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Autonomy and Social Welfare: The Assessment of Institutionalization for Those Suffering from Mental Illness

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Abstract
This study recognizes the limitations of using a purely consequentialist approach in the assessment of public policy. Policy proposals are generally evaluated using consequentialist methodologies such as cost-benefit analysis, which do not explicitly include the additional value of individual autonomy. When rights are impacted by policy, as in the case of institutionalization, this omission becomes problematic, often involving litigation in the aftermath of policy implementation. To address this limitation, two modified consequentialist models are put forth to assess the issue of institutionalization for those suffering from mental illness. These models incorporate both social welfare and individual rights considerations. Two important policy recommendations are made to lessen any bias and ensure fairness and justice in the hospitalization decision.

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I. Introduction

Care for those suffering from mental illness has changed dramatically over the past half century and has substantially impacted countless people. State psychiatric hospitals that long housed and cared for patients have closed and patients have been released, free to seek care independently in the community. This change has resulted in great benefits to some, thanks to increased personal autonomy, and great costs borne by others who have not received adequate care.

Some members of society who suffer from mental illness could best be served through temporary hospitalization, but refuse treatment because they believe they do not need help (NSDUH 2015). Conversely, others in need find appropriate care outside of

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hospitals and enjoy living autonomously. The decision of institutionalization versus treatment in the community for those in need has long been debated and is the focus of this study.

Public policy proposals are generally evaluated using cost-benefit analysis or other consequentialist models that consider rights only insofar they contribute to social welfare.[1] However, both individual rights and the welfare of society are critical in the assessment of effective care for those suffering from mental illness. As conflicts arise involving individual rights, they are generally dealt with ex post—often through litigation, as has been the case with deinstitutionalization.

The following critical decisions illustrate individual autonomy given precedence over welfare considerations in the courts. In two seminal cases (*O'Connor v. Donaldson* 1975; *Shelton v. Tucker* 1960) the courts made it more difficult for patients to receive involuntary treatment. California's Lanterman-Petris-Short Act in 1967, and the Wisconsin federal district court decision *Lessard v. Schmidt* (1972) cite the need to show that patients pose a danger to themselves or to others for them to be institutionalized involuntarily. In *Olmstead v. L.C.* (1999), the Supreme Court ruled that unjustified institutional isolation of persons with disabilities is a form of discrimination. Such cases greatly facilitated the process of deinstitutionalization.

Individuals suffering from mental illness often face cultural stigma, especially given that only one in twenty-five US adults experiences a serious mental illness in a given year, representing a small minority of the population. Thus, it is essential that their rights be protected in addition to welfarist considerations in hospitalization decisions. To this point, George Mason warned of "the danger of the majority oppressing the minority and the mischievous influencing of demagogues" (*Notes of Debates in the Federal Convention of 1787*, 1966). Mason's contention is as relevant today as it was in 1787.

Deinstitutionalization was not approved as a formal policy package, but evolved without an explicit plan, molded by divergent welfarist and human rights perspectives (Krieg 2003). This disparate approach to institutionalization is not conducive to a complete and comprehensive assessment of the appropriate care for those suffering from mental illness. Both individual rights and the welfare of society

[1] Consequentialism is the teaching that the morality of an action is to be judged solely by its consequences.

are critical in the assessment of effective care for those suffering from mental illness and both should be considered comprehensively.

This study develops two theoretical welfarist frameworks. Each incorporates personal autonomy in hospitalization decisions for those suffering from mental illness (such as schizophrenia or other psychotic disorders) to an extent that it becomes a normative decision whether or not to commit a patient. Including both perspectives is important because the right to autonomy can be at odds with the social welfare concerns of consequentialist models. These models also have policy implications, and recommendations will be posited subsequent to the presentation of the models.

Consequentialist and individual rights perspectives are provided in sections 2 and 3, respectively. Considerations from both schools of thought are then coalesced in section 4, which constructs the two theoretical frameworks and discusses policy recommendations. Section 5 summarizes the study's theoretical models and its policy implications.

