



**Research Insights** is a peer-reviewed journal of St. Joseph's Health Care dedicated to publishing mental health research. The submissions should be practice-oriented.

The journal will accept studies that are usually described as original research, quality assurance, proof-of concept, theoretical reflections arising from meta-analytic reviews and theoretical reflections from case studies. These could be submitted as regular articles, reviews or brief reports. Brief reports may involve preliminary results of ongoing research, clinical hypotheses and front-line perspectives on rehabilitative care and treatment delivery.

**Editor:** J. D. Mendonça PhD, CPsych

### **Instructions for Authors**

Manuscripts submitted for publication must follow the rules of APA Style® detailed in the *Publication Manual of the American Psychological Association*. For more details visit the [APA website](#).

*Regular articles* (not to exceed 4000 words) should contain the following sections: 1) Title page 2) Structured Abstract with Clinical Implications and Limitations, and Key Words 3) Body Text with Tables / Figures, References (as per APA style) and 4) Funding Support / Acknowledgements.

*Brief reports* (not to exceed 1500 words) may be submitted in the usual APA style or in two additional variations given below (while observing the APA citing and referencing style).

#### 1) *Front Line Perspectives*

The submission would consist of a description of actual or prototypical cases ( $n < 5$ , from hospital or community settings, de-identified, with patient consent placed in the clinical file).

Sections: Abstract, Introduction, Case Review, Commentary, Conclusions.

#### 2) *Clinical Hypotheses*

A hypothesis should include an organized structure of known facts and their real world impacts that are observable.

Sections: Abstract, Introduction, Hypothesis/Theory, Evaluation Pilot Data (if applicable), Clinical and Research Implications, Conclusions.

The editor may be approached for any unique manuscript variations required by the subject matter.

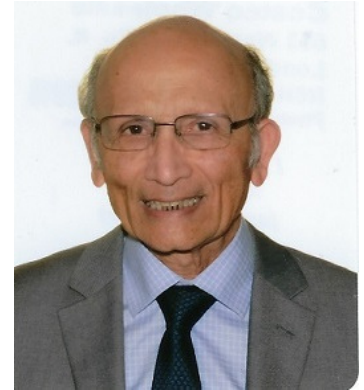
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## Editor's Note

The preamble to this issue of Research Insights was the article by Drs. Vaithianathan, Van Bussel and Burhan: “*Optimizing Mental Health Care for Seniors While Adjusting to COVID-19 Pandemic Public Health Regulations*”, which appeared in the previous issue of this journal (Vol. 17, No. 1, January 2021, titled “COVID-19 Challenges”). The authors of this article described the evolution of adaptations within various in-hospital and community care programs of the Geriatric Unit at Parkwood Mental Health Care in London, Ontario, Canada. The adaptations were triggered by the COVID-19 public health guidelines and restrictions. The full text of the article can be accessed via the Lawson Health Research Institute's *Research Insights* website (<https://www.lawsonresearch.ca/research-insights>).



For the current issue, we sent a request to various community agencies and programs at Parkwood Hospital and LHSC involved in the delivery of mental health programs to submit a brief article profiling the program adjustments and innovations that effloresced out of their efforts to reach out to their clients. To illustrate our intent and the theme of this issue, we enclosed a copy of the article by Vaithianathan et al in the mail-out of our call for submissions. Mostly these groups were experiencing reduced access to their mental health treatments and reduced access to the basics of shelter and food. We welcomed first person stories, accounts of program innovations and descriptions of methods used to support staff morale and prevent burn-out.

- James Mendonca, Ph.D., C.Psych

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## *COVID-19 Innovations in Community Care*

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## A Pandemic Transformation: The Challenge of Authenticity

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This article discusses the shift of values and the need for authenticity in the context of the COVID-19 pandemic. Borrowing from philosophy and psychology, we explore how the global crisis has given us a new perspective on what matters, bringing us closer to finding genuine happiness.

To "flatten the curve" and slow the spread of the SARS-CoV-2 virus, since March 2020 we have drastically changed our lives by making sacrifices to limit our contact with others, giving up what we value for the sake of the greater good (Office of the Premier, 2020). While small sacrifices such as making coffee at home instead of going to the coffee shop may not have a significant impact on our well-being, considerable sacrifices such as not visiting grandparents or missing out on milestone events like graduations, birthdays, and weddings have caused us to reconsider what is truly important in our lives. The sudden cancellation of all social aspects in our lives has triggered an emotional response from everyone (Reynolds et al., 2021). If, before the pandemic, our actions were mainly guided by routine, the lockdown has completely uprooted our habits. As we learned how to navigate this new reality, this pandemic has forced us to slow down and intentionally question how we want to live and who we want to be.

