

## **The Least Restrictive Alternative - is it Too Restrictive?**

**By Judy Clisby and Marilyn Starr**

***With thanks to consumers from Pete's Place who spoke to us about their experiences in hospital.***

### **Abstract**

The principle of 'the Least Restrictive Alternative' forms the basis of the 1991 UN Principles for the Protection of People with Mental Illness and for the Improvement of Mental Health Care, and underpins mental health policy, legislation and practice in Australia today. Yet there are varying understandings and interpretations of what is meant by the term 'least restrictive'. It will be shown that differences in understandings can lead to mental health practice that is more restrictive, even though mental health policy makers and practitioners may be committed to practice in accordance with 'the Least Restrictive Alternative'.

Using current literature and case exemplars, this paper challenges current interpretations of what is meant by 'the Least Restrictive Alternative'. It explores alternative ideas and conceptions to assist in understanding the complexities inherent in the provision of a service that is truly the 'least restrictive'.

Good afternoon. And thank you to you all for staying through to this last session!

Today we're talking about the principle of the Least Restrictive Alternative. We believe it is particularly important to talk about this, because it is the lynchpin of mental health legislation and policy in Australia today.

We're first going to give some background into the term Least Restrictive Alternative, tracing its origins in the United States through to mental health policy and law in Australia today. This will help give some understanding of how this principle might be interpreted in mental health practice today.

Despite its importance, there appears to be no general or common understanding of what the term the Least Restrictive Alternative means, yet there are times when it is used as justification for what might arguably be fairly restrictive practices, even if at times this happens with the very best of intentions. We're going to unpick that a little using case examples – in terms of what these practices may mean to the person who is receiving treatment.

The presentation will be restricted to individual experiences with mental health services and the psychiatric hospital. We could look at issues such as the impact of broad use of Community Treatment Orders, and whether this in fact means that overall, mental health practice is more restrictive than ever before, all in the name of the Least Restrictive Alternative. It's a huge topic, and today, in the half hour available to us, we'll consider only the individual perspective.

There is little doubt that the principle of the Least Restrictive Alternative originated in the United States (US). It has as its basis the US Supreme Court doctrine that government must achieve its goals by the most narrow means available to it (Perlin 2000).

Munetz & Geller (1993:967) cite its origins in *Shelton v Tucker* 1960, heard by the US Supreme Court in Alabama. In this case, teachers were appealing the State's requirement that teachers provide information about their past and present memberships of religious and other organisations. The court held in this case that the state "must achieve its ends with the least possible infringement on personal liberties."

Perlin (2000:1013) states that the Least Restrictive Alternative found "constitutional life" in *Lessard v Schmidt* in 1972. The Wisconsin Federal Court held that even where dangerousness and mental illness are present, a person could be involuntarily hospitalised only as a last resort. In addition, the Court held that it was the responsibility of the persons seeking the involuntary order to investigate alternatives to involuntary admission, and to demonstrate that these alternatives, such as day hospital, staying in hospital only overnight or remaining in the community with support, were not suitable.

The doctrine of the Least Restrictive Alternative became increasingly prominent in mental health policy and law in the U.S. In 1978 it was adopted by the US President's Commission on Mental Health (Munetz & Geller 1993), and in 1980, patient rights were detailed in Section 17 of the Mental Health Services Act (Mizrahi 1992). By 1980, 13 states had revised their statutes to comply with the President's Commission (Mizrahi 1992) and by 1999, 40 states had instituted community treatment laws (Torrey & Kaplan (1995) cited in Gray and O'Reilly (2005)).

Not only was the doctrine of the Least Restrictive Alternative in mental health policy and law becoming more widespread, other courts expanded the principle of the Least Restrictive Alternative beyond its use in cases for involuntary commitment to hospital (Appelbaum 1999).

Perlin (2000:1014) cites Keilitz as stating that factors to be considered when thinking about the Least Restrictive Alternative include environmental restrictiveness, the use of physical and chemical restraint, clinical variables, the

availability of family and community support and the effectiveness of alternative care and treatment. The Least Restrictive Alternative was used to justify the right to refuse treatment, but it was used equally in the argument for the right to treatment.