II. Social Welfare Approach

Assessments of public policy typically take a consequentialist perspective, seeking to formulate policy to maximize the social welfare of society. Measures used can include the concept of well-being, preference satisfaction, monetary values, or other measures of social welfare. A consequentialist analysis implicitly assumes that people make rational decisions in the interest of their well-being. In an analysis concerning institutionalization, it can be argued that this assumption is questionable for individuals suffering from severe mental illness, as they might not always make choices consistent with their own welfare That is, patients may choose to live independently in the community when it is in their best interest to make a temporary hospital stay that would better equip them to live independently in future years. Most people with severe psychiatric symptoms have spent most of their lives outside hospital walls. Care given can vary depending on one's income and family ties. People with lower incomes, or those alienated from their families, can find it especially difficult to receive appropriate outpatient care. They rely on an unconnected collection of emergency rooms, crisis centers, and case management assistance. In some cases, the pace of work in these settings is rushed and the resources are inadequate (Brodwin 2013). Patients' human capital and their cultural, physical, and social assets also influence their ability to receive adequate care (McLeod 2015).

For those suffering from mental illness, lack of adherence to appropriate medication is a not uncommon. Contributing factors include anosognosia (real or feigned ignorance of one's illness), alcohol or drug abuse, side effects of medication, and poor relationships with care providers (Treatment Advocacy Center 2016). Patients in need might truly believe it is in their best interest to discontinue needed medication. Moreover, Elbogen et al. (2007) find that those suffering from severe mental illness are more likely to become violent without proper medication.

Individuals suffering from mental illness are not always aware of their needs. For example, in the case of schizophrenia, such unawareness may be a manifestation of neuropsychological deficits associated with this illness. In a study of fifty-two patients with schizophrenia, McEvoy et al. (1989) find that those with more knowledge of their disability have an increased likelihood of seeking hospitalization than those with less insight. That is, many of those most in need of proper medication were found to be less likely to pursue those medications.

Homelessness is not uncommon for the more severely mentally ill (Hubley et al. 2014). Timms (2005) states "a surprising consistency exists across Europe, the United States, and Australia where schizophrenia and other major mental disorders have been noted over decades to be overrepresented in homeless populations." This problem has also been recognized in India (Seshadri 2004). In a Washington, DC, study, Susnick and Belcher (1995) find physical or mental illness to be the primary reason why respondents are homeless. Other concerns from health care providers include drug abuse, prostitution, and unsafe sexual practices (Davidson et al. 1996).

Homelessness can lead to further negative consequences, not the least of which is incarceration. Incarceration, often with a shortage of treatment resources, can hardly be considered therapeutic for those suffering from mental illness in comparison to staying in an appropriate hospital setting (Trestman et al. 2007). Moreover, Tanzman (1993) finds that the seriously mentally ill have suffered disproportionately from deinstitutionalization through homelessness or incarceration. In addition, Greenberg and Rosenheck (2008) discover that mental disabilities are associated with greater risk of homelessness among jail inmates prior to incarceration, a reflection of limited access to mental health services, particularly inpatient services.

Lamb and Weinberger (2001) find another potential problem for the criminal justice system: "persons who are thought to have committed a felony are arrested and brought to jail regardless of their mental condition. . . . If the person is thought to have committed a serious crime, the police and the criminal justice system generally do not want to leave this person in a psychiatric hospital where security may be lax."

For persons charged with misdemeanors, the situation becomes more complex. Abrahamson (1972) was the first to coin the term "criminalization of the mentally ill," observing that persons with mental disabilities who engaged in minor crimes were increasingly subject to arrest and prosecution in a county jail system. It does appear that a greater proportion of mentally ill persons are arrested compared with the general population (Teplin 1984). Torrey et al. (2010) find that in the United States there are more than three times as many seriously mentally ill people in jails and prisons than in hospitals and that 16 percent of inmates suffer from serious mental illness.

