

**CRUEL AND UNUSUAL? : THE IMPLICATIONS OF SECTION 12
OF THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS
ON RESTRAINT USE IN CARE FACILITIES**

by

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B.A., Simon Fraser University, 1995

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF ARTS (CRIMINOLOGY)

in the School

of

Criminology

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SIMON FRASER UNIVERSITY

December, 1997

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0-612-24114-9

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ABSTRACT

Medical literature identifies four types of restraint used in the treatment of persons in care facilities. Physical restraint is the most obvious form of the practice and is commonly used to prevent violent outbursts towards care-givers or to prevent self harm. Other methods of control include chemical, environmental, and psychological restraint.

All categories of restraint use have been identified in the abuse of incapacitated persons when use is extended from the truly legitimate into a routine practice that confounds the medical and legal interests of the patient. Neglect of the restrained person, overuse, and inappropriately placed restraint devices often result from the implementation of these restrictive forms of patient control, treatment and/or management. Functional decline, disorganized behavior and possible increased morbidity are among the risks equated with the practice. Loss of dignity, self determination and disregard for individual legal rights add to its controversial status in both law and medicine.

In British Columbia, one of four separate Acts that comprise the new adult guardianship legislation places strict controls on restraint use in care facilities. The *Health Care (Consent) and Care Facility (Admission) Act*¹ is expected to come into force in 1998. It will continue to permit the practice of restraint, yet for the first time in British Columbia it provides for a legal review of care decisions made for facility residents, including the use of restraint.

A patient centered paradigm shift in health care for the institutionalized elderly has driven the policy making cycle, culminating in the new restraints law. The progressive

¹ R.S.B.C. 1996, c.181.

thinking of a modern society is inspired by changing medical practices, ethics and societal values that have become statements of policy that reject paternalism in favor of autonomy and self-determinism for the care facility resident.

Section 12 of the *Canadian Charter of Rights and Freedoms* has been mentioned in legal literature discussing potential remedies with respect to patient abuse. However, no in-depth analysis has been undertaken on the relationship of the concept of “cruel and unusual treatment” and the use of restraints on residents in care facilities. Legal analysis of the meaning and application of the clause as it appears in the *Charter* and the preceding *Bill of Rights* supports an argument that the legislation regulating the practice of restraint use in extended care facilities might violate the legal prohibition against such treatment. In light of the recent development of viable alternatives to restraint, continued acceptance of the use of restraint in the long term care context might constitute “cruelty” due to the known adverse effects of the practice, and could be considered an “unusual” treatment of care facility residents where restraint alternatives can serve to adequately replace it.

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CHAPTER ONE

Introduction

...if the caretaker is aware of proper methods of restraining incapacitated persons, then misuse of restraints is considered Physical Abuse; inappropriate restraints due to lack of knowledge constitutes Physical Neglect...it should be presumed that the caretakers have received instruction in the proper use of restraints; the lack of such instruction is itself a deliberate act. Consequently, we include the improper use of restraints in institutional settings under Physical Abuse (Sengtock, McFarland, Hwalek, 1990: 34).

The use of restraints in long term care facilities presents a classic moral conflict between what is “best for the patient” and respect for the right to personal autonomy (Quinn, 1993: 148). Restraint use is common in many long term care and “nursing home” facilities, and it is often considered to be just “part of the environment” of the care facility (Blakeslee, 1991: 6). Restraint researchers and authors Neville Strumpf and Lois Evans estimated that “well over 500,000 persons are daily tied to their beds or chairs in U.S. hospitals and nursing homes, despite the known physical, psychological, and behavioral consequences to health and well-being”(1990: 122).

In an age where individual rights have become paramount in society, restraint use has become an issue of law. The United States first implemented federal restraint standards in 1984¹. In Canada, legislation addressing restraint use exists at the provincial level. British Columbia has recently undertaken a revisit of the regulation of restraint with the introduction of new adult guardianship legislation. As one of four separate Acts that

¹ US Dept. of Health and Human Services. (1984). Use of Restraints: Federal Standards. Washington, D.C.

comprise this legislation, section 25 of the *Health Care (Consent) and Care Facility (Admission) Act*² contains revised controls for the use of restraint in care facilities.

Restraint is defined in the *Care Facility Admission Regulation*³ as:

any chemical, electronic, mechanical, physical, or other means of controlling an adults freedom of movement in a care facility, such as by

- a) isolating the adult
- b) administering any medication that incapacitates the adult, or
- c) using safety devices such as safety belts, bed rails, and chair trays primarily to control the adult's behavior, but does not include the use of electronic devices that only monitor the whereabouts of an adult in a care facility.

For the resident, the experience of being in care can be described as a form of restraint. The individual, either as a voluntary or involuntary resident, at the very least gives up some independence to become part of a group dynamic of a care facility. Depending on the nature of the facility, and the level of care provided, the day to day actions of the residents can be moderately to severely restricted.

As a health care practice there are three primary methods of restraint: physical, chemical and environmental. Physical restraint is the most obvious of these in that the mechanism of restraint is applied to the body and the purpose is more blatantly obvious than is the case with chemical or environmental restraints. A chemical restraint is medication or over-medication administered exclusively for the purpose of controlling or stopping patient behaviors or movements that are considered intolerable or undesirable by the care-giver. Patient restraint may also be achieved by controls placed in the living environment. Locked doors or wards with restricted or privileged access and other

² R.S.B.C. 1996 c.181. Not yet in force.

³ Draft 12, 1997. Not yet in force.

techniques of preventing “unauthorized exiting” are commonly recognized as environmental restraint (Gutman, 1989; Haitt, 1991).

All of these restraint techniques exist with some variation in hospitals, mental health facilities, nursing homes and long term care facilities; everywhere people rely on others to provide health care, yet only where institutional care-givers choose to employ restraint in the provision of care. Each technique has claims to legitimate use, depending on the context of care. For example, it is widely held that a violent person must not be allowed to inflict harm upon others or to inflict self harm. Thus, the use of restraints in an instance where serious injury or death is imminent is likely to be considered both morally and legally acceptable. Such a case may occur when a mentally ill individual attempts to assault a care-giver or to injure himself in response to deluded thinking, or when the victim of a traumatic accident must be physically restrained in order to provide life saving emergency treatment. The dilemma around restraint use appears in the extension of these justifications for patient control onto behaviors that are not necessarily as urgent as those where morbidity or serious injury is threatened.

In the conventional use of restraint, control of the patient may be paramount to genuine concerns of safety with little regard for the protection of patient rights or the promotion of viable alternatives to restraint. A conundrum arises in the justification of restraint in order to prevent injury when the means of protection may place the individual at risk for injuries or other detrimental effects directly related to the use of the restraint as a “safety device”. Restraint may be rationalized as a control of symptoms, or in the antithesis, as a control for control’s sake. If restraint were considered a medical practice or

strictly a form of control, it is nonetheless potentially harmful and abusive when its use is extended from the truly legitimate into a routine practice that confounds the medical and legal interests of the patient.

The complex issues and the controversy associated with restraint use are presented in chapters one and two of this thesis. Various mechanisms and forms of restraint are described, and the rationale involved with the implementation of physical, chemical and environmental restraint is illustrated from the perspective of nursing and care staff.

Chapter three examines the care-giver's legal perception of restraint use; it is found to be largely based on illusory concerns of liability. Further, the discussion makes note of the ethical obligations involved when a physician or care-giver chooses to restrain a patient.

The latter part of chapter three identifies a "paradigm shift" in patient care, a trend that has included the development of an increased professional specialization in gerontology and dementia care. This trend has placed an emphasis on providing individualized care, with an overall movement away from the area's past concentration on care-givers' issues. This includes a recognition of the legal and human rights of incapacitated and institutionalized persons. Within this shift, many care-givers have become instrumental in developing philosophies and techniques that challenge the routine use of restraint in long term care. Restraint reduction programs and working models of restraint free care have established viable alternatives to the practice in long term care facilities. This changing, somewhat evolutionary approach to providing care to the elderly forms part of what can be termed "the progressive thinking of a modern society", and such

forward thinking is inevitably reflected in law making. This is evident in the forthcoming *Health Care (Consent) and Care Facility (Admission) Act* where restraint use is heavily restricted and regulated so as to prevent violations of the principles of autonomy and self determination through unwarranted or excessive restraint use.

The intent in chapter four is to scrutinize the potential of the new restraint legislation as a way of regulating restraint use in British Columbia. The legislation comes under some criticism for not correcting the conditions that initially lead to restraint use, by requiring use of the known, viable alternatives to restraint. However, the architects of the legislation must be credited for making review before an impartial tribunal an available option when the care-giver's decision to restrain is at issue.

Chapter five proposes a link between the use of restraint in the long term care facility and an infringement of the legal right to be free from "cruel and unusual treatment or punishment", as stated in section 12 of the *Charter of Rights and Freedoms*. The phrase "cruel and unusual treatment or punishment" is interpreted by way of case law and commentary. The impact of section 1 of the *Charter* is considered through an analysis of restraint use in the long term care context as a "cruel and unusual treatment", with arguments that legislation permitting such a treatment would likely never be found reasonable and demonstrably justified in a free and democratic society. The debate leads to a conclusion that long term care facility residents may look to the *Charter* for protection from abuses occurring by way of treatment in the institutional environment.

Chapter six concludes the thesis with possibilities for the direction of future research in the area of restraint use in long term care facilities. These research questions

take into account the large number of Alzheimer and dementia care patients expected to require long term care in the coming years.

CHAPTER TWO

The Practice of Restraint: Risks and Rationale

The following discussion describes four categories of restraint use in the health care setting. This literature review includes a wide array of published research concerning restraint, and from this, the rationale offered by care-givers for its use is noted. The reasoning of the care-giver who implements restraints in the process of caring for residents or patients is contrasted against the unintended physical and mental health problems related to the practice. Further, this chapter examines the restraint of elderly individuals with severe behavioral problems; residents commonly cared for in psycho-geriatric hospital wards or care facilities. Out of this discussion, the conflict between the benefits of restraint use in patient management and the risk to the patient's health and personal autonomy becomes evident.

a) Physical Restraint

In general, the rationale offered by health care workers for applying restraints is to ensure patient safety (Janelli, 1989; Liukkonen, Laitinen, 1994; Janelli, Kanski, Neary, 1994). The reasons most often cited for utilizing restraints are the patient's diminished physical and mental capacity related to age and cognitive impairment (Evans, Strumpf, 1989; Miles, 1992). Specifically, unsteadiness and the subsequent potential for falling, disruptive behavior, wandering, or to protect internal medical devices are factors in restraint use (Folmar, Wilson, 1989; Schnelle, 1989; Macpherson, Lofgren, Granieri, Myllenbeck, 1990; Magee, et al., 1993). Of those disruptive behaviors, untreated or

unrecognized delirium is noted to be strongly related to prolonged restraint use (Sullivan-Marx, 1994).

One American study of a non-acute care hospital found that nurses, selected from both extended care and nursing home units, offered up to 60 different rationales for applying restraints (Magee, et al., 1993). Sixty-three percent responded with "to prevent injury or falls" as their explanation for applying restraints. The other reasons offered were as follows:

- To prevent interference with treatment - especially with naso-gastric tubes (13% of respondents).
- To assist with balance, mobility and support (10%).
- To prevent harm to self or others (7%).
- To prevent wandering (7%).

A recent Finnish study illustrated a nursing perspective on physical restraints in geriatric wards by having the nurses rank order their reasons for using physical restraints (Liukkonen, Laitinen, 1994). They responded as follows:

- Concern that the patient may injure himself (47% of respondents).
- To prevent a patient from walking when he or she could not remember that (37%).
- Concern that something might happen to the elderly patient while the nurse was not in the room (24%).
- To force compliance with some routine on the ward (24%).
- To prevent disruptive behavior from disturbing other patients (22%).
- To prevent wandering (18%).
- To prevent fecal smearing (18%).
- To enable some activity (eating, washing) (17%).
- To stop aggressive patient behavior (17%).
- For restlessness (16%).
- To prevent patients from destroying property (14%).

Mion et al., (1996: 414) set out the following "facts" with respect to the decisions of hospital personnel to restrain:

- Nurses instigate the request for physical restraints.
- Nurses, as well as physicians, vary widely in their reasons for using physical restraint for the same patient.
- Although the two major reasons for using physical restraints are to prevent falls and to stop the patient from disrupting therapy, more than one reason for using physical restraint is frequently given for a single patient.

Research methods developed specifically to measure nursing attitudes concerning restraint have been utilized recently in North America. One such measurement device, a Likert scale "Attitudes Toward Use of Restraint" (ATUR) was used with accompanying measures of the education and experience levels of nurses to test feelings about the reasons for using restraints (Schott-Baer, Lusic, Beaugard, 1995). The subjects of the research were obtained from three nursing "divisions" defined as "medical", "surgical", and "critical care". The researchers made these conclusions about the nurse's opinions and feelings regarding the use of restraints:

- Restraints are not viewed (by nurses) as a form of punishment.
- Staffing problems are not an adequate justification for using restraints.
- Hospitals have an obligation to use restraints if a patient is in danger of being injured.
- Nurses were in agreement that they felt "bad" if a patient became upset after being restrained.
- Nurses were embarrassed when family members entered the room of a restrained patient.
- Family members did not have the right to refuse the application of restraints on a confused patient.
- Nurses were unsure whether the patient had the right to refuse restraints.
- Nurses felt comfortable taking care of a restrained patient.
- Nurses felt it was important to show care toward a restrained patient even though the patient may be confused or unaware of their surroundings.

Despite the views of some nurses that restraints may be a necessary component of patient care, the subsequent increase in health problems associated with their use are widely described in the literature. Evans and Strumpf (1989), Schnelle et al., (1992) and

Jones, (1996) list these common physical and mental health problems as related to the use of physical restraint:

- Loss of dignity, loss of personal freedom.
- Functional decline including urinary incontinence and muscle atrophy, loss of muscle mass and strength.
- Loss of bone mass, weakened bone structure.
- Nerve damage.
- Injury from falls.
- Accidental death by strangulation.
- Skin abrasions, breakdown, ulcers.
- Cardiac stress.
- Reduced appetite.
- Disorganized behavior including angry, belligerent or combative behavior, increased agitation.
- Emotional desolation, withdrawal.
- Increased dependency and learned helplessness.
- Possible increased mortality.

Robbins, in considering reports that “cantankerous, feisty patients may have better prognoses” comments that “the mere threat of restraint may encourage docility, placidity, and conformity that may not provide the optimal environment for recovery from illness” (1986: 597). Learned helplessness is a “less measurable consequence of restraints”. The long term outlook for the patient may be complicated as a loss of control may result in “the individual sinking into a state of carelessness and lethargy” (Conely, Campbell, 1991: 51).

The list of assorted brand names and types of physical or mechanical restraining devices is long and varies across North America. This reflects both a significant industry specializing in the manufacture and sale of restraints and the proliferation of these devices. As of 1987, the five companies manufacturing restraining devices in the United States sent representatives to personally assist nurses in choosing from among the assorted devices,

the one that would best meet the "safety need" of their resident/patient (Rose, 1987). Restraints are marketed as medical equipment, and in the United States are reimbursable through Medicare as "safety devices", "postural supports", or "patient aids" (Strumpf, Evans, 1989). Some of these devices are complex mechanisms with trademark names. Others are restraints devised simply from materials common to the health care environment. For example, sheets and bandages. Some of these devices are:

- *Posey* jackets.
- *Geri-chairs*, Wheel Chairs, or tilting *Buxton* chairs.
- Restraining belts, T-straps.
- Vests.
- Cuffs and Anklets.
- Roll Bars.
- Bedrails or Side Rails.
- Locked wheels on wheelchairs.
- Plain bandages.
- Mitts.
- *Fall out* chairs (a large deep chair meant to be difficult to get out of).
- *Preventative Aggression Devices* (PADS).
- The "twisted sheet restraint" used in combination with a *Geri-chair*.

Once restraints are placed on the patient, it is often the care staff who perpetuate the continued use of the restraint rather than the condition of the patient. Care staff may fear that the undesirable behavior will recur if the restraints are removed (Reigle, 1994). Further, many care-givers are reluctant to remove restraints that colleagues have applied as they may be unwilling to take responsibility for having removed the restraint (Brown, 1993). Nursing aids or attendants working in nursing homes have been shown to be more hesitant to reduce restraints than more experienced registered nurses (Thomas, Redfern, John, 1995).

It has been argued that care staff may initially be uncomfortable with restraint use yet, over time, they may become desensitized to the restraint, "no longer see[ing] them, and accepting them as part of the environment" (Blakeslee, et al. 1991: 6). It may follow then that the care-giver also becomes "desensitized" over time to the plight of the restrained person. Still other care staff have been noted to "minimize" or "deny" restraint use by indicating that their use of restraint vests "was not really tying the patient down", rather it serves as "a reminder" to call for assistance, something that "they (patients) don't really understand" (Quinn, 1993: 154). Nurse authors Conely and Campbell comment that "the elderly are often coerced into allowing restraints to be used and they often fear the consequences if they refuse" (1991: 51). Some patients may fear abandonment if they do not consent to restraints resulting in the restriction being placed under a subtle form of "duress" (Robbins, 1986: 597).

American researchers have observed that although federal regulations mandate that restrained patients must be released for exercise and repositioning every two hours, the nursing staff may fail to adhere to the guidelines and patients may not be monitored as they should. Schnelle et al., (1992) report that more than 60% of residents in two American nursing homes were restrained for intervals in excess of two hours, some much longer than the allowable time limit set out in the federal regulations. They note that both these homes had received "excellent state survey reports" in the two years prior to the study and that all the care staff had been trained according to the federal guidelines. This places into question the efficacy of restrictions and guidelines to prevent the abusive use of

restraints, not just in the United States where these guidelines have been in place for nearly ten years, but in British Columbia where the revised controls are soon to take effect.

Charting of restraint use has been found to be generally poor. Medical records, clear policy and documentation are recognized as the tools by which inappropriate and abusive restraint practices can be avoided (Spencer, 1994). In 1975, prior to the enactment of most legislation addressing restraint use, those institutions which had imprecise criteria for the use of restraints were urged to institute a system to establish clear authority and accountability (Bursten, 1975). Yet Mion contends that physicians and nurses often do not talk to each other about the use of restraint, and that the “practice was considered one that nurses, as well as physicians, apparently thought benign and unnecessary to monitor or evaluate” (1996: 415). One study found that only 38% of cases in which restraints were used were actually documented, while the reasons given for the application of the restraint was recorded in only 50% of the cases studied (Robbins, et al., 1987). In a Quebec chronic care hospital, researchers found that restraints were used without any written prescription on the patient's chart (Roberge, Beausejour, 1988). One may surmise that this documentation gap may be due to the lack of clear facility requirements that restraints and the reasons for their application be written on the chart.

Specific resident characteristics are predictive in the improper use of restraint. The resident's physical and verbal aggression and general unpleasantness have been found to be risk factors for staff failure to release restraints in accordance with regulations (Evans and Strumpf, 1989; Schnelle, Simmons, Ory, 1992). In addition, patients who impose a higher

burden of care or exhibit distressing behaviors including incontinence have been found to be at risk for neglect (O'Malley, Everitt, O'Malley, 1983).

When staff rely on the restraint to assist in meeting the demands of all patients, the restraint becomes a substitute for human contact (Robbins, 1986). This negates any compliance with regulations that require an increase in the supervision of a restrained patient. Day time hours find many residents strapped into *Geri-chairs* to ease the workload of care aids, especially during the dispensing of medication and at mealtimes. Some institutions rely on restraints to make up for staff shortages. The burden of care provided by only one or two registered nurses in a large facility could be considered excessively arduous without the assistance of restraints by which to control residents.

Conely and Campbell comment:

Nursing homes often have only one RN on staff to meet state regulations. Physicians, hospitals and long-term care facilities do not receive reimbursement from Medicare or Medicaid for a substantial number of their services. To reduce expenses, the provided services and numbers of staff are cut back. Realistically, nursing home cannot remain open without enough profit margin for the owners/investors to realize an increase in capital gains.

Restraint use often surfaces as a solution for the financial woes of institutions providing health care for the elderly. A tendency exists to rely on restraint to compensate for staffing shortages and increased health care costs. Convenience, compliance, cost-effectiveness and liability are rarely directly addressed in the literature when the use of mechanical and chemical restraints is considered (1991: 51).

Justification for a dependency on restraints on the basis of a lack of staff suggests that restraints may not be properly supervised in these instances. As "proper" restraint use

requires more care in the form of supervision and monitoring, the patient is neglected once restraints are employed in the place of adequate human contact.

Although restraints are officially placed with some effort to ensure patient safety, there are several reports in medical journals of deaths caused by restraining devices. It has been claimed that no other current medical device causes more deaths than the physical/mechanical restraint (Brower, 1992). Patients have reportedly been so desperate to get out of restraint vests that they have set themselves on fire while trying to burn off the restraint (Conely, Campbell, 1991). Some "sudden" or "unexplained deaths" after the application of restraints are reportedly due to the severe stress of being "tied up" (Wendkos, 1980; Robinson, Sucholeiki, Schocken, 1993). Yet, most restraint related deaths occur by asphyxiation caused when a restraint gathers, increasing pressure around the chest and subsequently preventing the patient from inhaling, or by strangling the patient when the restraint slides up to the neck (Dodge, 1984; Janelli, 1989; Miles and Irvine, 1992). In 1987, the U.S. Food and Drug Administration and the Consumer Product Safety Commission reported 35 known deaths by asphyxiation and strangulation both in Canada and the United States (Conely, Campbell, 1991: 51). Estimates are that unsupervised restraints cause at least one in every thousand nursing home deaths in the United States. Still other estimates claim that between seventy and two-hundred deaths yearly in America are restraint related (Brower, 1992).

Miles and Irvine (1992: 765) offer the following description of a "typical death caused by restraints":

An actively mobile, demented elderly woman has a history of sliding down in or escaping restraints. A nurse or aide applies a vest or strap restraint.

While unobserved for 10 minutes to several hours, the patient slides off the bed or chair so the restraint bears her weight and prevents her from sliding further down to a weight bearing surface. She is confused and unable to use her arms or legs to return to a safe position in her bed or chair. Her weight, transmitted throughout the restraint, creates a force about her chest. As she struggles, the restraint gathers, thus concentrating the pressure around her chest. She asphyxiates, usually because she cannot inhale, less often because the restraint slides up and gathers to act as a ligature on her neck.

Analysis of nursing home deaths in Minnesota indicated that death by restraining device is under-reported and under-recognized, perhaps because physicians and coroners do not investigate nursing homes deaths as vigorously as they should (Miles, Irvine, 1992).

A goal of keeping the patient safe from harm by applying a restraining device utilizes a questionable premise. A Canadian study conducted to measure the potential of restraints to reduce falls found no statistically significant increase in the frequency of falls resulting in serious injuries when the use of restraints was abandoned (Mitchell-Pederson, Edmond, Fingerote, et al., 1985, 1986). In other studies of the "safety" of restraint use, researchers report that the physical restraint does not necessarily prevent patients from falling (Strumpf, 1988).

Overall, physical restraint has been identified as highly problematic, wrought with risk to the patient, and is considered undesirable. Most of the literature on the use of restraints in patient care echoes the following caution:

Restraint and seclusion should *never* be used as a substitute for patient care or as a convenience for the staff. Patients in restraints are thought of as being "safer" and less troublesome. But when in restraint or seclusion, they are more vulnerable to a host of complications (Lewis, 1993: 77).

b) Chemical Restraint

The abusive use of chemical restraint occurs as an over-medication or medication solely for the purpose of restraint. In other words, the medication is dispensed with the intent to stop or control patient behaviors and movement that is considered intolerable or undesirable by the care-giver. Conely and Campbell (1991: 48) comment: "Drugs such as anxiolytics and neuroleptics generally are considered chemical restraints if given for the specific purpose of limiting and inhibiting specific behavior and/or movements. These psychoactive drugs are prescribed by physicians to address behaviors that are disturbing to the patient (Cefalu, 1995). Used properly, medication is implemented to benefit the patient rather than to adjust the patient's behavior to meet the standards of the care-giver.