### A Change in Values

During this 'down time', we've had the opportunity to examine our lives, which according to Socrates, in Plato's Apology (38a), is what makes life worth living. To live a better life, Socrates believes that we should constantly question our motivations and actions to gain self-awareness (Cooper & Hutchinson,

1997). Our values - that is, the beliefs, traits, or ideals that motivate us - have shifted as we have adapted to this new 'covid era'. As our lives are disrupted, we are left with our values to guide our actions which will ultimately have a positive or negative impact on our well-being. In the pre-pandemic days, one may have valued success more than time spent with family. Ordinary moments were perhaps taken for granted, but now, having been prevented from such situations we have an appreciation for times before the pandemic and long to relive those memories. Being away from loved ones has made us realize the importance of valuing social interactions. Our physical distance has us craving for conversation such that when we have the chance to engage with others, we strive for quality in our discussions. Ironically, in our isolation, we have learned how to meaningfully connect with others by expressing ourselves in sharing our joys and hardships. Our thirst for kinship stems from the basic psychological need for relatedness. Namely, the notion that all humans "[strive] to care for others, to feel that others are relating to the self in an authentic and mutually supportive [way]" (Deci & Ryan, 1991, p. 253). A collective threat has pushed us to collective action so that in socializing and cooperating with others, we are effectively creating a system of solidarity in which all feel they belong. Whether it is creating a Facebook page with activities for children or leaving

heartfelt notes in mailboxes, for over a year now, we have had to rethink our values and purposely make time to satisfy this necessity for social cohesion (Reynolds et al., 2021).

### **Simplicity Reigns**

Much like the need for conversation, this pandemic has simplified our expectations. Since our life has been reduced to staying home, so have our sources of happiness. Pre-pandemic, pleasure was associated with material objects or spending money on outings but since there is less of an opportunity to get these objects or to go out, we have to determine what exactly makes us happy. To do this, one must again, reflect and re-evaluate which values are most important. If family is essential, then one will adjust expectations and feel happiest while in the company of loved ones. If one realized that being generous makes them happy, one will look for ways to help others. This situation has compelled us to reduce our expectations such that our happiness is determined by actions that would have previously been considered ordinary. As Socrates claims in the Apology (30b), it is not in material wealth that we get happiness or "excellence", but in personal growth and contemplation as "excellence [or happiness] makes wealth and everything good for men" (Cooper, 1997). Since "human excellence is also happiness" (Parry & Thorsrud, 2021), we must continually strive to deliberately recognize the things that offer us joy, so that even when we are well accustomed to this way of life or have recovered from the pandemic, we continue to enjoy the small things. This thought is captured by 18th century philosopher Jean-Jacques Rousseau who writes in his *Discourse on the Origin of Inequality* (1755): "since these conveniences by becoming habitual had almost entirely ceased to be enjoyable, and at the same time degenerated into true needs, it became much more cruel to be deprived of them than to possess them was sweet, and men were

unhappy to lose them without being happy to possess them" (Rousseau & Cress, 1987). We should be content with what we have once we've discovered what makes us thrive. This pandemic has certainly allowed for us to do this, but we must remember what this happiness feels like when we get back to normal so that it does not escape us once again.

### **A Socratic Moment**

Since the beginning of the pandemic, our values have shifted. As a result, the third need of belongingness on Maslow's hierarchy of needs is greatly emphasized. While the lower basic needs are vital, it seems as though physical distancing has made it harder to achieve this third level, temporarily sending us down the pyramid, hindering our well-being (Block, 2011). We have learned that elements from the fourth level of esteem like staying up-to-date on the newest fashion trends or owning the most recent piece of technology to be recognized have not been enough to sustain us in isolation. Instead, returning to our roots, to authenticity amongst individuals is what keeps us going. As we emerge from the third wave of the pandemic, let us recall Socrates's teachings. The answer to how to live a better life lies within us and it is our responsibility to do the work to find it. This global crisis has provided us with the time and opportunity to do so, but we should not stop there. We must always have the courage to question ourselves to determine what we fundamentally need to be happy.

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## Pivoting to Virtual Mental Health Care in the Pandemic

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The authors report on the impact of the Pandemic on mental health services provided by a Mental Health Clinic in a Community General Hospital. The key points of impact were: maintenance of pre to post pandemic volume of services, and a mental health wellness program for staff and physicians of the Hospital.

This article is a follow up to a letter to the Editor of the Canadian Journal of Psychiatry published in December 2019 (Sethna & Persad, 2019). In that letter we (R.S. and E.P) responded to the debate on access to Psychiatrists in Ontario. We noted then that access for mental health services could be facilitated by streamlining referrals within a multidisciplinary mental health team. We demonstrated this approach and successfully reduced our waiting lists. In March 2020 a Pandemic was declared by the World Health Organization. The impact on our services was immediate and we endeavoured to minimise disruption in our services. Like all similar facilities, our outpatient Mental Program pivoted to the provision of care by virtual means. Of interest is the fact that the volume of services did not change significantly when the figures for March- February 2019-2020 were compared with the figures for March 2020- February 2021.

Crises bring opportunities as well lessons to be learnt. With that in mind we offer some comments.

The need for Mental Health Services is likely to increase following the pandemic and it is likely that virtual care would need to continue beyond the pandemic (Shields, 2020). We found that patients were pleased with the quality of services and favoured them, not least because of no impact on childcare or

not having to pay for parking. However, our clinicians are particularly mindful of the advantage of in person care in accessing acuity and risk and we work closely with the Crisis service operating out of the Emergency Department. We also noted that visits to the Emergency Department for Mental Health Crises over the period noted above remained the same.

