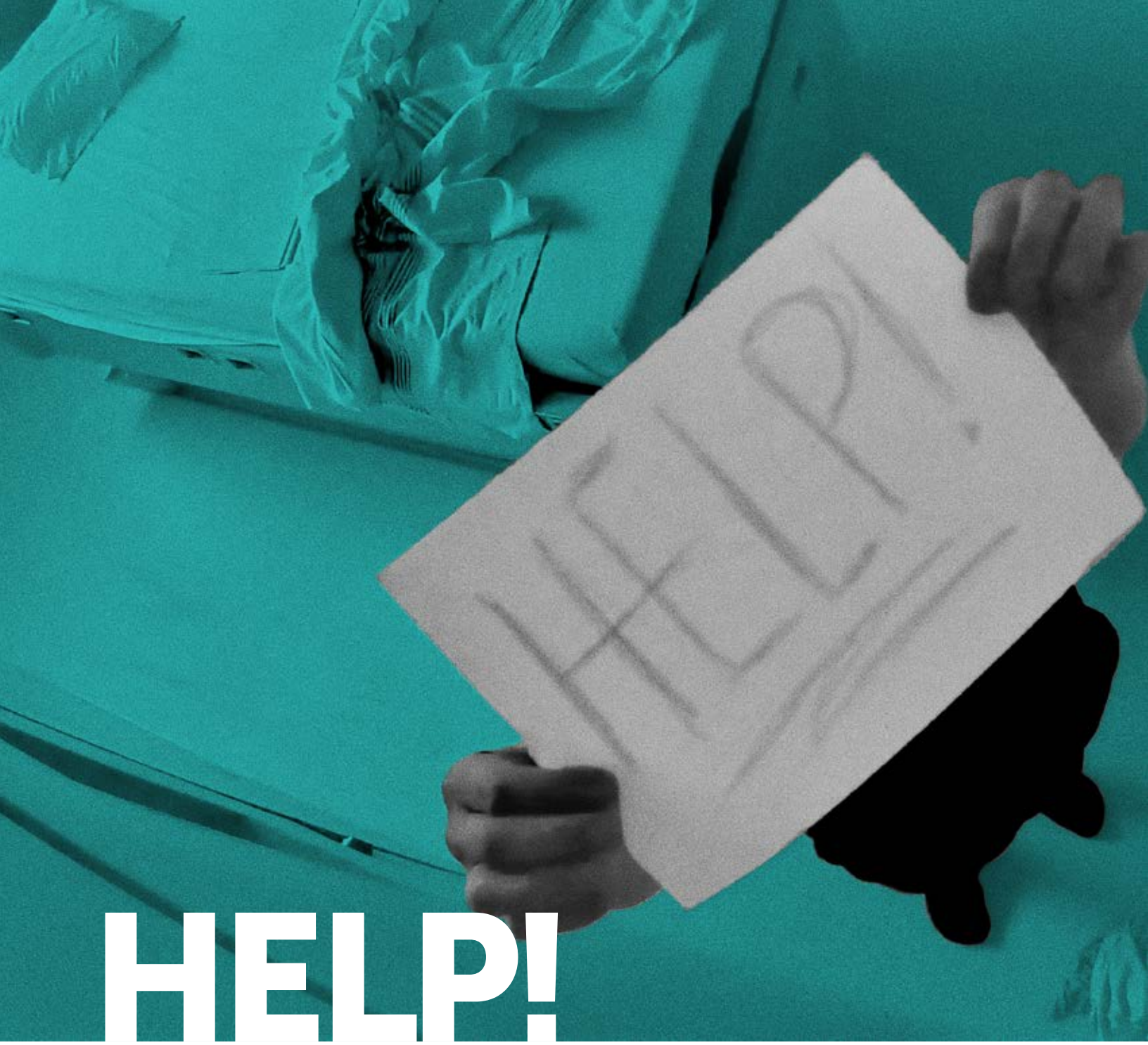

HELP!

A special investigation into the use of restraints in adult psychiatric facilities in New Brunswick

ombud

NEW BRUNSWICK • NOUVEAU-BRUNSWICK

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A CAUTION TO READERS

This report examines the use of restraints in adult psychiatric facilities. The situations described may be upsetting for some people. For those who have received psychiatric treatment, or their families and friends, the content of this report may evoke memories of traumatic personal experiences or those of loved ones.

If you or someone you know requires support, please reach out to any of the following services:

> If you are struggling and need someone to talk to, help is available 24/7. Call the free **New Brunswick Addiction and Mental Health Helpline** at 1 866-355-5550.
>
> **211 New Brunswick** provides programs and community services. Service is available by phone at 2-1-1, toll free 1 855-258-4126, toll free text based line 1 855-405-7446, email 211nb@findhelp.ca, or online through **https://nb.211.ca/search/**
>
> **9-8-8 Suicide Crisis Helpline** is a safe space to talk, 24 hours a day, every day of the year if you are thinking about suicide, or if you are worried about someone else. Call or text 9-8-8, or go online to **https://988.ca**.
>
> **Hope for Wellness Helpline**: Indigenous people who require support can also contact the Hope for Wellness Help Line and On-line Counselling Service. The service is available by phone at 1 855-242-3310 (toll-free) or online through **https://www.hopeforwellness.ca/**.

ACKNOWLEDGMENTS

The Office of the Ombud wishes to acknowledge the patients who are and have been under the care of psychiatric facilities in New Brunswick, especially those who have experienced the use of restraints. We thank those who were able to share their stories and hope that their experiences will contribute to long-term systemic changes to prevent psychological or physical harm caused by seclusion and other forms of restraints.

We also acknowledge the front-line staff who care for patients in psychiatric settings, as well as the managers and directors of these facilities. The issues raised in this report are aimed at structural and system deficiencies and should not be construed as minimizing their hard work and commitment. We recognize that working in this particular care environment is challenging and demanding. We thank the Vitalité Health Network, the Horizon Health Network and their psychiatric facilities and units, as well as the departments of Health, and Social Development for their full co-operation during the investigation and for their responsiveness to this report.

Thank you to the entire staff of the Office of the Ombud for their continued dedication to fairness, transparency and accountability in the public sector. And special thanks to the investigation team for their tireless efforts in bringing this investigation to fruition, namely: Jessica Guérette – Director, Investigations; Christine LeBlanc – Senior Investigator; and Stéphanie Caron – Senior Investigator.

MESSAGE FROM THE OMBUD

This report is the culmination of an investigation into the use of restraints in psychiatric facilities in New Brunswick. It was initiated following complaints from or on behalf of patients in one of those facilities. Knowing about the experiences of these patients led me to want to examine practices in other psychiatric facilities, especially knowing that not all patients are able to speak for themselves or have anyone to speak on their behalf.

My office's investigation team has had numerous discussions with the patients or their family members who contacted us. We've collected and reviewed thousands of pages of documents, notes, and patient files as well as approximately 950 hours of video footage. We've held more than 80 meetings with officials from psychiatric facilities, health networks and government departments over the course of the investigation. We visited every psychiatric unit in the province where we heard from staff first-hand about some of their day-to-day challenges. This, combined with careful consideration of all the information at our disposal, has contributed to the findings and recommendations outlined in this report.

I have personally been troubled and saddened by the treatment and living conditions that some of these patients suffered through. In reflecting on everything that I have witnessed, I cannot arrive at one unique point of failure. This is not simply the failure of a particular facility, or of a handful of employees, or management, or workplace culture. This is not the failure of a lack of policy and legislation, or the failure of legal systems and protections. This is not the failure of geography, or the pandemic, or of political or institutional leadership decisions past and present.

This is a failure that results from an entire system that is under pressure. It is also the failure of a society where those who suffer from severe mental illnesses continue to be stigmatized, marginalized and misunderstood.

The recommendations contained in this report are aimed at tackling some of the systemic changes that are required to do better by these individuals.

Any person who finds themselves in a psychiatric facility is someone's child, sibling, parent, family member, partner, or friend. Any one of us could be one traumatic experience away from finding ourselves in need of care in one of these facilities. I am grateful for the generosity and bravery demonstrated by the patients who shared their stories, and for their families who advocated for them. These patients deserve more than my, or anyone else's, indignation. They deserve meaningful action. They deserve true and lasting change.

Marie-France Pelletier
Ombud for New Brunswick

SUMMARY

An investigation into the use of seclusion and physical restraints in psychiatric facilities in New Brunswick was launched following complaints made to the Office of the Ombud. Between February 2021 and October 2023, the Office received 12 complaints from 11 patients or their family members. All complaints received emanated from one facility, the Restigouche Hospital Centre (RHC). The patients involved are from all walks of life and from every corner of the province. Some were sent to the RHC for a legal/forensic evaluation related to a criminal trial, others have lived at the RHC for many years.

This report details first-hand accounts of the care and treatment these individuals received. The Office is aware that some of the incidents reviewed through this investigation have led to disciplinary measures, including termination.

In January 2023, the investigation was expanded to review the use of restraint in all psychiatric facilities and units across the province. In July 2023 and June 2024, the Department of Health and the Department of Social Development were included in this investigation to explore certain aspects related to psychiatric care and reintegration of patients in the community.

The investigation resulted in 12 key findings stemming from the complaints involving the Restigouche Hospital Centre, and an additional 8 key findings regarding the use of restraints and other issues impacting psychiatric care in New Brunswick.

In relation to the complaints involving the Restigouche Hospital Centre, the Ombud found that:

- Patients spent extended periods of time in restraints.
- There was a lack of guidance to staff about when to remove the restraints.
- There was an inadequate use of de-escalation techniques to avoid having to use restraints.
- Inadequate use of force techniques were used.
- Some restraints orders were insufficiently documented in patient files.
- The assessment and monitoring of patients while in restraints was insufficient and not in accordance with policy.
- There were no effective means for patients in restraints to ask for assistance.
- Patients in seclusion rooms became disoriented to time.
- Patients were left in poor sanitary conditions in seclusion rooms.
- Some patients had difficulty eating their meals while in restraints.
- Incident reports were inconsistent at times with what was observed on video footage.
- There was a lack of opportunities for community re-integration of long-term patients.

SUMMARY

In relation to the use of restraints in psychiatric settings, the Ombud found that:

- Both the Vitalité Health Network and the Horizon Health Network have restraints policies in place, with some noted similarities and discrepancies.
- Neither Regional Health Authority has a system in place to monitor the use of restraints in any of their facilities.
- The ability for patients in restraints to communicate with staff varies across facilities.
- The availability and functionality of seclusion rooms, as well as video surveillance capacity varied across facilities.

The investigation also revealed other issues impacting the quality of care in psychiatric settings in the province. The Ombud found that:

- The infrastructure and physical design of some psychiatric units, including recreational areas and security features on the units, are not as functional as others.
- Some facilities do not have dedicated spaces for patients who are minors.
- The availability of specialized staff and health professionals poses a challenge.
- There are delays in community placements and a scarcity of housing options for patients ready to re-integrate into the community.

In keeping with these findings, the Ombud is bringing forward 21 recommendations across seven categories dealing with: **law reform; policy reform; care practices; monitoring and compliance; training; infrastructure;** and **system-wide collaboration.**

LAW REFORM

The Ombud recommends that the *Mental Health Act* be amended to reinforce the goal of minimizing the use of restraints; and to include requirements to measure, document, monitor and report on the use of restraints involving psychiatric patients.

POLICY REFORM

The Ombud recommends that several policies (Restraints, Use of force, Use of spit hoods, code white/patient incident reporting) be reviewed and updated to provide clear guidance, standards, and expectations to personnel related to the care of psychiatric patients.

CARE PRACTICES

The Ombud recommends collaboration between Regional Health Authorities and care providers to explore best practices that favour therapeutic approaches to aid in minimizing the use of restraints and the use of force involving psychiatric patients.

MONITORING AND COMPLIANCE

The Ombud recommends the implementation of a monitoring system for patients in restraints in all psychiatric units and facilities, assorted with a permanent internal audit mechanism to review instances where patients have been placed in environmental or physical restraints.

TRAINING

The Ombud recommends mandatory annual training courses on the standards of care for the use, application and monitoring of restraints; as well as on use of force and de-escalation best practices and techniques.

INFRASTRUCTURE AND EQUIPMENT

The Ombud recommends the development of a comprehensive infrastructure plan for the province's psychiatric units and facilities. More specifically, the Ombud recommends essential equipment for seclusion rooms, such as a reliable mechanism for patients to communicate with staff; surveillance cameras in common areas and seclusion rooms with protocols on the use, access, retention, and disposal of video surveillance footage. The Ombud also recommends that clear protocols and guidelines be developed to address situations where youth must be admitted to adult psychiatric units.

SYSTEM-WIDE COLLABORATION

The Ombud recommends continued collaboration for:

- The recruitment and retention of specialized personnel for the province's psychiatric care needs.
- Enhancing timely community placements and supports for patients who are ready to re-integrate into the community, including a task force to address systemic barriers, and gradual placements (step-down model) for certain patients.
- The establishment of a comprehensive consultation mechanism to take stock of the mental health care system in the province and find a path to address the issues identified.

The Ombud will be monitoring progress on the implementation of her recommendations and issuing monitoring reports.