Adults in care facilities and hospitals are at the highest risk of becoming chemically restrained. Burger (1991) identifies those most at risk as:

- The elderly.
- Cognitively impaired individuals and/or the physically restrained.
- Individuals with multiple physical illnesses.
- Patients exhibiting behavioral symptoms.
- Those who have had physical restraints removed.

The development of psychoactive drugs has reduced the need for physical restraint (Way, 1986; Lewis, 1993). Yet, restraint is a "multivariate entity" in that the reduction of one restrictive treatment may increase dependence upon another (Craig, 1989). It is notable that care facilities making efforts to reduce the use of physical restraint may, instead, rely more readily on chemical restraint to control unwanted patient behavior. One recent study examining the possibility of an increase in chemical restraint following a reduction in physical restraint found no such substitution. The implementation of in-

service education and evaluation of drug utilization was credited with the successful transition away from physical restraints without an increased reliance on chemical restraint (Werner, Cohen - Mansfeild, Farley, et al. 1994).

While the benefits of psychoactive medications are widely recognized in the treatment of socially disruptive behaviors, for example, hallucinations and delusions in the demented or psychotic patient, routine use of continuous *p.r.n.* (as needed) orders should be considered an inappropriate chemical restraint. Instead, drug orders in written care plans, scheduled "drug holidays", and restrictions of drug orders to two week periods for target behaviors only are preferred prescribing practices (Cefalu, 1995).

The potential for negative side effects from psychoactive drugs, especially in the elderly, have long been recognized in the medical community. For example, paradoxical agitation and secondary psychosis can be brought on by a state of relative sensory deprivation related to chemical restraint (Covert, Rodrigues and Solomon, 1977). Since then, the medical community (Burger, 1992; Reigle, 1994; Cefalu, 1995) has further identified numerous negative effects of chemical restraint such as:

- Diminution of mental or physical activity.
- Excessive sedation.
- Disordered thinking, delirium, depression, hallucination or delusions.
- Agitation.
- Urinary retention.
- Constipation.
- Dry mouth.
- Anemia.
- Skin problems, including pressure sores.
- Low blood pressure.
- Decreased appetite for foods and liquids leading to weight loss, malnutrition and dehydration.
- Tardive dyskinesia (repetitive, involuntary movements that are irreversible).
- Parkinsonian symptoms, muscle rigidity.

- Dystonia (A rigid holding of the head and neck, often hyperextended or turned to one side).
- Pneumonia.

As such, the risks of inappropriate chemical restraint in the elderly is well established.

c) Environmental Restraint

Locked doors or wards with restricted or privileged access, for example, doors equipped with key pads, deliberately heavy doors, locked half doors known as "Dutch doors" and "special care units", are commonly recognized instruments of environmental restraint. Considered less restrictive than physical restraints, environmental restraints still attract ethical considerations in that the free will of the individual is challenged (Hiatt; 1992). While the utilization of these environmental restraints may be considered necessary to ensure that the patient does not wander away or intrude upon other residents, used improperly, this type of restraint has the potential to inappropriately isolate the adult. Some modern techniques of preventing "unauthorized exiting" are: (Gutman, 1989; Haitt, 1991)

- Disguising exit doors by painting them the same color as the surrounding walls.
- Installing curtains over doors so that they look like windows.
- Covering doors with a large poster so they are perceived as pictures in frames.
- Placing door latches/handles much higher up than normal, making them both harder to reach and more difficult to open for cognitively impaired people.
- Electronic monitoring systems - bracelets, anklets, or devices clipped on clothing that trigger an alarm if the patient wanders past a sensor near doors. Some residents may learn to associate the alarm with the door and become conditioned to avoid approaching it.

Environmental restraint does not include the simple monitoring of the resident/patient in the care facility. It is the mechanisms that stop or otherwise control the movement of the patient that are considered to be restraint devices. For example, "talking signs" near elevators or doors, upon sensing the presence of a resident may direct him to move away, or alternatively trigger alarms or locking mechanisms. These devices, as part of the environment, control and restrict the movement of the resident.

The following is a definition useful in describing the unique nature of a "special care unit":

[A special care unit is] a physically separate unit in a nursing home that provides, or claims to provide, care that meets the special needs of individuals with Alzheimer's dementia. While these units are quite diverse, many of them do share one common characteristic - an alarm or locking system (Noyes, Silva, 1993: 12).

It has been argued that locked doors can be equated with physical restraints (Noyes, Silva, 1993). Both locked doors and physical restraints have the capacity to restrict the movement and choice of the resident and an ethical debate continues to brew concerning the autonomy of the person with dementia confined to a locked ward. The premise for locking doors in care facilities is based on the assumption that since persons with dementia have a diminished decision making capacity, their safety may be at risk should they wander away from the care facility. As the argument goes, the ethical approach is to engage in a paternalistic role of providing a locked environment that prevents harm in response to the patient's inability to choose "right from wrong" (Noyes, Silva, 1993).

Importantly, the relationship between locked doors in specialized care units and the actual safety of a resident has not been established through research (Noyes, Silva, 1993; Mace, 1993). The association may be much like the argument commonly used in supporting the use of physical restraints, namely that they prevent falls. This was considered “fact” prior to research indicating the contrary (Noyes, Silva, 1993).

d) Psychological Restraint

The element of psychological restraint appears to be the least discussed form of patient control in the restraints - related literature. Nonetheless, it is recognized by some experts as a method of restraint, usually taking the form of threats to the patient by staff members. For example, a threat to lock a resident in a room if he or she did not stay in a chair would be considered a psychological restraint (Barnes, Johnson, Peterson, 1995).

Jones (1996: 119) offers this observation of psychological restraint in a care facility:

I visited a very quiet dementia unit some years ago. Every single person sat quietly in their chair. No one except staff moved around the unit. This was so unusual that at first I suspected chemical restraint, but a review of the charts indicated only normal use of medication. As I passed a bedroom, a tiny lady who had been peering out scuttled back to the chair beside her bed. When I went in to talk to her she appeared very anxious and frightened, and she said “Am I going to be allowed to come out today?”

The role of psychological restraint in patient control may be an area of further investigation. However, as a form of control akin to emotional abuse, it is particularly difficult to define, and some may argue that this is not a category of restraint at all.

e) Managing Challenging Behaviors: Restraining the Psycho-geriatric Patient

Three categories of psychiatric disorders are prevalent in nursing homes (Rovner, Rabins, 1985). Cognitive Disorder is estimated to afflict 50 - 75% of nursing home residents. Alzheimer disease and multi-infarct dementia are the most prevalent causes of the disorder. Residents with dementia also may suffer secondary psychiatric disorders such as mood disorders and other problematic behavioral symptoms. Depression is also recognized as another category of mental disorder common in nursing home residents. Lastly, conduct including irritability, explosiveness, wandering, poor sleep, resisting nursing care and yelling, are very broadly termed as psychiatric illnesses in the category of "Disordered Behaviors" (Rovner, Rabins, 1985). Thus, it is not unusual for nursing home residents who are considered too ill to remain in the nursing home, elderly people just entering the care facility system, or other individuals considered mentally ill to be admitted to mental health institutions rather than nursing homes or private care facilities.

The 1985 American Psychiatric Association Task Force developed guidelines for the use of seclusion and restraint. This Task Force ascertained that restraint could be used appropriately in the in-patient setting to prevent imminent harm to the patient or other persons when other means of control are not effective. However, the Task Force also set out that restraint should not be used on individuals who have unstable medical conditions. The four-point restraints used in some psychiatric wards have been recognized as problematic for the elderly who, as a result of their fragility and tendency for complications resulting from immobility may be vulnerable to the unintended effects of restraint (Strome, 1988). The staff of one American psycho-geriatric facility reported

developing an "innovative" method of restraining elderly patients, a technique that they felt "provides many of the advantages of the traditional four point restraints, with fewer of the problems". Using a combination of "geri-chair, twisted sheet restraint, vest posey, padded leather cuffs, and locked seclusion", staff reportedly were "at ease" because they felt safe knowing that no harm could come to them from the patient (Strome, 1988: 20).

Elderly individuals with behavior problems termed as "severe" continue to populate provincial and state mental health hospitals. Research in these settings has found a prevalence of aggressive behavior among dementia patients particularly in mental health facilities. Staff-patient exchanges are cited as the major triggering event for aggressive episodes. For dementia patients in mental health hospitals, the treatment intervention used most frequently was *p.r.n.* medication, alone or with seclusion or physical restraint (Colenda, Hamer, 1991). Behaviors identified as "aggressive" are:

- Patient-patient exchanges or patient-staff exchanges including biting, hitting and pushing.
- Yelling or threatening behavior including cursing, yelling, or making verbal threats.
- Physical and vocal behavior towards staff or patients.
- Property damage.

Some psychiatric practitioners have argued that advocates against restraint use are too far removed from the clinical realities that bring it about to appreciate its necessity. Further, the argument is made that a non-restraint environment is achieved through patient selectivity; by admitting violent patients to mental health hospitals where they are managed with restraints (Bursten, 1975). In the psychiatric setting, restraint use, both physical and chemical is implemented in the management of the violent patient, and is a persisting form of treatment preferred over potential harm inflicted by the patient to the care-giver or by

the patient to him or her self through self injuring behaviors. Psychiatrists have been urged to use alternatives to physical restraints in the psychiatric setting by seeking alternatives, mostly in the form of medication (Guirguis, 1978). This may bring about a reliance on chemical restraints in order to control the behavior of patients in mental health facilities.

While legislative, policy, and educational efforts to restrict the practice of retraining patients in care facilities has been at work for many years, the psycho-geriatric patient in mental health facilities may be subject to restraint policies and practices likely not specifically designed for the elderly, and possibly more severe than those in the "nursing home" type of care facility. For example, one large provincial mental health facility in British Columbia uses the same restraint and seclusion policy for its psycho-geriatric residents as it does for the remainder of its psychiatric population. The age of the patients and the unique disorders that accompany age might be argued to compel such a facility to consider implementing a restraint policy specifically for use in its geriatric wards, as the needs of the elderly patient may differ significantly from those of a younger psychiatric population.

While much of the literature comments on the acceptability of restraint to prevent "harm", both to the patient and the care staff, it is interesting to note that "harm" is often not defined (Bock, 1988). Much of the restraint literature fails to indicate in much detail the kind of harm an elderly person in a non-psychiatric setting may be likely to inflict against the care-giver, the frequency, or instigating factors leading to such an attack. Yet demented patients are described as prone to what is described as "disinhibition" and they can become verbally and physically aggressive towards their care-givers or towards other

patients or residents. In commenting on the topic of aggressive behavior by demented patients, Haley and Coleton state:

In some cases, physical or chemical restraint may be necessary to control agitation or aggressive behavior...It is important that such cases be understood not as abuse, but as appropriate responses to a disease that renders patients unreasonable and difficult to manage (1992: 80).

There is mention in the unpublished literature of "catastrophic reactions" by which demented persons may act out violently against the care-giver in a fearful reaction related to the disorder. The wife of an Alzheimer patient wrote this about her husband's "catastrophic reaction" while in a care facility¹ :

I walked with my husband for four and a half years, feeding him on the run at home. In the hospital, they tried this method on him, which triggered such a catastrophic reaction that he pried a reclining chair apart and swung it at anyone who came near him.

The aggressive behaviors by dementia patients can be misinterpreted "as resulting from a willful effort to harm others...not recognized as part of a syndrome of dementia, which may lead to inappropriate responses by the family or service agencies" (Haley and Coleton 1992: 78). Jones (1996: 96) states that the aggressive behaviors of some dementia patients result only from the effects of the dementia, drawing the distinction that "violence does not equal dementia". As dementing diseases destroy the emotional centers of the mind, the "natural ability to interpret stimuli, to tolerate stress, to communicate and finally to use reason and judgment is lost" (Jones, 1996: 96). Thus, when cognitive abilities are

¹ Taken from personal correspondence to the Office of the Public Trustee, 1996. Used with permission.

damaged, patients placed in environments that are perceived by them as foreign, uncertain or frightening may react with aggressive behaviors.

CHAPTER THREE

Towards Recognition of Individual Rights of the Institutionalized Person

This chapter examines the care-giver's perception of the legal "obligation" to restrain persons who might otherwise be injured or cause harm to another by their own behavior or ambulatory difficulties. The perceived legal requirement to restrain is set out in the nursing literature, information which may lead to a compromise of the principles of autonomy and self determination within the care facility. Ethical issues are also included in this chapter, the perspectives of bio-ethicists on the practice of restraint as well as the ethical awareness of nurses and nurses aides. Further, this chapter traces the development of alternatives to restraint in long term care, with specific attention to a process termed a "patient oriented paradigm shift". Lastly, the manner in which modern policy reform reflects the shift in standards and expectations for care of the institutionalized population is analyzed within the framework of British Columbia's new adult guardianship law.

a) The Perception of Law and Liability

Two opposing perceptions of legality exist in the literature concerning restraint use. One is the pervasive, yet largely unfounded argument that health care facilities have a legal obligation to restrain elderly patients or other residents in order to protect them from harm and to avoid litigation against the "offending" facility and care-giver. The divergent argument recognizes that the civil rights of the patient are paramount in providing quality care. As such, the legal obligation is to protect the autonomy of the patient and their right to be free of restraint.

The litigious nature of the North American legal culture may be partly to blame for widespread misinformation pertaining to the obligation of a care facility to apply physical or chemical restraints to ensure patient safety (Burger, 1992). Similarly, a number of published legal interpretations and case commentaries relative to restraint use have contributed to the pressure on nursing staff to ensure patient safety through restraint use (Creighton, 1982; Evans, Strumpf, Williams, 1991; Kapp, 1991; Johnson, 1993). Frequently cited in this regard are the comments of Mary O'Reilly Yobb, a nurse/attorney, who in 1988 published an article in a critical care journal in which she stated that:

Nurses have a duty to exercise reasonable care in safeguarding a patient. Fulfilling this duty may involve providing increased supervision, using restraining measures such as side rails, limb restraints, or a jacket restraint if indicated by the patient's condition or doing both...nurses may be held liable when patients are injured because of failure to use restraints or improper use of restraints (32).

Another example of this perceived restraint mandate occurred when the American Nurses Association developed a poster to be displayed in nursing stations that outlined malpractice issues, including the use of restraints. It recommended that as one of the "frequent allegations against nurses", care-givers should "use restraints properly" (Evans, Strumpf, Williams, 1991: 92). The tone of these comments directed toward nurses may have the effect of misleading the nurse or care-giver by stressing liability if restraints are not applied, rather than stressing liability if the civil rights of the patient are violated or if restraints are improperly used. Further, the legal concept of *respondeat superior*, which holds that the health care worker's negligence or wrongful conduct is the legal responsibility of the care facility, may create liability issues for administrators if restraints

are mistakenly perceived as required by law to prevent injury and subsequent litigation against the facility (Kirschbaum, O'Connor, 1992; Johnson, 1993). In practice, American courts have repeatedly vindicated nursing homes for a failure to restrain even when residents have been seriously injured or died as a result of serious falls or wandering into danger, subject to evidence that the facility provided reasonable care to the resident (Kapp, 1991). In one such case, *Kildron v. Shady Oaks Nursing Home*¹, the court stated that "a nursing home is not the insurer of the safety of its patients. The standard of care imposed upon a nursing home is that of reasonable care considering the patient's known mental and physical condition".

While legal perceptions have played a role in mandating restraint use in care facilities by considering injuries to patients as avoidable by restraint measures *not improperly applied*, the implication has been that routine restraint use is considered by some to be an acceptable practice because they presumably prevent wandering, falls, and self injury. Legal concerns have contributed to the standard of care in that wandering and falls have been considered potentially problematic from a legal perspective, more so than the denial of the patient's liberty (Johnson, 1993). One nurse author writing about her obligation to restrain patients stated "If the patient falls out of bed on my shift, I can be sued for negligence" (Reigle, 1994). This sort of "common knowledge" leads care-givers to believe that they have an absolute legal obligation to restrain to prevent injury. This obligation appears to override the rights of the individual to be free and is contrary to the true standard set by American courts in leading cases that have addressed restraint

¹ 549, 2d 395 (La. App. Cir. 1989).

practice. Likewise, in Canada, there has never been successful litigation against a “nursing home” specifically *for not* using restraints, a fact that has reportedly surprised Canadian nurses during educational programs directed towards implementation of restraint-free care (English, 1989; Wells, Brown, McClymont, 1994).

There is very little Canadian legal commentary available on the legal aspects of restraint use. However, in the case *Stewart v. Extendicare Ltd.*³ liability was found where a head injured resident of a nursing home pushed another elderly resident who had wandered into his room, causing her to suffer a fractured hip. The court found that the employees of the nursing home did not “exercise reasonable caution and diligence” in preventing the head injured resident from coming into contact with the other residents when they were aware of his “propensities” to strike out. Although liability was found in this case, the court recognized as a “test” that hospitals “can successfully defend an action by showing it acted in accordance with general and approved practice”⁴. Evidence indicated that it was “approved practice” to allow the wandering of the injured resident, yet the care facility employees had a responsibility to take precautions to prevent the more aggressive resident from striking others. From this, a case can be made for restraint of the resident with violent or aggressive tendencies, but not necessarily for the wanderer.

In the United States, the practice of both restraint and seclusion came under legal scrutiny in the 1982 landmark case *Youngberg v. Romeo*⁵. In this case, the Supreme Court held that restraint was not permissible “except when and to the extent professional judgment deemed this necessary to assure such safety or to provide training...”, thereby

³ [1986] 4 W.W.R. 559 (Sask. Q.B.)

⁴ at page 562.

⁵ 102 Supreme Ct. 2452 (1982).

accepting restraint as a therapy or behavior control technique. As well, the court set out a test of presumptive validity (Wexler, 1984; Soloff, Gutheil and Wexler, 1985). The *Romeo* court established that if the decision to restrain is made by a professional, it is "presumptively valid" and "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment"⁶. Thus, the health care provider is well insulated against liability if the accepted standard of care is adhered to in restraint practice. However, the argument has been made that the courts are likely to move away from the grant of authority given to clinicians in *Youngberg v. Romeo* if it appears that this is abused and best clinical practice is not employed in the application of restraint and seclusion measures (Soloff, Gutheil and Wexler, 1985). At present, American law does not compel a movement away from restraint practice, however, it does promote a more judicious use of restraint that protects a patient's right to be free from inappropriate restraint.

b) The Ethics of Restraint Use: A Classic Moral Conflict

The practice of tying up individuals whose disturbed or disturbing behavior are perceived to need control pervades the history of patient care. In the 1st Century, the Greek physician-philosopher Soranus wrote about the need to restrain patients, a practice determined then to be used only minimally (Tardif, 1984). Through time, the behaviors of demented and deviant persons have been controlled by a policy of confinement and

⁶ at page 2463

restraint. While historical figures such as Pinel and Tuke are heralded with advocating against restraint practice in the asylums and prisons of the 18th century, the "advantages of restraint" in managing certain populations continued to be recognized and the total eradication of restraints has never occurred (Tardif, 1984).

Contemporary literature indicates that physical restraints are widely recognized as both morally and ethically undesirable and with detrimental physical and emotional effects when applied to the majority of the elderly population. (Evans, Strumpf, 1989; Morley, Solomon, 1994). Due to the potential for greater harm than good to the patient, there are several ethical considerations to be made by health care professionals when implementing restraints. Of significance is whether the patient can be restrained for the benefit of others and, when the safety of self or others may be at risk, whether it is ethically permissible to restrain despite objections from the patient.

Four main ethical principles guide the discussion of restraint practice from a bio-ethical perspective. They are: (i) *autonomy or respect for persons*, (ii) *beneficence*, (iii) *nonmaleficence*, and (iv) *justice* (Darr, 1992; Mattiason, Anderson, 1995). These principles encompass the moral obligations of all physicians as care-givers, and it is argued that they apply equally to health services managers and should be reflected in any care facility's philosophy (Darr, 1992). When an individual is at serious risk due to the behavior of a competent patient, outside of verbal threats, it is widely held that the personal autonomy of the violent patient may be nullified and restraints ethically placed (Moss, Puma, 1991; Haddad, 1994). Otherwise, restraint of the competent patient should be guided by the principle of informed consent. Even so, many patients in care facilities are

unable to consent to restraint. One argument regarding the ethical use of mechanical restraints suggests that for those patients who are unable to consent to restraint, "reliable proxy consent" should be obtained, "with full disclosure of risk and benefit and with regard for the virtue of compassion and the principle of respect for persons" (Moss, Puma, 1991).

A recent study examining the ethical awareness of nurses and nurses aides in a Swedish nursing home found that the principle of beneficence (acting with charity or kindness; doing good) was the dominant moral value when making a decision one way or the other to restrain a protesting elderly patient with a history of falls. For the nursing staff, "doing good" meant that the patient would be restrained; an understanding that "doing good" for the patient was to inhibit the patient's freedom of movement for his own sake (Mattiason, Anderson, 1995). Similar research findings reflect corresponding nursing beliefs; that not restraining patients who may suffer harm from falls would constitute negligence (Haddad, 1994). Yet, ethicists attest that one cannot act with charity or kindness when the risks of a treatment outweigh the benefits (Darr, 1992). Moss and Puma (1993) contend that in the case where restraints may be indicated, care plans that consider possible benefits and risks of restraints need to be in place in order for the practice to be considered ethical.

Nonmaleficence is analogous to the dictum *primum non nocere*, meaning "first, do no harm". While this dictum is associated with the physician's Hippocratic Oath, it is argued that it applies equally to those individuals managing health services (Darr, 1992). Thus, the owners and operators of care facilities are subject to the same ethical burdens as

physicians and nurses. The potential harm that the abusive and routine use of restraints on patients and residents of care facilities is well documented in the literature. The participation of doctors and other health care providers in this potentially harmful practice seems incongruent with the Hippocratic Oath and the principle of *primum non nocere*. It has been suggested that violation of the Oath may occur because those persons subjected to unethical medical practices are not seen as being included in the "traditional doctor/patient" relationship or because the patient is seen as less than fully human (Cohen, 1996).

Minimizing pain and suffering meets the burden of "doing no harm". Yet outside of making a reasonable effort to control the known violent or aggressive tendencies of a resident, it is argued that meeting that mandate cannot take the form of restraining a patient in order to *prevent* possible harm, pain, or suffering; for example, when an elderly person may potentially fall or suffer injury due to fragility or wandering tendencies. Incurring the risk of a fall or other injury protects the autonomy and freedom of the patient (Brower, 1992). Thus, autonomy and freedom are argued to be paramount when discussing the role of ethics in restraint use. Yet, the patient may be considered legally incompetent and thus health care workers may not feel obliged to honor the patient's decision not to be restrained. Physical movement is a function so basic that even the most truly "incompetent" person may make a genuine objection to restraint, and has the right as human being to have that objection considered very seriously by the care-giver.

