

“To Become Old is to Become Institutionalized and Imprisoned”¹: Comparing Regulatory Frameworks for the Use of Restraints in Long-Term Care Facilities

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“One of the essential functions of human-rights legislation is to protect human beings from the therapeutic good intentions of others. ... To give these human beings [patients] the benefit of informed consent, the rule of law, and such autonomy as they can exercise without harm to others is the proof that we actually believe in human rights.”² (Michael Ignatieff)

Introduction

Our commitment to human rights is tested when we enact laws and create policies that affect the elderly. As Kazin writes: “We are often sentimental about the old in the abstract but contemptuous of them in practice.”³ She continues that “many of us simply expect that to become old is to become institutionalized and imprisoned.”⁴ One form of imprisonment that is experienced by the elderly is restraint;⁵ indeed, some elderly persons regard the imposition of restraints as a routine part of care as they grow older.⁶

Restraint is a technique used to control and restrict a person’s freedom of movement, and as such it is vulnerable to being misused and/or abused. Regulation can serve as a framework to ensure that the human rights of the elderly are enabled and respected, serves to minimize the potential abuse and misuse of restraints, and may reduce the potential

harm to the person who is restrained. Accordingly, in this paper I examine how we, as a society, should regulate the use of restraints to ensure that they are not a routine part of the lives of the elderly.⁷ I compare and contrast two regulatory frameworks for the use of restraints in long-term care facilities and conclude by suggesting a new regulatory framework.

The Incidence of the Use of Restraints

International research suggests that nine percent of residents of long-term care facilities are restrained in countries such as Iceland, Denmark and Japan, 13.5-17 percent in the United States, 15-17 in France, Italy and Sweden, 15-26 percent in Australia and 40 percent in Spain.⁸ The most common justification for restraint use is that it is necessary to restrain an elderly person to prevent serious self-harm or serious harm to others. But these rationales do not completely explain the high levels of restraint use. Research from the US suggests that restraints are used by health providers for a number of other reasons including: adhering to policies; the health provider’s sense of security and comfort; and fear of legal liability.⁹ Other, more clinical rationales are said to include: behavioral control; confusion; poor judgment; and controlling agitated behavior or wandering.¹⁰

Certainty, Autonomy, Effectiveness and Abuse — Issues Pointing to the Need for A Regulatory Framework

In most jurisdictions in Canada, and in many international jurisdictions, the use of restraints in health facilities generally is not regulated.¹¹ It is left to the common-law, professional bodies, and individual institutions to create standards for restraint use.

There are four key arguments that suggest that to continue not to regulate restraints in long-term care facilities does not accord sufficient priority to the rights and needs of the elderly and to the interests of health care providers and society as a whole.

First, lack of regulation creates uncertain law and therefore uncertainty in practice. Under the common-law it is not clear when, why, how and in what circumstances restraints may be legitimately used. It is also not clear what impact the *Charter*¹² could have on this area. Regulation may create a degree of certainty as to the legality of restraint use and set out in detail the circumstances in which it may be used. It also may create standards for the application and monitoring of restraint use.

Second, an individual's right to autonomy needs to be accorded greater protection, which may be achieved through legislation specific to the issues in this area. When health providers argue that they need to restrain an elderly person to protect him/her from self-harm, such as the possibility of falling, they are acting out of a desire to protect that person. This protective instinct may be legitimate in some cases, perhaps if the person is not competent, but may be overly paternalistic in other circumstances. Competent individuals are free to choose paths that may lead to self-harm. Risks are a part of life and to deny the elderly the chance to take risks can be to deny their autonomy. If autonomy is to be limited for protection of self or others then it must be limited within a clearly articulated regulatory framework, otherwise it may violate the *Charter* or human rights law.

Third, regulation may reduce the levels of restraint use by limiting opportunities for health providers to misuse restraints. Often health providers will use restraint because an elderly person is agitated, wandering, or unsteady and

they fear that the person will fall. They consider that restraints are an effective tool to reduce that risk.¹³ However, recent research suggests that fall rates are the same whether restraints are used or not and that the severity of the outcome of the fall may be increased when restraints are used.¹⁴ Similarly, agitation may increase, rather than decrease.¹⁵ Restraints may therefore not actually achieve the ends that health providers hope they will. Regulation may create clearer evidence based criteria for restraint use that may reduce the opportunities to misuse restraints.