INTRODUCTION

This investigation report was prepared in three parts. The first provides an overview of the individual complaints the Office of the Ombud received about the use of restraints at a psychiatric treatment facility, the Restigouche Hospital Centre, from February 2021 to October 2023. The second part of this report examines the practices surrounding the use of restraints in all psychiatric facilities or units in New Brunswick. It also identifies some of the other issues that have had an impact on psychiatric care in the province. Finally, the third part of the report outlines the recommendations to address deficiencies and reinforce best practices to frame the use of restraints and sustain psychiatric care in the province.

To assist the reader, the following information provides context that will be useful as you read this report. A full list of terms is available in the glossary at the end of the report.

What is a restraint?

Though there are various types of restraints that may be used in psychiatric settings, this report has only examined the use of environmental and physical/ mechanical restraints.

ENVIRONMENTAL RESTRAINT

> *"Any obstacle or device that limits a patient's mobility, thereby confining him or her to a specific geographic area or location (e.g., half door)."* [1]

In this investigation, the only environmental restraints encountered were seclusion rooms, which is the term used throughout this report.

PHYSICAL RESTRAINT

> *"Physical or mechanical means or methods that stop or restrict voluntary capacity for mobilization of the entire or part of the body."*
>
> - *Total physical restraints (e.g., wrists, ankles, and abdomen)*
> - *Partial physical restraints (e.g., wrists or ankles or abdomen or chair with table and/or belt)."* [2]

In this report, the terms "restraints" or "physical restraints" are used to describe the equipment that restricts parts of the body such as the wrists, ankles, or abdomen. The term five-point restraints describes someone who is in total physical restraints (both wrists, both ankles and abdomen restrained with the equipment). Similarly, the terms three-point or four-point restraints describe partial physical restraints (where three or four parts of the body have been restrained).

1 As defined in the 2017 Vitalité Health Network Policy N°: GEN.3.80.15 Restraints.
2 Ibid

Overview of psychiatric services in New Brunswick

REGIONAL SERVICES

Psychiatric treatment services are available throughout the province at eight different hospitals in both regional health networks.

These hospitals have psychiatric units that provide adult acute (short-term) psychiatry in-patient care.

REGIONAL PSYCHIATRIC CARE IN NEW BRUNSWICK		
	Vitalité Health Network *Information as of March 31, 2025*	**Horizon Health Network** *Information as of July 30, 2025*
Hospitals with psychiatric treatment facilities	4[3]	4[4]
Psychiatric treatment beds occupied / total beds available	46/75	68/81
Patients awaiting community placement	12	18
Psychiatric patients considered to lack capacity or undergoing assessment	7 *(as of August 7, 2025)*	7

SPECIALIZED TERTIARY SERVICES

The **Restigouche Hospital Centre (RHC)** is located in Campbellton and is operated as part of the Vitalité Health Network. It is the only facility of its kind in New Brunswick and its specialized mental health services are offered to the entire province. It provides specialized medium- and long-term psychiatric rehabilitation services; consultation and stabilization for those suffering from complex psychiatric problems or other related illnesses; forensic psychiatry (assessment of fitness to stand trial and criminal responsibility); and care for those who have been found not criminally responsible because of mental disorders or who are not fit to stand trial.[5]

Centracare is located in Saint John and is operated as part of the Horizon Health Network. It provides specialized treatment and rehabilitative services for individuals with difficult to manage psychiatric challenges that are of medium or long-term duration.[6]

3 Edmundston Regional Hospital, Campbellton Regional Hospital, Chaleur Regional Hospital, Dr. G.-L. Dumont University Hospital Centre
4 Miramichi Regional Hospital, The Moncton Hospital, Saint John Regional Hospital, Dr. Everett Chalmers Hospital
5 https://vitalitenb.ca/en/services-and-locations/find-a-point-of-service/restigouche-hospital-centre
6 https://horizonnb.ca/services/addictions-mental-health/adult-services/centracare-2/

SPECIALIZED TERTIARY PSYCHIATRIC CARE IN NEW BRUNSWICK		
	Restigouche Hospital Centre *Information as of March 31, 2025*	**Centracare** *Information as of July 23, 2025*
Psychiatric treatment beds occupied / total beds available	82/100	25/28
Patients awaiting community placement	26	12
Psychiatric patients considered to lack capacity or undergoing assessment	21	24

PART I

COMPLAINTS INVOLVING THE USE OF RESTRAINTS AT THE RESTIGOUCHE HOSPITAL CENTRE

Context

From February to May 2021, the Office received three complaints from individuals or their family members in which they alleged poor treatment, health or living conditions while placed in a seclusion room and/or other restraints at the RHC. This prompted the previous Ombud to undertake an investigation into these complaints in May 2021. During the investigation, the Office received nine additional complaints from eight individuals from September 2021 to October 2023. In June 2022, the current Ombud expanded the investigation to include all the additional complaints received involving the use of restraints at the RHC.

RHC UNITS AND HOW THEY FUNCTION

To assist the reader, it is useful to note that the RHC has a current capacity of 100 beds to provide specialized psychiatric tertiary services for the province. The RHC is organized in five different care units, each with its own specialization.

Most of the complaints investigated involved patients who were housed in unit F1 or D1 during the incidents in question. Two patients were housed in units B2 and C1, and another was in unit D2.

DESCRIPTION OF RESTIGOUCHE HOSPITAL CENTRE UNITS

Unit	Capacity	Specialization
F1	20 beds	Legal/Forensic Psychiatry (Evaluations): Court-ordered assessments[7] to determine if an accused is fit to stand trial are conducted in this unit.
D1	20 beds	Legal/Forensic Psychiatry (Stabilization): Patients in this unit have been deemed not criminally responsible and unfit to stand trial. The Review Board (Board)[8] can order treatment and will assess if a patient can be discharged with or without conditions. The Board can also decide to detain a patient at the hospital for further treatment until they determine that a patient no longer poses a risk to public safety. If a patient breaches their conditions, they would return to this unit for stabilization.

7 Evaluations under subsection 16(1) of the *Criminal Code*.
8 "Review Board" refers to a board appointed under section 30 of the *Mental Health Act*, C. M-10

DESCRIPTION OF RESTIGOUCHE HOSPITAL CENTRE UNITS		
Unit	**Capacity**	**Specialization**
D2	20 beds	Legal/Forensic Psychiatry (Rehabilitation): Patients in this unit receive medical and therapeutic treatment based on their needs. Patients have access to more privileges approved by the Board. The goal is to rehabilitate patients and transfer them into the B2 unit so planning can begin for the patients to be reintegrated into the community.
B2	20 beds	Community Reintegration: The patients in this unit continue to receive treatment and are supported as they adapt to an environment that prepares them for a community reintegration.
C1	20 beds	Tertiary Psychiatric Care – Continuous Rehabilitation: Patients who have complex psychiatric disorders varying from autism, geriatrics, or others receive long-term care and treatment in this unit.

While some units have more robust security systems than others due to the population they serve, each unit has a nursing station located adjacent to the unit's common area, which typically has a TV, chairs, and tables. Some have a small kitchenette. Common areas can be used by patients during specific times of the day, depending on the unit's or patient's schedules.

Meals are typically brought around the same time each day and patients must observe a quiet time following lunch service until mid-afternoon. Some may attend planned activities depending on their circumstances. Among others, activities can include using the on-site gymnasium, going for coffee outside their unit with or without staff accompaniment, watching TV in their unit's common area, or spending time in their unit's secured outdoor space.

Patient rooms are set up in clusters along corridors. A set of doors separates each cluster from the common area, which can be locked for various reasons, including safety. Each room has a bed and a washroom; room doors can also be locked by staff when required.

SECLUSION ROOMS

The RHC is equipped with seclusion rooms that are used to isolate individuals in crisis. Most seclusion rooms at the RHC are bare, locked rooms, furnished with institutional beds that are equipped with physical restraint equipment. They have frosted windows for natural light, and fluorescent ceiling lights that can be turned on or off from outside the room. There are no toilets or sinks. The rooms are equipped with one camera that records video and audio so occupants can be monitored by staff through video surveillance. There is no call bell system or intercom system for a patient to use. The patients are typically told to wave at the camera if they need assistance.

Summary of complaints

A companion document to this report shares the experiences of some of the individuals who were placed in restraints while admitted for psychiatric care at the RHC between February 2021 and October 2023.

COMPLAINTS TIMELINE

Please note that the situations described below may be upsetting for some people. All names have been changed to protect the identities of the individuals.

- February 2021: Jonathan had a number of admissions at the RHC throughout the years. The Office received a complaint from one of his family members, stating that he had been placed in seclusion and left in restraints for an extended period without proper intervention while on unit B2.
- March 2021: Isabelle was a patient at the RHC for over 20 years. A family member made a complaint about her physical health and time spent in restraints while on unit C1. Her family member was concerned about respiratory issues Isabelle had been experiencing over a few months, and her physical and mental health seemed to be deteriorating rapidly. The relative also mentioned that their request for Isabelle to receive a second medical assessment was not being granted. They expressed their belief that Isabelle was in restraints for most of the time and did not have many opportunities to walk around. They believed that her physical health issues could be linked to this lack of mobility.
- May 2021: Hugo was admitted to the RHC as part of a court ordered assessment. He contacted the Office to make a complaint about his time in a seclusion room and in restraints while on units F1 and D1. He stated he was put in the seclusion room frequently, with and without physical restraints, and that staff were not responding to his needs to the point that he had to urinate and defecate on the floor.
- September 2021: Linda was admitted to the RHC as part of a court ordered assessment. She made a complaint about her time in a seclusion room while on unit F1. Linda stated that she had been left in the seclusion room for an extended period without being able to go to the washroom, forcing her to urinate and defecate on the floor.
- October 2021 and November 2022: Nicole had been a patient at the RHC for some time when she contacted the Office about her time in a seclusion room and in restraints while on unit D1. Nicole made two complaints. The first alleged that she had been left in five-point restraints all night without a blanket and without any in-person staff intervention. A year later, Nicole reached out regarding another complaint that was deemed to be minor. During the conversation she mentioned in passing that she had recently spent time in the seclusion room. She alleged that there had been use of aggressive force; that staff did not address her basic needs, including the need to urinate; that there was no supervision during the time in the seclusion room when she injured herself and staff did not assess her injury; and that she was not offered her regular medication.
- December 2021: Francine was admitted to the RHC as part of a court ordered assessment. She was housed on unit F1. We became aware that she had been in physical restraints without appropriate interventions and left laying soiled in her urine for an extended period.
- February 2022: Simon was admitted to the RHC as part of a court ordered assessment. He contacted the Office complaining that he was left in five-point physical restraints in the seclusion room on unit F1 from about 8:00 a.m. until about 1:00 p.m. the next day.
- June 2022: David was admitted to the RHC as part of a court ordered assessment. He contacted the Office after leaving the RHC to share his experiences in the seclusion room on unit F1. In total, he made four allegations: that he was denied a physical health assessment; that he spent long periods of time in five-point restraints without the required interventions; that he needed to urinate and defecate on the floor because his requests to go to the bathroom or take a shower were not responded to; and that staff used excessive force (he was placed in a headlock).

- August 2022: Adam was an involuntary patient at the RHC, under the Review Board's authority. He made a complaint about his time in a seclusion room and in restraints while on unit F1 when he was admitted. He alleged staff sexually assaulted him by pulling down his pants while he was physically restrained in the seclusion room and conversed casually amongst themselves in French during the intervention (a language he does not speak). This made him uncomfortable because he thought they were laughing at him. He alleged he had been placed in the seclusion room for what felt like a week and had been physically restrained for what felt like three days. He said he had to urinate and defecate on the floor of the seclusion room since staff did not take him to the washroom.
- November 2022: Nicholas was admitted to the RHC as part of a court ordered assessment. Several days after his time in the seclusion room, Nicholas contacted the Office to share his concerns about his treatment during this period on unit F1. He acknowledged that his behaviour on the unit deserved a consequence, but that he did not think that his actions justified placing him in physical restraints because he was not aggressive and did not have a history of injuring himself. Nicholas' complaint alleged he was physically restrained upon his arrival in the seclusion room for no justifiable reason and that staff used excessive force on him when they placed him in the room. Among other things, he said he was pushed roughly against the wall; he spent about three hours in physical restraints inside; his requests to use the washroom were not granted so he had to urinate on the floor; and his request to read incident reports about the events was denied.
- October 2023: Emma contacted the Office the day after she was released from the seclusion room alleging to have spent four days there; to have been placed in physical restraints for about eight hours; to have been refused access to the washroom during this time; and to express concerns about the force that was used on her by staff intervening in a particular code white[9] incident during this time. She also alleged that staff members had pulled her hair and slammed her head against the floor during the intervention and that her injuries were not assessed by a doctor afterwards.

Interactions with the RHC and Vitalité

Throughout the investigation, the Office maintained regular contacts with RHC and Vitalité officials. They were always responsive to interventions and cooperated fully with the Office. They provided detailed and timely responses to numerous requests for information and documentation.

