within our moral standards of community decency and appropriate behavior are those biases that

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84. See *id.* at 1223.

85. See TREATMENT OF OFFENDERS WITH MENTAL DISORDERS 3 (Robert M. Wettstein ed., 1998).

86. See LAFOND & DURHAM, *supra* note 46, at 46-57.

87. See PLATO, *supra* note 63, at 25.

88. *Developments in the Law—Civil Commitment of the Mentally Ill*, *supra* note 83, at 1209-10.

89. THOMAS SZASZ, M.D., THE MYTH OF MENTAL ILLNESS 175-76 (revised ed. 1974).

90. See, e.g., H. Richard Lamb, M.D., *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899, 900-01 (1984).

91. See, e.g., NICHOLAS N. KITTRIE, THE RIGHT TO BE DIFFERENT (1971); SCULL, *supra* note 61; THOMAS SZASZ, PSYCHIATRIC SLAVERY (1977); Christopher R. Williams, *The Abrogation of Subjectivity in the Psychiatric Courtroom: Toward a Psychoanalytic Semiotic Analysis*, 11 INT'L J. FOR SEMIOTICS L. (1998); Williams, *supra* note 39; ARRIGO, PSYCHIATRIC JUSTICE, *supra* note 12.

favor majoritarian standards of living and pro-social conduct.<sup>92</sup> By subjecting mental health consumers to involuntary confinement in the interest of the state (i.e., protection against harm to others) or in the interest of the disordered person (i.e., protection against harm to self), we maintain that such citizens are subjected to ethical standards constructed upon unjust foundations. They are unjust, of course, in the sense that they do not represent a respect for the interests of all people, but merely demand a respect for the interests of majoritarian rule. Thrasymachus, then, would stipulate that morals delimiting practices for involuntary confinement are not necessarily in the interest of persons with mental illness; rather, they benefit the state and the community. In this context, we recognize that the community's interests are esteemed only insofar as codified law (i.e., a political prescription) articulates a set of moral standards for the community and provides the illusion or misrepresentation of dangerousness regarding the conduct of the psychiatric consumer.

### B. Giving the 'Gift' of Rights to Persons with Mental Illness

As noted previously, individuals experiencing mental illness are in a unique position in contemporary society. Having lost their human *and* legal rights, they all too often exist as "prisoners" within a confinement setting.<sup>93</sup> Further, having been civilly and/or criminally committed against their will, they experience a pervasive struggle with institutional personnel to enjoy certain rights while detained.<sup>94</sup> At the historical origin of the asylum, the mentally ill were not only stripped of the right to exist in society, but also the right to exist within the institution that housed or, perhaps, warehoused them.<sup>95</sup> Of course, agents acting on behalf of citizens with mental illness have succeeded in establishing a panoply of rights *provided to* individuals within confinement settings.<sup>96</sup> While many advocates of psychiatrically disordered persons have been generally pleased with these developments, we contend there are certain ethical assumptions frequently neglected or overlooked when evaluating this progress.

We return to the notion of *dikaiosyne* for guidance. This time, however, we examine this idea in the context of rights *given back* to those whose rights have been appropriated. This process refers to

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92. See generally IRIS MARION YOUNG, *JUSTICE AND THE POLITICS OF DIFFERENCE* (1990).

93. See ENNIS, *supra* note 12, at 3-4.

94. See *Developments in the Law—Civil Commitment of the Mentally Ill*, *supra* note 83, at 1193-97.

95. See *id.*

96. See generally PERLIN, *supra* note 51.

morality that is established by the law, enacting and endorsing the liberty interests (rights) of persons with mental illness. Once again, we must question whether these afforded rights are in the best interest of such mentally ill citizens. Given Thrasymachus's perspective on *dikaiosyne*, we must look within these established rights to what may be hidden underneath their explicit meaning. In other words, are the liberty interests made available to individuals with mental disorders tainted by the concerns of those from whom the rights originate? At first glance, we assume that these rights represent the prerogatives of psychiatric citizens. This is not to suggest that mental health consumers do not *want* these rights; rather, we question whether the bestowal of these legitimated rights truly reflects the unique interests of those to whom they are given.

Thus, we can pose the question as follows: Do we (i.e., the community) want what mental health systems users want, or do we want what *we want for them*? We will return to this matter in the context of mental health advocacy. For now, however, we respect the possibility that the changes that are made in the way of rights for the involuntarily committed mentally ill are often informed by those granting such rights. For example, would the law truly provide rights for persons with psychiatric disorders if it were not in the interest of the law or community that it represented? At the very least, the law is unlikely to give something to someone or some group that disturbs or challenges its comfortable existence, its conventional way of being.<sup>97</sup> Thus, confronted with the Court's inevitable interest balancing model of weighing conflicting or competing constitutional rights, the question asked is not whether certain liberty safeguards are in the best interest of individuals experiencing mental illness; rather, the question posed is how will such protections, if bestowed upon persons with psychiatric disorders, endanger the community's rights as expressed through the law? In other words, what can the (clinciolegal) system afford to *give* them?

Machiavelli recognized the fact that certain things provided to others can endanger or, at least, alter one's own existence.<sup>98</sup> Accordingly, he presented an alternative that may be applicable to our

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97. See Arrigo & Williams, *supra* note 36, at 323-25. For a critical legal and criminological analysis of this position exploring the historical dynamics of paternalism in the civil commitment of the mentally ill, see Arrigo, *supra* note 4, at 7. Throughout the practice of confining persons with mental health disabilities in the United States, system-endorsing values have been at the heart of reform (salvation informed the moral treatment movement, science informed the mental hygiene movement, normalization informed the deinstitutionalization movement). See *id.* at 10-16.

98. See NICCOLO MACHIAVELLI, *THE PRINCE* 21 (Harvey C. Mansfield, Jr. trans., 1985) (1513).

present concern. Machiavelli echoed the sentiments of Adeimantus, another of Socrates' interlocutors in *The Republic*. Socrates' reply to Thrasymachus's announcement that happiness is best achieved through immorality involves a formulation of *kinds of good*.<sup>99</sup> The second kind of good that Socrates describes is contingent upon the consequences of one's actions.<sup>100</sup> In other words, actions are good (i.e. moral) if the effects of those actions are beneficial. Adeimantus, in turn, professes that indeed actions are commendable for their beneficial consequences, but such commendation derives also from effects that *appear* to be beneficial.<sup>101</sup> Thus, actions that are celebrated as moral and good for their beneficial consequences need only have effects that are *perceived* as beneficial.<sup>102</sup> Machiavelli, of course, repeats this sentiment in asserting that the Prince need not possess superior qualities that encourage respect, he need only *appear* to personify such admirable qualities.<sup>103</sup>

With regard to rights *re-presented* to persons with mental illness, we previously noted that such "gifts" were generally not given if the giver stood to lose something in the transaction. One possible way to circumvent this danger would be to *appear* to give gifts (i.e. rights) that benefit psychiatric citizens when, in reality, the rights merely embody the appearance of benefit. In this case, nothing real is lost by the giver, yet nothing real is gained by the receiver. A genuine facade is established. What ensues, in fact, is that the position of neither party in the transaction is substantially altered, yet the public (society) assumes that such beneficial change has occurred because it has been presented to them in that way.

Thus, providing rights to mental health systems users by way of gift-giving (i.e., endorsing rights claims) ensures the appearance of morality (and justice). This is an altered morality that would not have been necessary had persons with mental illness not been exposed to the injustices and immoralities of the past (i.e., the loss of human and legal rights). Consider, for example, the homeless mentally ill population. What is introduced into society is the notion that the consequences of involuntarily confining such persons are beneficial. That is to say, the person whose chosen standard of living is not necessarily compatible with society's will certainly benefit from forced confinement: the individual will be de-pathologized, made functionally well,

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99. See PLATO, *supra* note 63, at 43.

100. See *id.*

101. See *id.* at 55-56.

102. See *id.* at 56.

103. MACHIAVELLI, *supra* note 98, at 70.

and corrected.<sup>104</sup> Again, what is important here is that such an assertion is merely an appearance. It is a dramaturgical facade,<sup>105</sup> repeatedly staged to reassure society that everything is being done to improve the lives of deviant and diseased people when, in reality, such lives may not need alteration at all.<sup>106</sup> If a lesson is to be learned from Adeimantus and Machiavelli, it is that we must be wary of appearances: they are often deceiving.

### C. A Note on 'Intention'

An additional perspective we must consider before moving to the ethics of advocacy itself comes from Immanuel Kant. In *Foundations on the Metaphysics of Morality*,<sup>107</sup> Kant puts forth a decidedly nonconsequentialistic rebuttal to Socrates' "good contingent upon consequences" thesis. He establishes the concept of "good will" as the basis of morality.<sup>108</sup> "Nothing in the world . . . can possibly be conceived which could be called good without qualification except a *good will*."<sup>109</sup> When considering the morality of actions, we need not concern ourselves with the *actual* consequences of such actions.<sup>110</sup> These are unforeseeable and often uncontrollable.<sup>111</sup> Rather, what is important is the *intended* consequence or the motive of the action.<sup>112</sup> If the intention that gives way to an action is immoral, then the act is categorically immoral—regardless of its consequences and who and how many may benefit from it.<sup>113</sup>

To amplify this point, recall our discussion of rights given to persons with mental illness. If those bestowing such rights act fundamentally or exclusively in their own best interest, then the act of giv-

104. Arrigo & Williams, *supra* note 39, at 200.

105. See generally ERVING GOFFMAN, *ASYLUMS* (1961).

106. For example, see ARRIGO, *PSYCHIATRIC JUSTICE*, *supra* note 12, at 104-15. Our position is not a full-fledged endorsement of homelessness for persons identified as psychiatrically disordered. Rather, we are questioning the ethico-philosophical conditions that give rise to confining such citizens and the particular interests that are advanced in the process.

