President's Message:

The Most Beneficial Alternative: A Counterpoint to the Least Restrictive Alternative

In the last decade, the plethora of judicial decisions and legislative enactments have drastically altered the procedures and practices of the public mental health system. The prime focus of these changing policies has been a massive extension of legal protections to those hospitalized involuntarily. It is undeniably true that, with variations from area to area, involuntary commitment was characterized by arbitrariness, unbalanced discretion by decision makers, and benign and not-so-benign neglect. It is also true that the enormous growth of the legal establishment in the United States and the concern for the underprivileged and the powerless have brought the legally authorized hospitalization system under very close scrutiny.

Many of the effects of this sociolegal revolution have been good. The numbers of people hospitalized have lessened, and concern has been expressed about the care and treatment offered to those involuntarily institutionalized.

Other effects have not been good, particularly when the resulting decisions or policies have been harmful both to the individual and society. One inappropriate aspect of the changing environment has been the lumping of women, children, minorities, criminals, juvenile offenders and the mentally ill under one vast philosophical rubric which has not allowed for a suitable differentiation and discrimination of the need and status of the various groups. Vast expenditures in systems review have not been accompanied by improvement in the plight of the mentally ill.

Historically in dealing with the mentally ill, governmental attitudes have vacillated between emphasis on police power and *parens patriae* principles. When police power has been in the ascendancy, attention has been directed to dangerousness, social threat, and social tranquility. When *parens patriae* has occasionally been more of a dominant theme (the first half of the nineteenth century and the mid-portion of the twentieth), the focus was on the individual in terms of therapy and care needs. Research and therapeutic innovation were considered as positive approaches to the problem of those who could not care for themselves, had not the insight to seek remediation, and had judgmental deficiency in evaluating their own needs.

Where one could not reasonably make those decisions that others thought appropriate, the state would intervene, under certain circumstances, to do so. The basis for the intervention increasingly has been the social threat; state interventions throughout our history have meant incarceration or deprivation of freedom for this reason.

To many civil libertarians, freedom is the most valued of all societal rights.

To some, this meant that individual illnesses or behaviors never justify incarceration unless such illnesses or behaviors result in criminal acts, in which case criminality is the basis of the social intervention. To the Supreme Court, it meant that one could not be institutionalized unless there were special circumstances – if the individual was not dangerous (in *O'Connor v. Donaldson*, 95 S. Ct. 2486, 1975, a non-dangerous patient could not be deprived of liberty "without more"). To others, the deprivation must be balanced by the provision of treatment as a trade-off for the loss of freedom *(quid pro quo)*.

The U.S. Court of Appeals, in *Rouse v. Cameron*, 364 F. 2d 657 (1966) ruled that pursuant to a Washington statute allowing for hospitalization or "any other alternative course of treatment", the court had a duty to explore alternatives.

The concept of "the least restrictive alternative" has been subsequently utilized in many legal decisions, including the early *Lessard v. Schmidt* (349 F. Supp. 1078, 1972), *Wyatt v. Stickney* (344 F. Supp. 373, 1972), *Lynch v. Baxley* (386 F. Supp. 378, 1974), and *Suzuki v. Quisenberry* (411 F. Supp. 1113, 1976).

The focus in these cases in reference to the least restrictive alternative was directed to the least restrictive physical environment. For example, the Lessard case set out the requirement that less drastic means than commitment be investigated. These included out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services.

Certainly consideration of the least restrictive alternative as a factor in a decision as to appropriate placement is no longer controversial – as long as it is only a factor in such a decision. The problem has been twofold: in the minds of some, it seems to have taken hold as a determinant, disregarding other needs of the patient, and it has been extended, by some, far beyond its original applicability.

As Morris[1] has stated, application of the "least restrictive alternative" should not be limited to the decision whether institutionalization of the individual can be avoided. "Individuals for whom there is no less restrictive alternative than confinement itself should not be deprived of the right to the least restrictive conditions of confinement within the institution." In *Covington v. Harris* (419 F. 2d, 617, 1969), Judge Bazelon promulgated such a view:

"It makes little sense to guard zealously against the possibility of unwarranted deprivations [of liberty] prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. The range of possible dispositions of a mentally ill person within a hospital, from maximum security to out-patient status, is almost as wide as that of dispositions without."

Without belaboring the detail, a number of cases have utilized the principle of least restrictive alternative to justify a court review of placement within an institution or problems of transfer once placement has been accomplished. Lawyers have sought to apply this policy to placement of children, the retarded, the mentally ill, mentally ill offenders, and criminals.