We suggest that this is also an opportunity to examine the potential for community-based care. The perennial problem of access to Psychiatrists has been well studied (Rudoler, de Oliveira, Zaheer, & Kurdyak, 2019). Our experience suggest that novel ways exist to improve access to mental health services even considering the apparent shortage of Psychiatrists. In October 2004, Paula Goering authored a study on Community based mental health care (Goering, 2004). Those findings and recommendations remain relevant. The advantages suggested for increasing Home and Community care include reduction of costs, greater involvement of the Family, increase in adherence to treatment and less involvement of the Police. It is also an opportunity to re-examine the Community Treatment Program.

We also wish to report on a Pilot program established within our Mental Health Program to address the mental health needs of the Physicians and Staff of the



## Hospital caused by the Pandemic.

The evidence suggest that Health care providers are disproportionately affected by the pandemic. Conditions such as moral distress is unique to Health care workers. A recent report in the Canadian Medical Association Journal underlined the increase in burnout among physicians in Canada as a result of the pandemic (Duong, 2021). To this end our program initiated a Staff and Physician Wellness program, hiring one full-time mental health clinician to respond to the mental health needs of staff and physicians throughout our hospital. This program has had significant uptick since its start in August 2020 as per de-identified data collected on the number of one to one session, team huddles, wellness rounds, incident debriefs and group facilitation sessions occurring in both clinical and non clinical areas of the hospital. Based on its success and the needs in the organization, there is support from the hospital to grow the program with additional staff and dedicated space.

We are very grateful to our Psychiatrists and all clinical and administrative staff within our program for their diligence and hard work in challenging times. We also acknowledge the receipt of clearance from relevant authorities within the Hospital to submit this document for publication.

We have no conflict of interest.

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## Serving Marginalized Communities During the COVID-19 Pandemic: A Community Health Centre Approach

Roger Kabuya

London Inter Community Health Centre

Erin Williams

London Inter Community Health Centre

This article describes how the pandemic affected the delivery of services at the London InterCommunity Health Centre (LIHC). Several adaptive changes were made to programs which included educational materials in several languages, virtual interviews, provision of supplies needed for daily living at the back-door of the main centre, collaboration with Public Health for Covid testing / vaccine roll-out, and a staff wellness program.

The London InterCommunity Health Centre (Health Centre) provides inclusive and equitable health and social services to those who experience barriers to care in our community. We serve marginalized communities such as newcomers, seniors, and people living on a fixed income, individuals experiencing homelessness, folks who identify as transgender and LGBTQ2+, and those living with complex physical and mental health conditions.

We have three locations across London and many of our programs/services run in community spaces. See Appendix A for a list of our pre-pandemic programs and services.

The Community Health Centre model stands out from other healthcare models because we focus on primary care, health promotion, and community development. We give people a voice and a choice about the services they receive, and we connect them to our team of inter-professional health and social service providers. Together, we help individuals and neighbourhoods achieve their health goals.

When the World Health Organization declared a global pandemic due to the coronavirus, the Health Centre remained open. Our staff began training around new infection prevention and control practices and we adapted to new ways of serving our clients. Healthcare appointments were offered over the phone and virtually, and community programs were adapted

to be offered through Zoom. Our staff embraced new roles such as greeters/screeners, runners who offered logistics and communications support, isolation providers and switchboard coordinators to ensure heightened safety when offering services on-site in our new pandemic reality.

### Adaptive Change

#### *Providing Basics*

When other social services agencies closed their organizations, our marginalized populations were left without access to food and hygiene items. We made the decision to convert our backdoor into a space to offer basic needs. The Health Centre purchased items such as toilet paper, soap, shampoo, non-perishables, food, water, snacks, harm reduction supplies, socks, and facemasks and distributed them to people who are living on the streets. We identified isolated clients, who could not make it to the Health Centre, and our teams reached out to them by providing food and supplies.

#### *Health Outreach Mobile Engagement (H.O.M.E.) Program*

During this time, the Health Centre in partnership with Regional HIV/AIDS Connection, Addictions Services Thames Valley and the Middlesex-London

Paramedics Services, successfully launched the Health Outreach Mobile Engagement (H.O.M.E) program. This program provides a multi-disciplinary, multi-sectoral mobile response to improve the health outcomes and health equity of highly marginalized individuals in London. The H.O.M.E team provides mobile services such as medical care, harm reduction support, infectious disease testing, healthcare system navigation, social services, and housing support. Throughout the pandemic, this program has proven to be an effective approach to reaching individuals where they are at in the streets and all over the community.

### **Champions of Health Equity**

The Health Centre quickly realized one of the challenges our clients would be facing throughout the pandemic was access to COVID-19 services. We organized our teams and began to offer COVID-19 testing on-site for our clients, in shelters for those living in the streets, and in hotels for newly arrived government assisted refugees while they were ‘quarantining’. Our staff worked in hotels to support our clients who were experiencing homelessness and required an isolation space to self-isolate.