Darr (1991: 22) defines the principle of justice in the ethical treatment of patients by the fairness and equality of treatment. He comments that "part of the definition is that

persons get what is due them” and, further, that “equal treatment of equals is reflected in liberty rights”. This raises the argument as to whether the patient who is a candidate for restraint is “equal” to other persons or is “unequal” and thus may ethically have their liberty rights forfeited for the benefit of others. Society has responded to this question by considering the use of restraint permissible when grievous physical harm to the patient or the care-giver is threatened. Moss and Puma (1991: 24) comment:

When another identifiable individual is at risk of serious morbidity or mortality, or the public welfare appears in jeopardy, we believe that overriding the refusal of restraints by a competent patient or his or her proxy is ethically permissible. The ethical principle of preventing harm to identifiable others supersedes the patient’s right to refuse. The negative rights of an individual to be free of interference end as he or she violates the autonomy of another.

While ethicists offer many recommendations to govern restraint practice, overall they argue that the use of restraints in place of proper medical care, evaluation, and compassion is unethical, and ultimately that the routine use of mechanical restraints in acute or long term care facilities is unacceptable (Moss, Puma, 1991). Further, one can argue that the use of restraints to control patient or resident behavior in place of proper staffing and resources is likewise unacceptable. When considering the advancement of alternatives to restraint discussed in the following chapters, negating these alternatives due to staffing and resources allocation may be problematic beyond the fiscal concerns involved in allocating resources to make these alternatives a reality. If patients continue to suffer the effects of restraint due only to pressures related to staff and resource allocation, the ethical violation is undeniable.

c) Modern Care-giving: Changing Traditional Medical Structures

The movement in law and medicine towards recognition of the individual rights of institutionalized persons is discernible at several levels. Medical literature, primarily consisting of nursing literature, clearly encourages caution in the use of restraint, condemning questionable or routine restraint practices. Yet this attention to the problematic nature of restraint use can be related to another, larger trend in modern care-giving. Studies of aging and a growing specialization in gerontology and dementia care are gaining an important place in both medical and social sciences. Further, numerous patient oriented special interest groups and individual advocates have undertaken to improve medical care and treatment. This is evident in organizations such as the Canadian Cancer Society, and various “ribbon” campaigns for breast cancer and AIDS.

It can be argued that public involvement in medical care has arisen from the value that our society places on improving the well being of afflicted individuals beyond what the traditional medical structures have provided in the past. As growing numbers of people succumb to numerous diseases that impair cognitive functioning, the position of special interest groups like the *Alzheimer Society* will be reflected in the standards of care demanded for affected individuals. For example, in a 1996 policy document, the Society made the following statement regarding the treatment of persons with dementia: “in order to prevent, identify and check mistreatment and neglect in nursing residential care...the

use of drugs, locked doors or any other form of restraint should be open to independent scrutiny”⁷.

While special interest organizations often emphasize funding for the research of effective treatments, importance is also placed on the preservation of human dignity during the course of the disease. This includes protection of legal rights. Thus, society’s attitude towards the institutionalized person may no longer be one where expectations involve a simple warehousing of the demented population. Rather, care of the institutionalized elderly now encompasses multi-disciplinary forces in medicine, social science, and in law; efforts that endeavor to improve the quality of life and protect individual patient’s rights.

d) Care Evolution: A Paradigm Shift in Patient Management

In defining their version of an “*Alzheimer’s Disease Bill of Rights*”, Bell and Troxel identify this trend in long term care: “The focus of service providers will shift from the 1980’s emphasis on *care-giver* issues to greater concern and interest in providing services and therapeutic interventions to the *individual* with dementia” (1994: 4).

It is now very common to see documents such as a “Patient’s Bill of Rights” posted on ward doors and walls. Often these declarations of individual rights are drafted by the patients themselves with support from care-givers and non-profit organizations. Seeking to better manage the problem behaviors associated with institutionalized persons involves efforts to specifically recognize certain ideals to be met in the care environment. Of interest in exploring the transition to patient centered management is such declarations

⁷ Mistreatment of people with dementia and their carers: Principles, prevention and action guidelines for staff and volunteers of the Alzheimer Society. Nursing and Residential Care. pg. 17, section 6.5, 1996.

as “the right to be treated like an adult, not like a child” or “the right to be free from psychotropic medications if at all possible” as is stated in Bell and Troxel’s *“Alzheimer’s Disease Bill of Rights”* (1994: 5). Other institutions specifically state their “restraint free environment” as a philosophy of care; an up front assurance to incoming residents and their families. Brungardt considers the attempt to manage patients without restraints part of a “patient oriented paradigm shift” (1994: 50). The shift away from restraint use is an enterprise with three identifiable parts; the development of restraint alternatives by nurse practitioners and other specialists, a technological advancement in the physical design of the care facility, and finally, a reflection of societal values and attitudes within the complexities of law and policy making.

i) Alternatives to Restraint

Nurses have been instrumental in developing philosophies that challenge the routine use of restraint. Nursing and care aid staff may be recognized as being in a more powerful position to affect restraint use than the facility doctors, as nurses participate in the routine provision of chronic or extended care in the facility more so than physicians. Restraint use is a decision based mostly on the judgment of the nurse, and where a physician’s order is not required for restraint use, physicians may be unaware that their patient is restrained (MacPherson et al., 1990)⁸. The evolution of a professional standard of practice directed towards lessening the use of restraints has found many care facilities implementing restraint reduction programs (Gold, 1991). Inherent to the development of

⁸ In British Columbia, a physician’s order is required for restraint use. However, these orders are often *p.r.n.*, (as needed) and thus the physician may not know precisely when the patient is restrained, although in theory the restraint would be recorded on the individual’s chart.

these programs is the recognition that *restraint use in certain contexts of care is not essential* and that viable alternatives can replace most uses of restraint.

Within these programs, phrases such as "restraint proper care", "least restraint", and "non-restraint" are used to confer an opinion about restraint use particular to that philosophy of care. The philosophy of "least restraint" and non-restraint" contains a recognition of the patient's right to live with a certain amount of risk in order to be free from restraint (Wells, McClymont, 1994). "Least restraint" permits restraint use only when deemed necessary for the benefit of the patient. For example, the use of side rails, seat belts, or trays for a short period of time at mealtime or to prevent exhaustion from pacing. In practice, a strict policy of "non-restraint" states that no restraints are available as treatment options except in situations when serious physical harm to an individual is imminent, such as an emergency situation.

Restraint reduction programs employ a number of alternatives to assist in the mandate of restraint reduction. Literature from numerous reputable journals including *The Journal of the American Geriatrics Society*, *The American Journal of Nursing*, and *The Journal of Geriatric Drug Therapy*, is rife with numerous articles presenting, defining, and promoting successful applications of restraint alternative programs. Thus, alternative working models are available for institutions choosing to eliminate or reduce restraint use. To illustrate, Wells, (1994) in presenting the development of the least restraint program in Perley Hospital in Ontario, provides readers with a working formula for the "resounding success" of the program implemented in the facility in 1992. Not only does the article set out the elements of the program, access to program documents are made available to

other facilities by way of the facility mailing address and telephone number included in the article. Wells stresses the role of an education program for nurses and administrative support to affect the change in restraint use philosophy.

Stolley, (1995) in the *American Journal of Nursing*, defines six categories of “Alternatives to Restraint”. Primarily, key restraint alternatives are based on an increase in human resources in the facility; for example, more one to one nursing and volunteer time, and a modification to the physical environment. The program calls for the skills of physical, recreational and occupational therapists in consultation with increased nursing assessment of the needs of the patient. Further, Schnelle, Newman and White et al., (1992) published a study indicating that the rigorous restraint management system they developed could reduce restraint use and improve compliance with federal restraint regulations. Yet, the researchers caution:

The quality of care problems that have been documented to exist in nursing homes will only be remedied when direct - care staff are professionally managed...improving management with validated quality control technology is an important first step in improving resident care in long-term care facilities (1992: 385).

In British Columbia, dementia care experts Moyra Jones and Joyce Wright have published texts advocating alternative care philosophies that preclude restraint use in the care facility. Jones’ system named “GentleCare” proposes that restraint use is unnecessary in dementia care when individualized therapeutic care is provided in the institution along with the following provisions:

- The education of all staff in the pathology of dementing illness, the behavior caused by the disease process, and the effects of chemical and physical restraint.

- Creation of a safe, secure and comfortable area in which the person can move about freely.
- Provide programs that encourage the patient to interact in an environment with home like objects (e.g. music, pets, books, pictures, etc.)
- Provide individual medication assessment and documentation.
- Provide individual restraint assessment, documentation, and work towards the eventual permanent removal of the restraint, where one exists.
- Assessment of appropriate seating and movement area.
- Remove individual physical restraint devices from the facility once the individual has adjusted to freedom of movement. Make the commitment to never use that device again.
- Document new care strategy. Implement that any staff using restraint for the person under review must document all alternative strategies tried prior to the use of restraint, and the particular circumstances that warranted the action of re-introducing restraint.
- For every new person in the facility, avoid the use of both physical and chemical restraint and help keep them walking for the duration of the disease.
- Use an absolute minimum of adaptive equipment or furniture to ensure the comfort and safety of individuals who are so debilitated or excessively disabled that some form of safety device is necessary to assist with posture or comfort.
- Implement volunteer and family programs for walking and bed-sitting.
- Adapt physical environment. For example, provide bedrooms with lower beds, safety mats and Dutch doors. Limit exposure to the complex and demanding physical environment of a care facility.

The validity of the non-restraint or least restraint care approach is evident by the numerous care facilities that implement this care philosophy. For example, in British Columbia, the *Delta View Habilitation Center* is renowned for its implementation of a non-restraint care program. Other facilities working successfully with restraint reduction programs include *Finnish Manor* in Burnaby, British Columbia and *Riverview Care Center* in Washington State. The Kendal Corporation of continuing care homes in the United States claims to have provided restraint free care since 1973 (Blakeslee, Goldman and Papougenis, 1990). Kendal's restraint free program has been viewed with skepticism by their peers who have "regarded our resident population as having an acuity level atypical of resident populations found in most facilities" (Blakeslee, Goldman and

Papougenis, 1990: 79). In several publications in reputable nursing journals, the Kendal facilities have illustrated, in detailed discussion, the techniques by which they have achieved restraint free care, urging other facilities to adopt the same approaches (Blakeslee, 1988; Blakeslee, Goldman and Papougenis, 1990; Blakeslee et al., 1991).

ii) Design Intervention

One element of the patient oriented paradigm shift is evident in an industry that targets the patient for specific services. A specialization in dementia care has resulted in a trend towards care facilities placing many patients in "special care units" where particular attention is paid to a physical environment designed to control, as well as enable the demented person to live in a more comfortable, less stressful environment than that of the more architecturally typical care facility. Unlike businesses that manufacture simple restraint devices to the care-giver, industry now can be observed to be designing entire care facilities aimed at assisting the management of residents. Design intervention is a concept that has evolved from a trend towards providing environmentally appropriate care for the demented patient. The focus of such industry shifts from meeting the patient control needs of the care-giver towards meeting the needs of the patient, enabling them to live in a comfortable, relatively unrestricted environment. Architectural firms have found a niche in designing specialized care facilities that possess unique physical features considered essential in the management of demented residents. This deviation is evident in the appearance of advertisements placed by architectural design firms in medical journals, the intent of which is to promote the industry.

Although behavior control is an objective of the environment, the control is centered less with the care-giver as the tools for control have changed by design and technology. One could argue that the restraint has moved from its place on the patient's physical body out to an environment engineered to be restrictive. The patient can interact with the environment rather than becoming physically attached to a bed or chair within it. Thus, in a facility where environmental design is the mechanism of control, power is diffused between the care-giver and the patient in a more collaborative management of the patient's condition.

The traditional care facility building can be described as "monolithic" and "repetitious" with features that "contribute to unsatisfactory responses or behavior in mentally impaired people" (Hiatt, 1991: 5). Some common design features identified as contributors to problematic behaviors are: (Gutman, 1989; Haitt, 1991; Coulsen, 1993; Mace, 1993)

- Long and maze-like hallways littered with carts and with few residential "landmarks".
- Lack of texture, touchable surfaces or manipulable objects.
- Uncontrolled sound levels.
- Poor lighting.
- Little or no access to outside areas - courtyards that could not be seen from the inside.
- Bathrooms/toilets hidden behind closed doors.
- Slippery, highly waxed floors which may be instrumental in falls.
- "Colorless" environments which provide little orientation for residents.

One problem behavior that architects have attempted to alleviate purely by the design of the facility is *wandering*, a behavior common in demented patients, also likely to result in the use of restraints (Hiatt, 1991). Wandering is defined as "not one, but many behaviors where an individual walks or moves about and seems to lack judgment or cognitive capacity...pacing, roaming, or attempting to leave" (Haitt, 1992: 62). Depending

on the design and care philosophy of the care facility, this behavior may be problematic for reasons both directly and indirectly related to the physical environment (Haitt, 1992):

- The individual's behavior is unpredictable.
- The care-givers have not been trained to cope with the person and the motion.
- The behavior setting in which the motion occurs is not adequately designed to accept the motion or overt behavior associated with movements or the ecological environment poses risks or hazards.
- The behavior adversely affects other residents.
- The demands of the wanderer exceed the surveillance or management capacity of available staff.
- The behavior cannot be redirected or re-focused.
- The motion makes the person uncomfortable, unhappy, or produces other adverse effects.
- The individual receives physical injury or risks injury to others.

Higher rates of wandering have been reported in environments considered to be either over or under stimulating. Further, higher rates of restraint have been reported in facilities larger than ninety-eight occupied beds. Based on these observations, wandering and restraint use are believed to be related to environmental factors (Haitt, 1991) Thus the design of the care facility is fundamental in restraint reduction. Mace notes that when the doorways and exits of a building are controlled and the patients still have sufficient room to wander, this behavior ceases to be considered a problem by the care-givers (1993).

iii) Implementing the Alternatives

The abolition of physical restraint is not possible for all patients, and while perhaps well-intentioned, the effort entails significant risk, particularly without provision for additional staff training, improved staffing levels, and modification of physical plant (Read, Bagheri, and Strickland, 1991 in Mion, et al., 1996: 417).

Most experts agree that some form of restraint in certain contexts of care is necessary. Yet the evolution of care standards, prompted by advancements in science and technology have brought reductions and variations away from the routine restraint practices of the care facility, certainly in those that provide dementia care. However, the facility requirements demanded by these alternatives may cause implementation difficulties. The education programs proposed require administrative initiative, time, effort and commitment. Volunteer programs for patient walking programs and for bed-sitting require the same efforts. Design intervention requires practical planning and adjustment of physical care routines. Further, care facilities built in the style of traditional hospital architecture simply may not accommodate the proposed alternatives without an investment in costly renovations. Lastly, implementing the alternatives requires change in the personal philosophy of the care-giver as an individual. The physician, the nurse, the administrator and the care aid must relinquish paternalistic care approaches. Allowing the patient to accept risk, to be more autonomous and to behave “abnormally” rather than forcing “normalcy” by physical or chemical restraint may be a challenge for those who have practiced restraint as an accepted form of patient care. The toleration of “abnormal” behavior and a willingness to adapt the care facility to that element of behavioral irregularity may be the single most important alternative to routine restraint practice.

e) A Health Care Paradigm Shift and the Organization of Law

The multi-disciplinary field of gerontology has expanded and lawyers and social scientists have initiated studies of the relationship between law and population aging...The population aging phenomenon has been identified at a time when changes are occurring in the provision of health care services (Gordon, Verdun-Jones, 1992: 1-13).

i) The Reform of Adult Guardianship Law

Provincial adult guardianship laws provide for surrogate health, financial and legal decision making for adults with mental disabilities. For example, adult guardianship law “has a bearing on the protection of vulnerable, elderly people and their estates” (Gordon, Verdun-Jones, 1992: 1-13). In Canada, adult guardianship law has been under reform since the mid 1970’s, partly in response to criticisms of the “adequacy” of the legislation (Gordon, Verdun-Jones, 1992, Gordon, 1995). Recognition that the laws were archaic and excessively paternalistic coupled with the advent of the *Charter of Rights and Freedoms* and the dramatic increase in population aging have prompted modern policy reform. Currently, British Columbia’s adult guardianship law (passed in 1993) contains revised provisions for adult protection within care facilities. Legal standards regarding the use of restraints in care facilities are set out in one of the four statutes in new guardianship package, namely *The Health Care (Consent) and Care Facility (Admission) Act* (not yet in force).

A half century of de-institutionalization and trans-institutionalization of the aging population has placed the legal rights and civil liberties of the elderly at risk. As a policy of privatization and the development of community care facilities replaced the larger, government, hospital-like institutions, the elderly population moved into facilities that continued to retain decision making power and authority similar to the situation in mental hospitals. The distinction is that the “nursing home” elderly may not necessarily meet the medical or legal requirements for involuntary treatment as may the mentally disordered

patient admitted to a mental health facility. The individual residing in care may not be considered a “patient” in that conception but, rather, is simply a “resident” living in a facility environment; an individual who may assume the same legal rights and privileges as any other citizen unless proper legal and medical assessment determines otherwise. As Gordon and Verdun-Jones (1992: 1-15) explain, “the shift to community-based and private facility care and treatment was not accompanied by changes in the law, and a confusing and potentially dangerous situation has developed”. Thus, abuse may occur when the resident is denied self-determination and autonomy, and is “cared for” by overly restrictive and intrusive methods reminiscent of the state institutions. The inappropriate use of physical, chemical, and psychological restraint constitute some of these methods.

ii) The Reflection of Values in Law Making

As illustrated by the technological and philosophical advances that challenge the continued use of restraints in the care facility, the reform effort underway in restraint practice is not limited to the legal reforms in the field. Jackson and Ekstedt contend that law making is a reflection of values, visions, and principles, and a reflection of the beliefs of the society. They comment:

...from whence do these visions or images come from? ...how do these visions get translated into the organization of law, and what is the possibility of a new paradigm emerging? A short answer for the first question might be that the visions come from the collective experience of human beings in a society who, in their attempt to address social problems, derive beliefs about how those problems ought to be considered and, consequently resolved (1992: 1).

The progressive thinking of a modern society creates a shift in the values and standards that affect law making. These societal values become statements of policy. In

British Columbia, the government recognizes the following guiding principles in adult guardianship law⁹:

- Adults are entitled to live in the manner they wish and to accept or refuse the support, assistance or protection of others, provided that are capable of making such decisions and provided that they do not cause harm to others.
- Adults should receive the most effective, but the least restrictive and intrusive, form of support, assistance or protection when they are unable to care for themselves or their assets.
- Requests should not be made to the court for the appointment of decision-makers or guardians - and they should not be appointed - unless alternatives such as the provision of support and assistance have been tried or carefully considered.

Ekstedt (1995: 308) defines policy as "an expression of meaning" and further, that policy "is a declaration of social value, and it is upon the basis of the declared value that subsequent decisions are shaped" (Ekstedt and Griffiths, 1988: 102). The statutes that make up British Columbia's new adult guardianship legislation reflect a direction in policy-making that emphasizes the value of autonomy for the adult in need of assistance¹⁰. Gordon, in commenting on what he terms the new "waves" of Canadian guardianship legislation explains,

Key features of the new legislation include...a firm rejection of unbridled, benign paternalism in favor of balancing the right to both autonomy and self-determinism with the right to the most effective but least restrictive and intrusive form of intervention when support and assistance are needed (1995: 94).

⁹ *Adult Guardianship Act R.S.B.C.* 1996, c.6; s.2.

¹⁰ The new B.C. adult guardianship legislation consists of four separate Acts: *The Representation Agreement Act R.S.B.C.* 1996, c.405; *The Health Care (Consent) and Care Facility (Admission) Act R.S.B.C.* 1996, c.181; *The Adult Guardianship Act R.S.B.C.* 1996, c.6; and *The Public Guardian and Trustee Act R.S.B.C.* 1996, c.383. Not yet in force.

Evidently, the philosophy or guiding principles of the new legislation that will govern the use of restraints are those that strive for a policy of least or non-restraint. The wording of the policy statement is such that it reinforces the understanding or "expression of meaning" that interventions must be tempered by considerations for effective and least restrictive and intrusive methods, even "carefully considered" alternatives to an appointment of decision-maker or guardian. For legislation based on the values of autonomy and self-determination to permit unlimited use of restraint is incongruent to the values espoused. Thus, policy addressing the use of restraints in care facilities should uphold the standards and values declared within the four part package of British Columbia's new adult guardianship legislation.

CHAPTER FOUR

A Course of Action: The Potential of New Restraint Legislation.

This chapter examines the potential of the new restraint legislation. Several options are presented as “courses of action” that the government might have undertaken to better support the values of autonomy and self determination. The issues for various stakeholders involved in the reform of restraint use are discussed. Ultimately, this chapter suggests that the best course of action on restraint use might have been to infuse the long term care environment with care techniques that preclude restraint use rather than concentrate on the development of legislation that allows for its continued use in a highly regulated and controlled manner. Yet, it is noted that the effect of such a stringent restraint law may be to propel care facilities and care-givers towards the implementation of restraint alternatives. The chapter also sets out the challenge and responsibility of advocates to protect the legal interests of confined adults, as well as the role of the legal community in evaluating the long term efficacy of the new restraint law.

Some observers of the policy process involved in determining the lawfulness of restraint use that has culminated in section 25 of the *Health Care (Consent) and Care Facility (Admission) Act* are optimistic. It is anticipated that the Act will “eliminate the use of restraints unless all alternatives have been exhausted” while “undoubtedly influenc[ing] the current trend toward patient-directed health care, and the doctrine of informed consent” (Ogden, 1995). While both the *Act* and the *Care Facility Admission Regulation* will provide substantial detail directing a new bureaucratic burden upon the care facility

necessary to be in compliance, it can be argued that the *Act* may fail, in practice, to completely eliminate the paternalistic and innately problematic use of restraint.

Recognition of the values of patient autonomy and self determination has developed in most societies practicing western style medicine, and there appears to be a tendency for these nations to model each other in standards of care. For example, in the late 1900's professional nursing literature held out restraint reduction programs from Scotland and Scandinavia as models for North American consideration (Evans, Strumpf, Williams, 1991; Rader, 1991).

The United States moved much earlier than did any of the Canadian provinces to develop government policy on restraint use. Federal legislation on the use of physical restraints has included the U.S. Department of Health and Human Services *Use of Restraints: Federal Standards (1984)*¹ and the *Omnibus Reconciliation Act (OBRA)* passed in 1987. They have both endeavored to limit the use of restraints in American nursing homes. The philosophy and values of patient care reflected in the legislation are those that reject overt paternalism, as does the new British Columbia legislation. Yet, as is the case in Canada, the Americans have not made the complete eradication of restraint use part of the policy intent.

The use of restraint in some circumstances of care remains lawful. The *OBRA* identifies the need to "protect and promote" the rights of "each resident, including the right to be free from restraints"². This legislation also follows its policy through with a provision to enforce non-restraint procedures within nursing homes. U.S. Department of

¹ Washington, D.C.

² s. 1819 (c)

Health inspectors are mandated to enforce regulations against overuse and misuse of restraint (Bruno, 1994: 134). It seems that British Columbia's new policy is somewhat like its American counterpart; government has conformity mechanisms in the form of inspectors and other personnel from regional health authorities who can watch for restraint abuse during their visits to private hospitals and care facilities. However, this was one function of the Quality Assurance program and Licensing prior to the regionalization of health services and the development of new legislation³. The *Act* seems to place much of the burden of compliance on the facility operators, forcing a form of self regulation with a legal mechanism in place for the appeal of care related decisions.

Gray and Williams state that "policy is a course of action followed by a set of actors in dealing with a problem" (1980: 2). The American legislation - *OBRA* - as an example of federal law, fits that definition of policy in that the restraint reduction effort is complete; it has "a course of action" to deal with the problem. The *Health Care (Consent) and Care Facility (Admission) Act* also sets out a "course of action followed by a set of actors in dealing with a problem". Yet, upon closer examination, the "actors" authorized to deal with the problem of restraint are the care-givers, some of whom may be involved in inappropriate restraint practice⁴.