An attempt has also been made to apply the principle to the use of restraint and seclusion and even broadly to "maximum security confinement." For example, the New York statute limits the use of the latter.

In a proposed New Jersey statute, the propounders, in delineating the screening procedure for emergency and other evaluation of a person thought to be dangerous, would require that "such examination shall be conducted in the least possible restrictive setting." How one examines a person in a least restrictive setting is unclear inasmuch as most examinations take place in offices for a rather brief period. Is one required to use an out-patient office, an open space, or a corridor? The use of the words seems inappropriate both to the need and the actuality of a preliminary examination.

For the commitment itself, the proposed bill dictated treatment which "would appropriately meet the person's needs in the least restrictive setting."

In an alternative bill that I helped to prepare and which is also before the legislature, the reference to examination using the least restrictive alternative was eliminated as nonsensical. However, in that section dealing with dispositions after a court hearing, the bill now uses an expression that I have formulated to cover both the need to consider the degree of restriction necessary and the therapeutic needs of the patient. That bill (currently called A-475) states: "The court may designate in lieu of residential confinement in a hospital any partial hospitalization, out-patient service or other alternative service which would appropriately meet the person's needs as to the most beneficial alternative."

The criticism of the use of "least restrictive alternative" is based on two grounds. As indicated, the extension of the words beyond the fact of involuntary institutionalization (the physical aspect) has diluted its meaning. Further, the expression has tended to minimize the *parens patriae* aspect of hospitalization and to negate that which is of extreme concern to the medical profession, the provision of appropriate care and treatment. The issue clearly is not only one of freedom.

To illustrate the problems inherent in the broadening of the concept of "least restrictive alternative", some courts and lawyers have extended it to encompass both treatment and complications to treatment, thereby providing a new avenue for legal scrutiny in areas where such scrutiny is not so clearcut in terms of reasonable usefulness.

In the recent case of *Rennie v. Klein* (D.C., New Jersey, Civil Action No. 77-2624, Nov. 9, 1968), the court reviewed a case in which the plaintiff sought to refuse prolixin treatment. The court indicated that it felt that the concept of least restrictive alternative should be extended to the choice of medication. Under this theory, a patient "may challenge the forced administration of drugs on the basis that alternative treatment methods should be tried before a more intrusive technique like psychotropic medication is used" (this was taken by the court from an article dealing with psychotropic medication and competence to stand trial). The court also noted:

"The notion of least restrictive alternatives can also be applied to the threat of tardive dyskinesia."

The court did not believe that tardive dyskinesia was likely to be present in the plaintiff patient at the time of the hearing – "only a preliminary symptom *possibly* indicative of the disease has been shown." The court, however, did indicate that in this particular case, lithium and tofranil in combination should be used. "The court would find that all less restrictive alternatives have been exhausted if the lithium and tofranil regime was given a fair trial." The court further stated that if there were further refusal to accept any drug in a non-emergency situation, the court would hold an immediate hearing to determine a number of matters including whether any less restrictive treatments exist.

The result of cases such as these is to place medical treatment in a category not of medical treatment but restriction of freedom – as if that were the determining factor in the selection of a therapeutic regimen. Is the benign therapy which is not so effectual now to be dictated by the courts on the grounds of lesser restriction? How is the court to measure the appropriateness of the treatment regimen itself? How will the court decide when one drug is more restrictive than another or, for that matter, when one dose is more restrictive than another? Will we now have the least restrictive occupational therapy, milieu therapy, and recreational therapy? How far will a court have to go in monitoring all the changes that are seen in medical orders made on a day to day basis?

This trend in the law began with a focus on physical freedom and the concept was certainly not an unreasonable one. Like many code words, the expression has had a contagious quality which has been extended far beyond its original applicability.

It is therefore my suggestion that psychiatrists use as a counterpoint, the most beneficial alternative, to reflect the therapeutic goals involved in the treatment of the mentally ill, and that we encourage lawmakers to include the goal of most beneficial alternative as a guiding philosophy in commitment laws. In determining the most beneficial alternative for a given patient, consideration of the least restrictive setting is certainly appropriate, but it is one of many factors which should include likelihood of success in altering the course of mental illness and the likelihood of preventing the chronicity which so many recent policies actually seem to encourage. We cannot lose sight totally of the helping role in modern medicine just because the disease has so affected a person's judgmental qualities that he or she is thrown on the mercies of the courts who today are the final authorities in decisions as to health care. Freedom from illness and disease is also a philosophical concept that needs to be treasured along with the right of physical freedom. In the long run, one without the other is not freedom at all.

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Reference

1. Morris GH: Institutionalizing the rights of mental patients: Committing the legislature. 62 California L. R. 957, 1974