Moreover, many of those suffering from mental illness who commit serious and sometimes violent crimes might not have engaged in such behavior had they been receiving appropriate treatment (Dvoskin and Steadman 1994). Numerous studies have shown a relationship between mental illness and violence, especially among persons who are psychotic and do not take their medications (Swanson et al. 1997). Substance abuse also increases the risk of violent behavior, particularly in combination with severe mental illness (Stone 1997).

B. Benefits of Deinstitutionalization

Deinstitutionalization has brought greater autonomy to scores of individuals suffering from mental illness who obtain needed care in the community. Increased personal autonomy affords patients benefits and opportunities available outside of hospital settings, assuming they take advantage of any needed counseling and support services. As one would expect, studies indicate that patients generally prefer the autonomy of independent living (Tanzman 1993; Okin et al. 1995; Wills and Leff 1996). A variety of medications enable individuals with mental illness to better function in the greater community. Furthermore, individuals living in the outside community may benefit from a reduced stigma that could be present for those who are hospitalized.

Benefits from living autonomously vary by individual based on their unique mental conditions, financial resources, personal support, and employability. Without hospital care, patients living independently fare better if they have adequate income and insurance to cover their needs. Also, life in the community might mean a supportive network for those with family and/or friends. Many people suffering from mental illness are productive members of society inside and outside of the workforce, improving the social welfare of others.

C. Impact on Others

It has often been argued that the presence of those with mental illness has a deleterious impact on others in the community. The term "not in my backyard" (NIMBY) is sometimes applied to the location of mental health care facilities, making them difficult to establish. This can lead to a decrease in government funding for needed programs due to the lack of available sites and can also cause the closure of existing locations (Torrey 2014). Such negative attitudes are sometimes ascribed to prejudice or discrimination, but in some cases could also reflect concerns about decreasing property values, neighborhood appearance, and personal security.

Community attitudes concerning the location of such facilities are not always negative. Murphy et al. (1993) find a high level of sympathy for the mentally ill when accompanied by a low level of fear. Any change in the well-being of community members will vary depending on the severity of the mental illness and whether patients are considered to be a benefit, or cost.

Community members face other costs stemming from deinstitutionalization. One such cost is violence. Studies have found a positive association between neurological impairment and persistent violence (Krakowski and Czobor 1994; Lewis 1976). Swanson et al. (1997) find that in a given year, those diagnosed with schizophrenia are much more likely (8 percent) than others (2 percent) to engage in violent behavior. Lamb et al. (2007) find that 72 percent of persons with severe mental illness have an arrest history of violent offenses. In a quantitative meta-analysis of studies examining the relationship between psychosis and violence, Douglas, Guy, and Hart (2009) conclude that "compared with individuals with no mental disorders, people with psychosis seem to be at an elevated risk for violence."

Other costs stem from homelessness of underserved individuals suffering from mental illness. These homeless must find places to

sleep and spend their waking hours. They may spend time occupying public places such as libraries and parks, which may then need to fund additional staff. Moreover, homeless individuals may engage in panhandling and other behaviors that could irritate, frighten, or harm others (Torrey 2014).

Costs of care sometimes shift to family members when patients transition out of institutions, and these costs will vary depending on the type or degree of disability. Some families may incur pecuniary as well as psychic costs, while others are happy to provide care or support for family members and appreciate that their loved ones are outside of hospital walls.

III. The Right to Autonomy

The right to autonomy is central to the issue of institutionalization. Berlin (1969) distinguishes between negative liberty, or the ability to live free of outside interference, and positive liberty, or the ability to act on one's free will. Given the importance of the various rights in play in the institutionalization decision, it is helpful to delineate the various rights as they apply. Below is a list of rights applicable to the various stakeholders in mental health care.

