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Applying the Least Restrictive Alternative Principle to Treatment Decisions: A Legal and Behavioral Analysis

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The least restrictive alternative concept is widely used in mental health law. This paper addresses how the concept has been applied to treatment decisions. The paper offers both a legal and a behavioral analysis to some problems that have emerged in recent years concerning the selection of behavioral procedures used to change client behavior. The paper also offers ways of improving the application of the concept, which involve developing a more behaviorally functional perspective toward restrictiveness.

Key words: least restrictive alternative, treatment decisions, legal issues, behavioral programming

The term *least restrictive alternative* (LRA) refers to one of the most widely used, yet least understood, concepts in mental health law. Although some courts revere the concept, terming it a "constitutional standard" (*Romeo v. Youngberg,* 1980), others dismiss it as nothing more than "a slogan" (*Gary W. v. State of Louisiana,* 1976). In fact, the LRA principle serves as an important safeguard against unnecessary infringement of individual rights by the state. The LRA doctrine has diverse applications when governmental actions implicate the protections guaranteed by the Bill of Rights. In order to fully understand the importance of the LRA principle in the field of mental health law, it is necessary to trace the history of the doctrine.

ORIGINS

The LRA doctrine did not originate the mental health case law, but in cases concerning the First Amendment. It was established in *Shelton v. Tucker* (1960). This case involved an Arkansas statute that required each teacher in a state-supported school, as a condition of employment, to file annually a list of every organization to which the teacher belonged or made a contribution in the preceding 5 years. Although the government claimed a legitimate purpose in acquiring background information on teachers in public schools, the teachers asserted their constitutionally protected freedom to associate with whomever they chose. Shelton was one of many teachers who argued that compelled disclosures such as those required by the Arkansas statute would discourage exercise of the fundamental right of association protected by the First Amendment. In balancing the competing interests—the state's interest in checking the competence and fitness of its teachers and the teacher's right to associate privately—the United States Supreme Court held that

> even though the governmental purpose may be legitimate and substantial, that purpose cannot be achieved by means that broadly stifle personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in light of less drastic means of achieving the same basic purpose. (*Shelton v. Tucker,* 1960, p. 488)

The result of *Shelton v. Tucker* was the birth of the LRA principle, which is not a constitutional right itself but is a constitutionally rooted safeguard protecting the exercise of fundamental constitutional rights. No constitutional rights are absolute. For example, as the legal maxim states, the first amendment does not permit someone to yell "fire!" in a crowded movie theater. Nevertheless, restrictions of fundamental rights must not be overbroad. The LRA principle requires that when a constitutional right can be legit-

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imately restricted, it should be restricted only to the extent necessary to carry out a valid purpose. In *Shelton,* the Arkansas statute violated the principle because it required disclosure of every conceivable associational tie—social, professional, avocational, and religious—even though many relationships could have no possible bearing upon a teacher's occupational competence or fitness.

The LRA doctrine may be applied any time fundamental individual rights conflict with threatened governmental action, whether that action is legislative, administrative, or judicial. In addition to freedom of association, courts historically have applied the principle when government action affects fundamental rights such as freedom of speech (*Spence v. Washington,* 1976), freedom of religion (*Sherbert v. Verner,* 1963), equal protection (*Dunn v. Blumstein,* 1972), and due process (*Churchill Bd. of Ed. v. LeFleur,* 1972).

EARLY APPLICATIONS IN MENTAL HEALTH

Because mentally ill and developmentally disabled individuals do not lose their constitutional rights by reason of their disability, the LRA principle has been broadly applied in the field of mental health law. Not surprisingly, the doctrine first arose in mental health case law in the context of civil commitments. In *Lessard v. Schmidt* (1972), a class action was filed on behalf of civilly committed adults in Wisconsin to challenge the constitutionality of that state's commitment laws. The Wisconsin court recognized the legitimate interest of the state in confining mentally ill persons for self-protection and treatment and, in certain cases, for protection of the community at large. Weighed against the state's interest is the individual's constitutional right to liberty and privacy secured by the due process clause of the Fourteenth Amendment.

On balance, the Wisconsin court held that the individual's right could be overcome only when the state could prove a person to be mentally ill and a danger to himself or others. Because any involuntary commitment involves a massive deprivation of liberty, the *Lessard* decision imposed upon the state the additional burden of demonstrating the commitment was the least restrictive alternative: "Even if the standards for an adjudication of mental illness and potential dangerousness are satisfied, a court should order full-time involuntary hospitalization only as a last resort" (*Lessard v. Schmidt,* 1972, p. 1095).