Given the amount of complaints received, the extensive amounts of information to be examined, and most importantly the serious nature of some of the deficiencies observed in video footage and document review, it was imperative to share observations on a regular basis with RHC officials. Simply put, we did not want to wait until the end of the investigation for some of the problems to be addressed. As a result, RHC officials took measures to address specific issues in real time while also working on longer term strategies to address some of the ongoing challenges.

FORMAL BRIEFING WITH VITALITÉ AND THE RHC – SEPTEMBER 2022

The Ombud and the investigation team met with Vitalité's President and CEO as well as other members of the Vitalité leadership team and RHC officials at the RHC in Campbellton to learn about their facility and to share preliminary observations, based on the complaints investigated to that point.

Following this meeting, Vitalité's President and CEO provided a response with a list of immediate measures to be implemented to ensure the safety and well-

9 A code white is called when a response team is needed to assist in de-escalating a violent or aggressive situation (for a full definition, see Appendix 3).

being of patients placed in seclusion and physical restraints. This list included:

- All code white responses or use of seclusion rooms or use of physical restraints must be reported to the RHC Director, seven days a week, 24 hours a day.
- The leadership team must monitor the restraint practices to ensure that they are appropriately used, and provide recommendations to this effect.
- A member of the leadership team must review all video footage of every patient placed in seclusion and restraints.
- The psychiatrists were informed that the leadership team could ask them to present themselves at the patient's bedside for an assessment and provide recommendations.
- Acts and treatments that are not in compliance with the policies and procedures of the Health Authority would be addressed immediately.

Vitalité also shared strategies as part of their plan to address the issues identified and to minimize the use of seclusions and restraints. In summary they consisted of:

- Ensuring that staff understands the mission and values of the organization as well as the philosophy of care they offer.
- Collecting data for the purpose of identifying trends across all care units to help identify targets and report on improvements.
- Create an environment where policies, procedures and practices reflect trauma-informed care with an understanding of biological, psychological, social effects of trauma, and human violence.
- Reduce the use of seclusion room and physical restraints by incorporating a variety of tools and assessments to be integrated into each patient's treatment plan.
- Ensure that the patient's support system is engaged and included in the patient's care plan and recovery to help the organization reduce seclusion and restraint practices.
- Minimize the use of seclusion and restraint practices by using data and insights gained through the vigorous analysis gained from these events and to help inform policy and procedures.

FORMAL BRIEFING WITH THE RHC – MARCH 2023

The investigation team met with RHC officials to provide more preliminary observations regarding the additional complaints investigated at that time.

Following the meeting, the RHC's Director of Tertiary and Forensic Psychiatry Services issued a memo to RHC Managers and Supervisors, outlining additional measures required, namely that:

- Patients placed in seclusion with physical restraints must be placed under continuous observation (one on one).
- Continuous observation will be performed by a member of the unit's care team except for night shifts where there may only be two staff members on the unit throughout the night. In this case, another staff member from the RHC will be assigned to ensure observation. Staff must be with the patient in the seclusion room (ex. seclusion door open with staff sitting in the entrance of the room).

FORMAL BRIEFING WITH THE RHC – JUNE 2023

The investigation team presented an overview of the investigation to the new Corporate Director and the new Assistant Vice-President of Professional Services for Vitalité. This included presenting findings to date regarding the complaints received. Concerns were also presented related to use of force practices and the inappropriate use of a spit hood. The presentation highlighted some improvements observed in relation to the frequency of monitoring and assessments being performed by staff to better respond to patient needs and comply with policy requirements.

This meeting provided an opportunity for an important dialogue and facilitated a successful transition of the file with a new RHC leadership team following the departure of one of their key contact-persons. This also ensured transparency with the RHC leadership team prior to the Ombud sharing an investigation update and new findings to the President and CEO.

FORMAL BRIEFING WITH THE RHC – APRIL 2024

In January 2024, the investigation team had discussions with the RHC about observations regarding the last complaint received in October 2023 with respect to time spent in seclusion and restraints. The purpose of this meeting was also to ensure that the RHC was providing the complainant with appropriate Indigenous cultural support. Another important issue addressed the need for further education and training on the use of force interventions and de-escalation techniques in small spaces such as seclusion rooms.

FORMAL BRIEFING WITH VITALITÉ AND THE RHC – NOVEMBER 2024

The Ombud and the investigation team met with Vitalité's Assistant Vice President of Professional Services, Medical Director, and Regional Manager of Professional Practices, as well as several members of the RHC leadership team. The RHC leadership team provided a detailed update of the initiatives completed and underway to address the quality of care at the RHC.

SUMMARY OF MEASURES TAKEN BY THE RHC AS OF NOVEMBER 2024	
Data Systems	**Global Dashboard** Management system to track the hiring process, employees' attendance, workplace accidents, sick days, overtime, incidents, evaluations, readmission percentage, and percentage of transfers in the community.
	Daily Seclusion and Restraint Management System Management system to track the use of restraints, which calculates time spent in seclusion and/or restraints in real time for each patient.
	Daily Management System for Psycho-Legal Assessments Management system to ensure reports for the Court are prepared in due time.
Experience Enhancement	**Eagles Committee** Committee created in October 2023 to give a voice to patients. RHC management will consult the committee for different decisions that may affect members or their peers.
	Smudging Room An initiative from the Eagles Committee in collaboration with First Nations.
	Sensory Rooms Introduced by the occupational therapist and now available on each unit, except F1.

SUMMARY OF MEASURES TAKEN BY THE RHC AS OF NOVEMBER 2024	
Capacity	**Creation of New Positions** Four new roles: a resource nurse in clinical safety, who provides additional support to the RHC team in times of crisis; a resource nurse in addiction treatment, who offers help to individuals wanting to address their addiction(s); a specialized clinical nurse, who helps with complex cases; and a professional who is responsible to educate colleagues within the network on structural stigmatisation.
	Specialized Applied Behaviour Analysis Care As these resources were not available within the institution, the RHC deemed it necessary to proceed with a purchase of services to address the needs of individuals presenting with neurodevelopmental delays or on the autism spectrum.
Communication and Networking	**Media Opportunities** In 2024 and 2025, the RHC spoke with different media outlets to highlight their challenges as well as discuss their objectives to successfully reintegrate patients into community and reduce the stigma connected with individuals who have experienced mental health/psychiatric issues or have spent time with the RHC as part of their treatment.
	Expert Conferences – International Association of Forensic Mental Health Services In the Fall of 2024, leadership from the RHC attended international professional training.

SUMMARY OF RHC PLANNED INITIATIVES	
Data Systems	**Recommendations Management** Newly created data monitoring system to manage recommendations and their implementation.
Reducing the Use of Mechanical Restraints	**Removal of Restraint Beds** Restraint beds were removed in two different units to give the option to patients as to which room they prefer (when possible). This can alleviate the negative feelings associated with potentially being restrained.
	Revision of the policy on the use of restraints Project containing numerous initiatives to improve the use of restraints in psychiatric and/or hospital settings.

SUMMARY OF RHC PLANNED INITIATIVES	
Experience Improvement	**Employee outreach initiatives** The RHC management team holds quarterly meetings with employees to share successes and new initiatives. They also installed display screens at the nursing stations to share relevant information and to recognize employees who positively contribute to patient care.
	Peer Helper and Patient Partner Peer support is usually a staff member who, in the course of their work, openly acknowledge that they currently live, or have previously lived, with a mental illness or an addiction[10]. The patient-partner is an individual who was a patient at some point in their life, now able to share their experience.
	Safe environment The RHC management team proposes to enhance safety of the environment by removing tobacco products, securing the main entrance, exploring a weapon detection system, and exploring new equipment to safely transport patients in crisis.
	Therapeutic and recreational activities As the RHC noticed that patients are less likely to have difficulties if they are occupied; Vitalité has created eight new positions to coordinate activities for patients at the institution.
Capacity	**Staff training** The RHC management team aims to offer employees additional training, including training on trauma-informed care and the clinical model Safewards as well as increase the level of participation to training already offered.
	Consultation for a recovery-oriented culture The RHC management intends on consulting with a specific professional who has proven to make substantial changes to another institution caring for individuals with mental illnesses to transform the RHC culture into one of recovery.
Communication and Networking	**Partnerships** There is an interest in creating partnerships with professionals involved in the same line of work within Canada.

10 https://cmhanb.ca/peer-support/

Following the November 2024 meeting and in response to the preliminary findings, the President and CEO wrote to the Ombud in January 2025 emphasizing that the collaborative approach has helped Vitalité and the RHC put in place preventative measures to mitigate future risks of having similar situations happen. The President and CEO assured the Ombud that directives have been communicated to all employees within the RHC at every level, including the medical team, on the importance of respecting the Restraints Policy and that failure to do so can result in disciplinary measures including loss of employment.

Additional initiatives put in place include:

- A comprehensive review of the Policy No. GEN.3.80.15: Restraints ("Restraints Policy") within Vitalité. A working group was created in Fall 2023 with the purpose of updating the policy for all sectors, including psychiatry and long-term care, drawing on best practices.
- A budget request was submitted to create a position responsible for providing systemic oversight on the use of restraints within Vitalité and continuous improvements regarding the safety of patients, visitors, and employees.
- The implementation of a real-time monitoring system for the use of restraints and seclusion for all care and assessment units. This live dashboard, which is part of the monitoring requirements, allows staff to ensure that the use of seclusion and physical restraints are used for the shortest duration possible.
- A reminder to psychiatrists was sent in writing and discussed during a meeting to remind them that the practice of prescribing restraints as a *Pro re nata* (PRN)[11] order is not an acceptable practice and violates Vitalité's Restraints Policy. Failure to comply with the Restraints Policy and applicable procedures may result in disciplinary action up to and including termination of employment.

The RHC provided several statistics and additional information in January 2025 that illustrated the improvements documented in recent months, such as:

- A 13% decrease in the use of seclusion rooms from 2023 to 2024.
- A 48% decrease in the use of physical restraints from 2023 to 2024.
- A 15% improvement in the quality of staff interventions during code whites, which led to using less control measures (or restraints) on patients in favor of de-escalation techniques consistent with staff training.
- One seclusion bed was removed in a seclusion room at the RHC, and their objective is for such changes to continue.
- Increasing the use of a patient's own bedroom to isolate an agitated patient instead of bringing them in a seclusion room following a code white. This practice allows the patient to remain in a familiar and comfortable area, with access to a restroom as well as any stress-relieving objects they may have, which in turn sets the tone for a more successful de-escalation.

11 Pro re nata (PRN) is a Latin phrase meaning "as needed".

Overview of previous reports involving the RHC

▸ RACINE[12] AND LAPIERRE REPORTS, 2017

In 2017, Vitalité hired external experts to conduct two separate reviews to assess the quality of care and services at the RHC after concerns were identified by individuals, organizations, and the courts.

Concerns centered on absenteeism rates, the treatment of patients and the number of injuries suffered by staff from patients.

Dr. Simon Racine released his report in March of 2017 and made 30 recommendations to help improve the RHC's culture and services.

That same month, Dr. Patrick Lapierre audited tribunal and legal psychiatry files dating from 2015 to 2017. He conducted a random inspection to assess the quality of clinical services offered to short-term and long-term patients residing at the RHC and found evidence of negligent practices. His report contained 14 recommendations. It was not made available for public release.

▸ *FAILURE TO PROTECT REPORT*[13] – OFFICE OF THE OMBUD, 2019

The Office published its *Failure to Protect* report in 2019. This report examined patient care at the RHC and staff conduct when responding to code white incidents. It also concluded that patients had experienced negligent treatment, verbal abuse, and excessive use of force by staff.

The report also addressed the chronic staff shortage resulting in staff-to-patient ratios that affected the quality-of-care patients received. Some ratios were dangerously low and jeopardized the safety of patients and staff alike.

The report contained eight recommendations related to improving staff training, reducing the number of services offered at the RHC, and for the institution to continue to be assessed by external experts. Following the publication of the report, the RHC reduced the number of operating units from seven to five. They continued to deal with staffing issues and other challenges.

▸ WEBER REPORT[14], 2019

As a response to *Failure to Protect*, the Minister of Health retained WebX Executive Consulting to monitor and evaluate the services at the RHC and the Centre of Excellence for Children and Youth with Complex Needs (COE). This report was completed in April 2019 and included specific recommendations to improve the safety and services at the RHC.

12 Dr Simon Racine, Centre Hospitalier Restigouche, Rapport sur l'organisation et le fonctionnement, Confidentiel – Avis au PDG [Restigouche Hospital Centre, Report on the organisation and operation, Confidential – Advice to the CEO], (Simon Racine MD, Consultant, March 2017)

13 A Report of the Office of Ombud, *Failure to Protect*, February 2019

14 George Weber, *New Brunswick Restigouche Hospital Centre and the Centre of Excellence for Children and Youth with Complex Needs, April 2019*

Key Findings

Even if Vitalité and the RHC have demonstrated their commitment to addressing many of the issues raised in the investigation, it is important to be mindful of the fact that the RHC has faced numerous challenges over a number of years and that many reports have been issued to attempt to address these challenges.

