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NEW BRUNSWICK • NOUVEAU-BRUNSWICK

Ombud special investigation into the use of restraints in psychiatric facilities

Presentation to the Standing Committee on Procedure, Privileges and Legislative Officers

SEPTEMBER 23, 2025

Presentation Overview

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Background

Scope of the investigation

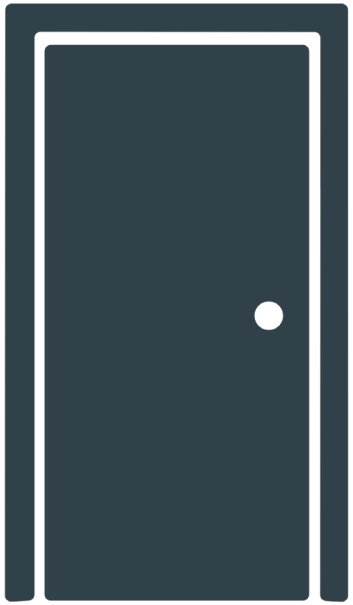
- An investigation was initiated following complaints from or on behalf of patients at the Restigouche Hospital Centre (RHC)
- The investigation was expanded to review the use of restraints practices in all psychiatric units and facilities in New Brunswick
- During the investigation, other issues emerged that have an impact on psychiatric care

- The public authorities involved with this investigation are:
  - Vitalité Health Network (Vitalité), including the Restigouche Hospital Centre (RHC)
  - Horizon Health Network (Horizon)
  - Department of Health (Health)
  - Department of Social Development (Social Development)

Investigation timeline

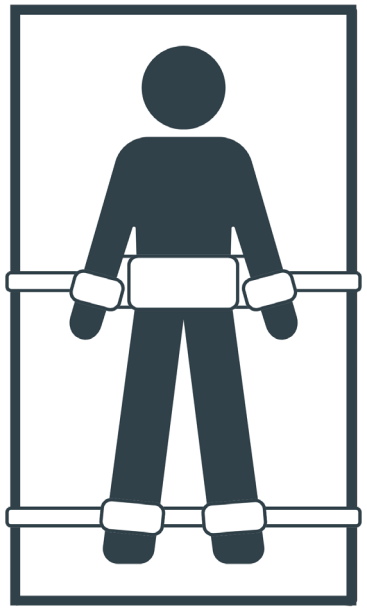
- May 2021
  - Investigation launched following receipt of 3 complaints
- June 2022
  - Investigation extended to include all complaints related to use of restraints at the RHC
- January 2023
  - Expanded investigation to all psychiatric facilities and units in New Brunswick
  - Both RHA's included in investigation
- July 2023
  - Department of Health included in investigation
- June 2024
  - Department of Social Development included in investigation

Types of Restraints



ENVIRONMENTAL RESTRAINTS (SECLUSION ROOMS)

Any obstacle or device that limits a patient's mobility, thereby confining him or her to a specific geographic area or location.



PHYSICAL RESTRAINTS

Physical or mechanical means or methods that stop or restrict voluntary capacity for mobilization of the entire or a part of the body.

Part I – Complaints involving the RHC

The patients

- Jonathan
  - February 2021
- Isabelle
  - March 2021
- Hugo
  - May 2021
- Linda
  - September 2021
- Nicole
  - Oct. 2021 & Nov. 2022
- Francine
  - December 2021
- Simon
  - February 2022
- David
  - June 2022
- Adam
  - August 2022
- Nicholas
  - November 2022
- Emma
  - October 2023

Note that all names have been changed to protect the identity of the individuals.