The court suggested a number of possible alternatives to be explored prior to an involuntary commitment decision, including outpatient treatment, day placements, night treatment, referral to a community mental health clinic, and home health aid services. The court ruled that no person could be committed unless all available less restrictive alternatives were deemed unsuitable. Because the statutory commitment procedure in effect in Wisconsin at the time failed to require that less restrictive alternatives to commitment be considered, the court found the procedure constitutionally defective.

Since *Lessard,* mental health cases have paid considerable attention to application of the LRA principle. However, the development of the doctrine has not been limited to judicial decisions. Because of effective advocacy by mental health support organizations, many states have adopted by statute so-called "bills of rights" for the developmentally disabled. The LRA principle has increasingly been explicitly incorporated into the statutory as well as regulatory schemes that seek to ensure that sufficient consideration be given to treatment and placement alternatives. Today, virtually every state has enacted some form of the principle in limiting the application of various mental health treatments or services (McGrath & Keilitz, 1984).

LRA AND THE SELECTION OF TREATMENT PROCEDURES

Much of the legal development of LRA has involved the field of developmental disabilities (see Turnbull, 1981). Perhaps the most obvious issues concern the placement of handicapped individuals in

residential, educational, or programmatic settings. In fact, LRA is sometimes referred to in this context as *least restrictive placement.* Much of the discussion of the least restrictive doctrine is in this area (e.g., see Taylor, 1988). Educational considerations have been especially prominent since 1975, when PL 94-142, the Education for All Handicapped Children Act, was passed by Congress (Myers, Jenson, & McMahon, 1986; Schifani, Anderson, & Odle, 1980).

Another set of applications of LRA concerns variety of issues that involve an individual's legal status and the consequences for the individual's choices in various areas, including medical treatment. For example, LRA is one of the legal foundations for how decisions are reached concerning involuntary commitment, guardianship, the right to refuse treatment, and the right to consent. These issues apply LRA to problems such as medical procedures, birth control, institutional or living conditions, and social life-style.

A third group of issues that involve LRA concerns the application of behavior-change methods. Here, LRA is sometimes referred to as *least restrictive treatment.* The present paper focuses on this use of LRA, which developed somewhat more recently than its role in placement issues. Perhaps this is why the LRA literature has surprisingly little explicit discussion of interpretations that seem to be increasingly represented in regulatory and statutory form and generally accepted in practice settings.

LRA is typically used to support a hierarchical approach to treatment decisions that may have originated in an incident in Florida's retardation system in the early 1970s (see Johnston & Shook, 1987). A multidisciplinary committee of national experts appointed by the governor proposed a general approach to delivering behavioral programming services (May et al., 1976), which then led an internal task force of the state's Division of Retardation to set a formal policy. This regulatory policy grouped accepted behavioral procedures into three levels of regulatory control (with two additional levels involving oversight functions). These three levels were partly defined by the level of technical expertise of the personnel who were allowed to approve and monitor their use (*Guidelines on Behavior Management,* 1975). Thus, a Level 3 procedure could be approved for use in a program only by a staff member holding Level 3 certification.

Neither task force couched its recommendations for selecting and using behavioral procedures explicitly in terms of LRA. However, this legal doctrine and associated concepts (such as individualization and normalization) were clearly part of the supporting rationale. The three levels of regulatory control were at least partly based on the degree of intrusiveness or restrictiveness attributed to the included procedures, although the dimensions for these groupings were not articulated. (For present purposes, the terms intrusiveness and restrictiveness will be used interchangeably.)

This regulatory approach to decision making about treatment procedures is now common (Reese, 1984; see also Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons, 1980; Finesmith, 1970; *Wuori v. Zitnay,* 1978). Familiarity has bred neither clarity nor consistency, however. There is no evidence of even general agreement about how to construct these hierarchies (see, e.g., Friedman, 1975, in contrast to Reese, 1984). Successive versions of Florida's regulations have reassigned various procedures, and the real criterion has become essentially political. The procedures whose use is most closely regulated are those of most concern to professional and other special interest groups, regardless of how their restrictiveness might be evaluated by other criteria (*Behavioral Programming,* 1989). In fact, it often seems as if restrictiveness is simply defined in terms of these cultural concerns in a version of what might be called the Supreme Court standard: "I can't tell you in advance what it is, but I'll know it when I see it."[1]

[1] Based on the well-known statement of Justice Potter Stewart in his concurring opinion in the Supreme Court's pornography decision in *Jacobellis v. Ohio* (1964).