107. KANT, *supra* note 72.

108. See *id.*

109. *Id.* at 11.

110. *Id.* at 20-21.

111. See *id.*

112. See *id.*

113. See *id.* This distinction between act and intent has been examined considerably in philosophical circles. The former (i.e., the act), is understood to be *teleological* because it focuses on the consequence and purpose of the act. See Nancy Ann Davis, *Contemporary Deontology*, in *A COMPANION TO ETHICS* 205, 206 (Peter Singer ed., 1993). The latter (i.e., the intent) is understood to be *deontological* because the focus is on the relative "goodness" of the behavior in all contexts. *Id.* at 206-07. Classic statements along these lines are found in Mill's utilitarianism (teleological) and Kant's ethical absolutism (deontological). For more on these matters see Mill, *supra* note 72; KANT, *supra* note 72.

ing is immoral for Kant.<sup>114</sup> Such an act would be without reference to one's "duty" as a human being; that is, the moral duty concerning the "oughts" that are *a priori* universals.<sup>115</sup> For Kant, the "good will" acts according to the moral law and not the law of the legal system.<sup>116</sup> If, as we proposed, the intention of the giver was to deceive society and psychiatric citizens into believing, through appearance, that they were the receivers of some good, the gift of rights would not be given for moral reasons. Even if mental health systems users were to benefit from such a gift, the intention behind the act of giving would render the act immoral.

Thus, Kant extends our ethical exploration of mental illness and the rights afforded to those so designated beyond the act of giving *per se*, and beyond the consequences of an action. The issue of intention becomes a decisive factor in the morality of giving and taking. We contend that intention, along with *dikaiosyne*, consequences, and appearances, underscores ethical considerations like those we have thus far presented. With regard to the confinement of persons with mental illness (i.e. taking rights away) and the bestowal of the gift of rights (i.e. giving rights back), we note the importance of questioning the underlying ethical motivations for our decisions and the decisions of others. As we subsequently demonstrate, these ethical issues become even more complex if we consider individual actions, including those of the mental health advocate.

## V. THE ETHICS OF MENTAL HEALTH ADVOCACY

As Lacan observed, "one feels good in the Good" (*Man fühlt sich wohl im Guten*).<sup>117</sup> In other words, happiness is achieved in the long term by accomplishing good (well-being of self or others) that represents an index of the Good.<sup>118</sup> For Aristotle, every human pursuit is one that aims at *some* good.<sup>119</sup> If Aristotle is correct, then we all adopt and pursue projects that will produce "good" (for Aristotle, this was measured by the pleasure that was produced by such goods<sup>120</sup>), either for ourselves or for others. Pursuing good for ourselves *or* for others lends itself to ethical treatment in the sense that we question whether, in fact, it is possible to *ever* act solely for the good of another. This is

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114. See generally KANT, *supra* note 72.

115. *Id.*

116. *Id.*

117. PHILLIPE JULIEN, JACQUES LACAN'S RETURN TO FREUD 84 (Devra Beck Simiu trans., 1994) (quoting JACQUES LACAN, *ECRITS* 404 (1966)).

118. See *id.* at 84, 86.

119. See ARISTOTLE, *THE NICOMACHEAN ETHICS* 25 (H. Rackham, trans., 1956).

120. *Id.* at 23.

historically captured by the philosophical debate concerning egoism and altruism.

Returning again to Plato's *Republic*, there is an ongoing assumption that is shared by both Socrates and Thrasymachus.<sup>121</sup> Throughout most of the *Republic*, the two espouse opposing ethical viewpoints; however, their convictions concerning individual interest related to individual action are somewhat harmonious. Though this is only implicit in the oration of Socrates, each seems to recognize that individuals would not act against their own interests (unless they are ignorant as to what is in their best interest).<sup>122</sup> In other words, individuals act in accordance with the interests of the self. This is the principal assertion of egoism's two forms: people are always motivated by self-interest (psychological egoism),<sup>123</sup> and people ought to be motivated by self-interest (ethical egoism).<sup>124</sup>

The polar opposite of egoism is altruism. Altruistic actions are those in which one appears to sacrifice the interests of oneself in order to achieve some good or benefit for another. If one adopts the egoistic perspective on humanity, altruism is not possible—one would never act against one's own interest.<sup>125</sup> Thus, following egoism, even an act that provides the *appearance* of altruism is, in fact, in some way beneficial to the individual performing the act.<sup>126</sup> In this sense, sacrificing one's interests in the name of another's is only conceivable if one considers the act of sacrifice to be in one's own interest. Thus, the sacrificial "good" is always already intertwined with self-motivations.

Given these observations on egoism and altruism, what is the role of the advocate? When one thinks of advocacy, one is immediately drawn to the interpretation that an advocate acts for the good of the client.<sup>127</sup> In light of the egoist claim that one never acts beyond one's self-interest, we must question the *intention* of the advocacy act. Does the mental health proponent stand to gain from her or his actions? Or, as the advocate would state, does the client's interest outweigh whatever self-motivation the advocate may wish to accommodate? In light of these issues, we turn, briefly, to several insights found in psychoanalytic thought. Psychoanalytic thought serves to advance our understanding of both the origins of altruism and its very possibility in forensic practice.

121. See generally PLATO, *supra* note 63.

122. See *id.* at 53.

123. JAMES RACHELS, THE ELEMENTS OF MORAL PHILOSOPHY 53 (1986).

124. *Id.* at 67.

125. See *id.* at 53.

126. See *id.*

127. See generally Woodside & Legg, *supra* note 49; Gutierrez, *supra* note 48.

### A. *The Psychic Origin of Individual Altruism*

Any act of altruism, be it pure or motivated by underlying self-interest, has its origin in some element of the actor's psyche.<sup>128</sup> That is to say, behaving in an altruistic manner because it is consistent with the aims of one's society is not sufficient to explain such actions.<sup>129</sup> There is always an intrapsychic component in such motives or, perhaps, needs.<sup>130</sup> Otherwise, where might this *desire* for action agreeable with the altruistic doctrine originate?

In order to adequately assess the source of altruism and its relation to mental health advocacy, we must briefly consider the infant's psyche. What is important here is the relationship of the newborn child to the primary caregiver (typically the mother). We must remember that the first satisfying object in the world for the infant is an object that is similar to the child.<sup>131</sup> The infant's sole means of gratification and well-being is the object of the caregiver.<sup>132</sup> Thus, the newborn child first learns to know, perceive, and recognize the outer world through an object that is similar to him or herself (i.e. another human being).<sup>133</sup> As a result, there is a profound realization that the object upon which the infant is utterly dependent is another human being.<sup>134</sup> The infant must develop a successful relationship with this other for gratification—indeed for life itself.<sup>135</sup> Of course, the newborn is also aware that the other can deprive the child of gratification.<sup>136</sup> Generally speaking, then, it is during the first years of the child's life that the infant discerns the gravity of other human beings and the need to identify with them as objects to benefit the self.<sup>137</sup>

The primacy of the newborn's relationship to the other is mostly unconscious over the course of its psychological development.<sup>138</sup> The significance, however, remains. What assumes primary importance in subsequent years, though, is the role of memory.<sup>139</sup> As Freud noted, ". . . if the object screams, a memory of the subject's own screaming will be aroused and will consequently revive [one's] experiences of

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128. Williams & Arrigo, *supra* note 28, at 231.

129. *See id.* at 231-37.

130. *See id.* at 237-40.

131. SIGMUND FREUD, THE ORIGINS OF PSYCHO-ANALYSIS 393 (Marie Bonaparte et al. eds., Eric Mosbacher & James Strachey trans., 1954).

132. *See id.*

133. *See id.*

134. *See id.* at 393-94.

135. *See* Williams & Arrigo, *supra* note 28, at 232.

136. *See id.*

137. *See* FREUD, *supra* note 131, at 393-94.

138. *See id.*

139. *See id.*



pain."<sup>140</sup> Thus, the initial relationship that develops between the infant and her or his "similar object" fosters a relationship shared among all human beings in which experiences of the other (often unconsciously) invoke memories of comparable events in one's own life.<sup>141</sup> For example, when we observe another person suffering we feel her or his pain *as another human being*. Through the repository of memory we store our own experiences of suffering and respond to the pain of others accordingly.

Thus, following Freud, human beings are identified in two ways by the individual psyche: as an "other"—a separate non-self that exists in the same world—and as a memory or part of the self.<sup>142</sup> As a result, when we experience other human beings, we experience them both as *separate* from ourselves and as *part of* ourselves.<sup>143</sup> Given these comments on the psychic origin of individual altruism and the psychoanalytic duality of our human existence, what, then, are the implications of these observations for purposes of mental health advocacy? To examine this question more closely, we must address the ethic of "love thy neighbor."<sup>144</sup>

### B. Love Thy Neighbor (As Thyself)

It is a common conviction that morality has been, and is still, immersed in various philosophical doctrines.<sup>145</sup> While this notion has some merit, we must understand that Christian dogma is itself relatively new. Further, the notion of altruism has no systematic conceptual place in the writings of the ancient Greeks such as Plato. The historical origin of altruism is often linked with Jesus the Nazarene, who taught his followers: "love thy neighbor."<sup>146</sup> This connection, however, is a misperception. What is often overlooked or, perhaps, neglected in this precept is the remainder of the statement; that is, "love thy neighbor *as thyself*."<sup>147</sup> When the phrase "as thyself" is rightfully appended to the maxim, it assumes something of an egoistic character. In other words, "as thyself" draws attention to the self in the exchange of love. Loving one's neighbor, then, arguably implies that the self is more important than the other. We should love our

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140. *Id.* at 393.

141. *See id.*

142. *See id.* at 393-94.

