

**AN INVESTIGATION INTO  
JANEWAY PSYCHIATRY UNIT J4D  
PROGRAMS AND SERVICES**



**OFFICE OF THE CHILD AND YOUTH ADVOCATE**

**PROVINCE OF  
NEWFOUNDLAND AND LABRADOR**

**MARCH 2010**

As the voice for the rights of children and youth in the Province of Newfoundland and Labrador, it is both the role and the desire of the Office of the Child and Youth Advocate (OCYA) to ensure that a child's right *to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health*<sup>1</sup> be realized.

*All* children of Newfoundland and Labrador have the right to an efficient and fully-operational mental health facility developmentally designed to address their specific needs. At present, the Janeway is the only inpatient facility in the Province servicing children and youth with mental health illnesses. It is the responsibility of Government to ensure that this, and all future mental health facilities, provides a therapeutic milieu for all children who require its services. It is further responsible to provide timely and appropriate treatment in a developmentally-suitable setting for those who fall outside of the parameters of its expertise.



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<sup>1</sup> Article 24 *Convention on the Rights of the Child*

\* The OCYA recognizes the contribution of Darlene Neville and Shirley Prior to this Investigation.

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March 2010**

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## **Acknowledgements**

The year 2008 was a challenging one for the inpatients, their family members, and the many professionals who were employed on Janeway Unit J4D. The OCYA would like to thank all individuals who participated in the Investigative process. It is our hope that the recommendations and findings of this Report will assist all parties in moving forward in order to provide the children and youth of this Province with access to appropriate mental health care services.

## **Dedication**

This Report is dedicated to the children and youth of this Province who bravely chose to share their experiences and lives with us. Your words allowed us to better understand the challenges that exist in the treatment of mental health, to identify areas in need of redress and to hopefully effect change for future children and youth of this Province who may one day require mental health services.

## **Executive Summary**

### **Background**

On December 13<sup>th</sup>, 2008, after multiple attempts to secure nursing staff, the Eastern Regional Integrated Health Authority (Eastern Health) made the decision to shut down Janeway Psychiatry Unit J4D – the only inpatient facility in the Province constructed and designed to service children and youth with mental health illnesses. This decision resulted in the transfer of two adolescent inpatients from a developmentally appropriate mental health ward to the adult Waterford Hospital. The Royal Newfoundland Constabulary (RNC), with nursing staff assistance, provided safe escort of these certified patients.

On December 15<sup>th</sup>, 2008, Darlene Neville, in her capacity as Child and Youth Advocate, responded by providing notice of her intention to conduct an Investigation into the psychiatric services and programs provided by the Janeway Children's Health and Rehabilitation Centre during the period January 1<sup>st</sup>, 2008 to December 31<sup>st</sup>, 2008. It applied to all patients who were either assessed by, or admitted to, the Janeway Psychiatry Unit J4D for reasons of self-harm, suicidal risk and/or behaviour which presented risk of harm to others.

Janeway Psychiatry Unit J4D re-opened to inpatients on January 5<sup>th</sup>, 2009.

### **J4D: An Acute Care Facility**

Child and Adolescent Psychiatry Unit J4D is a seven-bed acute care psychiatry unit. It is a short-term assessment unit where children under the age of 18 are admitted for a short period of time for observation, to initiate treatment, and either begin or regulate medication, if necessary. J4D typically services patients with behavioural problems, attention deficit hyperactivity disorder, oppositional defiant disorder, eating disorders, anxiety and depressive disorders, suicidal ideation, adjustment disorder, school refusal, and acute drug crisis.

The average length of stay on the Unit has historically been three-six weeks. More recently, the length of stay on J4D exceeds national averages. There are several reasons for these extended lengths of stay, including a lack of appropriate community-based wraparound services, which will be expanded on in the Report.

Discharge planning begins at admission. Reasons for discharge may include achieving stabilization with medication, the completion of a psychiatric assessment, a regulation in behaviour, or that generally the goals of admission have been met. While linkages may be provided to community services and local health practitioners, J4D staff may also provide follow up.

## **Analysis**

The Investigative process of the OCYA included individual interviews with Eastern Health staff as well as patients and family members, and a thorough documentation review. This analysis provided insight and perspective on how Unit J4D was functioning during 2008 and revealed a Unit in crisis and in need of intervention.

Several concerns emerged that, in our analysis, led to the closure of J4D. These concerns included issues of inconsistency, communication challenges, a lack of team cohesiveness and low morale. It also revealed human resource challenges, which included budgetary restraints, programming and treatment gaps, a lack of community wraparound services, as well as concerns surrounding recruitment and retention.

One of the key findings of this Report was that, as a non-specialized Unit, there is no requirement for J4D to hire psychiatric trained nurses. Training on the Unit is also not a requirement to maintain a nursing staff position. Many staff from various disciplines voiced concerns with the lack of training required for nursing staff in the area of mental health and were of the opinion that J4D should be designated as a specialized Unit.

## **A New Philosophy of Care**

Throughout this Investigation it has been clear to OCYA staff that significant changes are required to move J4D forward in order to better serve the mental health needs of children and youth in the Province. Training for all staff needs to be provided to ensure that people have the latest evidence, information and treatment techniques across the different diagnoses as they become more common. The Unit needs to be more patient centred, flexible, and adaptable. A mindset shift needs to occur. With such, J4D will be better positioned to meet the needs of its patients, decrease the level of stress experienced by staff and consequently increase the cohesiveness of the treatment team.

The OCYA hopes to assist the mental health staff of this Province in providing the best available treatment possible to the children and youth of Newfoundland and Labrador and is, therefore, proposing the following recommendations:

### ***Recommendation #1***

**THAT Eastern Health revise policies so that they are relevant to the patient population it serves.**

### ***Recommendation #2***

**THAT Eastern Health ensure consistent interpretation and implementation of policies and procedures.**



***Recommendation #3***

**THAT Eastern Health ensure:**

- (a) patients and families have a clear understanding of the treatment plan, their role in the plan, and who is responsible to monitor and implement the plan.**
- (b) patients and families receive written documentation at the end of each ICP meeting.**

***Recommendation #4***

**THAT Eastern Health designate a case manager within the treatment team to be responsible for coordinating, monitoring and managing a patient's individual treatment.**

***Recommendation #5***

**THAT Eastern Health conduct a needs assessment to expand J4D's programming component and ensure that all elements add therapeutic value to a patient's individual treatment plan.**

***Recommendation #6***

**THAT Eastern Health establish a *communications liaison* position to manage all aspects of each patient's care on the Unit. This would include overseeing the admission process, education, policy and procedure adherence, team cohesiveness, family involvement, etc.**

***Recommendation #7***

**THAT Eastern Health immediately conduct a needs assessment to address the physical limitations of the Unit layout.**

***Recommendation #8***

**THAT Eastern Health create a secure outdoor space that J4D patients can access regardless of acuity levels.**

***Recommendation #9***

**THAT the Provincial Government maintain child and adolescent mental health as a budget priority.**

***Recommendation #10***

**THAT Eastern Health address salary issues to ensure that the Unit is staffed with appropriately trained and compensated individuals.**

***Recommendation #11***

**THAT Eastern Health designate J4D as a specialized psychiatric Unit.**

***Recommendation #12***

**THAT Eastern Health revise J4D's constant care procedure and establish this in policy to better ensure safety of patients and staff.**

***Recommendation #13***

**THAT Eastern Health establish a process to address inappropriate admissions.**

***Recommendation #14***

**THAT the Provincial Government, in consultation with youth-serving agencies, develop a strategy to address the gaps in community wraparound services.**

***Recommendation #15***

**THAT Eastern Health develop a list of approved facilities and establish a formalized process for out-of-Province placements within child and adolescent mental health.**

***Recommendation #16***

**THAT Eastern Health develop a communications strategy to ensure better management of the Unit and a cohesive team approach.**

***Recommendation #17***

**THAT Eastern Health develop a plan for intra-hospital transfers in the area of child and adolescent mental health.**

***Recommendation #18***

**THAT Eastern Health provide all staff on J4D with opportunities to come to terms with the events that occurred on the Unit during 2008 and to move forward as professionals.**

## **1.0 Background**

On December 13<sup>th</sup>, 2008, after multiple attempts to secure nursing staff for the evening shift, Eastern Regional Integrated Health Authority's (Eastern Health) Regional Director of Mental Health and Addictions, in conjunction with the Chief Operating Officer (COO) of Community, Children and Women and Mental Health Services, made the decision to shut down Janeway Psychiatry Unit J4D – the only inpatient facility in the Province constructed and designed to service children and youth with mental health illnesses. This decision resulted in the transfer of two adolescent inpatients from a developmentally appropriate mental health ward to the adult Waterford Hospital.

On December 15<sup>th</sup>, 2008, Darlene Neville, in her capacity as Child and Youth Advocate, responded by providing notice to the Interim President and Chief Executive Officer of Eastern Health and to the Acting Deputy Minister of Health and Community Services, of her intention to conduct an Investigation as outlined under s.20 of the *Child and Youth Advocate Act*.<sup>\*</sup> This Investigation pertained to the psychiatric services and programs provided by the Janeway Children's Health and Rehabilitation Centre during the period January 1<sup>st</sup>, 2008 to December 31<sup>st</sup>, 2008. It applied to all patients who were admitted to the Janeway Psychiatry Unit J4D for reasons of self-harm, suicidal risk and/or behaviour which presented risk of harm to others. It also included children and youth who were assessed by the Janeway as being suicidal, displaying self-harming behaviours and/or behaviour which presented a risk of harm to others but were admitted elsewhere for treatment.

Janeway Psychiatry Unit J4D re-opened to inpatients on January 5<sup>th</sup>, 2009. Both patients, who had transferred from Unit J4D, maintained residence at the adult mental health facility. The search for an appropriate treatment facility continued; and in February 2009, one of the two adolescents deemed ready and accepted for placement, left the Waterford Hospital for out-of-Province treatment specifically designed to address this child's mental health needs. The other teen remained a patient of the adult Waterford Hospital.

In December 2008, Eastern Health made the decision to conduct its own *Review of Child/Adolescent Mental Health Unit J4D Janeway Hospital* (Review). This external Review took place over an eight-week period and was completed in June 2009. Its intention was to set future direction for the delivery of child and adolescent acute mental health services within Eastern Health, with a primary goal of improving the quality and efficiency of acute mental health services for children of the Province. The OCYA acknowledges the recommendations outlined in the Review and continues to be in regular contact with Eastern Health regarding its action plan.

The Investigation of the OCYA focuses on several key concerns, many of which were not addressed in the Review that, in our analysis, led to the closure of J4D. It

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\* See Appendix A.

addresses workplace as well as program and service issues that are clearly in need of revision and hopes to assist the mental health staff of this Province in providing the best available treatment possible to the children and youth of Newfoundland and Labrador.

## **2.0 Data Collection and Review**

### **2.1 Documentation Review**

On December 15<sup>th</sup>, 2008, pursuant to s. 21 of the *Child and Youth Advocate Act*, a documentation request was sent to the Interim President and Chief Executive Officer of Eastern Health and to the Acting Deputy Minister of Health and Community Services requesting all relevant documentation pertaining to the matter being investigated. The majority of documentation was received by the OCYA on or before January 30<sup>th</sup>, 2009. Further documentation was requested and provided on an ongoing basis. During the course of this Investigation, over 10,000 pages of documentation were reviewed by OCYA staff.

### **2.2 File Review Process**

Eastern Health forwarded copies of 61 patient files which, in their estimation, met the criteria as outlined in the Investigation. A detailed file review by OCYA staff determined that seven patients fell outside the parameters of this Investigation. The remaining 54 patient files were included in our analysis.

### **2.3 Parent/Patient Interview Process**

All 61 patients and parents/guardians were offered the opportunity to speak with OCYA staff on a voluntary basis concerning this Investigation. Contact was made through a mailout, followed up with a telephone call to individual families.

Fourteen interviews with patients and/or family members were completed during the course of this Investigation. Accommodation was made for one participant to provide a written response due to extenuating circumstances. All participants were assured of full confidentiality and privacy protection under s.13 of the *Child and Youth Advocate Act*. The majority of interviews were conducted at the Office of the Child and Youth Advocate, 193 LeMarchant Road, St. John's, NL. OCYA staff travelled to several communities throughout the Province to accommodate participants unable to travel to St. John's. Interviews were recorded by OCYA staff, and each participant was provided with a redacted copy of his/her transcript.

## **2.4 Eastern Health Interviews**

A total of 52 interviews were conducted at the OCYA under subpoena with employees of Eastern Health. These interviews began on May 25<sup>th</sup>, 2009 and concluded on December 18<sup>th</sup>, 2009. Participants were provided with a redacted transcript of their interview through their legal representative.

### **3.0 J4D: An Acute Care Facility**

The Janeway Children's Health and Rehabilitation Centre is home to Child and Adolescent Psychiatry Unit J4D: a seven-bed acute care psychiatry unit. It is a short-term assessment unit whereby children under the age of 18 are admitted for a short period of time for observation, to initiate treatment, and either begin or regulate medication, if necessary. The Unit maintains five psychiatry beds with the remaining two beds dedicated to the treatment of patients with eating disorders.

