HISTORIA DE LA UTILIZACION DE MEDIDAS COERCITIVAS EN LA ATENCIÓN PSIQUIATRICA EN CANADÁ DURANTE LOS PERIODOS DE PRE INTITUCIONALES E INSTITUCIONALES

Melodie Beryl Hull[1]

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RESUMEN:

Este artículo presenta una visión histórica de la utilización de medidas coercitivas como medio para controlar actuar y la violencia en las instituciones psiquiátricas en los períodos pre - institucionales e institucionales de atención de salud mental en Canadá, (mediados de los años 1800s - 1970s). Se explorarán las prácticas y los resultados que incluían la reclusión, la hidroterapia, quirúrgico, químico y restricciones físicas. Los tratamientos considerados eficaces durante el período también tuvieron efectos adversos, pero lo más importante que se utilizaron de manera coercitiva contra los pacientes. La evidencia será proporcionada para apoyar esto. El advenimiento de la aplicación de la psicología en el siglo XX a la práctica clínica y la introducción de la enseñanza de enfermería psiquiátrica será discutido brevemente en relación con el tema. Por último, el artículo hablará brevemente de las tendencias y prácticas actuales en la atención de salud mental tomando nota de la reducción significativa en el uso de medidas coercitivas en el período post- institucional.

Palabras claves: Canadá, las medidas coercitivas, enfermos mentales, institucionales, de la historia.

A HISTORY OF THE USE OF COERCIVE MEASURES IN PSYCHIATRIC CARE IN CANADA DURING THE PRE- AND INSTITUTIONAL PERIODS

ABSTRACT

This article will present an historical overview of the use of coercive measures as a means to control acting out and violence in psychiatric settings in the pre-institutional and institutional periods of mental health care in Canada, (mid-1800s- 1970s). It will explore practices and outcomes that included seclusion, hydrotherapy, surgical, chemical and physical restraints. Therapies considered effective during the period also had adverse effects, but more importantly they were used in a coercive manner against patients. Evidence will be provided to support this. The advent of 20th Century psychology applied to the clinical setting and the introduction of psychiatric nursing education will be discussed briefly in relation to the subject. Finally, the article will speak briefly to current trends and practices in mental health care noting the significant reduction in the use of coercive measures in the post-institutional period.

Keywords: Canada, mentally ill, coercive measures, institutional, history.

[1] RPN, MSC, MED, Nursing Faculty - College of the Rockies and Thompson Rivers University , Cranbrook, BC, Canada.

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INTRODUCCIÓN

This article will begin with a brief overview of Canada's history to set the context. Subsequently an examination of mental health care from the time of pre-institutional to institutional care will be undertaken focussing primarily on coercive measures used to manage aggression or violent acting out by patients with mentally illness or cognitive deficits. To that end, the author approaches the subject by defining coercion as any act undertaken by another or others against the free will of the recipient to either victimize or control. Coercive measures can include threats or actions[1].The article will include identification of some of the historical influences of medical science, clinical psychology and pharmacology on coercive practices. Finally, the article will speak briefly to current trends and practices in mental health care noting the significant reduction in the use of coercive measures in the post-institutional period.

The Context: A Brief History of Canada

Although its lands have been inhabited for millennia, Canada as a country is young. First Nations (aboriginal peoples) have been on the land for at least 10,000 years. The country's first known non-native settlers are confirmed as Scandinavian Vikings in the 15th or 16th centuries however they did not settle permanently. The country itself did not begin to take shape until the arrival of European explorers, traders and settlers in the 16th century, specifically the French and English who brought with them their customs and institutions of government, health practices, education and so on.

The French first colonized Canada and called it New France in the 16th Century. The British arrived shortly thereafter. Following years of tension and warfare with the British troops, New France fell to them in 1759 and although this country recognizes these two founding nations as equal under the constitution (alongside our First Nations, Métis and Inuit people), British rule of law and society came into prominence. This then included the philosophical underpinnings of education for health providers and the provision of health and mental health care.[2] Canada became a Confederation of the British Commonwealth of Countries in 1867. Today Canada has it's own independent Constitution (1982) but chooses to remain a member of the British Commonwealth.