With this in mind, good faith alone is not sufficient to ensure true and lasting change. The Ombud is formulating 12 key findings stemming from the investigation into complaints involving the RHC. As Part II of this report will show, some of these key findings are not necessarily unique to the RHC. Some of the challenges identified resonate throughout the psychiatric care system. As such, the Ombud has set out recommendations to address specific issues related to the complaints involving the RHC, as well as the psychiatric care system, in Part III of this report.

The 12 key findings are:

1. ***Extended length of time in restraints***

   On numerous occasions patients were placed in physical restraints or in seclusion rooms for extended periods of time, well beyond the intended scope of the current policy. In certain situations, it was not demonstrated that the use of restraints followed existing policy provisions, given patient behaviour and apparent cooperation at those given times.

2. ***Lack of guidance on the removal of restraints***

   Existing policy seems to place emphasis on the conditions surrounding when to use restraints, but offer little guidance concerning their removal. It was noted throughout this investigation that staff indicated to some patients they did not have the authority to remove a restraint, even when the patient appeared to be calm.

3. ***Inadequate use of de-escalation techniques***

   The investigation revealed that insufficient efforts were made to use de-escalation techniques or to explore alternatives to restraints to calm agitated patients. This led to the use of restraints, the use of force, or both in some cases. Consequently, patients were at times denied the right to the least intrusive and least restrictive treatment appropriate to their circumstance.

4. ***Inadequate use of force techniques, including spit hoods***

   The investigation noted that the RHC's application of code white responses were most often a first response to non-compliant, loud, and disruptive behaviour, and not as a measure of last resort as is intended in the policy. We acknowledge that there are circumstances that require intervention with the use of force. Guidance around this type of intervention is articulated in Vitalité's Code White Policy[15] that specifies they are to be used only when verbal de-escalation techniques fail.

   Multiple complaints alleged a use of force while the patient was in restraints, causing breathing difficulties in some instances. In many cases, it was questionable whether the force used on these patients was necessary or proportionate to the threat they posed, particularly the application of pressure and covering a patient's face with hands, blankets, or spit hoods while they were in 5-point restraints.

   There are also concerns around techniques where staff applied pressure and force in the neck area of a patient. In some situations, staff were observed applying pressure to a patient's neck and the head area of another patient during interventions.

15 Vitalité Health Network – Restigouche Hospital Centre, Emergency Management Manual: Policy No.: MUR.4.10.41 Code White-Violent Person (2023).

5. *Insufficient documentation of restraint orders*

In reviewing patient files during the investigation, it appeared that certain information required to be documented was not always found in patient files. This resulted in important gaps of information when trying to assess whether policies were followed. For example, the Vitalité Restraints Policy allows for the use of restraints in an emergency intervention for a "patient whose behaviour presents a serious and imminent danger for self or others and is a sufficient reason to act without prior medical order or consent." The policy also imposes a requirement that a medical order must be obtained from a physician as quickly as possible (within 24 hours) in the cases where restraints are used as an emergency intervention. This requirement must be renewed every 24 hours if the restraints are maintained. The patient's next of kin or legal representative must also be notified.

When a patient requires a planned intervention for restraint use, the policy indicates that the application of restraints be prescribed by a medical order. In such instances, the Restraints Policy requires a medical order to be on the patient's file. The medical order must specify the type of restraints authorized for use, specific behaviour that would justify the use of restraints, and the period of time for which the restraints are prescribed. Medical orders cannot simply authorize the use of a restraint as required without further details. They must also be "reassessed and repeated every 7 days." Consent from the patient, next of kin or legal representative must be obtained in instances of planned interventions that include restraints. If the consent cannot be obtained, a liability waiver form will be signed by the patient, next of kin or legal representative instead.

Examples of insufficient documentation can be noted in Isabelle's case. The orders directing the use of restraints over a lengthy period did not provide details on the specific behaviour or circumstances that would permit their removal. Though this may not have been the intention, over time the use of restraints seemed to become the norm for dealing with Isabelle's complex circumstances.

In Emma's case, there were a number of orders for "restraints as needed for safety" or "restraints PRN" (restraints as needed) during the four-day period of our review. These orders in turn appeared to delegate the decision to apply restraints to staff on the unit. No in-person assessments by medical professionals were observed during this time despite numerous instances of self-injurious behaviour by the patient. Vitalité officials acknowledged that the practice of providing medical orders "as needed" for the use of restraints is not consistent with their Restraints Policy.

6. *Insufficient patient assessment and monitoring*

Vitalité's Restraints Policy requires that patients in restraints be monitored every 15 minutes during the first hour and hourly thereafter. Routine checks must occur every two hours for bathroom breaks, monitoring of pressure points from restraints usage, and release from restraints for mobility purposes.

Routine verifications were not completed in specified intervals, as required by the Restraints Policy, when patients were placed in the seclusion room and/or in physical restraints. Such verifications include but are not limited to:

- Offering food and water.
- Giving patients the opportunity to relieve themselves.
- Verifying the tightness of each physical restraint / skin integrity / colouration of the limbs.
- Ensuring the patient can be released from restraints to move their limbs regularly.
- Responding to patient requests for assistance.

7. ***Lack of effective mechanisms for patients to ask for assistance***

The investigation found numerous patient requests for assistance went unanswered when they were placed in seclusion rooms with or without physical restraints. Patients were told to wave at the camera if they needed help because there are no communication systems or call bells inside the seclusion rooms. This was problematic, especially when patients needed to relieve themselves.

In the video footage reviewed, patients routinely asked for help, without success, by using different methods, such as:

- Waving and signaling at the camera for long periods.
- Knocking on the door window of their seclusion room.
- Banging on their door.
- Kicking on their door.
- Yelling for help.
- Writing "Help Me" with pieces of styrofoam cups.
- Writing messages and holding them in front of the video camera including: "Help!", "Need to Poop".
- Writing "Help me" on the mattress using water.

8. ***Disorientation to time***

Many patients in seclusion became disoriented as to time. Patients had no way of knowing how long they were spending in a seclusion room or in restraints as they had no access to clocks or calendars. When speaking with complainants regarding their time in the seclusion room and in physical restraints, they would often say that they spent what felt like days but could not express the exact amount of time. For example, Adam had underestimated the amount of time he had spent in the seclusion room and in physical restraints, believing he had been there for what felt like a week but in reality was there for 12 days.

9. ***Poor sanitary conditions in seclusion rooms***

Patients at the RHC were observed having to urinate and defecate on the floor of the seclusion room or in cups or pillowcases because they were not let out to relieve themselves. After these occurrences, they were often not offered opportunities to properly clean themselves (hands and/or body). In many cases, the waste was not cleaned within a reasonable timeframe.

10. ***Inconvenient ability to consume meals***

Many patients were left in physical restraints during mealtimes and were often required to eat while still partially restrained to beds in the seclusion rooms, sometimes with only one hand unrestrained. Certain restrained patients were observed having to eat while partially laying down, which could be unsafe.

11. *Inconsistent incident reporting*

In some cases, key details related to some of the incidents reviewed on video footage had not been noted in incident reports or patient charts. This may be due to the preparation of incident reports being designated to one member of the response team, instead of prepared by each member of the response team. The lack of details limits the sharing of critical information between various healthcare workers who may be attending to the patient. In correctional settings, for example, all staff involved in responding to an incident must prepare an incident report.

12. *Lack of opportunities for community re-integration of long-term patients*

There was a lack of appropriate resources to meet the best interests of individuals' complex needs in the community. While this is not limited to RHC patients, Isabelle's case provides a potent example of the effects of long-term hospitalization of individuals with complex needs. Though Isabelle benefitted from family visits to give her a form of belonging to a community outside the RHC, this may not be the case for other long-term psychiatric patients. A lack of community visits, isolation in their room or on the ward could be damaging for patients' health, well-being, and reintegration efforts.

PART II

USE OF RESTRAINTS AND OTHER ISSUES IMPACTING PSYCHIATRIC CARE IN NEW BRUNSWICK

Context

During the investigation into the complaints involving the RHC, the Ombud decided to undertake a broader examination of the practices surrounding the use of restraints across all psychiatric facilities and units in the province. The Office became aware of the issues at the RHC after being contacted by patients and their families. However, what about other psychiatric patients who are non-verbal and do not have anyone to speak on their behalf? What about the patients who are located in facilities where the Office is not as well-known as a resource?

It was important to have a better sense of whether the psychiatric facilities and units across the province were facing the same challenges as the RHC related to the use of restraints. While these facilities each had their particular set of challenges, they all had a common web of underlying issues that, though they may not always have a direct correlation to the use of restraints, certainly put strains on the capacity to deliver the best possible psychiatric care in the province.

Timeline for expanding the investigation

- January 2023: Notice of investigation letter to Horizon Health Network on the use of environmental and physical restraints for patients requiring psychiatric care in all psychiatric units.
- January 2023: Notice of investigation letter to Vitalité Health Network on the use of environmental and physical restraints for patients requiring psychiatric care in all psychiatric units (not just the RHC).
- July 2023: Notice of investigation letter to the Department of Health on the use of environmental and physical restraints for patients requiring psychiatric care.
- June 2024: Notice of investigation letter to the Department of Social Development regarding community placements for patients housed in psychiatric settings for prolonged periods.

Interactions with the health networks and departments

HORIZON HEALTH NETWORK AND VITALITÉ HEALTH NETWORK

Upon sending the notice of investigation letters in January 2023, the investigation team had a number of exchanges with both regional health authorities (RHA), namely, to examine information related to their policies, practices and standards on restraints use.

At a meeting held with both RHAs in March 2023, RHAs indicated that they are required to compile and submit to the Canadian Institute for Health Information (CIHI) the number of patients restrained in the first 72 hours of being admitted in their facilities. However, there is no tracking system in place for patients in restraints after that 72-hour period.

Given the absence of an existing tracking mechanism, the RHAs agreed that, for the purpose of the investigation, they would collect data in a manual chart audit and forward a sample based on 10 randomly selected patient files from each adult psychiatric unit.

The data collected by the RHAs from March to August 2023 revealed the complex nature of the issues that arise when dealing with individuals who present with serious developmental disorders, intellectual disabilities, limited capacity to communicate and/or severely challenging behaviours, such as:

- Verbal aggression: yelling, threatening staff, verbalizing intentions to self-harm or harm others.
- Physical aggression: hitting or punching walls, kicking doors, throwing or breaking objects, destroying property, attempting to assault staff.

There were multiple files where patients brought to emergency departments presented with aggressive behaviours that required the use of restraints for their safety and that of others. The complexity of these situations highlights the importance of efforts and resources to support staff dealing with complex cases, as well as continued specialized education to deal effectively with these challenging behaviours.

The investigation team also addressed concerns over youth being admitted to adult psychiatric units, as this may expose them to inappropriate language and aggressive behaviours. It also increases the risk of prolonged seclusion periods for them not to be in contact with adult patients and other environmental factors not suitable for youth. Clinical staff notes expressed the need for protocols with clear guidelines to deal with youth admitted in adult psychiatric units.

DEPARTMENT OF HEALTH

In July 2023, a notice of investigation letter was sent to the Department of Health. The notice informed Health of some observations to date and sought to better understand their efforts in several areas. The investigation team met with departmental officials in August 2023 and received documentation in October and November 2023.

Among the issues explored were Health's efforts in supporting Vitalité and the RHC in the implementation of the 2019 Weber Report. Health explained that they focused on developing the Stepped Care Model 2.0, which is a collaborative effort between Health and both RHAs to increase access to receiving addiction and mental health services by implementing one-at-a-time therapy in community.[16]

Health shared documents explaining the work that was being done following the creation of a new division focused on Health Workforce Recruitment and Retention, which works collaboratively with the RHAs, the Department of Post-Secondary Education, Training, and Labour, and the Department of Social Development.

16 Source provided by the Department of Health: *Implementing One-at-a-Time Therapy in community addiction and mental health centres*

Health also discussed cross-departmental efforts to prioritize patient reintegration in the community to minimize the effects of long-term hospitalization. Health explained the challenges for finding community placements for patients who are hospitalized. They confirmed that departmental officials meet with officials from the Department of Social Development on a regular basis to discuss complex cases.

On the issue of forensic assessments, they indicated that a psychiatrist was hired as a Medical Officer with the Addictions and Mental Health Services Division. Among other responsibilities, this role allowed for focus to be placed on improving the monitoring and the quality control of forensic assessments in New Brunswick. It has allowed Health to lead initiatives and work with government partners by forming a provincial steering committee that brings together the RHAs, psychiatry professionals, the Department of Justice and Public Safety, and Crown Prosecutions. This group has been collaborating on ways to assist courts in managing cases involving individuals with mental illness or who struggle with substance use. The steering committee has also been exploring options for a provincial framework to provide guidance to the forensic psychiatry work being carried out around the province.

DEPARTMENT OF SOCIAL DEVELOPMENT

In June 2024, a notice of investigation letter was sent to the Department of Social Development to better understand how they were supporting efforts to house patients with complex needs that are ready to be discharged from the RHAs. For the purpose of the investigation, the focus was placed on patients who were in adult psychiatric units for prolonged periods due to lack of community placement.

