Management of COVID-19 for Persons with Mental Illness in Secure Units: A Rapid-Response Guide
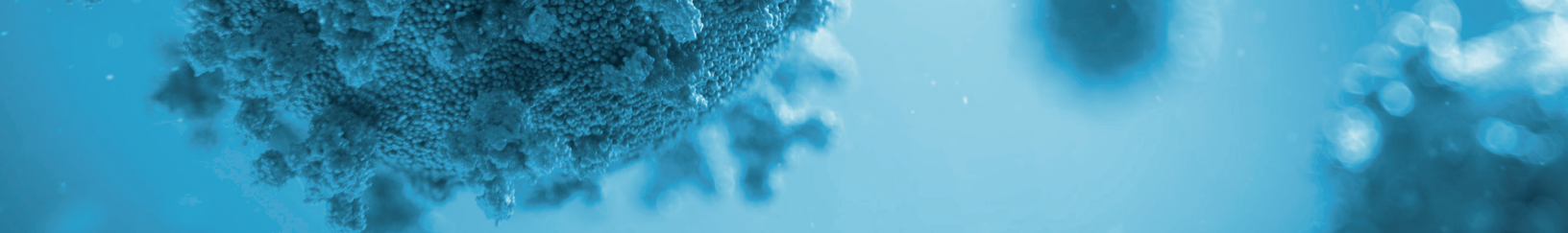
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Statement of Conflict of Interest

The participating authors and institutions declare having no conflict of interest related to this project.

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Mandate

On March 13, 2020, the Government of Québec declared a public health emergency for the entire province of Quebec, due to the COVID-19 pandemic. This triggered an immediate mobilization by the Institut national de psychiatrie légale Philippe-Pinel (INPLPP) forensic psychiatric hospital, through the creation of a COVID-19 crisis management unit and of a special inter-council COVID-19 committee. The crisis unit is composed of INPLPP managers, and meets daily to plan rapid and effective responses to pandemic-related issues. The inter-council committee is composed of the heads of the various clinical councils and provides recommendations for the INPLPP's executive committee and COVID-19 crisis unit. In parallel, the INPLPP's safety, justice, and mental health technology assessment unit (UETMI-SMJS[1]) was leading an International Association of Forensic Mental Health Services' international initiative documenting ongoing changes in forensic-psychiatry environments in response to COVID-19. As such, the UETMI-SMJS was invited to participate in the inter-council committee, to help orient its decision making on the basis of the afore mentioned initiative.

On April 9, 2020, in response to questions raised by the crisis unit and the inter-council committee, the UETMI-SMJS—via the provincial social services health-technology assessment (HTA) community of practice— invited other health technology assessment units to participate in a review of the literature related to COVID-19 and forensic-psychiatry environments. On April 20, 2020, the mental health technology assessment unit (UETMISM[2]) of the Montreal mental health university institute (IUSMM[3])—affiliated with the integrated university health and social services centre, Montreal Island East (CIUSSS de l'Est-de-l'Île-de-Montréal[4])—officially indicated interest in collaborating to this project. The request reflects each party's need to support their clinical leadership in the management of the pandemic. On May 13, a rapid-response project was officially approved and launched. The project report was submitted to the IUSMM and INPLPP leaderships on June 12, 2020.

The objectives of this rapid review were to:

- Identify information in the grey and scientific literatures on strategies applied in clinical and legal environments in response to the COVID-19 pandemic.
- Identify changes in professional and organisational practice flowing from these strategies, and the repercussions of these changes in forensic mental health settings.

By definition, a rapid review provides a timely synthesis of information for decision making, relative to systematic reviews. This is done by omitting certain steps, such as a comprehensive search of the literature as well as an evaluation of the methodological soundness of the literature reviewed, which should be taken into account when considering its findings.

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[3] Institut universitaire en santé mentale de Montréal
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Key Findings

Despite the methodological limitations of the literature-review process, this rapid review of the currently available literature has identified some key findings and recommendations in a number or areas.

Increased Vulnerability of Patients

- Secure units are at high risk for COVID-19 transmission, as they are densely populated and poorly ventilated.

- The unique characteristics of persons with severe mental illness (cognitive deficits, disorganised behaviour, psychotic symptoms, substance use) increase difficulties with social-distancing compliance.

- Multiple physical comorbidities (hypertension, respiratory problems, diabetes, obesity), lifestyle habits (smoking, sedentary lifestyle, substance use), and the potential interaction between psychotropic medication and COVID-19 symptoms all increase the risk of morbidity and mortality among patients in secure settings.

- In response to the negative psychological impact (psychological distress, negative emotions, etc.) of restricted social contact, remote technologies should be used to allow the patient's social network to participate in the recovery process.

Staff Composition and Personnel Management in Mental Health

- The multidisciplinary team (psychiatrists, psychologists, nurses, psychosocial support workers, etc.), should include at least one of the service user's close relatives or friends in order to ensure a broad base of support.

- Staff should accept new responsibilities and tasks, in order to rapidly respond to emergencies.

- The size of professional teams should be reduced to allow for the creation of standby replacement teams and to allow for rest times, especially for high-risk staff (older persons, pregnant persons, etc.).

- A dedicated task force should be created, with the responsibility of protecting staff and clients from COVID-19 infection and ensuring appropriate treatment.

- Medical staff should not be reassigned to other departments, to avoid reductions in care to patients who could suffer further deterioration of their mental and physical health.

- Staff should receive training on: 1) the risks and prevention strategies associated with COVID-19; 2) protection; 3) identification of signs and symptoms; 4) avoidance of transmission; and 5) appropriate care.

- Staff and patients should be regularly informed of the current situation and the rationale for measures that have been implemented.

Conditional Discharge and Return to the Community

- To limit transmission in secure units, recourse to community-based services is recommended.
  - Psychiatric environments
    - The reassignment of COVID-negative patients to healthcare services in the community should be planned.
  - Justice environments
    - Arrests and court proceedings for minor offences should be provisionally suspended.
    - Detainee transfers should be limited, and remote technologies should be implemented as replacements for visits for personal or legal purposes.
    - Round trips of detainees between the community and prison should be avoided.
    - Parole should be allowed for detainees who are the least likely to recidivate, are older, or have health problems.
- Follow-up in the community is necessary for this population.

Management of Transmission and Physical Spaces in Secure Units

- In order to reduce the risk of outbreaks, newly admitted patients should be isolated for 14 days, and be systematically examined (screening for COVID-19 symptoms, history of contacts, history of high-risk travel) before being placed in a care unit.
- In order to reduce the risk of transmission within institutions, the following distinct units must be created, and staffed with designated and trained professionals: 1) Hot zones, in which COVID-positive patients receive appropriate treatment; 2) Warm zones, which house suspected/symptomatic COVID cases awaiting the results of screening tests; and 3) Cold zones, which house COVID-negative individuals.
- Because patients may have difficulty identifying some symptoms, it is essential to systematically screen patients exposed to the virus.

Hygiene, Sanitary Issues, and Protection

- Managers must ensure the adequate supply and appropriate use of personal protective equipment (PPE), notwithstanding the fact that psychiatric/correctional institutions are often outside of traditional supply chains.
- Employees must be trained in the use of PPE. Clear protocols (with appropriately adapted equipment) must be established for each zone (hot, warm, cold). Each hot zone must have a designated changing room at its entrance.
- In keeping with the principles of empowerment, patients should have the choice of wearing or not wearing a face covering/mask, taking into account the risk level and the extent to which their psychiatric symptoms allow them to make an informed choice.
- Alcohol-based hand sanitizer dispensers should be available on care units, when this does not present a risk to patients.
- Institutions must promote best practices in hygiene (e.g. regular disinfection of surfaces and objects) in their staff and patients.

Continuity, Reduction, and Suspension of Services

- The management of the pandemic and the implementation of pandemic-related measures affect patient services: admissions and services may be reduced as a result of workforce losses or attempts to decrease the risk of transmission.

- Group activities held in common spaces should be suspended, in order to reduce the risk of transmission and facilitate social distancing of patients. This is particularly important with older patients and patients with multiple health problems.

- The decision to limit individual activities should take into account the risk associated with the activity, patient needs, and available alternatives, as reduction of care and services could lead to the physical or mental deterioration of patients. In some cases, it may even be necessary to consider increasing individual activities.

- Individuals who are isolated in a room or cell should be provided with a range of entertainment, physical, and personal-development activities.

Remote Technologies

- In many countries affected by the COVID-19 pandemic, remote technologies (videoconferencing, telephone) have allowed close relatives and friends to stay in contact with confined patients/detainees and reduce isolation.

- In-person meetings between medical staff is being increasingly replaced by virtual meetings using computers, cellular telephones, and electronic tablets.

- Remote interventions (remote consultations, management of prescriptions) is more common in the community than in hospitals, due in part to the relative rarity of the necessary technology in hospitals.

- In justice environments, remote practices are increasingly common (video court appearances, tele-assessment), and accelerate some stages of the judicial process.

Patient Rights: From Loss to Empowerment

- The use of isolation and deprivation of liberty to manage COVID-19 transmission is a key issue, as it contrasts the need to protect service users due to their multiple vulnerability factors with the notion of informed consent (cognitive, difficulties, behavioural problems, psychiatric symptoms).

- Measures which lead to a deprivation of liberty should be applied with caution, as they constitute a significant infringement of patients' rights.

- Measures which lead to a deprivation of liberty are perceived as punitive, provoke fear, deny individual dignity, and may retraumatize individuals with a history of significant trauma.

- Interventions should be trauma-informed and guided by safety, empowerment, transparency, collaboration, the role of peers, and cultural sensitivity.

1. Context of the Request

As COVID-19 spreads around the world, more and more countries have implemented guidelines and policies in order to flatten the infection curve and avoid overtaxing healthcare systems. For example, social distancing and confinement measures have been applied in the general population, and several countries have had to reassign medical and psychosocial staff to COVID-19 screening, management, and treatment services. These changes have been made in order to avoid the worst-case transmission and death scenarios.

These government measures and guidelines have a direct impact on institutionalised or incarcerated persons with mental health problems. Specialised mental health resources have been reassigned to short-term hospital services and long-term care facilities, and social-distancing measures have limited visitors' access to mental health environments. In addition, institutionalised or incarcerated persons with mental health problems have seen decreases in their access to practitioners and non-essential services, which has led to reduced care. Although these strategies are essential to protect these vulnerable persons from the pandemic, they can also have significant consequences on their recovery and well-being. Indeed, they are particularly susceptible to such consequences, as they were experiencing some form of confinement prior to the pandemic, as a result of their mental health problems.