Unit J4D also includes a secure area which contains two bedrooms, washroom facilities, a therapeutic quiet room and small lounge area. While the bedrooms in the secure area can be used for patient overflow should the need arise, as a locked area separated from the general population, its intention is to provide support to patients with severe psychosis or aggression as well as those experiencing suicidality who cannot be supervised in the general population either for reasons of their own safety or the safety of others. Only one patient is typically placed in the secure area at a time. Supervision is the responsibility of either two nurses or one nurse and a security guard from MUN Campus Enforcement and Patrol (CEP).

The average length of stay on Unit J4D has historically been three-six weeks. The typical patient base would include diagnoses of children with behavioural problems, attention deficit hyperactivity disorder, oppositional defiant disorder, eating disorders, anxiety and depressive disorders, suicidal ideation, adjustment disorder, school refusal, and acute drug crisis.

#### **3.1 Admission Process**

There are established policies and protocols in place to govern the standard of care on Unit J4D. Copies of these procedures are accessible to all staff and located in the Charting Room on the Unit. While some policies have been established under Eastern Health, others remain under the banner of the former Health Care Corporation.

Upon admission, each patient is taken through a three-four hour orientation process. A checklist to ensure that the appropriate issues are discussed and that a tour of the Unit is offered is contained within the *Psychiatric Nursing Assessment*. An information package on J4D Unit operations is to be provided to all patients/families during this time.

## 3.2 Nursing Supervision

Upon admission, a primary nurse is assigned to each patient. This individual is assigned to his/her patient on every scheduled shift and ideally attends Interdisciplinary Care Plan (ICP) meetings and weekly rounds concerning the patient. If the primary nurse is unable to attend, the responsibility falls to the Patient Care Coordinator (PCC) and the nurse in charge of the patient on that particular day.

One nurse can be responsible for the direct supervision and care of up to three patients on Unit J4D during a shift, although respondents have indicated that they usually maintain direct responsibility for two patients. In the event of a change in supervision level for one or more patients, nursing supervision on the Unit becomes challenged and additional nursing staff would be called.

The number of admissions and patient acuity\* levels make it difficult to ascertain definitive nursing staff numbers on any given day. According to respondents, on average, four nurses and the PCC would typically be scheduled on a day shift. During the evening shift, supervision may decrease to four staff with the overnight shift being staffed by two nurses and a Licenced Practical Nurse (LPN).

## 3.3 Patient Observation

J4D employs two types of patient supervision: *close* and *constant* observation. Under close observation, patients are observed every fifteen minutes. The placement of a patient on constant observation is utilized when levels of higher acuity are evidenced. The Health Care Corporation of St. John's Administrative Policy Manual defines constant observation as "in full view of a staff member at all times".<sup>1</sup> It involves a one-one assignment of patient to nursing staff. The decision to place a patient on constant observation is based on the individual assessment of a child through a Mental Status Exam (MSE) and, while typically decided by a psychiatrist, can be initiated by a member of the treatment team for reasons of self-harm or violent behaviour. Patients with an eating disorder are also placed on constant observation following mealtimes. In all circumstances, a change in supervision level from close to constant must be followed up with a written order from the psychiatrist to remain in place. Removal of constant observation can only occur through psychiatrist authorization.

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\* Acuity is a medical term which refers to the intensity and/or severity of patient symptomology or illness. It will be used extensively throughout this Report.

<sup>1</sup> See Administrative Policy Manual Number XVII-98.



### **3.4 Diagnosis and Education**

The psychiatrist maintains responsibility for providing each patient with a diagnosis and notifying the family/guardian(s). This process may be augmented by other members of the treatment team. The Charting Room on Unit J4D maintains written materials on various diagnoses, medications and treatment which can be provided to families. Psychiatrists also frequently direct parents to the Internet for online resource material.

### **3.5 Treatment Plan**

All information pertaining to a patient on Unit J4D is placed on the patient's individual chart. This includes: ongoing patient progress notes, which provide a detailed daily account of a patient's time on the Unit; Interdisciplinary Care Plan (ICP) meeting notes; rounds notes; medical information, etc. This collection of information and ongoing documentation is considered to be the treatment plan for each patient. The patient chart is accessible to all staff working on the Unit and is continually updated by all members of the treatment team.

The initial ICP meeting must occur within the first 48 hours of admission. This meeting is attended by all team members working with the patient for the purpose of reviewing the reason for admission and to discuss the intended plan for the patient. Thereafter, ICP meetings are open to parent(s), if interested in attending, and patients, if deemed appropriate by the treatment team. ICP meetings occur whenever deemed necessary by the treatment team; however, typically they are scheduled on a weekly or bi-weekly basis. The purpose of the ICP meeting is to discuss the plan for the patient and any issues or concerns in relation to his/her treatment.

Rounds occur every Thursday morning. During this time, each psychiatrist is given a set amount of time to discuss his/her particular patients. Rounds are ideally attended by all members of the treatment team.

### **3.6 Programming**

During 2008, J4D employed eight psychiatrists, a psychologist\*, an art therapist and one inpatient social worker. As a teaching hospital, most psychiatrists supervise a resident who also works with the patient. Music therapy was offered for a short duration during 2008 through a grant program. Pet therapy and play therapy, when available, are located in another area of the hospital and can only be attended by patients who are deemed able to maintain safety off the Unit.

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\* Between April and October of 2008, there was an overlap of two psychologists servicing both the inpatient and outpatient units.

In addition, three teachers and a principal from the Eastern School District maintain four classrooms on the Unit known as the Janeway Hospital School. It consists of a classroom for students in grades K-6, a Junior High classroom for grades 7-9, a high school classroom for grades 10-12 and a resource centre. All patients are required to attend; however, exceptions can be made for reasons of illness.

### **3.7 Therapeutic Passes**

Patients can be issued in-hospital passes to go off the ward or out-of-hospital passes wherein patients are permitted time away from the hospital. Out-of-hospital passes vary in length from a few hours up to a weekend, depending on the psychiatrist's order. While passes are ordered by the psychiatrist, patients are subject to a Mental Status Exam (MSE) prior to their release. Passes may be cancelled if staff reason the patient to be a safety risk once the MSE is complete.

### **3.8 Discharge Planning**

Discharge planning for a patient begins at the moment of admission. While each case is decided on an individual basis, possible reasons for discharge on a short-term assessment unit like J4D may include: achieving stabilization with medication, the completion of a psychiatric assessment, achievement of regulation in behaviour, or that generally the goals of admission have been met. Upon discharge, all patients can be provided with a follow-up appointment with their inpatient psychiatrist as well as the art therapist and psychologist if s/he was in receipt of these services during admission. Patients who reside outside the St. John's area are linked to local physicians or other community services if and when available.

## **4.0 Analysis**

### **4.1 Introduction**

The preceding section provides a brief overview of Psychiatry Unit J4D and presents the reader with a cursory view of the Unit's operation as it is meant to occur. The OCYA Investigation provided insight and perspective on how Unit J4D was actually functioning during 2008. The documentation review, coupled with the interview process, revealed a Unit in crisis; a Unit in need of reform and intervention.

The remainder of this Report will focus on the issues raised by patients, families and staff that led to the closure of J4D and the calling of this Investigation. It is our opinion that the people who witnessed these issues as staff, patients and families are best able to shed light on these concerns. Therefore, the words of respondents have been used whenever possible.

### **4.2 Admission Process**

As previously indicated, the J4D admission procedure consists of a three-four hour orientation process. According to nursing staff, patients and families are to be provided with an information package outlining the rules and expectations of the Unit. Several patients and families indicated that they did not receive any information upon admission and made repeated requests for written documentation on Unit policies and procedures throughout their stay as they experienced much inconsistency in how the rules were applied.

In fact, several families informed us that an information package received in November 2008, which highlighted various rules on the Unit, was the only such information received during their entire stay on the Unit. The aforementioned package of rules provided to families in November contained written discrepancies and, while signed by the Clinical Psychiatry Chief, was not produced on Eastern Health letterhead. While we are unable to verify whether written information was or was not received prior to this time, the number of discrepancies and complaints voiced by parents during this Investigation surrounding written Unit procedures is reason enough to guarantee better accountability of this process.

During the Investigation process, OCYA staff suggested that one way to begin to ensure better accountability of this process would be to require patients and families to sign a form indicating that a complete orientation had occurred or been refused and that written policy information had been received. We are pleased to report that J4D is now implementing this practice.

There is a further need to ensure that patients not only know what the expectations are, but are comfortable within the admission process. One patient indicated the need to provide new patients with more support and information regarding Unit expectations during orientation by sharing how they felt upon admission to the Unit, "...you're going into a Unit that they say is for mentally ill people and first off they don't warn you – they don't let you know that it's ok, we have it all under control, you're not going to get hurt or anything. And I never really thought I was going to get hurt but I was just kind of scared to leave my room because you don't know what kind of people are there and you don't know what's going to happen there; if you're going to get hurt or anything...the first morning I was there, I was afraid to go out of my room because I didn't know what time it was, I didn't know if I should be out of my room. I didn't know if I was allowed getting a shower at that time, I didn't have a clue what to do...I was afraid if I went out...and it was too early, I'd get in trouble or something. So it just shows that I didn't know what to do." During the interview process, several nurses also spoke to the need for staff to recognize the necessity for patients to know what is expected of them on the Unit.

It is the opinion of the OCYA that the creation of a *communications liaison* would be beneficial in addressing concerns related to the admission process. This would ***ensure that both patients and families understand the Unit's expectations and that patients receive ongoing comfort and support.*** The need for such a position will be developed throughout the Report.

### **4.3 Rules and Procedures Governing J4D**

As previously indicated, policies and procedures govern the standard of care on Unit J4D. Some respondents felt that various policies and procedures were in need of revision, given that current thinking and best practice is constantly evolving. For example, one established procedure surrounding school attendance states that a patient who refuses to attend school, must remain in their room while school is in session. In addition, when the school day ends, typical practice is for patients to further serve the equivalent of time missed by, again, staying in their room. According to nursing staff, this rule was not overly effective with older patients.

The majority of respondents interviewed, however, indicated that the main area of concern surrounded the inconsistent interpretation and implementation of specific policies and Unit rules. Among patients and parents, this was an area that caused significant and unnecessary stress. In the words of one patient, "I remember being there sometimes and it was like there was no rules...And other times it was so strict. You just never knew...the rules are very different for each nurse." A parent went on to say, "The sort of inconsistency on the floor in terms of...somebody says that you can wear a certain article of clothing, somebody else says you can't. Somebody says that you can use the bathroom by yourself, somebody else says you can't." Several parents also voiced frustration with how they felt this continual inconsistency affected their child's progress and mental health. According to one parent, "...it was the inconsistencies that used to cause her a lot of mental anguish."

Further attention was drawn to the policy on checking for potentially harmful articles as well as the conduct of patient searches. During the fall of 2008, there were major discrepancies regarding such policies and practices. While we understand that the extreme levels of acuity on the Unit intensified the desire to maintain the safety of all persons, the inconsistency of the practice resulted in confusion and hostility between families and staff. Documentation among Eastern Health staff further evidences the unawareness of staff on the Unit as to the stated protocol. While we were informed during the interview process that discussions surrounding patient searches and other such policies had occurred, to our knowledge a final policy revision had not been officially drafted during the writing of this Report.

Another main area of concern which surfaced during the mid to latter part of 2008 surrounded the interpretation and inconsistent implementation of policy related to constant observation. Families and respondents both referenced the fact that how a patient was observed while under constant observation often changed from one nurse to another. During times of privacy, for example, some nurses would provide space to the patient or make allowances when family was present. Other staff would operate more strictly and implement the policy as it was literally stated. This inconsistency further created unnecessary stress for nursing staff, families and patients who were placed on constant observation for lengthy periods of time.

These findings show a failure to appreciate how these inconsistencies impact patients, families, staff and the overall ability of the Unit to function effectively. As one patient summarized, “Consistent enforcement...a lot of the kids and even teenagers do get really upset about it, you know, because it’s not fair. It simply isn’t fair sometimes that one nurse lets you do one thing and another nurse says no. So I mean that could help a lot with some stress with a lot of the kids...just more structure to the rules, especially. I’m not saying any rule should be taken away.”

Nursing staff echoed this by saying, “... [it] goes back to the importance of patients knowing what’s expected of them and a lot of times they didn’t because it depended on what staff were on...There was no routine or structure that you could depend on. From one day to the next you’d come in and...maybe there would be a consequence for something and maybe there wouldn’t be.” The need for consistent application of procedures in order to more effectively serve the patient base and maintain a consistent standard of care cannot be underestimated.

***Recommendation #1***

**THAT Eastern Health revise policies so that they are relevant to the patient population it serves.**

***Recommendation #2***

**THAT Eastern Health ensure consistent interpretation and implementation of policies and procedures.**

#### 4.4 Diagnosis and Education

As previously stated, it is the role of the psychiatrist to educate both the patient and family on a particular diagnosis as well as to provide education surrounding medication. During the interview process, several parents indicated that they were not satisfied with the information provided on their child's diagnosis. As one parent stated, "...it [was] my first time going through that experience so I didn't know what was out there and nobody offered it..."