³ See note 15 in Chapter Five.

⁴ Section 25(1)(c) of the *Act* requires that the restraint be approved not only by the physician, but by another health care provider as well as a "substitute decision maker". The substitute decision maker is appointed under the *Adult Guardianship Act*. However, in an emergency - where a restraint is necessary to preserve life or to prevent physical harm - the "operator" of a care facility may use restraint without approval of the three entities noted above (section 25(3)(4)). In such a case, the operator must notify the person who accepted the facility care proposal for the adult of the use of restraint, and have a health care provider reassess the necessity for it every 8 hours.

It may be that the hope for achieving the goals of the legislation lies, in part, with the secondary actors; namely, the members of the administrative tribunal authorized by the *Act* to hear reviews of a decision to use restraint. The availability of legal counsel for the resident and the scheduling of a Review Board to hear an application to discontinue restraint occurs after the decision to restrain has been made.

The patient centered paradigm shift appears to have driven the policy making cycle culminating in section 25 of the new *Act*. The *Act* can be described as the formal representation of that shift. The official process is part of the initiative of the *Ministry of Health* and the *Ministry of the Attorney-General* in response to pressure by various stakeholders (those with an interest in restraint) seeking changes to restraint policy, and to further bring restraint laws in line with the stated values of the adult guardianship legislation. It is evident from internal discussion documents and government contracted literature reviews and recommendations that the resulting restraint policy is influenced by the values, vision and beliefs of the affected stake-holders as they relate to restraint use. One Ministry paper, entitled a "Restraint Reduction Document" was intended to elicit discussion amongst Ministry employees involved in policy development⁵. The discussion paper was never intended for public dissemination, hence it is very telling of the direction in which the Ministry alone envisioned the policy moving. It contains an "analysis of the use of restraints in residential care facilities on the basis of the current British Columbia legislation and regulations in light of the literature regarding the use of restraint in

⁵ Ministry of Health and Ministry Responsible for Seniors. Continuing Care Division. July, 1994. Under a section entitled "Purpose", this statement appears: "The paper provides a suggested position to be taken by CCD (Continuing Care Division) regarding the use of restraints as well as a suggested CCD Restraint Use Policy".

residential care facilities". Within the paper, the current legislation and the proposed new legislation are compared to accepted medical knowledge and accompanying values as they are presented in select articles from literature on the topic of restraint. The document subsequently makes recommendations for an official Ministry position and policy that reflect current social values regarding restraint (1994: 7):

- Upon completion of a thorough multidisciplinary assessment which includes the resident, their family and/or friend and at the exhaustion of all alternatives, only the least intrusive means of resident restraint may be employed to control a temporary emergency situation presented as a result of resident behavior.
- Any restraint method which limits an individual's voluntary movement must be applied only with the consent of the resident or the designated health care decision maker.
- The decision to continue restraint must be regularly reviewed.
- Documented evidence of the rationale for the decision to restrain, of resident consent and of monitoring and reassessment is required.

a) *What To Do About Restraint Practice*

...policy is nothing more than deciding what to do about a particular course of action and communicating that decision to those persons and agencies responsible for carrying the decision into practice" (Ekstedt, 1988: 102).

Faced with drafting the new adult guardianship laws, the policy makers needed to determine what exactly the "course of action" should be with regard to restraint use. Yet, important as the "course of action" is, it is not the only determination of section 25 of the *Act*. The meaning made of restraint practice is also examinable within the context of the section. Ekstedt states that policy "shapes, reflects and reinforces social values by the way in which it gives meaning to the activities of government..."(1988: 102). Thus, the

meaning made of restraint practice will be reflected in the force of the policy. The potential the policy maker has built into the *Act* will effect the social purpose professed. In effect, the values inherent in the policy must be able to be implemented at the human level, in this case inside the long term care facility.

b) The Course of Action: Possibilities, Impossibilities and Consequences

There are several different "courses of action" that the government of British Columbia might have undertaken to meet, in law, the values of autonomy and self-determination found in the restraint policy⁶. One might have been to eradicate routine restraint practice in long term care in favor of specific alternatives, in effect, to legislate the "best practice" model. Some courses of action could have included:

- The implementation of design intervention technologies, structural and environmental changes within institutions known, in practice, to help reduce reliance on restraint measures to control behavior. The successful implementation of this alternative would require the building of some new "state of the art" provincial care facilities or the renovation of existing ones. Needless to say, the cost would be significant, presenting a significant barrier to gaining approval, certainly difficult in light of the recent freeze on capital spending.
- To increase funding for non-private beds within private care facilities that have implemented design intervention and other non-restraint strategies. More beds within these facilities would place at least some patients who may be at risk for restraint in a non-restraint environment. Again, cost concerns would challenge such funding and, from that perspective, it would seem that the protection of the adult's right to autonomy and self-determination by this course of action is in part subject to funding.
- The implementation of province-wide non-restraint educational programming within existing institutions. Again, this would be an expensive effort requiring the support of the facility's administration. If existing administration is not supportive of the effort, the endeavor would likely be unsuccessful. The surrender of restraint devices, both physical and chemical would also require a surrender of the power and authority the

⁶ Here, "policy" refers to the course of action that the Ministry has adopted to control restraint use in care facilities by way the *Health Care (Consent) and Care Facility (Admission) Act* and the *Care Facility Regulation*. The legislation is a reflection of "policy".

care-giver has commonly held over the facility resident. This may prove problematic to some care staff accustomed to practicing health care from a paternalistic perspective.

- Legislate against the use of any restraint in long term care facilities. Non-emergency restraint would not be an option, and an individual requiring emergency restraint would be transferred out of the facility. As the *Act* does not apply to the provision of services or to treatment of anyone involuntarily detained under the *Mental Health Act*, the use of restraint could be permitted only in provincial mental health facilities and the psychiatric or gero-psychiatric wards of hospitals. Implemented on a time line, this would force the affected facilities to attain competence with existing alternative care methods or to develop their own alternatives to restraint. Clearly problematic and undesirable in this scenario is the number of individuals in long term care who suffer from diseases that cross over to the psychiatric realm, specifically in the dementing conditions of the elderly. Consequently a number of psycho-geriatric patients could find themselves admitted involuntarily to mental health facilities, and selective admission practices would determine eligibility for residence a long term care facility.

Outside of legislating best practice, another alternative is to regulate by law the continued use of restraint in the existing health care environment. This appears to be the path chosen in the new policy, and is evident in the legislation. Section 25 of the *Act* and sections 10 - 16 of the *Regulation* place restrictions involving monitoring and assessment requirements to be met by the facility operator when using restraint. The purpose of the restrictions are to prevent the negative effects and abuse possible when restraint is an available care option. However, the restrictions do very little to correct the conditions in facilities that lead initially to instances of preventable restraint.

Some stake-holders involved in the process associated with the new policy may take exception to this interpretation of the policy's "course of action", arguing perhaps that the *Act* does impose an environment of least or non-restraint. An examination of the *Act* reveals both arguments. Section 25 (1) reads:

The operator of a care facility must not restrain, by physical, chemical or other means, the freedom of movement of an adult who is living in the facility unless

- (a) all alternatives have been exhausted.
- (b) the restraint is as minimal as possible.
- (c) the restraint has been approved by a person authorized under section 22(1), (2) or (6) and by a medical practitioner whose approval is based on the opinion of another health care provider, and
- (d) the necessity for the restraint is periodically reassessed in accordance with the regulations.

While the first phrase in section 25 (the umbrella clause) seems to uphold the values of autonomy and self determination, stating that the care facility "must not restrain" the freedom of movement of the resident, the key word that undermines the force of the section is "*unless*", where after the exceptions that allow for restraint are subsequently set out. From that point on in section 25, it can be argued that the legislation digresses or "slides" into lengthy detailing of the necessity for restraint under the authority of the health care provider. This is illustrated in subsections (2),(3) and (4) of section 25:

(2) A person authorized...may approve a decision to restrain the adult's freedom of movement if

- (a) the person consults, to the greatest extent possible, the adult and with any spouse, relative or friend of the adult who asks to assist, and
- (b) the decision is in the adult's best interest or for the protection of others.

(3) The operator of a care facility may restrain the adult's freedom of movement, even though the restraint is not approved under subsection (1)(c), if

- (a) the restraint is necessary to preserve the adult's life or to prevent serious physical harm to the adult or others,
- (b) the adult is restrained for no longer than necessary and, at the most, for no longer than 72 hours,
- (c) a health care provider reassesses the necessity for the restraint at least every 8 hours, and
- (d) the operator ensures that the adult's comfort and safety is monitored in accordance with the regulations.

- (4) If the adult is restrained under this section, the operator of the care facility must
 - (a) notify, in the prescribed form, any person who accepted a facility care proposal for the adult, and
 - (b) record the restraint in accordance with the regulations.

Those care-givers who would choose to use restraint in the routine manner that conflicts with the values of autonomy and self determination are likely to have always held the position that the decision to restrain is in the adult's best interest or for the protection of others, and that a restraint is necessary to preserve the adult's life or to prevent serious physical harm to the adult or others.

Many adults at risk for inappropriate restraint suffer from dementia and thus may be unable to convey their objection to the application of a restraint or understand the risks associated with its use. The right to be consulted about the application of restraint may be the privilege of the more lucid resident or the resident with family available for consultation about care issues.

As has been discussed in earlier chapters, our society accepts that individuals do not have the right to place others at risk for serious physical harm, and in such circumstances it seems reasonable to allow for restraint if no other alternative exists. However, the provision in section 25(3) of the *Act* allowing for restraint when "necessary to preserve life" or "to prevent serious physical harm to the adult or others" is problematic in that the right of the adult to be personally *at risk* for physical harm is not recognized. One could argue that the right to be at risk is part of the philosophy of autonomy and self determination. Yet, by this *Act*, the care-giver may interpret the law to allow for the conventional use of restraint that the legal reform is intended to prevent. It is these types

of interpretive nuances taken from the *Act* that may threaten the values of autonomy and self-determination. However, the *Act* may not be the appropriate place for such statements of philosophy in regards to the resident's right to personal risk taking. Recognition of the care facility resident's right to some personal risk may be better addressed by education driven changes to ward-level care facility policies.

Part 3 of the *Regulation* is dedicated in its entirety to restraints. Since no comprehensive regulation of restraint has existed in the past, the forthcoming law can be considered by care providers and care facilities to be a significant set of limitations. However, section 3 of the proposed *Regulation* may be described and viewed as detail upon more detail accentuating and confirming, rather than actually limiting the authority of the care-giver to control the freedom of residents. Thus, the *Regulation* may be interpreted as moving even further than the *Act* to tolerate the practice of restraint. For example, the discussion of assessment requirements (non-emergency restraint use) in section 12 (3) confirms that although the facility has a legal obligation to reassess the restraint, the significant power that the care-giver has over the individual resident is undeniable. It reads:

The need for any other form of restraint must be reassessed

- (a) within 24 hours after the restraint was applied or, in the case of medication, after it was given, and
- (b) if the restraint continues, then,
 - (i) at the time specified by the persons who approved the restraint,
 - (ii) at the times specified in the resident's care plan, or
 - (iii) at least once every 30 days after the restraint was applied, or in the case of medication, after it was given, whichever results in the shortest intervals between reassessments.

After initial reassessments, the subsequent restraint reassessments occur only as determined by the authority of the care-giver or "once every month". However, in keeping with the legal principles of procedural fairness, a "Health Care and Care Facility Review Board" is established under the *Act* to hear reviews of decisions to restrain individuals if applications for review are made⁷. The Board may order that the restraint be discontinued, yet the remedy is after the fact and is an illustration that such "courses of action", as found in this policy can do little to prevent the problem from occurring initially.

At this point, one may question how else the practice of restraint can be regulated, if not by the method embodied in the *Act* and *Regulation*? After all, the *Act* appears to place extremely stringent controls on the practice, a progressive step towards reducing possible instances of abuse by restraint in the care facility. Criticism of the course of action on restraint use is not targeted directly at the specific controls within the *Act* and *Regulation* themselves but, rather, is directed at the underlying premise that non-emergency restraint use is necessary in the long term care environment. To state in the *Act* that non-emergency restraint is an acceptable method of care and then support that statement with lists of regulations and legal forms to empower the care-giver in the practice of restraint may undermine the movement away from restraint use towards preferred and proven alternatives to the practice. Thus, improper restraint use might have been discouraged not by employing the intricate legal measures undertaken in the *Act* and *Regulation* but, rather, the course of action could have been one of infusing the long term health care environment with care techniques that preclude restraint use.

⁷ See section 28 (2) of the *Act*.

Lastly, a case of questionable restraint practice about which an application for review has been made might become moot by the time the Board is prepared to hear it. The restraint could have been removed by the care-giver before the hearing date, rendering the hearing somewhat pointless from the patient's perspective. For the patient or resident, the time between an application for review and the hearing contains no avenue for release from the restraint other than the hope that it will be allowed following a reassessment⁸. This situation is analogous to the provincial mental health system where the *Mental Health Act* provides for tribunal hearings to review the involuntary admission and treatment of patients. Outside of retaining a lawyer to make an argument to the court as to why detention is not required, individuals who may be wrongfully denied their liberty are without legal recourse prior to Review Panel hearings, and may suffer the loss of liberty until release is ordered⁹.

One could argue that the section of the *Act* dealing with Review Boards should include a very short, specific time period before review to lessen significantly any undesirable waiting for a resident seeking legal recourse from the restraint. Currently, the *Act* stipulates in section 29 (2) that the hearing must be held within 7 days after the board receives the request. Further, it may be imperative in cases where liberty is so severely restricted, as it is with restraint or seclusion, that immediate review occur in non-emergency situations either before restraints are applied, or at least on the same day or within 24 hours of emergency restraint or seclusion. Some American courts have required the implementation of pre-restraint/seclusion hearings so that the patient has the

⁸ With the assistance of a lawyer, the patient/resident can seek removal of the restraint by way of judicial review.

⁹ *Mental Health Act* RSBC 1996 s. 33

opportunity to present evidence and have the decision to restrain made independently of the patient's own physician (Grant, 1991). If this approach were adopted in British Columbia, a hearing before the Review Board would be mandatory in any case where restraint was used or was considered for non-emergency use.

c) A Question of "Alternatives"

The *Act* states in section 25 (1) that restraint must not occur until "all alternatives have been exhausted". Yet the definition of precisely what alternatives fall within the scope of the *Act* remains undefined. The *Regulation* as it stands does not define the alternatives considered acceptable, and no related policy document at this time describes these alternatives. Different institutions will likely consider varying forms of patient control as "alternatives" to restraint. As illustrated, some institutions have developed alternatives to restraint that are unique to their facility. This begs the question as to what standard long term care facilities in British Columbia will adhere to in determining when all alternatives have been explored. In response, a Ministry policy should be developed to determine issues such as whether an alternative is excluded if its implementation conflicts with preferred or existing institutional policy and procedure. For example, one alternative to night-time restraints is the placing of mattresses on the floor to prevent falls out of bed. However, this might be considered in some facilities as un-hygienic. Further, staff may object to the fact that they must now stoop or bend down to attend to the resident's needs. If the restraint alternative can be argued to cause more physical or emotional stress to the care-givers or otherwise changes working conditions, one may question if this excludes the alternative, and who in the facility or Ministry will make that determination.

Government policy on restraints has not legislated "best practice". This would require that all facility care-givers undergo educational programming and that government dollars be allotted for implementing real "least restraint" or "non-restraint" care. Otherwise, there is likely to be little change in the conventional use of restraint in those long term care facilities that have not adopted the "least-restraint" or "non-restraint" care philosophies that have dramatically changed the perception and practice of restraint over the past decade.

The use of restraints as the government has made meaning of them is to tolerate them as necessary in certain circumstances within the existing health care environment, despite how this may appear to conflict with the values of autonomy and self determination intended to guide the new policy that underlies the legislation. The policy-makers¹⁰ are remiss not by tolerating restraint when absolutely no other choice exists, but by not fully supporting the implementation of restraint alternatives through mandatory restraint reduction and restraint reduction educational programs for care-givers.

Yet, the difficulty in attempting to directly control the behavior of health care institutions and, further, the behavior of health care providers as they practice restraint is problematic to the policy-maker as these domains have largely been considered self-regulating. As Brooks comments:

The para-public sector represents the outermost edge of the state system. The organization that comprise it clearly are instruments of public policy. But they operate with a large margin of autonomy from the government that provides all or most of their revenue" (1989:162).

¹⁰ The term "policy makers" refers to all those involved in the process that culminated in the final draft of the *Health Care (Consent) and Care Facility (Admission) Act* and *Care Facility Regulation*.

d) The Policy Potential: A Role for Legal Advocacy

The *Care Facility Admission Regulation* allows for legal advocacy organizations to advise residents of care facilities of their rights under the *Act* and to provide legal counsel at Review Board hearings¹¹. Three advocacy organizations are potentially able to provide this service; a member of the *Association of Community Law Offices of British Columbia*; the *Native Community Law Offices of British Columbia*; and the *Community Legal Assistance Society*. These offices may wish to undertake legal programs to advise care facility residents of their rights, establishing routines by which each resident is made aware, or has the opportunity to become aware of their individual legal rights. The key role of the legal advocate in supporting the intention of the policy will lie in challenging instances of inappropriate use of restraint before the Review Board.

The manner in which these advocacy organizations interpret their responsibilities to residents of care facilities will be reflected in the quality of representation received by clients. The client, in keeping with the fundamental principles of justice, has the right to the best possible representation when making an application for review of a decision made under the *Act*. Although funding for non-profit organizations has been, and continues to be, subject to cuts within the current government's fiscal squeeze, these organizations must provide qualified legal counsel to make educated and thoroughly argued submissions to the Board on behalf of their clients. It may be that the cases brought before the Review Board will further the rights of the elderly and other care facility residents before the courts as a result of arguments that go beyond the scope of the decision in question, or

¹¹ Part 1, s.3. (a),(b),(c)

even beyond the jurisdiction of the Review Board. As such, potential clients rely upon competent legal representation to bring deserving actions to the attention of the courts.

In this regard, the named legal organizations may interpret their role as being much larger than the appearance by counsel at scheduled Review Board hearings. Rather, it may be to ensure the compatibility of the restraint legislation in relation to the *Charter of Rights and Freedoms*. It may be argued that the *Act's* constitutional compatibility was the responsibility of government during the policy and legislative development processes, rather than that of legal advocates. However, the role of the *Charter* is not yet fully interpreted as it relates to those who are denied their liberty within long term care facilities and mental health institutions. It may be that the non-profit legal organizations involved in this policy process have the best chance at bringing these Charter arguments. Other legal organizations not named in the *Act* may also find a role in this regard (e.g., L.E.A.F).

Attention to the legal rights of the elderly may suffer in that access to legal representation may be limited by a lack of fiscal resources compounded by the rather isolated environment of the care facility. The legal organization shouldered with the responsibility of representing the legal interests of the confined adult has the opportunity to address both these problems; first by providing access to procedural fairness, and secondly by providing access to the court without cost to the individual.

Lastly, it may be the responsibility of these legal organizations to evaluate the long term efficacy of restraint policy as set out in the *Act*¹². Evaluations by organizations representing the competing interests evident in the legislation may bias their evaluations

¹² Section 27 of the *Public Guardian and Trustee Act* (R.S.B.C. 1996, c.383) requires periodic, independent evaluations of the effectiveness of all four Acts of the adult guardianship legislation including all regulations, policies and procedures enacted or developed under the Acts.

towards whether the interests of the represented stakeholder has been served. The legal perspective in a long term evaluative effort may be able to base appraisals on the goal of improved legal rights of the residents affected by the policy rather than the competing interests of patient control or the fiscal concerns of some policy stakeholders. Yet, one might argue that a legal advocacy organization must not evaluate the legislation for similar reasons of bias that may include the impact on funding for advocacy services. This leaves only an independent group to undertake the evaluation of the legislation that would include the perspectives of all stakeholders involved with the issue of restraint use in care facilities.

e) Continuing Restraint Practice in British Columbia: A Summary

[Policy is] a consequence of the *environment*, of the distribution of *power*, of prevailing *ideas*, of institutional *frameworks*, and of the process of *decision making* (Simeon, 1976 in Brooks, 1989:45).

The course of action chosen by the government to deal with restraint practice is constrained by the "institutional framework" of conventional care facility management. Conditions that allow for restraint practice that threaten the autonomy and self-determination of residents are difficult to address within the existing institutional framework of British Columbia's care facilities. Although the heavy regulation of restraint use in section 25 requires detailed reassessments of restraint use by the care-giver, the *Act* may be seen, paradoxically, as a confirmation of the acceptability of restraint use in long term care. Ultimately, restraint practice could become more "lawful" than ever before. The distribution of power between the care-giver and the resident is such that despite a

documented shift in the patient care dynamic, the resident still is subject to the medical and the legal authority of the care-giver, something that would be less likely to happen in a “state of the art” facility that fully employs restraint alternatives.

While this analysis paints a slightly critical picture of the new restraint legislation in British Columbia, the values and philosophies presented within the guiding principles are a reflection of current thought and thus a move forward to protecting the rights of adults in need. Unfortunately, in not fully addressing the conditions that instigate restraint practice, section 25 of the *Act* can provide only “after the fact” remedies. Yet, this may be a condition of policy development unique to para-public sectors, as Brooks describes them (1989: 159-163). Achieving direct control of an element of the health care sector would be unlikely as health care agencies have traditionally been self-regulating. However, the policy also imposes a new avenue to legal review of some decisions made in long term care including the decision to restrain. Further, the required reassessments of restraint implemented on the ward level force the care staff to re-examine their decision making on a regular basis, hopefully to discourage unnecessary restriction of the liberty of residents. These elements contribute a sense of recognition for individual rights within care facilities; which emanates from the underlying policy that drives the legislation.

CHAPTER FIVE

Charter Rights: A Legal Analysis of Abuse by Restraint

This chapter examines the legal implications of restraint use in care facilities. This is a shift away from the discussion, in previous chapters, of the medical, ethical and policy issues involved with restraint use. Here, the focus is on the potential role of section 12 of the *Canadian Charter of Rights and Freedoms* on restraint use within the context of long term care. An analogy is drawn between the use of section 12 in criminal cases that have determined lawful treatment, punishments and general living conditions in the penal context as well as in mental health facilities, and the implications this may have for establishing acceptable treatments in other institutional environments. It is proposed that the values embodied in those cases may be transferable to the use of restraint in long term care. The comparison between the penal and long term care institution is restricted to issues of confinement; no other similarities are proposed.

a) The Treatment of Captive Persons: A Case by Analogy

It can be argued that most long term care facility residents are “captive”, as are incarcerated criminal offenders, except of course, for the voluntary resident. The severely cognitively impaired resident likely has no option to living anywhere other than in an institution and leaving is either impossible or at the very least is a complex process requiring more skills than the resident may possess. There are some similarities between the living conditions of the care facility resident and the incarcerated offender on account of the nature of institutional environments. One of these is evident in the removal or lack

of capacity for independent decision making by both populations. The care facility resident and the incarcerated offender are subject to routines created not by the rhythm of their own lives but by the pace of the larger group. For example, residents cannot choose a daily menu that differs from the group, or set a different time to go to sleep or to bathe. Even more complex decisions like choosing to seek medical treatment are not made independently by the individual without some influence from the institution. Thus, the inhabitants of such controlled environments must tolerate the living conditions provided for them. The purpose of this collective approach towards the care of institutional residents is, in part, to meet the needs of numerous people simultaneously. Yet arguably, the purpose of the collective approach is to also meet the need of the institution itself; to manage and control its population.