The restrictiveness of forced use of psychotropic medication was considered; for example in the *Guardianship of Richard Roe III*, the Massachusetts Supreme Judicial Court declared that it could not decide whether involuntary hospital or forced medication was more restrictive (Munetz & Geller 1993:969). Bachrach (cited in Munetz and Geller 1993), questions whether a person receiving treatment in a hospital near their home is receiving a more restrictive intervention than the same person living miles away from their former home without access to mental health or rehabilitation services. Munetz and Geller (1993:972) conclude that restrictiveness cannot be predetermined, but must be individually assessed.

In 1991, the *Principles for the Protection of People with Mental Illness and for the Improvement of Mental Health Care* were passed by the UN Assembly without a vote. The principle of the Least Restrictive Alternative is a key feature of the UN Principles, used as a mechanism for balancing the tensions between the right of the community to safety and to protect the person from harm versus the right of any person to make decisions autonomously.

While Henry Steel, the chair of the group largely responsible for the development of the UN Principles (Rosenthal and Rubenstein 1993) was British, the clear focus on the Principle of the Least Restrictive Alternative throughout the principles indicates a strong US influence. It is therefore feasible that the meaning of the term as intended in the UN Principles was far broader than how we might see it interpreted in Australia today.

In 1992, Australia developed the National Mental Health Strategy, with the National Mental Health Policy and National Mental Health Plan 1993 – 1998. A key focus of the Strategy was the development of the National Mental Health Statement of Rights and Responsibilities, and the development of uniform legislation throughout Australia, all of which are underpinned by the principle of the Least Restrictive Alternative.

So what does this term mean? Put simply, the Least Restrictive Alternative means that the person will receive the least restrictive, or least intrusive treatment in the least restrictive environment.

It appears from our experience with the Community Visitors Program, that this is interpreted by clinicians and mental health treatment facility management in terms of a hierarchy of restrictiveness as follows:

1. Involuntary, Seclusion and/or Restraint
2. Involuntary admission, secure ward
3. Involuntary admission, open ward
4. Voluntary admission, open ward
5. Involuntary treatment, community
6. Voluntary treatment, community

This interpretation uses only two variables: voluntariness and environment, and environment is seen as the primary variable. Using this hierarchy, the most restrictive intervention is seen as occurring if a person is involuntary in a secure ward and placed in seclusion or restrained. The next most restrictive intervention would comprise involuntary admission to a secure ward without the use of seclusion or restraint, and then involuntary admission to an open ward. It would be considered even less restrictive to admit a person voluntarily to an open ward...and so on. Thus location is seen as the primary variable, with voluntariness as the secondary variable. We argue that the consumer's perception of their experience may be quite different from this.

Marilyn will now briefly give some examples which demonstrate that these two variables do not necessarily represent the situation from the view of the person receiving treatment.

The examples are drawn from real events in the Northern Territory, gained through the Community Visitor Program's work and by talking to consumers at Pete's Place, a program for mental health consumers in Darwin. No identifying details are included, and the case examples represent the stories we have heard from consumers but do not describe any one consumer's particular experience.

Case Exemplar 1:

*There are times when consumers, who feel that they are unsafe, attend a mental health facility seeking a safe place to be. In this situation, a consumer may feel safer if they are involuntary patients in a locked facility, because in this situation they know they are unable to harm themselves.*

Using the hierarchy outlined above, people in this situation would be seen as receiving the most restrictive care – that is, involuntary treatment in a locked ward.

From the consumer's perspective being involuntary and in the locked ward is less restrictive because the consumer feels safe.

### Case Exemplar 2:

*There may be other occasions when the consumer's status on the ward is ambiguous. The consumer may have been admitted as a voluntary patient, but knows that refusal of treatment or an attempt to leave the facility will in fact mean that their status will change to involuntary. They are voluntary, but they are de facto involuntary.*

*On these occasions, consumers may prefer to retain their involuntary status because this would mean at least that their status would be reviewed by a body such as the Mental Health Review Tribunal. Of course at the same time, even with the restrictions, the consumer may feel better about the admission because they are "voluntary".*

Using the hierarchy outlined above, consumers who are involuntary, even in an open ward, would have been considered to have been at the highly restrictive end of the continuum. Service providers may argue that by admitting consumers as voluntary patients whenever possible, they are acting in accordance with the least restrictive alternative.

