



ORIGINAL ARTICLE

On the concept of restraint in psychiatry



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Abstract The aim of the present article is to provide a concise clarification of the concept of “restraint” in the psychiatric context, with particular reference to the official sources. The concept of restraint in general refers to the measures that restrict the freedom of movement of an individual and comprises various types of restraints; an essential characteristic of restraint in psychiatry is its fundamentally coercive nature. The various types of restraint defined here are the following: physical restraint (manual and mechanical), physical psychological restraint (a concept I introduce that completes the concept of physical restraint), chemical restraint, environmental restraint and psychological restraint.

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Introduction

The aim of this article is to provide a concise clarification of the concept of “restraint” in psychiatry, with particular reference to the official sources. Any aspect of legitimizing restraint, whether clinical, legal or ethical, is beyond the scope of this article.

The concept of “restraint” refers to various restraint techniques, the definitions of which, sometimes, manifest major differences with respect to laws, regulations and scientific literature.¹ Even if we limit our investigation to Europe, we find that the regulations (wherever

exist) and clinical practice on restraint in psychiatry vary considerably.^{2,3}

It is noteworthy that the difficulties experienced by many scholars, in getting precise data on the use of restraint in various countries, are due not only to the lack of available data, but also to the high degree of variability in reference sampling and non-uniform terminology.⁴

I have considered the so-called *de-escalation* strategies (guidelines on communication such as softening voice volume, speak calmly, avoid excessive visual contact, negotiating etc.) as not pertaining to “restraint”, even though they are sometimes referred to as “verbal restraint” or “relational restraint”, because they are usually considered to be *alternatives* to restraint.⁵

Regarding the alternatives to restraint, it should be noted that *The American Association for Emergency Psychiatry*

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Project BETA De-escalation Workgroup created the “Ten domains of de-escalation” which included: (1) Respect Personal Space; (2) Do Not Be Provocative; (3) Establish Verbal Contact; (4) Be Concise; (5) Identify Wants and Feelings; (6) Listen Closely to What the Patient Is Saying; (7) Agree or Agree to Disagree; (8) Lay Down the Law and Set Clear Limits; (9) Offer Choices and Optimism; (10) Debrief the Patient and Staff.⁶

Restraint

The term “*restraint*” can be defined as something that limits an individual’s freedom of movement. Restraint is not confined just to psychiatry: it is indeed employed both in non-medical use (e.g. by law enforcement) and in medical use, including various medical fields such as emergency medicine, geriatrics and orthopedics. However, due to various reasons, the use of restraint by psychiatrists is controversial and specific compared to other medical specialties. First, historical reasons (it is sufficient to remember the use of restraint tools in asylums). Second, the fact that, in psychiatry, restraint is normally carried out against the patient’s will whereas, in other areas of medicine (except geriatrics and intensive care units) restraint is ordinarily carried out with the patient’s consent.

A further argument is that the very same need for the restraint in psychiatry is doubtful and controversial: already in the late 1700s William Tuke (1732–1822) and later John Conolly (1794–1866) proposed and implemented *no restraint* treatment methods for the psychiatric patient; and it is worth to note the existence in Italy of psychiatric wards where the use of restraint is strictly abhorred (the so-called no-restraint wards) and the experience of a few Pennsylvania hospitals where, as of 1997, the use of restraint has been dramatically reduced and, in some cases, completely abandoned.^{7,8}

Even if, as noted earlier, the term “*restraint*” recalls the act of somehow limiting an individual’s freedom of movement, it is nonetheless important to emphasize how the term, in psychiatry, refers more precisely to a *coercive* act that limits freedom of movement; this also applies to the judicial and bioethical arenas: when it comes to medicine, “*restraint*” implies coercion.

According to the Académie Suisse des Sciences Médicales, we may say that all actions that are carried out against the patient’s stated will (or presumed will, if he is not able to communicate) or cause him to resist must be considered “*coercive acts*”.⁹

A definition of “*restraint*” that includes both coercion and limitation of freedom of movement, is the one found in *Mental Capacity Act* (2005): «[A person] D restrains [another person] P if he (a) uses, or threatens to use, force to secure the doing of an act which P resists, or (b) restricts P’s liberty of movement, whether or not P resists». ¹⁰

It is worth to note that point (a) of this definition refers to the literal meaning of the word “*coercion*” as given in *Black’s Law Dictionary*, «compulsion by physical force or threat of physical force».

Other definitions of “*restraint*” that may be quoted are the ones given by the US *Joint Commission on Accreditation of Healthcare Organization* (JCAHO): «Any method (chemical or physical) of restricting an individual’s freedom

of movement, physical activity, or normal access to the body»,¹¹ and by the Italian National Bioethics Committee (NBC): «Mechanical or pharmacological limitation of an individual’s possibility of autonomous movement». ¹² These definitions clearly describe how restraint may be performed by different means, physical or chemical, as we will elaborate further on.