As part of our annual planning process, our teams worked together to assess the evolving needs of the various populations we serve to develop strategies for addressing their concerns and identify areas for responsive delivery of care and systems advocacy.

This year, in the context of the pandemic, themes arose around the need for street outreach, mobile services, digital literacy support, multilingual COVID-19 resources, social inclusion programming, COVID-19 testing, access to vaccinations and mental health support. Our staff have led incredible new initiatives, despite the limitations of pandemic restrictions.

### **Supportive and Engaging Workplace**

From the beginning of the pandemic, the Health Centre was acutely aware of the increased stress that COVID-19 placed on our frontline workers. Upon activating the pandemic plan, the Health Centre provided a virtual debrief for staff at the end of each day. During that time, staff members were given an opportunity to ask questions, to check in with each other, review challenges, and discuss opportunities to improve services. Staff also led reflection sessions with meditation exercises.

Our Human Resources department developed mental wellness initiatives for staff such as mental health focused activities, information about our Employee Assistance Program benefits and fun gifts to boost staff morale such as t-shirts, water bottles and branded facemasks. Most importantly, our staff had flexibility in their schedules to accommodate caregiver responsibilities in addition to paid sick time, lieu time and vacation time. The Health Centre also made COVID-19 testing available on-site for staff, their family members, and our community partners to ensure everyone’s safety and to decrease the stress and case-volumes at the traditional assessment centres.

To reduce the number of people working on-site and to prevent staff burnout, we modified staff schedules to accommodate working from home. Given our dispersed organization, keeping everyone connected and informed about the evolving pandemic became a priority. We developed a communications strategy, which included daily update emails, quarterly staff newsletters, weekly team check-ins, shared drives with COVID-related resources and virtual all-staff meetings. In order to facilitate the increased virtual communications, we purchased new software such as Slack, Zoom, Asana, and Microsoft 365.

### **Promoting Positive Client Experiences with Vaccine Rollout**

As the vaccines became available in London, a

growing concern began to arise around access for ethno-cultural communities. Specific communities identified a need for timely and accurate information about COVID-19 and the vaccine rollout in London. A team of primary care providers and community workers developed a plan with three phases: community engagement, education and awareness, and mobilizing communities (see Appendix B). Because of this plan, when the COVID-19 vaccines became available, they were able to quickly vaccinate groups of newcomers, refugee claimants, and people living undocumented or with no status.

### **Working in Collaboration with Public Health**

We have a long-standing good relationship with our local public health unit. When the pandemic was declared and the Health Centre activated a pandemic plan, we looked to the directions given by the Health Unit in order to fight and contain the COVID-19. At the beginning of the pandemic, we offered to provide community support in providing screening for folks who were living in the shelters and in the street. Along with the City of London, we coordinated screening for people living in the street before being given access and discharge from the temporary shelters.

We also provided COVID-19 screening including swabbing of the shelter staff, to facilitate a quick return to work. The Health Centre has conducted over 2000 swabs since the beginning of the pandemic. None of our COVID-19 services would be possible without our key partners at the London Middlesex Health Unit. They have played a vital role in supporting us as we offered COVID-19 testing and vaccinations to the various populations that we serve.

As the COVID-19 vaccine was made available to our staff, our internal COVID-19 vaccine task force worked with the Health Unit every step of the way. Our team began by setting priorities to determine eligibility for staff vaccinations. We organized virtual

staff Q&A education sessions and shared helpful vaccine information to support staff in making decisions about getting the vaccine. When eligibility opened for the public, we worked closely with the Health Unit at each phase to support clients with booking appointments, organizing interpretation services, and coordinating transportation.

In early April, the Health Centre became one of the pilot sites for primary care vaccination. We offered vaccines to our rostered and unrostered clients, contributing to the mass vaccination of the priority population in the City of London. We also opened our vaccine clinics to our volunteers and students, and the family members/friends of our staff. To date we have vaccinated just over 2,500 people.

### **Looking into the Future**

As we think about the future, we will need to focus our post-COVID-19 recovery on the need for a more equitable, integrated, stronger health system rooted in people and communities. We need to bring attention to the disparities that have been amplified during the COVID-19 crisis and the importance of addressing these inequities in future pandemic planning and COVID-19 recovery. Our belief is that we have an opportunity to reimagine what a healthy recovery should look like and redesign a health system that works for everyone.

## APPENDIX A

## Pre-Pandemic Programs and Services

Services Provided	Site Location		
	Dundas	Argyle	Huron
Primary Care	X	X	X
Mental Health Services	X	X	X
Systems Navigation	X	X	X
Diabetes Care	X	X	X
Physiotherapy	X	X	
Respiratory Therapy Education		X	
Foot Care	X	X	X
Team Care		X	
Trans Health Care	X		
Nutrition Services	X		
Options Clinic – Anonymous HIV/AIDS Testing	X		
Hepatitis C Care	X		
Seniors Tai Chi Program	X		
Seniors Drop-In	X		
Youth Outreach Services			X
Mindful Movement – Women’s Exercise			X
Northeast London Community Engagement			X

Additional Services for People Experiencing Homelessness	Programs in the Community
- Housing Referrals and Loss Prevention	- Newcomer Clinic for Refugees
- Addictions Assessments and Referrals for Treatment	- Women of the World Program
- MyCare Program – HIV Treatment	- Francophone Seniors Group
- Weekly Community Programs	- Community Development
- Safer Opioid Supply Program	- Health in Housing Initiative
- Identification Clinics	- Seniors WrapAround Program
- Showers and Laundry Facilities	

**APPENDIX B**

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**Vaccine Rollout Three-Phase Plan**

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**Phase I: Community Engagement**

Delivered educational sessions for community groups, in partnership with other community-based organizations, to answer questions around vaccine hesitancy and to encourage participants to get the vaccine.