143. *See id.*

144. *Galatians* 5:14 (Young's Literal Translation).

145. See the previous sections in which some connections were tentatively drawn between the philosophy of utilitarianism and morality, as well as ethical absolutism and morality.

146. *Galatians*, *supra* note 144.

147. *Id.*

neighbors, but only insofar as we love ourselves. Again, we are led to Hobbes' conclusion that altruism is an impossibility. It can never occur purely outside the interest of the self.<sup>148</sup>

An important dimension of this Article's discussion is whether it is even possible to want the good of the other (i.e., *velle bonum alicui*<sup>149</sup>), in regard to advocacy in law for persons with mental illness. Based upon our cursory analysis of individual altruism, its psychoanalytic origins, and the dualistic nature of our humanity, we must ponder the costs and benefits of this "good." In other words, does the mental health proponent want the good of the other *for the other . . .* or *for himself*? This question is of considerable import when contemplating the justice (and morality) of advocacy. Indeed, the "good" advocate (referring here both to clinicolegal skill as well as personal ethic) is always interested in the good of the client.<sup>150</sup> The philosophy behind advocacy itself is to improve the existence of psychiatric citizens by brokering and promoting certain qualitative changes (e.g., improved autonomy, self-determination, social standing) in their lives.<sup>151</sup> Thus, the advocate is a representative because he or she wants the good of the other.

It follows, then, that the revised concern in the altruistic notion of love thy neighbor is both *my* good *and* the good of the other. The interplay of love thy neighbor and *velle bonum alicui* produces certain revelations in our ethical treatment of advocacy. The "good" (*bonum*) is often that which I desire for myself and, consequently and by way of myself, desire for the other.<sup>152</sup> If, as Freud informs us, I see the other in myself (i.e., I feel the other in myself), then I must also see and feel myself in the other.<sup>153</sup> Thus, what I wish for the other is what I wish

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148. Indeed, Hobbes' caustic comments along these lines are worth noting. As Rachels explains:

The charitable [altruistic] man is demonstrating to himself, and to the world, that he is more capable than others. He can not only take care of himself, he has enough left over for others who are not so able as he. He is really just showing off his own superiority.

RACHELS, *supra* note 123, at 55 (interpreting Hobbes' description of charity: "There can be no greater argument to a man, of his own power, than to find himself able not only to accomplish his own desires, but also to assist other men in theirs: and this is that conception where in consistent with *charity*." 4 THOMAS HOBBS, *THE ENGLISH WORKS OF THOMAS HOBBS* (William Molesworth ed., 1845)). For a more detailed and philosophically animated assessment of Hobbes in relation to mental health advocacy, see Williams & Arrigo, *supra* note 28.

149. JULIEN, *supra* note 117, at 86.

150. See Williams & Arrigo, *supra* note 28, at 238-39.

151. See JULIEN, *supra* note 117, at 86. See also generally LEVY & RUBENSTEIN, *supra* note 36.

152. See JULIEN, *supra* note 117, at 86.

153. See *id.*

for myself and what I wish for myself is what I wish for the other.<sup>154</sup> The good of the other "is made in the image of mine."<sup>155</sup>

We must be mindful, then, of the negative therapeutic reaction that Freud discusses.<sup>156</sup> That is to say, we must be wary of desiring and acting (advocating) for the good of the other when the other, perhaps, does not even want this good (i.e., this good does not necessarily belong to the other).<sup>157</sup> The other's well-being is, at best, a mere reflection of our own sense of what is good, captured, albeit incompletely and falsely, in our advocacy for the other.<sup>158</sup> It is all too natural for human beings to move beyond empathy—to actually "see" and "feel" the self in the other and the other in the self. Given this, is it possible, in situations where the *bonum* of the other is of *prima sollicitudo*, to extricate the image of oneself from the other, and advocate for the other as solely other?

In psychoanalytic circles, similar concerns arise in the context of the clinician maintaining the posture of a "reflective mirror." Psychoanalytic theory, in particular ego psychology, recognizes the impossibility of the emotionless, reflective therapist.<sup>159</sup> Issues of counter-transference<sup>160</sup> (in addition to the unconscious ethical dynamic we have discussed) create significant impediments to the therapeutic process.<sup>161</sup> What is unconscious here becomes critical, as the process of "seeing" and "feeling" oneself in the other is largely latent and subliminal. Thus, the answer to our question concerning the possibility of extricating oneself from the other's image is resoundingly answered

154. *Id.*

155. *Id.*

156. See Williams & Arrigo, *supra* note 28, at 234-35.

157. JULIEN, *supra* note 117, at 86.

158. *Id.* at 86-87. There is a sense in which this advocacy approximates a Marxian brand of false consciousness. In short, "[p]eople accept the status quo out of lack of awareness that viable alternatives exist and out of ignorance as to how their rulers are violating their professed interests or out of ignorance of how they themselves are being harmed by what they think are their interests." MICHAEL PARENTI, *DIRTY TRUTHS* 210-11 (1996). Cohen describes this as "fabrications of justice," which are "false beliefs held by those disadvantaged by an injustice that they are intentionally led to hold by those benefiting by the injustice." Ronald L. Cohen, *Fabrications of Justice*, 3 SOC. JUST. RES. 53 (1989). False consciousness returns us to the hegemonic and reified legitimacy of the clinicolegal system alluded to earlier. For law-psychology applications of this phenomenon see, Dennis R. Fox, *Psycholegal Scholarship's Contribution to False Consciousness About Injustice*, 23 LAW & HUM. BEHAV. 9 (1999); Craig Haney, *The Fourteenth Amendment and Symbolic Legality: Let Them Eat Due Process*, 15 LAW & HUM. BEHAV. 183 (1991); John T. Jost, *Negative Illusions: Conceptual Clarification and Psychological Evidence Concerning False Consciousness*, 16 POL. PSYCHOL. 394 (1995).

159. See GERTRUDE BLANK & RUBIN BLANK, *EGO PSYCHOLOGY: THEORY & PRACTICE* 14-15 (1974).

160. Counter-transference is defined as the "unconscious excessive libidinal or aggressive feelings toward the patient, of which the therapist is unaware." *Id.* at 12.

161. *Id.*

in the negative (particularly if one were not aware of such unconscious dynamics). Perhaps the answer is and always will be "no." And, much like the recommendations of ego psychologists on this matter, one can only hope to be *aware* of such forces and their consequent impact on personal ethics and the advocacy process.<sup>162</sup>

Turning briefly to the egoist conception of act and self-interest in light of *velle* helps elucidate this matter. As Julien contends, the implications of *velle* are as follows: "I want it to be *me* and no one else who accomplishes your good."<sup>163</sup> In the case of some disparity between what the other wants and what I want for the other, a critical choice arises.<sup>164</sup> That is to say, does the advocate proceed with a *measured* altruism or, instead, does the advocate retain the self-interest that accompanies egoistic action and *impose* her or himself on the other?<sup>165</sup> The latter intervention is contained in such statements as, "You will have to acquiesce in light of my *velle*!" In this case, the well-being of the other is made to depend on the efficacy of the advocate. Thus, there is a denial of subjectivity—the client's desire is subjugated in favor of the advocate's (expert) knowledge/experience of what is in the mental health consumer's best interest.<sup>166</sup> Of course, as we discovered with *bonum*, this knowledge that one supposes often reflects an understanding of oneself (that is, to the extent that self-knowledge is possible). In either case (i.e., altruism or egoism), it would appear that the advocate must consciously assess the motives behind her or his actions. In light of the problems thus far explored with regard to mental health advocacy, our only answer may consist of this process of assessment, awareness, and deliberation.

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162. See HOWARD A. BACAL & KENNETH M. NEWMAN, THEORIES OF OBJECT RELATIONS: BRIDGES TO SELF PSYCHOLOGY 262-63 (1990); BLANCK & BLANCK, *supra* note 159. HEINZ KOHUT, THE ANALYSIS OF THE SELF: A SYSTEMATIC APPROACH TO THE PSYCHOANALYTIC TREATMENT OF NARCISSISTIC PERSONALITY DISORDERS 294-95 (The Monograph Series of the Psychoanalytic Study of the Child, Monograph No. 4, 10th prtg. 1989).

163. JULIEN, *supra* note 117, at 86.

164. *See id.*

165. *See id.*

166. See Bruce A. Arrigo, *The Logic of Identity and the Politics of Justice: Establishing a Right to Community-Based Treatment for the Institutionalized Mentally Disabled*, 18 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 1, 11 (1992). In mental health law circles, this decision-making is often referred to as "substituted judgement." Questions concerning the efficacy of such practices center around whether it is *ever* possible to make choices that the psychiatrically disordered person would make if the individual were competent to make them. For a brief, though accessible, review of this concept in the civil confinement context, *see id.* at 10-12. For a critical criminological assessment of this phenomenon in the criminal confinement context, see Bruce A. Arrigo, Ph.D. & Christopher R. Williams, *Law, Ideology and Critical Inquiry: The Case of Treatment Refusal for Incompetent Prisoners Awaiting Execution*, 25 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 367, 403-05 (1999).

## VI. THE PHILOSOPHICAL LIMITS OF ETHICAL (MENTAL HEALTH) ADVOCACY

We have very provisionally and critically traversed several philosophical boundaries within which ethical decisions concerning mental illness, rights, and advocacy take place. However, there are other ethical themes that fall within the scope of our investigation. While it is not our intention to canvass all of the intricacies related to this topic, there are, nevertheless, some additional matters that require cursory explication. These matters include the elitism and competence of the advocate, as well as the ethic of "ultimate ends" versus "responsibility." We contend that these issues are quite significant for the nature of mental health law and advocacy, citizen justice, and the future of humanism in the psycholegal field. Indeed, the attitude and posture of the psychiatric consumer's representative, in addition to the ethic of "ultimate ends" versus "responsibility," set important limits to the manner in which mental health advocacy unfolds.