All staff were quick to point out the fact that it is well known that people don't *hear* what they are told in medical appointments. As one psychiatrist stated, "...sometimes...[when] you discuss these things...what you say and what they hear and what they retain may be very, very different things. What they hear and what they want to hear are two totally different things sometimes." In other cases, providing an accurate diagnosis may take a lengthier period of time than families realize. That being said, we were assured by psychiatric staff that patients would be provided with information related to their symptomology while this assessment was being completed.

Several psychiatrists explained how they manage the education piece with the patient and family but made a point of indicating that oftentimes they prefer not to give brochure material as it is often written by pharmaceutical companies and may not therefore offer well-balanced information. One psychiatrist commented, "...I am very careful about what I give out, but I do give it out and I go over it with them and I give them a chance to go away and come back and ask questions." Another psychiatrist spoke to their philosophy on the role of the family and psychiatrist in education. "...I position myself on much more of a level playing field...to feel like parent and I are working together as often as possible along with the child or teenager to really understand what's going on. And that would include contributing my best understanding of what's going on diagnostically and at the same time being sure that that makes sense to them."

Several families were surprised to find that they were encouraged to conduct their own Internet search as a means of locating information. Others were encouraged to find books to read and one parent indicated that they purchased videos on their child's diagnosis and subsequently brought them to the Unit for staff to watch. It is essential that staff members take into account that much of this experience is unfamiliar, stressful and perhaps intimidating for many families and patients. The importance of having up-to-date resources available on the Unit that patients and families can access should be recognized.

While we understand that psychiatrists may encourage families to check out various online material, given the overwhelming amount of information available – much of which can be inaccurate, we would assume that several reputable websites would be outlined. For example, one psychiatrist indicated that they, "...will often steer parents to the website for the American Academy of Child and Adolescent Psychiatry...[as] a good website that has neutral, well-researched, highly-regarded information..."

According to several respondents, the educational information available on the Unit has recently undergone revision. “As part of providing parents with written information, our outpatient nurse now has developed sort of pre-done packages on diagnoses for different age groups. So there is generally a child version, a teen version and a parent version.”

The OCYA has no way of verifying what may have been verbally communicated to families during 2008 within the education process. Some of the files reviewed made limited reference to families being provided with specific information related to diagnoses. While we acknowledge that in such situations patients and families may not hear or retain all of what is said to them, *it is the opinion of the OCYA that family education needs to be a more organized process with a system of checks and balances in place. This would require staff to continually follow up with patients and families to ensure that they feel both well informed and supported in the education process.* As indicated earlier, the employment of a *communications liaison* would assist families at the onset as to what they can expect and have a right to receive, regarding their child’s diagnosis and treatment.

#### **4.4.1 Diagnostic Challenges in 2008**

Given that several patients who fell within the parameters of this Investigation received the diagnosis of Borderline Personality Disorder (BPD) and the challenges it created among treatment team members on the Unit, this Report would not be complete unless some factors were addressed.

One challenge with this illness, according to psychiatrists, is creating an understanding that, “...the diagnosis of borderline personality disorder is a process.” On a practical treatment level, “...the overall idea is to help teenagers with this problem develop their own skills, their own sense of...knowing themselves, their own way to soothe themselves, their own way to distract themselves when they’re having self-destructive impulses...”

Another challenge with this illness, according to respondents, is that historically it has not been the norm to diagnose adolescents with BPD as it was felt that the brain and personality were still continuing to develop. However, this mindset may be changing because, as stated by one respondent, “...there are people who say you can’t diagnose this disorder in adolescents, and I kind of disagree with that because when you’re not diagnosing them with that, you tend to be diagnosing them with other things that they don’t have and that’s to their detriment.”

In terms of treatment, according to most respondents, “...as a general rule for borderline personality, the idea would be as little time in hospital as possible. That’s obviously made easier when you have resources on the outside to support that person in the community. Even within that, the experts would agree there are times when the psychiatrist may feel forced to bring the person into hospital.” The reason this is the most

accepted form of practice is the belief that, according to psychiatrists, "...some patients with borderline personality regress, the majority probably would...regress in hospital." Another psychiatrist continued to address treatment components with this diagnosis. "There is no medication that's recommended. We often use the medication to treat other coexisting diagnoses, whether that be anxiety or depression...most of the Canadian literature and most of the American literature would reveal that for borderline personality disorder, hospitalization tends to cause regression and long-term hospitalization fosters a dependency and lack of control..."

According to respondents, clinical opinion is that psychotherapy is the predominant treatment. However, it is felt that several approaches to psychotherapy can be effective. As one psychiatrist commented, "...some sort of psychotherapy ...is the medically recognized course of treatment for child and adolescent patients with borderline personality disorder, and there are a variety of kinds, but dialectical behavioural therapy has had good success."

On a final note, the frustration of medical staff in having to defend their position and face continued controversy in the eyes of the public over the past year was duly noted. It was clear during the interview process that Eastern Health staff, and medical staff in particular, felt defensive about the fact that their professional competence was being called into question. The complexities of this diagnosis need to be recognized. The struggles and challenges faced by families in dealing with this diagnosis necessitate the need for appropriate therapeutic services while ensuring respect for their situations.

#### **4.5 Treatment Plan**

As previously stated, treatment plan documentation consists of page after page of continuous progress notes which are written in the patient's medical chart. According to staff, "...it is very difficult to find one spot in a chart where the ultimate plan occurs because it is re-evaluated day by day, moment by moment in some cases, and different members of the team can adjust their specific plan." According to the treatment team, "...it changes. It's completely dynamic...what it would entail would depend entirely on what the problem was, what the patient's individual situation was...either individual psychotherapy, family therapy, medication or any other services that might be of benefit..."

During the file review, it was difficult to ascertain what the actual treatment plan was for a specific patient. This view was held by many parents as well. As one parent who referenced a child having a medical illness stated, "...my...son was sick with [cancer] but I went in over there and they told me this is the type he's got, this is the course of treatment; we need to start it now; he's going to get sicker before he gets better; this is what you're going to see...We knew what the odds of success were. With the treatment for a person with mental illness, it's such a gray area..." In the opinion of another parent, the treatment plan was ineffective as in her view, "All children have the same treatment...one-size-fits-all approach."



During the ICP meetings, members of the treatment team verbalize their role in the ongoing treatment of the patient. However, several families reported that they did not see any clear plan result from the ICP meetings. They stated that these meetings were often rushed and time was spent looking back rather than looking forward. The expectations of many parents were unmet. As one parent stated, "I just expected that she would have a lot of structure brought to her life, that we would have a lot of support brought into our life...I expected for her to have structured treatment. I expected at the end of the day that I would take her out in a few weeks and...there would be a plan in place for her...it was never really anything concrete."

Coupled with this was the fact that in some cases during the latter part of 2008 the very nurses who were spending their shifts with these patients were unable to attend ICP meetings and/or weekly rounds due to staffing constraints. As one nurse stated, "...nursing is very important because we are the ones that are with the children 24/7. We're with them all the time, so, I mean, if we can't go, what in the name of God are we there for?" Along these lines, another nurse voiced frustration over their inability to attend rounds during 2008. "I would like to see more nursing involved in the rounds...they always close the school for these rounds...and education, yes, is a very important aspect of the child's care...however, I do feel that the nursing aspect is just as important, if not more, because they are there, really, for psychiatric reasons versus the educational part of it..."

Since the re-opening of Unit J4D, we have been informed that a concerted effort has been made to have an extra staff person scheduled when rounds occur in order to make the primary nurse available to attend rounds when his/her patient is being discussed. The consistent implementation of this approach will hopefully assist in increasing the likelihood of a cohesive team approach to patient care.

The communication between families and the treatment team needs to be improved. Assigning a case manager within the treatment team would alleviate many concerns and ensure better organization and consistency of care.

***Recommendation #3***

**THAT Eastern Health ensure:**

- a) **patients and families have a clear understanding of the treatment plan, their role in the plan, and who is responsible to monitor and implement the plan.**
- b) **patients and families receive written documentation at the end of each ICP meeting.**

***Recommendation #4***

**THAT Eastern Health designate a case manager within the treatment team to be responsible for coordinating, monitoring and managing a patient's individual treatment.**

## 4.6 Programming

### 4.6.1 Therapeutic Programming

As indicated earlier in the Report, during 2008 J4D employed eight psychiatrists, one psychologist, one art therapist and an inpatient social worker who shared his time with another unit. In addition to this, Unit J4D was staffed 24 hours a day by nursing personnel. Despite the number of employees, programming on J4D was limited.

With only one psychologist for much of the year who was responsible for servicing both the Inpatient and Outpatient Child and Adolescent Psychiatry Units, there was an extensive waitlist for patients in need of this intervention. One would assume this created stress for the psychologist who was unable to meet the needs of patients and also had an affect on the progression of patients who would have potentially benefited from psychotherapeutic treatment. As stated by one nurse, "...psychotherapy is not offered to all patients that come on the Unit and it should be. It should be one of the first therapies that are offered."

Having only one psychologist also limited the types of psychotherapies available. As one respondent commented, "...if you have one psychologist you're really limited to their sort of repertoire...an ideal would be that you would have different people with different sorts of areas of expertise...you'll get the type of psychotherapy that might help for that patient and more likelihood that they might engage..." Aside from psychotherapy, the only other regularly-scheduled treatment available was art therapy, which was offered to patients for whom it was deemed effective.

Given that weekly services such as pet therapy and play therapy are located in another area of the hospital, they could only be attended by patients who were deemed able to maintain safety off the Unit, ruling out a number of inpatients on J4D during 2008. While music therapy was offered with positive results for a short period in 2008 through a grant program, at the time of writing, the Unit had not been able to secure funding for continued music therapy.

Several staff members indicated that, over the years, programming on J4D has actually decreased. As one respondent commented, "there were more programming options available on the Unit 10 years ago compared to what is currently in existence. The Unit has gone from three psychologists to one and no OT<sup>\*</sup>. There was also an RT<sup>†</sup> working on the Unit in previous years, but this position has been vacant for three-four years."

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\* J4D successfully secured funding for an occupational therapist during 2009 after repeated requests for this service.

† Recreational Therapist

#### **4.6.2 Group Therapy**

While there have been attempts to operate various types of group therapy on the Unit, in the view of some staff members, it has been ad hoc due to the wide range of presenting illnesses, the age range of patients and either lack of available nurses to operate this form of programming or lack of a particular skill set to feel competent in this area. Some respondents felt that, "...the issue with groups on our Unit is that we don't have the numbers [of patients] to do formal groups in a consistent way...one week you might have one child who would be suitable, and then there'd be two weeks where there would be nobody available." Another perspective was, "...I think there was a level of discomfort from the nursing staff there in being able to provide it because there had been no training for staff...There were quite a few nurses who weren't psychiatric nurses. So, they had no experience or anything with groups."

Other respondents felt that staffing constraints further impacted the ability to implement groups. "...because we have chronically been short staffed, even people that could do things don't have that ability."

However, not all staff agreed with these viewpoints and felt that with some planning, creativity and the right skill set, more effective group programming could be implemented. "...even with acute care you have structured activities and even with children...It can be done..."

#### **4.6.3 School**

The school program operates in conjunction with the Eastern School District and is a large part of the programming component on J4D. As the Unit currently stands, school is the only service on the Unit that provides structure and routine. "...school provides the structure, even though I would argue that it's certainly not necessary to the extent that we have it, but it provides structure to the day." Several respondents also took issue with the fact that school formed the majority of the programming component on an inpatient psychiatric unit. As one psychiatrist stated, "...to think that you need to have a full school day while you're in the hospital to me seems like overkill...it's a lot of hours in the course of a day that I think could be spent in a far more productive way given the fact that the child is basically in the child psychiatry intensive care unit." Another psychiatrist further commented, "...the focus of the admission is not academics and one could argue in these cases the academics is sort of the least of their concern." One psychiatrist addressed the fact that school, in and of itself, fails to provide a therapeutic element which should be the main focus of the Unit. When questioned about the amount of therapeutic programming on the Unit, psychiatry staff commented, "The only thing we have on our Unit is school, and I would argue we need less school – more therapeutic intervention; because the school itself is not a therapeutic intervention, it is school."

Given the emphasis on schooling, during the months of July and August when it is not operational, patients on J4D were left with many unstructured hours in their day.

When questioned as to how these hours were spent, nurses indicated that sometimes they would play games, bake, or do crafts. “There didn’t seem to be a lot of structured programming. Many of us did our best to...do crafts with patients, try and keep them busy with other things that might be helpful.” A parent referred to their child’s daily routine, “A typical day would be getting up – and this is in the summer – and literally having your breakfast, playing cards, you might see a resident for 15 minutes...you’re chatting with the nurses, you’re chatting with the patients, then 4:00 we’d get off work and go and pick her up. If she wasn’t up to a pass, she’d go in and go to bed. And that was her day...There was no active treatment...” A patient further commented, “Summer [there is] no programming whatsoever... You just sit down and look out the window. That’s what I did at least. That’s what most kids I remember doing. Sitting down, wishing you were outside.”