Similarly, restraints are not necessarily safe interventions — restraint use carries with it its own risks, particularly for the elderly. If physical restraints are not applied properly, and the person who is restrained is not monitored regularly and effectively, injuries, even death, can ensue.¹⁶ In addition, immobility caused by restraint use can contribute to the development of pressure sores, as well as the development or worsening of other conditions.¹⁷ Chemical restraints also have side effects. These include

symptoms such as dizziness, sedation, and increased agitation, which may contribute to an increased risk that the person will fall, may reduce the person's capacity¹⁸ or cause ill health.¹⁹ Regulation can set standards for safe and appropriate restraint use, especially for those with multiple health conditions who are more vulnerable to adverse effects caused by restraint, like the elderly.

Fourth, regulation may reduce or prevent abuse of the power to restrain by health providers. In an institutional environment where there may be a profound power imbalance between the elderly person and staff or when the elderly person lacks capacity, misuse or abuse of such a powerful tool is not unheard of. In the face of the potential for abuse, regulation is necessary to protect those who are most vulnerable.

Those jurisdictions that do not currently have regulations limiting and monitoring restraint use should enact law that specifically addresses this issue. However, the regulation of restraint use in health facilities is complicated by the fact that restraints are used in a variety of environments, by a variety of health providers, some of whom are trained professionals and some of whom are not, on a variety of people with differing needs, who are from a variety of cultural, religious, ethical, social and ethnic backgrounds and who all have different personal histories. In the next section I exam-

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ine models of regulation for restraint use that have been implemented or suggested in two jurisdictions to see whether lessons can be learned and direction taken from these models.

Regulatory and Legislative Frameworks for Restraint Use in Long-term Care Facilities

There are two main types of regulatory frameworks evident in legislation that address the use of restraints in health facilities: facility-focussed regulatory frameworks (British Columbia); and patient-focussed regulatory frameworks (proposed in New Zealand). Each of these frameworks indicates different terminal values in health systems.²⁰ Facility-focussed frameworks focus on institutional compliance with procedural norms that aim to achieve safe, consistent systems within institutions, in accordance with the quality improvement and safety model that to a certain extent dominates health system management discourse at this time. Patient-focussed frameworks aim to maximize observance of and respect for the human rights of individuals in health care systems, in accordance with a more patients rights centred approach, which postulates the patient at the centre of the model of care.

Facility-Focussed Regulatory Frameworks — British Columbia

In British Columbia, the regulatory framework for restraint use is set out in s. 25 of the *Health Care (Consent) and Care Facility (Admission) Act*.²¹ This states that operators of care facilities²² must not use physical, chemical or other means of restraint to restrict the freedom of movement of an adult who lives in that facility unless: all alternatives have been exhausted; the restraint is as minimal as possible; the patient/substitute decision-maker and a physician approve a plan devised by another health care provider agreeing that it is in the patient's best interest or for the protection of others; and the need for restraint is periodically reassessed. Restraint may be used in an emergency without consent if it is necessary to preserve the person's life or to prevent serious physical harm to others as long as he/she is restrained no longer than necessary, and is monitored and reassessed at regular intervals. The operator must record restraint use in the patient's clinical record.

The *Adult Care Regulations*²³ also provide a regulatory framework for the use of restraints in long-term care facilities. Restraints must not be used for punishment or discipline or for the convenience of staff, but may be used if all

alternatives to the use of restraint have been exhausted, the restraint is as minimal as possible, the restraint is approved by the resident or his/her substitute decision-maker, restraint is documented in the care plan, staff are trained, and there are written policies and procedures acceptable to the Medical Health Officer.

Patient-Focussed Regulatory Frameworks — New Zealand

The New Zealand Law Commission reviewed the current legislative framework in New Zealand for the use of coercive physical force on disadvantaged groups in the health and disability sector in its report *Protections Some Disadvantaged People May Need*.²⁴ It accepts that on occasion coercive powers to apply physical force need to be available to health or welfare officials but concludes that this power is not currently available in New Zealand law. Accordingly, it recommends the introduction of a new section into the *Protection of Persons and their Property Act*²⁵ to give the Family Court the power to hear applications for the use of physical restraints and to authorise restraint use.²⁶ The Commission also suggests that the Family Court periodically review restraint orders. The Commission recommends that the powers of District Inspectors of Mental Health²⁷ monitor the rights of compulsory psychiatric patients be expanded to include monitoring of the rights of persons in respect of whom coercive orders have been made wherever they may live.