### A. *The Advocate: Elitism and Competence*

In response to Jeremy Bentham's "calculus of felicity," John Stuart Mill introduced the notion of *quality* into the conceptualization of "good."<sup>167</sup> Bentham claimed that as all human beings pursue the pleasure principle, such pleasure could be measured quantitatively against un-pleasure, or pain.<sup>168</sup> When considering the behavior of an individual, the pleasure or pain that such action produces can be measured against other alternatives.<sup>169</sup> Thus, the "calculus of felicity" determines what action is good based on the good it produces.<sup>170</sup> What Bentham contributes to our investigation is the notion that quantitative examination of alternatives can be employed in ethical decision-making processes to determine the best course of action.

Mill's recourse consisted of the introduction of *quality* into Bentham's quantitative schema.<sup>171</sup> For Mill, different goods possessed different qualities, and the quality of these different goods required consideration before contemplating action.<sup>172</sup> In other words, it was not merely enough to identify what actions produced good; rather, the *kind* of good produced mattered when determining the best course of

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167. Mill, *supra* note 72, at 10.

168. JEREMY BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION 38-41 (J.H. Burns & H.L.A. Hart eds., 1970).

169. *See id.*

170. *See id.*

171. *See* Mill, *supra* note 72, at 10.

172. *See id.* at 12.

action. According to Mill, there were both higher or cultivated desires and lower or uncultivated desires.<sup>173</sup> What is important in this treatment of "good," are the persons measuring it. Thus, to measure the quality of good that action produces, one must retain a certain degree of competence; that is, one must be cultivated or knowledgeable enough to know what is a "better" good compared with other goods. Mill feared that if every individual had an equal vote—given that the majority of individuals were not cultivated—civilization would suffer.<sup>174</sup>

In Mill's ideal scenario, only a small minority would have the right to express an opinion regarding an issue.<sup>175</sup> The best educated, the most powerful (in short, the societal elite) would retain decision-making power.<sup>176</sup> As abhorrent and inhumane as this may seem, we submit that it is, in some meaningful way, the philosophy under which present day mental health law in the United States operates.<sup>177</sup> The state assumes that most "uncultivated" citizens (e.g., the mentally ill, the poor, the disenfranchised) are largely incompetent to make decisions regarding matters about which they are not educated.<sup>178</sup> Thus, this country functions under a representative democracy; that is, a government in which a select few competent individuals, whether appointed or voted in, are chosen to represent the interests of the people.

To what extent and, in what respect, are these notions found in the psychological and legal communities? The answer is far from inconspicuous. This "elite" status is one we often unquestioningly confer upon attorneys, psychologists and, clinicolegal advocates. Their specialized knowledge speaks *for* others. Under the present system, the mental health law advocate represents the interests of the psychiatric consumer.<sup>179</sup> Of course, a "re-presentation" always loses

173. See *id.* at 10.

174. See generally *id.*

175. See generally *id.*

176. See generally *id.*

177. For example, see LAFOND & DURHAM, *supra* note 46, at 4-22.

178. Perhaps the most profoundly disturbing example of the state deeming persons with psychiatric disorders incompetent is the matter of execution. An entire body of law exists exploring the vagaries under which a prisoner competently exercises (or fails to exercise) his or her rights in the face of impending death. For a detailed legal analyses on this matter, see Ford v. Wainwright, 477 U.S. 399 (1986); Washington v. Harper, 494 U.S. 210 (1989); and Perry v. Louisiana, 610 So. 2d 746 (1999). For an in-depth law and social science analysis of competency to be executed in relation to one's right to refuse treatment, see WINICK, *supra* note 10. For a critical assessment of the right to refuse treatment doctrine and competency to be executed, see Arrigo & Williams, *supra* note 166.

179. We question the ability of mental health advocates to speak for or on behalf of the psychiatric citizen without also, in some meaningful way, attending to the representative's self-interests. For a standard law-psychology analysis in which an evaluation of mental health advocacy programs is considered, see Gutierrez, *supra* note 48. For a critical sociolegal assessment of

something: it can never fully embody the client's interests as initially experienced within his or her subjective being.<sup>180</sup> This is a danger inextricably lodged within the current system of mental health law. Further, given our previous analysis on egoism, this re-presentation of interests potentially signifies the erosion of citizen justice and humanistic practices, even from the most well-intended of advocates.

*B. Ultimate Ends Versus Responsibility: Weber the Untimely Advocate*

The ethics of advocacy postulated by Max Weber proposed a difference between ultimate ends and responsibility.<sup>181</sup> Ultimate ends implies that a set of values exists that is *ultimately* right, and that these values should be fiercely enacted and endorsed.<sup>182</sup> The ultimate end is inconsequential in that it does not regard effects as a factor in determining action.<sup>183</sup> According to Weber, the logic of ultimate ends requires that we live by these values without concern for the consequences they produce.<sup>184</sup> Contrastingly, an ethic of responsibility recognizes and, perhaps, celebrates the numerous systems of value and perspective contained within a given society.<sup>185</sup> Thus, the ethic of responsibility endeavors to maximize the values of all persons, irrespective of some ultimate ethical "Truth" that is mistakenly proclaimed to exist.<sup>186</sup>

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the philosophical dynamics limiting such advocacy, see Williams & Arrigo, *supra* note 28.

180. The re-presentation of the psychiatric consumer's interests is problematic on two fronts. As Williams and Arrigo explain:

On the one hand, the [interests] of the [client] become an unconscious reflection of the representative's [interests] or sense of what is "good" and, consequently, fails to embody completely the wishes and well-being of the client. Thus, advocating for the good of another is, at best, a re-presentation and, accordingly, can never be the good that the patient intimately and fully desires. On the other hand, what is lost in this filtration process of re-articulating, re-presenting, re-constituting the client's [interests] are all the subtleties and nuances of meaning that form the basis of the client's [need] for . . . mental health advocacy. [Thus] the client is not able to convey his/her own true sense of agency, identity, being . . . the subject forfeits his/her interior self for the sake of conveying meaning that will be heard (through the voice of the advocate), albeit incompletely, inadequately, falsely.

Williams & Arrigo, *supra* note 28, at 240. For more of a philosophical and psychoanalytic review of how this process of re-presentation un-does the interests of mental health system users generally, see ARRIGO, *PSYCHIATRIC JUSTICE*, *supra* note 12, at 143-74; Bruce A. Arrigo, *Legal Discourse and the Disordered Criminal Defendant: Contributions from Psychoanalytic Semiotics and Chaos Theory*, 18 *LEGAL STUD. F.* 93 (1994).

181. See FROM MAX WEBER: *ESSAYS IN SOCIOLOGY* 120 (H.H. Gerth & C. Wright Mills eds. & trans., 1946).

182. See *id.* at 120-21.

183. See *id.*

184. See *id.*

185. See *id.* at 121.

186. See *id.*

For the advocate, the distinction between the ultimate ends versus responsibility models is of consequence, particularly in relation to one's own ethical values, the values of the medicolegal system, and the values of the client. For example, if one considers the advocacy role to consist of "fighting" for the rights of clients at all costs, (e.g., preventing involuntary hospitalization regardless of client repercussions because such confinement amounts to unjustified imprisonment that is the pinnacle of institutional inhumanity), one is acting from within an ethic of ultimate ends.<sup>187</sup> However, as most would concede, it is, on occasion, in the best interest of the client to be hospitalized, medicated, treated, etc., as the person's well-being may very well depend on these interventions. If advocates made choices within such a narrowly construed ultimate ends perspective, they might fail to recognize that their actions were not consistent with their client's interests. If, on the contrary, they were willing to recognize that maximizing the good of all persons might entail action that advocates are not inclined to invoke (e.g., not involuntarily hospitalizing a homeless mentally ill client who claims to prefer the outdoor chill of subzero degree weather to the comfort and warmth of temporary housing or shelter), their decision-making would be governed by an ethic of responsibility.<sup>188</sup> In both instances, however, the problem of egoism as we described it remains.

This dilemma in advocacy, based on Weberian ethical models, is complicated further when turning to the standards of professional organizations, or the law itself, for guidance. If we accept, at all costs, those standards delineated in the canons of ethics for psychologists, social workers, nurses, lawyers, and so on, or even the codified system of case and statutory law under which rules are established, we subscribe to preconfigured or *defined* values as ultimate ends. This method is undesirable. It necessarily neglects the variable nature of being human: the differing needs of individuals; the differing necessities of situations; and the differing consequences and differing effects of action. As we have argued, this is the ethical model too many of us have come to adopt without sufficient reflection. Something quite profound about our humanity (and the humanity of others) is intrapsychically and interpersonally lost in the process. To embrace an ethic of responsibility, however, is similarly problematic. This course of action can be the basis of negligence suits, disbarment, suspended and revoked licenses, and other similar professional difficulties. Interestingly, Weber's position is to endorse an ethic of responsibility when

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187. *See id.* at 120-21.

188. *Id.* at 121.



faced with consequential situations.<sup>189</sup> Regrettably, however, his thesis does not examine the matter of egoism as we have delineated it.

## VII. ETHNOGRAPHIC CONSIDERATIONS

In the pages that follow, we present four case studies.<sup>190</sup> These anecdotal accounts demonstrate how the ethics of advocacy is fraught with philosophical considerations that, in many instances, are profoundly problematic, if not altogether vexing. While the circumstances in the individual cases vary, they nevertheless symbolize several ethical pitfalls associated with mental health advocacy.