There are also different interpretations of exactly how LRA applies to a treatment procedure hierarchy based on intrusiveness or restrictiveness. For instance, in practice some feel that before a procedure can be implemented, all or at least some less intrusive procedures must have been tried and shown to be ineffective. Others feel that only a "reasonable justification" that less restrictive procedures are inappropriate or would at least be ineffective is required. The former view can lead to long delays in clients receiving effective treatment while less restrictive alternatives are tried and found wanting (Repp & Deitz, 1978). However, the latter can lead to violations of the LRA principle.

Of course, the process of trying less restrictive alternative procedures itself raises LRA considerations. Determining whether less restrictive procedures will work means that there will often be some delay before an effective, though perhaps more restrictive, procedure is finally tried. During this period, the client will continue to suffer restrictions associated with the behavioral problem itself. These aspects of restrictiveness must be balanced against the initial use of a more restrictive procedure that has a greater likelihood of effectiveness. These problems in applying LRA to behavioral programming decisions highlight the lack of a coherent legal and behavioral analysis examining how this legal doctrine can be integrated with behavioral technology and the way that behavior really works.

A BEHAVIORAL INTERPRETATION OF LRA

Functional Nature of Stimuli

At the root of problems with the application of LRA to treatment decisions is the difficult issue of how the legal concept can be translated into professional actions concerning behavior. LRA has its foundation in a colloquial, mentalistic conception of human nature, but the phenomenon of behavior does not work the way the founders of our constitution, legislators, and judges have assumed.

For example, the assumption seems widespread that the involvement of punishing stimuli makes a procedure more restrictive than if the procedure is otherwise the same but involves only positive reinforcement. However, simple reinforcement and punishment procedures are operationally identical. Only their effects on behavior differ. These differences in effects depend on the functions of the stimuli used as consequences for behaving (Catania, 1984).

One problem with assigning an inherently greater restrictiveness to punishment procedures in general is that what functions as a punisher for one person may serve as a reinforcer for another, or for the same individual at another time. In other words, *we cannot always define or predict the effects of stimuli from their physical properties.* Therefore, any attempt to interpret restrictiveness strictly in the terms of the physical properties of stimuli is doomed from the outset because such a standard does not accommodate the functional nature of behavior–environment relations.

Issues of Control

The above assumption about the restrictive nature of punishing consequences seems to be based on the idea that using punishing stimuli is inherently more controlling or even coercive than using positively reinforcing stimuli. Aside from the problem of defining stimuli in terms of their physical properties, this view implies a distinction between coercion and control, with coercion being a form of control that is more "restrictive" than other forms. Although this is not a difficult distinction to argue from a cultural or behavioral (i.e., functional) perspective (see Sidman, 1989), for Mother Nature, control is control. That is, although we can make political or even functional distinctions between one kind of control and another, behavior is always fully and equivalently influenced by surrounding environmental events.

This means, for example, that a class of responses whose occurrence is reduced

by the procedure known as differential reinforcement of other behavior (DRO) is no less controlled than one that is under the influence of an overcorrection procedure or even a reinforcement procedure. The deterministic assumption guiding scientific study is that all response classes have some sources of influence or control. Although we can certainly distinguish coercion from other "forms" of control in terms of a cultural or legal perspective, coercion is not a fundamentally distinctive form of control in nature by procedure, mechanism, or effect.

Definitions of restrictiveness based on the idea that different procedures generically involve different degrees of control lead to procedural hierarchies that are unavoidably arbitrary and therefore inconsistent with regard to the individual case. There is simply no basis for arguing that Procedure A is inherently more restrictive than Procedure B if the foundation for such categorization is the degree of control involved. For instance, it is tempting to say that a simple positive reinforcement procedure is less controlling than seclusion time-out. However, the required arguments can be based only on arbitrary assumptions or definitions of value for the different elements of each procedure. At the level of behavioral principles, reinforcement and punishment cannot be distinguished in terms of the extent of control over behavior, any more than the laws of fluid dynamics could be said to be more or less "controlling" than the laws of nuclear fission. In the abstract, all behavioral procedures involve equivalent control because they are merely applications of various laws of nature, which are always at work anyway.