Individuals in Need of Care

Negative Rights

- Refuse medication (prima facie)
- Refuse counseling (prima facie)
- Choose living arrangements (inalienable)

Positive Rights

- Right to treatment and services (prima facie)
- Informed consent (prima facie)
    - Requires patients to be informed of risks, benefits, side effects (promotes self-determination)

Rights of Others (family, community, providers)

Negative Rights

- Freedom from harassment by those in need of care (prima facie)
- Protection from crimes committed by those suffering from mental illness (prima facie)

Positive Rights

- Access to friends and/or family suffering from mental illness (prima facie)

While it is impossible to definitively rank the above rights by merit, only the right of individuals to choose their living arrangements—to be free of involuntary confinement in hospitals—would generally be considered a fundamental or inalienable right. Personal autonomy has long been considered an inalienable right. John Locke, in his *Second Treatise on Civil Government*, asserts that our rights to life, liberty, and property are natural rights, possessed by all, to be preserved and not taken away. Similarly, Thomas Jefferson and other authors of the US Declaration of Independence refer to life, liberty, and the pursuit of happiness as inalienable rights.

When we refer to individual autonomy, we speak of the ability to act as one's own person and to live life according to one's will rather than according to the will of others This ability is of primary importance in the analysis of involuntary commitment. As autonomous individuals, we make choices independently, charting our own paths.

Conversely, mental illness can be seen as inhibiting the attainment of self-reliance and the ability to function as a productive member of the community. The appropriate care—which might include involuntary hospitalization—can increase positive liberty in the long term. Common law permits such confinement if patients are threats to themselves or others, as put forth in California's precedent-setting Lanterman-Petris-Short Act. Other rights delineated above can be seen as prima facie duties (Ross 1930) in that one is not categorically obligated to adhere to them. Such rights can be overridden if other rights have a stronger claim.

Prima facie rights can be considered instrumental to social welfare and easily lend themselves to consequentialist analysis. For example, harassment from those suffering from mental illness would lower one's quality of life and thus impact net social welfare. However, an inalienable right such as personal autonomy (the right to live one's life freely based on one's convictions) might be seen as having sufficient importance to potentially override welfarist considerations in the hospitalization decision. Consequently, in this analysis, discussion of rights will focus on the right to autonomy, while prima facie rights will be considered as instrumental variables, contributing to the consequentialist calculus.

A. The Right to Autonomy

Autonomy was important to Immanuel Kant. A Kantian categorical imperative would reconcile autonomy as an inalienable right insofar

as an act against another's autonomy would violate one's duty. It follows that this fundamental right must be protected if we are to act as rational autonomous agents. In addition, Kant's contention that we always treat people as ends and not as means affirms the inherent value of one's life. It follows that independence from involuntary hospitalization allows for freedom that contributes to our intrinsic worth, allowing us to live freely without institutional constraint. Moreover, in a Kantian sense, autonomy can be seen as an inalienable right constituting part of our inherent worth, as "the ground of the dignity of human nature and of every rational nature" ([1785] 1964, p. 103). Kant ([1797] 1996) viewed freedom as "independence from being constrained by another's choice," as long as it can coexist with the freedom of others.

However, even those who have argued for a natural sovereign autonomy have agreed that persons have the right to self-government if and only if they have the capacity for self-government (Kelsen 1961). Locke and Kant addressed limitations to the right to autonomy with respect to those suffering from mental illness. In Locke's discourse on individual rights, he makes exception for those who are not capable of being free, stating that one "is never let loose to the disposure of his own will (because he knows no bounds to it, has not understanding, its proper guide) but is continued under the tuition and government of others, all the time his own understanding is incapable of that charge. And so lunatics and idiots [*sic*] are never set free from the government of their parents" (1986, p. 35).

In a similar sense, Kant makes an exception when he states, "I cannot do good to anyone according to my concept of happiness (except to young children and the insane [*sic*]), but only according to that of the one I intend to benefit" ([1797] 1996, p. 203). John Stuart Mill also saw limitations on liberty, arguing that "this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children . . . Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury" (Mill 1975, p. 13). He further states that individual liberty should be limited so that one "must not make himself a nuisance to other people" (p. 53).