Physical restraint (manual and mechanical)

Although “*physical restraint*” is not the only form of restraint, it represents the psychiatric restraint par excellence; very often, the literature reference to otherwise non-specified “*restraint*” usually refers to physical restraint.

In the most recent version of *U.S. Code of Federal Regulations* we find a definition of “*restraint*”, as given by the US Federal Agency *Centers for Medicare and Medicaid Services* (CMS), *Department of Health and Human Services*. The first part of this definition refers to physical restraint: «Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely»¹³; the second part pertains instead to chemical restraint, of which we shall deal with later.

We recall another definition given by CMS: «“*Physical Restraints*” are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body, that the individual cannot remove easily, which restricts freedom of movement or normal access to one’s body». ¹⁴

Physical restraint can be implemented by two different means, although the goal is common, i.e. to limit a person’s possibilities of autonomous and spontaneous movement. The first requires one or more staff members (usually, at least three) who physically grab or engulf the patient in such a way as to control his ability to move freely: we refer to this as “*manual restraint*” or, more simply, “*physical restraint*”.

Let us exemplify this: physically grabbing of a patient and immobilizing him with the purpose of administering some drugs is manual restraint; in contrast, sustaining a patient so that he can be escorted to a given place is not manual restraint as long as the person can easily free himself from the staff members’ grab.

The second means of physical restraint is carried out by suitable mechanical devices which, either directly applied to the patient’s body or adjacent to him, and not easily removable, preventing, limiting or controlling his body movements: we then speak this as to “*mechanical restraint*”.

Among the devices used in psychiatry for mechanical restraint – the historical straightjacket, the belt with wrist-cuff, wrist and ankle cuffs tied to the bed, bed-side bars – according to CMS interpretation, may as well be considered to be restraint devices to the degree that they are used to prevent a person from leaving his bed. Conversely, they are not restraint devices: if they are used to prevent a fall-prone patient from hurting himself, if they leave a free opening by which the patient may leave the bed, if the patient may easily remove the device or, finally, if the patient cannot leave the bed even without bars. ¹⁵

An idea of the different types of available restraint devices may be obtained from the websites of the manufacturers and resellers of such devices such as Posey and Rehab Mart.

It must be noted that a major difference between manual restraint and mechanical restraint lies in its time-span: manual restraint is intrinsically limited to a few minutes while mechanical restraint may last for a few hours.

Mechanical restraint in psychiatry is not completely independent from manual restraint: the latter is normally employed in order to implement the former, although it may be used as it is, without being followed by mechanical restraint.

Physical psychological restraint

The aforementioned CMS definitions, point very clearly to those psychiatric practices that are usually referred to as "physical restraint", but overlook other kinds of practices which seem to fit it, e.g. when the staff threatens a patient with mechanical restraint unless he agrees to undergo a given drug therapy: it is clear that this may just as well be considered a physical restraint.

Coercive measures, in fact, are those which fulfill their goal by subjugating an individual with force, rather than seeking spontaneous cooperation from him: the potential use of force, if the eventuality of its actual use is tangible, ranks therefore it as a coercive measure.

It is thence possible to recognize the existence of measures, different from manual and mechanical restraint which, being aimed at limiting a patient's freedom of movement, are literally "coercive" and must therefore fall within the concept of "physical restraint"; we refer to these measures as "physical psychological restraint", defined as the use of intimidation, command or psychological pressure by one or more staff members on a patient aimed at forcing him to do (or not to do) something.

The coercive nature of "physical psychological restraint" is further sustained because a patient: (i) in a psychiatric ward, is subject to a very unbalanced relationship with the staff as far as power is concerned; (ii) might not be free to leave the ward due to be subject to forced hospitalization such as civil commitment or, in Italy, the *trattamento sanitario obbligatorio*; (iii) might have been already subject, maybe in the very same ward, to some form of manual or mechanical restraint.