More precisely, information was requested about: cross-departmental strategies in place; the current process undertaken when Social Development is advised about a patient ready to reintegrate into the community by the RHAs; and the number of patients with complex needs that were waiting for a community placement as well as the duration of their wait time. Information was also requested about the number of special care homes or nursing homes suited to provide housing for individuals with complex needs, along with the respite available to special care homes and nursing homes when individuals become unwell and need stabilization.

Social Development provided information with respect to cross-departmental strategies to prioritize psychiatric patients' reintegration into the community to minimize the effects of long-term hospitalization. They confirmed:

- Participating in an initiative led by Vitalité to develop guidelines to aid transition planning, facilitate collaboration between partners and address gaps.
- Being a member of the Provincial Integrated Support Committee to provide guidance and support across multiple departments.
- Supporting the Department of Health's Inter-Departmental Addiction and Mental Health Action Plan (2021-2025).
- Holding regular meetings with the RHC and Centracare to understand the needs of specific individuals.

With respect to the process undertaken by Social Development for psychiatric patients ready to be discharged by RHAs, the department explained that it begins with an information-gathering process as soon as they are made aware by the RHAs of a patient being ready for discharge. Social Development explained that the greater the complexity of the needs are, the harder it is to find a suitable placement. Nevertheless, they explore alternate solutions, such as broadening their search in other areas of the province or offering training to existing placements.

Social Development explained that discharges are more successful when patients are linked to a community health clinician and when there is collaboration among service providers such as Social Development, Community Mental Health, RHAs and other departments involved.

In July 2024, Social Development indicated there were 23 adults in hospitals and 44 at either the RHC or Centracare waiting for community placements. Of those individuals, wait times spanned one week to over two years. The following table shows updated data on the number of patients and wait times for a community placement.

WAIT TIMES FOR PSYCHIATRIC PATIENTS AWAITING COMMUNITY PLACEMENT – MARCH 2025
Source: Department of Social Development
Data is approximate based on manual tracking

Facility/Hospital	Number of clients	Wait time
Restigouche Hospital Centre	22	17 patients: 1 month to 2 years 4 patients: 5 to 7 years 1 patient: 11 years
Centracare	11	1 month to 2 years
Bathurst	1	4 months
Campbellton	1	1 year
Edmundston	1	2 years
Fredericton	1	2 years
Miramichi	2	6 months and 10 months
Moncton	3	1 month to 1 year
Saint John	11	1 week to 4 years

Social Development mentioned that they do not have a specific waitlist for adult residential facilities or community placements. Their efforts focus on individual needs and the placements available at the time. This process is different than the nursing homes process for admitting patients prescribed in the *Nursing Homes Act* and its regulations.

In July 2024, Social Development shared that, in New Brunswick, there were 104 beds available in five nursing homes that are in units designed for individuals with long-standing history of mental illness, dementia and other chronic disorders whose conditions are well-maintained or stabilized. Social Development also advised that as of June 2024, 645 beds were available within adult residential facilities (commonly known as special care homes) in New Brunswick. The caveat

is that some have vacant beds but refuse to accept patients with complex needs.

Officials further explained that adult residential facilities and private service agencies can refuse an admission. The reasons for refusal are often associated to the following factors: aggressive behaviours; belief that the care required is beyond the skill set of the staff; concern that the facilities won't get adequate support from departments; or sometimes the individual or legal guardian refuses the placement offered.

With respect to resources available within communities to provide support and respite to adult residential facilities, nursing homes and service agencies, Social Development officials explained that there are limited resources available for the provision of respite when a patient is presenting with aggressive behaviours. All measures are explored to stabilize a patient before sending them to an RHA and there are no standardized protections in place to mitigate the risk of losing a placement while a patient is being treated at the hospital.

In terms of efforts to create more placement options, Social Development reported:

- Working with Health to develop a clinical consultation model to increase clinical support and additional training to service providers or caregivers.
- Mapping out gaps and opportunities with Health.
- Collaborating with other departments to explore the development of an integrated collaborative care planning framework.
- Working to explore a potential financial model (per diem) different than the current one.
- Monitoring the Community Residence pilot model currently in place which involves a partnership with Community Mental Health and increased intervention from Social Development.
- Ensuring preliminary engagement with community partners to generate proposals on partnerships to offer residential supports to patients with concurrent intellectual disabilities and mental health conditions.
- Exploring options to increase the capacity and supports offered to facility operators.

Site visits at every psychiatric unit and facility in New Brunswick

As part of the investigation, the Ombud asked the investigation team to supplement the information collected to date by touring each of Vitalité's and Horizon's psychiatric facilities and units. The team appreciated the welcome reception and the opportunity to engage in meaningful discussions with employees at various levels about the operations of their respective units. During each visit, it was evident that the staff have a profound passion for their work and want to prioritize the best interests of their patients. Despite the challenges they face, staff demonstrated remarkable resourcefulness to find solutions in overcoming obstacles while delivering services for their patients.

Key Findings – Issues related to the use of restraints in psychiatric settings

1. ***Restraints policies***

   Each RHA has adopted its own policy to regulate the use of restraints in all facilities, including psychiatric units. As detailed in the table below, the policies differ from each other in some respects, while having some similar provisions in terms of patient assessments.

POLICIES AND PROVISIONS	VITALITÉ	HORIZON
Restraints Policy	Policy on Restraints[17] regulates the use of restraints in all psychiatric units, including the RHC.	Policy on Least Restraint[18] regulates the use of restraints in all inpatient nursing units and psychiatric units, including Centracare. The policy also states that *"specialty units (e.g., psychiatry) may have unit specific policies, however these must be congruent with the intent of this regional policy."*
Staff assessment frequency for restrained patients	*"When restraints are placed if possible and as needed: verification of BP (blood pressure), pulse and respiration".* *"Every 15 minutes during the first hour and every hour afterwards: consciousness/ mental status, behaviour/ problem observed, colour of limbs/ release of restraints as needed".* *"Every hour and as needed: adequate position of restraints, hydration need, skin integrity, range of motion maintenance".* *"Every 2 hours: feeding need, elimination need, removal of restraints for a minimum of 10 minutes for passive/active exercises".*	Every 15 minutes *"until the patient is settled"* and every 30 minutes *"until restraint discontinued: level of consciousness, respiratory status, patient behaviour."* Every two hours for *"– all restraints: skin integrity assessed, toileting offered, nourishment offered, range of motion/ position change. … Restraints are removed for at least ten minutes every two hours to provide opportunity for ambulation, toileting, exercise and other care."*
	The above-mentioned criteria is for emergency interventions, there are slight differences for planned interventions. There are no provisions for constant observational care, but the policy states that *"more frequent monitoring may be required depending on the nursing clinical assessment or as specified in the medical orders".*	The policy does not differentiate between an emergency or planned use of restraints. The policy states that *"the use of a five-point restraint device requires constant observation of the patient".*

17 Policy No: GEN.3.80.15, Restraints (2017).
18 Policy HHN-PC-010, Least Restraint (2021).

POLICIES AND PROVISIONS	VITALITÉ	HORIZON
Policy on the use of spit hoods (also known as protective face hoods)	No mention of their use in current policies, but their use was observed in the incidents discussed in this report. It is unclear what training requirements are needed for staff authorized to use the device.	Policy on Protective Face Hood[19] regulates their use, such as stating that only security staff are authorized to use the device, that staff must request compliance from the person "*acting out*" to stop spitting and authorization must be received from the clinical team before using the device on the patient. Staff are also required to remove it if at any time the device appears to be causing physical distress to the person wearing it. All security officers must review the related training video and policy during their initial orientation as well as twice annually.

2. *Monitoring the use of restraints*

Both Vitalité and Horizon indicated that there are no systems (digital or manual) in place to track the use of restraints in any of their facilities. Therefore, a chart audit would need to be performed to gather some of the data the Ombud requested in relation to statistical trends on the use of restraints. This gap in data collection is of concern because it means little oversight is in place to monitor or review their use after said interventions have occurred.

In response to this investigation, the RHC informed the Office that they have created an electronic "*Live Dashboard*" that staff are required to fill out when a patient is placed in physical restraints with or without the use of a seclusion room. This electronic tool automatically documents the time at which restraints were applied. The fields automatically change colour after specific time intervals, thus flagging to the management team to follow-up with the appropriate unit. The "*Live Dashboard*" is accessible remotely and on site by the RHC management team and other designated team members.

Despite policies in place, there does not appear to be a consistent mechanism to trigger a review of policy violations in institutional settings. Management at these facilities could benefit from having internal quality assurance processes that identify instances of policy violations to ensure corrective measures are taken before complaints arise. Random audits of patient files could also provide an early warning system. During the investigation, Vitalité initiated a complaint driven audit and review process to ensure that patients who had complained of policy violations were properly cared for on a going forward basis.

19 Policy HHN-SA-038, Protective Face Hood (2019).

3. ***Communicating with and assessing patients while in restraints***

Communication practices also varied across the system. Some seclusion rooms, such as at the RHC, do not have any form of communication systems. Some facilities' seclusion rooms have communication devices fixed to the wall, either call bells or intercom systems that allow staff to communicate with the patient. Even if they have access to an intercom system, staff at the Campbellton Regional Hospital reported that they never use their system out of concern that hearing someone's voice without being able to see them could cause distress to an already agitated patient.

Assessing restrained patients varied among the facilities. Some units have staff posted in the room with patients who are restrained, while others monitor them via camera or do 15-minute interval checks.

4. ***Seclusion rooms***

Some discrepancies were noted in the availability or functionalities of seclusion rooms in psychiatric units.

For example, the Edmundston Regional Hospital does not have dedicated seclusion rooms available.

Seclusion rooms at the Miramichi Regional Hospital are the only ones to have washrooms, including a shower, in the seclusion rooms allowing patient access without requiring staff assistance.

Video surveillance capacity varied in each facility. Seclusion rooms at the Chaleur Regional Hospital do not have video surveillance cameras and many of the systems do not retain footage. The Miramichi Regional Hospital does not have video surveillance in their unit's common areas although these areas are visible from the nursing station.

Key Findings – Issues impacting quality of care in psychiatric settings

UNIQUE CHALLENGES AMONG FACILITIES AND UNITS

1. ***Infrastructure and physical design of psychiatric units***

While some psychiatric facilities and units appeared to have spaces that are more functional than others, visits revealed several inconsistencies, even within the same RHA. Unit layouts varied greatly as did security measures on the units, and access to programs and other types of infrastructure (ex. recreation).

Some units had layouts that offered ample space for patients to socialize and spend time doing activities outside of their rooms, while others were quite small considering the number of patients being treated at the time of the visit, such as at the Dr. Georges-L.-Dumont University Hospital Centre.

These discrepancies can impact the ability to enforce a provincial framework that can meet the needs of patients receiving care.

2. ***Colocation of youth and adults in some units***

The space for caring for psychiatric patients who are minors varies between regions. Many hospitals have dedicated pods inside their adult units to keep youth in separate areas, or distinct units altogether. However, some hospitals do not have a dedicated space for youth, which means that they are placed in the adult units with one-on-one staffing. The lack of dedicated space for patients who are minors is a concern given the risks associated with youths and adults sharing spaces, especially in seclusion areas.

SYSTEM-WIDE CHALLENGES

3. *Availability of specialized staff*

Staff in all facilities described challenges related to staffing levels. This is similar to the challenges experienced throughout the health care system. The difficulty to attract and retain a variety of health professionals is compounded when trying to ensure they are also trained and qualified to work in a specialized psychiatric setting.

4. *Delays in community placements and scarcity of housing options*

Staff in the majority of psychiatric units reported that there were patients in their care that had been waiting for community placements for a year or more. Staff explained that if a placement is not found, Social Development often closes the patient's file. This means that resources are no longer actively looking to find the patient a community placement. Overcrowding in psychiatric units can cause challenges throughout the hospital with new psychiatric patients waiting to be admitted and taking up space in emergency rooms.

Some of the delays in community placements are no doubt impacted by a lack of available housing options (private and public) within communities, particularly for patients with developmental disorders. The scarcity of housing options often leads to prolonged hospitalization in psychiatric units even after the patient has been stabilized and medically discharged. This longer stay in the unit can lead patients to regress and redevelop problematic behaviours that need to be stabilized again before they leave.

Many officials within both RHAs have stated ERs and hospitals often admit psychiatric patients with complex behavioural issues exhibiting aggressive behaviour because their caretakers or their community placement are no longer able to care for them. This is due to the few community placements and specialized resources available.

The lack of community placement appears to have created a bottleneck effect in the health care system. Officials shared that patients with serious developmental disorders, intellectual disabilities and limited capacity to communicate require different services and supports that are not easily accessible, especially outside hospital walls. They expressed the need for a coordinated response to ensure a successful community placement for these complex patients with clear protocols that promote a gradual transition model. When these patients are in crisis, it is also important to establish a preventative model by ensuring that patients access timely clinical intervention while they are in community when their condition begins to destabilize.

PART III

RECOMMENDATIONS

This investigation into the use of restraints in psychiatric facilities led the Ombud to form observations on the improvements needed towards the goal of restraint minimization as set out in the *Mental Health Act*. Over the course of the investigation, it became apparent that there are a number of issues that impact the proper functioning of psychiatric facilities and quality of care patients receive not only in these facilities, but as they prepare to reintegrate into their communities.