Mental Health Care in Canada

Historically, Canadians have cared for people with mentally illness and cognitively deficits in manners similar to those traditions of the country's founding peoples, the French and English. There have been 3 distinct periods of mental health care in Canada: pre-institutional (moral/humanitarian), institutional, and de-institutional. Initially, in both Canada and the USA, persons with these mental illnesses or disabilities (i.e.: mental or cognitive deficits) were cared for at home, by religious charities in large care homes (almshouses) or were jailed.[3,4] Late into the 19th century, the Canadian government took an interest and began to fund the construction of major psychiatric asylums and provide funding for patient care.[5] By the 20th Century, the institutional period had begun.[6,7]

Humanitarianism and Moral Therapy

Prior to the 1870s in Canada, humanitarian, philanthropic or religious groups believed the mentally ill or disabled both needed and had a right to humane care. They believed patients would thrive when given opportunities to develop moral and social behaviour. Canadian care incorporated the moral, humanitarian approach advocated by influential late-18th Century humanitarians such as William Tuke of England (1732 - 1822) and Philippe Pinel (1745 – 1826) of France. [2] The moral-humanitarian philosophy of care approach referred to those in care as patients (rather than inmates) and advocated strongly for the least restrictive; least coercive uses of force when working with them. The use of restraints and punishments used to control behaviour were considered inhumane and as a result of this new philosophy, the utilization of such methods were expected to lessen or disappear completely.

The original precepts of moral therapy included a belief that care should be provided in smaller, more home-like environments and that treatment should include opportunities to work, play and develop healthy interpersonal relationships.[8] Many of the charitable or church organizations constructed working farms for their residents, since work was deemed as moral and purposeful.3 However, once

the Canadian government got involved, moral therapy became a stanchion of institutional care and the environmental principle evolved from one of smaller, more interpersonal and therapeutic care to that of care in large institutions with strict routines, codes of conduct and an emphasis on conforming to norms.6 While the intent was humanitarian, as institutions grew in size and the population of residents within increased, the goals of moral therapy attainable.[7]

The humanitarian approach was intended as the end of the use of physical restraints for the mentally ill or deficient patient. The approach failed.[5] Despite the best efforts towards stabilization and rehabilitation, incidents of aggression and violence prevailed and coercive measures used in Canada to control and calm acting out or aggressive patients included use of straitjackets, wristlets (cloth or leather cuffs), leather mitts and removing people's clothing: full nudity.9 In some institutions, crib beds (beds enclosed by bars like a cage) were used for exceedingly unmanageable behaviour. Restraint chairs or restraining patients in chairs remained a popular therapeutic intervention throughout the era. Seclusion, isolation or strong rooms also began to appear in mental health asylums. Each and every one of these coercive measures were designed to get patients to calm down in a less stimulating environment and comply with the wishes and demands of the staff. Custodial care meant less concern about any rehabilitative goals or humanitarian needs for care and comfort.

The Period of Institutionalism

Although asylums for the insane appeared in Canada prior to the 20th Century, the actual period of institutionalism on a grand scale began in the late 1800s/early 1900s and carried through to the 1960s.[2,3,5] The principle behind their construction was that patients could be more safely and humanely housed and treated in this setting.[3]

Institutionalism grew out of the moral/humanitarian period and the concepts that patients would improve their lives and behaviours when given access to safe, clean, bright living environments.[5] Additionally patients would be allowed some autonomy: unfettered, they could roam about the asylum grounds rather than be kept indoors continuously. The early supposition that institutions could deliver this caring approach was short lived. Eventually, the humanitarian/moral approach to treatment gave way to medical science,5 somatic treatments and developments in psychiatry.[6]