#### ***4.6.4 The Need for Structure and Routine***

The lack of daily structure and routine, especially of a therapeutic nature, presented as a main concern for patients on Unit J4D. With hours of unstructured activity for weeks at a time, it was no surprise to hear physicians state, “Patients were incredibly bored. I’ve had patients complain of being bored.” Instead of gaining insight into their illness and moving forward in their treatment, many patients were left idle, unengaged, and under stimulated.

Patients spent countless hours completing crossword puzzles and working on jigsaws. As a result of the lack of structure and therapeutic programming, some respondents indicated that patients deteriorated. One respondent commented, “...there was too much time, too much idle time, too much unstructured time that I felt was unhealthy. And clients sometimes regress when they’re in hospital for so long, depending on presenting symptoms.” As one psychiatrist stated, “A lot of the kids that I work with sort of deteriorate when left to their own devices...with nothing to do they tend to regress as opposed to moving forward.”

One patient spoke of their own experience on the Unit and the need expressed for more structure. “...it was unnecessary for me to be in there for a year without any of the therapy...I’d really like to see, sometime in the near future, more structure and for it to be at least a half enjoyable place. Because it’s just no fun, especially if you’re not well enough to get passes. Just to be lazing around and sleeping in the daytime...It gets boring after a while of just playing cards and board games, as many board games as we play...And I can definitely say it made me more depressed. It made everyone more depressed really...” The patient summarized their thoughts with the statement, “I don’t want any other kids to go through the same experience that I went through.”

#### **4.6.5 Addressing Programming Gaps**

There is a need for further development and expansion of the therapeutic programs and services provided to inpatients on J4D. One psychiatrist commented, “I don’t think we have enough programs and services for child psychiatry – period...we could benefit from so many more resources...the wish list would be almost endless...” Another psychiatrist further commented, “...the inpatient unit should have all these therapeutic opportunities available, otherwise it would be just glorified babysitting service, just to make sure they don’t do something dangerous. It wouldn’t be treatment.”

In addition to expanding programming, there needs to be a clear distinction between involving patients in activities for the sole purpose of occupying their time, as opposed to engaging them in activities with the goal of providing therapeutic insight. As one psychiatrist stated, “...I would distinguish activities, from programming or therapeutic activities...keeping busy and entertainment...doesn’t have much value...unless some meaning is made of it...the activities that people are doing are being done for...just having something to do and that seems kind of like a waste of time to me.”

During 2008, it was reported that the focus of the Unit was more geared toward safety and observation as opposed to providing therapeutic programming. As one psychiatrist stated, “... providing a monitored observed site for anyone who was suicidal or dangerous in some way to be in a contained setting with regular observation and monitoring...the Unit provides that and does that well.” However, “...in terms of providing a therapeutic venue, a place where kids and teenagers who get admitted to what is basically the child and adolescent psychiatric intensive care unit with the most complicated problems that exist in the Province...for them to get care in a setting that is therapeutic in every way or therapeutic in most ways...that doesn’t exist.”

Along these lines, while it was agreed that nursing staff excelled performing general nursing duties and maintaining safety, many respondents felt that nursing staff could be better utilized in providing more therapeutic intervention to patients. As one psychiatrist stated, “...they do administer the medications...observe the patients for symptoms related to their illness and improvement or deterioration, those kinds of things. I think their role could be expanded a lot...I think they would have a lot to offer with respect to groups. I think they would have a lot to offer even with individual psychotherapy with their patients that they’re assigned to.” Another respondent echoed this viewpoint. “...people sometimes [on the Unit] are sadly underutilized. I think everybody has an important role to play and I think not recognizing that would be a problem...”

There is no question that the amount and type of therapeutic programming on J4D needs to be expanded and improved. And while we understand that during 2009 an occupational therapist was hired for the Unit, many gaps in the area of programming still exist. We acknowledge the Review’s recommendation to hire Child and Youth Workers and would further suggest that the need for more psychologists, a recreation therapist, and music therapist, just to name a few, cannot be underemphasized. However, *it is the*

*opinion of the OCYA that simply employing more therapeutic staff does not go far enough in addressing the underlying issues entrenched on the Unit. A more in-depth understanding of psychiatric mental health and how it relates to a philosophy of care needs to be addressed.* This will be expanded on later in the Report.

***Recommendation #5***

**THAT Eastern Health conduct a needs assessment to expand J4D’s programming component and ensure that all elements add therapeutic value to a patient’s individual treatment plan.**

## **4.7 Therapeutic Passes**

Therapeutic passes are a valuable component of the treatment plan. Oftentimes, during 2008, patients and families voiced concerns surrounding the cancelling of passes. Many patients indicated that they would be issued a pass by a psychiatrist only to have it cancelled by nursing staff. According to parents, no sufficient explanation was provided as to why this cancellation had occurred. Understandably, this left families, and patients particularly, feeling frustrated, disappointed and confused. It also negated any value that was to be gained from having time away from the Unit.

*It is the opinion of the OCYA that the process of administering and cancelling therapeutic passes must be clearly outlined and communicated to the patient and family.* For example, psychiatry staff should clearly communicate to patients that, in their absence, as the main caregivers on the Unit, nurses will conduct the MSE. If they deem the patient unsafe, the pass will be cancelled. Detailing this procedure would go a long way in providing a clear understanding among patients of the process. It would further create a more cohesive team environment and a unified approach to patient care.

## **4.8 Discharge Planning**

From a patient perspective, the planning around discharge was often unclear as was the overall goal of what they were working toward. According to one patient, “I mean a lot of times it was just like ‘do you want to be discharged’ and every time they asked me I said yes, because I wanted to be...I didn’t know what I was really supposed to achieve.” Along these same lines, when asked if they felt they got the help they needed on the Unit, another former inpatient commented, “Not really. I don't feel any different...After a while I kind of gave up and said screw it, I just want to get out of here.” When asked what they had hoped to find during their time as an inpatient, the response was “...to find out what was really wrong with me.” The parent perspective reiterated this viewpoint as one parent outlined what they thought discharge would produce, “My expectation was that she would be a little bit more stable than she was when she came home.” For these respondents, there was a sense of disappointment and disillusionment with what time spent on J4D would bring about. While this may be indicative of a lack of

understanding as to what an acute care unit is meant to achieve, it also speaks to the disconnect between patients, families and the staff of J4D.

According to some psychiatrists, prior to discharge, each discipline involved with the patient will schedule their own follow-up appointments if outpatient treatment is deemed necessary. However, the file review process revealed that oftentimes this responsibility is left to the patients. ***It is the opinion of the OCYA that J4D staff should be responsible for the scheduling of follow-up appointments prior to discharge and that it not be left to the patient.*** For patients who reside in rural areas of the Province, as stated earlier, linkages should be made to local health professionals, whenever possible. A couple of psychiatrists engage in telepsychiatry and travel clinics do occur from time to time. The creation of a *communications liaison* position has been emphasized throughout this section of the analysis. This position would alleviate many issues of communication and inconsistency as well as provide a focused, proactive approach to Unit management and patient care.

#### ***Recommendation #6***

**THAT Eastern Health establish a *communications liaison* position to manage all aspects of each patient’s care on the Unit. This would include overseeing the admission process, education, policy and procedure adherence, team cohesiveness, family involvement, etc.**

### **4.9 Facility Limitations**

Many comments were made by families, patients, and staff regarding the physical layout of the Unit, issues with the particular patient mix, the inability to take patients outside securely and the physical presence of security on the Unit.

The physical interior of J4D was also brought to the attention of the OCYA on many occasions during the interview process. As one staff member commented, “The physical space of some of the bedrooms is probably unsafe, due to the little alcoves that are there...I just think that for a child on an inpatient psychiatry unit, we should do everything that we can to create a physical space that would promote wellness and recovery, and I don’t feel it does.”

Another issue that emerged regarding the limitations of the facility was the mixing together of patients with various diagnoses, from various ages and stages of development. As one psychiatrist commented, “...sometimes the mix is not good...if you have...a patient on the Unit with severe aggression or if you have an acutely and severely psychotic agitated patient on the Unit you’re not going to bring in, you know, a six year old in that mix.” Parents also provided feedback on how they saw the patient mix. For example, many families were concerned with the fact that younger children would be affected by many of the incidents that occurred on the Unit. Others voiced concern with the possibility of patients negatively influencing one another’s behaviour. “You’ve got kids in there who’ve got eating disorders...Then you have kids with behavioural

issues...they're all meshed together...So the kids are watching this stuff happen and I know I used to have a lot of concerns about that..."

As with many other concerns brought forward in this Report, facility limitations were largely impacted by staffing issues and shortages. Many respondents spoke of the fact that J4D contains two nursing stations that were put in place with the goal of allowing staff to divide the Unit to best meet the treatment needs. It is our understanding that this has never been put into effect. One respondent commented, "...the goal was to divide the patients and have a bunch down in one end and the younger ones up in the other end or whatever...but it becomes a staffing issue. There are still common areas where they need to eat...plus it assumes a balance and there is rarely a balance."

The lack of a secure outdoor area and the inability to provide fresh air and exercise to patients was referred to time and time again. Parents frequently questioned, "...why is there not a secure playground out there that they can go out and see the sunshine?" Psychiatry staff also echoed these concerns and viewed the lack of a secure outdoor yard as a downfall. As one psychiatrist stated, "...we don't have a physical space, a secure physical space that's outside...a space where if somebody is acutely psychotic or acutely suicidal or homicidal, God forbid, that they can just get out and get some sunshine and just stretch their legs, and that is a real limitation...you definitely see...just frustration with that, you're looking outside and it's sunny and you're stuck inside." While many people are aware of the benefits of activity, one psychiatrist further elaborated that, "...exercise has been proven to be as helpful as antidepressants in mild depression, but one staff can't usually go and...walk around the lake with one child." Several respondents felt that the high levels of acuity on the Unit during 2008 prevented nursing staff from taking patients outside. It is our opinion that a secure outdoor area for J4D patients would remedy this challenge.

Another issue regarding the facility voiced by respondents concerned the fact that the physical environment did not give the impression of being kid friendly. "...a concern I've had for a long time is actually the physical space of the Unit. Our Unit looks like a jail. It has concrete walls..." In addition to the institution-like feel of the physical environment, during 2008, security maintained a constant presence on the Unit. Due to the high levels of acuity, J4D operated as a locked facility for much of the calendar year. While some respondents stated that they had an issue with the amount of time that they had security guards on the Unit and felt that "it was detrimental to other patients..." others felt that, "We needed the security on our Unit because of the intensity and lethal behaviours..." Despite the necessity, several respondents spoke of the atmosphere the Unit took on. "...it was unfortunate for other patients and families in that they probably felt it was a prison-like atmosphere. Yet, it was needed for the safety of the Unit. We couldn't do without them. And I have to say, security treated the patients with dignity and respect and total kindness." While we understand the need to maintain safety on the Unit, ***it is the opinion of the OCYA that on a child and adolescent mental health unit, consideration should be given to alternatives.***



***Recommendation #7***

**THAT Eastern Health immediately conduct a needs assessment to address the physical limitations of the Unit layout.**

***Recommendation #8***

**THAT Eastern Health create a secure outdoor space that J4D patients can access regardless of acuity levels.**

## **4.10 Human Resource Challenges**

Throughout the course of this Investigation, it has been made clear that human resource challenges played a key role in the shutdown of Unit J4D on December 13<sup>th</sup>, 2008, and continue to be a cause of concern for the Unit in general. Areas of challenge included budgetary concerns, staff shortages as well as difficulties in recruitment and retention.

### ***4.10.1 Budget***

Most decisions on resource allocation, policy development, strategic planning, and quality improvements are made by the Regional Director of Mental Health and Addictions in consultation with others. The creation of new services, new positions or any kind of critical incident that may involve public disclosure would be referred to the Chief Operating Officer (COO).

According to Eastern Health Administration, "...children's mental health services are largely unfunded, not only in this Province but I think nationally and internationally..." Administrative staff did indicate that, "There is a regional strategic plan for Mental Health and Addictions and there is a provincial strategic plan for Mental Health and Addictions...in the last five years they have had priorities go forward to Government for funding and each year they have received funding...[However]...most of the funding has gone to adult services."

While recently more attention has been given to the area of child and adolescent mental health, historic shortages and under funding continues to leave this area under resourced.

***Recommendation #9***

**THAT the Provincial Government maintain child and adolescent mental health as a budget priority.**

#### **4.10.2 Nursing Shortages**

During the Investigative process, we heard frequent complaints of a lack of available nurses to staff the Unit. Sick leave, annual leave and an overall nursing shortage were all cited as contributors. The PCC indicated that as much as half of her day could be spent attempting to staff the Unit. As one respondent stated, “We complained about it all the time, but it was like we’re in a catch-22 situation. We can’t knit nurses. What are we going to do? Where are we going to get them?” It is also worth noting that, according to the J4D Program Manager, these nursing shortages did not relate to budgetary constraints to hire staff. For a Unit where nursing staff function as the main caregivers, this issue cannot be ignored.