In light of these issues, it became essential to examine the potential impact of changes in practice of various kinds (legislative, organisational, clinical, ethical) on institutionalised or incarcerated persons with mental health problems. Doing so will allow managers and clinicians to respond to the health issues raised by the COVID-19 pandemic and take appropriate action. Accordingly, the INPLPP's COVID-19 crisis unit, in collaboration with the mental health, substance use, and homelessness program[5] of the CIUSSS de l'Est-de-l'Île-de-Montréal, requested a rapid review to answer the following question:

What strategies have been implemented in response to the COVID-19 outbreak in clinical and legal environments (general psychiatry services, forensic psychiatry services, correctional services) in which persons with mental health problems are confined?

This review also addresses a logical corollary of this question, namely:

Given the potential impact of these strategies in these environments, should they be maintained after the pandemic?

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[5] Direction des programmes santé mentale, dépendance et itinérance

2. Methodology

2.1. Search Strategy

A non-systematic review of the grey and scientific literature on clinical and legal environments (general and forensic psychiatry services, correctional services housing persons with mental health problems) was carried out between May 10 and May 16, 2020. To be included in the review, the publications had to be in French or English, and published between December 2019 (when Chinese health authorities identified the first cases of COVID-19 in Wuhan, China) and May 2020. Two librarians searched the Medline, Pubmed, PsycInfo, CINAHL, EMBASE, EBM Reviews, and HeinOnline bibliographic databases, as well as Internet sites of some international organisations active in health technology assessment (HTA), some national and international health organisations, and Google Scholar. The primary keywords used included terms related to psychiatry (e.g. psychiatric, mental disorder, mental illness), correctional activities (correctional, offender), and forensic psychiatry (e.g. forensic); these were then combined with keywords related to COVID-19 (e.g. coronavirus, SARSCoV-2)[6].

2.2. Selection of Documents

The reference search yielded 679 publications[7]. Of these, 561 were in the seven reference databases, 110 were found using Google Scholar, and 8 were found through manual searches of the references of previously identified publications and scientific journal newsletters. Elimination of duplicates (n = 216) resulted in 463 publications, of which 368 were not retained; this reduced the number of eligible publications to 95. These 95 publications were read, and after applying inclusion and exclusion criteria, 46 were excluded. This review is therefore based on 49 publications.

All the documents were independently selected by two professionals trained in HTA. Inter-rater reliability was assessed using a 25% sample of the publications retained after the first selection stage and 20% of the publications retained after the second. In the case of divergent evaluations, a third professional cast the deciding vote.

2.3. Data Extraction, Coding, Analysis, and Synthesis

The three HTA professionals developed an extraction form, and extracted data from the publications after an analysis of inter-rater reliability using a 20% sample of the documents retained for analysis. The primary data extracted were: 1) description of the measures implemented (and, if described or measured, their impact); 2) primary clinical, practical, or ethical issues; and 3) recommendations for changes in practice[8]. The data was then coded by the three HTA professionals and grouped into thematic categories. The quality of the studies was not evaluated. The results are presented below in narrative form.

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[6] The concepts and keywords are described in Appendix 1. The search strategy is available upon request.
[7] The flow chart for the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) model can be found in Appendix 2.
[8] The data extraction form is available upon request.

3. Summary of Results

The 49 publications reviewed were all published in 2020 in, most commonly, China (13 publications), the United States (7), Italy (6), France (4), and Ireland (3). Germany, Singapore, the United Kingdom, and Australia contributed two publications each, and India, Brazil, Canada, New Zealand, South Korea, Scandinavia, Switzerland, and Spain contributed one each.

These publications were primarily (n = 39) opinion pieces by experts (editorials, letters to the editor, other correspondence). There were also one rapid literature review, five narrative (i.e. non-systematic) literature reviews, and four empirical studies (two surveys and two descriptive studies). Reference documents (laws, standards, guidelines, etc.) were also consulted[9].

The rest of this section presents a synthesis of information collected from the literature reviewed. The authors of the publications (most of which are non-empirical), primarily discuss issues related to the management of the pandemic in psychiatric environments, and present recommendations based on their own experience with COVID-19 or on previous studies. Eight main themes are discussed: 1) increased vulnerability of confined persons with mental health problems; 2) composition and management of mental health teams; 3) release from prison, and return to the community; 4) management of transmission and physical spaces in secure units; 5) hygiene, sanitary issues, and protection; 6) continuity, suspension, or reduction of services; 7) remote technologies; and 8) patient rights.

3.1. Increased Vulnerability of Patients

Persons with mental health problems are more vulnerable to COVID-19: both morbidity and mortality are greater in this population, in large part because of their living environment, comorbid physical, mental and substance use disorders and medication regimen. The current context may also increase the risk of relapses. This section discusses the factors that increase the vulnerability of this population during the pandemic, and suggests avenues to minimize undesirable effects.

Living environment

Transmission of COVID-19 is greater in secure units, such as forensic and psychiatric hospitals, remand centres, and prisons (de Girolamo et al., 2020; Liebrenz, Bhugra, Buadze, & Schleifer, 2020) as social distancing is challenging due to population density (Kothari, Forrester, Greenberg, Sarkissian, & Tracy, 2020; Kozloff, Mulsant, Stergiopoulos, & Voineskos, 2020). Moreover, in order to prevent suicide, windows are often locked, which leads to poor ventilation, itself a risk factor for transmission (Kozloff et al., 2020). Correctional environments, already underfunded and overcrowded prior to the pandemic, struggle as austerity measures amplify pre-existing challenges (Kothari et al., 2020).

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[9] These complementary resources are listed in Appendix 3.

Clinical issues

Some patients need constant reminders of social distancing rules due to illness-related cognitive problems or disorganised behaviour (Chevance et al., 2020; Kozloff et al., 2020; Percudani, Corradin, Moreno, Indelicato, & Vita, 2020). Concomitant substance use affects some persons' judgement, and ability to comply with these rules (Kozloff et al., 2020). Some patients suffering from psychosis are less motivated to comply with rules regarding social distancing and infection control (E. Brown et al., 2020; Rajkumar, 2020). Agitated patients may spit on staff or other patients, which increases the risk of transmission (Brown, Keene, Hooper, & O'Brien, 2020). Finally, some environments restrict the use of alcohol-based hand sanitizers, fearing patients will ingest them (Kozloff et al., 2020).

Comorbidities

Respiratory-disease mortality and morbidity are higher in these groups, because of the presence of multiple physical comorbidities (C. Brown et al., 2020; Cui, Wang, & Wang, 2020; Garriga et al., 2020; Percudani et al., 2020; Tor, Phu, Koh, & Mok, 2020; Yao, Chen, & Xu, 2020). Members of this population often exhibit serious mental health problems co-occurring with conditions such as hypertension, chronic respiratory problems, diabetes, and obesity. In addition, some lifestyle factors—such as smoking, sedentary lifestyle, and substance use—also increase the risk of complications related to COVID-19 (Kavoor, 2020; Kozloff et al., 2020).

Little is known about the interaction of COVID-19 and medication, but some authors suggest that special attention be paid to this issue. To date, it is unknown whether psychotropic medication increases the risk of developing serious respiratory complications (Javelot et al., 2020). It is thus crucial to closely monitor COVID-positive persons who take psychotropic medication (Chevance et al., 2020). Special attention should be paid to persons taking clozapine and lithium, which may alter COVID-19 symptoms (Chevance et al., 2020; Javelot et al., 2020), and to those in smoking cessation programs as they often require titration of psychotropic medication (Javelot et al., 2020). Moreover, to ensure compliance with isolation measures in their rooms, patients are sometimes sedated, which may aggravate respiratory symptoms (Chevance et al., 2020).

Relapse

The impact of COVID-management measures on psychiatric relapses must be emphasized. Relapses may be triggered by increased stress secondary to confinement, as well as by pandemic-related discharge and early return to the community (Garriga et al., 2020). In addition, relapses may lead to secondary problems, including problematic hygiene, inability to comply with social distancing guidelines, and inability to comply with a treatment plan (Kavoor, 2020).

Multiple COVID-19 vulnerability factors have thus been reported in the literature in psychiatric and correctional settings. These are also noted by Thome, Coogan, Fischer, Tucha, and Faltraco (2020) in their editorial on forensic-psychiatry environments. In light of these considerations, protecting patients who are older or exhibit comorbidities, is essential. However, they are usually less likely to have access to screening tests and appropriate treatment (Cullen, Gulati, & Kelly, 2020).

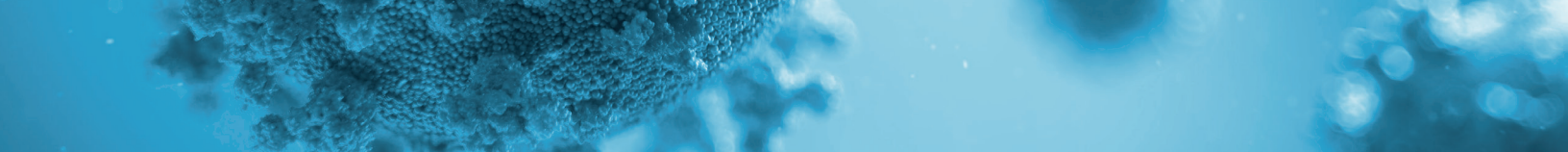## 3.2. Staff Composition and Personnel Management in Mental Health

The management of the COVID-19 pandemic has led to significant changes to the organisation of care, and especially to staff composition and personnel management in clinical settings. In the current context, it may prove useful to create an inter-profession task force (comprising psychiatrists, nurses, and psychosocial workers) to oversee the operational aspects of interventions. For example, L. Li (2020), in China, reported the creation of a group that meets several times a day to determine the information to be disseminated and the clinical decisions to be made. Similarly, Tor et al. (2020) reported the creation of a Disease Outbreak Task Force (DOTF) at the Singapore Institute of Mental Health, a facility with 1 900 beds that treats 80% of the national psychiatric population. The DOTF was created to protect institute staff and clients from infection by COVID-19, and to ensure the continuity of psychiatric treatments—especially electroconvulsive therapy (ECT), which had been interrupted in two of five departments in Singapore because of the pandemic. The DOTF adopted national guidelines, based on the Disease Outbreak Response System Condition (DORSCON) framework, for the level of severity of COVID-19 infection. The four levels of severity are colour-coded—green (Level 1), yellow (Level 2), orange (Level 3), and red (Level 4)—and define the safety measures patients and staff must follow in order to avoid COVID-19 infection during ECT.

