Ethical Exploration of the Least Restrictive Alternative

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Although there have been critiques about the application of the "least restrictive alternative" to mental health policies in the past three decades, no critical analysis of the ethical logic of this principle has been put forward. The author explores three main ethical theories—liberalism, utilitarianism, and communitarianism—and explains how liberalism and subjective utilitarianism, which evidently uphold the least restrictive alternative in the name of individual rights and preference for liberty, effectively disenfranchise patients and members of their family. Contrarily, objective utilitarianism, with its highlight on cost-effectiveness analysis, would actually lay solid ground for mental health policies that attend not simply to ideological belief but rather to the question of which treatments can most cost-effectively meet the complex needs of patients. In addition, under communitarianism the evidence derived from cost-effectiveness analysis can be used to reinterpret the traditional value in mental health policies and thereby lead to the policy in favor of the most cost-effective alternative. (*Psychiatric Services* 54: 866–870, 2003)

Since the deinstitutionalization movement of the mid-1950s, the "least restrictive alternative" has become the central ideology of mental health policies for treating persons with severe and persistent mental illness. Accordingly, the pronounced principle of mental health policies is to treat these persons in nonhospital settings, collectively referred to as "the community." However, the impact of deinstitutionalization has been the focus of increasing concern for decades (1–6).

One of the major concerns is whether the public commits to equitably allocating scarce resources to this vulnerable and often dependent population and their families in a given society. The other concern is the critical need for comprehensive services to maintain continuity of care in the community. In fact, there is such a tremendous shortage of community service programs that the immense burden of caring for this vulnerable population has fallen on families. Finally, given the critically limited resources of community services, what are the optimal treatment modalities for persons who are noncompliant, whose illness is treatment refractory, and who are at risk of suicide, violence, and self-neglect in the community?

As a consequence of the ways in which deinstitutionalization is implemented, patients often shuttle back and forth among the streets, various community service facilities, nursing homes, shelter dormitories, and even prisons (7,8). This kind of "transinstitutionalization" results in receipt of fragmented, patchwork community services and inevitably deprives patients' lives of structure, stability, security, and support (9). Homelessness among persons with mental illness is the epitome of these problems (10–13).

Although several authors have criticized the application of the least restrictive alternative to psychiatric settings from historic, legal, clinical, semantic, sociological, and cost-comparison perspectives (14–21), two critical questions are thus far unanswered. First, what is the ethical basis for allowing the current concerns to persist? Second, what is the ethical theory that could lay a solid logical ground for truly resolving the current concerns stemming from deinstitutionalization?

Ethical analysis of the least restrictive alternative

The following analysis explores three main ethical theories—liberalism, utilitarianism, and communitarianism—proposed by Roberts and Reich (22).

Liberalism

Libertarianism. The least restrictive alternative is consistent with the basic principle of liberalism (22,23)—that is, to respect the right of every individual to exercise free will with regard to his or her body and property without restraint and infringement. From the perspective of libertarianism (22–25), there is never justification for the state to help people out of their own suffering. If a person decides to live on the streets, that choice should be permitted. If a person wants to seek help but cannot afford it, that is no concern of the state—there can be no restriction or infringement of rights in the name of treatment. From this perspective, providing the least restrictive alternative to people who are willing to receive treatment can certainly be justified. On the other hand, under the same ethical logic, such in-

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dividuals can freely decide to receive either the most restrictive alternative or even to receive no treatment at all, as long as they do not harm others.

Libertarianism highlights the free market as an expression of individual free will through which people could freely sell and buy mental health services, such as inpatient, outpatient, and community-based treatment programs. Under such a system, the price for these services would be set according to market principles. According to Frank and Goldman (5), "foremost among these principles are (a) having enough choices available to consumers . . . to give them power in the market, (b) consumers being able to observe and judge the nature of the service delivered, and (c) the cost of exercising consumer choice."

However, in the mental health market, too few alternative services are available to patients. In addition, the high-quality programs can serve only a small percentage of the most needful patients. There are also many barriers preventing patients from judging the quality and outcome of treatment programs and from changing providers freely and at low cost (5). Indeed, these features disenfranchise patients and their families in the mental health service market. Even so, under libertarianism, the state is not supposed to intervene in the market. In the absence of public intervention, it would fall upon families and charitable organizations to care for persons with mental illness. However, neither family support nor charity would be able to meet all the needs of persons with mental illness. And how could we rely on charity to ensure that people get the treatment and care of the least restrictive alternative?