Throughout each case, we are mindful of: (1) the practical dilemmas psychiatric consumers confront when subjected to the clinicolegal system and its interpretation of rights-claiming in the face of confinement; (2) the obvious limits of the existing apparatus in meaningfully addressing the circumstances of different mental health citizens; and (3) the essential ethical dilemma mental health advocates confront, given rights-claiming by psychiatric citizens and the shortcomings of the clinicolegal system. On this latter point, consistent with our philosophical analysis, two fundamental questions will be considered: was the mental health advocate's intervention in the best interests of the psychiatric consumer (i.e., altruism), did it satisfy the psychiatric citizen's interests and those of others (i.e., measured altruism), or did it meet the needs of others without reflective concern for the mental health system user's identified needs (i.e., egoism)?; and finally, did the mental health advocacy endorse an ethic of ultimate ends or an ethic of responsibility?

For purposes of simplicity and clarity, we begin our presentation of each case with some basic and relevant ethnographic data.<sup>191</sup> This

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189. See *id.* at 120-21.

190. Portions of this section are drawn from ARRIGO, *PSYCHIATRIC JUSTICE*, *supra* note 12, 104-14. We note, however, that in the previous work, attention was given to the troubling values that law and psychiatry esteem, producing "casualties of confinement." *Id.* at 104. These casualties are the result of clinicolegal decisions and practices that inadequately determine and/or inappropriately discern how some persons with psychiatric problems endure in the midst of homelessness, crime, chemical addiction, poverty, and the like. For purposes of the present inquiry, we interpret these four life stories mindful of our philosophical assessment regarding the ethics of mental health advocacy.

191. The methods used to collect the data were direct and personal: case study observations, field notes, and interviews conducted over a six-year period (1985-1991) encompass the bulk of the data collection. All of [the] research [was] based upon extensive contact with [persons experiencing psychiatric illness in] Pittsburgh, Pennsylvania, [while employed in the mental health outreach field, addressing the needs of] the city's poor and marginally housed citizens. [W]e recognize that generalizing from anecdotal material is often challenged as an empirically unsophisticated technique; [however,] the four chosen narratives were selected from literally scores of other, equally serviceable, life stories. What makes

information allows us to respond fairly and completely to the respective questions identified above. Thus, we examine each narrative separately, as if interpreting four independent and isolated case histories. The final section of this Article offers some concluding comments about the ethics of advocacy for persons with psychiatric disorders.

### A. *The Case of Edith*

Edith lived in the Hill District, a section of Pittsburgh notorious for its urban decay, high crime, and housing projects. She was a frequent "guest" of Jubilee Soup Kitchen, a haven for the hungry and homeless providing meals and modest social services seven days a week to anyone who walked through its doors. It was at the entrance doorway to Jubilee Soup Kitchen that we first met Edith.

As she cushioned herself against the wooden archway, Edith spoke loudly of her passion for "poetry and booze." Her frame was petite but bulky. Her complexion was sallow and weather beaten; this was a woman whose life experiences lined her face. Her crimson eyes shone like two fire balls behind her battered spectacles. Her body seemed to perspire almost uncontrollably, in part due to the season and weather (it was summer, very humid and hot). Her speech was slowed and slurred and she struggled to be alert and coherent. By all indications Edith had been drinking and was intoxicated. As we approached her, she was cordial and receptive. It was at this time that we noticed a cane positioned by her side. Having dispensed with the introductions, we used our curiosity over the walking stick as a vehicle to launch a conversation.

To our dismay, Edith spoke nonchalantly about a relatively recent suicide attempt in which she jumped from a seven-story building, shattering the bones in one of her legs. The cudgel was used as both a mechanism for physical balance and as a symbol for how emotionally unbalanced she felt. Edith apparently was no novice when it came to flirtation with death. "I've tried killing myself (pause) I can't tell you how many times. The only thing that stops me is the liquor (laughing), and that's

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these accounts so significant is that they magnify just how inadequate existing confinement [practices] are [when] responding to the [unique situations of diverse] mental health systems users.

ARRIGO, PYSCHIATRIC JUSTICE, *supra* note 12, at 104. This includes the ethical problems posed by existing advocacy efforts and the philosophical dynamics that give rise to particular interventions.

why I wanna get shit-faced all the time. It's this (drinking) or I die."

What was additionally startling was her capacity to explain how drinking was not the solution to what she referred to as "obvious emotional problems." It was on many subsequent visits to Jubilee and to her apartment that these "emotional problems" were recounted for us. Rather than detailing the many psychosocial factors that brought Edith to Jubilee for services and support, we want to focus our attention on her association with the mental health and civil commitment system, especially as they relate to her housing dilemma [and the ethics of advocacy that subsequently materialized].

Given the permanent injury to her leg, Edith's mobility was markedly impaired. Complicating her physical impairment were her limited economic resources. As a welfare recipient [Edith's] income was modest (under two hundred dollars a month). Although [she] lived across the street from Jubilee, [Edith] did not visit the soup kitchen daily. Complaining that the steep uphill walk was "too painful," Jubilee take-out food was delivered to her apartment on those days when she did not visit the soup kitchen. On several occasions, we volunteered to deliver jarred hot soup to Edith. It was during these instances that we realized just how inadequate her living arrangement was in light of her alcohol abuse and chronic depression.

Edith lived alone (with an unnamed cat) in a dilapidated two-story building that was mostly abandoned. She occupied the basement flat. Upon entering the apartment, a very small and narrow kitchen greeted you. This area quickly opened up to a larger living room. Off to the immediate right was a bathroom, and further in this direction there was a bedroom. The apartment was festooned with newspapers, magazines, clothing, jars of food (many of which were from Jubilee), and other assorted paraphernalia. When we visited Edith, she was either drinking excessively or talking about death. On at least two separate occasions this fixation with death prompted a thorough discussion of treatment options, which inevitably included the possibility of civil commitment. During both conversations, Edith concluded that she needed to be psychiatrically hospitalized. [Ostensibly, our advocacy goal], then, was to facilitate the process as quickly and as smoothly as possible.

Since Edith did not have insurance (other than what welfare's medical assistance provides) she was not eligible to seek private

care. This meant that her choices were limited to the various community mental health facilities in the city of Pittsburgh. County guidelines in many states, however, require that an individual requesting psychiatric services must receive said services from the Base Service Unit (BSU) in which that person resides. Pittsburgh and Allegheny County adopt this position. Edith could only be treated at the BSU, at that psychiatric facility in the area in which she lived, *regardless* of her comfort level with that particular institution. In the past, Edith had relied upon the very community mental health center to which we were forced to take her. Her prior experiences with this hospital were not good. By her own admission, Edith was a difficult patient—condescending and offensive to staff, obnoxious and troublesome to other patients.

The initial assessment included separate questioning. A clinical social worker met with Edith to discuss her emotional condition followed by consultation with us regarding our own involvement with Edith. Both sessions dealt with why Edith needed to be hospitalized and treated. Subsequent inquiry was conducted by an attending psychiatrist. On both occasions when hospitalization was explored, the outcome was the same. First, Edith was dually diagnosed: she was *chemically* dependent, and appropriate psychiatric treatment would require that alcohol detoxification and rehabilitation be pursued as a necessary precursor to any intervention with her clinical depression. Although securing detox/rehab would be difficult (the available space was limited and the typical waiting lists for such services were long), the chemical dependency issue would, nonetheless, need to be addressed first. Second, Edith was not dangerous or gravely disabled in the clinicolegal sense.<sup>192</sup> Therefore, psychiatric hospitalization (voluntary or otherwise) was not warranted. Some suggestions were made about alternative housing for Edith, including, community residential rehabilitation (CRR) services designed to provide structured care. The intimation was that monitoring Edith would be wise and that if CRR housing could be obtained, our concerns for Edith would be allayed. In any case, Edith was free to go.

The underlying problem with the hospital staff's advice was (is) directly linked to the failure of civil commitment laws and their relationship to inadequate housing for psychiatric consumers.<sup>193</sup>

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192. In order for one to be civilly committed, mental illness alone is insufficient. In addition, the person must either be a danger to her or himself or others, or be gravely disabled. *See, e.g.*, 50 PA. CONS. STAT. ANN. § 7301 (Supp. 2000).

193. For a detailed assessment of this problem, see *THE HOMELESS MENTALLY ILL* (H.

Mental health systems users are denied access to hospital treatment because they must demonstrate that they are a danger to themselves and/or others. In Pennsylvania this is understood to mean that the person is *a clear and present danger* as evidenced by certain behaviors identified over the past thirty days in which the individual has formulated some plan in the furtherance of their being a danger.<sup>194</sup> Drinking yourself to death does meet the dangerousness criterion in Pennsylvania or any other state. Complicating the matter is the fact that persons who might otherwise be treated in psychiatric facilities if confinement laws were expanded must rely upon alternative systems for services and care. Because these systems (drug and alcohol facilities as well as supportive housing agencies) are burdened by the needs of an array of consumers (e.g., the decarcerated, the elderly, the physically disabled, veterans, etc.), resources are scarce. The net effect is that persons like Edith must choose between two dissatisfying options—become mentally ill in the clinicolegal sense in order to receive psychiatric treatment, or exist as they are and hope that waiting list delays are only short term. The tragedy of Edith's predicament was that two years after our first encounter with her, she was found dead in her apartment. In order to arrest her chemical dependency, she was prescribed the alcohol inhibitor antabuse. Unfortunately for Edith, she drank while on antabuse, which produced uncontrollable convulsions, vomiting, chills, and the like. She subsequently suffered a massive heart attack. Given the manner in which she lived (alone and as an invalid), no one was present to intervene or help her.<sup>195</sup>

In the context of mental health advocacy, the case of Edith is ethically problematic. Although she wanted to be hospitalized and treated for her depression, Edith could only appeal to the very system (i.e., the clinicolegal apparatus) responsible for determining her present status as a (psychiatric) consumer. The system to which she turned was unwilling to acknowledge that Edith was both chemically addicted and psychiatrically depressed. Instead, the community mental health facility, consistent with the law, required that she receive

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Richard Lamb ed., 1984). For a legal analysis see Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375 (1982). For a philosophical critique of the legal and psychiatric response to the homeless mental ill, emphasizing community-based treatment see Arrigo, *Logic of Identity*, *supra* note 79.