Ordering a patient to remain in a particular physical position (e.g. flat on his back) until he is allowed to move, is an example of physical psychological restraint; another example is ordering a patient to stay in a given space, such as a corner of the room (a practice known as "exclusionary time-out"). I shall point out that in a recent research, part of the Eunomia project (international project on restraint in psychiatry, funded by the European Commission), concerning the use of coercion on involuntary patients in ten European Countries, the researchers have considered "coercion" to include not only physical restraint and isolation, but also forced medication carried out through a heavy psychological pressure by at least three staff members.¹⁶

Chemical restraint

In order to define "chemical restraint", sometimes also called "pharmaceutical restraint", "acute control medication" (ACM) or "rapid tranquilization", we shall again refer to the definition of "restraint" given by CMS and used in the *U.S. Code of Federal Regulations*: «A drug or medication, when used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement, and is not a standard treatment or dosage for the patient's condition».¹³

Another CMS definition is as follows: «"Chemical Restraints" is defined as any drug that is used for discipline or convenience, and not required to treat medical symptoms. "Discipline" is defined as any action taken by the facility for the purpose of punishing or penalizing residents. "Convenience" is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. "Medical Symptom" is defined as an indication or characteristic of a physical or psychological condition».¹⁴

Similar to physical restraint, chemical restraint has also the purpose of limiting a patient's freedom of movement and control his behavior. However, unlike the former, the latter attains such purpose through chemical substances, rather than manual or mechanical means; drugs used for chemical restraint include sedative and antipsychotic drugs – typical or atypical, or a combination thereof.^{17,18}

When a drug is prescribed merely as a reaction to the patient's behavior, rather than a component of a reasonable treatment program, we may call it chemical restraint.¹⁹

As regards to the chemical restraint, I think it is possible to recognize a "soft chemical restraint" defined as the use of some psychopharmacs to minimize agitation symptoms or suffering which do not aim at making the patient sleep as at rendering the situation more affordable by de-escalation techniques or verbal contention and then remove mechanical restraints.

"Chemical restraint" and "forced therapy" are related concepts, but are not synonymous: the difference lies in the fact that chemical restraint does not cure the patient's psychiatric disease (drugs are indeed given regardless of their specific indication, paying no attention to any approved dose, both in terms of quantity and frequency of administration, and/or in the absence of an actual diagnosis) whereas forced therapy is aimed at curing such disease (indications and doses are correct and based on a previous diagnosis); it is worth mentioning that antipsychotic drugs used in chemical restraint «require days to weeks to exhibit effects on the positive symptoms of psychosis, clinicians in essence make use of the extensive side-effect profiles of these agents to achieve rapid sedation without immediately affecting the underlying pathology».²⁰

Chemical restraint might be used together with, or instead of, physical restraint, and it is usually anticipated by manual or mechanical restraint to facilitate the administration of drugs. The exclusive use of physical restraint without some sort of sedative is very unusual and, as someone pointed out, «any maximal physical restraint without chemical restraint is at all times unacceptable».²¹

Many MDs and psychiatrists claim that the term "chemical restraint" is derogatory and does not reflect the possibility that such form of forced administration of drugs may clinically be necessary and beneficial to the patient.^{22,23} However, the term is found in scientific literature and used in regulatory contexts, e.g. in *The Omnibus Budget Reconciliation Act* of the United States,²⁴ the *Loi sur le services de santé et les services sociaux* of Québec²⁵ and the *Disability Act* of the State of Victoria²⁶ (in these contexts chemical restraint is considered to be akin to physical restraint). Indeed, chemical restraint must be considered as a full-fledged restraint technique, both because it limits the possibilities of spontaneous movement in the patient and because it is coercive.

The coercive nature of chemical restraint is even more evident whenever these drugs are administered to a patient through physical restraint (be it manual, mechanical or psychological), in any case its coercive nature is undeniable owing to its aptitude to subject a patient to other's will (i.e. the will of medical staff), by making him incapable of resistance by administration of (unwanted or non-consented) drugs.

The use of force aimed at overwhelming an individual's will, so characteristic of coercive acts, is also found as well in chemical restraint, where such force is not manual or mechanical but chemical, and the individual's will, rather than being overwhelmed, is pharmacologically nullified.

Emphasizing the analogy between physical and chemical restraint is the very fact that in both cases, the means that is used acts directly on parts of the human body: the physical restraint tools act on wrists, ankles etc., while the chemical restraint tools (psychiatric drugs) act on the nervous system. The idea that psychiatric drugs may be used as restraint tools is not new: already in 1957 Thomas Szasz defined antipsychotic drugs as "chemical straitjackets" and in France, in the sixties, the term "camisole chimique" was used to disapprove their use.

Other restrictive means: environmental and psychological restraint

Various means of restriction are in use in psychiatric wards that are different from physical and chemical restraint or isolation, but nonetheless affect the patient's personal freedom; these are a heterogeneous mix of measures aimed at limiting a patient's freedom of movement (or ability to act) that, as such, must be classified as restraint, although less invasive than physical or chemical restraint. Owing to this heterogeneity, there is no uniform and internationally-accepted terminology that includes all such restrictive measures: let us however quote the concepts of "environmental restraint" and "psychological restraint".