From the consumer's perspective, involuntary status may in fact be preferable because it would mean access to Tribunal review and so would be, from their perspective, more restrictive. Other consumers may in fact find it less restrictive to be admitted voluntarily. The key variable in this example is consumer choice.

### Case Exemplar 3

*Over the past twenty years or so there has been an increased use of Community Treatment Orders or Community Management Orders in Australia. Consumers may be discharged from hospital on an involuntary Community Order. In these circumstances, the consumer lives in the community but receives treatment involuntarily.*

*Imagine a situation where there are severe side effects to the medication. The side effects may be impotence, or tiredness, or tremor, or restlessness to name just a few. Sometimes, the case manager may not understand the impact the side effects are having on the consumer's life. Even if the treating team does know that the consumer is experiencing side effects to the medication, they may believe that the consumer must be treated involuntarily in the community because the consumer may be a danger to self or others when unwell.*

Using the hierarchy with voluntariness and environment as two measures of restrictiveness, it would seem that in this example, the consumer is receiving a service that is less restrictive than either of the examples above, as treatment is being provided in the community, even though this is involuntary.

Yet the consumer may consider the treatment to be highly restrictive because the medication affects the ability to live a normal life. The consumer may also believe that concerns that are expressed about medication are not being heard.

In each of the three case exemplars, consumers potentially view the restrictivity of their experience in a different way from how it may be viewed by mental health professionals, and how it might be considered using the hierarchy of restrictiveness outlined above.

In all three case exemplars, the determinants of restriction are potentially different for consumers, and are far broader than the two variables of environment and voluntariness.

These examples illustrate that the Least Restrictive Alternative encompasses far more than the two variables that are generally considered to apply. The key variable in these examples is the consumer's view of what is most restrictive. Consumer consultation and choice must therefore be considered when determining the least restrictive intervention.

The aim of mental health intervention is promotion of the autonomy of the individual. People receive treatment, both voluntarily and involuntarily, in order to remain well and live as independently as possible.

The Least Restrictive Alternative is a principle that is about ensuring that a person is able to maintain their autonomy – remember, it is about the State intervening in as narrow a way as possible. For this reason, the hierarchy of restrictiveness must, wherever possible, include the most important variable: respect for the choices of the person receiving treatment.

Thank you very much.

## REFERENCES

- Appelbaum, P.S. (1999) Law & Psychiatry: Least Restrictive Alternative Revisited: Olmstead's Uncertain Mandate for Community-Based Care **Psychiatric Services** Vol 50 pp1271-1280  
<http://www.psychservices.psychiatryonline.org/cgi/content/full/50/10/1271>
- Gray, J.E. & O'Reilly, R.L. (2005) Canadian Compulsory Community Treatment Laws: Recent Reforms. **International Journal of Law and Psychiatry** Vol 28 pp 13 – 22
- Mental Health Consumer Outcomes Task Force (1995) **Mental Health Statement of Rights and Responsibilities**. Adopted by The Australian Health Ministers March 1991. Commonwealth of Australia, Canberra
- Mizrahi, T. (1992) The Right to Treatment and the Treatment of Mentally Ill People. *Health and Social Work* Vol 17:1 pp 7 - 11
- Munetz, M.R. & Geller, J.L. (1993) The Least Restrictive Alternative in the Postinstitutional Era. *Hospital and Community Psychiatry* Vol 44:10 pp 967 - 973
- Northern Territory (1998) **Mental Health and Related Services Act**.
- Perlin, M.L. (2000) "Their Promises of Paradise": Will *Olmstead v L.C.* Resuscitate the Constitutional "Least Restrictive Alternative" Principle in Mental Disability Law? **Houston Law Review** 37:4 pp 999 – 1054
- Rosenthal, E & Rubenstein, L.S. (1993) International Human Rights Advocacy under the "Principles for the Protection of Persons with Mental Illness". **International Journal of Law and Psychiatry** Vol 16 pp 257 – 300
- United Nations (1991) **Principles for the protection of person with mental illness and the improvement of mental health care**. Adopted by General Assembly Resolution 46/119 of 17 December 1991.