Coupled with the inability to recruit new nursing staff, high levels of acuity in the patient base complicated the issue of staffing even further. As the year progressed, the main priority and objective of the Unit, from a nursing perspective, was to keep patients safe. This became an issue of daily concern. Nursing staff were consumed with supervising patients under their care who were determined to bring harm to themselves. They were also taking increasing amounts of sick leave due to the stress and fatigue of working in that environment. As the situation deteriorated and nurses reached unprecedented levels of exhaustion, the focus for nursing staff was one of survival. The situation on the Unit during 2008 reached the point where many nurses admitted that they would arrive on the Unit burdened with the thought that “I hope I can get through the shift.”

There were concerns regarding whether the Unit could continue to maintain the safety of the patients; and there were concerns with the mental capacity of the nurses to continue to personally manage the long-term effects of working in such an atmosphere on a daily basis. While it was discussed among nursing staff in monthly meetings it does not appear that the situation on J4D was ever discussed in an interdisciplinary fashion, prior to the closure.

One other impact relating to nursing shortages was the inability to admit patients to the Unit. Several respondents indicated that this continues to be an issue. As one psychiatrist stated, “...it’s a year later, I don’t have any other staff. You’re still telling me I can’t admit people...for me that’s a problem.” Another psychiatrist echoed this sentiment, “Most of the time...when I want to admit a patient...the constant refrain is we don’t have staff...There are five beds for children and adolescents with severe psychiatric problems for the entire Province, which is not much. And if you cannot admit patients, even to those five beds... This has been a chronic problem while I have been there.” Another psychiatrist commented, “...staffing on our Unit is a huge issue...we’re often short staffed...the events of this last year has not addressed that. It is still cropping up...it’s still an issue with admitting patients to the Unit. There is not enough nursing staff.”

### **4.10.3 Recruitment and Retention**

In addition to nursing shortages, Unit J4D experiences shortages across all therapeutic disciplines. In the words of respondents, "...we can identify needs...We still can't fill the jobs. So...you might want to recommend we can have three social workers, four psychologists...a recreational therapist or two, it looks lovely on paper but there is no bodies...We've had trouble recruiting psychiatrists in the past. We're the lowest paid in the country...Psychologists get paid a fortune to work in the community relative to what they get paid to work in the hospital, and they get paid a lot more money to work elsewhere – as do nurses – as do social workers...If they're not tied to Newfoundland for some reason they're going to go, and that's the reality of our situation."

Given that recruitment is such a challenge, retention of employees becomes that much more important. Salary limitations are a large issue in both the recruitment and retention of staff. "I can't speak for other provinces but the reasons that people usually leave or often leave are cited as being monetary."

#### ***Recommendation #10***

**THAT Eastern Health address salary issues to ensure that the Unit is staffed with appropriately trained and compensated individuals.**

### **4.10.4 Establishing a Specialized Psychiatric Unit**

The OCYA was informed that because J4D is not designated as a specialized Unit, there is no requirement to hire psychiatric trained nurses. During the interview process, nursing respondents indicated that the only training offered was workshops on Therapeutic Crisis Intervention and Suicide Intervention. While some nurses may be both interested and willing to pursue mental health training of their own volition, it is not a requirement to maintaining their position on the Unit and no incentive is offered for doing so. Other than a small bi-annual fund and an occasional workshop, education occurs on one's own time and at one's own expense.

Many staff from various disciplines voiced concerns with the lack of training required for nursing in the area of mental health and were of the opinion that J4D should be designated as a specialized Unit. As one respondent commented, "Children and adolescents with psychiatric illness are an extremely vulnerable population...I believe psychiatric nursing is an important specialty, especially when it comes to caring for children with psychiatric illness. I don't understand how, for example, nurses in the community working with adults who suffer from serious and chronic mental illness must be Psychiatric Nurse IIs, while a nurse with no psychiatric nursing background whatsoever can care for children and adolescents with psychiatric illness."

Along these same lines, another respondent further commented, "...just like if you're going to work in the neonatal intensive care unit, you need special training in that area... There is more to psychiatric nursing than talking to a patient and documenting what they ate and wondering if they slept all right and those kinds of things... you can actually... do harm if you don't know what you're doing, because the patients are very vulnerable." In conjunction with this, one respondent indicated that, "...in Toronto Sick Kids [Hospital] you have to have [the Canadian Nurse Exam Certification] completed and passed to work there in the psychiatry unit. But it's not mandatory here and that would be a big challenge..."

One respondent offered an interesting perspective on how a lack of training can impact patient care. "...it is a concern when you have someone coming to an inpatient psychiatry setting who has no mental health training, because what happens then is you bring your own parenting perspective to dealing with children who are mentally ill, and it doesn't always work..."

Several respondents indicated frustration with the fact that some nurses would transfer to the Unit to accommodate their personal or professional needs. In fact, several respondents indicated that it was not uncommon for nurses to come to J4D prior to retirement thinking it would be a less stressful environment in which to work. "The nurses there are fabulous but... you have to have the skill set. You got to. You are dealing with really sick children... their spirits and their hearts are broken... we have nurses that came in because of accommodation... Nurses who came in because they were going to be retiring maybe in a couple of years and they saw that as an easy place to retire... Nurses who might have had great skills in other areas but not in psychiatry."

Even patients indicated their surprise in learning that many nurses did not have a background in the area of mental health. One in particular commented, "I just thought that it was kind of weird that nurses from surgery and the emergency room and stuff like that would be brought to a psych ward."

Another respondent questioned why specialized training was not required when working with such a vulnerable population. "...why should staff have the expectation that they can come to our Unit without... a knowledge in that area and the expertise in that area... I would never go and apply to an intensive care unit... I wouldn't know what to do there... why should this Unit with psychiatry be any different?" This same respondent provided insight on what this level of training and understanding could bring to the Unit. "...if I'm sitting down having a game of cards with somebody I'm assessing them all the time. It is not just a social interaction... if you don't get nurses who are skilled in this area, then no matter what other clinicians are on the Unit, you are going to have a falling down in service because we are the people who are with them all the time. And if we don't have those skills, then we can't have credibility with the other professions."

In addition to the professional perspective, parents and patients also offered feedback on whether or not they felt that J4D nursing staff were equipped to deal with the behaviours and diagnoses with which they presented. One patient stated, "With my

behavioural problems, yes, but not mentally at all...They were always like there if you needed to talk to them or anything.” Another patient also commented, “I think they’re kind of just there to watch you and I’m not trying to be rude or anything when I’m saying that. Because some nurses do try – a couple of them do really try – to get inside your head and help you with some things but I find a lot of the nurses are just there and they just kind of watch you.”

Clearly, as one staff stated, “...there is a wide range of comfort and familiarity with psychiatric illnesses amongst the nurses.” Providing the Unit with a designation as a specialized Unit would better serve child and adolescent psychiatric patients. A designated unit would require changes in the current staffing approach to ensure that staff are academically trained in psychiatry and that time and funding are provided for mental health training. This viewpoint is summed up eloquently in the words of J4D’s Program Manager, “I would like to see child and adolescent psychiatry inpatient designated as a specialized area where you have to have some sort of specialized training to work there...That would be my dream.”

#### ***Recommendation #11***

**THAT Eastern Health designate J4D as a specialized psychiatric Unit.**

#### ***4.10.5 Patient Observation***

The area of human resource challenges would be incomplete if we did not address the constant care procedure on Unit J4D during 2008. As a result of policy issues and nursing shortages, nursing staff were required to endure many hours in a position of constant observation. While we do not dispute the fact that during this time frame there were several extremely challenging patients on J4D, we do question the operation of constant observation on the Unit.

The Health Care Corporation of St. John’s Administrative Policy Manual<sup>2</sup> states that a nurse can remain in a position of constant observation for a maximum of eight hours per shift. During 2008, nurses on J4D were frequently spending 12, and in some cases up to 16 hours, in a position of constant observation due to extreme acuity levels on the Unit and staffing constraints. Breaks were often missed. In fact, many nurses would complete their scheduled shift only to find that they would be asked to remain. In extreme circumstances, nursing staff could be ordered to work due to shortages. While this raised many concerns among nursing staff, supervision in this manner continued to occur. The result was exhaustion on the part of the staff, low morale and a stressed work environment.

Throughout the interview process we heard countless examples of frustration and fatigue from nursing respondents surrounding constant supervision and challenging working conditions. “...sitting for lengthy periods of time, like for 12-hour shifts. There were cases where some people sat for 16 hours...the expectations of us to work

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<sup>2</sup> See Administrative Policy Manual Number XVII-98.

overtime. I'd get sometimes three and four calls in the run of a day at my house to come back to work. This created a lot of tension, and relationships were strained at work because on one hand you felt like you knew your co-workers were at work and they didn't have enough help, and on the other hand you had family commitments and you needed a break."

Patients also voiced concerns with supervision. "...It wasn't so much that I felt unsafe, it was just I could do something right now and no one would know. Because there is...people in that ward that had required 24 hour [supervision] and they always had nurses with them, and somehow all the nurses got sucked up and there is no one left for the other five of us..." Many nurses also shared this perspective. As one stated, "...oftentimes the whole focus would have to be on [certain patients] and that had to have taken away from other patients."

As a point of comparison, the Waterford Hospital operates constant observation on an hourly rotation, whereby staff are relieved from the intense supervision of one patient on an ongoing basis. When questioned as to why this practice was not utilized on J4D, staff indicated that at the time they were unaware of this practice. They further indicated that at various points during 2008 as many as four patients could be on constant observation with a team of five nurses, making relief from constant observation an impossibility as any break would simply mean switching from one constant patient to another. It has been brought to our attention that J4D has since modified procedures regarding constant observation; however, it does not appear that any changes in practice have been officially drafted in policy.

#### ***Recommendation #12***

**THAT Eastern Health revise J4D's constant care procedure and establish this in policy to better ensure safety of patients and staff.**

### **4.11 Inappropriate Admissions**

Some respondents commented on how the lack of community services throughout the Province results in both inappropriate admissions and long-term stays on the Unit. Frequently respondents commented on the fact that J4D has become a Provincial *catch all* for child and adolescent mental health.

Further comments spoke to the lack of understanding of what J4D has to provide, even among professionals within the community. As one psychiatrist stated, "...other professionals are looking for admission to J4D when the problem is not necessarily psychiatric in nature...you have six beds in an acute psychiatric unit for the whole Province that they're wishing to be used as respite beds, which is very difficult...I find a lot of times that people don't understand that ...we may be viewed as being difficult when sometimes they want these patients admitted and it is clear that there is no indication for the admission."

In the words of Eastern Health Administration, “Certainly in 2008 I think there were a lot of unrealistic expectations on J4D...I think people looked at J4D as being everything...also during 2008 there were a number of situations where it was looked at as...providing respite services.” In addition to this, other respondents indicated that many admissions were inappropriate. “I think a lot of patients who are admitted are admitted for sometimes the wrong reasons because of lack of community resources.”

Along these same lines, another respondent voiced frustration with what is expected of J4D, “...there’s a big need for somewhere to put those children, and there’s so many of them out there. I mean usually in the summertime we get them in just for respite work for three weeks because there is nowhere to put them. There is nowhere in the system to put them. You can’t put them on the surgical unit. You can’t put them on the medicine unit. So, oh, J4D got a lovely secure area down there. So...ship them off over there and the nurses will look after them down in the secure area...”

In the words of one psychiatrist, “We often have young people in hospital awaiting transitional placement to different foster homes because their foster home placement is broken down. And also for children from some of the other regions, we tend to keep them a little bit longer because there is no psychiatric service out there.”

### ***Recommendation #13***

**THAT Eastern Health establish a process to address inappropriate admissions.**

## **4.12 The Need for Community Wraparound Services**

As previously stated, during the course of this Investigation many respondents spoke of their concerns regarding the long-term stay of some patients and how this challenged J4D’s mandate as an acute care Unit. According to medical staff, a hospital is not designed as a place for children and adolescents to learn realistic coping strategies and should be used as a last resort. In the words of one psychiatrist, “...we always try to make hospital [stays] sort of as brief as possible and get people back to their homes because we believe fundamentally that’s where children should be...”

J4D uses data from the Canadian Institute for Health Information. From a statistical standpoint, the length of stay on J4D is longer than the national average. According to the Regional Director of Mental Health and Addictions, “The average length of stay is generally longer than it should be throughout our units in mental health...But making hospital units more efficient requires a lot of things. And I guess one in particular is the necessary community supports...”

In the words of a psychiatrist, “...in Toronto or in Ottawa the children’s hospitals there act as tertiary care centres. They make the diagnosis, they begin the treatment and then they send them back to other centres. We don’t have any other centres here. We are it. So the children are there until stabilization is to such an extent that it may require extensive periods of time...even when they were stabilized enough to go back out into

the community there is no place for them to go...if those...short-term and long-term units were in place how much easier would my job be and how much easier and productive would all the staffs' jobs be? It's pretty frustrating when you have a child either in emergency or on the Unit and it is time to discharge the child and there is no place to put them, and you have to keep them in hospital because there is absolutely no other place for that child to go."

