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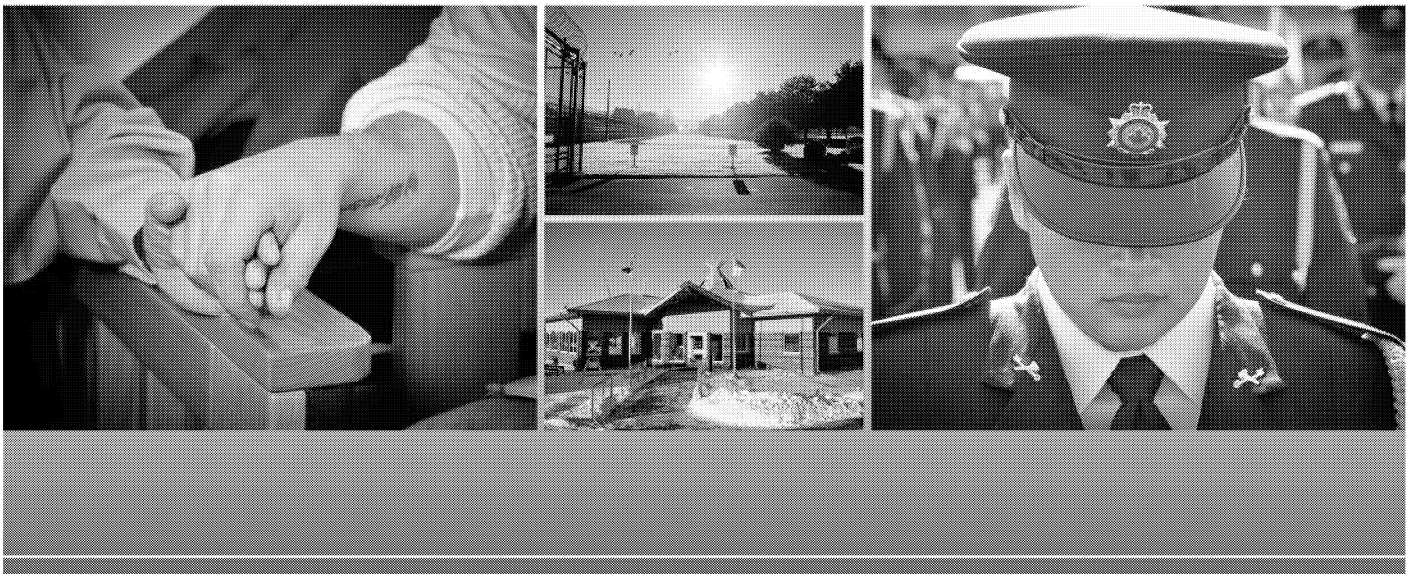

Plan for Mental Health Services in Response to COVID-19

JUNE 3, 2020

Table of Contents

Introduction

For Correctional Service Canada (CSC), the continued health, safety and well-being of employees and offenders is critical, as is the ongoing ability to maintain safe and secure environments as well as public safety.

The role of health care professionals and the provision of health services is critical. As part of the response to COVID-19, the following outlines recommendations for the provision of mental health services to prevent the spread of COVID-19 while reducing the risk of infection and continuing to provide essential health services and interventions in keeping with CSC's mandate.

The recommendations ensure consistency of health service delivery across all levels of mental health care including Regional Treatment Centres, Intermediate Mental Health Care (IMHC), Primary Mental Health Care and Community Mental Health Services. It is recognized that regional differences and the ever-changing nature of the pandemic may further impact the provision of these services. In addition, these recommendations should be considered in conjunction with other CSC guidelines and directives related to COVID-19.

Across all levels of care, it is very important for health care professionals, in collaboration with the health care team as possible, to continue to review the needs of current clients as well as new referrals to ensure appropriate and effective triage and the prioritization of service provision.

Documentation and Consent

To ensure communication and continuity of care documentation in the Electronic Medical Record (EMR) continues to be essential, including method of service delivery, consent, and any limitations of services and reasons for same. Health care professionals are reminded that documentation requirements as outlined in the *Integrated Mental Health Guidelines* (IMHG) should be maintained however timelines for session notes can be completed within reasonable time periods. Please note documentation should be timely for services such as crisis intervention, assessment/intervention of individuals at risk for self-injury or with complex mental health needs. For appropriate communication and continuity of care, health care professionals should ensure ongoing and appropriate documentation of services provided in EMR.