**Phase II: Education and Awareness**

Gathered educational materials related to COVID-19 in several languages, which we distributed through community programs and primary care appointments. Developed COVID-19 vaccine information videos in 6 different languages and promoted them among specific communities based on language spoken.

**Phase III: Mobilizing Communities**

Coordinated onsite clinics for specific ethno-cultural communities in order for families and friends to be vaccinated together. Provided interpretation services all day to support clients throughout their appointments at the clinics.

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## Crisis Motivates Change

Christine Sansom

CMHA Thames Valley Addiction and Mental Health Services

This article describes challenges of homelessness, opioid overdose deaths and police/justice systems partnerships that have marked the Canadian Mental Health Association’s (CMHA) response to the COVID-19 pandemic.

Many of us who work in the field of addiction and mental health (see Table 1) could never have anticipated how a pandemic could identify how viscerally obvious isolation and a community shutdown could have affected all of us. Each person has faced a challenge in one way or another. The dream of working from home every day has not been as sweet as we anticipated. However, over the past 15 months we have learned (out of necessity) that adjusting how we offer services can be dynamic and flexible. This would not have happened had it not been absolutely necessary to keep ourselves and those we support safe.

It has been the responsibility of the social service agencies to maintain strength and resilience during a most challenging year. The pandemic affected our operations, including programs and services, staff relations and morale, and how we engage with our participants. What does good care look like during a pandemic? While essential services were maintained, how do you manage mental health supports when supporting participants face-to-face is not permitted? New programs have emerged as a result of the pandemic and services had to adapt and change.

Since the declaration of the pandemic in March 2020, we have continued to provide essential programs such as supportive housing and crisis services, both in-person and virtually. We have also modified programs such as case management, outreach programs at My

Sisters’ Place (London) and Elgin Social Recreation (St. Thomas) as well as community wellness programs. We responded to the needs of our community through the creation of our Friendly Callers program, a call-out phone line for seniors that provides check-ins, supportive listening, and assistance with community services. What we did not anticipate were the glaring gaps in resources identified within our own programs.

### Homelessness

What has become a systemic concern is the number of individuals who are homeless and living rough in our community. During the pandemic, not even a washroom was readily available to our participants.

*Table 1. Operations as found in the 2019/2020 Annual Report*

	Middlesex County (pop. 455,526)	Elgin County (pop. 88,978)
Unique clients	7,847	2,932
Clients engaged in housing supports	414	415
Case-management	1,597	404
Crisis assessment and response visits	9,994	2,626
Clients served in rural communities	2,626	396
Calls received by Support Line	23,398	-
Visits to Crisis Stabilization Space	1,495	-
Contacts for My Sisters’ Place	26,238	-
Contacts for London Coffee House Program	20,030	-
Clients supported by counselling	-	28,398
Counselling visits	-	820



We were fortunate to partner with the City of London to create Holly's House and Henry's House, transitional housing opportunities to help women and men experiencing homelessness securing more stable housing. Individuals received support in a safe, comfortable hotel suite space where they received food and were able to rest. This environment promoted connections to services, referrals to housing and other resources. Such a simple concept of meeting the person where they were located and assisting with meeting basic needs has led to many recovery journeys.

### **The Opioid Crisis**

With the growing number of individuals dying of overdoses and substance-related deaths, new models of support continue to solidify the need for more outreach in our community. The Connectivity Table actively presented high-risk situations during the pandemic, with the majority of the situations involving addictions and mental health. Those identified as being at an acutely elevated risk were presented to a table of agencies (26 partners) for the opportunity to offer a wraparound response within 24-48hrs. Mitigating risk and offering support in a rapid engagement model confirmed that integrated care is brilliant and necessary as we move forward. We cannot go back to our 'siloed' ways. Exceptional care comes from supporting the whole person and working together.

### **Police Partnerships**

Meanwhile, by addressing gaps and exploring a different approach, the Community Outreach and Support Team (COAST) was established, which is a partnership between St. Josephs Health Care, Middlesex London Paramedic Services, London Police Service and CMHA Elgin-Middlesex. COAST is an enhancement to the London Police Service (LPS) collaborative community response strategy,

with a focus on outreach and prevention. The team includes four police officers, one paramedic, one mental health professional from the assertive community treatment team, and one mental health professional specializing in mental health crisis response. The mandate of COAST is to regularly engage with individuals in the community living with serious mental health issues, individuals in frequent crisis and individuals who are at risk of crisis. Again, we find that meeting individuals where they are located and minimizing the justice lens often is the right approach to community outreach.