New Zealand already has a national standard to inform the development of institutional policies as to when and how physical restraints should be used.²⁸ Facilities are audited to determine whether they have institutional policies that comply with general and specific national standards, including the restraint standard, and may not be licensed if they do not comply.²⁹

Evaluating the Frameworks from British Columbia and New Zealand

In this section I evaluate the regulatory frameworks having regard to three criteria: autonomy, adherence and monitoring systems.

i. Autonomy

The proposed New Zealand system focuses on the rights and needs of individuals rather than facility compliance. Assuming that the Family Court has the time and expertise to evaluate the appropriateness of restraint for each individ-

ual, an independent assessment can be made of whether restraint unduly compromises the rights of incompetent individuals or is necessary to protect the individual or to protect others from serious, imminent and reasonably certain harm. This system would appear to limit the opportunities for restraint to be abused or misused. However, there seem to be two serious difficulties: New Zealand's proposed mechanism promises to be reasonably resource intensive, at least initially; and it does not appear to address issues relating to competent patients and when it is clinically and legally appropriate for restraints to be used for this group. Resource issues are not necessarily fatal objections to such a scheme. As a society we offer costly protections to other groups subject to coercive mechanisms, such as the mentally ill and prisoners, and we should do no less for the elderly. The New Zealand system also has the potential to clog family court processes. It may create the risk that restraint approval by the courts becomes a pro forma process.

In contrast, although the system in British Columbia focuses on institutional compliance with statutory requirements and thus is facility focussed, the legislation itself is patient-focussed. Patients or surrogate decision makers (if the patient is not competent) must give consent to restraints being used unless the emergency provisions apply. The legislation also sets out criteria within which restraints may be used, limiting the opportunities for misuse or abuse and thus prioritizing the autonomy of the patient.

ii. Adherence

One of the greatest challenges faced by regulators, particularly in the health sector, is creating regulation that is likely to be adhered to by the public, or in this case health providers. As Eastman and Peay note:

People use law; law does not use people. Law is not an actor, only an instrument of human actors whose interest is not in how the law *thinks* people act, but how they *do* act; people are not passive participants of the law — they use it, abuse it and stretch it in order to stay creatively within it and/or to frustrate its objectives. People *inter-act* with law.³⁰

The British Columbia framework encourages adherence by the operators of long-term care facilities, because it is not procedurally cumbersome. Facilities need not make applications for each individual to the court for permission to restrain, they must merely comply with the set of specific criteria set out in the legislation in order for restraint use to be lawful.

In contrast, one of the problems with the Law Commission's proposed framework for New Zealand is that it requires long-term care facilities to be pro-active and make an application to the courts seeking authorization to use restraints on an individual. Alternatively, health providers must encourage the family (presuming there is one) to apply to the courts for such an order. However, inaction is a powerful force. Provider/facility/family costs associated with making applications to the family court in adherence to law are an issue that may also discourage adherence, for example, the costs of legal representation, expert evidence etc. Similarly, health providers and/or facilities in New Zealand may try to avoid legal mechanisms (whether because of fear, ignorance, dislike of red-tape or a reluctance to enter the legal system and to attract further institutional monitoring). Providers and facilities may therefore choose to rely on common law doctrines or, as the proposed New Zealand system does not address the use of chemical restraints, it creates the risk that health care providers will use chemical restraints as an alternative to physical restraints. In contrast, the framework from British Columbia addresses emergency restraint use, thus removing the common-law from the equation, and it also covers all forms of restraint use.

iii. Monitoring

Monitoring how services are provided is a crucial step in ensuring that individuals receive treatment or health care that is safe. When the services in question are those that can cause serious harm and perhaps more importantly can be abused it is important that such monitoring is independent of the health providers who provide the service. Yet ultimately the framework in British Columbia seems to rely upon self-policing by institutions. Although the Medical Health Officer must approve an institution's restraint policy, it is not clear that this policy is regularly reviewed after approval is given. No independent agency enters facilities to review restraint use. Therefore, the capacity of this framework to police restraint application on individuals is non-existent, and abuse or misuse is not likely to be identified and stopped.