It cannot be disputed that some admissions were longer than necessary due to the lack of wraparound services available in the community and the fact that the Province is essentially devoid of alternative options for placement. As one respondent stated, "...if there were other services in other parts of the Province or even other services in town here to provide more intensive care or treatment after discharge...you'd be able to discharge patients sooner...absent that, then yes, patients stay in longer than they otherwise would need to..."

According to the Regional Director of Mental Health and Addictions, budgetary and resource constraints play a significant role in allowing Eastern Health to provide effective programs and services to Unit J4D. However, she also wished to emphasize the need for community services in order to allow J4D to fulfill its mandate. "...the ability...of J4D to carry out its mandate is heavily influenced by the lack of community-based services and dedicated funding...when there is a case of a child or youth in the community who needs intensive supports, wraparound services, may need alternate housing...families, Child, Youth and Family Services, even Government, all feel the pressure then to have the person admitted to hospital. And, of course, that's not what the Unit is intended for...."

Other administrative staff supported this view. "I think we're certainly lacking in a number of community-based children's services in this Province, certainly in terms of residential options and intensive wraparound services. And I think with the lack of some of these services it certainly [added] significant pressure on J4D to respond to the gaps." This person continued to say, "...certainly there needs to be more funding put into community-based service, because I think we need to focus on creating a continuum and ensuring that all aspects of that continuum are funded properly."

One respondent summarized the issues surrounding J4D and the child and adolescent Provincial mental health resources at large in the comment, "I can't say enough that fixing the inpatient Unit isn't enough. The outpatient resources have to be addressed...I think there are patients that have stayed because of the lack of community resources...even if we built a residential care setting...that may not ...solve all of that."

Enhanced mental health services in the community are desperately needed. If a hospital admission is meant to be short term, there must be mental health community supports for that to continue. Despite the recent allocation of funding for the establishment of two child and adolescent residential facilities, community gaps still exist.



***Recommendation #14***

**THAT the Provincial Government, in consultation with youth-serving agencies, develop a strategy to address the gaps in community wraparound services.**

### **4.13 Out-of-Province Placements**

Out-of-Province treatment is a controversial issue when it comes to children and youth. In some cases, the treatment team may identify that an out-of-Province facility is deemed beneficial for a specific patient as the appropriate therapeutic approach may not exist in the Province. While the OCYA is working to ensure that Government makes the necessary changes to address the many gaps in the area of child and adolescent mental health, it is no secret to Newfoundlanders and Labradorians that residents must leave the Province from time to time to obtain necessary health care.

The OCYA questioned why there is not more of an organized and effective process put into effect for child and adolescent mental health when out-of-Province treatment is deemed necessary. For example, for some patients who fell within the parameters of this Investigation, it took months to evaluate whether a transfer to another facility would result.

From a treatment team perspective, one key factor in the process of securing out-of-Province placement is the patient's state of readiness as well as the suitability of the patient in terms of meeting the facility's admission criteria. As stated by one respondent, "...a patient's willingness to participate was needed and that was a bit of a barrier...I particularly remember...resistance from families who really didn't want to have to leave. That was upheaval for them, so there was a certain amount of waiting to find out are they going to decide to take advantage of this or not...[then] when we thought we had something in place there would be some reason that the person wasn't suitable..."

Along similar lines, another key aspect that bears significance is the stress it places on families. "...you can imagine how taxing it would be to have your child in another Province or country where you can't work, where you have no place to live, where you're completely separated from all your supports, I mean that's a big step...you also have to remember that you're taking them away from family, friends...I guess the security of being home."

There are certainly conflicting viewpoints among staff concerning out-of-Province treatment for patients. In the words of one respondent, "I personally think sending kids out of Province for mental health treatment is a folly. It takes a community to create mental health in a person...if at all possible we should be looking at doing what we can do for them here instead of sending them away...It does take time to grow and evolve and make these programs happen. You have to develop the expertise. It has to be based on need and multiple competing interests." Others within administration stated, "I think there may always be a need to send people out of the Province...I don't think it is possible to develop a facility that's going to be able to address every need."

Several respondents commented that there are not a lot of available facilities in other provinces where patients can be appropriately transferred for mental health treatment and as historically this transfer out-of-Province was rare, no clear approach had been established. As one psychiatrist stated, “It’s a relatively uncommon thing to happen and when it does it’s so unique to the patient and the circumstances around it...you’re not going to find anywhere a list of available...treatment programs across the country for a particular diagnosis. It’s really people going out and doing searches and calling experts in other provinces and seeing what’s available in Ontario and Saskatchewan and Alberta and bringing all the stuff back...” For staff, “...it’s very time consuming for people to try to do the research in looking at what’s available to meet the needs of that particular individual and then get the approval sought after that.”

In interviews with Eastern Health Administration, it was confirmed that there is a list of approved out-of-Province facilities in place for adults requiring mental health treatment. From their perspective, the development of a list of approved facilities for children and adolescents would make the process of out-of-Province treatment more effective. “There is no provincial process for sending children and youth out of Province for mental health treatment. It is not covered within the insured services program. So there is no guidelines and there is no process and there is no policy. There is coverage for adults and a provincial policy and procedure for sending adults out of Province...Child, Youth and Family Services have their own policies and dedicated funding for their clients, but when a kid is not in protective care and has complex mental health problems that require out-of-Province treatment, there is no dedicated funding or policy...” From an administrative viewpoint, “It became very problematic in 2008 and continues into 2009 as arrangements have had to be made for several youth, and in each case the arrangements and the funding have been different and have gone different routes and have required different processes.” In the end, the administrative stand was that the lack of a formalized process is ineffective and inefficient. “Should we have a more formal process? Absolutely. We should be a little bit more equipped to deal with these issues in a more timely manner.”

With funding for new facilities being allocated and new programs being researched, the Province is taking some of the necessary steps needed. However, until these facilities are up and running and offer appropriate mental health intervention to assist J4D in its mandate as an acute care Unit, children and youth who need either residential or longer term care in the area of mental health will continue to be serviced out of the Province or remain in the Province with less than ideal programming.

While we understand that each case needs to be decided on an individual basis, we are of the belief that research which would result in a list of approved facilities is an important proactive measure to ensure that a clear plan is available for patients should the need for out-of-Province placement arise.

***Recommendation #15***

**THAT Eastern Health develop a list of approved facilities and establish a formalized process for out-of-Province placements within child and adolescent mental health.**

**4.14 Communication Issues on J4D**

Throughout this Report, respondents have continually spoken to issues which ultimately lead one to conclude that poor communication and inconsistency permeated throughout the Unit. In the opinion of many respondents, there were divisions amongst staff which caused rifts in the treatment team. This lack of cohesiveness affected not only staff morale, but ultimately, patient care.

Throughout the Investigation, we heard many reports of communication challenges on the Unit. The words of one respondent verbalized the desire for improvement in this area. "...I wish that there had been communication more in a structured way, that we could have all gotten together and tried to talk about this, or people been able to express their concerns...I think that the nurses didn't feel supported by the doctors. I don't think they felt heard... [The doctors] felt they needed to keep the patients in and that they were doing the best they could do...but they didn't have to deal with the patients twenty-four hours a day...it was a perfect storm."

There are philosophical differences both between and among the various disciplines on the Unit. This will, in turn, lead to differences in approach to patient care. When these differences are not discussed and debated, nor education provided to expand various viewpoints, it creates animosity and lack of understanding.

The philosophical differences in psychiatric care came through in one nurse's comment which states, "...these new doctors, the new psychologists, the new psychiatrists, do not believe in rules...I don't know if I can work on a psychiatry unit with no rules. It just becomes a free-for-all...and that's what it was becoming...I'm really big into rules and consequences...I like a lot of consistency and I found it difficult."

For some respondents, the frustration revolved around the fact that rules were inconsistently applied in terms of patient care. For example, as one nursing staff commented, "They didn't have to follow any programs. If they didn't want to go to school, they didn't have to go to school. If they didn't want to take medications, they didn't have to take medications. So, I mean as a nurse it was very difficult to have any consistency with [these patients] and consistency on psychiatry is extremely important."

From the perspective of a frontline worker, this approach was particularly frustrating. "...all the nurses felt that things were escalating...there was a fragmented approach...there was staff splitting...from a nursing perspective there were times when the approaches weren't consistent...there weren't policies or anything written down to say, okay, if a patient does this, then the nursing staff do this." Clearly, these staff

members were requesting that issues of inconsistency, team cohesiveness, and a respect for their daily experience be addressed.

Many nurses felt left out of the treatment process altogether, which not only led to further division with psychiatry staff, but left them feeling unappreciated despite their extreme dedication to maintaining safety on the Unit amidst a very chaotic work environment. As one nurse stated, "...I think we should have been more involved when they were meeting with the patients. I know sometimes they need to meet with patients in private, but even if they met with them in private at least give us a heads-up on what was discussed so that we could know what to expect or be on the same page." Another respondent went on to say, "...when it came to the ICP...the problem would be ...that sometimes you weren't in on them to be able to have your input and express your opinion as to maybe whether you agreed or disagreed or thought that there should be something else..." In the end, one respondent stated her opinion on divisions among the staff: "There's such a gap. It's almost like the Grand Canyon in between a nurse and the physician...We're oceans apart."

In order for any work environment to function in a healthy and effective way, you need healthy staff and a team approach. "We'd have to have some strong leaders. I mean leaders in management, leaders in nursing, leaders in physicians. It has to be a team, and we are definitely not a team...you need a really strong team...And if the team doesn't work and there's no leadership...everything falls apart."

#### ***Recommendation #16***

**THAT Eastern Health develop a communications strategy to ensure better management of the Unit and a cohesive team approach.**

### **4.15 Unit Closure**

The preceding information sheds light on the challenges faced by staff – and nursing staff in particular – on a daily basis on Unit J4D. It is our opinion, that failure to adequately address these issues in both a unified and timely fashion, led to an escalation of events that resulted in the closure of the Unit on December 13<sup>th</sup>, 2008. Many respondents have referred to the situations and conditions on J4D as "the perfect storm". Clearly, staffing issues and the lack of felt support across disciplines on the Unit increased the level of stress experienced by staff in working with the challenging issues of long-term patients. The words of many of those involved and their feelings surrounding the events that occurred leading up to the closure speak for themselves.

To provide a context, the first formal meeting held with Eastern Health administration surrounding the issues that were clearly emerging on J4D occurred in August 2008. At that time, nursing staff voiced their concerns in a meeting with the Regional Director of Mental Health and Addictions. Many nurses indicated, however, that while Eastern Health Administration sympathized with their position, a response was slow in coming. As one respondent summarized, "[It was]...reassuring that it was being

worked on, but it didn't help the stress level." The nursing staff were crying out for support and recognition of what they were dealing with. "...there was no sense of acknowledgement or support from the other disciplines of the difficulties that we were facing because we were the people with these patients all the time. Other people could just go in and walk out. But we were there to take the brunt of whatever was going on."

After months of planning, a one-day retreat was held in November for available nurses to address issues of consistency, teamwork and healthy boundaries. It was also supposed to be a time to discuss the need to reinforce rules on the Unit where staff had strayed from consistency. Through the interview process, many respondents indicated that discussing these issues in isolation with nursing staff (many of whom were unable to attend) and administration was ineffective. The need to voice these concerns with all disciplines in a context conducive to discussion and healing was long overdue.

As one respondent stated, "...there was a retreat just for the nurses. I refused to go, I refused to go because it made us look like it was all our problem, and it wasn't all our problem, and I just said no...it should be a retreat with the nurses and the doctors, the psychologist...everybody should be there again to come together on some issues...I really think we should have had some meeting – nurses and doctors – and come to some ground rules for the Unit."

By December, nothing had changed. Many respondents were understandably frustrated with the lack of progress. As one commented, "...Notifying staff in August and still waiting in December is not fast enough...Process is unacceptable when it takes six months when you are going down a path that is detrimental to patients." One nurse detailed how it felt to go to work, in saying, "...it got to the point where the main thing was...for me and my nursing of these children...that they were alive and breathing at the end of my shift. That became my goal and that was my objective." Even the Program Manager spoke of the strain this caused nursing staff in the statement, "No nurse is able to handle three-four suicide attempts on a daily basis."

For the frontline worker the acuity remained high and the Unit itself was rapidly deteriorating. The Regional Director of Mental Health and Addictions stated that, "The nurses were feeling devalued. They were also feeling unsafe." It was also impacting their own physical and mental health. "The last going off... people were...jumping ship because they were sick...Staff were ordered off sick by family doctors because we were suffering from hypertension and stress..."

One Eastern Health Administrator supported this viewpoint in commenting, "...not only were people calling in sick – and I believe people actually were sick – they were so stressed and traumatized themselves...that they didn't feel that they were the people who could now keep these girls safe." The intense and unhealthy work environment finally took its toll.

#### 4.16 Patient Transfer and Police Involvement

On December 13<sup>th</sup>, 2008 the Royal Newfoundland Constabulary (RNC) received two requests for assistance to provide safe escorts of two certified patients from the Janeway to the Waterford Hospital. The RNC was advised by nursing staff that due to a staffing shortage at the Janeway that evening a decision had been made to transfer both patients to the Waterford where trained staff could monitor their behaviour.