By the turn of the 20th Century medical science increasingly concerned itself with the possibilities of inherited or congenital etiology for mental illnesses and cognitive deficiencies.[2] Research also began to identify brain damage, brain abnormalities as well as disease processes as causative for mental illnesses. And while medical science and research provided some positive direction for the care and treatment of patients in the institutions, they also had a long lasting detrimental effect. Theories such as determinism arose that legitimized a sense of no need for treatment or hope an improved quality of life were simply not to be expected of some patients. In other words, these people's fate was pre-determined and they would always be insane or mentally defective. Since the expectation was that the patient was not capable of insight or ability to learn, they could be treated differently from those society deemed normal.[10] Coercive measures were not seen as inappropriate to control this institutionalized population. Such methods were often punitive and abusive in nature. For example, inappropriate, unacceptable, aggressive, violent or otherwise noncompliant behaviours would be punished with measures such as forced cold shower or spinning (long periods restrained in a chair and spun).[3]

Meertens[10] cites the eugenics movement as a good example of the negative influence of medicine and social psychiatry on the care of the mentally ill or deficient. McLaren11 provides the specific Canadian example she is referring to when he reports on a clearly coercive act (referred to then as a treatment) based on the theory of eugenics. This was the government sanctioned legal sterilization of the cognitively impaired (mentally deficient) to prevent their procreation. Research in psychology also contributed to this. For example, the intelligence quotient test for children, a diagnostic tool developed by French psychologists, Alfred Binet and Théodore Simon circa 1910.[12] While there both helped children and harmed them. Intelligence testing swept the nation and it led to many young people and adults being placed in Canadian institutions based on IQ levels (intelligence quotients). Positively, this led to the separation of those with cognitive deficits into

separate institutions from the mentally ill.12Adversely, individuals with low IQs were institutionalized and legally and publicly referred to as idiots, imbeciles and lunatics. These individuals often spent their entire life in the institution with little expectation of release.

While the institutions housing the cognitively impaired (mentally deficient) tried to incorporate a philosophy of moral therapy (occupational, recreational therapies and social activities to keep the mentally disabled purposefully and fruitfully engaged), these institutions too soon succumbed to problems over-crowding just as the mental institutions were facing.[12] Therapy in both types of institutions soon gave way to custodial care and behaviour management.[3,5,13,14] Coercive measures to control idle or acting out residents could include very cold showers or very hot, scalding baths, shackling, hitting, being stripped naked for long periods, extended periods of isolation.15 Additionally, coercive measures helped manage the effects of overcrowding, poor environmental and social conditions, and the impact these environmental factors had on the resident patients. So-called somatic therapies such as seclusion, chemical and physical restraints became common practices in an attempt to keep a sense of harmony and safety in the institutions. No regard was given to the contributing factors leading to increased incidents of acting out and aggression. Some examples follow.

Somatic Therapies

Hydrotherapy- from treatment to coercive measure

Originally intended as a helpful treatment to calm agitated, aggressive, manic and psychotic patients, hydrotherapy was a common treatment modality in Canada for the mentally ill and deficient from the late 19th Century through to the mid-20th Century.[9] The belief that exposure to or immersion in water at various temperatures would bring about positive therapeutic effects was paired with the perceived need to control and punish acting out behaviours. For example, the application of cold water was thought to constrict the blood vessels to the brain, thus reducing the blood flow which in return lessened cranial pressure which then was seen to reduce mental and physical activity. In other words, the patient would de-escalate.

Hydrotherapy was coercive.[16] No consent was sought or given. The practice involved subjecting a patient to a forced cold water shower or cold water, pressurized spray or the patient could be restrained in long, continuous warm baths. An agitated or non-compliant patient could be forcefully strapped into a chair and a hospital staff member would stand high above him or her. In its earliest days, the staff would drop pails of either cold or warm water over the patient creating a shocking, shower-like effect. As the treatment session continued, the hyper-aroused patient would eventually move into a state of physical and mental exhaustion and the acting out behaviour would be extinguished. With the advent of more modern showers in the institutions, this procedure could be carried out in an actual shower. Today in retrospect, the use of these 'therapeutic' forced showers can clearly be seen as non-therapeutic: stress-invoking, frightening and even traumatizing.