Consent for health services is required, however, verbal consent is acceptable during the pandemic so long as it is appropriately documented in EMR at the time of service.

It is also important for health staff to ensure ongoing discussion and consultation with operations when providing health services to ensure health staff are providing services in keeping with any operational protocols specific to a particular individual and to document these in the EMR.

Prioritization of Services

With the ever-changing health care demands, prioritization of health services will need to be re-evaluated on an ongoing basis to ensure optimal use of health care professionals across the levels of care. There is a recognition that there may be challenges to meet all timelines and processes outlined in the IMHG, but as regions make these shifts, policy compliance in relation to the following are still required:

- The assessment and management of people who are suicidal or self injurious as per the policy requirements of CD 843, *Interventions to Preserve Life and Prevent Serious Bodily Harm.*
- Risk assessments for the PBC or otherwise mandated by law.
- In-depth mental health assessments within 28 days of admission to a Structured Intervention Unit (SIU).
- For individuals identified as having a Considerable or higher overall level of mental health need on the *Mental Health Need Scale* (MHNS), timelines and processes for assessment, treatment planning and interventions should be consistent with the IMHG.
- For individuals identified as having Low or No overall level of mental health need, services should be provided as operational requirements permit.
- Continue to review the needs of current clients as well as new referrals to ensure appropriate and effective triage and the prioritization of service provision, keeping in mind that mental health need is dynamic and there may be changes in mental health need as a result of uncertain times.

Interdisciplinary Mental Health Teams

- Meetings are not required on a regular basis. Instead there should be adequate and documented consultation with required staff (Health Services, case management and operations) to ensure continuity of care and overall intervention assessment/planning for individuals with a Considerable or higher overall level of mental health need.
- Review of referrals to Intermediate Care or Psychiatric/Hospital Care should continue to be completed with required documentation and consultation prior to submission.

Confidentiality and Information Sharing

- Issues of confidentiality and information sharing should be consistent with guidelines and policy (CCRA; Guidelines for Sharing Personal Health Information; IMHG; relevant CDs). As best can be achieved and given operational needs, health care professionals should attempt to secure confidentiality for any **Assessments and Interventions.**

Regional Treatment Centres (including Intermediate Care Units in RTCs)

Patient care

- Follow guidelines on Personal Protective Equipment.
- Patients that are placed on medical isolation must be assessed daily by health care professionals.
- Patients should not be transferred from one unit to another unless there is an emergency or urgent psychiatric or medical reason to do so. Screening questions and vital signs should be done prior to any urgent/emergency transfer, and patients who are symptomatic or under suspicion should not be transferred.
- Patients should have daily screening questions (when safe to do so). Documentation of screening questions only needs to be entered in the EMR if abnormal. Usual precautions should be taken of handwashing before and after any patient interaction.
- Long-acting or other injections should be given taking into consideration the Guidelines on Personal Protective Equipment...

Health Care Units

- Admission and discharge criteria and processes should be maintained as outlined in the IMHG, but admissions should only proceed on an emergency or urgent clinically necessary basis where the person cannot be treated elsewhere without jeopardizing safety (i.e. an individual suffering of a Major Mental Disorder and at high risk to himself and/or others, serious physical impairment and/or serious mental or physical deterioration). Where possible, COVID-19 patients or those suspected of COVID-19 should not be admitted until they have been medically cleared of COVID-19, and if they must be admitted they must be kept in appropriate medical isolation until medically cleared.

- Patients and staff are to maintain social distancing measures (2 meters between patients, patients and staff, and staff and staff).
- All individual sessions should include reminders of the importance of social distancing and hand hygiene, screening for symptoms and exploration about how the person is coping.
- Individual sessions are to proceed in a room or area that allows 2-metre social distancing. This may include meeting with patients outside their rooms or in a common area with safeguards for confidentiality.
- Make allowances for patients to be seen by video conference (VC) or telephone for individual sessions with staff who are based on another unit, institution or working from home. Preference would be for VC or phone room to be on the living unit or otherwise close-by with the phone, chair, and table being cleaned/disinfected after every use.
- In cases where a person is on restricted movement (eg. Clinical seclusion, enhanced observation, medical isolation, SIU, institutional or unit modified routine) and is a known risk to throw fluids, health staff should collaborate with their managers and operations to devise a strategy as to how best to conduct assessments and interventions for each particular case to minimize the chances of contamination. It should be noted that patient specific protocols may vary on a case by case basis depending on the individual along with institutional dynamics, infrastructure and resources, and these may need to be reviewed and updated on an ongoing basis. .
- Groups can proceed in rooms that allow for 2 metres between all group members and staff (if necessary groups can be smaller and held more frequently). All group members should be asked to wash their hands before and after entering the group room, including staff.
- Groups should not mix patients from different living units. Group rooms should have tables and chairs cleaned and disinfected before and after each group session.