Egalitarian liberalism. Egalitarian liberalism (22,23,26,27), which is not concerned with free-market principles, seems more promising than libertarianism for persons with mental illness. However, it is noteworthy that the essential issue of egalitarian liberalism is how to decide what kinds of social resources are basic needs: acute psychiatric inpatient treatment or comprehensive community service programs? More restrictive treatments or less restrictive treatments? Furthermore, which individuals are the worst off? How should we deal with these individuals' potentially huge claims on resources? How much of society's resources should be redistributed? How could we rely on "rational people," under the hypothetical "veil of ignorance" of social and cultural understanding—first posited by Rawls (26)—to achieve unanimous consent and an abstract social contract that favors the least restrictive alternative? Finally, how much can be spent on mental health services without squeezing the resources and opportunities of individuals who have a different set of health problems and miseries but who are also among society's worst off? Clearly, such decisions always involve significant trade-offs. After all, facing scarce resources, egalitarian liberals still need to apply various means of calculation to decide how much to redistribute while upholding equality of opportunity.

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Another dilemma facing egalitarian liberals is that the state's view of what constitutes a basic need may not coincide with a mentally ill person's view. Often, patients may not be able to decide what kind of treatment they need, given their impaired cognitive function and lack of insight. Many are noncompliant and have treatment-refractory illness.

Under liberalism, the only scenario under which the state can be justified in implementing treatment against a person's will is one in which the mentally ill person poses an imminent danger to self or others or becomes gravely disabled. These conditions are delineated in the civil commitment law, the embodiment of individual liberties. Even under this scenario, participants in the civil commitment process do not agree on the interpretation and implementation of civil commitment (28,29). Many proponents of liberalism argue that unanimous consent is the only justification for forcing compliance with public policy.

Communitarianism

Under communitarianism (22,23,30–33), the least restrictive alternative can be justified through the traditional values in any free society like the United States. However, this approach may not be justifiable in societies that have different traditional values. No matter what kind of society the mentally ill live in, the basic concerns are the same. Who has the power to interpret the traditional values—patients, their families, community leaders, social activists, or politicians? What are the political and legislative processes for determining the mental health policies reflecting these values?

People with mental illness, as well as their families, are minorities across various societies. They often lack the power to argue for what they really need. Under communitarianism, their destinies are determined through traditional values, laws, and political power. They are persuaded or even coerced into receiving the treatments that reflect the values of their society, regardless of whether the treatments are effective for meeting their needs. In fact, in many countries the least restrictive alternatives—"care by community" and "care in the community"—are simply the law or are the projection of prevailing social values and ideologic beliefs (34,35). These alternatives may be politically correct but are not necessarily the most effective.

However, if enough scientific evidence could be accumulated to make strong arguments for more cost-ef-

fective treatments, the process of reinterpreting traditional values would be galvanized. Perhaps a change of social values and attitudes would then occur, and new laws and policies would ensue. The passage of laws concerning seat belts as a means of reducing the number of motor vehicle fatalities in the United States is a good example of this process. The prevailing value of individual liberty and choice over whether to fasten one's seat belt succumbed to statistics showing the effectiveness of seat belts in preventing injuries and fatalities. As members of the public, mental health care consumers and providers, advocates, and policy makers begin to learn the critical lessons of deinstitutionalization (1), it is not impossible that mental health policy could be similarly transformed.

Utilitarianism

Subjective utilitarianism. The basic concern of utilitarianism is how to achieve the greatest good for the greatest number of people with a set amount of resources. In fact, utilitarianism represents the ideal of replacing moral intuition with the rationality of calculation and thus extols scientific evidence as the only reliable justification for public policy.

Contemporarily, subjective utilitarianism (22,23,36–38) uses cost-benefit analysis as a quantitative means of analyzing the benefits of a policy by measuring the sum of various beneficiaries' willingness to pay for their gain compared with the costs. This measure is nearly always monetary; an implicit assumption of cost-benefit analysis is that a dollar reflects the same change in preference for each individual. In addition, subjective utilitarians believe that the free market is a means for measuring people's preferences rather than an expression of individual choice—a value in itself under libertarianism.

Under subjective utilitarianism, individual preferences would be traded for aggregate preferences in the market. It is possible that there would be no demand for the least restrictive alternative from society as a whole on the basis of aggregate subjective preference calculated by using cost-benefit analysis. Community services for persons with severe and persistent mental illness would probably be downsized, because—for the most part—the society would prefer to keep the mentally ill population behind closed doors (39–41). This almost visceral response of "not in my backyard" is universal. People would rather assume that the harm associated with the more restrictive treatments is far less vicious than the harm associated with respecting the personal preferences of persons with severe and persistent mental illness, many of whom will ruin their lives and deteriorate progressively without timely treatment (42).