Cold wet-sheet packs were also a form of hydrotherapy. This intervention was implemented primarily to reduce agitation, aggression and/or anxiety. Sheet pack temperatures ranged from 9°C to 21°C. The therapy involved wrapping a naked patient in a wet-sheet pack and then covering him or her with a blanket. If the patient resisted, he/she would be restrained for this lengthy treatment.[16]

Electroconvulsive therapy (ECT) - from treatment to coercive measure

Electroconvulsive therapy was a treatment thought to safely and effectively treat schizophrenia, depression and extreme mania.[17]The treatment was frequently used from the 1940s through the 1960s in Canada18 when it was replaced at least temporarily by the advent of psychotropic medications as the treatment of choice. In those early days however, ECT was also used with another intention - one that it was not specifically designed for, behaviour control. ECT was used to treat the hostile, aggressive, patients as well. There was no scientific evidence to support its use in this manner nor is there evidence for its use under the circumstances of violence today. Many institutions did not require patient consent for ECT treatment in Canada and if they did, and the patient seemed to refuse treatment, they would be deemed involuntary and the treatment would proceed without consent.19 Today in Canada, electroconvulsive therapy is quite widely used but with strict guidelines, required

consents, protocols and it is used with very select patients.[18] Today, ECT can be done in hospital or in out-patient departments of hospitals for the treatment and maintenance of persons suffering from hard-to-treat depression.

Surgical Restraints - from treatment to coercive measure

Lobotomies were not uncommon from the late- 1940s into the early 1960s in Canada at which time they were replaced with psychotropic medications and newer therapies arising from clinical psychology. Simmons[20] identified how this surgical procedure was hugely abused, identifying how it was often used coercively - for experimentation, to remedy over-crowding; shortages of staff; to deal with non-compliant aggressive and hostile patients. Frontal lobotomies were considered effective in the treatment of aggression and indeed, those who had this treatment performed were often passive, dull and had difficulty learning. This method of restraint was given without patient consent.

Behavioural Therapies

Physical, Mechanical Restraints and Seclusion - from treatment to coercive measure.The use of physical restraint has been historic in psychiatric care. Traditionally, men were employment in the mental institutions in Canada than women.[21]This may simply be by fact they were needed to assist in dealing with unruly, violent or aggressive patients. Historically, male staff (including male psychiatric nurses) would be called to critical incidents such as these. The staff would attend with the intention of restraining the patient and then removing them to a seclusion room or the baths. In the early days of the mental institutions, this process required little training nor moral judgment and the processes of restraint and seclusion could be rough for both patients and staff. With the development of newer medications and least restrictive restraint policies the need for burley male staff has lessened, and today males are working with the mentally ill as professionally qualified psychiatric nurses.[21]

Physical, Mechanical Restraints - from treatment to coercive measure

Mechanical restraints in institutions included straitjackets, strong sheets, leather belts or straps that cuff around each ankle and wrist, abdominal belts, mittens strapped on at the wrist, and restraining chairs. With the exception of straitjackets, modern version of these types of mechanical restraints can still be seen in the few institutions left in Canada as well as in some acute care health settings (both medical and/or mental health).

Seclusion and Physical Restraint - from treatment to coercive measure

Sound dampening rooms, opened only from the outside, were used for seclusion. These could be cold and completely void of furniture. Some offered a special mattress or canvas sheet (strong sheet) that could not be destroyed by the patient. Often patients were stripped naked to spend their time in seclusion. Sometimes aggressive patients would be restrained in chairs with the use of straps around their wrists and ankles. The rooms were often dark. This manner of removing the patient from a stimulating environment into a non-stimulating environment could be interpreted as a method of behaviour management. This practice changed with the advent of new philosophies for patient care.