This part of the report identifies the areas where the Ombud is making recommendations for improvements and a path to continue to examine the state of mental health care and services as a whole.

Law Reform

In Canada, the undisputed goal is to minimize the use of restraints strictly to that which is necessary, and even to eliminate their use where possible. Nonetheless, the Supreme Court of Canada has recognized a right and duty to restrain a person under care in emergency situations to protect the person or others[20]. The courts have also considered the impact on involuntary patients' Charter rights in these kinds of situations. They have held that restrictions on individual's life, liberty and security of the person may sometimes be justified[21]. This common law right and duty is now reflected in every Canadian jurisdiction's respective mental health legislation.

The New Brunswick *Mental Health Act*'s provisions on the use of restraints for involuntary patients provides some helpful parameters on when restraints can be used[22] and creates an implied duty to document restraint use in the patient's file[23]. The New Brunswick purpose clause speaks to the need for restraints (and all other care and treatment) to be "the least restrictive and intrusive for the achievement of the purposes[24]". This is a standard that is reflected in legislation across the country.

While New Brunswick's legislation provides more requirements and guidance than some other jurisdictions, it falls short of those seen in many other Canadian jurisdictions (Quebec, Ontario, Manitoba, Alberta, Yukon, Northwest Territories, and Nunavut).

For example, mental health legislation in several jurisdictions in Canada define or explain what is meant by the use of restraints. This includes using the least amount of force, mechanical means, or chemicals (such as medication) to prevent harm to the patient or others, and in some cases, is framed in terms of use of force or control.[25]

20 *Wellesley Hospital v. Lawson*, 1977 CanLII 29 (SCC), [1978] 1 SCR 893
21 *Rodriguez v. British Columbia (Attorney General,* [1993] 3 S.C.R. 519, 107 D.L.R. (4th) 342; *Conway v. Fleming*, 1999 CanLII 19907 (ON SC)
22 For example: ss. 1.1(c), 7.1(4)(c) of the *Mental Health Act* and s. 5(1) of Regulation 94-33 ; *General Regulation - Mental Health Act*
23 See s. 16.1(1)
24 See para. 1.1(c) of the *Mental Health Act*
25 See Ontario's *Mental Health Act*, RSO 1990, c M.7, s. 1(1); Manitoba's *Mental Health Act*, CCSM c M110, s. 1; Alberta's *Mental Health Act*, RSA 2000, c M-13, s. 30; Yukon's *Mental Health Act*, RSY 2002, c 150, s. 18(1); Northwest Territories' *Mental Health Act,* RSNWT 1988, c M-10, s. 95; Nunavut's *Mental Health Act,* SNu 2021 c 21, s. 2(4).

Some Canadian jurisdictions require that certain details about the use of restraints on patients be recorded in the patient file, such as the type of restraint used (including medication, dosage, and frequency), how long the restraint was used on the patient, and a description of the patient's behaviour that required the use of restraint.[26] As patients have a right to access their patient files, this means they also have the right to know what restraints were used while they were receiving care and why.

The law in Quebec is unique in Canada to date as it requires health care institutions to adopt procedures about the use of restraints that is consistent with ministerial guidance. It also requires health care institutions to advise patients of its procedures and to evaluate the use of restraint measures yearly.[27] These statutory requirements in Quebec go much further than in New Brunswick by insisting on measuring, monitoring, and reporting on efforts to curb the use of all forms of restraints, in hospital settings and particularly in psychiatric patient care.

While not all other jurisdictions in Canada have a purpose clause in their respective mental health laws, some have enacted preambles or clauses that speak to patient dignity, respect, self-determination, self-reliance, cultural safety, equal treatment, and other fundamental rights.[28]

Some areas where the *Mental Health Act* could be improved, compared to other mental health legislation around the country, include:

- A clear legislative definition of what "restrain" means and includes.
- A duty to document certain details about the use of restraints in the patient file/clinical record.
- Set procedures for the application/use of restraints on involuntary patients in psychiatric facilities, plus ongoing training and awareness requirements and review processes to assess the use of restraints on involuntary patients.
- A stronger purpose clause that speaks to patient rights to dignity, respect, self-determination, self-reliance, cultural safety, equal treatment, and other fundamental rights.

Recommendation 1

PUBLIC AUTHORITY: DEPARTMENT OF HEALTH

Prepare and present amendments to the *Mental Health Act*, modelled on best practices in leading jurisdictions, to reinforce the goal of reducing the use of restrictive controls in psychiatric care, and include requirements to measure, document, monitor and report on the use of restraints involving psychiatric patients.

26 See Manitoba's *Mental Health Act*, CCSM c M110, s. 29(4); Yukon's *Mental Health Act,* RSY 2002, c 150, s.18(2) and 18(3).
27 See Québec's *Act respecting the governance of the health and social services system*, chapter G-1.021, s 397.
28 See for example Nova Scotia's *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s. 2(1); Yukon's *Mental Health Act,* RSY 2002, c 150, preamble; Northwest Territories' *Mental Health Act,* RSNWT 1988, c M-10, s. 3.1(2); Nunavut's *Mental Health Act,* SNu 2021 c 21, s 1.

Policy Reform

RESTRAINTS POLICIES

Existing policies and procedures will need to be updated to ensure consistency with and to give full effect to new legislative provisions aimed at framing and minimizing the use of restraints. Building upon the many essential aspects of the existing policies within Vitalité and Horizon, new policies for restraint minimization in psychiatric care could include the following elements:

- Standards for the maximum time period during which patients can remain in a seclusion room and/or in physical restraints, before requiring a mandatory review.
- Standards for the maximum time period during which a patient can be placed in a seclusion room and/or in physical restraints before being seen by a medical professional.
- Standards for routine verifications of patients' health and well-being while in restraints.
- Specific detailed criteria to guide the imposition of restraints and to facilitate their removal, for instance by establishing a process to ensure staff can receive the necessary approvals quickly when the attending staff determines that the patient seems calm and no longer needs to be restrained (or allow for any attending staff member to make the decision to remove restraints and seek approval later, as is the case for placing the restraints).
- Directives stating that the use of physical or environmental restraints should not interfere with a patient's routine medical care, rest, meals and hygiene, including the patient's own need to relieve themselves.
- Details on the information required to be documented in the patient's file, including that the patient has been made aware, in comprehensible terms, of the reason for the use of restraints and the required circumstances for them to be removed.

Restraint minimization policies should be communicated to personnel, health professionals, patients, family members and legal representatives.

Recommendation 2

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Update restraints policies to harmonize them with new requirements under the *Mental Health Act*, and to provide clear guidance and expectations related to standards for the application, use, and removal of restraints.

USE OF FORCE / SPIT HOODS POLICIES

In situations where use of force is required, there needs to be sufficient specific guidance for employees to feel confident that they can administer the techniques with minimal risk to patient health and well-being. This is also true for the use of spit hoods during an intervention with a patient. Use of force, including spit hoods, is outlined in existing policy as being an intervention technique only after verbal de-escalation techniques have failed. The investigation found multiple instances where the necessity and proportionality of a use of force was questionable in regards to the patient's exhibited behaviour.

The use of spit hoods should be reexamined altogether as an intervention technique. For instance, the Department of Public Safety's Adult Custody Services has abolished the use of spit hoods in provincial correctional centres. Vitalité has indicated that they are conducting their own research and reviewing their use of force policy, including determining if they will continue to permit the use of spit hoods.

Recommendation 3

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Review use of force policies and standards to ensure that proper techniques are clearly defined, including justifying the specific circumstance that required the applied use of force technique.

Recommendation 4

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Examine the use of spit hoods to determine if it should continue, and if so, develop policy guidance to ensure that proper techniques are clearly defined, including justifying the specific circumstance that required the use of a spit hood.

CODE WHITE/INCIDENT REPORTING POLICIES

Vitalité's Code White Policy provides that only one person needs to prepare an incident report when required. As a result, most RHC incident reports reviewed during the investigation were prepared by only one of the staff responding to a given incident. As noted earlier in our report, this resulted at times in incomplete incident reports.

Horizon's Patient/Non-Patient Incident Reporting states that the first witness of an incident will complete the incident report[29].

At a minimum, important information to note in incident reports includes:

- All participants and witnesses to the incident.
- Details of the incident, including time and location.
- Writer's role and involvement / actions in the incident.
- Actions by the patient that necessitated the use of force.
- Attempted de-escalation efforts that were used.
- Injuries and treatment of persons involved, if applicable.

Recommendation 5

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Review code white/patient incident reporting policies to include a requirement for patient incident reports to be prepared by all personnel involved in responding to an incident. The revised policy should include the possibility for patients who are able to do so to provide a statement to document their perception of the incident in their file. The policy should also include what information should be detailed in the incident report.

Recommendation 6

PUBLIC AUTHORITY: VITALITÉ HEALTH NETWORK

At the Restigouche Hospital Centre, resume the practice of having all personnel that responded to a patient incident be required to prepare incident reports, as soon as possible after it occurred, and that the incident reports be placed in the patient's file/chart.

Care practices

Best practices in mental health and psychiatric care are in constant evolution. To achieve the best possible care for vulnerable patients, it is important to foster a culture of continuous improvement to adopt new approaches.

ALTERNATIVES TO THE USE OF RESTRAINTS

Therapeutic approaches aimed at minimizing the use of restraints could be further explored and implemented, such as:

29 Policy HHN-SA-016, Patient/Non-Patient Incident Reporting (2020).

- Attempts to redirect a patient's energy towards other tasks they are known to enjoy.
- Attempts to re-engage and communicate with the patient to determine how they are feeling and what could be done to improve their situation.
- Identify therapeutic environments that the patient enjoys and integrate them as part of individualized care plans, including finding effective redirection techniques.
- Using other less restrictive tools to mitigate the safety concern posed by the patient's behavior – if the patient refuses to use these tools, consistent and regular efforts can be employed to continue introducing them as part of their routine.

Recommendation 7

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Collaborate with a cross-section of care providers to explore and recommend best practices that favour therapeutic approaches to aid in minimizing the use of restraints and the use of force involving psychiatric patients.

Monitoring and compliance

Effective monitoring and compliance practices are essential for enhancing the quality of care and ensuring the safety and standards are adhered to. The implementation of a system-wide approach can ensure that best practices are shared amongst hospitals regardless of the health authority they fall under. It is important to have clear accountability measures in place to monitor that standards and policies are being respected. It also serves as an opportunity to identify areas that require further training and adjustments with the goal of continuously promoting practices that foster an environment of care, safety, and dignity.

RESTRAINTS MONITORING SYSTEM

One of the system improvements that is most needed is a better enforcement of the monitoring tasks already required under the various restraints policies. As indicated earlier in this report, the RHC has developed a live dashboard that captures information on each patient that is placed in restraints, the date and time when patients are placed in restraints, the date and time restraints are no longer used, whether a code white was called and whether there are injuries to report. The electronic monitoring system tracks real time information and can be assessed by the leadership team. This type of data should be recorded and tracked province wide.

Recommendation 8

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Institute and implement a common monitoring system for patients in restraints in all psychiatric units and facilities.

AUDIT AND RISK MANAGEMENT PROCESSES

Psychiatric patients, particularly those in long-term tertiary care, are especially vulnerable because they may lack the capacity to properly assert their rights, and they may not benefit from close family supports who might otherwise defend their best interests. Increased auditing and improved risk management processes for this sector are an important aspect for providing safeguards for these patients.

In addition to performing random file audits, processes should also include a list of elements or specific instances that would automatically trigger an internal audit, such as situations where:

- A patient spent 24 consecutive hours or more in a seclusion room.
- A patient spent 12 consecutive hours or more in physical restraints.
- Complaints were received from a patient, a family member, a facility staff member or other related parties regarding the time a patient spent in a seclusion room and/or physical restraints.

Recommendation 9

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Develop and implement a permanent internal audit mechanism to review instances where patients have been placed in environmental or physical restraints, including a requirement to conduct random file audits as well as complaint-based audits.

Training

Strong legal protections and good policy work together to ensure quality of care. Neither will fully succeed without a commitment to support care providers with continuous training opportunities to integrate legislation and policy requirements and new ways of doing things.

Recommendation 10

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Develop a mandatory annual training course on the standards of care related to the use, application and monitoring of restraints in a psychiatric care setting for any staff involved in applying or monitoring the use of restraints.

Recommendation 11

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Develop a mandatory annual training course on the use of force and de-escalation best practices and techniques in a psychiatric care setting for any staff involved in responding to a code white.

Infrastructure and equipment

Proper care and quality of life for patients requires that the appropriate infrastructure and equipment be available to care providers. The investigation noted infrastructure and equipment needs that could improve service provision for patients.

UNIT INSTALLATIONS

Site visits during the investigation found that all psychiatric units within the province have vastly different layouts, which impacts some of the correlated services available to patients. Some had ample space for recreational activities, sensory rooms, outdoor green spaces, etc. Such correlated services can contribute to patient stabilization efforts and their eventual reintegration into the community. Meanwhile, other units seemed quite small and crowded for the number of patients under care.

An infrastructure plan should be developed to identify:

- The current state of psychiatric units and facilities.
- Minimum standards for available infrastructure, equipment and services.
- Any gaps from the current to the desired state.
- An investment plan for addressing discrepancies.