Reassigning psychiatric hospitals into COVID hospitals has required mental health staff to take on new roles and tasks. Many patients are likely to suffer an exacerbation of mental health problems as a result of pandemic-related stress (Yao et al., 2020), and psychiatrists must therefore be familiar with screening and triage procedures, and work closely with physicians and other healthcare professionals to minimize the risk of transmission of the virus among these patients (Zhu et al., 2020). Cullen et al. (2020) warn that reassigning staff to other departments—as occurred in Wuhan, where many psychiatrists and psychologists discontinued services to attend hospitalized COVID-19 patients (S. Li & Zhang, 2020)—will compromise the care of patients, whose mental and physical health are likely to deteriorate further. The authors therefore suggest undertaking targeted community-oriented interventions (e.g. remote interventions) and supporting the wellbeing of front-line staff through peer support and services, similar to those offered by the US Centers for Disease Control and Prevention, dedicated to safeguarding their mental and physical health.

In the field of forensic mental health, managers of French psychiatric services opted for the creation of nine specifically designed hospital units, each of which has a section reserved for maintaining continuity of psychiatric care patients with COVID-19 requiring hospitalisation (Chevance et al., 2020).

In Madrid, a reduction of services offered in psychiatric emergency wards, together with the closing of psychiatric departments in university hospitals and day services, led managers of the psychiatry department of the Hospital General Universitario Gregorio Marañón to establish a psychiatric liaison service (Arango, 2020). Originally composed of three psychiatrists and three psychologists, the service has grown to 25 persons in three programs. The service operates 24 hours a day, seven days a week, and provides support for: 1) the mental health of staff (small group meetings of 4-6 people); 2) the families of patients who cannot be visited (using hospital video-conferencing); and 3) the families of the deceased. This psychiatric liaison service also intervenes when patients wish to leave the hospital or refuse to take

their medication. While most of their consultations are now delivered via teleconferencing or telephone, nurses nevertheless perform home visits for the purposes of medication (in Spain, most patients with serious mental health problems live with their parents).

Some authors have pointed out that the disruptive behaviours of some hospitalized patients and the limited access to services during the pandemic mean that psychiatrists must work with other health professionals to ensure access to screening and adequate treatment (Chevance et al., 2020; Shalev & Shapiro, 2020). This is also true in correctional settings, where the role and function of teams, services, and professionals are changing. In all cases, therefore, it is important to build consensus and foster inclusion among staff (Kothari et al., 2020). In some cases, staff will find themselves performing new tasks that require additional training and support (Kothari et al., 2020). Moreover, it has been proposed that intervention teams working with persons with serious mental health problems comprise not only psychiatrists and psychologists, but also psychiatric nurses, social workers, and loved ones, friends, peers or volunteers in order to promote a holistic approach and provide a unified support system through which information and solutions to mental health issues can be exchanged (S. Li & Zhang, 2020). It has also been recommended that teams of healthcare professionals be reduced in size, in order to create standby replacement teams that can incorporate providers in non-clinical administrative roles. This would permit the staff most at risk of infection (workers who are older, pregnant, or in fragile health) to avoid undue exposure and allow work teams to have rest periods (L. Li, 2020; Tor et al., 2020).

One of the major challenges facing most managers of psychiatric hospitals and detention centres (Lie-brenz et al., 2020) is filling vacancies caused by the loss of COVID-positive staff (Kavoor, 2020; Kothari et al., 2020). Skilled staff management is required to replace staff who are absent because they are infected or afraid of being so, to avoid resorting to extended work schedules that favour burnout, and to manage staff's infection-related anxieties (Kothari et al., 2020). Psychological stress and low morale are real dangers among care providers, who must juggle the high demands put on them, reductions in resources, and their own feelings of ineffectiveness in their new, and changing, roles (Kothari et al., 2020). In addition, staff absenteeism will inevitably lead to reductions in services, which may aggravate tensions in institutions such as correctional facilities (Kothari et al., 2020). Cullen et al. (2020) recommend that in these circumstances, staff be offered temporary work leave.

Several authors recommend that the management of front-line staff (psychiatrists, psychologists, social workers, etc.) be based on six principles: 1) implementation of a staff-management plan (cancelling and rescheduling holidays, financial compensation); 2) equitable treatment of staff, and attention to their well-being; 3) training and appropriate supervision of staff; 4) psychological support for teams facing challenging situations daily; 5) good communication and strong collaboration between professionals and teams; and 6) validation of the work and skills of those most at risk (Kothari et al., 2020; Ornell, Schuch, Sordi, & Kessler, 2020; Poremski et al., 2020). To reinforce affiliation and allow debriefing after each work shift, an employee-manager buddy system can be established (Kothari et al., 2020). These guidelines are justified by the fact that healthcare professionals must not only take on new roles and responsibilities but also rapidly adapt to work environments characterized by tense relationships and uncertainty about COVID-19 transmission (Muirhead, 2020).

Staff training

It is clear from the literature that there is a need for training programs on COVID-19 risk and prevention strategies, in order to equip professionals to deliver appropriate care that minimizes the risk of infection, and rapidly identify the signs and symptoms of the infection (C. Brown et al., 2020; Druss, 2020). Guidelines on symptom evaluation, patient transfers to intensive care units, and functional links between psychiatric services should be produced and disseminated (Thome et al., 2020).

In France, a telephone system coordinated by psychiatrists and psychologists offers support services to front-line clinicians in psychiatric wards who have to make challenging therapeutic and clinical decisions (Chevance et al., 2020). To ensure effective interventions, D'Agostino, Demartini, Cavallotti, and Gambini (2020) recommend that psychiatric hospitals encourage skills development and provide training in crisis management. Nevertheless, according to an online survey conducted February 1-15, 2020, Shi et al. (2020) found that some psychiatrists and nurses in China still base the care they dispense to hospitalised COVID-positive patients on their experience and on information obtained from the Internet, television, and other media.

Rajkumar (2020), citing Banerjee (2020), notes that psychiatrists must now provide public education on the psychological effects of the pandemic, preventive measures related to these effects, and management strategies related to the crisis. However, this presupposes that psychiatrists are regularly informed about the differential diagnosis of COVID-19, and on the risk factors for infection and transmission (e.g. advanced age, comorbidities, chronic respiratory diseases, hypertension). It is therefore important that information be shared with both healthcare and correctional staff; in the latter case, it is recommended that posters and email be used to regularly communicate up-to-date information (Kothari et al., 2020). Several authors have noted a knowledge gap about the pandemic among staff (Rajkumar, 2020; Zhu et al., 2020).
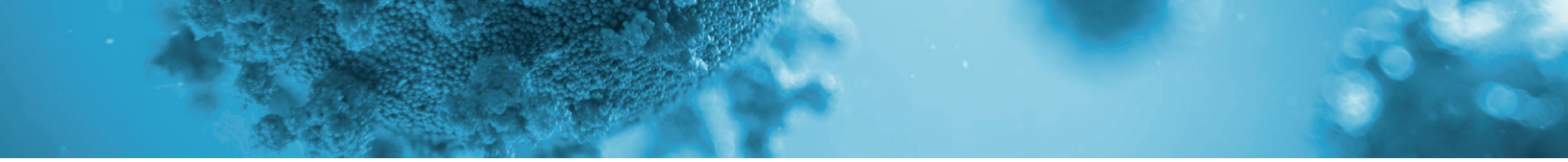
3.3. Conditional Discharge and Community Release

As overpopulation of secure units increases the risk of COVID-19 transmission, it is recommended that incarcerated or institutionalised persons be returned to the community whenever possible. Transitions of persons between community and correctional or institutional settings are associated with an increased risk of COVID-19 transmission, and several measures and recommendations related to community release have been developed. In psychiatry settings, return to the community is largely the result of early releases to free up hospital beds for the treatment of COVID-positive persons. In both cases, follow-up is essential.

The increased criminalization of some social groups (ethnic minorities, homeless persons, persons with substance-use problems, persons with mental health problems) is reported to increase transmission of COVID-19 in correctional settings (Akiyama, Spaulding, & Rich, 2020). Moreover, these repeated transitions to and from their living environment and prison (i.e. "the revolving doors of justice") increase the transmission of COVID-19 in both the community and correctional settings.

In response to this problem, public authorities in the United States (states, municipalities, and the Federal Bureau of Prisons) have limited inmate transfers and have implemented videoconferencing as a replacement for inmate visits for personal or legal reasons. In addition, Akiyama et al. (2020) have

formulated recommendations for this population, most notably: 1) release from prison of persons with the lowest risk of recidivism, of older inmates, and of persons wi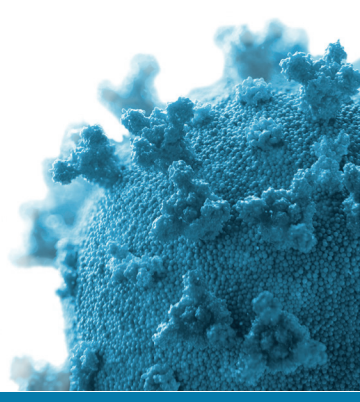th health problems; 2) provisional suspension of arrests and court proceedings for minor offences; 3) isolation of persons who are, or are suspected of being, COVID-positive; 4) preparation of protocols for the transfer and hospitalisation of inmates with severe cases of COVID-19; and 5) identification of infected and recovered staff who may have acquired greater immunity and could therefore be assigned to duties related to the hygiene and care of COVID-positive inmates.

To prevent transmission of the virus in prisons, the Bazelon Center for Mental Health (Washington DC, United States) recommends the immediate release of inmates with mental health problems, and the exclusion from prisons of any arrested person with a mental health problem (Canady, 2020a). In the United Kingdom, new legislation has modified the admission and diversion conditions for legally detained persons with mental health problems, and strongly incites Mental Health Trusts to transfer these persons to, and treat them in, the community (C. Brown et al., 2020). On the other hand, although public health authorities in England have also recommended early release of correctional detainees, this has only been carried out partially, and has been ineffective in reducing prison deaths due to COVID-19 (Kothari et al., 2020).

The diversion of COVID-negative patients from psychiatric hospitals to psychiatric services in the community must be planned. Since psychiatric hospitals have been reassigned to admit COVID-positive persons, community mental health services must prepare themselves for a wave of new admissions (Choi, Heilemann, Fauer, & Mead, 2020).