### **Next Steps**

When the pandemic begins to wane, unfortunately its impact on mental health is likely to remain for quite some time. Numerous studies have emphasized the increase in feelings of isolation, loss, anxiety, and grief, along with the family stress, unemployment, and broken relationships that have occurred during the pandemic. At CMHA Elgin-Middlesex, we have already started to experience the growing demand for supports and services as well as requests for education and access from those we might have not engaged with previously. We are actively collaborating with other organizations to address the escalating needs and advocating to ensure that the system can respond. An increased number of youth are seeking supports and our programs aren't set up to accommodate their needs. We need to listen, adjust and course correct in order to effectively support them.

What has been evident is that this crisis has motivated change. Traditional care models are not working anymore. With the inception of the Ontario Health Teams, it is imperative that we work in a collaborative manner moving forward. No more should we blame each other for the state of our system. We are the system.

## The Impact of COVID-19 on Forensic Mental Health Care

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The coronavirus disease 2019 (COVID-19) pandemic has brought unique challenges throughout the healthcare system in Ontario, including the forensic mental health system. With the prioritization of public health at the forefront during the height of the pandemic, governmental and hospital authorities enacted strict precautionary measures. Such measures had wide-ranging adverse impacts to the provision of forensic services. In this article, we review the impact of such policies on services at the Southwest Centre for Forensic Mental Health Care through fictional accounts of prototypical patients. In particular, reduced community supervision in the civil mental health system, as well as quarantine procedures in correctional institutions and hospitals, impacted forensic assessment services. Severely restricted access to protective factors, including community engagement and personal supports, impacted risk assessment and rehabilitation services. We also review some indicators of patient resilience in the face of pandemic restrictions.

### First: Who are “Forensic Patients?”

Forensic mental health patients are amongst the most stigmatized members of society (West, Yanos, & Mulay, 2014). They wear the dual labels of being both “mad” and “bad.” High profile (and rare) forensic cases involving serious violence are sensationalized by the media (Casey, 2020; Mayer, Schwartz, & Stastna, 2014), striking fear in the public imagination - and our political leaders, perhaps sensing opportunity, are often quick to join the fray (Jones, 2019; Mackrael, 2013). Hearing such messages from authority, one could be misled into believing our patients are usually “axe-wielding murderers” (Jones, 2019). They are not.

Before they became “forensic patients,” individuals receiving forensic mental health services were usually the same patients we care for in general mental health settings. They are typically confronted with difficult life circumstances and complex mental illnesses. The difference was that whatever remained of their safety net failed.

Most forensic stories begin with a broken law. In many cases, the Mental Health Act was insufficient to

support our patients in the lead up to their index offences. Their gradual declines often happened in plain view, to the horror of their loved ones and care providers. Repeated Mental Health Act forms and revolving-door emergency visits provided little reprieve. Ultimately, their behaviours brought them into conflict with the Criminal Code, marking their initiations into the forensic system.

The COVID-19 pandemic, of course, represents an exceptionally challenging circumstance for all of our society, and forensic patients are no exception. In this paper, we follow the cases of fictional, but prototypical, patients who receive forensic mental health services at the Southwest Centre for Forensic Mental Health Care. Our intent is to highlight some of the impacts of COVID-19 on the provision of those services - and the consequences to the health and recovery of those under our care. We also review some preliminary indicators of the resilience present in our patient population.

### A Primer on the Forensic System

The forensic mental health program at the Southwest

Centre can be broadly divided into assessment and treatment/rehabilitation services.

Courts can refer individuals accused of crimes who likely have significant mental health problems to the Assessment Unit. The assessment team then helps clarify specific psycholegal questions, such as whether an accused is Fit to Stand Trial, or Not Criminally Responsible on Account of Mental Disorder (NCR), which can impact the court's next steps.

If the court returns an individual to hospital following their trial (for example, if they are found NCR), they transfer to treatment/rehabilitation services. On the Treatment Units, acute symptoms and risk issues are addressed. Once safe community living becomes foreseeable, patients are transferred to one of the Rehabilitation Units. They undergo enhanced functional assessment, connect with community services and social supports, and eventually transfer to community living under the supervision of the multidisciplinary Forensic Outreach Team. Once they are deemed to be no longer a significant threat to public safety, they are discharged from forensic services altogether. COVID-19 has had wide-ranging impacts across the forensic system.

### **Lockdowns and Crumbling Support Systems**

Mr. Wyatt was a young man with a history of Schizophrenia. He previously struggled with behavioural problems and substance use, but had been fairly stable for several years. He lived at home with his mother. Their relationship was conflictual in the past, but had improved since he began receiving regular mental health care from an Assertive Community Treatment (ACT) team. For the past year, he was able to maintain part-time supported employment at a local coffee shop, where he enjoyed interacting with the regular clientele.