This penal/care facility analogy is strictly limited to issues of confinement. The populations are overwhelmingly different, thus, no connections other than those relating to the controlled environment can be said to exist. The prison operates on a mandate of control, punishment, and rehabilitation whereas the purpose of a care facility is to provide care and treatment. At no time is the legitimate use of restraints in care facilities a method of punishment, although they are used for control as part of the care/treatment process. The *Care Facility Admission Regulation* states specifically that restraint is not to be used for punishment or discipline¹. The dilemma is one of care vs. control, and the delicate balance that exists between the two potentially conflicting conditions.

¹ Draft 12, 1997. Part 3. Not yet in force.

Protection of the captive person is an issue that has been addressed by the courts in determining an acceptable standard of prison living conditions. Further, the courts have considered the use of restrictive controls such as segregation and the use of physical restraints in prisons. Since 1982, inmates have sought remedies for unacceptable living conditions under the legal rights section of the *Canadian Charter of Rights and Freedoms*². Prior to the advent of the *Charter*, protection of these rights was sought under section 2(b) of the *Canadian Bill of Rights*³. Both these sections speak to the prohibition of cruel and unusual treatment or punishment and have been implemented in instances of restraint use. However, the courts have not examined the same issues with respect to the residents of long term care facilities.

Although *Charter* remedies seem logically suited to infringements of legal rights in the criminal context, there is no particular reason why the *Charter* should be restricted to criminal circumstances. The legal rights of other “captive” populations, namely those individuals living within various government institutions are similarly protected by the *Charter*. In the mental health context, for example, the courts have considered issues of confinement and treatment in a number of cases (Gaudet, 1994).

In the 1991 Ontario Court of Appeal case *Fleming v. Reid and Gallagher*⁴, the issue was whether the state may administer neuroleptic drugs to involuntary psychiatric patients who, when mentally competent, refused to take the drugs. Gallagher and Reid were involuntary patients having been found not guilty by reason of insanity for criminal offenses. Dr. Fleming, the attending physician for Mr. Reid and Mr. Gallagher, requested

² Part 1 of the Constitution Act, 1982. Schedule B of the Canada Act 1982 (U.K.), 1982, c.11.

³ 1960.

⁴ (1991) 82 D.L.R. 4th 298.

permission from the Review Board to order the treatment to which Mr. Reid and Mr. Gallagher were opposed, and the Board granted the orders on the basis that this would be in the “best interests” of the patients. Messrs. Reid and Gallagher, represented by the Public Trustee as litigation guardian, appealed the Review Board decision to District Court. The principal challenge was that the Ontario *Mental Health Act* deprived patients of their right to security of the person guaranteed by section 7 of the *Charter*.

The trial judge found no violation of *Charter* rights. Thus, the Review Board, under the *Mental Health Act*, was empowered to overrule the patient’s competent wishes if the Board’s opinion was that the treatment was in the “best interest” of the patient. On appeal, Judge Robins with two other Court of Appeal judges concurring found that certain sections of the *Mental Health Act* were inconsistent with section 7 of the *Charter*. In the court’s view, “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”. Judge Robins stated at page 317 (h):

A legislative scheme that permits the competent wishes of a psychiatric patient to be overridden, and which allows a patient’s right to personal autonomy and self determination to be defeated, without affording a hearing as to why the substitute consent-giver’s decision to refuse consent based on the patient’s wishes should not be honored, in my opinion violates the basic tenets of our legal system and cannot be in accordance with the principles of fundamental justice.

In the 1992 case *C.W. v. The Mental Health Review Board*⁵, the Manitoba Court of Queen’s Bench found that sections of the *Manitoba Health Act* and the *Manitoba Evidence Act* violated section 7 of the *Charter* in that they forced a psychiatric patient to

⁵ (1992) 12 C.R.R. (2d) 352.

give evidence at a Board hearing. Involuntary patient C.W. had applied to have his detention reviewed but did not give evidence at the hearing. The Board sought to examine C.W., but his counsel maintained that C.W. was not a compellable witness by virtue of section 7 of the *Charter*. The Board argued that it had the right to compel C.W. to testify because it was charged with the duty of informing itself of all matters relating to this type of application. Further, the Board claimed that if such an action was contrary to the “principles of fundamental justice” protected by section 7, this was shielded by section 1 as a reasonable and demonstrably justified limitation. C.W. was served with a subpoena to testify, but a Judge quashed the subpoena, declaring that C.W. could not be forced to testify. Judge Hanssen stated: “It seems to me that it would be a very rare case where the State would have to resort to the evidence of a psychiatric patient in order to establish that the patient should be detained as an involuntary patient”.

In 1993, the constitutionality of the involuntary admission criteria of British Columbia’s *Mental Health Act* was challenged in *McCorkell v. Director of Riverview Hospital*.⁶ Mr. McCorkell was detained within a mental health facility on the certification of two doctors who were of the opinion that he displayed dangerous and aggressive behavior during a manic phase of a mood disorder. The patient requested a review of his detention before a Mental Health Act Review Panel and was detained by the panel in three subsequent hearings. Among other issues, Mr. McCorkell challenged whether the criteria of the *Mental Health Act* provisions conformed to section 7 of the *Charter*. The challenge was not successful, with the court finding that the standards for involuntary admission

⁶ (1993) 104 D.L.R. 4th 391 (BCSC).

“strike a reasonable balance between the rights of the individual to be free from restraint by the state and society’s obligation to help and protect the mentally ill”.

i) Medical Treatment and the Charter of Rights

An overview of mental health law (Gaudet, 1994) indicates that amendments have been made to mental health statutes to comply with the requirements of the *Canadian Charter of Rights and Freedoms*, often in relation to section 7. Further, additional *Charter* rights including equality have been at issue in other cases. In *C. (J.) v. British Columbia*⁷, the plaintiff argued that as a female patient, she was denied an equal right to treatment in the forensic psychiatric facility⁸, and thus the policy of the institute to not permit female patients to reside in the lower security cottages at the facility was a breach of section 15 of the *Charter*. “Budgetary restrictions” prevented the housing of female patients in the cottages which were considered by the treatment team as an integral part of the rehabilitation scheme and preparation for return to the community. The issue specifically involved the treatment the plaintiff received pursuant to the *Criminal Code* and the *Forensic Psychiatric Act*⁹. The court found that although there was a rational connection between the objective and the exclusionary policy (the plaintiff being female while all other cottage residents were male), there was no evidence that the exclusionary policy was the least drastic measure that could be taken, nor were any other alternatives explored. The section 15 violation was therefore not justified under section 1 of the *Charter*.

⁷ (1991) 65 B.C.L.R. (2d) 386 (BCSC)

⁸ The forensic facility is a government institution.

⁹ R.S.B.C. 1979, c.139

It is evident from a review of mental health law cases that the Court will apply the *Charter* to issues of treatment within government controlled health care facilities, particularly mental health facilities, with careful attention to the role of society in protecting persons perceived to be in need of care. It is important to note that this will occur only where the care facility can be considered “government” and the applicable legislation is found to violate the *Charter*.

ii) The Application of Charter Rights to the Standard of Treatment in a Long Term Care Facility

It is widely acknowledged in Canadian constitutional law that the application of *Charter* rights to the activities of a non-government organization or institution hinges on “the nature and extent of the control which the government exercises over them [to] warrant the conclusion that they are part of the machinery of government” (Beaudoin, Ratushny, 1989: 86).

Based on a 1990 Supreme Court of Canada decision, it can be argued that hospitals are not subject to the dictates of the *Charter*. In the case of *Stoffman v. Vancouver General Hospital*¹⁰, a four - three majority of the court concluded that the Vancouver General did not form part of government within the meaning of section 15 of the *Charter* (equality rights). The initial impression the decision in *Stoffman* may give is to release hospitals altogether from the responsibility of adhering, in their administration of health care, to the supreme law of the Charter. Canadian hospitals are governed generally by hospital and health statutes and regulations. However, it should be noted that the

¹⁰ [1990]3 S.C.R.

Stoffman case was decided on an issue far removed from the treatment and care of patients. As well, the case, particularly in *obiter*, contains strong opinions from the dissenting Justices as to how the hospital as an institution performs the functions of government, operates as government, and thus is subject to *Charter* dictates. Therefore, the argument may remain that the *Charter* does apply where hospitals and/or care facilities are affected by legislation that regulates how care is provided for patients within the institution, as is the case with the use of restraints in care facilities. Arguably, “hospitals” as they were discussed in *Stoffman* are different institutions than care facilities, and although some may be “hospital - like” in appearance and function, the care facility provides services somewhat distinct from a hospital.

At issue in *Stoffman* was a section of Vancouver Hospital’s “Medical Staff Regulation” as adopted by the hospital board, the effect of which was argued to be an infringement of the equality rights of physicians over the age of 65. The “Regulation”, passed by a sixteen member board (14 of whom were appointed by government) required that physicians retire at the age of 65, unless they could prove that they had “something unique to offer the hospital”.

Supreme Court Justices Dickson C.J., LaForest and Gonthier JJ. agreed that the Vancouver Hospital did not form a part of government, as it is an “autonomous body”, and the provision of the public service of health care does not qualify the hospital *per se* in

the meaning of section 32 of the *Charter*¹¹. The court considered whether the government exercised control over the day-to-day operations of the Vancouver Hospital, stating, at page 485(f):

A difference between ultimate or extraordinary and routine or regular control must be drawn. While the fate of the hospital is ultimately in the provincial government's hands, the responsibility for routine matters such as policy on the renewal of admitting privileges lies with the Board and is not subject to government control, barring extraordinary circumstances...The Lieutenant Governor's power of appointment was simply a mechanism to ensure the balanced representation of these groups and organizations on the hospital's principle decision-making body. It was not a means to exercise regular government control over the hospital's day-to-day operations.

In this case, it is in part the delineation between "routine" control of a policy setting hospital board or "ultimate or extraordinary" control that determined whether the hospital functions as government. As Justices Dickson, LaForest and Gonthier state at page 485, "[The regulation] did not arise because of an executive or legislative action and accordingly did not attract *Charter* review". Justice LaForest, in delivering the judgment in *Stoffman* states at page 508(b):

The evidence does not show that [the regulation] was instigated by the Minister of Health, or that it in any way represents ministerial policy with respect to the renewal of admitting privileges. Instead, it shows that the regulation was the end result of an internal review of policies relating to the retirement of medical staff...

¹¹ Section reads: 32. (1) This Charter applies

(a) to the parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest territory; and

(b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

It might then be taken from *Stoffman* that should a proposed hospital policy or regulation be one that follows directly from legislation, the resulting control is likely to attract *Charter* review. Arguably, the regulation of restraint use in care facilities and hospitals goes far beyond any general guidelines established by the legislature in the administration of hospitals boards for the purposes of staff management and the like. The detailed nature of section 25 of the *Health Care (Consent) and Care Facility (Admission) Act* in setting out the standards for restraint use in care facilities may be argued to cause the care facility to meet the broad test for “government” developed by Justice Wilson in *McKinney v. University of Guelph*¹² and cited by her in *Stoffman* at page 533(f). The criteria for “government” include:

1. Whether the legislative, executive or administrative branch of government exercises general control over the entity in question;
2. Whether the entity performs a traditional government function or one recognized in more modern times as being a state responsibility;
3. Whether the entity acts pursuant to statutory authority specifically granted to further an objective that government seeks to promote in the broader public interest.

British Columbia’s adult guardianship law, of which the restraint legislation is part, contains provisions for the protection of adults within care facilities. Thus, the care facility forms an integral part of the state’s responsibility to adults with mental disorders and disabilities, serving a public interest in protecting vulnerable individuals and their estates¹³.

Justice Wilson, in her dissent from the majority decision in *Stoffman* makes the argument that when power to proceed in administrative duties, such as that of the hospital

¹² [1990] 3 S.C.R. 229

¹³ See the discussion “The Reform of Adult Guardianship Law” in Chapter Three.

board, “flows” from a related statutory authority, the policy in question would be subject to review under the *Charter*. Justice L’Heureux-Dube at page 489(h) concurred with Justice Wilson in finding that hospitals are part of government noting, however, that there may be times when a hospital function is not government and thus not subject to *Charter* review:

In Canada, both historically and even more today in terms of function, hospitals are an “arm of government” and perform a governmental function. An appointed hospital board may enjoy a certain independence in formulating policies...but the situation is similar to that of government departments setting up their own agenda and policies, subject only to general guidelines established by the legislature.

The issue in *Stoffman* was that of a policy of withholding admitting privileges for “aging” physicians unless “they had something unique to offer the hospital”. This policy likely never, as Justice LaForest notes, came to the attention of the Minister and his staff and was simply a “rule or directive of internal management”¹⁴. Thus, the Vancouver Hospital did not function as a “government” to discriminate, by way of the “Medical Staff Regulation”, against the retiring physicians. This differs significantly from the use of restraints in the context of providing care for care facility residents. Their regulation resulting in section 25 of the *Health Care (Consent) and Care Facility (Admission) Act* has been very much in the forefront of the development of British Columbia’s new adult guardianship law.

It is possible to argue then that the *Stoffman* decision does not necessarily guarantee an exemption of the hospital or care facility from *Charter* dictates. The

¹⁴ at page 510(g)

argument is this: The element of governmental action that resides in the “restraint” legislation outlining the conditions by which restraint may or may not be used, places the residents of care facilities whose care is affected by that legislation within the realm of *Charter* protection. The presence of mechanisms to regulate compliance with the *Act* by regional health authorities cements the relationship of the long term care facility to “the machinery” of government¹⁵. One needs only to look at the history of adult guardianship law and the policy process that brought about the *Act* and *Regulation* to recognize this relationship¹⁶. In addition, it is obvious that that the provisions in the *Health Care (Consent) and Care Facility (Admission) Act* and the *Care Facility Admission Regulation* which themselves are the result of direct government action address the use of restraint and are subject to *Charter* scrutiny.

As a general rule, a discussion of *Charter* rights also includes consideration of the role of the section 1 limitations clause; that an infringement of the rights and freedoms in question is subject to “reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society”. However, the analysis of restraint use as a “cruel and unusual treatment” will be quite different from other cases where *Charter* rights are applied to the circumstances of institutionalized populations in the sense that the right protected by section 12 can be considered to be *absolute*. The right to be free from a treatment or punishment that is “cruel and unusual” cannot, or very likely cannot, be justifiably limited (Hogg, 1992: 35.14). However, the argument is problematic from a

¹⁵ These mechanisms are currently in a state of flux; thus the agencies that may regulate compliance with the *Act* have been or will be, reorganized. It is likely that these compliance mechanisms will function through regional authorities but subject to provincial government policies and standards.

¹⁶ See discussion in Chapter Four.

practical point of view in that the use of restraint in some very unique contexts of care (e.g., psychiatric institutions) can be justified in that it achieves some important social objective (e.g., safety). The argument against restraint use in long term care where the population consists mainly of the elderly maintains that restraint use in that particular context of care is “cruel and unusual” by virtue of the availability of viable alternatives that render the practice unnecessary. If found to be “cruel and unusual” in one context of use, the medical practice of restraint may be considered morally, if not legally permissible (because the right is absolute and cannot be limited) in some other context, for example, when providing protection or safety when no other alternative exists.

b) The Charter as Remedy for Abuse by Restraint

Feehan and Bailey (1994: 85) mention the utilization of the *Charter* as a potential remedy for certain cases of patient abuse by the practice of restraint. Sections 7, 9, and 12 are considered to be the most relevant:

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
9. Everyone has the right not to be arbitrarily detained or imprisoned.
12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

Feehan and Bailey (1994: 85) also comment on the use of section 24 of the *Charter* to seek remedy of such a violation, by a court of competent jurisdiction. However, no case law is offered to support their proposition that an abused patient pursue

section 7, 9, or 12 rights, or seek remedy under section 24. The potential of a *Charter* remedy for patient abuse, specifically in pursuing rights under section 12, is mentioned only fleetingly in the legal literature (Feehan, Bailey 1994; Grant, 1991). Very little in-depth analysis is available from legal sources.

The following discussion by Grant (1991:19) makes the same connection as Feehan and Bailey in detecting a relationship between restraint practice and “cruel and unusual treatment”:

Section 12 of the *Charter of Rights and Freedoms* protects an individual from cruel and unusual treatment. It can be argued that restraint or seclusion, except in the most extreme circumstances of danger to the patient or to others, constitutes cruel and unusual treatment. The absence of uniform guidelines across the province would support a *Charter* argument. Many critics argue that such important decisions about liberty should not be left to the total discretion of hospital staff and believe that there should be clear legislative guidelines with adequate protections for the rights of the patient (Grant, 1991: 19).

Comments such as Grant’s above make two assumptions about the use of restraints. The first is that restraint is by definition a “treatment”. An examination of the exact purpose of restraint may place such a definition in question. One may ask, if restraint is not a treatment, then what is left to justify its use? It is possible to argue that restraint is not a treatment, medical or otherwise but rather a method of patient control and management. The counter argument is such that patient management is part of the larger treatment afforded by the care-giver to the resident. Management of the cognitively impaired person constitutes a significant element of the care provided in a long term care facility. As has been illustrated in the earlier chapters of this thesis, behaviors that are likely to result in the use of restraints are symptoms of dementing diseases. Thus,

management and control are part of the treatment for the disease. The provision of care and treatment is considered conjunctive in the context of long term care. Yet, the care vs. control dilemma can be resolved to some extent when the opportunity to minimize the element of control presents itself through restraint alternatives and the element of care is emphasized within the care/control dialectic.

The second assumption apparent in Grant's statement is that uniform restraint/seclusion guidelines will in some way remedy the injustice of improper restraint practice. It is possible to take the argument beyond that claim: to demonstrate that the use of restraints even within "uniform" legislated guidelines may constitute an infringement of section 12 of the *Charter*, if the guidelines do not fully support alternatives to restraint.

Presently, the only legislated standard for the use of restraints is in section 10 of the *Adult Care Regulations*¹⁷. It reads:

10(2) The licensee shall not

- (a) except in an emergency, apply or permit an employee to apply a physical restraint to a resident without first obtaining the written consent of the resident's medical practitioner;
- (b) require a resident to remain in or lock a resident in a room; and
- (c) physically, verbally or mentally abuse a resident.

There is no process in the *Regulation* that allows for a review of the decision to restrain a resident, and there is no requirement for a re-assessment where restraint use has been implemented. Under the *Adult Care Regulation* the resident or family member has no means by which to challenge the use of the restraint, or to ask for a review of the decision to restrain, except by judicial review. The *Adult Care Regulation* would therefore not

¹⁷ B.C. Reg. 536/80.

survive a *Charter* challenge as the principle of procedural fairness is absent from the legislation.

The continued use of restraint in a society where technology and the prevailing philosophy of care have moved routine restraint use to the outer limits of acceptable treatment may be both cruel and unusual treatment as defined by section 12. The precise legal definition of “cruel and unusual treatment or punishment” can be argued to support this and follows in the analysis of section 12 case law in the criminal context. In criminal law, several themes appear within the legal discussion of cruel and unusual treatment or punishment, and may be transferable to the issue of cruel and unusual treatment in the care facility context.

c) The Meaning of “Cruel and Unusual Treatment or Punishment”: Case Law and Commentary

In *Rodriguez*,¹⁸ the Supreme Court narrowly rejected the argument that a section of the Criminal Code prohibiting assisted suicide violated the rights of a terminally ill woman under sections 7, 12 and 15(1) of the *Charter*. The Court commented that there must be an “active state process in operation” in a cruel and unusual treatment imposed by the state, “even assuming that `treatment` within the meaning of section 12 may include that imposed by the state in contexts other than penal or quasi-penal”. The Court rejected the section 12 application altogether in *Rodriguez*, claiming that to be subjected to treatment by the state, “there must be some exercise of state control over the individual, whether it is positive action, inaction or prohibition”. As Ms. Rodriguez was not subjected

¹⁸ *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519

by state administration or justice system to an actual treatment, her claim to cruel and unusual treatment “would stretch the ordinary meaning of being “subjected to treatment” by the state”. In *Rodriguez*, the Court’s discussion of the meaning of the phrase “cruel and unusual treatment” is brief as the circumstances of the case were not considered to fall within the bounds of section 12. Yet, the Court does imply that where there is state control or operation over an individual, section 12 considerations may include medical care or treatments imposed by the state.

As is evident from *Rodriguez*, reported case law does not offer much concerning the application of the section 12 prohibition against “cruel and unusual treatment or punishment” to medical treatment, or the lack thereof, outside of the penal institution. Although most case law discussing section 12 is based on criminal cases, it is proposed here that the values inherent in the legal interpretation of the phrase may be generalized to an argument that legislation permitting restraint use in a long term care facility falls within scrutiny of the section 12 prohibition on “cruel and unusual treatment”. As the populations of care facilities and prisons are otherwise incomparable, the analysis is restricted to that of the legal requirements for acceptable, state-imposed, institutional living conditions.

In pre-*Charter* cases, it was not until the 1976 British Columbia case of *McCann v. The Queen*¹⁹, that the courts considered “cruel and unusual treatment or punishment” in terms of an inmate’s prison living conditions. Except for *McCann*, where it was held that the use of solitary confinement was “cruel and unusual”, section 2(b) of the *Bill of Rights* was primarily implemented as a challenge to capital punishment or as a barrier to

¹⁹ (1975), 29 C.C.C. (2d) 337 (F.C.)

disproportionate punishment. For example, in *R. v. Shand*²⁰, the seven year minimum term imprisonment for the importation of narcotics was found, in the initial case, to be “cruel and unusual”. Although the exact question before the courts in these cases varied between cruel and unusual treatment as it related to capital punishment or to the length of imprisonment, the courts did identify several specific values connected to the clause “cruel and unusual treatment or punishment”. For example, in *Shand*, the court confirmed that a term of imprisonment as a punishment could be considered to be “so obviously excessive, as going beyond all rational bounds of punishment in the eyes of reasonable and right thinking Canadians”, and thus was characterized as “cruel and unusual”. In *R. v. Miller and Cockreill*²¹, the death penalty was criticized as “barbaric in itself” and “degrading to human dignity and worth”; this in response to the question of whether the punishment of death itself is “so excessive as to outrage the standards of decency”.

Judicial use of the words “rational bounds”, “barbaric”, “degrading” and “reasonable and right thinking” illustrate the unique nature of the “cruel and unusual” clause as being composed of subjective value judgments made by particular Justices upon a government imposed activity. The meaning the courts attach to the clause “cruel and unusual” is evident from the use of these terms, and further, in the tendency of the Court to repeat and expand on them in subsequent cases. One can argue that the court gives more validity to these interpretations each time they appear in various cases. For example, in *Miller and Cockreill*, Justice Laskin confirmed the test adopted in other cases, of “excessiveness so as to outrage standards of decency”. He was convinced that, as a test, it

²⁰ (1976) 30 C.C.C. (2d) 23 (S.C.C.)

²¹ (1975), 24 C.C.C. (2d) 401. (S.C.C.)

was “not a precise formula for s. 2(b)”, but doubted whether “a more precise one” could be found. With that statement, Laskin helps to substantiate the utility of the test.

The principles of “cruel and unusual treatment or punishment” as they were defined in *Bill of Rights* cases continued as the tests used in subsequent *Charter* cases. Yet, more “precision” in defining the phrase “cruel and unusual treatment or punishment” is apparent by way of judicial interpretation in recent cases. Other than some refinement in the scope of the section, the fact that these cases would now be argued under the *Charter of Rights and Freedoms* rather than the *Bill of Rights* made little difference to the enduring subjective values attached to the phrase “cruel and unusual treatment or punishment”. The phrase “cruel and unusual” has persisted through time in English, American and Canadian jurisprudence, with some evidence of evolution in its meaning and application.