The Advent and Influence of Applied Psychology in the Institutional Period

In Canada, the explosive growth of applied psychology in the early to mid-20th century eventually reached the institutions. This included intelligence testing, behaviourism and the beginnings of psychotherapy. Principles of behaviourism and behaviour therapy were common.

Behaviourism in clinical practice - from treatment to coercive measure

Behaviourism is the study of observable behaviour and the belief it can be explained as a learned phenomenon. Theoretical approaches to behaviour management developed from in the 1920s

but these did not find their way into Canadian mental institutions in any meaningful way until almost 20 years later. Treatment methods focussed on intervening to either support or interrupt a learned response to maintain or extinguish behaviours.

McCallum[15] in her report on the care of the cognitively disabled shows how even its earliest uses, behaviour modification was frequently used to coerce patients into doing what the staff wished them to do. A system of rewards and punishments would be used. Non-compliant, aggressive, violent, acting out patients could be penalized by long periods of seclusion, physical restraint, and the use of cold showers. Behaviour modification in the institutions circa 1940 - 1970 found an accord with the concept of determinism. McCallum[15] cites evidence that patients who were thought unable to learn and to behave in appropriate ways were more likely to be treated with negative consequences for their actions and very often given no rewards or incentives to change. She reports how the intended therapeutic intervention of behaviour modification became punitive and controlling.[15]

Elements and principles of behaviour therapy are still seen today in non-institutional settings such as group homes for the mentally ill or cognitively impaired. Canadian psychiatric nurses are all familiar with the original and now, the advanced tenets of this approach and clearly aware of its need to be situated in the appropriate context with the appropriate client. For example, behaviour modification programs are still in effect in some manner on acute care psychiatric units, group homes for patients with intellectual or cognitive deficits, and with special needs children at home or in educational settings.[22]In these cases, a reward system is used as reinforcement with compliance with treatment or evidence of progress (i.e., demonstration of self-control). Punishment is not used. Withdrawal of privileges is used to encourage behaviour modification and self-control.[22]

Hydrotherapy and behaviourism combined - from treatment to coercive measure

As a more behaviourist-approach to the therapeutic use of hydrotherapy emerged, aggressive patients were no longer simply given cold showers. Instead, they were placed for prolonged periods in baths. Warm continuous baths were used to treat patients considered to be suicidal and/or assaultive. The therapeutic goal was to calm excited and agitated behaviour. Continuous baths were the most effective when held in a quiet room with little light or sound stimulation, thus allowing the patient to relax and possibly even fall asleep. A patient could expect a continuous bath treatment to last from several hours, over night or several days.15 Bath temperatures typically ranged from 33-36° Celsius so as not to cause injury to the patients however, this was not always the case. More recent inquiries into the care and treatment of, for example, the cognitively impaired in Canada attest to incidents of scalding of the patients in these types of baths.15 Once in the tub, wet sheet packs (sheets dipped in varying temperatures of water) were wrapped around the patient for several hours, cocooning him or her in almost a womb-like state. Hydrotherapy is no longer in use in mental health care in Canada.

The Advent of Psychotropic Medications in the Institutional Period

The introduction of psychotropic medications mid-20th Century in Canada led to many changes in the way patients were cared for in institutions for the mentally ill or deficient. This was particularly so by the 1970s when research began to explore neurotransmitters and new medications were developed. As therapeutic as they are, psychotropic, neuroleptic drugs can and have been used coercively to control behaviour. For example, forcing patients to take their medications is a coercive act in itself even when the use of medications is part of a comprehensive, multi-faceted treatment plan.