The COVID-19 pandemic began. The first lockdown accompanied the state of emergency announced on

March 17, 2020. Mr. Wyatt's employment was suspended, leaving him without a sense of structure or purpose. His appointments with his ACT team abruptly transitioned to virtual platforms. He had limited access to stable internet to attend, his daily medication check-ins stopped, and he began feeling more isolated. In the context of increasing stress, psychotic symptoms gradually re-emerged. A grumbling sense of unease led to thoughts that others could read his mind. He started hearing voices criticizing him, and telling him he was hopeless. Absent timely intervention, Mr. Wyatt's condition worsened further. In the middle of the night in May 2020, he became convinced his mother had been replaced by an imposter. She began stealing his thoughts, and was aware of everything he was thinking. She could even control his movements. He was trapped, and a voice told him she was about to kill him. In a state of disorganized fear, he stabbed her in her sleep. She survived, but he was charged with Attempted Murder, and arrested.

Mr. Wyatt joined the many patients, previously succeeding in the community, who fell victim to a removal of protective factors during the early stages of the pandemic. In our experience, many patients admitted for court-ordered assessments during the pandemic experienced a withdrawal of protective factors (including mental health services and community engagement) as a consequence of the pandemic restrictions. Combined with the enhanced level of stress, there was a re-emergence of symptoms. As their symptoms further decompensated without supervision, their psychosis drove them to commit criminal acts, earning them the label of "forensic patients".

### **COVID-19 and Forensic Assessment**

Before Mr. Wyatt got to the Southwest Centre for an assessment, he had to endure jail with an active psychotic illness. Even prior to the pandemic,

individuals with serious mental illness were significantly overrepresented in the correctional system: the jails are lamentably amongst the most common mental health care providers in North America (Torrey et al., 2014; Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017). During one of his early court dates, the judge ordered an assessment of Mr. Wyatt's criminal responsibility. In Canada, one can be found Not Criminally Responsible on Account of Mental Disorder (NCR) if, on balance, it is more likely than not that they have a mental disorder, and that the mental disorder rendered them incapable of appreciating the nature and quality of the act or omission, or of knowing it was wrong (Glancy & Regehr, 2020). All sides in court suspected that was the case, but they needed a forensic expert to provide opinion evidence during his trial.

As facilities across the province struggled with COVID-19 outbreaks and rapidly-changing admission policies, Mr. Wyatt languished in jail for several weeks before a forensic bed was available. Suspicious and distressed, he refused to see the psychiatrist, or to take any medication, and his mental state continued to decline. He was in the psychiatric equivalent of heart failure, gasping for air, and unable to access care.

When a bed was finally available at the Southwest Centre, Mr. Wyatt was so unwell that he had to be admitted directly into a seclusion room, due to his acute risk of violence. Even after his clinical risk had decreased, he was too disorganized to follow COVID-19 policies, such as wearing a mask and remaining in his room for a two-week quarantine period. As a result, he spent over a week in seclusion - with potentially serious negative consequences to his mental state (Fisher, 1994). Once he could finally organize himself to wear a mask, he had to remain isolated in his room for yet another week, reducing staff's ability to assess and engage him. Even when his quarantine was over, and his mental state had begun to improve, no visitors were allowed into the hospital. Improving insight led to extreme guilt and

shame for what he had done, but was unable to see his mother in person.

During the early stages of the pandemic, patients throughout the hospital have had to endure very limited, if any, real contact with social support from the outside world. Unlike most civil psychiatric admissions, forensic admissions are often measured in years. Given social support is known to be risk-mitigating (Douglas, Hart, Webster, & Belfrage, 2013), the pandemic robbed our patients of yet another protective factor.

### **COVID-19 and Forensic Rehabilitation**

Forensic patients - usually, individuals found NCR - are supervised in Canada by provincial tribunals ("review boards"). The Ontario Review Board (ORB) holds annual hearings for each patient, wherein they hear evidence about violence risk and recovery prospects for the coming year. The ORB then creates a disposition, outlining how much freedom a given patient can have for the next 12 months. Dispositions can range from detention in hospital, to living in the community, to absolute discharge from the forensic system altogether. In deciding which disposition would be most appropriate while simultaneously being the least restrictive, the ORB must consider the individual's psychiatric condition and other criminogenic needs, a gradual reintegration plan into the community, and balance it all with public safety. Patients can use their track record of safe engagement in appropriate community activities to "prove" themselves safe for more freedom next year, at their annual ORB hearing.

It is difficult, if not impossible, to prove you are safe to reintegrate into the community if you cannot enter the community.

Mrs. Hale was a middle-aged teacher with Bipolar Disorder. She lived at home with her husband and two teenage daughters. Her index offence happened

in 2017. On multiple occasions that year, she was found trespassing on properties in her neighborhood with a camera, accusing people of monitoring her family's telecommunications. The police brought her to the Emergency Department each time. She would leave against medical advice within a day or two. She did not quite meet the stringent criteria for involuntary hospitalization, and the general hospital faced enormous bed pressure to discharge patients anyway. She never took medication after leaving. Her family, frustrated and concerned, was never privy to information about her condition, and felt let down by "the system." The cycle repeated. We have all heard this story many times: it's the typical Psychiatric History section in a forensic report. Eventually, in the context of a manic psychosis, she "realized" her husband was the mastermind behind her perceived persecution. Like Mr. Wyatt, she thought she was at imminent risk. She seriously assaulted him; in her irrational perception, her act was in self-defence. She was charged with Aggravated Assault.