According to the *Voluntary Code of Practice for the Elimination of Restrictive Practices* of the State of Western Australia, «an "environmental restraint" restricts a person's free access to all parts of their environment»²⁷ and similar definitions have been proposed, e.g., by *Long Term Care Homes Act* of Ontario²⁸ and by the Irish *Department of Health*.²⁹

The closed doors in the psychiatric ward are an exemplary case of environmental restraint, installing CCTVs may also

be regarded as such a type of restraint, even more so when they are used for preventing a patient from leaving a given area. The isolation theoretically also fits into the definition of "environmental restraint", but it is usually considered a measure of its own, different from restraint.

The concept of "psychological restraint" is broader and less determined than the concept of "environmental restraint". A short definition is given in the current *Pennsylvania Code*: «Psychological restraints include those therapeutic regimes or programs which involve the withholding of privileges and participation in activities». Taking away certain objects from a patient, preventing him from performing certain activities or denying the possibility of social interaction as a consequence of his *non-compliance* or other form of disagreement with the staff are all forms of psychological restraint. Sometimes these measures take the form of blackmail, and the patient is told that they will be kept in force until he behaves "well" or, more precisely, if he does not comply with the staff orders (the so-called "consequence-driven strategies").

According to the English *Royal College of Nursing*, psychological restraint «can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in night wear with the intention of stopping them from leaving».³¹

Environmental and psychological restraint measures must be considered to be coercive not only when, and not only because, they are against the patient's will, but also because they are usually implemented by force whenever the patient actively resists or opposes them.

We may refer to the environmental and psychological restraint with the term "psycho-environmental restraint" defined as follows: a measure different from physical or chemical restraint or isolation which, by means of an action on a person's surrounding environment and/or any form of psychological pressure, has the purpose and/or the effect of limiting the person's freedom of movement and/or freedom of choice.

Psycho-environmental restraint may include measures such as: closed doors, limiting contacts, visits or communications with the outside world, time schedules for utilizing common areas, restricting the access to outdoors areas, closed refrigerators and closets, obligation to wake up and eat on a specified time schedule, the use of cameras or electronic monitoring devices (such as the electronic bracelet), limitation in the use or misappropriation of personal objects (radio, TV, cell phones, metal forks and knives, cigarettes, books etc.) or limiting the possibility to choose a kind of diet (e.g. vegan or vegetarian etc.), limitation or a blunt ban on social interaction, or obligation to wear a specific dress.

At the end of this paragraph, I acknowledge how sociologist Erving Goffman can be considered the first scholar to have ever pointed out and deeply analyzed the various means used in psychiatric wards that, though less obvious than physical restraint, were nonetheless aimed at limiting a patient's freedom; in *Asylums* (1961) Goffman observed

Table 1 Summary of the various types of restraint.

Type of restraint	Definition
Physical restraint – manual restraint	Any manual or physical method that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely
Physical restraint – mechanical restraint	Any mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely
Physical restraint – physical psychological restraint	The use of intimidation, command or psychological pressure by one or more staff members on a patient aimed at forcing him do (or not do) something
Chemical restraint	A drug or medication, when used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement, and is not a standard treatment or dosage for the patient's condition
Environmental restraint	An environmental restraint restricts a person's free access to all parts of their environment
Psychological restraint	Psychological restraints include those therapeutic regimes or programs which involve the withholding of privileges and participation in activities
Psycho-environmental restraint	A measure different from physical or chemical restraint or isolation which, by means of an action on a person's surrounding environment and/or any form of psychological pressure, has the purpose and/or the effect of limiting the person's freedom of movement and/or freedom of choice

how in such hospitals every aspect of life was subject to control by a single authority, revealing the existence of a detailed list of everyday activities which do not keep into account the patients' needs or desires, but is rather forced upon them by the authority (Table 1).

Conclusions

Briefly defining the concept of "restraint", revealed that how such concept encompasses a great number of restraint techniques, differentiating among them not only by the means and tools employed in their implementation, but also by the different degrees of coercion and invasiveness.

Physical restraint, whether manual or mechanical, represents textbook "restraint" in psychiatry, but it seems appropriate to introduce the concept of "physical-psychological restraint" in order to keep a proper account of such measures which, much like manual and mechanical restraint, are coercive in nature (literally) and limit a patient's freedom of movement.

The concept of restraint also includes chemical restraint, although some argue against the existence of such form of restraint, and a broad range of heterogeneous measures that may be referred to as "environmental restraint" and "psychological restraint".

The variety of restraint types and the lack of an internationally agreed-upon terminology for their definition, require that any study aiming at a thorough research on restraint (especially if it collects data on its diffusion) must pay special attention to accurately defining the types of restraint it seeks to investigate. Similarly due care must be taken in the programs aimed at banning or limiting the

use of restraint, so as to recognize those measures which, though less evident and invasive than physical and chemical restraint, are nonetheless a form of restraint.

Conflicts of interest

None.

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