Chemical Restraints - from treatment to coercive measure

The term 'chemical restraint' refers to the use of medication to restrain acting out or aggressive behaviour. Chemical restraints are used in behavioural emergencies.[23] Mood altering medications even today can be used to control behaviours when patients are at risk for self-harm or harming others. They can have a positive, settling effect. In the past however, they were often used to deal with negative behaviours stemming of situations of over-crowding, lack of choice and free will, and failure to comply with not

only treatment but with directions given by staff. There is now evidence that the use (or misuse) of medications to restrain patients for convenience or control rather than therapy is not only unethical but can lead to injuries amongst staff and of the patient. Emanuel, Taylor et al.23 identify risk involved with their use as seizures, cardiovascular crisis, respiratory distress and so forth.

From Institutionalization to Deinstitutionalization

Deinstitutionalization is an abstract construct; a philosophical approach adopted in Canada and elsewhere around the 1960s and finally realized here by the end of the 20th Century/early 21st Century.[2,13,55] Overtime, deinstitutionalization became a social movement that eventually shifted care from psychiatric institutions to new psychiatric units in general hospitals. The movement also led to increasing research. Evidence surfaced that institutionalization of the mentally ill or those with cognitive deficits was non-therapeutic and isolating.24 Numerous accounts of abuse and coercion were found across the country. [2,15] Evidence of the use of coercion to control patients ,surgical experimentation on patients, lack of effective treatments, poorly run, poorly staffed and equipped institutions and over-crowding became public knowledge.6 Through this, Canadians became aware of the negative impact on a person's quality of life and opportunity for self-determination resulting from periods of long term institutionalized care.2 This included a diminishing of social skills and abilities, acts of aggression and the development of an authoritarian and sometimes adversarial relationship that pitted staff against patients.2 This gave strong impetus to find alternative means of caring for these patients that could and would replace the large institutions. Deinstitutionalization was also influenced positively by major developments in clinical psychology and the advent of psychotropic, psychiatric medications.6 The 1980s and 1990s in Canada saw the move of psychiatric care not only to general hospitals in Canada but to primary care situations with a health promotion and health maintenance approach. The target population(s) were able to be cared for through community mental health clinics and care teams, and to reside in community group home settings. Psychiatric nurses were situated at each and every juncture to promote independence and wellness. Large mental institutions are now all but obsolete in Canada.

A Note about the Development of Psychiatric Nursing Education and Professionalization in Canada

Psychiatric nursing education began in Canada in the early 1920s and in the beginning was predominately the purview of women. Their contributions to care led to improvements in care for the mentally ill and deficient in slow increments. It was not until they began to demand adequate educational preparation and strove to become professionals that greater improvements in psychiatric/mental health care became apparent.21 Psychiatric nurses in Canada are found in 2 groups of nursing. There is an educational and regulatory stream for Registered Psychiatric Nurses in Western Canada while the rest of Canada there is another stream for generalist Registered Nurses. For RNs their is a professional suggestion (but not yet a requirement) advanced training in psychiatric/mental health nursing.25 Registered psychiatric nurses (RPNs) are a proud and independent profession, dedicated to the care and advocacy of all persons with mental health, psychiatric and addiction needs.[21,26] They combine many of the aspects of medicine and general nursing with a predominant focus on mental health in their baccalaureate education.

As psychiatric nursing advanced and the period of institutionalism declined, the profession has had more and more influence over care and treatment and the use of coercive measures with this client population has decreased significantly. The nurses' knowledge of nursing, medicine, psychiatry, psychology, sociology and so forth all combine to produce best practices in non-violent crisis intervention and place high ethical standards on the use of the least restrictive, non-coercive measures of care in all situations.[23,27]

Summary

This article has provided an overview of the historical use of coercive measures in care in Canada during the pre- and institutional periods of mental health care. Coercion was defined and applied in the context of care for the mentally ill or cognitively impaired. Examples were provided and evidence cited to support key points. the period of

deinstitutionalization, the professionalization of psychiatric nursing and the decrease in use of coercive measures were introduced.

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