194. For a detailed assessment of the relevant involuntary civil commitment standard in Pennsylvania, see Susan Paczak, *Pennsylvania Standard for Involuntary Civil Commitment of the Mentally Ill: A Clear and Present Danger?*, 27 DUQ. L. REV., 27, 325 (1989).

195. ARRIGO, PSYCHIATRIC JUSTICE, *supra* note 12, at 105-08 (citations added by author).

alcohol detoxification and rehabilitation services before any mental health treatment occurred.

Our advocacy posture toward Edith (to champion the cause of involuntary treatment) was ethically driven, knowingly or not, by the principle of measured altruism. In addition, the philosophical limits of our representation were guided by the ethical principle of ultimate ends decision-making. These observations can be traced to how Edith interpreted her situation and how we responded to it. Indeed, Edith's repeated plea for hospitalization, for example, was a vivid reminder to us of her fragile mortality, and of our own. The excessive drinking became simultaneously the source and the product of her depression.

I've got an illness, a disease. It's not my fault. I can't stop myself from thinking. I can't stop myself from thinking (holding her head with her hands firmly and crying). Look at me. I'm nothing. I'm already dead. The drinking, it's about being dead. I need to go to the hospital. I'm dead (crying). I'm all dead! If they put me away a least I can die like the crazy fool that I am. At least I can die there with my illness.<sup>196</sup>

It is difficult, if not impossible, to stare in the face of a person's suffering, knowing full well that it pervades her or his life. This is particularly true when the depth of the pain is genuine, agonizing, incessant. We could easily relate to Edith's torment. Her insistence that she be hospitalized spoke to us, passed through us, activating our own experiences of suffering, loss, and misery. Edith wanted to rid herself of her demons. We wanted to assist her, in part, because we understood her pain and the possibility of dying. Connecting with these realities (i.e., suffering and impending death) is a function of being human. Thus, our mental health advocacy proceeded from this vantage point and, accordingly, was informed by both her very real dread and by our identification with it.

In addition, our motivation to assist Edith stemmed from how we interpreted her unique situation and what we believed was in her best interest. Based on the comments she made about her acute condition and our appraisal of her life circumstances, an ethic of ultimate ends guided our advocacy efforts. The ethic of ultimate ends intervenes on behalf of another when some larger, desirable good (e.g., truth) is at stake. We believed Edith would die and, like her, did not want this to happen. Affirming life was the ultimate end that motivated our ethical posture toward Edith and the mental health law system to which she was intimately, albeit partially, connected. Here,

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196. Interview by Bruce A. Arrigo with Edith, Pittsburgh, Pa. (Jul. 1986).

too, we note how our concern for Edith's well-being made sense by way of the value we assigned to living. Thus, measured altruism was linked both to the ethics of our advocacy and to its philosophical limits.

### B. *The Case of James*

We first met James when the downtown YMCA [in Pittsburgh, Pennsylvania] voiced some concern about how he was living. The YMCA had a history of providing subsidized housing to various low-income groups.<sup>197</sup> Apparently James had not been seen outside his room for some time, and the housekeeping and front desk staff were concerned about his overall condition.

James was a frail and emaciated man with unkept hair/beard and disheveled clothing. He appeared to be in his early sixties. He lived in a single-room unit that had no cooking facilities and no bathroom. However, there was a cafeteria in the lobby and two community bathrooms were provided on each of the sixteen floors for tenants. James' flat was [messy] and odorous. Various papers and linens were scattered about and the stains on his sheets indicated that he suffered from urinary incontinence. He moved awkwardly and slowly, feet barely rising above the tiled floor of his room. His speech was slurred and his thought processes were disorganized. He was not oriented to time or place. James was expressionless during most of our conversations and his affect was typically flat.

Our preliminary assessment was that he had some form of organic brain dysfunction. There was, however, one thing that captured his attention. A large color television was strategically positioned against the wall facing his bed. Every time we visited James, the channel was set to a soap opera. When asked who he identified with in these soap operas, James' response was always the same: "I like the doctors." When we pressed him to describe why he liked the doctors, he eventually told us: "because I'm a physician."

At first we stared blankly in disbelief. Then, after we asked him to repeat what he said, James went to his cluttered desk and

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197. Various minority and vulnerable groups constituted the YMCA. In some instances, these groups experienced difficulty with community reintegration and resocialization. In other instances, there was less difficulty with assimilation. For an assessment of how the community functioned, mindful of crime and deviance in the community, see Bruce A. Arrigo, *Rooms for the Misbegotten: Social Design and Social Deviance*, 21 J. SOC. & SOC. WELFARE 95 (1994).

pulled out some papers. These papers were college and medical school diplomas. He also showed us records verifying that he was an honorably discharged veteran and pay stubs documenting that he had spent some time working at the Allegheny County Morgue as a forensic pathologist. All of this material left us feeling unnerved and stunned. What he [told us] was true. Our concern[, however,] was with why this man lived the way he did and whether he wanted to change his situation. [It was at this juncture that we began to assess how we might advocate on his behalf.]

After many visits to James' single-room apartment over several months, we learned that he had experienced cardiac problems several years prior to his arrival at the YMCA. As he lived on his own, there was no one to attend to James' physical needs. He also was a frequent inpatient of the local mental health veteran's hospital, where he was treated for depression and chronic organic brain syndrome (OBS) difficulties. . . .

James had been involuntarily hospitalized on four separate occasions from 1976 to 1984. Three of these confinements lasted approximately 28 days. The other civil commitment extended over a three month period. In each instance, hospitalization and treatment were legally ordered because James was gravely disabled; he was deteriorating to a point where he no longer was eating, sleeping, or generally caring for his physical well-being. On each occasion, however, when the hospital determined that he was able to care for himself as evidenced by his ability to reason and his willingness to consent to outpatient psychiatric care, James was released. The release was based upon the hospital's commitment to the least restrictive alternative doctrine as articulated through the law. . . .<sup>198</sup> While James initially kept his promise to frequent the veterans' hospital for medication monitoring and other services, in time he simply disappeared leaving no trace of his whereabouts. Following his lack of hospital contact, he typically ran out of his prescription medications or no longer relied upon them to help him through the day. Moreover, those symptoms which so poignantly struck us when we first encountered James, resurfaced and haunted him during his more protracted periods of anonymity.

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198. Essentially, the doctrine requires that the locus of care be the least restrictive and the type of intervention be the least invasive. For a law and social science assessment of this doctrine, see Arrigo, *supra* note 53. For a legal interpretation of this right see, *Jackson v. Indiana*, 406 U.S. 715 (1972).



So complete was James' psychiatric decompensation that much of the preceding information he could not recall himself. Medical charts filled in the missing bits of information. James had cycled in and out of the mental health system almost by chance. Fortunately for him, people in his community were concerned about his general welfare. Every person filing [civil commitment papers] requesting that involuntary treatment be [explored] was essentially a stranger to him. The point is that [the psycholegal system] did not work to ensure that James received the on-going, non-crisis care that he needed. [We concentrated our advocacy efforts principally with those systems that were obligated to attend to James' psychological and social needs.] In the end, because he had so deteriorated, the veterans' hospital [agreed] to accept him as a[n] [in-patient] in their geriatric unit, where he lived until he passed away some five years ago.<sup>199</sup>

The rights-claiming problem for James was that he became a part of a revolving door system of psychiatric care. The lack of regular community-based mental health assistance and intervention sustained his cycle of short-term, in-patient treatment. The ethical dilemma we confronted as advocates was particularly onerous. Indeed, similar to Edith, James expressed a desire for hospitalization, although for very different reasons. On those occasions when James did communicate with us, he made clear just how complicated his situation was. Commenting on his place in the YMCA, James explained:

[t]his is where I live . . . but it's not where I belong. I'm a doctor and sometimes I go to the hospital but I don't stay. I can't stay. It's not possible for me to stay even though I'm a doctor.<sup>200</sup>

Unlike Edith, who wanted to be civilly committed because she believed imminent death would follow absent treatment, James wanted to be hospitalized because he identified with the world of physicians, notwithstanding his chronic symptoms of psychiatric illness. Our response to James was to present his interests to the veterans' hospital, but not for the reasons that he so desperately desired. We did not broker on his behalf by explaining to the veterans' hospital that James' status as a physician required that they psychiatrically care for and treat him. This was, however, what James wanted. This was his expressed interest. Instead, we re-presented his needs to the hospital in such a way that they acknowledged his status as a physician but responded to him as a decompensating patient. In other words,

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199. ARRIGO, PSYCHIATRIC JUSTICE, *supra* note 12, at 108-10 (citations added by author).

200. Interview by Bruce A. Arrigo with James, Pittsburgh, Pa. (Dec. 1986).

the staff honored its commitment to James as a sick veteran in need of ongoing, in-patient mental health services but not as a fellow doctor whose chronic decompensation exacerbated his already physically debilitating and emotionally depleting life circumstances.

Ethically speaking, therefore, our mental health intervention was philosophically informed by egoistic principles. We wanted to assist James, but on our own terms, believing this to be in his best interest. In addition, the limits of our advocacy were conditioned by ultimate ends decision-making. In short, we valued the goal of psychiatric treatment above all else, including his heart-felt wish to be esteemed as a physician. This is not to suggest that we failed to appreciate James' identification with physicians; rather, while recognizing this we, nonetheless, arranged for hospital intervention.