Robert Nozick (1974, p. 166) makes the case that "rights do not determine a social ordering, but instead set the constraints within which a social choice is to be made." He contends that violation of some rights is inherently wrong and should be impermissible even it furthers the common good. So while rights do not aid in prioritizing

policy options, they do take precedence over welfarist considerations in that they set boundaries that society cannot breach regardless of the weight of corresponding social welfare impact. The problem is the lack of agreeable boundaries on the use of inalienable rights. This study constructs a modified consequentialist model to incorporate the moral weight of the right to autonomy, along with prima facie rights of others and other welfare considerations.

In constructing modified consequentialist models, this paper takes a more moderate view of rights constraints. For example, this view would allow a rights violation to take place if it caused social welfare to rise to a threshold level that would make it acceptable. For the purposes of this study, if violating a patient's personal autonomy through hospitalization brought about a sufficient benefit to the patient and the rest of society, hospitalization could be justified. However, the benefit needed to override such a moral constraint can be substantial. As Alexander (2000, p. 1) argues:

> One may not kill or torture an innocent person in order to save two or three other innocent people from death or torture—even though purely consequentialist considerations might dictate otherwise. However, if the number of innocent people who can be saved from death or torture gets sufficiently large, then what was morally proscribed—the killing or torture of an innocent person—becomes morally permissible or mandatory.

While it would be hard to disagree with the contention that at some point the death of one to save the lives of a great number of others may be justified, what is considered a "sufficiently large" number will vary by culture, and even by individual. A model developed below incorporates a sliding scale to capture differences with respect to human rights in the hospitalization decision.

IV. Models of Assessment

Section four discusses a major deficiency of consequentialist models in assessing public policy, drawing largely from the work of John Stuart Mill. Two models are then constructed augmenting consequential assessment with the moral weight of human rights.

A. Limitations of Consequentialism as a Policy Tool

A critical limitation of consequentialism as a policy tool is that it imposes no external constraints in the quest to attain the highest level of social welfare. Thus, if the net welfare of an event is positive, it

must be chosen regardless of additional meritorious considerations. This is a serious shortcoming in the analysis of institutionalization, which at the center lies the right to personal autonomy: an inalienable right.

Maximization of well-being is a worthy goal in public policy analysis. However, it is not necessarily the only goal, and other values are worthy of consideration. As Amartya Sen points out, both rights and consequentialist methodologies are inadequate by themselves in evaluating states of affairs (1982).

One reason that rights and consequentialist approaches are generally not combined in assessments is that they have often been seen as incomparable, with rights constraints considered incommensurable with welfare considerations as measured by a consequentialist. However, economists (among others) routinely assign value to one's life and other intangible resources in court cases and scholarly work. In welfarist models such as are presented here, units of measurement can assume various measures of social welfare. An early welfarist model and one of the most influential is the utilitarian model.

Jeremy Bentham and John Stuart Mill established themselves as pioneers of utilitarianism. Bentham is well known for his greatest happiness principle contending that the sole goal of individuals and society is to maximize a generic sense of happiness. However, this principle does not fully incorporate individual rights. While human rights contribute to happiness, their value or moral weight goes beyond happiness.

Mill (2001) goes beyond Bentham's happiness principle and recognizes the inherent difference between matters of justice and other issues that he refers to as "ordinary expediency and inexpediency." Mill does not explicitly discuss how rights can be incorporated into utilitarianism. However, in his discussion of how individual agents are to treat one another, he hints at a human rights constraint, stating, "The thoughts of the most virtuous man need not on these occasions travel beyond the particular persons concerned, except so far as is necessary to assure himself that in benefiting them he is not violating the rights—that is, the legitimate and authorized expectations—of anyone else" (2001, p. 19).

Mill also addresses rights specifically. He acknowledges a different level of morality concerning rights, in that "a right residing in an individual, implies and testifies to this more binding obligation." He goes on to say, "It appears from what has been said, that justice is

a name for certain moral requirements, which when regarded collectively, stand higher in the scale of social utility, and are therefore of more paramount obligation, than any others." Conversely, Mill continues, "particular cases may occur in which some other social duty is so important, as to overrule any one of the general maxims of justice" (p. 63), giving examples of stealing food or medicine to save a life.