Eastern Health Administration was adamant that every possible option was considered before the decision was made to close the Unit and transfer two inpatients to the Waterford Hospital. For example, the possibility of transferring Waterford Hospital staff to J4D was contemplated but determined to be an impossibility given the number of nurses that would be needed to staff the Unit, cover breaks, etc. Other possibilities included a possible transfer to the Health Sciences Centre which, again, was deemed unsuitable. In the end, Eastern Health Administration felt that the Waterford Hospital provided the best solution given the circumstances being faced; we would be remiss, however, if we failed to acknowledge that this was not viewed as an ideal, but the best choice available at the time.

In addition to the decision to close the Unit, the circumstances surrounding the transfer received a lot of public attention. Much was made of the fact that the two patients were transferred in handcuffs under police escort. It is the opinion of the OCYA that a lack of understanding of the issues on the Unit, the level of acuity of the patients involved, a lack of available options that could ensure the necessary safety, as well as a general lack of understanding of certification and police involvement under the *Mental Health Care and Treatment Act*<sup>\*</sup>, created a biased view that failed to adequately represent the challenges involved.

The Regional Director of Mental Health and Addictions stated, “If a client is certified, most but not all, of the transfers are done by police. This is because persons are being detained against their will under legislation; and if it is expected that the person will actively resist, the safest mode of transportation is with the police.”

According to the Regional Director, although ambulance services were called regarding transporting the patients, ambulances are designated to provide service for community emergencies. The only service they provide for hospital transfers is planned ahead of time as an organized process. As the situation involved inpatients, and was not viewed as emergent, the ambulance could not be made available. It was further decided that this mode of transport was not a safe option for the patients, given their refusal to comply. “...It was very evident to both of us that [an ambulance] wouldn't be a safe transport for the girls...So I spoke to the families and informed them that we had to move forward with using the police...And then each [patient] was accompanied separately by nursing staff and police...and with their parents following.”

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\* SNL2006 cM-9.1 as amended.

The authority of the RNC to assist in the conveyance of mentally ill patients is set out in the *Mental Health Care and Treatment Act*. According to RNC Chief of Police, the responding officers' use of handcuffs during transfer was in compliance with the RNC's policy on the conveyance of persons suffering from mental disorders under the *Mental Health Care and Treatment Act*.<sup>3</sup> In a written statement to the OCYA, the Chief of Police stated that "handcuffs are the least restrictive device available to police to safely restrain a person." He further commented, "The use of handcuffs for this conveyance was, in my opinion, a reasonable measure taken by the officers to ensure the safe conveyance of these two patients who were known to be violent, suicidal and a high flight risk."

Somewhat ironically, given the many differing opinions surrounding patient treatment plans and the lack of team cohesiveness across disciplines, staff were in agreement on the decision to involve the police. As one nurse stated, "I have experience at transporting patients, and I felt then and I feel now, that the police car was the best method of transportation for those [patients]. Being handcuffed was for their safety; for our safety also...The police car was the respectful, safe method of transportation."

Further to this, one psychiatrist stated, "I would much rather be here discussing why the RNC were involved than to be here discussing a dead patient and why they weren't involved."

Another staff member voiced bewilderment with the public response. "I thought the method was more than appropriate. When I heard the following week of all the hype about what happened I truly was surprised, because the hype that would have happened if a child was transported from the Janeway to the Waterford *not properly contained* and went across that highway and caused injury to herself or to the driver or to the staff that were with her...would have been much greater...Nobody transports people like that unless there's a reason."

The new Clinical Chief of Mental Health and Addictions appropriately addressed how uninformed public opinion can create challenges with clinical decisions. "It is hard to watch a teenager in handcuffs...That does get people's attention; but if it is the safest way of transporting a person from one facility to another, and if it is absolutely necessary then I guess the patient's safety is more important than how it looks..." This respondent went on to say, however, that, "There certainly are alternatives...I think the police have other things to do besides helping a hospital transfer patients between building to building...I think having a designated service that isn't sort of paramedic-based, I think that's worth looking at."

In the end, given the options that were available at the time of the December 13<sup>th</sup>, 2008 transfer, Eastern Health staff and the RNC were satisfied with how this situation was handled by the professionals involved. As stated in a written statement by the Chief of Police, "it is regrettable that public comment on this case has been made without a full

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<sup>3</sup> s.21 of the *Mental Health Care and Treatment Act* authorizes the use of reasonable measures, including physical restraint, to effect a safe conveyance to a treatment facility.

understanding of the case in question and the legislative authority...which the police are mandated to follow under the *Mental Health Care and Treatment Act*.”

***Recommendation #17***

**THAT Eastern Health develop a plan for intra-hospital transfers in the area of child and adolescent mental health.**

#### **4.17 Media Involvement**

Many respondents voiced irritation with the very public way the challenges on J4D unfolded and how things were being portrayed in the media. According to a representative of Eastern Health Administration, “if [it] wasn’t challenging enough in trying to provide effective treatment and care for these patients...the staff had to contend with extensive one-sided media coverage...where treatment plans and the care of these patients was being publicly put out there, and I think that really had an impact on the staff and really questioned how they were providing services.”

In the eyes of respondents, the real story and the day-to-day reality that was occurring behind the scenes was inaccurately represented, “...unfortunately the media, as you know, always portrays things in a bad light. They never want the true story of what really transpired on our Unit, and that’s something that we have to deal with. It was very hard to listen to the media...they just don’t know who you are or what you’ve been through or what you’ve done. We’ve had lots of success stories, and I wish people knew about our success stories. Unfortunately, the media preys on the sensationalism that’s put out there and because of our confidentiality we can’t respond to that; we can’t defend ourselves. That was really hard to take...That hurt very deeply.” Other respondents also addressed their frustration with how their positions within Eastern Health rendered them to silence. “Confidentiality is the big thing that ties our tongue. It doesn’t seem to tie anybody else’s tongues but it seems to tie ours...You can’t go on the defence, you can’t go on the offence, you can’t do anything other than to say well...don’t quite believe everything you hear in the news...I think it led to a great lack of morale on the Unit...”

Another respondent spoke of decreased public trust and false accusations. “I feel that the media attention really decreased public confidence in our Unit...And it increased the stress of the staff...the nurses did not just call in sick; nurses *were* sick. Nurses were physically sick, nurses were mentally sick. However, the public perception – even other nurses’ perception – was that it was a union tactic that we called in sick...I just feel that the media attention added so much salt to the wound...” Another respondent continued, “...in the media I felt that nursing was really devalued. We were not given any support for what we did and it was extremely upsetting to know that we worked our guts out – we really did – to the detriment of our own families and our own health; and yet we were seen as the bad guys.” “I think that the media just killed us, and I think that we deserve an apology. I really, really think we deserve an apology in the media.”



In another vein, the words of one psychiatrist spoke to the impact such media attention can have on staffing. "...Given our issues with recruitment and retention...if we create a climate where people are tried in the court of public opinion, where there is no amount of care that's considered good enough, and where people are held to a standard that doesn't exist anywhere else in the modern world, I don't see how we're going to have people work here...In this current climate I will say that I'm amazed anyone continues to work here and I suspect people will leave because it is just getting at a point where it really doesn't make any sense to work in a climate where people are openly...slandered really...perhaps the line is right that there is nothing that can be done about it, but people's family, their children's friends are hearing that they're incompetent, that they should be suspended...and people are not – for half the money, with less resources – going to continue to stay in that climate. Rationally, it makes no sense. So I think we've got a major problem – not even in recruitment – I don't think ultimately, we're going to keep the people that we have...The people that are going to suffer are the people that aren't going to get services and I don't know whose job it is to worry about that, but I feel like it should be someone's job..."

Another staff member commented, "...this is an open line population. I have never seen people so willing and able to sacrifice their confidentiality, to live out their family tragedy in the public forum...I have never seen a media without any kind of editorial prudence. We know reporting on these stories creates more stories to report on, and we've got reporters who are seen as heroes in the local area for championing these problems and yet completely ignorant of the fact they they're actually part of the treatment team...It is a failure to appreciate the complex psychological dynamics around cases...these cases are being acted out in the newspaper and on the evening news and...that's not fair...that never should have happened."

One respondent made the suggestion that, "...if we're going to move forward on this, we need to make sure that there is checks and balances in place. I think there needs to be a strong Advocate's office. I'm a hundred percent supportive of strong advocacy and a balanced media and competent clinical care...let's get good programs in place for people. Let's grow our programs in a way that allows people to get perhaps more timely access to care. Let's build capacity but let's do it on the basis of evidence and the basis of research and the basis of what we know might work."

#### **4.18 The Need to Move Forward**

According to the Regional Director of Mental Health and Addictions, staff were offered education sessions on safety policies, stress debriefing sessions as well as several sessions on vicarious trauma which were provided by trauma team social workers. One of the administrators indicated, "We did a number of education sessions on self-care, respectful workplace, vicarious trauma. We did education sessions around policies in particular, around constant observation levels. We started to engage senior mental health nurses to try to help out the Unit. We arranged for debriefing sessions for staff through REFAP, and we also started... building conflict resolution process..."

Despite these offerings, the Regional Director stated that, "...people haven't been attending what we've even given them...I think you have to have a mindset to be open to training and education." While that is true, there are valid reasons for low attendance. For example, "...if you're on a Unit where you don't feel appreciated and you feel devalued and disrespected and those kinds of things, you're hardly in a mindset to want to go..."

From a nursing perspective, what was being provided by administration was not sufficient and in some cases, according to respondents, never actually materialized. "They recommended a three-day workshop with all the staff to deal with vicarious trauma. That never happened. You know our staff have been traumatized by this. So they had professionals that work within Eastern Health come in and say: okay, this is what we recommend. This is what your staff needs, but we never did receive it." "They did bring in a team from the Waterford. I did get to go to one debriefing, but I could have been in debriefings every day, because every shift I worked there was something. I went to one debriefing and we had a precarious trauma team. They did meet with us in December and felt that we needed a three-day workshop with all the team, and it hasn't happened yet."

One nurse voiced the opinion that they needed more than sessions that focused on incidents that occurred on the Unit; they needed the opportunity to heal and to move forward as a team. "...after all the incidents that happened...I really feel like something needs to be done, like maybe a bigger debriefing or something has to be done to get rid of all this negative emotional energy...it will affect how you're nursing in the future...It's not dealt with yet...it's a presence in our Unit and it needs to be gotten rid of."

***Recommendation #18***

**THAT Eastern Health provide all staff on J4D with opportunities to come to terms with the events that occurred on the Unit during 2008 and to move forward as professionals.**

## **5.0 A New Philosophy of Care**

Throughout this Investigation, it has been clear to OCYA staff that significant changes are required to move J4D forward in order to better serve the mental health needs of children and youth in the Province. Many Eastern Health staff have also voiced the opinion that change is necessary. In the words of one psychiatrist, "...we've run a very custodial...rules-based kind of Unit and I think we need to be much more open to having a Unit that's based on needs and strengths and encouraging that. It hasn't been a very open place..." Another psychiatrist elaborated in saying that a custodial Unit provides a safe place to stay, but "is really different than being optimally therapeutic..."

There is a need for Unit J4D to acknowledge that its patient base has changed. Training for all staff needs to be provided to ensure that people have the latest evidence, information and treatment techniques across the different diagnoses as they become more common. "If we're going to be the only inpatient psychiatric child and adolescent psychiatric Unit in the Province, we can't afford to be just a short-term stabilization Unit anymore because the needs are greater...the main concern should be the patients, and...what we're not doing to stabilize them..." The Unit needs to be more patient centred, which includes the need to be both flexible and adaptable in its philosophy of care, instead of a one-size-fits-all approach. As one respondent appropriately stated, "...if you have the fundamental values that you're going to work on each child's strength and support them...that means that you're going to have five very different looking programs and five very different responses to the same incident and five different children...I think that we sometimes lose sight of that in a one size fits all."

Continuing along these lines, as one respondent stated, "...in a union setting, where there are rules about needing to do hires based on seniority and hiring staff who have been doing something else and...are now thinking about a shift over to psychiatry because it's perceived as easier – those aren't the staff that you want to hire as you're creating a change..." Such a mindset will do little to move J4D forward in providing optimum care for children and youth in the area of mental health. "...you want people who are excited and enthusiastic and are eager to get to know these kids..."

From a treatment perspective, team members need to be aware of the importance of actively including parents and patients in the treatment plan and recognizing the significant role they play. Some staff admitted that, as a Unit, "We [haven't made] allowances, and I think as a group we've kind of shut parents out. We'll bring your child in, fix them, and send them back to you and we expect you to make the changes, instead of being more family centred."