Obviously, the situation is different in every country affected by COVID-19. According to Clerici et al. (2020), psychiatric hospitalisations lasted longer in March 2020 than in March 2019 in some regions of Italy, because of difficulties ensuring that patients could return to a safe home environment. Sometimes, relocation of hospitalized patients to community-based services occurred very rapidly, without any transition period (Muirhead, 2020). For example, in France, patients who could be quarantined (14 days), had a stable psychiatric state, and were able to comply with confinement requirements were released early from psychiatric hospitals in order to free up psychiatric beds for pandemic patients. To provide support for these patients following their early release from hospital and home confinement, they were followed up remotely, through telephone and a home-intervention unit (e.g. Psymobile) that responded to emergencies (decompensation, suicide risk, etc.) (Chevance et al., 2020).

3.4. Management of Transmission and Physical Spaces in Secure Units

Infiltration of the COVID-19 virus into institutions and secure units is often inevitable, despite the implementation of measures intended to prevent just that. It is therefore essential to put in place measures that minimise transmission, such as tighter monitoring of admissions, "patient cohorting", and reorganisation of physical spaces.
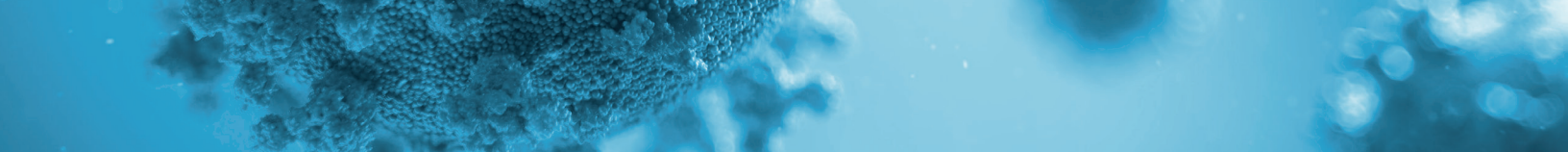
Admissions

Several authors have reported the isolation of new patients for 14 days before integration into regular care units (Cheung, Fong, & Bressington, 2020; Ji, Li, Huang, & Zhu, 2020; W. Li et al., 2020; Starace & Ferrara, 2020; Zhu et al., 2020). In addition, it has been recommended that discharge procedures be revised, in order to minimise discharged patients' contact with newly admitted patients and to ensure their safe return to the community (D'Agostino et al., 2020). Prior to admission to an inpatient care unit, all patients seen in emergency wards should be screened for COVID-19 symptoms, including a history of travel to high-risk regions, and a history of contacts with persons confirmed to be COVID-positive or exhibiting COVID-like symptoms (D'Agostino et al., 2020; Ji et al., 2020; W. Li et al., 2020; Starace & Ferrara, 2020; Zhu et al., 2020). Many hospitals have suspended admissions (D'Agostino et al., 2020) or tightened admission criteria (Muirhead, 2020; Starace & Ferrara, 2020; Xiang et al., 2020). The evaluation of newly admitted patients may be performed by an infectious disease care unit, which should be available at all times and could also provide follow-up for COVID-positive patients and consult with care teams (Percudani et al., 2020).

Detection of positive cases

Vigilance for COVID-19 symptoms should be constant and dynamic, in order to prevent outbreaks on units (D'Agostino et al., 2020). In a paper on their experience in a psychiatric institution in Wuhan, China, Ji et al. (2020) reported the problems encountered in the management of COVID-positive patients. In particular, they noted that these patients often presented with atypical symptoms and were unable to correctly and rapidly identify their own symptoms. As a result, it was difficult to provide these patients with appropriate and timely treatment. It has also been reported that inmates in correctional facilities were reluctant to report symptoms, out of fear that they would be subjected to additional isolation precisely when they were feeling particularly vulnerable and alone (Kothari et al., 2020). Ji et al. (2020) recommend that the examination procedures for patients who are symptomatic or may have been in contact with COVID-positive persons be improved, and that these persons receive blood tests and chest CT scans. This presupposes the availability of staff capable of performing these examinations.

When a COVID-positive case is identified, all patients on the unit should be tested for COVID-19, and a protocol should be in place for their transfer to a designated COVID care unit (such as a pulmonology department) should their health deteriorate. Care units for COVID-positive patients should have protocols for clinical and paraclinical observation and evaluation, and monitoring of symptoms, given the additional health risks related to the virus (Percudani et al., 2020). Symptomatic patients in isolation should also be monitored closely should they exhibit suicidal or violent behaviours (L. Li, 2020). Each care unit should develop and regularly revise isolation procedures, in order to ensure the continuity of psychiatric care for COVID-positive patients with few or no symptoms

(D'Agostino et al., 2020). The decision to transfer a patient to a designated hospital should be based on the patient's level of risk and needs, determined through a procedure established by the local government (Zhu et al., 2020). Akiyama et al. (2020) recommend that managers of prisons and correctional facilities in the United States prepare for a high morbidity rate, given the multiple vulnerability factors of incarcerated persons.

Positive cases and physical spaces

Several authors have reported the creation of distinct units ("patient cohorting"): 1) Hot zones, in which COVID-positive patients receive appropriate treatment; 2) Warm zones, which house suspected/symptomatic COVID cases for 14 days while they await the results of screening tests; and 3) Cold zones, which house COVID-negative individuals (Arango, 2020; Cui et al., 2020; L. Li, 2020; Percudani et al., 2020). In addition, distinct corridors may be created within these units for staff and patients, in order to limit the risk of transmission (Chevance et al., 2020). In France, some institutions dedicate trained staff to each of these care units, in order to avoid contamination between units. The segregation of patients into different units on the basis of the risk of transmission should be prioritised whenever possible, as it allows patients to continue their activities as freely as possible in their designated units, and avoids more restrictive measures such as room isolation (C. Brown et al., 2020). If necessary, COVID-positive patients may be isolated in individual designated rooms for 14 days, although this may require closing down beds in double-occupancy rooms (de Girolamo et al., 2020; L. Li, 2020; Starace & Ferrara, 2020; Xiang et al., 2020). If it is not possible to provide a unit dedicated to COVID-positive patients, a care unit in a general hospital with psychiatric-support staff may be created (Percudani et al., 2020).

In a letter to the editor, C. Li et al. (2020) recommend assigning security staff to each zone, because of some patients' violent behaviours. Fagiolini, Cuomo, and Frank (2020) report that decisions in Italian psychiatric hospitals were made locally. In Siena, all inpatient units have been allocated to the non-COVID zone, and new admissions were assigned to a newly created COVID zone. In Northern Italy, new COVID-positive patients with serious problems were assigned to specific zones. Patients who could not be isolated or who had violent behaviours were assigned to a room reserved for this purpose, and larger rooms were assigned to COVID-positive patients. With regard to correctional facilities in the United States, Akiyama et al. (2020) recommend that inmates suspected of being or known to be COVID-positive be isolated and separated from the general population.

3.5. Hygiene, Sanitary Issues, and Protection

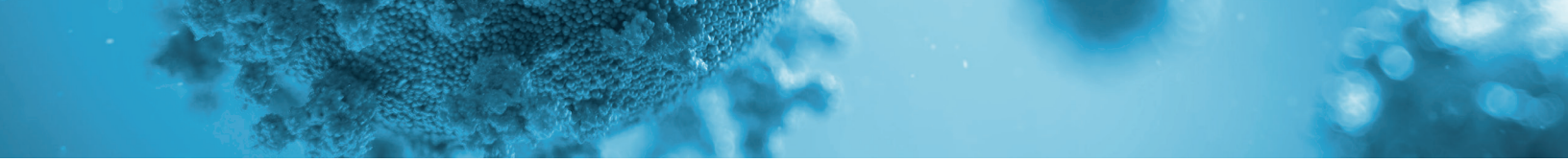### Issues related to disinfection and supplies

The implementation of enhanced hygiene measures and of personal protective equipment (PPE, e.g. masks, face coverings, protective suits) faces many obstacles, especially with regards to supply, safety, training, and use. Arango (2020) reports that most of the infections of staff and patients in Spain were the result of the absence of disinfected spaces. In one psychiatric hospital in Madrid, 18% of the staff were COVID-positive, compared to 14% of health professionals in Spain as a whole. Contaminated common spaces, such as elevators and staircases used by staff, may have contributed to the transmission of the virus. Moreover, several authors have reported insufficient supplies of clothing and PPE, as well as deficient training in the use of such equipment (Arango, 2020; Enos, 2020; Ji et al., 2020; Xiang et al., 2020). Psychiatric institutions' difficulty obtaining adequate supplies may be due in part to the fact that they lie outside traditional supply chains and maintain little PPE on the premises (Enos, 2020). Obviously, difficulty obtaining PPE is also an important issue in prisons (Kothari et al., 2020).

It is also important to consider the inherent hazard of some situations in secure units: masks may be used as ligatures (Enos, 2020), and alcohol-based hand sanitizers may be prohibited in care units, due to the risk of patients consuming them (L. Li, 2020). Several authors have noted challenges in compliance with standard hygiene guidelines, such as frequent hand-washing, coughing or sneezing into one's elbow, or maintaining a distance of two metres in patients with certain symptoms or cognitive problems (Kavoor, 2020; L. Li, 2020; Xiang et al., 2020).

Personal protective equipment

Ensuring continuity of care to patients requires adequately protecting staff (Choi et al., 2020). Managers must therefore do everything in their power to ensure not only adequate supplies of PPE for the current health crisis but also adequate reserves for future emergencies (Enos, 2020).

There is no mention in the literature of any uniform, standardised, protocol for PPE use. Many authors recommend that all staff wear a mask, in order to reduce the risks of infection on psychiatric units (Cheung et al., 2020; Enos, 2020; C. Li et al., 2020). Some specifically recommend the use of a N-95 mask and a full-body suit (Ji et al., 2020), while others note that cloth masks or other face coverings may be used if surgical masks are unavailable (Enos, 2020). Yet others recommend that when the supply of PPE is limited, the equipment should be reserved for interactions with patients with fever and respiratory symptoms (L. Li, 2020). Another option is for all personnel, including non-medical staff, to change into medical uniforms upon arrival in order to minimize transmission from the community to the institutional setting and vice versa (L. Li, 2020). In some cases, changing rooms have been set up to allow staff to don surgical masks and disposable suits before entering units with COVID-positive patients (Chevance et al., 2020; Percudani et al., 2020). When staff must enter the room of a COVID-positive patient, they should wear disposable cap and surgical gown, protective glasses, shoe covers, and gloves that extend over their suit (Chevance et al., 2020). In correctional environments, staff caring for detainees should dispose of sufficient PBE supplies (especially masks), and disinfectant (Liebrenz et al., 2020).