Recommendation 12

PUBLIC AUTHORITY: DEPARTMENT OF HEALTH

Develop an infrastructure plan for the province's psychiatric units and facilities, in consultation with the Vitalité Health Network and the Horizon Health Network.

SECLUSION ROOMS

The size, layout, and equipment in seclusion rooms varies throughout the province. While these discrepancies can be addressed through the development of a provincial infrastructure plan, an important area to address with more urgency is the ability to communicate with patients. The investigation noted several instances where patients were not able to get the attention of a staff member, which caused additional stress and risks to the patient. The lack of clocks negatively impacted some complainants as they described their inability to keep track of time or measure the amount of time they spent in the seclusion room and/or in restraints. Finally, hygiene essentials, such as portable toilets and wash basins, should be readily available for seclusion rooms.

Recommendation 13

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Take steps to equip seclusion rooms with a reliable mechanism for patients to communicate with staff, sensory-friendly clocks, and hygiene essentials.

VIDEO SURVEILLANCE CAPACITY AND PROTOCOLS

The investigation revealed inconsistent use and availability of video cameras to monitor seclusion rooms across facilities. It is important that patients placed in restraints, as a measure of last resort, are carefully monitored for their own safety and well-being. While the constant monitoring of these patients is an intrusion into their privacy, their best interests can be achieved with appropriate safeguards in place in relation to video footage recording, retention, and secure destruction of these records.

Recommendation 14

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Ensure that all common areas of psychiatric units and facilities, as well as any seclusion rooms, have surveillance cameras with audio and recording capacity installed. The live feed from these cameras should also be available at the nursing stations.

Recommendation 15

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Adopt protocols regarding the use, access, retention and disposal of the video surveillance footage collected.

COLOCATION OF YOUTH AND ADULTS

Another area of concern involved instances where young patients are admitted in adult psychiatry units to obtain care. Many of these instances are due to a lack of psychiatric care space for minor aged patients. This sometimes leads to placing young patients in seclusion rooms to avoid contact with the adult patients.

The necessary infrastructure improvements required to ensure appropriate separation of youth from adult patients may prove to be extensive. In the meantime, alternative solutions at a patient care level would be a worthwhile endeavor to mitigate risks for young patients, including clear protocols and guidelines to navigate situations where the only option is to admit young patients in adult psychiatric units.

Recommendation 16

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Develop clear protocols and guidelines to address situations where youth must be admitted to adult psychiatric units. These protocols should also outline the requirements for allowing such instances to occur, based on an 'only option' level of tolerance.

System-wide collaboration

The challenges outlined throughout this report make it clear that resolving systemic issues cannot be accomplished by a single entity. It will require developing partnerships between various government departments, agencies, and community-based resources. Psychiatric care has not escaped the widespread staffing challenges experienced throughout the health care system, impacting both in-hospital care and community reintegration placements.

RECRUITMENT AND RETENTION OF SPECIALIZED PERSONNEL

As mentioned previously, the Department of Health, the two RHAs, the Department of Social Development and the Department of Post-Secondary Education, Training and Labour (PETL) are collaborating to address personnel recruitment and retention challenges. Though initiatives to recruit and retain health care professionals are underway, further efforts may be required to recruit specialized personnel for the province's psychiatric care needs.

Recommendation 17

PUBLIC AUTHORITY: DEPARTMENT OF HEALTH

Continue to coordinate retention and recruitment efforts with the Department of Social Development, the Department of Post-Secondary Education Training and Labour, and the Regional Health Authorities in order to recruit and retain personnel specialized in providing psychiatric care in institutional and community settings.

COMMUNITY REINTEGRATION

As illustrated through Isabelle's story and her decades-long life in institutional care at the RHC, there is a need for better options to assist with the timely reintegration of individuals with complex needs. For example, both the departments of Health and Social Development refer to implementing a step-down model for patients in these types of situations, as there appears to be a level of care missing between psychiatric facilities and community placements. A step-down model is meant to allow patients who need treatment to continue receiving it while the reintegration process is initiated for them to leave the hospital system when they are ready to do so.

Throughout this reintegration process, it is also important to continue taking into consideration the best interests of the patients and the input of families. The availability of designated supports, clinical experts to help identify an efficient community placement, equipping providers with appropriate resources, and increasing available housing options (private and public) are all integral to provide individuals with the best placement options to suit their needs.

Regional teams charged with developing individual care plans for people with complex needs have been in place for over 15 years. As the teams develop individual care plans, they are often faced with systemic barriers to reintegration, which they are only able to address on a case-by-case basis, if at all. Meanwhile, the root causes of these systemic barriers remain in place and continue to stall reintegration repeatedly.

All public authorities involved in this investigation have expressed frustration with some of these barriers (legislative, policy, budgetary, human resources etc.). The time has come for public authorities to commit and collaborate meaningfully in addressing those systemic barriers once and for all, and not just in a piecemeal fashion.

An inter-departmental task force could serve to complete a comprehensive review of the Interdepartmental Care Plans: Guidelines and Standards to assess effectiveness and address systemic issues that have emerged over the implementation period. The review should include input from all participating departments, regional health authorities, front-line service providers, and individuals who are directly impacted. Based on the findings, an action plan should be developed and implemented to address the identified challenges, streamline processes, and strengthen interdepartmental collaboration, with the goal of ensuring timely, coordinated and sustainable responses to the complex health and social needs of adults requiring psychiatric support. The actions should aim to address the common systemic barriers conclusively.

Recommendation 18

PUBLIC AUTHORITIES: DEPARTMENT OF SOCIAL DEVELOPMENT AND DEPARTMENT OF HEALTH

Establish a joint task force responsible for addressing the systemic barriers to the timely community placement and re-integration of patients in a patient-centric manner.

Recommendation 19

PUBLIC AUTHORITIES: DEPARTMENT OF SOCIAL DEVELOPMENT, DEPARTMENT OF HEALTH, VITALITÉ HEALTH NETWORK, AND HORIZON HEALTH NETWORK

Develop a shared and integrated database identifying accessible community supports and placement options prioritizing patients at risk of long-term hospitalization, ensuring that no one is excluded from placement opportunities.

Recommendation 20

PUBLIC AUTHORITIES: DEPARTMENT OF HEALTH AND DEPARTMENT OF SOCIAL DEVELOPMENT

Develop and implement a step-down model in each region, focused on facilitating the community reintegration process for eligible patients, in collaboration with the Regional Health Authorities.

THE FUTURE STATE OF MENTAL HEALTH CARE

Though the original intent of this investigation was to look into the practices surrounding the use of restraints in psychiatric care in New Brunswick, it seemed that at every turn, there emerged a web of underlying issues too numerous to address all at one time. It soon became apparent that there is a fundamental need to take stock of the mental health care system as a whole to find a path to address the multitude of issues encountered.

As such, the task became to find the form that such a system-wide review might take. The recommended option is inspired by the concept of the "estates general" ("*états généraux*") that first originated in France, but in modern days has been used in francophone and Acadian parts of Canada to re-think various community challenges from a broad perspective.

The purpose of an estates general is to shed light on the current state of a particular situation, and to identify possible solutions to bring about positive changes to improve the situation in question. It is a collective approach to mobilize a variety of stakeholders and the public, to examine an issue from every facet, to reflect and build together a common and shared vision. More than just a public consultation, it is a vehicle to involve stakeholders in crafting solutions, having gained insight into the challenges faced by others, not just their own.

This approach seemed the best suited to the task at hand. This consultation model could begin by organizing a series of sectoral tables to discuss specific themes involving the state of mental health in the province. Such themes could include:

- Community supports: availability of programs and services throughout the province; housing; respite care.
- Judicialization of mental health: rates of incarceration; forensic assessments; mental health courts.
- Addictions: addressing root causes, availability of resources, alternative approaches to treatment.
- Adults under protection: processes for appointment of legal representatives; role of the Public Trustee; role of psychiatric patient advocates.
- Destigmatization: how to change societal views on people suffering from mental health and addictions and the institutions that care for them.
- Making way for different needs: notably Indigenous Peoples, youth and seniors.

At the end of those consultations, sectoral tables would be called upon to convene to a provincial mental health summit to report on their discussions and the solutions they were able to identify to improve the state of mental health care in the themes they explored.

The mental health summit would provide an opportunity to collate what has been learned, to determine the areas where there is consensus, and to identify the areas where more work is needed. More than just a work plan for government, it would result in a call to action for everyone having a stake and a role to play in the future state of mental health care in the province: the health care system, care homes, community and non-profit organizations, health care providers, professional associations, unions, employers, local governments, businesses and economic development organizations, the legal system, law enforcement, correctional institutions, the education and post-secondary education system, patients and their families or support systems, and the public in general.

Recommendation 21

PUBLIC AUTHORITY: DEPARTMENT OF HEALTH

Establish a comprehensive consultation mechanism on the state of mental health care in the province. The consultation mechanism should be appropriately resourced to complete its work within two years.

APPENDIX 1

SUMMARY OF RECOMMENDATIONS

The Ombud for New Brunswick recommends the following:

Recommendation 1

PUBLIC AUTHORITY: DEPARTMENT OF HEALTH

Prepare and present amendments to the *Mental Health* Act, modelled on best practices in leading jurisdictions, to reinforce the goal of reducing the use of restrictive controls in psychiatric care, and include requirements to measure, document, monitor and report on the use of restraints involving psychiatric patients.

Recommendation 2

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Update restraints policies to harmonize them with new requirements under the *Mental Health Act,* and to provide clear guidance and expectations related to standards for the application, use, and removal of restraints.

Recommendation 3

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Review use of force policies and standards to ensure that proper techniques are clearly defined, including justifying the specific circumstance that required the applied use of force technique.

Recommendation 4

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Examine the use of spit hoods to determine if it should continue, and if so, develop policy guidance to ensure that proper techniques are clearly defined, including justifying the specific circumstance that required the use of a spit hood.

Recommendation 5

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Review code white/patient incident reporting policies to include a requirement for patient incident reports to be prepared by all personnel involved in responding to an incident. The revised policy should include the possibility for patients who are able to do so to provide a statement to document their perception of the incident in their file. The policy should also include what information should be detailed in the incident report.

Recommendation 6

PUBLIC AUTHORITY: VITALITÉ HEALTH NETWORK

At the Restigouche Hospital Centre, resume the practice of having all personnel that responded to a patient incident be required to prepare incident reports, as soon as possible after it occurred, and that the incident reports be placed in the patient's file/chart.

Recommendation 7

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Collaborate with a cross-section of care providers to explore and recommend best practices that favour therapeutic approaches to aid in minimizing the use of restraints and the use of force involving psychiatric patients.

Recommendation 8

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Institute and implement a common monitoring system for patients in restraints in all psychiatric units and facilities.

Recommendation 9

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Develop and implement a permanent internal audit mechanism to review instances where patients have been placed in environmental or physical restraints, including a requirement to conduct random file audits as well as complaint-based audits.

Recommendation 10

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Develop a mandatory annual training course on the standards of care related to the use, application and monitoring of restraints in a psychiatric care setting for any staff involved in applying or monitoring the use of restraints.

Recommendation 11

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Develop a mandatory annual training course on the use of force and de-escalation best practices and techniques in a psychiatric care setting for any staff involved in responding to a code white.

Recommendation 12

PUBLIC AUTHORITY: DEPARTMENT OF HEALTH

Develop an infrastructure plan for the province's psychiatric units and facilities, in consultation with the Vitalité Health Network and the Horizon Health Network.

Recommendation 13

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Take steps to equip seclusion rooms with a reliable mechanism for patients to communicate with staff, sensory-friendly clocks, and hygiene essentials.

Recommendation 14

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Ensure that all common areas of psychiatric units and facilities, as well as any seclusion rooms, have surveillance cameras with audio and recording capacity installed. The live feed from these cameras should also be available at the nursing stations.

Recommendation 15

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Adopt protocols regarding the use, access, retention and disposal of the video surveillance footage collected.

Recommendation 16

PUBLIC AUTHORITIES: VITALITÉ HEALTH NETWORK AND HORIZON HEALTH NETWORK

Develop clear protocols and guidelines to address situations where youth must be admitted to adult psychiatric units. These protocols should also outline the requirements for allowing such instances to occur, based on an 'only option' level of tolerance.

Recommendation 17

PUBLIC AUTHORITY: DEPARTMENT OF HEALTH

Continue to coordinate retention and recruitment efforts with the Department of Social Development, the Department of Post-Secondary Education Training and Labour, and the Regional Health Authorities in order to recruit and retain personnel specialized in providing psychiatric care in institutional and community settings.

Recommendation 18

PUBLIC AUTHORITIES: DEPARTMENT OF SOCIAL DEVELOPMENT AND DEPARTMENT OF HEALTH

Establish a joint task force responsible for addressing the systemic barriers to the timely community placement and re-integration of patients in a patient-centric manner.