The desire for change was voiced by many respondents. The insight of one staff member effectively shows how change could make J4D more effective in addressing the needs of its patients. "...the best inpatient units are the ones that provide a therapeutic environment, a therapeutic milieu for kids and teenagers to be evaluated...and everything from... eating breakfast, to getting washed up, to going for walks, to playing, to having to

be engaged with peers is understood in a therapeutic context. You can make meaning of it and learn something from every interaction...then there is a real opportunity for increasing awareness of what's going on that led the kid to be admitted to the hospital in the first place...to do that would require staff who were there around the clock on J4D...to really be engaged with kids, to be warm and curious and close and connected...asking questions about everything that's going on and really trying to understand who this kid is as they build a relationship with them...That doesn't happen on J4D. That's not the culture of the place...the way the Unit is set up it's about the rules, it's about compliance, it's about structure. It's not about flexibility, it's not about curiosity, it's not about a genuine eagerness to learn what are the particular quirks of this kid that I can work with...that we can then incorporate into our treatment plan...to do that would take a whole mindset shift and that's what this place needs. That's what would make this place a fantastic resource for the kids and teenagers of this Province.”

A mindset shift needs to occur. With such, J4D will be better positioned to meet the needs of its patients, decrease the level of stress experienced by staff and consequently increase the cohesiveness of the treatment team. “...any activity with a different mindset...has the possibility of informing the staff about really who this kid is...which then gives you a better working understanding, a better diagnosis and a better treatment plan that you can then offer up back to the child or teenager themselves along with their parents to move on from the hospital with new information and new knowledge.”

If the current culture on J4D remains the same, implementing new programs and services will not matter. “...unless people know what they're doing in some kind of really integrated way...I don't think there's going to be any substantial change to the Unit.” But following a mindset shift, there is no end to the specific programs and services that could be of benefit. As one psychiatrist summarized, “...with the same ingredients you could make...pancakes or a fancy chiffon cake...” This respondent continued by saying, “...there are people here with amazing talent...there are plenty of local resources to take advantage of in the context of a program that is coming at the care of kids from a whole different perspective.”

Respondents spoke of the need for Eastern Health Administration to be committed long term to the change process. All staff must possess both a desire to change and an openness to looking at new ways of approaching patient care. As one staff member stated, “...the commitment has to be from a much higher level than just the program or divisional level.” Change is difficult. Challenges will occur along the way, but these challenges can result in: a better trained staff, a more therapeutic milieu, a more cohesive team approach, and more effective mental health treatment for the children and youth of this Province.

## **6.0 Conclusion**

J4D continues to admit children and youth, some short term and some for a longer duration. The issues that so clearly came to a head in 2008 cannot be ignored simply because the current climate on the ward is now of a lower level of acuity. Patient acuity levels can change at any given time and staffing challenges remain an issue.

The Province must respond. And it must respond in a way that sufficiently and effectively meets the needs of child and adolescent mental health. The therapeutic needs of patients have to be addressed. If Janeway Unit J4D is to remain the only mental health treatment facility for children and youth in the Province; then there is a responsibility to not only address the gaps in treatment, but to more appropriately revamp the Unit's philosophy on the therapeutic milieu it will provide. This does not negate the fact that a more specialized wing or facility may need to be considered or that a standardized link to residential treatment and community resources must be established. Staff can be better utilized, and communication and teamwork must improve. The development of a therapeutic milieu can be implemented regardless of whether a facility is an acute care or a longer-term facility. What is required is a willingness on the part of the staff and the highest levels of Government, to be committed to providing a consistent, therapeutic approach to patient care.

It is our hope that this Investigation will provide an opportunity, "...for people at the highest levels of leadership at the Health Authority and in Government to get behind, to support making a significant philosophical shift in the way care is provided on this Unit."

## **7.0 Recommendations**

### ***Recommendation #1***

**THAT Eastern Health revise policies so that they are relevant to the patient population it serves.**

### ***Recommendation #2***

**THAT Eastern Health ensure consistent interpretation and implementation of policies and procedures.**

### ***Recommendation #3***

**THAT Eastern Health ensure:**

- a) **patients and families have a clear understanding of the treatment plan, their role in the plan, and who is responsible to monitor and implement the plan.**
- b) **patients and families receive written documentation at the end of each ICP meeting.**

### ***Recommendation #4***

**THAT Eastern Health designate a case manager within the treatment team to be responsible for coordinating, monitoring and managing a patient's individual treatment.**

### ***Recommendation #5***

**THAT Eastern Health conduct a needs assessment to expand J4D's programming component and ensure that all elements add therapeutic value to a patient's individual treatment plan.**

### ***Recommendation #6***

**THAT Eastern Health establish a *communications liaison* position to manage all aspects of each patient's care on the Unit. This would include overseeing the admission process, education, policy and procedure adherence, team cohesiveness, family involvement, etc.**

### ***Recommendation #7***

**THAT Eastern Health immediately conduct a needs assessment to address the physical limitations of the Unit layout.**

### ***Recommendation #8***

**THAT Eastern Health create a secure outdoor space that J4D patients can access regardless of acuity levels.**

### ***Recommendation #9***

**THAT the Provincial Government maintain child and adolescent mental health as a budget priority.**

***Recommendation #10***

**THAT Eastern Health address salary issues to ensure that the Unit is staffed with appropriately trained and compensated individuals.**

***Recommendation #11***

**THAT Eastern Health designate J4D as a specialized psychiatric Unit.**

***Recommendation #12***

**THAT Eastern Health revise J4D's constant care procedure and establish this in policy to better ensure safety of patients and staff.**

***Recommendation #13***

**THAT Eastern Health establish a process to address inappropriate admissions.**

***Recommendation #14***

**THAT the Provincial Government, in consultation with youth-serving agencies, develop a strategy to address the gaps in community wraparound services.**

***Recommendation #15***

**THAT Eastern Health develop a list of approved facilities and establish a formalized process for out-of-Province placements within child and adolescent mental health.**

***Recommendation #16***

**THAT Eastern Health develop a communications strategy to ensure better management of the Unit and a cohesive team approach.**

***Recommendation #17***

**THAT Eastern Health develop a plan for intra-hospital transfers in the area of child and adolescent mental health.**

***Recommendation #18***

**THAT Eastern Health provide all staff on J4D with opportunities to come to terms with the events that occurred on the Unit during 2008 and to move forward as professionals.**

## **Appendix A**





**Office of the Child and Youth Advocate**  
PROVINCE OF NEWFOUNDLAND AND LABRADOR

December 15, 2008

DELIVERED BY COURIER  
STRICTLY PRIVATE AND CONFIDENTIAL

Mr. Don Keats  
Acting Deputy Minister  
Department of Health and Community Services  
West Block, Main Floor  
Confederation Building  
St. John's, NL

Dear Mr. Keats:

Re: Notice of Investigation Pursuant to the *Child and Youth Advocate Act*  
Eastern Regional Integrated Health Authority  
Inpatient Psychiatric Services  
Janeway Children's Health and Rehabilitation Centre  
St. John's, Newfoundland and Labrador

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I write at this time to provide notice of my intention to conduct an Investigation of the services and programs provided by the Janeway Children's Health and Rehabilitation Centre during the period January 1, 2008 to December 31, 2008 to the following patients:

1. Patients who were admitted to the Janeway Children's Health and Rehabilitation Centre due to:
  - (i) suicidal risk;
  - (ii) self harming behaviour; and/or
  - (iii) behaviour which presented risk of harm to others.
  
2. Patients who were diagnosed and/or treated for:
  - (i) suicidal risk;
  - (ii) self harming behaviour; and/or
  - (iii) behaviour which presented risk of harm to others,

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during their admission to the Janeway Children's Health and Rehabilitation Centre.

3. Patients who were assessed by the Janeway Children's Health and Rehabilitation Centre as being:

- (i) suicidal;
- (ii) exhibiting self harming behaviours; and/or
- (iii) behaviour which presented risk of harm to others,

but where admitted elsewhere for treatment (i.e., Health Science Centre, Waterford Hospital, etc.).

This Investigation will be conducted in accordance with the provisions of Section 15.(1)(a) of the *Child and Youth Advocate Act* (the "Act"), which states:

15.(1) In carrying out the duties of his or her office, the advocate may

- (a) receive, review and investigate a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the advocate.

In accordance with Section 20 of the Act, I am now informing you of my intention to conduct an Investigation.

20. Before reviewing or investigating a complaint, or before conducting a review or an investigation of a department's or agency's services, the advocate shall inform the deputy minister or the administrative head of the department or agency of the government affected of his or her intention to conduct the review or investigation.

To further advance the ability of the Child and Youth Advocate to carry out this Investigation, Section 21 of the Act provides that:

21.(1) The advocate may require a person who, in his or her opinion, is able to give information relating to a matter being investigated by him or her

- (a) to furnish the information to him or her; and
- (b) to produce a document, paper or thing that in his or her opinion relates to the matter being investigated and that may be in the possession or under the control of the person,

whether or not the person is an officer, employee or member of a department or an agency of the government and whether or not the document, paper or thing is in the custody or under the control of the department or agency of the government.

- 21.(2) A person who has custody or control of information to which the advocate is entitled under subsection (1) shall disclose the information to the advocate.

I request that your Department provide to the undersigned all information and documentation with respect to the delivery of services and programs to the patient population identified in this notice that is in the custody and control of your Department. Please provide copies of relevant policy or protocols governing the delivery of services in existence during the period January 1, 2008 to December 31, 2008, including any changes made during this time period. A similar request has been made to Ms. Louise Jones, Interim President and Chief Executive Officer, Eastern Regional Integrated Health Authority.

Please provide this information by January 5, 2009. We will advise you of further requirements as they develop.

Thank you in advance for your cooperation in this matter.

Sincerely,



Darlene Neville  
Child and Youth Advocate

DN/sp



**Office of the Child and Youth Advocate**  
PROVINCE OF NEWFOUNDLAND AND LABRADOR

December 15, 2008

DELIVERED BY COURIER  
STRICTLY PRIVATE AND CONFIDENTIAL

Ms. Louise Jones  
Interim President and Chief Executive Officer  
Eastern Regional Integrated Health Authority  
South Wing, Waterford Hospital  
Waterford Bridge Road  
St. John's, NL A1E 4J8

Dear Ms. Jones:

Re: Notice of Investigation Pursuant to the *Child and Youth Advocate Act*  
Eastern Regional Integrated Health Authority  
Inpatient Psychiatric Services  
Janeway Children's Health and Rehabilitation Centre  
St. John's, Newfoundland and Labrador

I write at this time to provide notice of my intention to conduct an Investigation of the services and programs provided by the Janeway Children's Health and Rehabilitation Centre during the period January 1, 2008 to December 31, 2008 to the following patients:

1. Patients who were admitted to the Janeway Children's Health and Rehabilitation Centre due to:
  - (i) suicidal risk;
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2. Patients who were diagnosed and/or treated for:
  - (i) suicidal risk;
  - (ii) self harming behaviour; and/or
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during their admission to the Janeway Children's Health and Rehabilitation Centre.

3. Patients who were assessed by the Janeway Children's Health and Rehabilitation Centre as being:

- (i) suicidal;
- (ii) exhibiting self harming behaviours; and/or
- (iii) behaviour which presented risk of harm to others,

but where admitted elsewhere for treatment (i.e., Health Science Centre, Waterford Hospital, etc.).

This Investigation will be conducted in accordance with the provisions of Section 15.(1)(a) of the *Child and Youth Advocate Act* (the "Act"), which states:

15.(1) In carrying out the duties of his or her office, the advocate may

- (a) receive, review and investigate a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the advocate.

In accordance with Section 20 of the Act, I am now informing you of my intention to conduct an Investigation.

20. Before reviewing or investigating a complaint, or before conducting a review or an investigation of a department's or agency's services, the advocate shall inform the deputy minister or the administrative head of the department or agency of the government affected of his or her intention to conduct the review or investigation.

To further advance the ability of the Child and Youth Advocate to carry out this Investigation, Section 21 of the Act provides that:

- 21.(1) The advocate may require a person who, in his or her opinion, is able to give information relating to a matter being investigated by him or her

- (a) to furnish the information to him or her; and
- (b) to produce a document, paper or thing that in his or her opinion relates to the matter being investigated and that may be in the possession or under the control of the person,

whether or not the person is an officer, employee or member of a department or an agency of the government and whether or not the document, paper or thing is in the custody or under the control of the department or agency of the government.

- 21.(2) A person who has custody or control of information to which the advocate is entitled under subsection (1) shall disclose the information to the advocate.

I request that the Eastern Regional Integrated Health Authority and, in particular, the Janeway Children's Health and Rehabilitation Centre, provide to the undersigned all information and documentation with respect to this Investigation that is in the custody and control of the Eastern Regional Health Authority. This request applies to all levels of management within the organization and professional staff involved in the delivery of services and programs to the patient population identified in this notice. I specifically request all documentation related to the following:

- patient medical charts;
- professional notes (including medical, nursing, social work, psychology, occupational therapy, physiotherapy, dietician, etc.);
- all outside referrals and responses;
- all correspondence;
- all memoranda;
- all consultations, including documentation of peer reviews and/or consultations (including medical, nursing, social work, psychology, occupational therapy, physiotherapy, dietician, etc.); and
- all internal reviews and/or audits conducted including reports of internal reviews and/or audits completed and all documentation related to ongoing internal reviews and/or audits.

Please provide this information by January 5, 2009.

Thank you in advance for your cooperation in this matter.

Sincerely,

*Darlene Neville*  
Darlene Neville  
Child and Youth Advocate

DN/sp



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