Some commentators would argue that the definition of the phrase “cruel and unusual treatment or punishment” is elusive and that no “precise formula” can be offered. Boyd (1995: 79) proposes this quandary:

“How, then are we to define the expression, “cruel and unusual treatment or punishment”?...the ultimate difficulty is that there is no literal or easily reconcilable understanding of the wording. There is, instead, an inherent subjectivity in defining the boundaries of acceptable treatment or punishment: one person’s remedy may be another person’s torment”.

Hogg claims that “cruel and unusual” has never been “satisfactorily defined” citing the difficulties in determining the boundaries of the tests themselves; for example, in setting out the “standards of decency” (1992: 50.2). Nonetheless, the courts have

applied these tests, however subjective they might be, in various cases brought under section 12.

In the 1987 case *Smith v. The Queen*²², six Supreme Court Justices commented on the meaning of section 12 of the *Charter*. Examination of judicial opinion as it appears in the case provides an opportunity to examine the tests required of a section 12 argument. Evident is the legal history of the phrase “cruel and unusual” and the meaning made of the expression by way of English and American customs and society. Further apparent in the case are definitions of the social objectives that may allow an otherwise cruel or unusual treatment or punishment to be permissible. In the criminal context, it is apparent that the deterrence of criminal behavior is considered an important social objective²³. If the meaning of section 12 were to extend to a question of cruel and unusual treatment in the care facility, control and treatment of the resident would form the important social objective to be weighed in determining whether an otherwise cruel or unusual treatment is a valid social aim.

In *Smith*, Justice McIntyre comments on the “civilizing influence of the late 19th and 20th century” to reduce the “barbarous punishments of earlier times”. He explains that the phrase “cruel and unusual punishment” first appeared in the *English Bill of Rights of 1688*, and then in the *Eighth Amendment to the American Constitution (1788)*. Justice McIntyre takes note of the “broadening process” of the phrase occurring by the inclusion of the word “treatment” to “cruel and unusual punishment” in the *Canadian Bill of Rights* and then in the *Canadian Charter of Rights and Freedoms*. He observes at page 106:

²² 34 C.C.C. (3d) 97 (S.C.C.)

²³ Per Lamer J. and Dickson C.J.C. in *Smith*.

The addition of treatment to the prohibition has, in my view, a significant effect. It brings within the prohibition in section 12 not only punishment imposed by a court as a sentence, but also treatment (something different from punishment) which may accompany the sentence. In other words, the conditions under which a sentence is served are now subject to the proscription...There are conditions associated with the service of sentences of imprisonment which may become subject to scrutiny, under the provision of section 12 of the *Charter*, not only on the basis of disproportionality or excess but also concerning the nature or quality of the treatment.

It is notable that Justice McIntyre includes medical treatments, including surgical interventions such as lobotomies and castration, in the “field for the exercise of section 12 scrutiny in modern penal practice”. He uses several descriptive phrases, often repetitively, in the course of defining what encompasses a “cruel and unusual treatment or punishment”. These same phrases are echoed by the other Justices contributing to the judgment. McIntyre states:

- In my view, in its modern application the meaning of “cruel and unusual treatment or punishment” must be drawn “from the evolving standards of decency that mark the progression of a maturing society”²⁴.
- The phrase is a compendious expression of a norm which draws its meaning from the evolving standards of decency that marked the progress of a maturing society...A punishment will be cruel and unusual and thus violate section 12 if it has one or more of the following characteristics: (1) the punishment is of such character or duration as to outrage the public conscience or be degrading to human dignity; (2) The punishment goes beyond what is necessary for the achievement of a valid social aim, having regard to the legitimate purposes of punishment and the adequacy of possible alternatives; (3) the punishment is arbitrarily imposed in the sense that it is not applied on a rational basis in accordance with ascertained or ascertainable standards²⁵.

²⁴ at page 108. McIntyre quotes here from *Trop v. Dulles* (1958), 356 U.S. 86.

²⁵ at page 100.

- ...to be cruel and unusual treatment or punishment” which would infringe section 12 of the *Charter*, the punishment or treatment must be “so excessive as to outrage standards of decency”...To place stress on the words “to outrage the standards of decency” is not, in my view, to erect too high a threshold for infringement of section 12²⁶ .

The significance of American law on the development of the prohibition of cruel and unusual treatment and punishment in the *Charter* is recognized by Justice McIntyre in *Smith*. He acknowledges that “American jurisprudence upon the question...is more extensive than Canadian and provides many good statements of general principle which merit consideration in Canada”²⁷ . From this acceptance of the influence of American case law, the opinions of American Justices are employed to give weight to the interpretation of section 12. For example, Justice McIntyre’s statement that “cruel and unusual treatment or punishment must be drawn from the evolving standards of decency that mark the progression of a maturing society” is referenced from the American case *Trop v. Dulles*. In another example, the following principles are reiterated in *Smith* by Justice McIntyre as they appeared in the American case of *Furman v. Georgia*²⁸ :

- “...punishment should not be so severe as to be degrading to the dignity of human beings.”²⁹
- “The State...must treat its members with respect for their intrinsic worth as human beings.”³⁰
- “...where a punishment is not excessive and serves a valid legislative purpose, it still may be invalid if popular sentiment abhors it.”³¹

²⁶ at page 109.

²⁷ at page 111.

²⁸ (1971), 408 U.S. 238.

²⁹ at page 271.

³⁰ at page 270.

³¹ at page 274.

Academic commentaries on the prohibition of cruel and unusual treatment or punishment also take into consideration American jurisprudence on the same topic. In Tarnopolsky's (1978: 32-33) examination of the clause "cruel and unusual treatment or punishment" he provides a summary of the various tests employed in both Canadian and American courts. While the tests are directed towards application in the penal context, the *values* inherent in these same tests might be applicable to "cruel and unusual treatment" as it relates to restraint use in the care facility setting:

1. Is the punishment such that it goes beyond what is necessary to achieve a legitimate penal aim?
2. Is it unnecessary because there are adequate alternatives?
3. Is it unacceptable to a large segment of the population?
4. Is it such that it cannot be applied upon a rational basis in accordance with ascertained or ascertainable standards?
5. Is it arbitrarily imposed?
6. Is it such that it has no value in the sense of some social purpose such as reformation, rehabilitation, deterrence or retribution?
7. Is it in accord with public standards of decency or propriety?
8. Is the punishment of such a character as to shock general conscience or as to be intolerable in fundamental fairness?
9. Is it unusually severe and hence degrading to human dignity and worth?

i) Evolving Standards of Punishment or Treatment in the Institution

Commenting on the meaning of section 12 of the *Charter* in *Smith*, Justice Wilson accepts the interpretation of section 12 as a prohibition against treatments or punishments

that are “so unusual as to be cruel and so cruel as to be unusual”. Her comments indicate that certain living conditions may be recognized over time to be unacceptable. She comments further that:

Section 12 on its face appears to me to be concerned primarily with the nature or type of a treatment or punishment. Indeed, its historical origins would appear to support this view. The rack and the thumbscrew, the stocks, torture of any kind, unsanitary prison conditions, prolonged periods of solitary confinement were progressively recognized as inhuman and degrading...³²

Justice Wilson’s point, that treatment and punishment practices change over time, with archaic approaches abandoned in favor of more modern efforts relates well to the change in acceptable medical practices over time. History shows that numerous medical treatments used with the best of intentions toward the patient have been abandoned in the face of evolving medical practices. Prescription drugs are routinely replaced in favor of more effective drugs, just as advanced surgical techniques tend over time to replace older practices. It would be considered malpractice today for a physician to prescribe contraindicated drugs to a patient, although perhaps the same drug would have been widely prescribed prior to an advance in medical knowledge exposing the risks related to the use of that medication. For example, the drug thalidomide was widely prescribed to expectant mothers in the 1950’s to prevent morning sickness, which it did with some effectiveness. Shortly thereafter, the drug was found to cause limb deformities and other birth defects in the infants of mothers who ingested the drug and its use during pregnancy was halted. However, the drug’s use is considered entirely acceptable in other contexts,

³² at page 147.

notably in the treatment of leprosy and AIDS (Blaney, 1995:1). Thus, treatments carried out by care professionals must meet changing standards or be considered unacceptable.

While the use of restraint in long term care does the job of controlling the resident, with its use being appropriate where serious physical harm may otherwise occur, the risks associated with restraint use have been widely documented as is evident in the overview of restraint literature in Chapters One and Two of this thesis. Advances in care techniques have indicated that alternatives to restraint are effective in controlling many of the undesirable behaviors that have justified restraint use in the long term care population without placing individuals at risk for the severe, yet unintended, effects of the practice. Thus, these techniques must be implemented to reflect changing standards for care and treatment, just as the nature of other medical treatments have changed over time, and as acceptable treatments in state penal facilities have changed.

d) The Three Principles of McCann: Institutional Living Conditions and Section 12 of the Charter

In prison, the difference between treatments and punishments becomes somewhat blurred, certainly with the use of seclusion or, as it is referred to in the correctional milieu, “solitary confinement” or “administrative segregation”. Control of the inmate is the underlying purpose of treatment or punishment methods that serve to physically confine the offender (seclusion), just as control of the mentally disordered person is the purpose of restrictive treatment methods (restraint) in institutional care. One court has considered how these control methods can be considered part of an acceptable standard of life in an

institutional environment. The plaintiffs in the 1975 case of *McCann*³³ claimed that their confinement to the “special corrections unit”, or as it was then termed “solitary confinement”, in the British Columbia Penitentiary constituted cruel and unusual treatment as prohibited by section 2(b) of the *Bill of Rights*. The importance of *McCann* for the development of section 12 *Charter* jurisprudence was to affirm three main principles for consideration in section 12 cases. To reiterate briefly, these principles hold that a treatment that serves no positive purpose, that is unnecessary because of the existence of alternatives, and that is not in accord with standards of public decency is cruel and unusual within the meaning of section 2b of the *Bill of Rights*.

The *McCann* decision brings forward the responsibility of the institution to provide humane care and treatment for those in it. The principles in the *McCann* decision may be applied to the argument that all institutionalized persons can look to the *Charter* for protection from abuses occurring by way of treatment in the institutional environment, providing that the institution is government in the meaning of section 32 of the *Charter*. These three principles support a proposition that some restraint use currently practiced in many long term care facilities serves no positive treatment purpose, is unnecessary because of the existence of alternatives, and is not in accordance with the standards of public decency.

e) Section 12: The Absolute Right

It may be the failure of my imagination, but I find it difficult to accept that the right not to be subjected to any “cruel and unusual treatment or punishment” could ever be justifiably limited. This may be an absolute right. Perhaps it is the only one (Hogg, 1992: 35.14).

³³ *Supra* at 12.

The similarity of the section 1 *Oakes* test³⁴ to that of the test for a section 12 “cruel and unusual treatment or punishment” will have an impact on any argument that an infringement of section 12 can be saved by section 1. Thus, the possibility that a “cruel and unusual treatment or punishment” is reasonable and demonstrably justified under section 1 is nearly impossible. The four criteria to be satisfied by law as a reasonable limit upon a right that can be demonstrably justified in a free and democratic society are as follows (Hogg, 1992: 35.9):

- I. The law is sufficiently important to justify limiting a *Charter* right.
- II. The law must be rationally connected to the objective.
- III. The law has impaired the *Charter* right no more than is necessary to accomplish the objective.
- IV. The law must not have a disproportionately severe effect on the persons to whom it applies.

Hogg claims that the third objective, “least drastic means” is the “center of inquiry into a section 1 justification” (1992: 35.9). He states that “nearly all section 1 cases have turned on the answer” of whether the law has impaired a *Charter* right no more than is necessary. In the tests established for a section 12 argument, the inquiry as to “whether the treatment or punishment goes beyond what is necessary for the achievement of a valid social aim, having regard to the legitimate purposes of punishment and the adequacy of possible alternatives³⁵” mirrors that of the “least drastic means” element in the *Oakes* test. The law that has impaired the *Charter* right can do no more than is necessary to accomplish the objective. Thus, a section 12 infringement is unlikely to survive section 1

³⁴ R. v. Oakes [1986] 1 S. C. R. 103.

³⁵ McIntyre in *Smith* at page 100.

scrutiny as the tests for each are so similar. It is unlikely that a medical treatment that exceeds what is necessary to accomplish patient control will be saved by section 1.

f) “Outrageous in the Public Eye”

Seclusion is not the only restrictive means employed to control the inmate in the correctional facility. Restraint devices are also available to restrict movement even more than by the segregation of the inmate. For example, the use of handcuffs is the most obvious of the restraint devices commonly in use to ensure custody and control of the individual. Yet other, more restrictive restraint devices are available in correctional facilities and provincial or city jails. Recent media reports reveal instances where individuals taken into custody have been chained for lengthy time periods, as in the case of a 29 year old woman in Saskatoon who was chained to the floor of her jail cell for almost eight hours after being arrested for public drunkenness³⁶. One can argue that these sorts of reports find their way into the newspaper and television media because the treatment afforded these individuals (despite their status as criminal offenders) is outrageous in the public eye. From a human rights perspective, this sort of restraint use in the “law and order” domain is as offensive to human dignity as is the use of restraint on an elderly person living in a long term care facility. The reason for the use of the restraint is secondary to the offensive nature of the restraint as its own entity - as a device with capabilities for torture.

Restraint devices have the capacity to be used improperly, as has been found in the long term care environment, as well as in prisons and jails. In the 1996 case *MacPherson*

³⁶ “Chained woman gets apology” Vancouver Sun. October 17, 1996.

*v. New Brunswick*³⁷ an inmate of a provincial jail was subjected to “unreasonable and excessive force” by jail guards when he was tied to a stretcher in his cell for a period over two hours. The incident was recognized by the court as an infringement of Mr. MacPherson’s rights under sections 9 and 12. Fortunately for Mr. MacPherson, a surveillance video tape submitted as evidence to the court gave his claims of abuse undeniable credibility. The court described the incident as it appeared on the video tape:

...Mr. MacPherson had been kicking the heavy solid steel door with his sock feet intermittently for about an hour and one-half as a way to try and get the guards to let him call a lawyer...On the tape Mr. MacPherson replies to the warning to cease banging the cell door by hitting the door and shouting at the guard: “Are you going to let me call a lawyer you piece of shit?” Mr. MacPherson had been trying to get a lawyer for a least 40 days...On the video the guard disappears from view. Mr. MacPherson kicks the cell door a bit more...then all is quiet for several minutes until a group of guards come into sight of the camera and open the door. Mr. MacPherson does precisely what they tell him to do. He offers no physical resistance...[he] lies face down on a long padded board which has some straps attached to it. The board is some sort of stretcher. It is about six feet long.

The group of guards secure Mr. MacPherson face-down to the stretcher with a number of seat belt and other fasteners...It appears that Mr. MacPherson is securely fastened to the stretcher at the upper back, waist, knees, ankles and wrists with the seat belts, handcuffs and what appears to be plastic ties, somewhat like those use to tie electrical cables together. The evidence does not suggest that Mr. MacPherson was strapped to the stretcher for his own protection or for the protection of others. The conversation on the video tape indicates that Mr. MacPherson was strapped to the stretcher for banging of the door and creating a disturbance. On the video a hockey helmet, with attached wire mesh face mask, is secured to Mr. MacPherson’s head. Apparently that helmet was put on him so that he would not hurt his head while strapped to the stretcher.

Then the guards carry Mr. MacPherson on the stretcher back into his cell. The fastenings are then checked and adjusted by a guard kneeling on Mr. MacPherson’s back and appearing to re-tighten the strap across his upper back. That strap is rigged on the outside of one arm and on the inside of the other. At about that time Mr. MacPherson feels he was beaten or jabbed, although it is hard to tell from the video...

³⁷ 106 C.C.C. 3d 271 (N.B.Q.B.)

Although Mr. MacPherson offers no physical resistance to the guards, he makes a number of comments that are recorded on the tape at different times while the guards are securing him on the stretcher. Among the things Mr. MacPherson says are:

“My circulation in my hand is cut off...
The circulation is cut off...
I just wanted to call a lawyer man...
I’ll charge you with forcible confinement...
This is insane...
You’re sick man...
You’re hurting me...
You’re choking me, I can’t breath, get off of me...”

Then the tape shows the guards leaving Mr. MacPherson alone on the floor of his cell, strapped to the stretcher. A guard shuts the cell door and lock it. The camera continues to be pointed at the cell door and to record occasional noises and guards coming in sight to briefly glance through the window in the door of the cell. After about four minutes has passed the tape records Mr. MacPherson calling repeatedly for help. He loudly complains that his circulation is cut off and his hand is turning purple.

The response to Mr. MacPherson’s cries for help from the guards seems very slow on the video. He continues to cry for help about his hands and that they are cold. He may also be shouting “my head”. After his cries sound as if he is panicking, the guards enter his cell.

While strapped to the stretcher alone in his cell Mr. MacPherson had somehow managed to get the hockey helmet off his head. The video shows a guard using wire cutter to cut off a plastic tie from Mr. MacPherson’s right wrist. Then eventually the guards replace that plastic tie. As he remains lashed to the stretcher on the cell floor Mr. MacPherson tells the guards such things as:

“This is illegal man...
Look at what you’re doing to me...
It’s all on film...
I want to call a lawyer...”

Eventually a woman who appears to be a nurse arrives within the field of view of the camera inquires to a guard about the helmet being off Mr. MacPherson, takes and record Mr. MacPherson’s pulse and then leaves. That record of his pulse was not offered in evidence. Nor was there any evidence offered as to any possible health risks associated with treating a human being the way Mr. MacPherson was being treated. The helmet was not put back on Mr. MacPherson.

...Every 15 minutes or so a guard appears and glances in the window of the cell door... Throughout the video the seven uniformed guards and the nurse appear to be doing their jobs. Their cool, relaxed and unhurried manner suggests that

strapping Mr. MacPherson on the stretcher and checking him is just another routine event in the public service of the Province of New Brunswick... When Mr. MacPherson is complaining just before the nurse checks him, one of the uniformed guards says to Mr. MacPherson: "I have a job to do and I'm doing my job, mind your own business".

The Court, in finding that Mr. MacPherson's section 9 and 12 *Charter* rights had been violated, made reference to the regulations made under the *New Brunswick Correction Act*³⁸ which prohibited the use of excessive force on inmates. The existence of legislation did little to prevent the occurrence of abuse documented in this case, as well as the other likely instances of the same sort of abuse alluded to by the Court as a matter of "routine events in the public service of the Province of New Brunswick". The Court granted Mr. MacPherson *habeas corpus* relief and relief under section 24 of the *Charter* including a reduction in his sentence and leave to sue for damages.

The *MacPherson* case contains similarities to the conditions of long term care facility residents subject to routine restraint practice. One striking similarity is the routine nature of the process and procedure of the restraint application, that it is just part of "my job" as the guard responsible for Mr. MacPherson stated. Many nurses and care attendants have also used restraint as a means of resident control, considering them "necessary" to the job (Blakeslee, 1988: 833). This is further evident by the reported numbers of elderly care facility residents restrained daily in North America³⁹. Brower comments that "restraints are viewed by nurses as a necessary evil to be avoided, but to be used as needed" (1991:18). Blakeslee et al, make this observation about restraint use in the "caring process": "Staff often become complacent about using restraints, believing they

³⁸ N.B. Reg. 84-257. (Corrections Act), s. 21.

³⁹ See Strumpf and Evans estimates, pg. 3.

are necessary to manage residents, and consequently they use restraints as a means of control...over time, it is as if staff no longer see the restraints and accept them as part of the environment” (1991: 5 - 6).

Other similarities in confinement by restraint between the two kinds of institutions are observable. For example, in the jail, MacPherson’s protests about the restraint were ignored while several restraints were placed on his body at the same time (seat belts, handcuffs, plastic ties, and a helmet) when it was perceived by staff that confinement to the cell itself was ineffectual to control Mr. MacPherson’s behavior. In the care facility, additional restraints may be placed when the initial ones are ineffective. The simultaneous use of different forms of restraint is common in some care facilities, with both chemical and physical restraints implemented together to manage behavior, or in extreme cases, as Strome (1988) reported, a combination of “geri-chairs, twisted sheet restraint, vest posey, padded leather cuffs, and locked seclusion” to provide “security” from the violent patient⁴⁰. One geriatric clinical specialist related that most of her patients were routinely restrained at night with both chemical and physical restraints in order to “counteract disruptions” during the night time shift (Brannan, 1988: 114). Current nursing literature advises nurses to combine pharmacological restraint with physical restraint if required (Mion, et al. 1994).

As was the practice in the New Brunswick prison, a nurse appears periodically to check on Mr. MacPherson’s condition, taking his pulse, etc. This would also occur in the case of a resident restrained in a long term care facility. Medical literature instructs nurses

⁴⁰ Care facilities in British Columbia do not have “seclusion rooms” such as the type found in psychiatric facilities.

to check their restrained patients regularly, and institutional policies generally require strict monitoring of the patient in physical restraint. In an article authored by a physician, the following instructions are directed to nursing staff (Bursten, 1975: 758):

Assume that the patient will resist or fight the restraints...check the patient every half hour to make sure his circulation has not been limited and his skin does not have abrasions...loosen the restraints periodically. Remove each limb from the restraint at least once an hour. Check for edema, weakness, numbness, and tingling. Pad the head of the bed if necessary. Check the pulse, hydration, and general physical condition of a restrained patient who struggles continuously, to guard against exhaustion.

More current nursing literature, while encouraging non-restraint approaches be attempted prior to restraint, provides similar advice to the nurse. For example, University of British Columbia nursing literature includes an article giving instructions to “release the patient at least every two hours” (Mion, et al. 1994). Care facility policy generally requires regular monitoring of the patient. One B.C. care facility policy states, in a 1994 document, that “restrained residents are monitored every 30 minutes to ensure their comfort and safety”.

In *MacPherson*, the presence of the medical person appears to be an effort to legitimize and make “safe” the use of the restraint even when, under the circumstances, it was an abusive act towards the inmate and recognized as such by the court in the ensuing trial. In the long term care facility, the “medical” presence of nurses and care aids is a constant factor, as it should be. However, as was demonstrated in Chapters One and Two of this thesis, restraint use that may compromise the health and human rights of the resident becomes legitimized when cloaked as an essential medical treatment.

The residents of long term care facilities are likely unable to loudly or forcefully communicate objections to the restraint treatment. Thus, they may not be able to seek legal counsel or even be aware that legal advice is available concerning treatment decisions. This is a clear disadvantage for the care facility resident as securing legal counsel is impossible without the ability to communicate as Mr. MacPherson did during and after his ordeal. Further, vehement objection to a perceived abusive treatment might be effective in impressing upon the care-giver the possibility that the use of restraint is unjust.