Some authors recommend all patients on psychiatric units (Cheung et al., 2020) and residential facilities (Enos, 2020) wear masks while awake. Others recommend that only COVID-positive patients wear masks and disposable suits (L. Li, 2020). To foster empowerment, patients should be offered the choice of wearing or not wearing a mask, so that they can feel that they have some control over their situation (Canady, 2020b). If a patient is incapable of wearing a mask due to their psychiatric symptoms or safety considerations, those near them should wear a mask or face covering, in order to reduce the risk of transmission (Enos, 2020).

Finally, it has been emphasized that while wearing a mask can reduce infection, it should never be allowed to become an obstacle to caring and compassion (Kim & Su, 2020). Furthermore, staff should be trained in the use of PPE (Percudani et al., 2020; Shalev & Shapiro, 2020).

Enhanced hygiene measures

In the current context, it is essential to increase the availability of alcohol-based hand sanitizer in care units (Enos, 2020), and to promote best practices concerning its use, such as handwashing in both staff and patients (Enos, 2020; Muirhead, 2020; Xiang et al., 2020).

Surfaces (e.g. doors, shared computers, identity cards, metal or plastic surfaces that facilitate virus transmission) and frequently used locations (e.g. dining rooms) should be disinfected (L. Li, 2020). In COVID-positive units (hot zones), additional hygiene measures, including regular disinfection of all medical equipment and non-medical equipment (e.g. keys, telephones), is also necessary (Chevance et al., 2020). Some authors also report practices such as

emptying rooms of all non-essential equipment and assigning specific equipment to each patient in hot zones. When the latter procedure is not possible, equipment should be disinfected between each patient interaction. Disposable dishes and cutlery should be used, and patients' bedding should be considered contaminated, and handled and cleaned accordingly (Chevance et al., 2020). Temporarily stored food and items should be inspected and disinfected by staff before their distribution (C. Li et al., 2020). Staff should be monitored for symptoms (L. Li, 2020) and even have their temperature taken when they enter and leave wards (Starace & Ferrara, 2020; Xiang et al., 2020; Zhu et al., 2020).

Some authors recommend using highly visible posters to remind patients to protect their respiratory system and frequently wash their hands (C. Li et al., 2020; Starace & Ferrara, 2020). These posters could also provide information on COVID-19, the virus' means of transmission, and the differences in the safety protocols applicable to staff and patients (Canady, 2020a).

3.6. Continuity, Reduction, or Suspension of Services

The measures necessary for the management of the pandemic have impacts on the delivery of services to patients. Several authors have reported reductions in service as a result of workforce losses or attempts to decrease the risk of transmission.

Reduction of the number of psychiatric beds

In a letter to the editor, Cui et al. (2020) report the difficulty maintaining services to persons with mental health problems in Hubei, China. This was due in part to two phenomena. On the one hand, most general hospitals stopped caring for psychiatric patients to free up beds for COVID-19 cases and reduce the risks of transmission. On the other hand, psychiatric hospitals limited their admissions to allow for the creation of units for symptomatic or positive COVID-19 cases. In addition, the suspension of public transport compromised the continuity of outpatient services. Choi et al. (2020) recommend developing a continuity-of-care plan in response to the reduced availability of psychiatric beds. Furthermore, reductions in admissions to psychiatric units should be compensated for by increases in the capacity of psychiatric services in less-intensive, community-based, environments (Choi et al., 2020; Cui et al., 2020)—these environments should therefore have plans to that allow them to ensure continuity of service and accommodate patients in crisis.

Arango (2020) and Garriga et al. (2020) reported similar situations in Spain. In Madrid, the number of psychiatric beds had fallen by more than 60% (Arango, 2020). University hospitals no longer have psychiatric units, as the beds were reassigned to COVID-19 patients. All psychiatric outpatient services were closed. The psychiatric emergency ward operated at 75% capacity, and 70 beds were setup in a gymnasium for older patients who were infected and could not be admitted to other psychiatric units. To ensure continuity of care in the face of these changes, one hospital modified its delivery of psychiatric services, notably through the creation of a psychiatric liaison department that follows up patients who wished to leave the hospital or refused to take medication. The situation was similar in Italy, where D'Agostino et al. (2020) reported that a decree by the regional public health authority concerning the treatment of COVID-19 patients resulted in the ASST Santi Paolo e Carlo (department of mental health, San Paolo) suspending admissions. In response, the hospital converted two secure psychiatric units (29 beds) into intensive care units for COVID-19 patients.
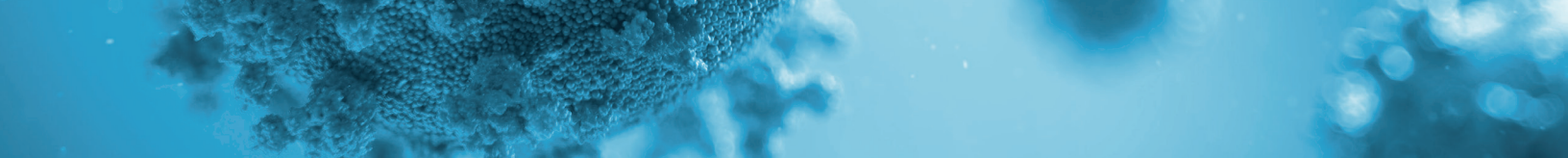
Closure of community-based clinical and psychosocial services may also limit opportunities for discharge (L. Li, 2020). In addition, the admission of new patients takes longer, which contributes to overtaxing psychiatric emergency services. At the same time, treatment orders and involuntary admissions take longer to process when court proceedings are suspended or limited, and this may exacerbate existing psychiatric problems. Finally, although the effects of this temporary reduction in clinical services have not been quantified, it is probable that it hinders the recovery of persons dealing with serious mental health problems that require regular and intensive services (Cheung et al., 2020).

Suspension of group activities

Several authors have recommended the reduction, if not complete suspension, of group activities and activities held in common rooms, as well as the restriction of the number of participants in group activities, especially those involving older patients with multiple comorbidities (L. Li, 2020; Xiang et al., 2020). However, limiting group activities could lead to greater loneliness in already isolated patients, and exacerbate psychiatric symptoms (Xiang et al., 2020).

Reductions in the number of participants in order to facilitate social distancing, and suspension of group activities in common rooms, have in fact been reported

in mental health units (D'Agostino et al., 2020; Muirhead, 2020) and forensic psychiatric environments (Tomlin, 2020). However, support from other health professionals and cultural services was maintained in these cases, and patients were involved in the planning and creation of new activities.

Individual activities and interventions

In Lombardy, Italy, activities for COVID-negative patients remained unchanged (Percudani et al., 2020). Poremski et al. (2020), state that the decision to reduce individual activities should take into account the risk posed by the activity, patient needs, and existing alternative services. Cullen et al. (2020) fear that reducing services will lead to a deterioration of patients' mental and physical states, and recommend increasing care during this period of crisis.
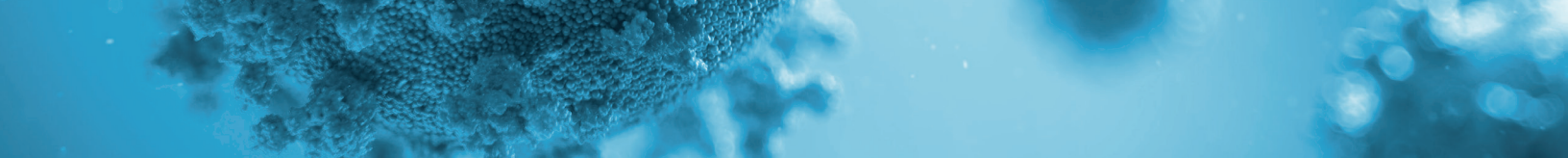
The results of a national online survey of centres practicing ECT reveal a reduction of service as a result of the pandemic. Respondents emphasized the potential impact of this service reduction, particularly: 1) a major aggravation of symptomatology; 2) complications due to immobilisation (such as bedsores); 3) an increased risk of isolation, and even chronic restraint, for patients with excited catatonia who are unresponsive to medication; 4) prolonged hospitalisation; and 5) involuntary hospitalisation (Amad et al., 2020). The authors of the survey recommend that the impact of the reduction of ECT activities be evaluated and that staff remain alert to the specific neuropsychiatric consequences of the pandemic. Further, they believe that reductions in services could lead to decreased effectiveness of ECT, as effectiveness decreases as wait time increases. Similarly, Chevance et al. (2020) and Tor et al. (2020) consider ECT an essential service, and recommend maintaining ECT sessions that do

not require anaesthesia, disinfecting equipment between each patient, ensuring staff wear PPE, and designating a specific ECT team, and, in the case of quarantine, an alternate team.

Tomlin (2020) recommends that forensic mental health environments plan how often patients go outdoors and enjoy exercise periods, to ensure that they receive the minimum time outdoors recommended by the United Nations' Nelson Mandela Rules (at least one hour of outdoor physical activity per day, weather permitting). Kothari et al. (2020) recommend that prisoners in cells receive entertaining material such as jigsaw puzzles and playing cards, as well as personal-development material such as guides to yoga or physical fitness. A variety of levels should be available, with activities for beginners and experts, and spaces could be modified to facilitate access. They also report that detainees greatly appreciate these basic interventions.

Reduction of mental health services in prisons

Liebrenz et al. (2020) emphasize that mental health problems are disproportionately frequent among incarcerated persons. Even under normal conditions, psychiatric care in prison environments is inadequate—during a crisis, psychiatric and psychological needs are that much greater, due to increased feelings of fear and uncertainty, and the undesirable effects of isolation measures. Notwithstanding the greater need for psychological support in the context of the COVID-19 pandemic, psychosocial services (psychologists, social workers, etc.) should be reduced, in order to reduce the risk of transmission of the virus.

For some authors, ensuring the continuity of psychiatric and psychological services during the COVID-19 pandemic is paramount. To this end, they recommend: 1) regional coordination of psychiatric and correctional services; and 2) liaison with courts and probation officers to screen for mental health problems and ensure adequate follow-up. They also emphasize the need to triage persons with serious mental health problems, by identifying risk factors—such as pre-existing mental health problems, risk of harm to self or others, violent or aggressive behaviour, and refusal to eat—and to consider the recommendations of professionals with prior knowledge of the detainee. These individuals should be prioritised for care (Kothari et al., 2020). Furthermore, professionals who provide psychosocial care should be regularly informed of the evolution of symptoms (Liebrenz et al., 2020). Finally, in order to ensure that follow-up is congruent with the constantly evolving situation, new practices should be regularly re-evaluated and redeveloped, and all changes should be clearly explained to staff and detainees (Kothari et al., 2020).