In contrast, the monitoring system currently in place, through national standards, and that proposed by the New Zealand Law Commission, will enable monitoring at both ends of the spectrum. Institutional compliance is audited independently as part of a certification process to ensure that standards are met and facilities take responsibility for guiding staff. The welfare of the individual who is being restrained is also monitored by an independent agency to ascertain the person's safety, the effectiveness of the intervention and to ensure that the person's rights are being

impinged upon to the least possible extent. If the rules are obeyed and monitoring is effective, the incidence of abusive, inappropriate or unsafe restraint use could decrease under this model.

Hybrid Framework

Both of the regulatory responses described above have both positive and negative features. If policy makers wish to privilege individual autonomy to its greatest extent, and minimize the incidence of misuse and abuse of restraints, I suggest a hybrid framework drawing from the strengths of both frameworks. Briefly, in this hybrid model blanket authorization for restraint use is set out in legislation but is subject to stringent conditions. Health providers who use restraints on their patients are required to keep excellent records, setting out when, why and how restraints were used and what strategies were used to make restraint an option of last resort. Health providers/facilities must report each incidence of restraint use to a monitoring agency. That agency will actively monitor an individual's experiences with restraint, as well as whether the facility has formulated a policy to ensure that restraint is used and applied in a manner that maximizes the resident's safety. The monitoring agency should be independent and have the power to make random inspections. The hybrid model is both facility *and* patient focussed and may contribute to autonomy, minimizing restraint use and reducing the likelihood that restraints are used in an abusive or inappropriate manner.

Conclusion

Regardless of the model chosen, what is certain is that a robust regulatory and monitoring framework surrounding the use of restraints in long-term facilities, and indeed in all healthcare facilities, is important to safeguard the autonomy of the elderly and to minimise abuse and misuse.

It is also important to acknowledge that regulation is only part of the answer. Barham and Barnes note:

[The law] can define the circumstances in which action to limit the autonomy of citizens can be legitimated, and the procedural rights available to citizens to challenge such limitations, but it cannot require action to enable the *practice* of citizenship.³¹

If, as a society, we wish to free the elderly, as much as possible, from the use of restraints there are at least two remain-

ing problems that the law cannot address: resource issues; and the perceptions and attitudes of health providers, families and the general public.

Moving to an institutional environment where restraint use is at a minimum requires an investment in the care of the elderly. Alternative mechanisms used to reduce the need for restraint use, such as special beds and diversion therapy, are not without cost and these costs may be significant in an area that has traditionally attracted little support and funding from government. It also may be significant for private facilities that must return a profit to investors in the facility.

But perhaps the most significant issue in the restraint conundrum is the attitudes, perceptions and beliefs of providers, patients, families and the public. Ageism and the protective mantra that accompanies it must be addressed through a shift in societal perceptions accomplished by education and increasing awareness of the rights of the elderly. As Michael Ignatieff states:

... human rights alone are not enough. ... we need extra resources, especially humour, compassion, and self-control. These virtues must in turn draw on a deep sense of human indivisibility, a recognition of us in them and them in us, that rights doctrines express but in themselves have no power to instil in the human heart.³²

Effective regulation is but a first step to allow the elderly to be free from the expectation that to become old is to be institutionalized, imprisoned, and stereotyped as incapable and in need of protection.³³

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1. C. Kazin, "'Nowhere to Go and Choose to Stay': Using the Tort of False Imprisonment to Redress Involuntary Confinement of the Elderly in Nursing Homes and Hospitals" (1998/1999) 137 U. Pa. L. Rev. 903 at 903.
2. Michael Ignatieff, *The Rights Revolution* (House of Anansi Press: Toronto 2000) at 39.