Recommendation 19

PUBLIC AUTHORITIES: DEPARTMENT OF SOCIAL DEVELOPMENT, DEPARTMENT OF HEALTH, VITALITÉ HEALTH NETWORK, AND HORIZON HEALTH NETWORK

Develop a shared and integrated database identifying accessible community supports and placement options prioritizing patients at risk of long-term hospitalization, ensuring that no one is excluded from placement opportunities.

Recommendation 20

PUBLIC AUTHORITIES: DEPARTMENT OF HEALTH AND DEPARTMENT OF SOCIAL DEVELOPMENT

Develop and implement a step-down model in each region, focused on facilitating the community reintegration process for eligible patients, in collaboration with the Regional Health Authorities.

Recommendation 21

PUBLIC AUTHORITY: DEPARTMENT OF HEALTH

Establish a comprehensive consultation mechanism on the state of mental health care in the province. The consultation mechanism should be appropriately resourced to complete its work within two years.

Recommendations monitoring

The Ombud for New Brunswick is requesting that by December 1, 2025, public authorities each provide their work plan outlining how they intend to proceed on each recommendation involving them, as well as their proposed implementation calendar.

APPENDIX 2

PUBLIC AUTHORITIES' PRELIMINARY RESPONSE TO THE RECOMMENDATIONS

RECOMMENDATION	PUBLIC AUTHORITY	PRELIMINARY RESPONSE
RECOMMENDATION 1 Prepare and present amendments to the *Mental Health* Act, modelled on best practices in leading jurisdictions, to reinforce the goal of reducing the use of restrictive controls in psychiatric care, and include requirements to measure, document, monitor and report on the use of restraints involving psychiatric patients.	Department of Health	Accept
RECOMMENDATION 2 Update restraints policies to harmonize them with new requirements under the *Mental Health Act*, and to provide clear guidance and expectations related to standards for the application, use, and removal of restraints.	Vitalité Health Network	Accept: The policy on the use of control measure is currently under review.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 3 Review use of force policies and standards to ensure that proper techniques are clearly defined, including justifying the specific circumstance that required the applied use of force technique.	Vitalité Health Network	Accept: The Code White Policy is currently under review.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.

RECOMMENDATION	PUBLIC AUTHORITY	PRELIMINARY RESPONSE
RECOMMENDATION 4 Examine the use of spit hoods to determine if it should continue, and if so, develop policy guidance to ensure that proper techniques are clearly defined, including justifying the specific circumstance that required the use of a spit hood.	Vitalité Health Network	Accept: This practice is currently under review to determine its relevance and define clear guidelines.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 5 Review code white/patient incident reporting policies to include a requirement for patient incident reports to be prepared by all personnel involved in responding to an incident. The revised policy should include the possibility for patients who are able to do so to provide a statement to document their perception of the incident in their file. The policy should also include what information should be detailed in the incident report.	Vitalité Health Network	Accept: Vitalité Health Network will review its documentation practices to ensure that incidents are recorded comprehensively.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 6 At the Restigouche Hospital Centre, resume the practice of having all personnel that responded to a patient incident be required to prepare incident reports, as soon as possible after it occurred, and that the incident reports be placed in the patient's file/ chart.	Vitalité Health Network	Accept: Vitalité Health Network will review its documentation practices to ensure that incidents are recorded comprehensively.

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RECOMMENDATION	PUBLIC AUTHORITY	PRELIMINARY RESPONSE
RECOMMENDATION 7 Collaborate with a cross-section of care providers to explore and recommend best practices that favour therapeutic approaches to aid in minimizing the use of restraints and the use of force involving psychiatric patients.	Vitalité Health Network	Accept: Vitalité Health Network will collaborate with Horizon Health Network to share best practices and reduce the use of control measures.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 8 Institute and implement a common monitoring system for patients in restraints in all psychiatric units and facilities.	Vitalité Health Network	Accept: The new control measures policy will provide a framework for monitoring restraints.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 9 Develop and implement a permanent internal audit mechanism to review instances where patients have been placed in environmental or physical restraints, including a requirement to conduct random file audits as well as complaint-based audits.	Vitalité Health Network	Accept: The new control measures policy will guide the audit mechanism.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 10 Develop a mandatory annual training course on the standards of care related to the use, application and monitoring of restraints in a psychiatric care setting for any staff involved in applying or monitoring the use of restraints.	Vitalité Health Network	Accept: Vitalité Health Network will review the current training program and the frequency of its delivery to meet this recommendation.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.

RECOMMENDATION	PUBLIC AUTHORITY	PRELIMINARY RESPONSE
RECOMMENDATION 11 Develop a mandatory annual training course on the use of force and de-escalation best practices and techniques in a psychiatric care setting for any staff involved in responding to a code white.	Vitalité Health Network	Accept: Vitalité Health Network will review the current training program and the frequency of its delivery to meet this recommendation.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 12 Develop an infrastructure plan for the province's psychiatric units and facilities, in consultation with the Vitalité Health Network and the Horizon Health Network.	Department of Health	Accept
RECOMMENDATION 13 Take steps to equip seclusion rooms with a reliable mechanism for patients to communicate with staff, sensory-friendly clocks, and hygiene essentials.	Vitalité Health Network	Accept: Vitalité Health Network, in collaboration with the Department of Health, will establish a plan to equip seclusion room with a communication system.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 14 Ensure that all common areas of psychiatric units and facilities, as well as any seclusion rooms, have surveillance cameras with audio and recording capacity installed. The live feed from these cameras should also be available at the nursing stations.	Vitalité Health Network	Accept: Vitalité Health Network will establish a plan to ensure an appropriate surveillance system.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.

APPENDIX 2

RECOMMENDATION	PUBLIC AUTHORITY	PRELIMINARY RESPONSE
RECOMMENDATION 15 Adopt protocols regarding the use, access, retention and disposal of the video surveillance footage collected.	Vitalité Health Network	Accept: Vitalité Health Network is currently reviewing the protocol for viewing, storing, and sharing video footage.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 16 Develop clear protocols and guidelines to address situations where youth must be admitted to adult psychiatric units. These protocols should also outline the requirements for allowing such instances to occur, based on an 'only option' level of tolerance.	Vitalité Health Network	Accept: Vitalité Health Network will review the current protocol.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 17 Continue to coordinate retention and recruitment efforts with the department of Social Development, the department of Post-Secondary Education Training and Labour, and the Regional Health Authorities in order to recruit and retain personnel specialized in providing psychiatric care in institutional and community settings.	Department of Health	Accept
RECOMMENDATION 18 Establish a joint task force responsible for addressing the systemic barriers to the timely community placement and re-integration of patients in a patient-centric manner.	Department of Social Development	Accept: SD will work with Health on a task force to address systemic barriers which will include continued development and implementation of a collaborative care model with access to clinical consultation teams as required.
	Department of Health	Accept

RECOMMENDATION	PUBLIC AUTHORITY	PRELIMINARY RESPONSE
RECOMMENDATION 19 Develop a shared and integrated database identifying accessible community supports and placement options prioritizing patients at risk of long-term hospitalization, ensuring that no one is excluded from placement opportunities.	Department of Social Development	Accept: SD will work with Health and the RHAs to explore the feasibility of existing technical solutions and pursue the necessary information sharing requirements.
	Department of Health	Accept
	Vitalité Health Network	Accept: Vitalité Health Network will continue to collaborate with the Department of Health and the Department of Social Development on community placement.
	Horizon Health Network	Accept: Horizon will undertake a thorough review leading to the development of an action plan to make the necessary revisions to programs.
RECOMMENDATION 20 Develop and implement a step-down model in each region, focused on facilitating the community reintegration process for eligible patients, in collaboration with the Regional Health Authorities.	Department of Health	Accept
	Department of Social Development	Accept: SD has identified the need for a dedicated bridge within the housing continuum between hospital stays and appropriate housing options. This should be a step-up and step-down approach. It would require intensive health supports and SD could play a key role in ensuring that alternative models to current Special Care Homes are available to support these clients when they have had a period of stabilization.

APPENDIX 2

RECOMMENDATION	PUBLIC AUTHORITY	PRELIMINARY RESPONSE
RECOMMENDATION 21 Establish a comprehensive consultation mechanism on the state of mental health care in the province. The consultation mechanism should be appropriately resourced to complete its work within two years.	Department of Health	Accept

APPENDIX 3

GLOSSARY OF ABBREVIATIONS AND TERMS

ABBREVIATION OR TERM	DEFINITION
CODE WHITE	A code white is called when a response team is needed to assist in de-escalating a violent or aggressive situation. For example, if a patient exhibits aggressive behaviour that can potentially harm others or themselves. This may also require the response team to use force, but they are expected to use the least amount of force necessary to gain compliance and control.[30]
DE-ESCALATION TACTICS	The primary function of de-escalation is to help the distressed person reduce the intensity of their problematic behaviour quickly and effectively while maintaining that person's safety and others. When attempting to de-escalate troublesome behaviour, it is important not to inadvertently make the situation worse by doing or saying something that will exacerbate the problem." [31] Vitalité's Policy on Restraints[32] sets out a list of measures and intervention techniques as alternatives to the use of restraints. Here are some examples: • Use a soft hand contact/smile • Make reassuring comments • Assess if hungry/thirsty/warm/cold Horizon's Least Restraint Policy[33] describes identifying potential root causes of behaviour such as pain/discomfort, hunger, boredom, need to eliminate, thirst, need for activity, to determine appropriate alternate care measures including recognizing and addressing triggers for agitation, aggression, wandering, confusion.
HEALTH	Department of Health
HORIZON	Horizon Health Network

30 Vitalité Health Network – Restigouche Hospital Centre, Emergency Management Manual: Policy No.: MUR.4.10.41 Code White-Violent Person (2023).
31 Maria Ferlick, De-Escalation Is a Go-To Tactic for Behaviour-Related Incidents: Reducing the intensity of problematic behaviour is a step-by-step process, Psychology Today (February 2022).
32 Policy No: GEN.3.80.15, Restraints (2017).
33 Policy HHN-PC-010, Least Restraint (2021).

APPENDIX 3

ABBREVIATION OR TERM	DEFINITION
INTERVENTIONS	**Planned intervention** Intervention included in a patient's care plan with a restraint prescribed in a medical order authorizing its use, describing the context requiring it, and for which consent was previously obtained from the patient or the patient's legal representative."[34] **Emergency intervention** Unplanned use of restraint on a patient whose behaviour presents a serious and imminent danger for self or others and is a sufficient reason to act without prior medical order or consent."[35]
OFFICE	Office of the Ombud for New Brunswick
PRESSURE POINT	A pressure point is "an area on the body sensitive to pressure such as: a discrete point on the body that when pressed causes pain."[36]
PRN	*Pro re nata* is a Latin phrase meaning 'as needed'.
RESTRAINT(S)	The word "restraint" refers to any means used to stop or restrict capacity for mobilization in any form, whether it be physical, chemical, or environmental.[37] **Environmental restraint (seclusion room)** Any obstacle or device that limits a patient's mobility, thereby confining him or her to a specific geographic area or location (e.g., half door).[38] A seclusion room is a form of environmental restraint and is defined as a room isolated from the rest of the general population, where an individual is usually placed in an involuntary manner. A seclusion room is generally equipped with a lockable door, a small window, a ceiling-mounted surveillance camera, and a floor-fixed bed. **Physical restraint** Physical or mechanical means or methods that stop or restrict voluntary capacity for mobilization of the entire or a part of the body. • Total physical restraints (e.g., wrists, ankles, and abdomen) • Partial physical restraints (e.g., wrists or ankles or abdomen or chair with table and/or belt).[39]

34 Vitalité Policy No.: GEN.3.80.15, Restraints (2017).
35 *Ibid.*
36 Merriam-Webster Dictionary.
37 Vitalité Policy No.: GEN.3.80.15, Restraints (2017).
38 *Ibid.*
39 *Ibid.*

ABBREVIATION OR TERM	DEFINITION
RESTRAINT(S)	**5-point restraints** • Used to describe a patient who is restrained at 5 different points on their body (both ankles, waist and both wrists). This is the maximum level of physical restraint. **4-point restraints** • Used to describe a patient who is restrained in 4 different places on their body. This level of restraint can range from intentional to unintentional (unintentional, for example, when the patient succeeds in freeing themselves from one of the restraints). **3-point restraints** • Used to describe a patient who is retrained in 3 different places on the body. For example, one ankle restraint, one wrist restraint and the waist restraint. **2-point restraints** • Used to describe a patient who is restrained at 2 different points on the body. For example, one ankle in restraint and one wrist in restraint.
RHA	Regional Health Authority. The Horizon Health Network and the Vitalité Health Network are the province's two Regional Health Authorities.
RHC	Restigouche Hospital Centre
REVIEW BOARD	Refers to a board appointed under section 30 of the *Mental Health Act*.
SOCIAL DEVELOPMENT	Department of Social Development
SPIT HOOD	A mesh/cloth hood that is specifically manufactured and designed to be placed over the head of an acting out person who is actively spitting or threatening to spit at staff. The material deters the acting out person from spitting and/or biting, but is thin enough to allow them to breathe freely and to communicate.[40]
USE OF FORCE	Use of force means the application of physical or mechanical measures to compel compliance.
VITALITÉ	Vitalité Health Network

40 Horizon's Policy HHN-SA-038, Protective Face Hood (2019).