3.7 Remote Technologies

The use of remote technologies in hospital and correctional environments allows patients to remain in contact with their families and with professionals, while preventing the transmission of COVID-19.

Technology as the interface for patient-family meetings

Several countries have promoted the use of remote technologies to ensure hospitalized patients remain in contact with their families. In the absence of in-person visits, videoconferencing (when available) and telephones have become the principal means of contact between these groups (Garriga et al., 2020).

In Hong Kong, where psychiatric units were closed to visitors, videoconferencing allowed families to maintain contact with confined patients and break isolation (Cheung et al., 2020). In Madrid, the psychiatric unit of the Hospital General Universitario Gregorio Marañón is one of the few to have remained open since the outbreak of the pandemic, but preventive measures have prohibited in-person visits between patients and their families. However, families can turn to a psychiatric liaison department, which provides videoconferencing technology for virtual visits with patients (Arango, 2020). In Lombardy, Italy, significant measures were adopted in the first four weeks following the appearance of the first confirmed cases of COVID-19, including a restriction of in-person visits to psychiatric hospitals. Some of these hospitals possess the remote technology needed for videoconferencing with patients' close relatives and friends, and provide psychological support to grieving families (de Girolamo et al., 2020).

In the United States, the National Association of State Mental Health Program Directors (NASMHPD) recommends patients stay in touch with their loved ones via videoconferencing (Muirhead, 2020), FaceTime, or Skype (Canady, 2020a)[10]. In addition, the National Alliance on Mental Illness (NAMI) published a guide that explains, among other things, how to contact an incarcerated close relative or friend with a mental health problem[11].

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[10] NASMHPD. "Peer-Led Recommendations for Supporting Individuals Receiving Care in State Psychiatric Facilities During the COVID-19 Crisis". Retrieved from https://www.nasmhpd.org/content/peer-led-recommendations-supporting-individuals-receiving-care-state-psychiatric-facilities.

[11] NAMI. "COVID-19. Resource and Information Guide". Retrieved from https://www.nami.org/Support-Education/NAMI-HelpLine/COVID-19-Information-and-Resources

Remote interventions

In response to the COVID-19 pandemic, some public authorities rapidly turned to remote delivery of patient services, with the justice environment being no exception. In Ireland, the experience has been positive (Kennedy, Mohan, & Davoren, 2020): the use of video court appearances has resulted in meetings adhering more closely to the agenda, triage being more rigorous and effective, and detainees being more likely to appear. Regarding telemedicine, some care units, such as those of the Irish National Forensic Mental Health Service and the Irish Prison Service, offer videoconferencing interventions. Kennedy et al. (2020) believe that video court appearances and telemedicine accelerate some elements of the judicial process and propose that they be continued after the COVID-19 crisis.

Prior to the COVID-19 pandemic, communication technologies dedicated to intervention were not always available or used for this purpose in psychiatric settings (Shalev & Shapiro, 2020). A survey conducted by Simpson, Dumas, McDowell, and Westmoreland (2020) in March 2020—in which 101 psychiatrists in 29 US states were asked to assess the quality of, and access to, mental health services—reveals that even today, these technologies are not always used when available. Psychiatrists reported being more likely to use telemedicine technologies for outpatients than for inpatients, whose health status increases their susceptibility to COVID-19 infection (Simpson et al., 2020). The current situation may reflect the apprehension some health professionals have in the use of these technologies as alternatives to in-person meetings with service users. Nevertheless, this apprehension is continually diminishing as the value of these communication technologies in hospital environments is recognized; as a result, uptake of the technologies is growing. For example, a telepsychiatry hotline implemented by a team of psychiatrists in a hospital in Paris, France, was well received by medical staff and by patients who were relocated outside the hospital (Corruble, 2020). A similar approach was implemented in other Paris hospitals for the management of persons experiencing a suicidal crisis (Chevance et al., 2020). Although virtual contacts may be used in secure-hospital rooms or cells for interventions or checks of mental state, they may present some challenges in shared spaces, such as prison cells and double-occupancy rooms, where they compromise confidentiality and may increase stigmatisation and feelings of shame (Kothari et al., 2020).

The recourse to remote technologies, be they videoconferencing or telephone consultations between professionals and patients (Arango, 2020), or FaceTime or Skype discussions between staff, requires staff training in the technology in question (Canady, 2020a). Moreover, psychiatric hospitals should use these remote technologies not only for patient consultations but also for the management of medication and communications with patients' close relatives and friends (de Girolamo et al., 2020). In fact, the value of these technologies is increasingly recognized, and remote consultations with patients are becoming widespread in the face of social distancing measures applicable to patients and healthcare personnel (S. Li & Zhang, 2020; Muirhead, 2020). Furthermore, the use of computers, cellular telephones, and tablets for virtual team meetings is increasingly common, and is consistent with recommendations by institutional authorities to find alternatives to in-person meetings (Corruble, 2020; Shalev & Shapiro, 2020; Shao & Fei, 2020).

3.8. Patient Rights: From Loss to Empowerment

Loss of rights and confinement

Preventive isolation measures have forced many psychiatric care and residential treatment settings to confine patients who were normally free to come and go. This has been reported in Italy (de Girolamo et al., 2020; Starace & Ferrara, 2020), Scotland (C. Brown et al., 2020), New Zealand (Muirhead, 2020), and China (Zhu et al., 2020), and is also true generally in forensic psychiatry environments (Tomlin, 2020). However, loss of rights and freedoms is a fundamental concern when implementing isolation measures with populations that are already confined. One of the issues raised for some patients is their difficulty observing guidelines for in-room isolation without resorting to sedation which could aggravate respiratory symptoms (Chevance et al., 2020).

Video court appearances and tele-assessment : Not as good an idea as it seems?

Kelly (2020) reports that COVID-motivated legislative changes in the Republic of Ireland affect the assessment, treatment, and judicial process of persons with mental health problems. Thus, the Emergency Measures in the Public Interest (Covid-19) Act 2020 made significant but temporary changes to the Mental Health Act 2001. The most noteworthy changes concern assessment procedures (both remote and in-person evaluations are now allowed), member composition of the tribunal (the tribunal can now be composed of only one person rather than three), and tribunal procedures (both video and in-person appearances are now allowed).

Although these provisional changes to the law were adopted in response to the heightened need for psychiatrists dispatched to other sectors, Kelly (2020) notes that they have had a significant impact on patient rights. Although patients are not obligated to attend hearings, some patients choose to do so as it is an opportunity to be heard. In addition, video appearances may raise additional barriers to access for patients with literacy or cognitive difficulties, placing a further burden on the patient's legal representative, who must ensure that their client comprehends and participates in the proceedings. Also, the mental health tribunal's reduced size and wider powers may compromise the fairness and equity of hearings. The authors recommend that such changes be avoided in future mental health legislation.

Loss of rights and isolation

The United Kingdom Coronavirus Act modified some provisions of the Mental Health Act (C. Brown et al., 2020). The changes regarding psychiatric evaluations and the procedures of administrative tribunals are similar to those described above for Ireland (Kelly, 2020). Again, modifications facilitate the isolation and detention of persons with mental health problems, in the interest of preventing transmission. These changes supplement existing legal provisions in the United Kingdom—especially Section 5 of the European Convention on Human Rights, the Mental Capacity Act (MCA 2005), and the Mental Health Act (MHA 1983)—that deprive individuals of their liberties in the interests of their safety or that of others.

Isolation and deprivation of liberties is a crucial issue, because of psychiatric patients' vulnerability factors and ability to provide informed consent (due to cognitive impairment, behavioural problems, and psychiatric symptoms). These measures must

therefore be applied with caution, as they are significant infringements of patients' rights. In order to avoid COVID-19 transmission in the community or in institutions, protocols that ensure isolation guidelines are observed must be put in place. Isolation should only be implemented after measures more respectful of individual liberties (e.g. parole and patient cohorting) have failed. To help clinicians make decisions about the best measures to apply under the circumstances, C. Brown et al. (2020) illustrate, through case vignettes, situations in which patient isolation is required to avoid virus transmission.

In C. Brown et al.'s (2020) view, existing laws regarding the confinement of psychiatric patients who are, or are suspected of being, COVID-positive are deficient. Moreover, the use of isolation to prevent COVID-19 transmission is a security and contamination risk-management issue, not a mental health treatment issue. The legal apparatus surrounding isolation must reflect this, and public health acts must be adapted to reflect the situation of persons with mental health problems. The authors recommend that, in light of this legal grey zone, governments issue clear and concrete guidelines regarding COVID-19 isolation measures in psychiatric units, and that the power to implement isolation measures under public health acts be delegated to care providers. In the absence of formal recommendations, each health institution should develop clear COVID-19 isolation policies which are the least restrictive of individual liberties.

Favouring empowerment and trauma-informed approaches

In a Mental Health Weekly paper, Canady (2020a) pointed out that measures in place in hospitals and prisons may trigger painful memories of trauma. In response, the National Association of State Mental Health Program Directors shared peer-led recommendations emphasizing safety, empowerment, transparency, collaboration, peer support, and cultural sensitivity. Empowerment may also be reinforced by the continuous communication of decisions, based on reliable sources, which affect patients—as long as the stream of communications does not overload staff and patients. In addition, participation of patients in the layout of their living spaces should be encouraged (Muirhead, 2020). In the same vein, regularly and adequately informing patients of the current situation and of the reasons for the measures taken to protect their health is essential (L. Li, 2020; Zhu et al., 2020). To ensure decision-making transparency, patients should therefore be informed of changes in procedures and of measures underway in the hospital environment (Canady, 2020a). To this end, they must be able to have discussions with staff and obtain information they can easily understand (Tomlin, 2020).

Tomlin (2020) reviewed the literature on the effects of restrictive measures on the perceived freedom of patients in forensic psychiatry environments, and concluded that these measures are perceived as punitive, provoke fear, and deny the dignity of patients. Patients subjected to these measures feel diminished, bored, frustrated, and dehumanized. Echoing Canady (2020a), Tomlin (2020) states that measures that patients perceive to be fair, less restrictive, and contextually appropriate (e.g. context-specific rather than one-size-fits-all) are also perceived as more legitimate, and are thus more likely to be respected.

4. Discussion

The objective of this rapid response guide was to identify strategies that have been developed in response to the COVID-19 pandemic and applied in clinical, forensic, and penal environments housing legally detained persons with mental health problems. More specifically, the intent was to characterize the impact of these measures, in order to identify the best practices to promote, now and going forward. The literature reports transformations around the world, primarily in psychiatric environments, but also in correctional and forensic psychiatry environments. The publications reviewed describe real-world situations, identify issues relevant to patient and detainee management, and issue recommendations.