Criterion of Clinical Effectiveness

Of course, one procedure may work more effectively than another with regard to some goal in a particular application for certain reasons. Therefore, another way to define restrictiveness is in terms of the degree of clinical effectiveness obtained in each case. That is, if restrictiveness is associated with degree of control (which, in turn, might be seen as synonymous with degree of effectiveness), then procedures that do not work well or consistently are less restrictive than those that do, and vice versa. This position says that if Procedure A is generally less effective in attaining a treatment goal than is Procedure B in reaching the same or even a different clinical objective, Procedure B is more restrictive because it is more effective. For example, if social disapproval is more effective in decreasing inappropriate sexual behavior than is seclusion time-out in reducing aggressive behavior, social disapproval would be considered more restrictive.

Because the resulting restrictiveness categories necessarily depend heavily on the features of each application, this approach does not provide a good basis for a general hierarchy of restrictiveness. In the above examples, for instance, seclusion time-out may be inappropriately or poorly applied to a particular behavior or in a certain situation and therefore not work very well. This result would mean that time-out would be categorized as less restrictive than another procedure in that instance (social disapproval, for example), even though a simple modification of some feature of the time-out procedure might greatly improve its efficacy. A standard of clinical effectiveness therefore requires individualizing the concept of restrictiveness. Although this step is in some ways desirable, this particular approach to individualization greatly limits the way that the concept of restrictiveness can be used because it can only be defined after the fact.

Behaviorally Arbitrary Criteria

Of course, there are more complex definitions of restrictiveness or intrusiveness that have been offered. Reese (1984) listed six that are typical: (a) the public's rating of the acceptability of the procedure, (b) the deprivation of liberty necessary to implement the procedure, (c) time in the habilitation program, (d)

amount of risk associated with the procedure, (e) amount of discomfort and stress that the procedure produces, and (f) degree of irreversibility of expected or unexpected effects.

Although these criteria are value laden and behaviorally arbitrary, some are not difficult to translate into workable regulations. However, some of their features are a problem. For instance, what is the definition of liberty or freedom that will be used in (b)? The colloquial meaning of "freedom" is contrary to the way behavior works, as Skinner (1971) has argued at length. In (d), what are the criteria for risk? They will probably impose additional arbitrary criteria. In (e), how are discomfort and stress to be defined? It might be difficult to avoid "loading" such definitions with culturally based assumptions about control, freedom, and so forth.

Finally, item (f) is especially problematic. In a general sense, all behavioral effects are reversible, in contrast to the effects of medical procedures (e.g., hysterectomy). Of course, the goal of most behavioral programs is to build in support for the durability of a procedure's effects—in other words, to work toward irreversibility. One could program toward the goal of weakening or dismantling the effects of a previous treatment procedure, but this would be pointless. Irreversibility as a criterion for restrictiveness seems to make little sense for behavioral treatment.

In summary, the legal concept of restrictiveness cannot be easily applied to the task of managing behavior without setting up criteria that have their basis in unrecognized, vague, and unworkable cultural values rather than in behavioral processes. The kind of criteria that have been published or that are implied in present regulations do not accommodate the fundamental nature of behavior. Moreover, they not only present serious problems of interpretation and application but may also result in decisions that are not in the best interests of clients.

As a result, decisions about treatment procedures that are supposed to be consistent with the LRA principle are arbitrary, inconsistent, and often contrary to the spirit of the LRA doctrine. Attempting to construct a universal or even local restrictiveness hierarchy that is consistently meaningful across individuals and circumstances cannot succeed because it requires faulty notions of behavioral control and fails to consider the functional character of behavior. Individualizing the concept of restrictiveness cannot help when doing so merely equates restrictiveness with post-hoc effectiveness. Is there a better way of translating these important legal issues into a practical decision-making system that is consistent with the fundamental nature of behavior?