Other Precautions

- Meals and medication lines should be staggered to allow social distancing of 2 metres between patients. If necessary, consideration should be given to meals and medication dispensing at patient rooms.
- Use tape on the floor in interview rooms, group rooms, eating areas, medication line areas to remind of social distancing, and place signage/posters in living units to remind of the importance of social distancing and washing hands frequently (i.e., before eating/brushing teeth/flossing/touching the face).
- Reassign and/or train staff as needed for tasks that may be outside their usual duties within their scope of competence, including to do unregulated duties (e.g., doing screening questions; taking temperatures, vital signs, oxygen saturations; delivering medications; cleaning and disinfecting; tracing new COVID-19 cases; etc.).
- Make allowances for staff to care for patients using the telephone from another unit or from home.
- Avoid, as much as possible, staff working on multiple units or moving from unit to unit.
- To minimize the likelihood of staff cross contamination and spread, identify separate groups of staff to work (e.g., Team A, Team B) to permit distinctly separate zones so they do not interact with the other group(s). Given unique dynamics in each institution and treatment center, as well as inmate populations, mental health managers should develop appropriate plans of these teams and scheduling of work, which may include shifting those

who work weekday days to a 24/7 rotation where permitted by the collective bargaining agreement or on a volunteer basis. These types of arrangements can be implemented in special circumstances such as the current COVID-19 pandemic. It is imperative to ensure compliance with the respective collective agreements and work collaboratively with unions when modifications are required.

- Handover between teams to be done remotely using electronic means, telephone, or VC as much as possible.

Primary Care and Intermediate Mental Health Care at Mainstream Institutions

Patient care

- Follow guidelines on Personal Protective Equipment.

Health Assessment (including mental health) Process at Intake

- First-day Health Assessments should be completed within 24-hours as per the IMHG. Given current COVID-19 circumstances and possible delay in other health assessment processes at intake, health care professionals should ensure that instructions are provided to individuals on how to access health services.
- CoMHISS testing and follow up can be completed as permitted by operational requirements. If testing was not completed, documentation of reasons should be placed in the EMR. Triage of any referrals for mental health services during the time period that individuals are in the Intake Unit should be prioritized and completed.
- Mental Health Assessments should firstly be completed for any referrals by health care professionals; otherwise these can be prioritized by need and operational requirements

Other Considerations

- Admission and discharge criteria and processes to Intermediate Mental Health Care unit should be maintained as outlined in the IMHG.
- COVID-19 patients or those suspected of COVID-19 should not be admitted to an IMHC unit until they have been medically cleared of COVID-19.
- Individual sessions are to proceed in a room or area that allows 2-metre social distancing. This may include seeing people on/or nearby their living units, from outside their rooms or in a common area with safeguards for confidentiality.
- All individual sessions should include reminders of the importance of social distancing and hand hygiene, screening for symptoms and exploration about how the person is coping.
- Identify patients who could be seen remotely by VC or telephone by staff elsewhere within the institution, at another institution or working from home, and such sessions should be supported whenever possible.
- Make allowances for individual sessions by VC or telephone with staff who are working in another area of the institution, another institution or working from home. Preference would

be for the VC or phone room to be in the living unit or close-by with the phone, chair and table being cleaned/disinfected after every use.