### *C. The Case of Larry*

Larry was a young man in his early thirties, approximately 5 feet 5 inches tall with a compact and sturdy frame. He lived in an apartment on the South Side of Pittsburgh. Our introduction to Larry occurred while he was waiting for St. Mary's "Red Door" Church to open. This church provides a late-morning lunch, usually including sandwiches and donuts, to anyone who stops by, Monday through Saturday. On this particular day, Larry was early and stood in line with others waiting for the "Red Door" to open. His head was shaved except for a thick batch of hair that dangled from the center of his crown to the small of his back. His ears were pierced and several tattoos were visible. Among these were "love" and "hate," proudly displayed on both his hands. He wore a goatee and sported a patch over his left eye. In sum, his appearance suggested a pirate or some other menacing figure.

When we approached Larry, he was overly gracious, thanking us routinely and relying upon other conventions of polite conversation. Strangely enough, woven into his affable commentary, was a dependency on vulgarity and violent imagery. He would in one breath be inquisitive and kind and then demanding and nasty. It was as if he was attempting to control (suppress) the one side of his personality that troubled him (the offensive side) but not always with success. The sheer strength of character and depth of intelligence with which he undertook this task was amazing. We soon came to realize that Larry presented himself as a schizophrenic.

What interests us in this narrative, though, is [the character of our mental health advocacy, given that existing] confinement laws and policies did not provide a large enough safety net for Larry's unique situation and personality.

Given Larry's unusual behavior, he at times seemed abrasive and rude. During many subsequent conversations we found him to be alternately pleasant and acerbic. Some would simply ignore his more repulsive conduct while others felt compelled to respond. When questioned about his more caustic remarks, Larry explained them as follows:

I don't know what happens to me. It's like I'm talking and then suddenly, man, there someone else that's talking for me but like it's still me. I don't know why I do it. I don't know why I do it! It just happens and then people get pissed off."

On one occasion when Larry's offensive personality surfaced, he repeatedly referred to someone's mother as a "bitch and whore" without the slightest provocation. Not surprisingly, there was a brutal scuffle and the police were called. Both men were taken to the county jail. In Larry's case, "doing time" in the local lock-up only exacerbated his more primitive persona. He became hostile with other inmates. Complicating his situation was a history of prior offenses including multiple assaults and other violent activity. While the criminal justice system had previously incarcerated Larry and had acknowledged his schizophrenia by treating him in a unit with other persons considered criminally insane, he was eventually released from custody. Since Larry was often very successful with holding in check his violent personality, especially when on the appropriate antipsychotic medication, civil commitment was not explored. He was well, or well enough, according to conventional clinicolegal wisdom and therefore was free to live as he chose. Unfortunately for Larry, his violent outbursts accumulated to the point where a judge sentenced him to a three-to-nine year prison term, where he remains to this day.

Larry's case, as it relates to institutionalization, illustrates the inflexibility of the present apparatus. Persons like Larry are *well* in the eyes of the law. They possess the capacity to maintain themselves for extended periods of time without the assistance of the mental health system. This capacity is proven time and time again when these consumers attend to their outpatient therapy/medication appointments or otherwise remain in contact with

community-based social service agencies. In Larry's instance, living on his own as he did for many years, visiting St. Mary's church routinely, engaging in polite conversations, were all signs that he was competent. [The manifestation of] felonious conduct therefore result[ed] in his being treated as a potential criminal. Larry's violent behavior was not excusable nor do we question his [psychological abilities]. Moreover, the point is not that the criminal justice system, given existing options, mistakenly intervened when adjudicating Larry's case. What we draw attention to is how the confinement system, through the . . . law, renders services to a narrowly defined constituency that does not include individuals who are, in many respects, like Larry. [The practical problem for Larry was] not so much a matter of a forced choice: become mentally ill in the clinicolegal sense or exist as you are and hope that other health and human service agencies assist you (the case of Edith). The [practical] dilemma [was] not one of reactively acknowledging mental illness in which treatment merely follows decompensation, thereby perpetuating a cycle of hospital care (the case of James). Instead, the practical issue was one of defining *wellness*! If you are not sick in the clinicolegal sense you must therefore be well. This notion is applied to a broad range of psychiatric consumers. Not only do the laws and practices of confinement identify who is deserving of hospitalization and treatment, but they also determine what it means to be well and who qualifies for such services. The result is that for persons like Larry, confinement policies offer no relief and no protection. Consequently, incarceration is perceived as the only logical alternative.<sup>201</sup>

Larry's rights-claiming was confounded by our ethical treatment of him and by our advocacy posture toward him. On the one hand, we admired Larry's ability to contain his demons so efficiently. The sheer force of will it took to manage his interpersonal relations and social surroundings was remarkable. On the other hand, Larry was so unpredictable that we were never certain when he would harm himself or someone else. Indeed, his repeated past behavior was a clear indicator of his potential for violence at any moment. Thus, notwithstanding his protestations to the contrary, our advocacy was guided by the principle of egoism; that is, we believed it was in Larry's best interest to be confined.

We also note that Larry's struggle to understand his own identity was truly insightful, as it significantly impacted our advocacy stance toward this deeply tormented individual. Not only did Larry appreci-

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201. ARRIGO, PSYCHIATRIC JUSTICE, *supra* note 12, at 110-12.

ate the confinement dilemma he confronted, he could lucidly articulate why he should remain free from any form of institutional control:

They put me away, man. It's not right. That's all I mean to them. I'm someone to put away to rot. I'm not an animal, no sir. You can't put me away like that, can't treat me that way. Sure I get upset. Everybody gets upset. Then I'm supposed to take this medicine (revealing a pill container) and be good. I am good, right? They put me in the hospital with crazy people. I know I'm sick but I'm not crazy, right? I don't think I'm crazy. (Laughing). Crazy people can't think straight. Look at me. I got a place to live. I get my money and eat and take care of myself. And then they lock me up an the jail. (Angrily) I'm not a criminal! I get upset. I get upset, that's all. People get on my nerves sometimes, that's all. They don't understand me. I'm just a little sick but you can't tell me I'm crazy, and I'm not someone who, like, robs a bank or something. That's not me.<sup>202</sup>

We admired Larry's ability to frame his predicament as thoughtfully and powerfully as he did. We felt a certain kinship toward him and his resolute hope for unencumbered, independent living. Thus, the limits of our advocacy philosophy were informed by the ethical values he espoused regarding his freedom. Indeed, an ethic of responsibility was very much a part of our engagement with Larry. We wanted to maximize his interests, his values, his way of knowing and experiencing the world (i.e., the ethic of responsibility), but only from within the preconfigured limits of what was best for him—that is, what was best for society (i.e., the philosophy of egoism). This strange and contradictory mixture produced in us a curious allegiance to Larry; one that applauded his presence in the community but also breathed a sigh of relief when civilly or criminally institutionalized.

#### *D. The Case of Clay*

[Similar to] Larry, we first met Clay at St. Mary's Church. He sat nervously, huddled-up by the doorway, inhaling a bologna and cheese sandwich. His hair was long, matted, and blond. His clothing was tattered, loose-fitting, and fading. Clay (or "Caveman" as he was called on the streets) wore no socks or shoes, owned no articles of clothing other than the ones on his back, lived in no home or apartment, collected no income from a job or from a government check, boasted of no family or friends. His only possession was a satchel that contained the miscellane-

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202. Interview by Bruce A. Arrigo with Larry, Pittsburgh, Pa. (Sept. 1986).

ous items of a would-be artist—various textured papers, assorted pencils, and brushes.

Clay had never been inside a mental institution. In many respects this was no surprise to us. He was engaging, intelligent, and inquisitive. This is not to suggest that Clay was not unusual, especially given the manner in which he lived. The point is that he was no danger to himself or others. Clay did, however, ruminate about several matters. We spent many frustrating hours discussing his feelings on a variety of life issues: his indecisiveness toward and apathy for work, his anxiety and torment over returning to Hagerstown, Maryland (his birth place), his rage and sense of abandonment over a failed romantic relationship. In [some important sense], Clay's existence symbolized the fear (in his case horror) one confronts when taking a position or making a decision. He was immobilized by his fear, unable to fully embrace any notion and therefore avoiding the consequences of his choice [making] at all costs. The only belief he was wedded to was a profound sense of despair for his present condition and his uncertain future.

Clay's narrative is also important given the existing state of confinement laws. Unlike Larry, who was known to the mental health system as someone who could mostly manage on his own, Clay became the target of involuntary (civil or criminal) treatment. Over the seven years we maintained contact with Clay, he stayed just one night in a [city] shelter, two weeks at an acquaintance's apartment, [and] one weekend in the county jail. In the first instance, the weather had plummeted to 10 degrees below zero with a wind chill factor that made it feel closer to 50 degrees below zero. In the second instance, Clay was engaged in a large clean-up project that forced him to work late at night. He neither received nor asked for any compensation and simply worked until he was exhausted. In the third instance, the local police were instructed by the Mayor's office to engage in a "sweep of the streets" to protect homeless people from the anticipated harsh ([i.e.,] bitter [and deathly] cold) weather. Clay was spotted on the street, resisted the police intervention, was eventually apprehended, and was subsequently confined. On all other occasions, Caveman lived in the woods, relying on a make-shift tarp for comfort and newspapers for warmth.

Clay was very much aware of the vagrancy laws and the [Pennsylvania] statute[s] governing civil commitment.<sup>203</sup> He

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203. 50 PA. CONS. STAT. ANN. § 7301 (Supp. 2000).

understood the dangerous and gravely disabled standards in Allegheny County and had argued, quite convincingly, that he was taking care of himself.