TOWARD A BETTER MODEL

Cultural Values and Behavioral Facts

An affirmative answer to this question depends of the candid acknowledgment of the cultural agenda underlying the legal concept of restrictiveness. The law is about cultural values, and the LRA legal doctrine cannot be translated into regulatory form until its basis in cultural values is fully identified. It is of no help to say that LRA is a legal description of a widespread cultural desire to use as little intervention as possible to accomplish therapy and training objectives for developmentally disabled individuals. What constitutes "intervention" is defined only by contrast to the environments customarily encountered by individuals who are not disabled. A discussion among professionals of what in general is customary, what constitutes an intervention, and what is justifiable under what conditions inevitably leads to significant disagreements. Adding opinions from the full range of interested parties seems to guarantee divisiveness. And yet, because LRA has no meaning independent of such views, it cannot usefully guide decision making unless these conflicts are identified and resolved.

For instance, if we want to say that procedures based on positively reinforcing consequences are generally preferred over those that use punishing consequences, then we should be prepared to accept such a value on its own terms,

without pretending that it has anything to do with coercion or control. If we feel that seclusion time-out should be used only if other forms of time-out are obviously inappropriate or have failed to produce the desired effect, then we should accept such values without having to rationalize them in terms of restrictiveness.

In identifying these values and developing a consensus about their role in treatment decisions, we must be prepared to analyze their critical elements with unblinking honesty. Exactly what makes the contingent delivery of a spray of water mist in a client's face unpleasant to some staff? Why is time-out that requires a client to sit in a corner less troublesome to some observers than time-out that requires the individual to go to his or her room? Why are we willing to subject ourselves and others to "restrictive" medical and dental treatment procedures in the interest of eventual health benefits but less inclined to accept a similar balance when dealing with behavior? Do the accumulated values embody contradictions that should be faced and resolved?

One obligation the law will require is that culturally based standards be consistently applied. If, for example, a preference for reinforcement over punishment procedures is to be a guiding principle, then we must be thorough in evaluating the elements of commonly accepted procedures and adjusting our use of them so as to be consistent with value-based rules. Thus, social disapproval must be acknowledged to be as much a punishment procedure as is contingent water mist. The programmatic use of certain physical "holds" for the purpose of restraining a client will probably have to be evaluated as involving punishing consequences for the client's behavior, however contrary this may be to our intentions. Similarly, we must be clear that many formal and informal contingencies involving a loss of reinforcement or access to reinforcement are no different in this regard than seclusion time-out.

A thorough examination of cultural values that seem to be related to the colloquial sense of restrictiveness will reach well beyond the features of behavioral procedures. We must consider other general factors, such as the nature of the target response class and its effects on both the client and others. Is the response class one that necessitates many limitations on the client's freedom? What will be the general effects of modifying this form of behavior? Will effective training or treatment improve the client's life only modestly, or will the effects be dramatic? For example, reducing serious aggressive behavior will probably lead to more changes in a client's daily life (not to mention the lives of others) than reduction of inappropriate greeting responses.

What will be the effects on the remainder of the client's repertoire that are likely to follow from changing the target response class? For instance, learning to stay on task for extended periods is more likely to lead to unprogrammed changes in other behavior patterns (e.g., learning new work skills) than is learning a color-naming skill. What will be the effects of the pace at which the target response class is changed? If serious self-injury is ameliorated slowly, for example, unnecessary damage may result. When considering restrictiveness issues, these kinds of questions about target behaviors and settings seem to be as pertinent as the palatability of different procedures. Any review of values that might impinge on treatment decisions should also consider these non-procedural issues so they can contribute to the balance of any analysis.

Any single individual might be able to conduct this analysis of his or her values related to behavioral procedures without serious difficulty. Doing this collectively, even among professionals, will certainly ensure protracted debates with emotional overtones. Involving the complete range of interested parties in this venture will hardly aid in resolving differences. Nevertheless, failure to conduct such an analysis will only guarantee that we will continue to confuse cultural values with scientific and technical judgments, to burden staff with decisions they are ill-prepared to make, and to make clinical decisions that have inconsistent and sometimes deleterious effects on clients. The so-called "aversives" controversy is

certainly an unfortunate example of our failure to face these difficult issues.

Basic Considerations for a Model

Generality. In establishing the limitations cultural values might place on treatment procedure decisions, it should be clear that we must abandon the Holy Grail of an LRA-based treatment selection model that outlines a simple, universal hierarchy of procedures, however that hierarchy may be justified or labeled. Even though a cataloging of cultural values might permit such a hierarchy to be developed, its use as a simple decision-making tool would ignore many other idiosyncratic factors that must be considered. As suggested above, these include the nature and effects of the target behavior; the constraints on procedural options stemming from staff, the physical setting, and other aspects of the treatment environment; the history of previous interventions; and the impact of an effective intervention on other behavior.