Mill (1975) goes even further in his treatise *On Liberty*, where he states, "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others (p. 12)."

While Mill goes beyond traditional consequentialists in his consideration of rights, he does not express how we might treat rights explicitly in the assessment of policy matters. Although he speaks of rights as a "more binding obligation," he does not put forth any kind of moral constraint that could supersede utilitarian concerns.

In an attempt to overcome the shortcomings of stand-alone consequentialist policy evaluation, modified consequentialist models are constructed to assess the hospitalization decision comprehensively. In section 4.B, a threshold model is constructed incorporating the value of personal autonomy in addition to welfarist considerations in formulating a human rights constraint to be used within a consequentialist framework. Then, in section 4.C, human rights-based and consequentialist methodologies are coalesced in a two-stage process designed to eliminate any bias in the decision-making process.

B. A Single-Stage Modified Consequentialist Model

This section constructs a modified consequentialist model of the hospitalization decision explicitly combining welfare considerations with the additional moral weight of the right to personal autonomy. To justify institutionalization in this model, any net social welfare gained from hospitalization (including benefits and costs outlined above) must outweigh the added constraint developed to reflect community mores with respect to the moral valuation of personal autonomy.

The value of autonomy resulting from independent living is now examined in three components: (1) the intrinsic or inherent value of personal autonomy as it contributes directly to social welfare, (2) the instrumental or indirect effect of one's personal autonomy on social

well-being, and (3) a premium reflecting the additional value of autonomy above and beyond welfare considerations.

The first two components are incorporated in consequentialism. The intrinsic component reflects the inherent value of personal autonomy of agents in and of itself that contribute to social welfare in the Millian sense (2001). That is, insofar as we are rational agents with sovereignty over our minds and bodies who desire free will and the ability to act on it, autonomy is a characteristic that we value independent of its instrumental effects on welfare. This inherent value of the right to autonomy contributes to social welfare directly. In the case of institutionalization, this includes avoiding any possible diminishment of one's dignity and humiliation resulting from hospitalization.

The instrumental component of the value from autonomy reflects social welfare effects of autonomy independent of its intrinsic value, as living autonomously outside of a hospital is not only valued per se, but also generates enjoyment for agents through various activities available in the outside community and further enables them to contribute to society. Here, we consider three ways that personal autonomy can contribute to social welfare.

First, patients living in the community can contribute to workforce productivity through compensated employment. Second, through any beneficent behavior, they might contribute voluntarily to the betterment of society. Third, this freedom affords agents the amenities available outside of a hospital, many of which can be therapeutic, adding to the welfare of patients themselves. Instrumental impact on social welfare will vary among people depending on their contributions inside and outside of the workplace and the opportunities available to them.

Instrumental costs of hospitalization to patients might be assumed to be positive given one's proclivity for the freedom and flexibility of living outside of an institution, but can take on negative values for those whose long-term benefits from hospitalization outweigh any pecuniary and psychic costs incurred. Using *true* preferences, such costs can be negative even if an agent's *perceived* net benefits are positive due to impaired rationality or lacking the possession of all relevant information. Similarly, benefits accruing to others who are affected by one's hospitalization can take on positive or negative values depending on whether benefits such as acts of kindness outweigh any costs incurred by others as a result of this individual's living in the community.

The model is formulated mathematically below. The concepts of costs and benefits contributing to social welfare are used, although it would not alter the discussion if other units of social welfare or preference satisfaction were employed. In a purely consequentialist model as depicted below, when the benefit of one's institutionalization is greater than the cost, one ought to be cared for in a hospital setting rather than in the community at that point in time.

$NSW_i = B_i - C_i$, where

B_i = benefits to society from the hospitalization of individual i

C_i = costs to society resulting from the hospitalization of individual i

NSW_i = net social welfare resulting from the hospitalization of individual i

From a purely consequentialist perspective, if $NSW_i > 0$, hospitalization would increase social welfare, thus justifying hospitalization.