3. Kazin, *supra* note 1.
4. *Ibid* at 904.
5. When I use the terms “restrained” or “restraint” in this paper I mean physical restraints, including a health provider holding a resident, the use of equipment and furniture, and environmental factors, including contained environments, seclusion, or strategies to reduce the levels of social contacts or stimulation. I also include chemicals that are used to control a person’s behaviour or limit their freedom of movement.
6. These are the results from a small qualitative assessment of elderly persons who were physically restrained in an acute hospital after surgery. See, R. Gallinagh, *et al.* “Perceptions of Older People Who Have Experienced Restraint” (2001) 10:13 *Brit. J. Nurs.* 852.
7. I focus on the elderly as restraints are often used on the elderly, a group that may suffer greater harms from restraint use because of their age.
8. G. Ljunggren *et al.*, “Comparisons of Restraint Use in Nursing Homes in Eight Countries” (1997) 26 *Suppl. Age & Aging* 43.
9. K.S. Dunn, “The Effect of Physical Restraints on Fall Rates in Older Adults who are Institutionalized” (2001) 27:10 *J. Geron. Nurs.* 41 at 42; and Julie Braun & Elizabeth Capezuti, “The Legal and Medical Aspects of Physical Restraints and Bed Siderails and Their Relationship to Falls and Fall-related Injuries in Nursing Homes” (2000) 4:1 *DePaul J. Health Care L.* 1 at 7-8.
10. *Ibid.*
11. British Columbia, Ontario and Quebec have regulatory schemes.
12. *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.) 1982, c.11.
13. Dunn, *supra* note 9 and Braun & Capezuti, *supra* note 9.
14. Dunn, *supra* note 9; M. Arbesman & C. Wright, “Mechanical Restraints, Rehabilitation Therapies and Staffing Adequacy for Risk Factors For Falls in Elderly Hospitalized Patients” (1999) 24:3 *Rehabilitation Nursing* 122; L. Evans, *et al.* “A Clinical Trial to Reduce Restraints in Nursing Homes” (1997) 45 *J. Am. Geriatric Soc.* 675; L. Bradley, C. Siddique & B. Dufton “Reducing the Use of Physical Restraints in Long-term Care Facilities” (1995) 21:9 *Geron. Nurs.* 21; R. Lofgren, *et al.* “Mechanical Restraints on the Medical Wards: Are Protective Devices Safe?” (1989) 79:6 *J. Pub. Health* 735; M. Tinetti, E. Liu & S. Ginter, “Mechanical Restraint Use and Fall-related Injuries Among Residents of Skilled Nursing Facilities” (1992) 116:5 *Annals of Internal Medicine* 369.
15. Gallinagh *et al.*, *supra* note 6. Similarly, benzodiazepines, hypnotics and anti-psychotic medications, all commonly used to chemically restrain the elderly have as side effects the possibility of increased agitation.
16. The physical risks of restraint use for the elderly include: occurrence and worsening of pressure sores; infections; incontinence; fecal impaction; functional impairment from lack of movement; cardiac stress; nutritional impairment; bone resorption due to demineralization; electrolyte losses; injuries that result in increased morbidity and mortality; and, on rare occasions, accidental strangulation. See discussion in V. Dawkins, “Restraints and the Elderly with Mental Illness: Ethical Issues and Moral Reasoning” (1998) 36:10 *J. Psychosocial Nursing* 22; Dunn, *supra* note 9 at 42. See also, H. Archibald Kaiser, “Restraint and Seclusion in Canadian Mental Health Facilities: Assessing the Prospects of Improved Access to Justice” (2001) 19 *Windsor Y.B. Access Just.* 391 at 395-96; S. Miles & P. Irvine, “Deaths Caused by Physical Restraints” (1992) 32 *The Gerontologist* 762.
17. *Ibid.*
18. Medications used for restraints may have a sedating effect and may increase confusion, therefore reducing the person’s mental capacity.
19. Psychotropic medications are commonly used as chemical restraints. These are drugs that affect brain activities associated with mental processes and behaviour. There are four broad categories of psychotropic medications: anti-psychotic drugs, anti-depressant drugs, anti-anxiety drugs (including benzodiazepines) and hypnotics, all of which have serious side effects. The side effects are also more common in the elderly and may be more severe. Benzodiazepines may cause more daytime drowsiness; therefore falls and related accidents may be more common. Confusion, anxiety, depression, amnesia, and, more rarely, delusions, disorientation, agitation, aggression, and hallucinations may increase. Addiction is also a serious risk. Hypnotic medications have similar side effects to benzodiazepines. The side effects of anti-depressants include, excessive sedation, blurred near vision, confusion, disorientation, and orthostatic hypotension (which can cause a predisposition to fall). Anti-psychotics may have a sedating effect, may increase confusion and/or agitation, and may cause rigidity, tremors, and a change in gait. The