Individualization. These considerations must be individualized, and so must our application of value-based constraints on procedural decisions. This emphasis on the individualization of LRA interpretations does not mean that a general model cannot be developed. Such a model will be necessary for professional and staff training, protection of treatment staff from harassment, monitoring of decision-making practices, and ensuring a consistent framework for decisions. However, this kind of model should be sufficiently general to permit treatment and training decisions based on the details of each case. It should provide only a framework for decisions, which must then be developed by the professionals familiar with the unique features of individual clinical situations.

Functional approach to consequences. This model should also be consistent with the technology being applied. For instance, the model should take a functional approach to the role of stimuli. This means that consequences for behaving would not be distinguished on the basis of their physical characteristics, except perhaps for those few whose use might be unalterably prohibited by cultural values. This perspective would therefore allow a given consequence to be acceptable for one client but unacceptable for another, depending both on its function for each client and on other idiosyncratic factors.

Separate procedures from consequences. This approach will also require us to distinguish between procedures and the environmental events used as discriminative stimuli and reinforcing or punishing consequences. Although, in a general sense, a behavior-change procedure might be understood as including the consequences required for the client's behavior, it is important to evaluate procedures separately from the environmental events involved. Procedures are operations set up or managed by staff, including arranging contingencies between responses and the antecedent and consequent events surrounding them. For instance, the procedure of positive punishment involves presenting a consequence immediately following each targeted response.

The reason for evaluating the cultural acceptability of procedures separately from the antecedent or consequent events used is that it is usually the latter that is culturally problematic, not the procedure. For example, as already noted, at their simplest, positive reinforcement and punishment involve exactly the same procedure (i.e., delivery of a consequence immediately following a response), but this is not the basis for cultural concerns. This distinction may often allow us to narrow our deliberations and make more consistent decisions.

Inappropriate Considerations

Two common considerations are inappropriate for a decision-making model. First, it is not especially meaningful to distinguish between procedures on the basis of ease of use. Well-trained professionals realize that the complexity or difficulty of using a treatment procedure is not usually a relevant dimension because the proper application of all procedures

involves many of the same operational elements. In fact, it might be ventured that if one procedure seems to be significantly easier or more difficult than another, then it is probably the case that important subtleties are being overlooked.

Second, the same general argument applies to differentiating among procedures on the basis of any harm that might result from improper use. Although it is often implied that procedures using punishing consequences are riskier than those based on positively reinforcing consequences, it is easy to argue the converse. In fact, misapplied reinforcement is often the reason that undesirable patterns of behavior have developed. It is almost impossible to predict the possible effects on behavior of improperly applying a procedure because there are so many ways in which any procedure can be misused and so many unique features of each client and situation that will be part of any unintended effects. Any model for selecting behavior-change procedures must assume that they will be properly implemented. We should never select procedures that we know are unlikely to be applied correctly.

Objective Versus Subjective Application

The model under discussion will still require extensive reliance on the complex decision-making and oversight bureaucracy that presently plagues the delivery of behavioral services to developmentally disabled individuals. We should be quite concerned, however, about the extent to which a system of cultural values—even if well developed—infringes on technological capabilities. The price of this infringement will be paid by the clients we are trying to serve. If we choose to avoid or prohibit the use of effective procedures in the interest of supporting the collective likes and dislikes the culture has accumulated, who will speak for the client, who may have a different set of interests?

The law is supposed to serve this role. Thus, further support for the individualization of LRA considerations comes from legal quarters. The initial application of the LRA principle in the field of mental health law played an essential role in articulating the rights of developmentally disabled and mentally ill individuals. The development of the principle can be attributed to the fact that governmental actions affecting the disabled were either grossly inadequate or so overly broad that individual rights were jeopardized. However, as state agencies have become more sensitive to the needs of the disabled and more sophisticated in treatment and placement decisions, the promise of the LRA principle has dissipated (Parry, 1985). No longer is the principle applied on an individualized basis. Instead, the concept usually has been viewed as an objective principle that judicial decision makers have applied uniformly with little or no analysis.