- Identify patients on the present case load who are relatively stable that can be seen less frequently than usual if there is insufficient staff resource.
- In cases where a person is on restricted movement (eg. Clinical seclusion, enhanced observation, medical isolation, SIU, institutional or unit modified routine) and is a known risk to throw fluids, health staff should collaborate with their managers and operations to devise a strategy as to how best to conduct assessments and interventions for each particular case to minimize the chances of contamination. It should be noted that patient specific protocols may vary on a case by case basis depending on the individual along with institutional dynamics, infrastructure and resources, and these may need to be reviewed and updated on an ongoing basis.
- Identify and prioritize high risk or vulnerable patients for required assessments. This includes individuals who are either: assessed at risk for acute suicide or serious self-harm; placed on enhanced observation; are unstable and at risk of serious mental or physical deterioration; or who require a risk assessment for the PBC or otherwise mandated by law.
- Identify and prioritize high risk or vulnerable patients for follow up care at the usual or greater frequency. This includes individuals who are either: assessed at risk for suicide or serious self-harm; placed on enhanced observation; are unstable and at risk of serious mental or physical deterioration; identified as having a Considerable or higher overall level of mental health need on the Mental Health Need Scale; and/or are due for a long acting injection.
- Individuals requiring a visit to the health care unit, including those in need of a long acting injection, should have screening questions and vitals signs before entering the main health care unit area. If possible, individuals should be seen in an area of health care that minimizes walking distances. Long-acting injections should be given using the usual precautions of handwashing before and after the injection, sterilizing the injection site and following guidelines on Personal Protective Equipment.
- Prescriptions and blister packs should extended as per pharmacy memo, and some DOT medication can be given unopened or uncrushed or be given in blister packs (as recommended by the Most Responsible Physician or nurse practitioner).
- Primary Care group interventions are suspended until further notice.
- IMHC Groups can proceed in rooms that allow for 2 metres between all group members and staff (if necessary groups can be smaller and held more frequently). All group members should be asked to wash their hands before and after entering the group room, including staff.
- IMHC Groups should not include patients from other living units. Group rooms should have tables and chairs cleaned and disinfected before and after each group session.

Other Precautions

- Meals and medication lines should be staggered to allow social distancing of 2 metres between patients. If necessary, consideration should be given to meals and medication dispensing at patient rooms.

- Use tape on the floor in interview rooms, group rooms, eating areas, medication line areas to remind of social distancing, and place signage/posters in living units to remind of the importance of social distancing and washing hands frequently (i.e., before eating/brushing teeth/flossing/touching the face).
- Reassign and/or train staff as needed for tasks that may be outside their usual duties within their scope of competence, including to do unregulated duties (e.g., doing screening questions; taking temperatures, vital signs, oxygen saturations; delivering medications; cleaning and disinfecting; tracing new COVID-19 cases; etc.). Make allowances for staff to care for patients using the telephone from another unit or from home.
- Avoid, as much as possible, staff working on multiple units or moving from unit to unit.
- To minimize the likelihood of staff cross contamination and spread, identify separate groups of staff to work (e.g., Team A, Team B) to permit distinctly separate zones so they do not interact with the other group(s). Given unique dynamics in each institution and inmate populations, mental health managers should develop appropriate plans of these teams and scheduling of work, which may include shifting those who work weekday days to a 24/7 rotation where permitted by the collective bargaining agreement or on a volunteer basis. These types of arrangements can be implemented in special circumstances such as the current COVID-19 pandemic. It is imperative to ensure compliance with the respective collective agreements and work collaboratively with unions when modifications are required.
- Handover between teams is to be done remotely using electronic means, telephone, or VC as much as possible.

Community Mental Health

Patient Care

- Follow guidelines on Personal Protective Equipment.
- Complete day-to-day tasks via telework, as appropriate and respecting privacy of health information.
- Continue to consult and collaborate with health services staff, case management and community service providers, as required.
- Prioritize and triage mental health services based on mental health needs and maintain the following services as able, using teleservices as appropriate and available:
    - triage new referrals;
    - review caseloads to prioritize service delivery based on offender need and available resources, with an effort to provide services in response to high priority mental health needs;
    - psychiatric clinics;
    - respond to offenders at risk for suicide and/or self injury according to relevant professional standards;
    - provide services to offenders with PBC conditions to prevent breaches in conditions and those with higher risk of reoffending; and
    - continue assessing specific circumstances on a case-by-case basis, including by telephone if possible.

As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours.

Other Precautions

- Health care professionals in the community are to follow measures and staff safety considerations outlined in the direction provided to community corrections when meeting in-person with offenders to maintain physical distancing (2 metres) and use active screening health questions.