To strengthen this model, the value of autonomy—apart from welfare considerations—will now be addressed. While an absolute approach to rights would prohibit the violation of a rights constraint, a moderate approach would allow such constraints to be overridden if the resulting good or reduction of negative consequences is great enough to meet an acceptable threshold (Brennan 1995).

The inclusion of a constraint denoted as premium, P, enables additional rights considerations to supplement the consequentialist analysis, thereby extending the model. P measures the extent to which net social welfare must exceed zero to warrant hospitalization. The value of P for strict adherence to upholding rights would be infinite, as under no circumstances is one to violate the right to personal autonomy. However, P would take on a finite value for a more moderate or minimalist adherence to rights, such that past a certain threshold, a constraint of autonomy no longer holds. For a pure consequentialist, the value of P would be zero and the model would gravitate to a strictly consequentialist model. Thus, the value of P has the following range: $0 \leq P \leq \infty$.

Variation in P allows cultural differences with respect to the value of the right to human autonomy and its impact on the hospitalization decision. Employing the modified consequentialist model outlined above, to warrant hospitalization, net social welfare must exceed the constraint P:

$$NSW_i = B_i - C_i > P$$

This model brings consideration of rights into play in the institutionalization decision, above and beyond what is provided in a purely consequentialist framework. It is noteworthy that using this modified model, it is possible for net social welfare from hospitalization to be positive, without justifying hospitalization. Hospitalization is justified only when net social welfare rises to the level of the constraint *P*.

In sum, this model can assesses whether benefits of institutionalization would generate sufficient net social welfare to outweigh a premium stemming from living autonomously in the community. While a pure consequentialist model might yield positive net social welfare from hospitalization, the inclusion of the premium (constraint) can tilt the scale in favor of community living, particularly in communities with more pronounced preference for personal autonomy.

C. A Two-Stage Modified Consequentialist Model

This section develops a two-stage theoretical model of vertical integration incorporating both the right to autonomy and consequentialist considerations in the assessment of the institutionalization decision. Stage one develops a threshold reflecting the value of the right to personal autonomy under which society will operate. The threshold level reflects the value of autonomy apart from traditional consequentialist considerations. Stage two employs a consequentialist methodology to work within the rights constraint developed in stage one to comprehensively assess the hospitalization decision. The process is structured to give full consideration to human rights through the use of unbiased agents.

More specifically, in stage one, a threshold *T* embodying the weight of one's personal autonomy independent of welfare considerations is developed in a scenario somewhat analogous to that of John Rawls' "original position" (1971). In this theoretical model, unbiased autonomous agents with no prior knowledge of their status in life (including any mental disability) agree upon a constraint that, if exceeded, hospital admission would be justified. In this model, every person has a right, as agreed to in stage one, to eschew involuntary hospitalization if the net social welfare associated with hospitalization is below the threshold, but has the responsibility to seek hospital care if the level is above the threshold. This process addresses human rights concerns since the use of unbiased agents in stage one eliminates the possibility of the "majority" (those without significant

mental illness) benefiting at the expense of the "minority" (those suffering from mental illness).

Stage two uses the consequentialist methodology developed in section 4.B to model the institutionalization decision, subject to the rights threshold generated in stage one. The constant T developed in stage one includes the value of personal autonomy above and beyond social welfare considerations, as determined by unbiased agents. As agreed to in stage one, every person has a right to live autonomously, seeking care in the community if the net social welfare associated with hospitalization is below the threshold T, but has the responsibility to seek hospitalization if the level is above the threshold.

Under a strictly consequentialist model, if NSW_i is greater than zero, one should be institutionalized. However, using the modified consequentialist model developed here, individual i should seek hospital care if $NSW_i > T$, as agreed in stage one. That is, society's welfare resulting from hospitalization must reach a level exceeding not only general welfare gains from living outside of hospitalization, but also the moral weight associated with a rights threshold agreed upon in stage one of the model to justify hospitalization.