- manufacturers recommend that elderly persons prescribed anti-psychotics be regularly monitored.
20. Nuala Kenny, *What Good is Healthcare? Reflections on the Canadian Experience* (Ottawa: CHA Press, 2002).
 21. *The Health Care (Consent) and Care Facility (Admission) Act - Supplement*, R.S.B.C. 1996 C. 181. Section 25 is not yet in force.
 22. *Ibid.* This is defined in s. 2 to include community care facilities, private hospitals, hospitals and facilities designated by regulation as care facilities.
 23. *Adult Care Regulations* B.C. Reg. 536/80 sections 10.9, 10.10 and 10.11.
 24. New Zealand, Law Commission, *Protections Some Disadvantaged People May Need: Report 80* (Law Commission: Wellington, 2002), online at: The Law Commission <<http://www.lawcom.govt.nz>> (date accessed: 20 January 2003) [Law Commission].
 25. *Protection of Personal and Property Rights Act 1988* (N.Z.), 1988/4. This is New Zealand's adult guardianship legislation.
 26. Law Commission, *supra* note 24 at 19. Court orders allowing restraint use must be expressed precisely, the purpose must be set out in the order and the order must not be capable of being construed to justify a greater degree of restraint than is necessary to achieve the purpose of the order. The Family Court may impose conditions on its order. For example, that restraint may be used only as long as necessary for the care of the patient or the protection of others. Also coercive powers must be exercised so as not to compromise the dignity, privacy or self-respect of the person concerned.
 27. District Inspectors of Mental Health are appointed pursuant to section 94 of the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (N.Z.), 1992:46 [MH(CAT)]. They monitor the conditions of, and respond to complaints from, patients who are subject to compulsory treatment orders.
 28. *New Zealand Standard 8141:2001 Restraint Minimization and Safe Practice* (Wellington: Standards New Zealand, 2001) [*Restraint Minimization Standard*]. The standard incorporates the following components: cultural recognition, particularly of cultural safety and recognizing the philosophy of Te Whare Tapa Wha (the four cornerstones of Maori health); assessment, to be undertaken by suitably skilled persons in partnership with the resident and his/her family and includes the individuals personal and cultural needs, triggers and precursors and other factors and to be regularly reviewed; risk and quality management systems to develop institutional policies and improve communication with staff; compliance with legal and professional standards, including human rights, natural justice, and the *Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996* (N.Z.), 1996/78; respect for dignity and privacy; consumer support and communication during and after the restraint, including debriefing; staff training and competency assurance; an institutional approval process for various types of restraint, where residents, family, internal and external health providers, cultural advisors and specialist input when required, will consider education, competency and evaluation requirements for staff, indications for use, policies and procedures, monitoring and observation requirements, documentation, evaluation and review frequency and maintenance frequency (for equipment); monitoring during restraint use including the provision of food and nourishment, personal hygiene and toileting, clothing, medications, exercise and activity and cultural safety; evaluation and review to ascertain whether an individual plan was followed, it was the least restrictive intervention, de-escalation techniques were tried, what impact the restraint had on the individual, family and staff and that adequate support was provided; quality review of restraint use at six-month intervals; and specific requirements for the use of seclusion under MH(CAT), *ibid.*
 29. Section 9 of the *Health and Disability Services (Safety) Act 2001* (N.Z.), 2001/93 requires that all health care services (hospital care, residential disability care and rest home care) must (among other requirements) meet all relevant service standards. The *Health and Disability Services (Safety) Hospital Care, Residential Disability Care and Rest Home Care Standards Notice 2002* (N.Z.), 2002/24 approved the *Restraint Minimization Standard*, *ibid.* Existing facilities have two years to comply with the standard from 1 October 2002. External auditors will audit each facility for compliance at approximately two yearly intervals. If they do not comply with the standards they may lose their license.
 30. Nigel Eastman & Jill Peay, "Law Without Enforcement: Theory and Practice" in Nigel Eastman & Jill Peay, eds., *Law Without Enforcement: Integrating Mental Health and Justice* (Oxford & Portland, Ore.: Hart publishing, 1999) 1 at 25.
 31. Peter Barham & Marian Barnes, "The Citizen as a Mental Patient" in *Law Without Enforcement*, *ibid.*, 133 at 144.
 32. Ignatieff, *supra* note 2 at 39.
 33. Kazin, *supra* note 1.