For example, in the area of placement decisions, a plethora of cases assert that institutions are inherently more restrictive than community placements. These cases therefore establish an objective standard that is not necessarily appropriate when dealing with the needs of individual clients. The use of the LRA principle as an objective standard results in the creation of hierarchies because judges and legislatures often make sweeping treatment and placement decisions for individuals without taking into account individualized needs. Very little room exists in hierarchical approaches for tailoring treatment and placement decisions to the needs of the individual. As a consequence, mental health professionals are increasingly becoming removed from the decision-making process and losing any opportunity to determine what is best for their clients.

An example of this problem arose recently in a California case. California, like many other states, promulgated a statutory bill of rights, part of which contains a right to treatment and habilitation "in the least restrictive conditions necessary to achieve the purpose of treatment" (Lanterman Developmental Disabilities Act). In interpreting this specific provision, the Court of Appeals in *In re Bor-*

gogna (1981) discussed the relation between state hospital and community residences as set forth in the statute. The court concluded that "throughout [the statutory scheme], the assumption is that the most restrictive and undesirable custody is in a hospital, and that the ward, or those most interested in his welfare will be opposing that placement" (*In re Borgogna,* 1981).

The court's analysis rests on the faulty notion that a state hospital is always a more restrictive placement than any other alternative. The premise represents a broad societal value judgment that fails to take into account individual values and needs. Indeed, the *Borgogna,* the seemingly anomalous situation arose in which the state sought to remove Andrew Borgogna from a state hospital and place him in a community residence, arguing that he could be effectively treated in a "less restrictive" community setting. Andrew, however, through his conservator, opposed the proposed transfer. The testimony was that he wanted to remain in the state hospital, was happy with his living conditions, and greatly feared a disruption in his routine by transfer to a community residence.

Unfortunately, the California court failed to recognize the effects of the "least restrictive" placement for Andrew Borgogna. A correct application of the LRA principle would have required the court to determine whether a less structured, more open placement was in fact more restrictive in Andrew's case. The "less restrictive" setting may have restricted his existing repertoire. Andrew may have needed the security of a state hospital to achieve his maximum developmental potential. Indeed, the test may show that Andrew was functioning quite well in the state hospital. It was for that very reason that the state inflexibly argued he should be transferred to a community setting.

What the courts may sometimes fail to appreciate are the behavioral issues implicit in the fact that what may be less restrictive to one individual in certain circumstances may not be less restrictive to another. A stroll in the park may be an ideal way to spend a summer's day for some people, but for an agoraphobic, it can be terrifying. This conceptual shortcoming should not be surprising, however, because judges and legislators are obviously better prepared to interpret cultural values than scientific laws. They are frequently called upon to make such value judgments. As a result, hierarchies of placement settings and treatment modalities easily develop.

For example, under the Eighth Amendment, capital punishment is considered the most severe penalty, even though a particular individual may find death more tolerable than life imprisonment without the possibility of parole. In states in which capital punishment is allowed, courts impose death sentences without first inquiring whether a murderer finds life imprisonment more distasteful than death. Instead, society has already made that determination when legislators set forth the sentencing hierarchy. Similarly, some state legislatures are currently wrestling with bills to ban "aversive therapies" based on a societal value judgment that the use of aversives is so much more restrictive than other treatment modalities that they go beyond the bounds of accepted forms of treatment. As argued earlier, this determination is made on a moral rather than on a scientific basis.

In order to be an effective constitutional safeguard, the LRA principle cannot remain an objective standard but must be a subjective and dynamic principle tailored to individual needs (Parry, 1985). Individual preferences and needs simply cannot be neatly fitted into a universal objective continuum. Indeed, the very basis for promulgating the constitutional Bill of Rights was to protect the individual from the overbearing will of the majority. Likewise, in determining the needs of the developmentally disabled, treatment decisions cannot be made in isolation from the individual's personal preferences, values, and circumstances. When the individual is incompetent, the right to consent to treatment is exercised through a substitute decision

maker, such as a conservator or guardian. The function of the substitute decision maker should be to support the incompetent individual's wishes as best as can be determined based on a subjective determination of what is less restrictive for that person, given his or her particular values and preferences. So long as the decision is consistent with the basic goals of the state, the individual decision is entitled to be respected (Parry, 1985). Instead of being prevented from exercising their judgment, clinicians and other professionals will be restored to their proper role, which is to inform the individual (or the substitute decision maker) of the best course of treatment for addressing his or her clinical needs. The individual (or substitute decision maker) then weighs that information, together with other information concerning the individual's values or preferences, and arrives at a judgment.