While this model is theoretical, it does have implications for public policy reform. The model shows that the key to implementing such initiatives is the provision of unbiased input into the decision-making process that would, in effect, work toward achieving the results of a human rights threshold agreed upon by unbiased agents. The use of unbiased agents in hospital admissions policy would facilitate this outcome since they would empathize with patients and the value of their human rights, contributing to a lessening of possible bias in admission decisions.

One practical method of mitigating possible bias in decision making would be through the use of large simple random samples, or stratified samples of agents, ensuring inclusion of those suffering from mental illness who are living effectively in the community. These unbiased agents can aid in developing hospitalization standards that they would be willing to *apply to themselves* if need be. Inclusion of significant representation from those suffering from mental illness ensures that the resulting standards will likely minimize any bias and thus function to emulate the human rights threshold in the model.

An additional method of mitigating bias in decision making involves the structure of the admissions decision-making team itself. Typically, such decision-makers include a small team chosen from

psychiatrists, nurses, and social workers. A policy to include an additional decision-maker who previously went through this process as a patient but has now successfully transitioned back to society would lessen any bias in the decision-making process. Having been in patients' shoes before, such agents would provide credibility and empathy to patients concerning their human rights. The additional agent would not be there to advocate for one side or another, but would provide empathetic input, with an understanding of what the patient is going through. The inclusion of such a decision-maker would emulate results that would be achieved through a human rights threshold by lessening any possible bias while working to better protect human rights.

V. Summary and Policy Implications

Public policy assessment typically includes the value of rights only insofar as they influence measures of well-being as put forth in consequentialist models. In the assessment of the involuntary hospitalization of those suffering from mental illness, it is important to not only consider overall happiness or well-being, but also the protection of rights, especially the inalienable right to personal autonomy.

This study developed two theoretical models incorporating the moral weight of personal autonomy in addition to instrumental welfare effects, providing for a comprehensive assessment of institutionalization. With this more inclusive framework, human rights of those suffering from mental illness are more fully considered.

In the first model constructed, the constraint employed embodies the value ascribed to autonomy as characterized above. This constraint can vary to reflect the degree of moral weight attributed to rights by the relevant community, making the model adaptable across communities where mores differ with respect to personal autonomy vis-à-vis social welfare considerations.

Next, a two-stage model was constructed, also incorporating the moral value of the right to autonomy together with welfarist considerations. Rather than using a constraint that can vary according to community values, the second model uses a constraint agreed to ex ante by unbiased agents in stage one of the model. In this stage, the threshold at which one should seek hospital care is determined by unbiased agents prior to knowing whether they will suffer from mental illness. This process eliminates the problem of the minority

(those suffering from mental illness) having much less influence than the majority (those not suffering from mental illness) in the institutionalization decision, thus protecting the human rights of those suffering from mental illness. This threshold is then used along with a consequentialist model in the second stage for a comprehensive assessment of the hospitalization decision.

Policy implications of the theoretical models stem from the need to overcome any bias in the institutionalization decision, to emulate the human rights threshold outlined in the model above. To reduce possible bias, policy should include input from productive members of society who have suffered from mental illness and can provide empathy for others suffering from mental illness. This standard will mitigate any possible bias in hospitalization decisions. More specifically, two such policy recommendations follow.

1. Use large, stratified samples of agents to include significant representation of successful people suffering from mental illness. These groups can develop new standards concerning the commitment decision that they themselves would be willing to accept if they were being considered for commitment.
2. Include agents in hospital admissions decision-making teams who have suffered from mental illness and have been institutionalized in the past. These agents will appreciate one's autonomy in these cases and feel empathy for individuals being considered for admittance. Agents would not be there to take sides but rather to mitigate possible bias in decision making.

Both policy prescriptions would emulate the results of a human rights threshold and protect the rights of those suffering from mental illness.

One's right to autonomy is central to the hospitalization decision. Moreover, given that those suffering from mental illness are generally in the minority and often face a stigma, one's right to autonomy should be given due consideration in public policy-making where pure consequentialist social welfare models are the norm. It follows that it is worth considering a more comprehensive assessment of the institutionalization decision as presented here, one that extends measures of social welfare to ensure fairness and justice.

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