Mrs. Hale's first two years in hospital were challenging. After her NCR assessment, she was transferred to a Treatment Unit. Because of her brittle, treatment-refractory illness, her mental state was unstable, alternating between periods of aggression and suicidality. Despite being obviously ill, she never quite met the legal test for treatment incapacity. Mrs. Hale finally agreed to try a new injectable medication in 2019 and had a remarkably positive response. It was suddenly realistic that she could live in the community in the foreseeable future.

As a result, Mrs. Hale was transferred to the Forensic Rehabilitation Unit, where the focus shifted from medications to community engagement. Her partner, previously reluctant to engage in her care, reconnected with her around Christmas. He expressed that he felt he had his wife back. He agreed to apply to be an Approved Person, a process that would enable her to be accompanied by him in the community and finally see her children at home for the first time since

entering the hospital. His approval by the hospital in February 2020 brought much optimism to the team that they could use successful community passes with family to advocate for a community-living provision during her next ORB hearing, scheduled for July.

Pre-pandemic, forensic rehabilitation patients spent much of their time in the community. Depending on their goals, they may have gone on outings to Canadian Mental Health Association programs, attended adult education classes, drug rehabilitation groups, or visited with family. However, the familiar flow through the forensic system was halted during the first wave of the pandemic, when all passes to the community were suspended except under exceptional circumstances starting March 17, 2020.

During her ORB hearing in July, the Crown Attorney argued that Mrs. Hale had not yet demonstrated any safe community access, and thus it was unrealistic to assume she could live at home anytime soon, especially with the victim, even more so if the hospital was not allowing "non-essential" community passes at all.

One of the goals of the forensic mental health system is to simultaneously address public safety and community reintegration. The dual roles of the system can create ethical tension in therapeutic relationships. For much of the pandemic, our rehabilitation hands have been largely tied. As Mrs. Hale's case illustrates, the precautionary measures implemented to reduce the risk of COVID-19 outbreaks complicated a process that was already viewed as adversarial by many patients. When all passes into the community were suspended, it was at the cost of eliminating access to rehabilitation opportunities available only in the community. Patients are typically granted passes with specific therapeutic goals such as completing school or engaging in volunteering or employment activities. The consequences of limiting passes were two-fold: a stalemate in addressing criminogenic factors, which

in turn affected a patient's ability to progress through to discharge as continuous assessment for risk could no longer be conducted.

The ORB looks to evidence-based violence risk assessments to guide them in granting dispositions. The evidence shows that structured community engagement and social connections are risk-reducing (Douglas et al., 2013; Fiorillo & Gorwood, 2020). Most patients spent over a year without leaving the hospital grounds. Forensic rehabilitation had turned into forensic stasis. Mrs. Hale's children would have to wait at least another year to have their mother at home again.

### **Resilience and Optimism**

So far, we have reviewed a lot of generally bad news. However, focusing solely on the negative does not tell the whole story. Our patients and teams have demonstrated remarkable resilience, which is arguably a central theme to the story of the pandemic.

Given the increased stress, pessimism, and compromised community access throughout the pandemic, we were surprised to learn that there was no meaningful difference in the frequency of Code Whites (intended to signal actual or imminent violent behaviour) at the Southwest Centre, or the use of seclusion and restraint, in the year before and after the onset of the pandemic (Vandevooren, 2021).

Our restrictions, while onerous, have been comparable (and at times more liberal) than amongst comparable forensic hospitals in Ontario.<sup>12</sup> So far, we have avoided a COVID-19 outbreak. While restrictions were slower to loosen than we personally liked, designated visitors were eventually allowed to see their loved ones in hospital during ebbs in the pandemic. Visitor policies recently relaxed again in June 2021 after several previous reversals, bringing back social connectedness even if only for a few hours each week. For the first time since the pandemic began, patients are able to attend community

recreational outings with staff again. In July, patients began entering the community with Approved Persons (usually, their family) for a few hours per day.

Sometimes we forget how frightening and oppressive the forensic world must feel from a patient perspective. For much of their journey, they face indefinite detention with no real prospect of a discharge date. Despite promises of opportunities from care teams and the ORB coming up empty for over a year, forensic patients have demonstrated remarkable flexibility and adapted to the at-times dizzying policy changes during the pandemic. We are not out of the woods yet, but there is a sense of light at the end of the tunnel.

Finally, mental health professionals put a premium on "insight and judgment" in our assessments. Throughout the pandemic, our patients at the Southwest Centre have been highly attuned to what is happening in the world outside their walls. The first dose of a COVID-19 vaccine was given to a patient on April 20, 2021. At the time of writing, nearly 90% of our patients have been fully vaccinated (Vandevooren, 2021). As we have reviewed, forensic patients are highly stigmatized. They have serious paranoid illnesses and personal life stories giving them many reasons to distrust authority figures. Yet, they are outpacing the rest of the country in doing their part to bring the pandemic to an end.

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