Six major conclusions can be drawn from this literature review.

First, persons confined in psychiatric or correctional settings are more vulnerable to COVID-19, due to their multiple physical and psychiatric comorbidities, and to the characteristics of the environments themselves. It is therefore necessary to take these factors into account when planning patient management strategies during this health emergency when vulnerability factors are accentuated. Although certain group activities should be suspended to minimize the risk of transmission, patients/detainees will probably require additional individual interventions.

Second, frequent, and transparent communication between management, treatment teams, and patients/detainees is essential to ensure effective and acceptable changes in the organisation of services in response to the pandemic. Involving patients/detainees in communication activities and changes gives them a feeling of control which helps reduce the negative impacts of disruptions and may enhance compliance.

Third, changes in care trajectories due to early release or to restricted admission policies must be compensated for by intensive community services and ongoing follow-up.

Fourth, contagion-control measures that are least restrictive of individual liberties should be favoured. When in-room or in-cell isolation is necessary, it should be compensated for by more extensive psychosocial services.

Fifth, managers of institutions must ensure supplies are adequate, staff is trained, PPE is used, and equipment to support enhanced hygiene measures is available. Clear protocols that are proportionate to the risk of transmission must be implemented, and staff and patients/detainees should be informed of them.

Sixth, the use of remote technologies (videoconferencing, computers, tablets, telephones, etc.) appears to be a valuable strategy for maintaining contacts between patients and their families, between patients and their treatment teams (telemedicine), and between professionals (for professional discussions and team meetings). It also appears to be useful for maintaining the continuity of essential judicial activities (video court appearances, tele-assessment). Although these technologies appear promising, it is necessary to consider their impacts on confidentiality, their suitability for persons with literacy or cognitive deficits, and the subjective experience of patients/detainees, who may feel that they are not understood as well as during in-person interactions.

It is important to bear in mind that although there are specific issues to be considered when planning service delivery to forensic psychiatric patients—such as the risk of violence and the higher prevalence

of functional deficits (Beach et al., 2013; Nijdam-Jones, Nicholls, Crocker, Roy, & Somers, 2017)—the scientific literature reviewed only identified a small number of publications which related specifically to the forensic mental health context. The grey literature reviewed somewhat fills this gap. Of particular interest is the document entitled "COVID-19: Secure Hospital and Criminal Justice Settings"[12] of the Royal College of Psychiatrists in the United Kingdom, and the "Recommandations en psychiatrie légale - épidémie Covid-19" [Recommendations in Forensic Psychiatry – Covid-19 Epidemic][13] of the *Association des jeunes psychiatres et des jeunes addictologues* in France. These publications note the importance of the factors mentioned in this rapid-response guide, but also point out the need to take into account the following factors upon admission, detention, or hospitalisation: 1) transfer and follow-up procedures; 2) the patient/detainee's legal status; 3) the patient/detainee's individual risk factors (e.g. family violence, sexual violence, paedophilia); and 4) the use of isolation and restraint measures when behavioural problems arise.

Another noteworthy point is the scarcity of literature specifically focusing on persons who have mental health problems and are in correctional settings. This literature review has demonstrated that mental health problems are an additional challenge to be taken into account in the management of persons in detention, but did not undertake an in-depth analysis of the specific situation in correctional settings, which pose specific challenges, such as inadequate psychosocial care and relatively heterogeneous populations (Mulvey & Schubert, 2017).

For recommendations specific to correctional environments, the reader is encouraged to consult "Organisation de la prise en charge sanitaire des patients détenus nécessitant des soins psychiatriques" [Management of healthcare for detained patients requiring psychiatric care][14] of the *Association des établissements du service public de santé mentale* in France. For recommendations and a discussion of the issues in correctional environments in general, readers should consult Fair Trials' COVID-19 alerts[15]. In addition, readers may find it useful to consult the International Association of Forensic Mental Health Services' compendium on "Addressing the COVID-19 Pandemic among Justice Involved Persons with Mental Illness"[16] for an up-to-date list of practices in, and recommendations of, the international forensic-psychiatry community.

Limitations of the Rapid Review

This rapid review has some limitations that should be taken into consideration when interpreting the results presented. The main limitation pertains to the type of literature reviewed: given the novelty of the COVID-19 pandemic, it was decided not to limit the review to empirical studies. In fact, the publications reviewed are mostly opinion pieces by experts (editorials, letters to the editor, other correspondence). Moreover, it was not possible to evaluate the quality of the conclusions drawn by the rare (and non-systematic) reviews of the literature and descriptive studies found, as their authors did not describe (or described in little detail) their methodology.

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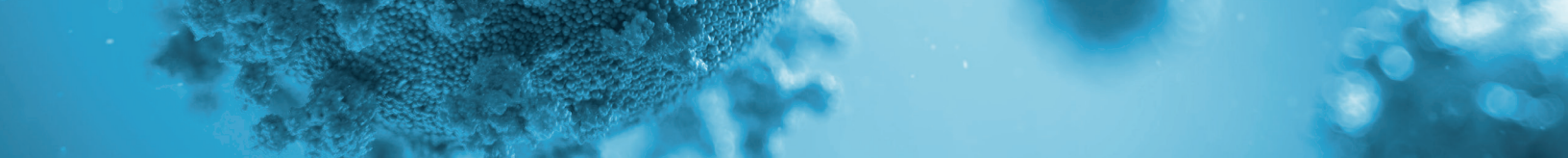
[12] Retrieved from https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/secure-hospital-and-criminal-justice-settings
[13] Retrieved from https://www.ajpja.fr/uploads/file/5e853089ec30b_EUhPsvPWAAE6au1.jpeg
[14] Retrieved from http://www.adesm.fr/wp-content/uploads/2020/04/Covid-19-Fiche-établissements-pénitentiaires.pdf
[15] Retrieved from https://www.fairtrials.org/newsmap?field_country_tid=58
[16] Retrieved from http://www.iafmhs.org/h-19-Resources

The review period (December 2019 to May 2020) corresponds to the period which saw a rapid outbreak of COVID-19 around the world. The content of the publications analysed reflects the urgency of the situation in hospital and correctional environments in many countries. Most of the publications report recommendations, issued by practitioners and local authorities, that modify professional practice and the organisation of services offered to persons with serious mental health problems and who are confined in one of these settings. Although these recommendations are based on clinical knowledge or previous research, it should be noted that they are not systematically based on empirical knowledge of the impact of COVID-19 or of the measures implemented. The next step in responding to our framework question would therefore be to revisit our research when enough time has elapsed to allow empirical research to have been conducted in this area. This second review could contrast the COVID-related recommendations reported here with the results of empirical studies and develop guidelines for future health emergencies of this kind. Finally, as was mentioned early in the report, given the nature of the publicati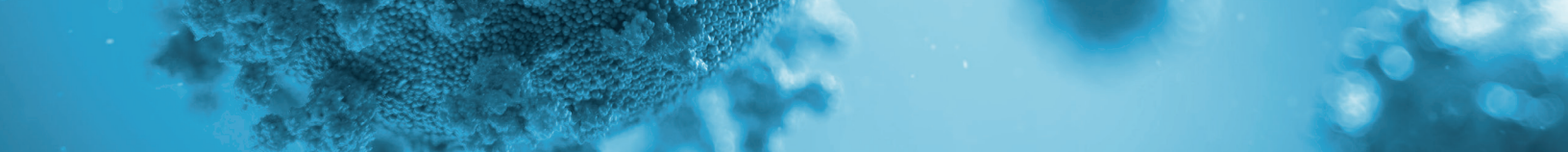ons, methodological quality was not evaluated in this review. Readers should therefore be cautious in their interpretation of the results and recommendations reported.
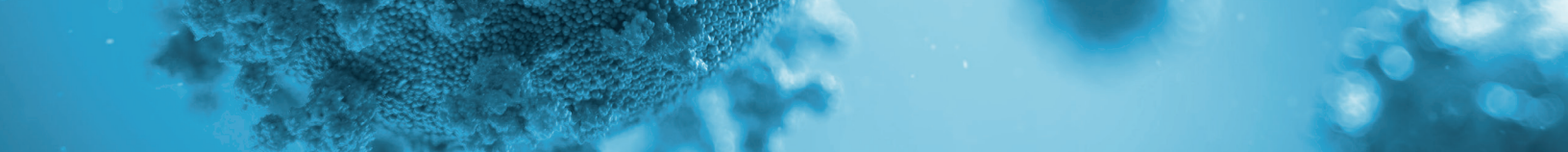
Conclusion

This rapid response guide was intended to identify best practices for persons who have serious mental health problems and are confined in secure units during the COVID-19 pandemic. Although the literature review and the conclusions thereafter are based primarily on opinion pieces rather than empirical studies, this guide will nevertheless help managers of psychiatric services in forensic psychiatry and correctional settings make decisions related to the management of the COVID-19 pandemic. It should also stimulate reflection on the best way to ensure the safe management of patients and detainees that minimizes undesirable effects on recovery from mental illness.