Types of issues raised

- Time spent in seclusion
  - From 2 hours to 285 consecutive hours
- Time left in restraints
  - From 3 hours to 58 consecutive hours
- No responses to calls for assistance
- Basic needs not met (elimination, cleanliness, etc.)
  - From 2 hours to 60 consecutive hours in unsanitary environment
- Use of force
  - Pressure applied to neck

Key Findings

1. Patients spent extended periods of time in restraints
2. Lack of guidance for staff about when to remove restraints
3. Inadequate use of de-escalation techniques to avoid restraints
4. Inadequate use of force techniques, including spit hoods
5. Insufficient documentation of some restraint orders
6. Assessment and monitoring of patients in restraints was insufficient

Key Findings (continued)

7. No effective means for patients in restraints to ask for assistance
8. Patients in seclusion rooms became disoriented to time
9. Patients left in poor sanitary conditions in seclusion rooms
10. Patients had difficulty eating their meals while in restraints
11. At times, incident reports were inconsistent with observed video footage
12. Lack of opportunities for community reintegration of long-term patients

Part II – Use of restraints and other issues impacting psychiatric care

Key Findings: use of restraints in psychiatric settings

1. Both Regional Health Authorities have restraints policies
2. Neither Regional Health Authority has a system in place to monitor use of restraints
3. Ability for patients in restraints to communicate with staff varies across facilities
4. Availability and functionality of seclusion rooms and video surveillance varies across facilities

Key Findings: other issues impacting psychiatric care

1. Infrastructure and physical design of some units are not as functional as others
2. Some facilities do not have dedicated spaces for patients who are minors
3. Availability of specialized staff and health professional poses a challenge
4. There are delays in community placements and a scarcity of housing options for patients ready to reintegrate into the community

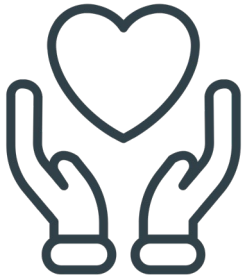
Part III – Recommendations

Recommendations by themes

21 recommendations across seven categories in the areas of:

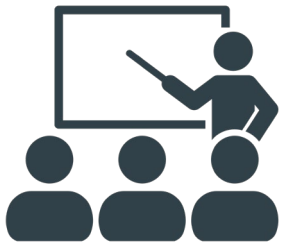
LAW REFORM

POLICY REFORM



CARE PRACTICES

MONITORING AND COMPLIANCE



TRAINING

INFRASTRUCTURE

SYSTEM-WIDE COLLABORATION

Summary of recommendations

Law Reform

1. Amend *Mental Health Act*

Policy Reform

2. Amend restraints policies
3. Review use of force policies
4. Examine the use of spit hoods and policies
5. Review code white/patient incident policies
6. Resume practices re: incident reports at the RHC

Care Practices

7. Collaborate to explore therapeutic approaches to minimize use of restraints

Monitoring and Compliance

8. Institute a monitoring system for patients in restraints
9. Develop and implement an internal audit mechanism

Summary of recommendations (continued)

Training

10. Mandatory annual training courses on standards of care for the use, application and monitoring of restraints
11. Mandatory annual training courses on use of force and de-escalation techniques

Infrastructure and Equipment

12. Develop an infrastructure plan for psychiatric units and facilities
13. Equip seclusion rooms with communication mechanism
14. Ensure surveillance cameras are installed
15. Adopt protocols for video surveillance footage
16. Develop protocols for youth placements in adult units

Summary of recommendations (continued)

System-Wide Collaboration

17. Continue recruitment and retention efforts of specialized personnel
18. Establish a joint task force to address barriers to community reintegration
19. Develop a shared database to identify placement options
20. Implement a step-down model in each region to facilitate community reintegration
21. Establish a comprehensive consultation mechanism on the state of mental health care in the province

Recommendations by public authority

Public Authority	Number of Recommendations	Preliminary Responses
Health	7	Accepted
Horizon	14	Accepted
Social Development	3	Accepted
Vitalité	15	Accepted

Recommendations Monitoring

By December 1, 2025, public authorities are to provide their work plan outlining how they intend to proceed on each recommendation involving them, as well as their proposed implementation calendar.

We will be monitoring the recommendations' implementation and will be reporting publicly on its progress.

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