In light of the difficulties associated with bringing a criminal case on behalf of the abused long term care facility resident, the presence of security video cameras equipped with a time and date function to ensure admissibility as evidence can facilitate protection of the resident. In the *MacPherson* case, the video tape provided clear and convincing evidence of the alleged abuse. Further, video evidence can also protect long term care staff from false allegations of abuse. However, as the purpose of the care facility differs completely from that of the penal institution, the presence of video surveillance in a care facility may serve more to offend the right to privacy for the resident than to provide a visual record of daily care. The care facility cannot be considered a “secure” institution in the same sense as a prison or detention facility. Residents’ autonomy and personal freedom within a home like environment would be compromised by the presence of such intrusive security features.

g) A Conclusion

Based on considerations of section 12 of the *Charter* and of section 2(b) of the *Bill of Rights* in the cases and commentaries examined above, the following conclusions can be offered:

- The clause “cruel and unusual treatment or punishment” has a lengthy history in law and has undergone a broadening process to include what are considered to be “modern standards of decency”. An emphasis is placed on the public conscience, human dignity, rationality and possible alternatives to the treatment or punishment in question.
- The clause applies to treatment or punishment within the penal institution including medical/surgical treatment and the clause may apply to treatment outside the penal institution where the person is subject to state imposed treatment by positive action, inaction or prohibition. The use of restraint in a long term care facility can be argued as such a treatment⁴¹. Positive action is evident in the regulated use of restraint in the long term care facility, inaction is possible when alternatives to restraint are unavailable to the facility, either by lack of funding or simple indifference to the importance of the alternatives in resident/patient care.
- Essential to justifying the application of a punishment or treatment is a “valid social aim”. When such a valid aim is non-existent, the punishment or treatment is at the very least questionable as an infringement of the right not to subject a person to cruel and unusual treatment. Thus, where the population of residents of a long term care facility is “non-violent”, the use of restraint can show no valid social aim in that environment as far as a medical treatment can provide it.
- When “public sentiment abhors it”, a treatment or punishment may be unacceptable under the proscription of section 12 of the *Charter*. Public sentiment, if taken as a reflection of published criticisms of the practice can be characterized as finding restraint use offensive. Specifically, medical and nursing literature on the topic forms the bulk of criticism of abusive and routine restraint use, as was illustrated in the literature review in Chapters One and Two of the thesis.
- The right not to be subject to a cruel and unusual treatment is a standard evolving in the face of societal values. Thus, protection of human dignity must also evolve to include the advances of science and medicine. The development of alternatives to restraint are reflective of the evolving standards of care in the current health care

⁴¹ The long term care facility must be considered “government” for the use of restraint to come under the scrutiny of the Charter. See discussion of *Stoffman* case at page 71.

environment. To subject a human being to a treatment that is potentially harmful and not reflective of the advances of science and medicine may comprise the “evolving standard” facet in the meaning made of the phrase “cruel and unusual treatment” as it has been argued in case law.

h) Seeking a Charter Remedy above a Criminal or Civil Action

As illustrated in *MacPherson*, a care facility resident found by the court to have been abused by restraint use under the law may seek remedy by way of section 24 of the *Charter*⁴². The court has a very wide discretionary power in granting any remedy which is “appropriate and just in the circumstances” (Hogg, 1992, note 79 at 37.20). In *R. v. Mills*,⁴³ the Supreme Court comments on this wide discretion in that there is no “binding formula for general application” of the remedy which may be provided in various cases.

Questionable credibility and high legal costs present significant barriers to the cognitively impaired individual seeking to lay criminal charges of assault or take civil action in battery against abusers. The standard of proof in a criminal case - “beyond a reasonable doubt” - makes success in such a case extremely difficult if there is no obvious or convincing evidence to support the charges, or if there are no other witnesses aside from the patient or resident to give credible evidence. Rightly or wrongly, evidence offered by a demented or mentally ill person may have little to no credibility against that of an articulate professional. When evidence from a direct examination of the patient or resident is assessed against the statements of the health care professional, “beyond a reasonable doubt” may be too onerous a standard of proof to meet. As for civil remedies, Feehan and Bailey caution that these actions incur a great expense, and that “in many

⁴² see footnote #41.

⁴³ [1986] 1 S.C.R. 863

cases there will be no point in proceeding with an action as most actions conclude with judgment of a low damage award, or even nominal damages” (1994: 85).

Further, one may question the ethics of encouraging an individual patient or resident to participate in a stressful civil or criminal legal action when this individual is already so frail as to have suffered because of an incident of inappropriate restraint. Defending an alleged abuser will invariably involve discrediting the patient by making obvious to the court or tribunal any potential for incredibility. For a mentally impaired individual, this process can be demeaning. Although “fair” in the sense of achieving procedural fairness for the accused, the dynamics of a legal hearing can be damaging to the self esteem of the impaired individual. Thus, a legal action, including that of appearing before a Review Board, may serve only to cause further harm to the individual⁴⁴. The process of “going to court” can increase anxiety. *Normal* participation in such an environment may be an expectation far too high for most long term care facility residents. Stressful environments exacerbate the symptoms of a dementing illness, and can make the behavior of the individual appear bizarre in the court room, while in the secure “home” environment the individual might appear much more calm and in a reasonably sound mental state.

One case argued before the British Columbia *Review Panel* under the *Mental Health Act* poignantly illustrates this point⁴⁵. An elderly woman was involuntarily admitted to the geriatric ward of a mental health facility on the basis that she was interfering with

⁴⁴ In the *Review Panel*, the burden of proof is not that of “beyond a reasonable doubt”, rather it is based on “the balance of probabilities”.

⁴⁵ Review Panel hearings are unreported - this case is recounted from the author’s personal experience as the patient’s advocate.

the treatment of her very ill husband in hospital, this as a result of her own dementing condition. Thus, it was argued that she was placing another at risk of serious harm. The evidence given during the hearing by family members indicated that this woman could adequately manage herself and her apartment, and that she had developed strict routines for shopping and cooking that facilitated her independence. While she had the mental capacity to seek legal advice and a hearing to determine the legitimacy of her detention, her mental capacities failed and she “fell apart” when she was placed in the unfamiliar and adversarial environment of the hearing. For the two hour duration of the hearing, several unfamiliar people asked her complex and intensely personal questions. She simply could not respond “normally” in that environment. Thus, her escalating bewilderment and often nonsensical responses made her appear truly in need of treatment in a mental health facility, while outside the hearing, she behaved in a much less confused manner. The obvious solution in such a case is to give the resident the opportunity to be excluded from the hearing. However, the resident may genuinely wish to participate, despite any concerns that the resident may damage their own case in doing so. Further, the Panel members themselves may wish to have the opportunity to observe and ask questions of the resident during the course of the hearing, although patient’s counsel can argue that the client is not a compellable witness.

A *Charter* case, if brought by a non-profit law office would be free of cost to the individual. This may be the only means by which to bring such a time and resource consuming legal action to the courts. A section 12 *Charter* argument would focus on the legal prohibition of restraint as a “cruel and unusual treatment” in that its use in a certain

context of care (the “nursing home facility”) may be found to be unacceptable. This is a level of examination not pursued in a criminal or civil action without a *Charter* component. Discussion of this issue within a *Charter* case would have an impact far beyond that of the lesser decisions of Review Boards, or even civil or criminal trials. Although damages would not be awarded, the court may give leave to seek damages upon a finding of wrongdoing by the care facility.

The argument against restraint use from the medical/nursing perspective is a somewhat moralistic one in that the practice of restraint is perceived to be “bad” *per se*; that it, at the very least, offends the dignity and autonomy of the person while also placing the individuals health at risk by complications associated with it. A legal approach to the problem based on the principles of the *Charter of Rights and Freedoms* seems appropriate in that the *Charter* is thought of as the “mirror of the nation’s soul”; a document resting on moral principles of right and wrong in Canadian society.

The restraint device itself (physical, chemical or otherwise) can form the central piece of evidence of abuse by the offending care-giver. This may appear as a somewhat more powerful piece of evidence rather than evidence of abuse based on the statements of persons whose credibility is easily picked apart. For the purposes of argument, if restraint is available for use in the institution and can be shown to have been used either outside of the established guidelines or even within the guidelines with detrimental effects, then complete denial of abuse as may be the case with the beating or sexual assault of a patient may be a more difficult position to maintain for the alleged abuser or offending institution.

Restraint use may be considered cruel when it is implemented despite the availability of alternative forms of control/treatment that do less to compromise the dignity and physical well being of the resident. Legislated guidelines that permit discretionary restraint use, despite the availability of alternatives, may be allowing for cruelty by the care-giver.

It would be important in such a case to examine whether the frequency of restraint use in the alleged offending institution exceeds that of other institutions also using restraint. If the conditions of restraint are found to be more severe in that institution than in other institutions with a similar population, the term “unusual” in the clause “cruel and unusual” is supported by that fact. Restraint use, if excessive in comparison to most or at least some other long term care institutions becomes unusual simply by its disproportionate rate of use.

The analogy between the pursuit of section 12 rights in the penal institution and that of the long term care facility has one significant distinction; the necessary element of deterrence to criminal behavior as an important social objective to justify an otherwise cruel and unusual treatment or punishment is obviously absent from the situation of the long term care facility resident. Deterrence is an element of section 12 jurisprudence confined to the punishment and treatment aspect of correctional practices rather than state imposed medical treatments outside of corrections. The lack of deterrence as a necessary element in section 12 jurisprudence may make the argument against restraint use in non-penal environments even more compelling.

When, as Boyd (1995: 79) states, “one person’s remedy is another person’s torment”, that tormenting remedy must be examined for a defect. Torment, anguish, misery and suffering when imposed by state action or inaction are the very things targeted for a challenge by section 12 of the *Charter*. Those who would claim that section 12 is relatively useless in light of its ambiguity ignore the significant legal commentary available on the clause whereby a logical application is possible. More so, it is upon these academic commentaries and judicial opinions within section 12 case law that such a case could be argued before the courts.

CHAPTER SIX

Conclusion

In 1991, 161,000 Canadians over the age of 65 suffered from Alzheimer disease¹. Statistics Canada reports that all forms of dementia in senior citizens will be an increasing health concern in the years to come, this owing to Canada's aging population. The increase in Alzheimer's patients has been characterized in the media as "dramatic"². The following numbers indicate the oncoming scourge of the degenerative disease:

- Currently, dementia afflicts 28 in 1,000 women aged 65 to 74, with an increase to 371 cases in 1,000 women aged over 85.
- Currently, dementia afflicts 19 in 1,000 men aged 65 to 74, and increases to 287 in every 1,000 men over 85.
- 238,000 people are predicted to have Alzheimer's disease by the year 2001.
- By the year 2031, this number is likely to rise to 500,000 people.

Based on the expected increase in these demented elderly persons, the burden of care for these individuals will grow enormously. At the very least, individuals in the mid to end stages of dementing diseases will require nursing care in an institutional environment. Thus, the Canadian long term care system can expect a dramatic increase in the demand for care of the dementing population in the next century. As an option, Canadian health care providers may seek to pursue the development of alternative methods to manage the increasing numbers of people requiring institutional care.

¹ Statistics Canada (1996). *Canadian Study on Health and Aging*.

² Elizabeth Aird *The Vancouver Sun*. A3. Tuesday, November 19, 1996.

Chapters One through Three of this thesis provided an overview of the medical literature commenting on the highly controversial use of restraint in the health care setting. Medical and nursing practitioners are widely cautioned in the use of physical, chemical or other conditions of restraint, although the use of restraint is considered permissible when grievous physical harm to the patient, other residents or the care-giver is threatened. Despite a general awareness among the care community concerning the risks associated with restraint use, reports of abuse are widespread in the published literature and among individuals and groups associated with long term care. There appears to be a consensus that restraint use has the potential to become an abusive mechanism of control or “treatment” when its truly legitimate use is extended to a routine practice that confounds the medical and legal interests of the patient.

Literature on the topic exposes some trepidation on the part of care-givers that the abandonment of routine physical and chemical restraint use will result in an increased risk of injury to both patients and their care-givers. Further, some care-givers are of the opinion they will be liable for any harm that comes to the unrestrained person, even if the harm results from risks inherent in normal daily activities. Many of these concerns vary in intensity depending on the severity of the symptoms displayed by the patient or resident in care. There may also be a conviction among care-givers that they are morally and ethically responsible to eliminate risk from the lives of their patients or residents. For care-givers who hold this opinion, proper “care” translates to restraint use as a legitimate care option; the resident’s personal risk as an aspect of everyday life is not recognized as an acceptable part of life in the care facility. Here, the care facility is not recognized as a “home” in the

community sense but rather is a living environment based on the objectives of control and management of the group.

Education of the care-giver concerning acceptable risks and the implementation of restraint alternatives have been argued to be the key to reducing the routine use of restraint. Yet, some facilities may choose to keep restraint as a care option rather than make the commitment to bring the facility up to the standards (both architecturally and in care philosophy) required to care for residents without restraints. For example, where wandering by a demented facility resident poses a risk to health and safety, restraint may be chosen over the implementation of a safe “wandering” environment.

In modern society, care of the institutionalized person has grown to include multi-disciplinary forces in medicine, social science and law. No longer is institutional care the warehousing of aging or disabled human beings. Instead, professional specialization in gerontology and dementia care have formed the trend in long term care. As well, special interest organizations like the Alzheimer Society endeavor to improve the quality of care and treatment of individual patients or care facility residents by pursuing increased funding for research and promoting recognition of the group as possessing unique rights and needs. Changing expectations and standards for care of the institutionalized population have culminated in a health care paradigm shift and a change in the organization of law to protect the “rights” of individuals in care. Modern policy reform reflects this shift and is evident by the recent reform of adult guardianship law containing provisions for adult protection within the care facility, including the regulation of restraint use.

The legal argument outlined in the preceding chapter suggests the possibility of a challenge to the practice of restraint in long term care facilities based on section 12 of the *Charter of Rights and Freedoms*. Critics would argue that the “cruel and unusual” clause is much too ambiguous to ever pursue as a precise legal question regarding a specific medical treatment or practice. However, section 12 case law supports an argument indicating that advances in medical treatment may be part of the “evolving standards of decency that mark the progression of a maturing society”, a test commonly cited in section 12 case law. Recognition of acceptable treatments and living conditions in a contemporary long term care facility where the state legislates care practices would form an integral part of the requirements of a section 12 legal analysis. Practices not reflecting these standards may be considered within the scope of the legal prohibition on cruel and unusual treatment. The use of routine restraint in some long term care facilities when other similar facilities have implemented restraint alternatives might be considered both “cruel” and “unusual” as they form an odd choice for the treatment and care of residents when other less restrictive and far less dangerous methods are utilized in similar long term care situations.

As has been demonstrated, there are viable alternatives to the use of restraints in the management of long term care facility residents. Indicative of this is the availability of design intervention, or architectural or environmental controls and other alternative care philosophies that reject restraint use as an appropriate practice on the institutionalized population. Also evident in the literature on the topic is the good will and dedication necessary to implement such alternatives so as to avoid the severe effects related to

restraint use on individual residents. Jones' (1996) *GentleCare* system is just one example of this. In light of the alternatives to restraint and the movement away from paternalistic approaches in patient care, the objective of patient control in the treatment of long term care residents is not so difficult to attain that the right not to be subject to the possibility of cruel and unusual treatment by restraint use must be violated.

The availability of review of an important health care decision such as the use of restraint is in keeping with the principles of fundamental justice; that any such restrictive, controlling or confining treatment must be reviewable before an impartial tribunal. The passing of legislation meant to safeguard against inappropriate restrictions of care facility residents through health care decisions forms an important step in the overall reform of adult guardianship law, one principle of which is to provide adults with only the least intrusive form of support, assistance or protection. The Review Board is in place on the assumption that an abusive or questionable use of restraint may occur despite the existence of legislated guidelines. There can be no guarantee of protection by any legislation as long as restraint remains an option in the care facility.

However, the process for a legal review of restraint use in the long term care facility cannot be without criticism. The "procedural fairness" model of the legal establishment is imposed on cognitively impaired people who have no guarantee of access to legal counsel at any time during their institutional stay, except if a legal advocate, family member or other representative works as a "watchdog" for questionable restraint use. The likelihood of a hearing is based on the presumption of the ability of a resident, their representative or an advocate to first identify and communicate an alleged abuse of

restraint use and then make a request for a hearing. Expectations that the legislation will completely guard against abuse by restraint could be considered rather unrealistic as the model of legal review may be too intricate for the cognitively impaired individual who must participate at some level in its complexities.

Thus, the intended use of legal review in the long term care context may not serve individuals who cannot fully participate nor appreciate the process. The alternative, then, to ensure that no abuse by restraint ever occurs is to remove physical restraints altogether from the long-term care facility to be reserved only for use in psychiatric or medical hospital units, preventing their implementation in instances where alternatives may have sufficed. The use of medication would likewise require careful review to ensure that the effects on residents were not only to restrain them.

Future research on the topic of restraint use in long term care may seek to examine the following questions:

- I. Will the practice of routine restraint use continue in some long term care institutions despite the heavy regulation of section 25 of the *Health Care (Consent) and Care Facility (Admission) Act* (when in force). Specifically, will the implementation of the *Act* have the effect of discouraging restraint use so much that requests for review are infrequent, or conversely, will the Review Board hear a significant number of restraint cases?
- II. How effective will the restraint legislation be from the perspectives of varying stake holders involved in long term care? The opinions of residents, their families, care-givers, and the legal community may each provide an opinion of the efficacy of the restraint legislation. An analysis of the effectiveness of restraint reduction philosophies, programs and legal regulation might well be examined in the number of reports of restraint abuse once section 25 of the *Act* and accompanying *Regulation* are proclaimed in force.
- III. Will realization of the expected increase in the population of demented patients in long term care facilities promote an increased awareness and acceptance of the restraint reduction movement in the care facility community?

IV. What will be the effect on long term care by the increased demand for care of the Alzheimer's population in combination with the fiscal restraints of government ministries? For instance, will the restraint reduction movement or other efforts to protect human rights within long term care facilities be displaced by fiscal concerns, making restraint use part of the care/control process where restraint alternatives and education cannot be funded ?

For the "incoming" generation of Alzheimer patients and other elderly persons to the long-term care institution where restraint continues to remain a care option, a genuine concern for the prevention of abuse continues to exist. The debate among firm advocates of non-restraint and those care-givers who hold that restraint must be available on a discretionary basis appear to have found some middle ground within section 25 of the forthcoming legislation. Section 25 of the *Act* requires that family members be consulted prior to the application of restraints, and the *Act* clearly obligates the care-giver to regularly review the decision to restraint. Thus, the care-giver still holds restraint as an available option, yet the family or representative of the resident is somewhat empowered to question the decision to restrain.

The legal community has the opportunity to play an important role in evaluating the long term efficacy of restraint policy as set out in the *Act*. Further, how legal advocates choose to pursue the issue of restraint use in long term care facilities in British Columbia will affect the course of future policy development on the topic. Health law advocates who find restraint use in long term care offensive from a human rights perspective may seek the courts' opinions on the practice, arguing that the population of residents may be better cared for and controlled with less restrictive methods. The legal approach can be one of seeking protection against abusive restraint practice by way of the *Charter*. *Charter* dictates other than the "cruel and unusual" clause might also be applied to the legislation

that regulates the practice of restraint use. Sections 7 and 9 in conjunction with the section 12 prohibition may serve to further strengthen the case against restraint use, and are worthy of exploration in the continuing health care and restraint debate.

BIBLIOGRAPHY

- APA Task Force on Psychiatric Uses of Seclusion and Restraint, A Summary (1985). *Hospital and Community Psychiatry*, 36 (6), 677, 679.
- Barnes, Irene, Louise Johnson and Jane Peterson (1995). *Special Care Unit Resource Manual*.
- Bell, Virginia Marsh, and David Troxel (1994). An Alzheimer's Disease Bill of Rights. *The American Journal of Alzheimer's Care and Related Disorders and Research*, September/October, 3-6.
- Beaudoin, Gerald-A. and Ed Ratushny (1989). *The Canadian Charter of Rights and Freedoms*. Second Ed. Carswell: Toronto.
- Blakeslee, J. (1988). Untie the elderly. *American Journal of Nursing*, 88 (6), 833-834.
- Blakeslee, J., Goldman, B., and D. Papougenis (1990). Untying the elderly: Kendal's restraint-free program at Longwood and Crosslands. *Generations*, 14 (Suppl.), 79-80.
- Blakeslee, J., Goldman, B., Papougenis, D., and Curt A Torell (1990). Transition to Restraint Free Care: A Model for Change. In *Untie the Elderly: Quality Care Without Restraints*. Symposium before the Special Committee on Aging. United States Senate, One Hundred First Congress. First Session Washington D.C. December 4, 1989. Serial No. 101-H.
- Blakeslee, J., Beryl Goldman, Dawn Papougenis and Curt A. Torell (1991). Making the Transition to Restraint Free Care. *Gerontological Nursing*, 17 (2), 4-8.
- Blaney, Carol (1995). Second Thoughts About Thalidomide. *NCCR Reporter*. (November/December).
- Bock, K. and E. Schilder (1988). Physical Restraints. *Canadian Nurse*. 84 (7), 34-37.
- Boyd, Neil (1995). *Canadian Law: An Introduction*. Harcourt Brace: Canada.
- Bradley, L., C.M. Siddique and Brian Dufton (1995). Reducing the use of Physical Restraints in Long Term Care Facilities. *Journal of Gerontological Nursing*, 21 (9), 21-34.
- Brannan, Patricia (1988). Using Nursing Skill Instead of Restraints. *Geriatric Nursing*, 9 (2), 114-115.

- Brooks, Stephen (1989). *Public Policy in Canada: An Introduction*. Toronto: McClelland and Stewart.
- Brower, H. Terri (1991). The Alternatives to Restraints. *Journal of Gerontological Nursing*, 17 (2), 18-22.
- Brower, H. Terri (1992). Physical Restraints: A Potential Form of Abuse. *Journal of Elder Abuse & Neglect*, 4 (4), 47-57.
- Brown, Barbara (1993). A Restraint-Free Environment for Seniors in Long-Term Care Facilities: An Aspect of Quality Care? Community Paper Series. Paper #2. University of Victoria Centre on Aging. Victoria, B.C.
- Bruno, Ronald (1994). Policy for the People: One Facility's Introduction to Restraint Reduction. *Journal of Gerontological Social Work*, 22 (3/4),
- Brungardt, Gerard S. (1994). Patient Restraints: New Guidelines for a Less Restrictive Approach. *Geriatrics*, 49 (6), 43-44.
- Bursten, B. (1975) .Using mechanical restraints for acutely disturbed psychiatric patients. *Hospital and Community Psychiatry*, 26, 757-759.
- Carpenter, M.D., Hannon, V.R., McCleery, G., and J.A. Wanderling (1988). Variations in seclusion and restraint practices by hospital location. *Hospital and Community Psychiatry*, 39 (4), 418-423.
- Canadian Psychiatric Association Position Paper - Broad Principles. Limitation of Freedom of Movement (Including Seclusion/Restraint). University Hospital Information, Vancouver, B.C. February, 1988.
- Cefalu, Charles A. (1993). Hospital restraint use in the elderly. *Hospital Physician*, 29 (4) 25-36.
- Cefalu, Charles A. (1995). Nursing Homes: what you need to know for quality patient care. *Geriatrics*, 50 (12), 37-50.
- Colenda, C.C., and R.M. Hamer (1991). Antecedents and interventions for aggressive behavior of patients at a geropsychiatric state hospitals. *Hospital and Community Psychiatry*, 42 (3), 287-292.
- Cohen, Irwin (1996). *Primum non nocere: The Medical Doctor's Role in Torture*. Simon Fraser University. Unpublished Manuscript.