Objective utilitarianism. From the viewpoint of today's prevailing fiscal pragmatism, objective utilitarianism (22,23,43–45), which relies on cost-effectiveness analysis rather than market and cost-benefit analysis, would be the sound ethical ground for mental health policies. (Cost-effectiveness analysis is different from cost-benefit analysis in that cost-effectiveness analysis considers measurement of nonmarket and nonmonetary goods, such as diverse dimensions of health and life.) Clearly, in the context of finite resources, cost-effectiveness should be the major criterion for defining optimal treatments that can best meet individual patients' needs through high-quality care. The least restrictive treatment alternative could also be one of the most cost-effective treatments, although cost-effectiveness is not a consideration in the least restrictive alternative.

To make the least restrictive alternative sustainable within today's fiscal constraints, people should demonstrate the cost-effectiveness of this alternative through applying cost-effectiveness analysis. Thus far a dozen community psychiatric treatment programs, such as the Program for Assertive Community Treatment (PACT) and supportive employment programs, have been proven cost-effective by scientific evidence (46–51). This ethical theory does not necessarily devalue or idealize any treatment program. Although the first and foremost goal of any treatment program remains to provide services to persons with mental illness in a cost-effective way, service planners and providers could still incorporate any value—such as individual liberty, personal preference, and consumer satisfaction—into their definition of program effectiveness. On the other hand, this ethical theory discards the idea that "the cheapest way is also the best." Effective treatment for persons with severe and persistent mental illness is not necessarily cheap. Indeed, the concept of cost-effectiveness is to pursue the best value for money rather than the lowest price.

Conclusions

Liberalism and subjective utilitarianism advocating individual rights and preference for liberty are the central ethical theories surrounding the least restrictive alternative. The irony is that relying on the market as an expression of individual choice (as with libertarianism) and as the measure of individual preference (as with subjective utilitarianism) effectively disenfranchises the vulnerable population of persons with severe and persistent mental illness. Egalitarian liberalism, which does not rely on the market to distribute resources and highlights distributive justice for the worst-off members of society, still faces many dilemmas, such as how to define basic social resources and what quantity of resources should be redistributed to the people who are worst off.

Advocates of individual liberty and preference tend to deny or minimize the devastating impact of mental illness on patients and on their families and thus may not focus on building a mental health service system that can meet the complex needs of persons with severe and persistent mental illness. Unfortunately, as Lamb points out, "ideology often wins out over clinical reality" (52). Communitarianism could be applied as an ethical basis for any policy, as long as the policy conforms to the values and traditions of the community in which it will be enforced. Therefore, this ethical theory does not guarantee that any policy principle, including the least restrictive alternative, will be universally accepted. Neither does it mean that any policy adopted by a given society is the most cost-effective one for addressing the various needs of per-

sons with mental illness, unless cost-effectiveness is the priority traditional value of the society.

Under communitarianism, in order to change mental health policies, people must find local culture-relevant solutions rather than import what has worked in other communities. Thus one possible way to make a mental health policy not only value-consistent but also clinically effective and economically feasible in a given community is to reinterpret traditional values in light of solid and abundant evidence from cost-effectiveness analysis.

From the perspective of objective utilitarianism, any treatment program, no matter what degree of restriction it represents, should be scrutinized and forged by the cost-effectiveness analysis to achieve the greatest good for the greatest numbers. Also, we ought to use scientific evidence to shed light on the conditions that make the current concerns persist. Such evidence will also be of great value for our society in defining problems and formulating mental health policy on the basis of facts rather than rhetoric.

Ideally, every patient should be treated with programs that best meet his or her needs with minimal infringement on personal liberty. The reality is that although many patients can adjust well in the open community setting, many other persons with severe and persistent mental illness still cannot live in the community without a higher degree of structure (52). However, the principle of the least restrictive alternative has simplistically drawn people's attention to the interest of individual liberty and preference, not to the various and complex needs of persons with severe and persistent mental illness, for the past four decades.

What patients desperately need is the full treatment and setting continuum that can most effectively relieve the suffering imposed by their illness. The continuum varies in the degree to which the treatment programs "supply freedom versus restrictions; protection versus demands and responsibilities; care versus self-reliance; and normative identity versus patient identity" (53). The degree of restriction is but one variable to consider, and individual liberty and personal preference can merely be one aspect of effectiveness that every program is supposed to pursue. In the face of the contemporary environment of fiscal pragmatism and the trend toward managed care, it would be wise for all participants in policy making and service provision to consider replacing the principle of the least restrictive alternative with that of the most cost-effective alternative to ensure that individual patients and society as a whole get the best value for money.

Thus, in the process of searching for a new ideology for the postinstitutional era, as Munetz (54) pointed out, "The pendulum of mental health ideology and policy keeps swinging, in America and around the world. One can only hope that at some point the pendulum will suspend itself over some middle ground, where the ideology is to provide what each individual needs along the full treatment continuum." The concept of cost-effectiveness and its underlying ethical theory, objective utilitarianism, together with communitarianism, would be able to help the pendulum suspend itself over the middle ground. ♦

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