This is my life! I have the right to do what I want with it. Why should I get a job? . . . For what? Who needs the hassle and responsibility that you put up with on minimum wage, or that comes with living like everybody else? I know where I live. I know I eat here (St. Mary's). I know I ain't got any money. Big deal! At least no one's after me to pay my rent, put food on the table or make more money. And don't tell me about Welfare neither (sic) because it's all part of the same bullshit system. You're the ones that are crazy for giving into the system.

Despite his insight, Clay was susceptible to the moral outrage of any person willing to invest the time and energy to pursue his institutionalization. This was especially the case during those cold and wintry months where he would sit on the pavement shivering, his body a ball-shaped object, rocking himself for comfort. On two separate occasions, Caveman was hospitalized for psychiatric care. Eventually he was released and spoke of nothing but his outrage.

The story of Clay is [significant] because it once again is indicative of a confinement system that struggles to identify an effective mechanism for psychiatric intervention. Unlike the previous cases, Clay symbolizes those individuals who challenge existing social norms about how one should live. The point is not that persons who are homeless deserve to be so or that they all choose their circumstances. However, those individuals who consider or accept an alternative way of life like homelessness—although uncomfortable to witness and accept—lack protections. The laws of confinement fail individuals like Clay because, regardless of how well these citizens think they are or act, they are considered to be sick and in need of treatment by clinicolegal decision brokers.<sup>204</sup> Unlike Larry, who needed some type of

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204. One seminal legal case along these lines is the story of Billie Boggs. *Boggs v. New York City Health and Hosp. Corp.*, 132 A.D.2d 340 (1987). Boggs, a homeless woman, found herself subjected to involuntary civil commitment, notwithstanding her capacity to care for herself, albeit in an unconventional way. She lived on Second Avenue, in New York County, which was "identified as her bedroom, toilet, and living room." *Id.* at 343. The psychiatrist testifying on behalf of Project Help (a New York City-based service for homeless persons with psychiatric disorders), determined that Ms. Boggs was severely mentally ill and required "immediate hospitalization." *Id.* At the administrative hearing for sustained civil commitment, Ms. Boggs was released. *Id.* at 360. The hearing judge found that Ms. Boggs was "rational, logical, [and] coherent" throughout her testimony, and was not a danger to herself at the time of the initial

[ongoing] monitoring because of his propensity for violence, Clay needed to be left alone until he was ready to make a decision about his life. [Thus, our mental health advocacy for Caveman unfolded accordingly. Notwithstanding our efforts,] the confinement system made decisions for Clay. His way of life and his ["offensive"] condition suggested to clinicolegal practitioners that he was in significant distress or was seriously deteriorating and, therefore, was unable to care for himself. The result of the system's intervention is that today Caveman continues to live on the streets, mostly avoid[ing] contact, and distrust[ing] anyone who approaches him.<sup>205</sup>

Philosophically speaking, our advocacy posture toward Clay was motivated by principles of measured altruism. In addition, the limits of our representation were guided by the ethic of responsibility. Our relationship with Caveman led us to conclude that he was capable of living without most, if not all, forms of state-sponsored assistance. To a large extent, we admired Clay's rugged independence. His indignant frankness and righteousness about how systems manipulate and control people spoke to us, passed through us, connecting with our own experiences of how, intended or otherwise, the criminal justice, mental health, social welfare, and child and youth systems pathologize, criminalize, and normalize (i.e., fail) the very people for whom their interventions are designed. Clay wanted to be free to travel as he pleased, without governmental intrusion. We wanted to assist him, in part, because we understood and embraced his convictions. Thus, our mental health advocacy unfolded from this unique filter and was simultaneously anchored by his and our belief in the right to self-determination.

In addition, affirming the values that gave meaning to Clay's life underscored our (mental health) advocacy efforts. When one recognizes the uniqueness of situations and makes ethical decisions that maximize the good of persons where chosen actions may not be consistent with how one would otherwise elect to socialize, live, or be, then an ethic of responsibility governs behavior. We did not glorify or romanticize Clay's life as a street dweller. We were not enamored

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hospitalization. See *id.* at 365-66. On appeal, the New York County Supreme Court, Appellate Division reversed the hearing judge's decision. *Id.* at 366. The appellate court was particularly concerned with *how* Ms. Boggs cared for herself. The court argued that civil commitment could be order if petitioner's mental illness "manifests itself [as] neglect or refusal to care for [one]self to such an extent that there is present 'serious harm' to [one's] own well-being." *Id.* at 362. For additional analysis of the Boggs case, mindful of several philosophical and sociolegal problems associated with it, see Williams & Arrigo, *supra* note 166.

205. ARRIGO, PSYCHIATRIC JUSTICE, *supra* note 12, at 112-14 (citations added by author).



with his wandering, living mostly alone, with few resources and even fewer friends. Instead, we understood how homelessness mattered to him and, thus, we were ethically prepared to accept it and philosophically willing to advocate for it, for his good and for our own.

### VIII. SUMMARY AND CONCLUSIONS

The four case studies previously described dramatically reveal how inadequately the mental health law system addresses the individualized needs of psychiatric citizens. We maintain that at the center of this failure are matters of ethics, texturing the advocacy that occurs. Moreover, we contend that a number of philosophical limits substantially underscore the nature of this ethical re-presentation. Although clearly not exhaustive, the cases of Edith, James, Larry, and Clay collectively indicate that the philosophy of egoism and measured altruism do motivate mental health advocacy dynamics, and that their contours are varyingly linked to an ethic of ultimate ends (i.e., idealized truth) and responsibility (i.e., the psychiatric consumer's truth).

In this Article, we argued that questions about ethics, rights, mental illness, and advocacy, in the context of clinicolegal decision-making, affect the humanity and justice of those individuals involved in the process. This was certainly the case for Edith, James, Larry, and Clay. In general, we have not provided many answers. This was not our intention. Instead, we explored a myriad of questions. The purpose of this exploration was to educate and to encourage thought, consideration, and introspection. Our excursion was meant to take the reader beyond the obvious, beyond books and conscious experience, to conceptual vistas she or he may not have immediate access to on an everyday level. These are the often uncharted places on the map of one's profession. Perhaps they do not even appear on the blueprints that our profession provides us. These are the destinations of personal insight and social change—places that move human thought forward where previously it stood still and stagnant.

To be sure, clinicolegal advocacy, as an institutional mechanism for advancing mental health consumer interests, produces a curious form of justice for persons with psychiatric disorders. From its unsettling relationship with rights giving (i.e., psychiatric citizens legitimizing the hegemony of the clinicolegal establishment) and rights taking (i.e., psychiatric citizens experiencing civil/criminal confinement), to its problematic association with ethical egoism (i.e., advocates/experts presenting their own interests or incompletely re-presenting the concerns of consumers) and measured altruism (i.e., advocates/experts re-presenting the concerns of consumers consistent with the "good" of

the advocacy specialist), mental health systems users are at least one step removed from advancing their own justice-based sensibilities. This conclusion may not appear problematic or troubling to most. After all, persons with diagnosed mental disorders are defined as variably sick, diseased, and unable to speak on their own behalf. Thus it follows that someone else, in particular a conscientious consumer advocate/activist, most likely would be best positioned to represent those psychiatric citizens who could not champion their own causes. As a critical and philosophical matter, we contend that this state of affairs, while certainly well-intended, remains deeply distressing.

If advocacy in mental health law is anchored by clinicolegal interpretations of rights, illness, competency, and the like, and if confinement decisions hinge, fundamentally, on an appeal to established structures of civil and criminal institutional authority, what room, if any, is legitimately left for the disparate voices of persons with psychiatric disorders? Indeed, given these constructed realities, on whose behalf is the advocacy truly initiated?<sup>206</sup> Firmly lodged within these questions is a concern for how (and why) the system of mental health law substantially misses the mark with citizen justice and psychological humanism.<sup>207</sup> This observation squarely returns us to the thesis entertained in this Article; namely, providing a critically-inspired and philosophically animated examination of the ethics of advocacy for mental health systems users.

We recognize that human beings are vulnerable. As such, the ethical standards that inform our everyday decision-making should not be regarded as invincible or intractable. When too rigidly or dogmatically imposed, they dismiss, sanitize, diminish, or otherwise conceal the fragility of being human. If too artificially or abstractly wedded to the ebb and flow of human conduct and social interaction, ethical precepts eliminate the possibility that one may terrify another by illuminating her or his vulnerability. This is precisely the prism we

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206. Consider, for example, Warren's classic ethnographic study of civil commitment for the mentally ill in the fictitiously named "Metropolitan Court" in California. During an administrative hearing, where a determination was made to extend or not involuntary confinement beyond the initial 72 hour observational period, attorneys representing the interests of the institutionalized, routinely forfeited their role as zealous client advocates and adopted a psychiatrically-informed commonsense and consensual definition of mental illness. WARREN, *supra* note 57, at 139-40. Further, as she concluded, "attorneys view[e]d their clients as crazy and therefore refrain[e]d from standing firmly in the way of involuntary incarceration." *Id.* at 140.

207. There are both everyday and ideological explanations for the failure of the mental health law system to attend adequately to the interests and needs of psychiatric consumers. In substantial part, we have linked these explanations to police power and *parens patriae* concerns. We submit that beyond these justifications is the legal and psychiatric community's investment in paternalism. For a detailed assessment of paternalism in psychiatric justice, see ARRIGO, *PSYCHIATRIC JUSTICE*, *supra* note 12, at 139-74.

all too frequently avoid. This light of innocence and uncertainty exposes the flaws, the ironies, and the absurdities of being human. This glow, however, is not cataclysmic. It is the light that makes growth and discovery possible. It illuminates the road that may, if we choose, lead us to another place, a better place, a more just and humane place. We contend that identifying this juncture in the law-psychology arena is sorely needed. It is especially important for those ethical matters impacting society's approach to mental illness, confinement and advocacy. Indeed, it may be the path that, one day, helps restore dignity to all those who are or will be institutionalized.