- Conley, Linda Gottlob and Lisa A. Campbell (1991). The Use of Restraint in Caring for the Elderly: Realities, Consequences and Alternatives. *The Nurse Practitioner*, 16 (12), 48-52.
- Coulsen, Irene (1993). The Impact of the Total Environment in the Care and Management of Dementia. *The American Journal of Alzheimer's Care and Related Disorders and Research*, May/June, 18-24.
- Covert, Anthony B., Rodrigues, Theresa and Kenneth Soloman (1977). The Use of Mechanical and Chemical Restraints in Nursing Homes. *Journal of the American Geriatric Society*, 25 (2), 85-89.
- Craig, C., Ray, F., and C. Hix (1989). Seclusion and Restraint: Decreasing the discomfort. *The Journal of Psychosocial Nursing*, 27 (7), 17-19.
- Creighton, H. (1982). Are Siderails Necessary? *Nursing Management*, 13, 45-48.
- Cubbin, J.K. (1970). Mechanical Restraints: To Use or Not to Use?
- Darby, Stuart (1990). Containing the Wanderer. *Nursing Times and Nursing Mirror*, 86 (15), 42-42.
- Darr, Kurt (1991). *Ethics in Health Management*. Baltimore: Health Professions Press.
- Dodge, P. (1984). Patient Restraints. *Dimensions in Health Services*, 61, 12.
- Donius, Maggie and Joanne Rader (1994). Use of Siderails: Rethinking a Standard of Practice. *Journal of Gerontological Nursing*, 20 (11), 23-27.
- Ekstedt, John and Curt T. Griffiths (1988). *Corrections in Canada: Policy and Practice*. 2nd ed. Harcourt Brace & Company, Canada.
- Ekstedt, John (1995). Canadian Justice Policy. In M.A. Jackson and C.T. Griffiths, eds. *Canadian Criminology* 2nd ed. Harcourt Brace & Company, Canada.
- English, Ruth A. (1989). Implementing a Non-Restraint Philosophy. *The Canadian Nurse*, March 52-55.
- Evans, L.K., and N.E. Strumpf (1989). Tying down the elderly: A review of the literature on physical restraint. *Journal of the American Geriatric Society*, 36, 65-74.
- Evans, L.K. (1989). Current Status and Needs for Research. In *Untie the Elderly: Quality Care Without Restraints*. Symposium before the Special Committee on Aging. United States Senate, One Hundred First Congress. First Session Washington D.C. December 4, 1989. Serial No. 101-H.

- Evans, L.K., and N.E. Strumpf (1990). Myths about elderly restraint. *Image: Journal of Nursing Scholarship*, 22, 124-128.
- Evans, L.K., N.E. Strumpf and Carter Williams (1991). Redefining a standard of care for frail older people: Alternatives to routine physical restraint. In Paul R. Katz, Robert L. Lane and Mathy D. Menzey, eds, *Advances in Long Term Care*. Springer, New York.
- Feehan, K. P. and Tracey Bailey (1994). Patient and Staff Abuse: Rights, Expectations, Options and Policies. *Health Law in Canada* 14, 73-87.
- Folmar, Steven and Holly Wilson (1989). Social Behavior and Physical Restraints. *The Gerontologist*, 29 (5), 650-653.
- Freidman, Freda B. (1983). Restraints: when all else fails, there still are alternatives. *RN*, 46, 79-88.
- Gaudet, Maureen Anne (1994). Overview of Mental Health Legislation in Canada. Health Canada.
- Gerber Eigsti, Diane and Nora Vrooman (1992). Releasing Restraints in the Nursing Home: It Can Be Done. *Journal of Gerontological Nursing*, 18 (1), 21-23.
- Gold, Maria F. (1991). Moving Away From Restraints. *Provider*, 17 (1), 20-23.
- Gordon, Robert M., Simon N. Verdun Jones (1992). Adult Guardianship Law in Canada. Carswell, Toronto.
- Gordon, Robert M. (1995). Adult Guardianship and Adult Protection Legislation in Canada: Recent Reforms and Future Problems. *Canadian Journal on Aging*, 14 (2), 89-99.
- Grant, Isabel (1991). Mental Health Law in British Columbia. University of British Columbia.
- Greene - Burger, Sarah (1992). Eliminating Inappropriate Use of Chemical Restraints. *The Journal of Long-Term Care Administration*, 20 (2), 31-35.
- Guirguis, E.F. (1978). Management of disturbed patients: An alternative to the use of mechanical restraints. *The Journal of Clinical Psychiatry*, 39 295-300.
- Gutheil, Thomas G. (1980). Restraint Versus Treatment: Seclusion as Discussed in the Boston State Hospital Case. *American Journal of Psychiatry*, 137 (6), 718-719.

- Gutman, Gloria M. (1989). **Dementia Patients in Institutions: A Review of Recommendations and Research Concerning Their Design, Staffing and Programming Needs.** Gerontology Research Center. Simon Fraser University.
- Haddad, H. (1994). Ethics in Action: A med/surg Nurse is concerned about an elderly man. *RN*, 57 (3), 18-20.
- Haley, William E., and Marci I. Coleton (1992). **Alzheimer's Disease: Special Issues in Elder Abuse and Neglect.** *Journal of Elder Abuse and Neglect*, 4 (4), 71-85.
- Haitt, Lorraine G. (1987). Environmental design and mentally impaired people. In: H. Altman, ed. *Alzheimer's disease: Problems, prospects and perspectives.* New York: Plenum, 309-320.
- Haitt, Lorraine G. (1991). **Nursing Home Renovation Designed for Reform.** Butterworth Architecture: Boston.
- Haitt, Lorraine G. (1992). Restraint reduction with special emphasis on wandering behavior. *Topic in Geriatric Rehabilitation*, 8 (2), 55-78.
- Hunt, Alan R. (1989). Legal Issues Involved in the use of Restraints: **Analyzing the Risks.** In *Untie the Elderly: Quality Care Without Restraints.* Symposium before the Special Committee on Aging. United States Senate, One Hundred First Congress. First Session Washington D.C. December 4, 1989. Serial No. 101-H.
- Hogg, Peter (1992). **Constitutional Law of Canada (3rd ed.).** Scarborough: Carswell.
- Irvine, Patrick, and Steven H. Miles (1992). Deaths caused by physical restraints. *The Gerontologist*, 32, 762-766.
- Jackson, Margaret and John Ekstedt (1992). *Social Ethics and Law: Back to Basics.* Paper Presented at the Meeting of the Canadian Law and Society Association, University of Prince Edward Island, Charlottetown, N.B.
- Jackson, Michael (1983). **Prisoners of Isolation: Solitary Confinement in Canada.** University of Toronto Press: Toronto.
- Janelli, Linda M. (1989). Physical Restraints: How Little We Know. *Nursing Homes*, 38 (1/2), 10-12.
- Janelli, Linda M. (1989). What Restraint Policies Don't Say. *Geriatric Nursing*, 10, p.7.
- Janelli, Linda M., Genevieve W. Kanski and Mary Anne Neary (1994). Physical Restraints: Has OBRA Made a Difference? *Journal of Gerontological Nursing*, 20 (6), 17-21.

- Johnson, Sandra H. (1993). Law and quality in Long-Term Care. *The Journal of Long-Term Care Administration*, 21 (3), 75-77.
- Jones, Moyra (1995). Gentle Care: Changing the Experience of Alzheimer's Disease.
- Kane, Rosalie A. (1993). Ethical and Legal Issues in Long Term care: Food for Futuristic Thought. *The Journal of Long -Term Care Administration*, 21 (3), 66-74.
- Kanski, Genevieve W., Mary Anne Neary, Yvonne K. Scherer, Linda M. Janelli, et al. (1990). Current Practice in the Use of Restraints. *Nursing Homes*, 39 (3/4), 25-27.
- Kapp, Marshall B. (1989). Legal Liability Issues. In *Untie the Elderly: Quality Care Without Restraints*. Symposium before the Special Committee on Aging. United States Senate, One Hundred First Congress. First Session Washington D.C. December 4, 1989. Serial No. 101-H.
- Kapp, Marshall B. (1991). Nursing Home Restraint and Legal Liability: Merging the Standard of Care and Industry Practice. New York: Commonwealth Fund.
- Katz, L, F. Weber and P. Dodge (1981). Patient Restraint and Safety Vests: Minimizing the Hazards. *Dimensions in Health Service*, 58, 10-11.
- Keys, Patricia A. and Karen A. Powers (1991). Ethics, Psychotropics and the Geriatric Patient. *Journal of Geriatric Drug Therapy*, 5 (4), 5-19.
- Kirschbaum, Lisamarie and Stephen J. O'Connor (1992). The legal impact of restraining the elderly in nursing homes. *Topics in Geriatric Rehabilitation*, 8 (2), 29-34.
- Lewis, Susan (1993). Restraint and Seclusion. In *Managing the Violent Patient*. Edited by Patricia E. Blumenreich and Susan Lewis. Brunner Mazel: New York.
- Liukkonen, Arja and Laitinen, Pirjo (1994). Reasons for uses of physical restraint and alternatives to them in geriatric nursing: A questionnaire study among nursing staff. *Journal of Advanced Nursing*, 19, 1082-1087.
- Magee, Rose, Elizabeth C. Hyatt, Sally B. Hardin, Diane Stratmann et al. (1993). Institutional Policy: Use of Restraints in Extended Care and Nursing Homes. *Journal of Gerontological Nursing*, 19 (4), 31-39.
- MacPherson, David S., Richard P. Lofgren, Rosanne Granieri et al. (1990) Deciding to Restrain Medical Patients *Journal of the American Geriatric Society*, 38 516-520.
- Maclean, Jill, Judith Shamian, Pat Butcher, Ruth Parsons et al. (1982). Restraining the Elderly Agitated Patient. *Canadian Nurse*, 78, 44-46.

- Mattiasson, Anne-Catherine and Lars Anderson (1995) Moral Reasoning Among Professional Caregivers in Nursing Homes. *Western Journal of Nursing Research*, 17 (3), 277-291.
- McHutchion, Edna and Janice M. Morse (1989). Releasing Restraints. *Journal of Gerontological Nursing*, 15 (2), 35-40.
- Miles, Steven and Patrick Irvine (1992). Deaths Caused by Physical Restraints. *The Gerontological Society of America*, 32 (6), 762-766.
- Mion, Lorraine, C., J. Dermont Frengley, Chelry A. Jakovic and Jorn A. Marino (1989). A Further Exploration of the use of Physical Restraints in Hospitalized Patients. *Journal of the American Geriatrics Society*, 37, 949-956.
- Mion, Lorraine C., Neville Strumpf (1994). Use of physical restraints in the hospital setting; implications for the nurse. *Geriatric Nursing*, 15 (3), 127-132.
- Mion, Lorraine C., Ann Minnick, Robert Palmer et al. (1996). Physical Restraint Use in the Hospital Setting: Unresolved Issues and Directions for Research. *The Milbank Quarterly*, 74 (3), 411- 433.
- Mitchell - Peterson, L. Edmond L., Fingerote, E., and C. Powell (1985). Let's Untie The Elderly. *OAHA Quarterly*, 21, (10).
- Mitchell - Peterson, L. Edmond L., Fingerote, E., and C. Powell (1986). Reducing Reliance on Physical Restraints. *Today's Nursing Home*, 7 (2), 40-47.
- Moss, Robert and John La Puma (1991). The Ethics of Mechanical Restraints. *Hastings Center Report*, Jan/Feb 22-25.
- Morley, John E., and David H. Solomon (1994). Major Issues in Geriatrics over the Last Five Years. *Journal of the American Geriatrics Society*, 42 (2), Feb. 218-225.
- Morse, Janice M. and Edna McHutchion (1991). Releasing Restraints; Providing safe care for the elderly. *Research in Nursing and Health*, 14 (3), 187-196.
- Neary, Mary Anne, Genevieve Kanski, Linda Janelli, Yvonne Scherer et al. (1991). Restraints as Nurses Aides See Them. *Geriatric Nursing*, 12 (4), 191-192.
- Newbern, Virginia B. and Ina H. Lindsay (1994). Attitudes of Wives Toward Having Their Elderly Husbands Restrained. *Geriatric Nursing*, 15 (3), 135-138.

- Noyes, Lin E. and Mary Cipriano Silva (1993). The Ethics of Locked Special Care Units for Persons with Alzheimer's Disease. *The American Journal of Alzheimer's Care and Related Disorders and Research*, July/August, 12-15.
- Okin, R.L. (1985). Variation Among State Hospitals in Use of Seclusion and Restraint. *Hospital and Community Psychiatry*, 36 (6), 648-652.
- Olsen, C.G., and J. Tangemen (1992). Caring for nursing home patients: Strategies to avoid conflict. *Geriatrics*, 47 (Feb.) 50-57.
- O'Malley, T. Everitt, D., and O'Malley H. (1983). Identifying and preventing family mediated abuse and neglect of elderly persons. *Annals of Internal Medicine*, 98, 998-1005.
- O'Reilly -Yob, Mary (1988). Legal Issues in Nursing: Use of Restraints - Too Much or Not Enough? *Focus on Critical Care*, 15, 32-33.
- Osborne, Judith (1987). Human Rights and Civil Liberties. Study Guide. Criminology 335 School of Criminology, Simon Fraser University.
- Pawlson, Gregory L. (1989). Use of Restraints in Nursing Homes. In *Untie the Elderly: Quality Care Without Restraints*. Symposium before the Special Committee on Aging. United States Senate, One Hundred First Congress. First Session Washington D.C. December 4, 1989. Serial No. 101-H.
- Porszt, L., Florian, M. and Burton, J. (1988). A Pilot Study on the Effect of Rapport on the Task Performance of an Elderly Confused Population. *Canadian Journal of Occupational Therapy*, 55 (5), 255-258.
- Powell, C., Mitchell-Pederson, L., Fingerote, E., and Edmond, L. (1989). Freedom from restraint: Consequences of reducing physical restraints in the management of the elderly. *Canadian Medical Association Journal*, 141, 561-564.
- Phillips C.D., Hawes C, and B.E. Fries (1993). Reducing the use of physical restraints in nursing homes: Will it increase costs? *American Journal of Public Health*, 83 342-347.
- Quinn, C.A. (1993). Nurses' perceptions about physical restraints. *Western Journal of Nursing Research*, 15, 148-162.
- Rader, Joanne (1987). A Comprehensive Staff Approach to Problem Wandering. *The Gerontologist*, 27 (6), 78-82.
- Rader, Joanne (1991). Modifying the Environment to Decrease Use of Restraints. *Journal of Gerontological Nursing*, 17 (2), 9-13.

- Rader, Joanne (1991). Leveling Off Restraints. *Geriatric Nursing*, 12 (2), 71-73.
- Reigle, Juanita (1994). Health Care Ethics Forum 94: Ethical Challenges in the Critically Ill: Use of Restraints. *AACN*, 5 (3), 329-332.
- Riter, Robert N. (1995). To integrate or segregate the cognitively intact in nursing homes: Lessons to be learned from educational mainstreaming. *The Journal of Alzheimer's Disease*, Sept/Oct. 12-16.
- Robbins, L. J. (1986). Restraining the elderly patient. *Clinics in Geriatric Medicine*, 2 591- 599.
- Robbins, L., Edward Boyko, Judy Lane et al. (1987). Binding the elderly: A Prospective Study of the Use of Mechanical Restraints in an Acute Care Hospital *Journal of the American Geriatric Society*, 35 290-296.
- Roberge, Roger and Rene Beausejour (1988). Use of Restraints in Chronic Care Hospitals and Nursing Homes *Canadian Journal on Aging*, 7 (4), 377-381.
- Robinson, B.E., R. Sucholeiki and D.D. Schocken (1993). Sudden Death and Resisted Mechanical Restraint: a case report (comments). *Journal of the American Geriatric Society*, 41 (4), 424-425.
- Rogers, Joan C. (1989). Therapeutic activity and health status. *Topics in Geriatric Rehabilitation*, 4 (4), 1-11.
- Roper, Janice M., Adam Coutts, Janet Sather and Rosella Taylor (1985). Restraint and Seclusion: A Standard and Standard Care Plan. *Journal of Psychosocial Nursing*, 23 (6), 18-23.
- Rose, Joan (1987). When the Care Plan Says Restrain. *Geriatric Nursing*, 8 (1), 20-21.
- Rose, Sarah L. (1995). "Cruel and Unusual" Need not be cruel, unusual or punishment. *Capital University Law Review*, 24 (4), 827-859.
- Rovner, B.W. and Rabins, P.V. (1985). Mental illness among nursing home patients. *Hospital and Community Psychiatry*, 36, 119-120, 128.
- Scherer, Yvonne K, Linda M. Janelli, Genevieve W. Kanski, et al. (1991). The Nursing Dilemma of Restraints. *Journal of Gerontological Nursing*, 17 (2), 14-17.
- Schlentz, Marilyn D. (1993). The Minimum Data Set and Levels of Prevention in the Long Term Care Facility. *Geriatric Nursing*, 14 (2), 79-83.

- Schnelle, John F., Newman, D. White, M. Volner, T. Burnett, J., Cronquist, A., and Ory, M. G. (1992). Reducing and managing restraints in long term care facilities. *Journal of the American Geriatrics Society*, 40, 381-385.
- Schnelle, John F., Sandra F. Simmons and Marcia G. Ory (1992). Risk factors that predict staff failure to release nursing home residents from restraints. *The Gerontologist*, 32 (6), 767-770.
- Schott-Baer, Darlene, Stephanie Lulis and Kay Beauregard (1995). Use of Restraints: Changes in Nurses Attitudes. *Journal of Gerontological Nursing*, 21 (2), 39-44.
- Sengstock, Mary C., McLarland, Marilyn R. and Melanie Hawalek (1990). Identification of Elder Abuse in Institutional Settings: Required Changes in Existing Protocols. *Journal of Elder Abuse and Neglect*, 2 (1-2), 31-50.
- Sherman, David S. (1988). Psychotropic Drug Misuse in Long Term Care: Some Contributing Factors. *Journal of Pharmacy Practice*, 1 (3), 41-46.
- Sloan, P.D., Matthew, L.J., Scarborough, M., Des, J.R., Koch, G.G., and Tangen, C. (1991). Physical and pharmacological restraint of nursing home patients with dementia: impact of specialized units, *JAMA*, 265 (10), 1278-1282.
- Soloff, P.H. (1978). Behavioral precipitants of restraint in the modern milieu. *Comprehensive Psychiatry*, 19, 179-184.
- Soloff, P.H., Thomas G. Gutheil and David B. Wexler (1985). Seclusion and Restraint in 1985: A Review and Update. *Hospital and Community Psychiatry*, 36 (6), 652-657.
- Spencer, Charmaine (1994). Abuse and Neglect of Older Adults in Institutional Settings. Discussion Paper - Building From English Language Resources. Mental Health Division, Health Programs and Services Branch, Health Canada.
- Stilwell, Edna M. (1991). Nurses Education Related to the Use of Restraints. *Journal of Gerontological Nursing*, 17 (2), 23-26.
- Stolley, Jacqueline M. (1995). Freeing Your Patients from Restraints *American Journal of Nursing* Feb, 1995 27-31.
- Strome, Therese M. (1988). Restraining the Elderly. *Journal of Psychosocial Nursing and Mental Health Services*, 26, 18-21.
- Strumpf, Neville E., Lois K. Evans (1988). Physical Restraint of the Hospitalized Elderly: Perceptions of Patients and Nurses. *Nursing Research*, 37, 132-137.

- Strumpf, Neville E., Lois K. Evans and Doris Schwartz (1990). Restraint Free Care: From Dream to Reality. *Geriatric Nursing*, 11 (3), 122-124.
- Strumpf, Neville E., Lois K. Evans (1991). The Ethical Problems of Prolonged Physical Restraints *Journal of Gerontological Nursing*, 17 (2), 27-30.
- Sturmanis, Donna (1994). Berta Michel: The 'All Hugs No Drugs' Angel of Alzheimer's Disease. *Okanagan Life Magazine*, Spring 23-27.
- Smith, Jeff (1994). Reading around...risk and restraint. *Journal of Dementia Care*, Jan/Feb 18- 19.
- Sullivan-Marx, Eileen M. (1994). Delirium and Physical Restraint in the Hospitalized Elderly. *Image: The Journal of Nursing Scholarship*, 26 (4), 295-300.
- Sundram, C. J., Stack, E. W., and W.P. Benjamin (1994). Restraint and Seclusion Practices in New York State Psychiatric Facilities. New York State Commission on Quality of Care for the Mentally Disabled.
- Susselman, S. (1973). The use of physical restraint: Its relation to other forms of psychotherapeutic intervention. In S.A. Szurek and I.N. Berlin (Eds.), *Clinical Studies in Childhood Psychoses*, (pp.522-528). New York: Bruner/Mazel.
- Summary of the Report of the American Psychiatric Association on the Psychiatric Uses of Seclusion and Restraint. (1985). *Hospital and Community Psychiatry*, 36 (6), 677.
- Synder, Lorraine Hiatt, Peter Rupprecht, Janine Pyrek, Sandra Brekhus, and Tom Moss (1978). Wandering. *The Gerontologist*, 18 (3), 272-280.
- Tardif, K. (1984). The psychiatric uses of restraint and seclusion. Washington, D.C: American Psychiatric Press.
- Tarnopolsky, Walter S. (1978). Just Deserts or Cruel and Unusual Treatment or Punishment? Where do we go for guidance? *Ottawa Law Review*, 10 (1), 1-34.
- Telintelo, S., Kuhlman, T.L., and C. Winger (1983). A study of the use of restraint in a psychiatric emergency room. *Hospital and Community Psychiatry*, 34, 164-165.
- The National Center for State Long Term Care Ombudsman Resources (1989). Detrimental Effects of Physical (PR) and Chemical (CP) Restraints on Residents. In *An Ombudsman's Guide to Effective Advocacy Regarding the Inappropriate use of Chemical and Physical Restraints*. National Citizen's Coalition for Nursing Home Reform. Washington D.C.

- Thomas, A., L. Redfern and R. John (1995). Perceptions of Acute Care Nurses in The Use of Restraints. *Journal of Gerontological Nursing*, 32-38.
- Tuominen, J. (1988). Prescription Drugs and the Elderly in B.C. *Canadian Journal on Aging*, 7 (3).
- VanRybroek, G., Kuhlman, T.L. and G. Maire (1987). Preventative aggression devices: Ambulatory restraints as an alternative to seclusion. *The Journal of Clinical Psychiatry*, 48 (10), 401-405.
- Way, Bruce (1986). The Use of Restraint and Seclusion in New York State Psychiatric Centers. *International Journal of Law and Psychiatry*, 8, 383-393.
- Wells, C.F., D. Brown and A.A. McClymont (1994). Development of a Least Restraint Program - One Hospital's Experience. *Perspectives*, 18 (2), 10-13.
- Werner, Perla, Jiska Cohen-Mansfield, Jeanne Farley, et al. (1994). Effects of the Removal of Physical Restraints on Psychotropic Medication in the Nursing Home. *Journal of Geriatric Drug Therapy*, 8 (4), 59-71.
- Werner, Perla, Jiska Cohen-Mansfield, Vivian Koroknay and Judith Braun (1994). The Impact of Restraint Reduction Program on Nursing Home Residents. *Geriatric Nursing*, 15 (3), 142-146.
- Wendkos, M.H. (1980). Psychiatric Patients and Sudden Death. (letter) *American Journal of Psychiatry*, 137, 1627-1628.
- Wexler, David B. (1984). Legal Aspects of Seclusion and Restraint. In Kenneth Tardif ed. *The Psychiatric Uses of Seclusion and Restraint*. American Psychiatric Press. Washington, D.C.
- Wilson, Holly (1989). Social behavior and physical restraints. *The Gerontologist*, 29, 650-653.
- Williams, Carter (1989). Liberation: Alternative to Physical Restraint. *The Gerontologist*, 29 (5), 585-586.
- Wilson, Emily T. (1986). The Use of Physical Restraints in Nursing Homes. In *Untie the Elderly: Quality Care Without Restraints*. Symposium before the Special Committee on Aging. United States Senate, One Hundred First Congress. First Session Washington D.C. December 4, 1989. Serial No. 101-H.
- Wright, Joyce (1995) *Beyond Love: A Resource Book for Caregiver Support and Education*.

Young, Kathryn F. and Patricia A. Vucic (1990). Turning a Dream into Reality:
Developing a Restraint-free Environment. *Nursing Homes*, 39 (3/4), 29-32.