The final decision is therefore made with necessary clinical input from professionals who are in a unique position to determine what is appropriate for their clients. When the law requires courts to become involved in the process, the role of the judge is not to enforce treatment standards based on objective criteria, but instead to review the substitute decision maker's determination to ensure that it is based on proper clinical information and with appropriate respect given to the individual wishes of the client.

TOWARD AN IDEAL MODEL

We have recommended an LRA-based model for making treatment decisions that avoids a simplistic hierarchy of procedures in favor of a general framework that individualizes the evaluation of how cultural values and behavior-change technology should be coordinated. Although such a model is probably a reasonable goal at present, it is only one step toward a more ideal method of making decisions. Consider the possibility that the primary attractiveness of the traditional hierarchical approach to the selection of treatment procedures stems from the fact that paraprofessionals and nonprofessionals usually make these important decisions. This genuine need for quality control is the result of (a) a still-immature behavior-change technology that often requires complex, clinical judgments in the context of an experimental style of the decision making and (b) a severe shortage of personnel who have the necessary training and skills to make and implement these treatment decisions properly.

In the field of medicine, by contrast, physicians do not adhere to a formal restrictiveness hierarchy of treatment procedures because a better developed medical technology and an adequate number of physicians allow a more sophisticated approach to decision making. The individual physician considers all of the relevant cultural and professional standards, recommends a course of treatment to the patient, and proceeds if consent is given. The patient is always free to ask about alternative treatments or to obtain other opinions. The physician's judgments are bounded by laws, professional rules, and scientific literature. They are also monitored after the fact through both professional and state mechanisms. However, suppose that the effectiveness of medical techniques was as uncertain as it was 100 years ago, or that nurses and orderlies made medical treatment decisions. The degree of flexibility now permitted the individual physician might have to be replaced by the relatively simple and rigid rules for making decisions represented by treatment procedure hierarchies in the field of developmental disabilities.

In other words, the real problem we face is not so much that we are struggling with what the legal issues are concerning restrictiveness or how they apply to retarded individuals, but that we are not clear about the cultural values that impinge on behavioral interventions. Furthermore, our technology is hardly fully developed and is certainly poorly applied much of the time because of limitations in the number of expert staff. We are trying to accommodate these difficulties by

following simple rules for what are actually very complex decisions. If we hypothetically remove these unnecessary burdens, the regulatory task gets considerably simpler.

Let us assume, for example, that any questions about the constitutionally guaranteed rights of clients under various circumstances have been settled. Let us also assume that a reasonable consensus regarding culturally based limitations on treatment options has been reached and certified by professional standards and bureaucratic regulations. The question then becomes one of how to ensure that these rights and values are respected for each individual in routine, daily practice. If we further assume that (a) there is a nationally established doctoral and master's level training curriculum that assures a high level of expertise in behavioral programming, (b) these individuals are employed in adequate numbers in service delivery settings, (c) these individuals are identified by certification or licensure and are alone empowered to make treatment decisions, and (d) they have adequate support personnel and other resources to offer state-of-the-art behavioral services, then the problem might become not one of controlling treatment decisions before the fact but one of monitoring a sample of such decisions post hoc, even if we make the discouraging assumption that the technology is no more sophisticated than it is at present.

In this "best of all possible worlds," properly trained and supported professionals would reasonably be expected to make treatment decisions and supervise their implementation sufficiently well that only a limited program of state and professional monitoring would be required to ensure that everything was consistent with legal, regulatory, and cultural dictates. As unthinkable as it might sound in today's unsettled regulatory environment, each professional would simply be left to apply legal and regulatory constraints and professional judgments to the unique features of each case in designing treatment programs. Although this approach is certainly not appropriate under today's treatment conditions, we routinely permit medical professionals the same leeway in decisions involving far greater risk to health and life, decisions that are often irreversible in their consequences.

Of course, we cannot make these assumptions of legal clarity, consensus of values, and proper training and support of adequate numbers of professional and paraprofessional staff. However, we can at least attempt to develop a model of LRA-based decision making that is consistent with both cultural values and a scientific understanding of human behavior, while accommodating the unique features of each treatment situation. Perhaps most importantly, we should give the highest priority to creating a more effective and reliable technology, a more appropriately trained corps of professional and paraprofessional personnel, and more effective service delivery systems so that we will no longer feel the need to reduce complex and individual treatment decisions to crude bureaucratic rules.

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