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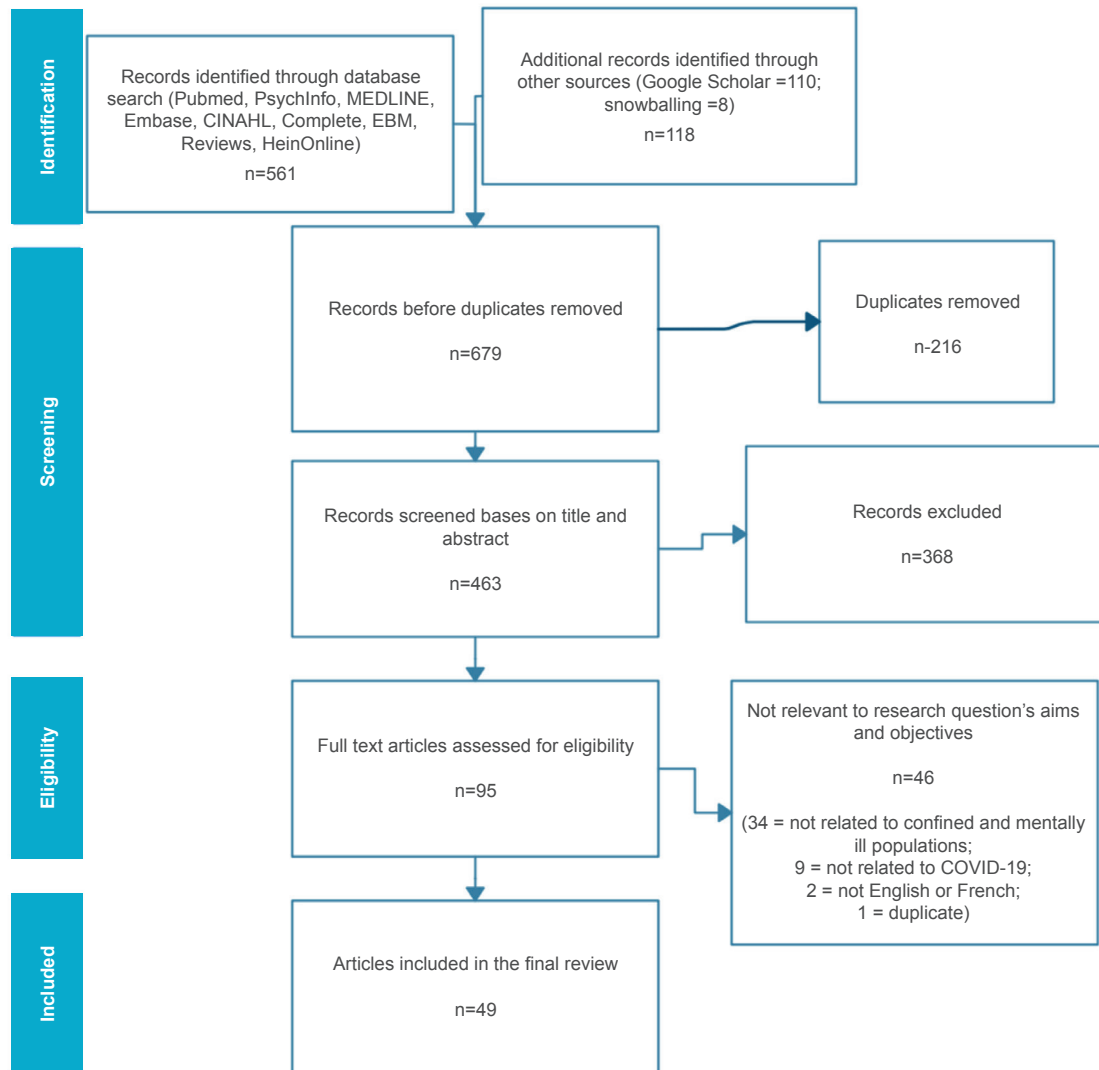
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Appendices

Appendix 1. Concept Table

COVID-19	Psychiatry (general, forensic)	Institutions (hospitals, detention centers)
Subject headings (MeSH terms) "COVID-19" [Supplementary Concept] "severe acute respiratory syndrome coronavirus 2" [Supplementary Concept] "Coronavirus Infections"[Mesh:NoExp] "Betacoronavirus"[Mesh:NoExp] **Textword search strings** Coronavirus coronaviruses coronovirus coronoviruses coronavirinae Wuhan Hubei Huanan "2019-nCoV" 2019nCoV NCoV2019 "nCoV-2019" "COVID-19" COVID19 "CORVID-19" CORVID19 WN-CoV" WNCoV "HCoV-19" HCoV19 CoV "2019 novel" Ncov "n-cov" "SARS-CoV-2" "SARSCoV-2" "SARSCoV2" "SARS-CoV2" SARSCov19 "SARS-Cov19" "SARSCov-19" "SARS-Cov-19" Ncovor Ncoronavirus Ncoronovirus NcovWuhan NcovHubei NcovChina NcovChinese	**Subject headings (MeSH terms)** "Mental Disorders"[Mesh] "Psychiatry"[Mesh] "Mental Health"[Mesh] "Mentally Ill Persons"[Mesh] "Commitment of Mentally Ill"[Mesh] **Textword search strings** Psychiatry Psychiatric Mental disorder(s) Mental illness(es) Mentally ill Mental disease(s) Personality disorder(s) Psychotic Psychosis Psychoses Schizophrenia Bipolar manic depression manic-depression positive symptom(s) negative symptom(s) Telepsychiatry tele-mental health mental health mental healthcare Forensic Secure(d) Security Not guilty by reason of sanity Not criminally responsible Diminished responsibility Competency to Stand Trial Insanity Defense expert testimony Criminal Responsibility Diminished Capacity Legal Competence Legal Witness Commitment of mentally ill ((Involuntary OR compulsory OR manda-tory) AND (commitment OR confinement OR hospitalisation OR treatment)) Review Board Hearing Treatment Order(s)	**Subject headings (MeSH terms)** "Hospitals, Psychiatric"[Mesh] "Psychiatric Department, Hospital"[-Mesh] "Delivery of Health Care"[Mesh] "Mental Health Services"[Mesh:NoExp] "Emergency Services, Psychiatric"[Mesh] "Inpatients"[Mesh] "Hospitalization"[Mesh] "Prisons"[Mesh:NoExp] "Prisoners"[Mesh:NoExp] "Criminals"[Mesh] **Textword search strings** HHospital(s) Hospitalization Hospitalisation Hospitalized Hospitalised Facility(ies) Unit(s) Ward(s) Department(s) Service(s) Setting(s) Inpatient(s) Correctional Offender(s) Criminal(s) Crime(s) criminality Prison(s) Prisoner(s) Custodial Imprisonment Incarceration incarcerated Inmate(s) Jail(s) Detention(s) Detained Penitentiary(ies)

Appendix 2. PRISMA[17] Flow Chart

Identification

Records identified through database search (Pubmed, PsychInfo, MEDLINE, Embase, CINAHL, Complete, EBM, Reviews, HeinOnline)
n=561

Additional records identified through other sources (Google Scholar =110; snowballing =8)
n=118

Screening

Records before duplicates removed
n=679

Duplicates removed
n-216

Records screened bases on title and abstract
n=463

Records excluded
n=368

Eligibility

Full text articles assessed for eligibility
n=95

Not relevant to research question's aims and objectives
n=46

(34 = not related to confined and mentally ill populations;
9 = not related to COVID-19;
2 = not English or French;
1 = duplicate)

Included

Articles included in the final review
n=49

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[17] Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., . . . Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic reviews, 4*(1), 1.

Appendix 3. Complementary Resources

Organisation	Country	Title	Link
Canadian Agency for Drugs and Technologies in Health	Canada	Infection Prevention and Control Measures in Mental Health Facilities: Guidelines	https://covid.cadth.ca/infection-control/infection-prevention-and-control-measures-in-mental-health-facilities-guidelines/
Institut national d'excellence en santé et services sociaux	Canada (Quebec)	COVID-19 et la phase de rétablissement à la pandémie pour les personnes avec des problèmes ou des troubles de santé mentale	https://www.inesss.qc.ca/covid-19/retablissement-et-reprise-des-activites/phase-de-retablissement-a-la-pandemie-pour-les-personnes-avec-des-problemes-ou-troubles-de-sante-mentale.html
Institut national de santé publique du Québec	Canada (Quebec)	COVID-19 Mesures de prévention et contrôle des infections pour les installations et les unités de soins psychiatriques	https://www.inspq.qc.ca/sites/default/files/covid/2991-soins-psychiatriques-covid19.pdf
American Psychiatric Association	United States	Practice Guidance for COVID-19	https://www.psychiatry.org/psychiatrists/covid-19-coronavirus/practice-guidance-for-covid-19
American Psychological Association	United States	Ethical guidance for the COVID-19 era	https://www.apa.org/ethics/covid-19-guidance
Center for the Study of Traumatic Stress	United States	Taking Care of Patients During the Coronavirus Outbreak: A Guide for Psychiatrists	https://www.cstsonline.org/assets/media/documents/CSTS_FS_Taking_Care_of_Patients_During_Coronavirus_Outbreak_A_Guide_for_Psychiatrists_03_03_2020.pdf
National Alliance on Mental Illness	United States	Covid-19. Resource and information guide	https://www.nami.org/Support-Education/NAMI-HelpLine/COVID-19-Information-and-Resources
National Council of Behavioral Health	United States	COVID-19 Guidance for Behavioral Health Residential Facilities	https://www.thenationalcouncil.org/covid-19-guidance-for-behavioral-health-residential-facilities/
Substance Abuse and Mental Health Services Administration	United States	Covid19 interim considerations for State Psychiatric Hospitals	https://www.samhsa.gov/coronavirus
The National Association of State Mental Health Program Directors	United States	Peer-Led Recommendations for Supporting Individuals Receiving Care in State Psychiatric Facilities During the COVID-19 Crisis	https://www.nasmhpd.org/sites/default/files/TIC_Recommendations_for_Hospitals_regarding_COVID-19.pdf
European Psychiatric Association	Europe	Management of psychiatric patients with suspected covid-19	https://www.europsy.net/app/uploads/2020/04/ALGORITHM-Hospitalisation-COVID_EPA.pdf

Organisation	Country	Title	Link
Association des établissements du service public de santé mentale	France	Organisation de la prise en charge sanitaire des patients détenus nécessitant des soins psychiatriques	http://www.adesm.fr/wp-content/uploads/2020/04/Covid-19-Fiche-étab-lissements-pénitentiaires.pdf
Association des jeunes psychiatres et des jeunes addictologues	France	Recommandation en psychia-trie légale - épidémie Covid-19	https://www.ajpja.fr/uploads/file/5e853089ec30b_EUhPsvP-WAAE6au1.jpeg
Association française de psychiatrie biologique et de europsychopharma-cologie	France	Prendre soin des patients pen-dant l'épidémie de coronavirus: un guide à destination des psychiatres, psychologues et soignants en santé mentale	https://www.afpbn.org/prendre-soin-des-patients-pen-dant-lepidemie-de-coronavirus-un-guide-a-destination-des-psychiatres-psycho-logues-et-soignants-en-sante-mentale/
Centre de ressources en réhabilitation psychosociale et remédiation cognitive	France	Critères de fragilité face au covid-19 chez les usagers en santé mentale	https://centre-ressource-rehabilitation.org/IMG/pdf/vulnerabilite_face_au_covid-19-1.pdf
Centre de ressources en réhabilitation psychosociale et remédiation cognitive	France	Recommandations pour la prévention des contamina-tions associées au COVID-19 et pour la prise en charge des personnes infectées souffrant d'un handicap psychique sévère ou d'un trouble du spectre de l'autisme	https://centre-ressource-rehabilitation.org/recommandations-pour-la-pre-vention-des-contaminations-asso-ciees-au-covid-19-et?var_mode=calcul
Ministère des solidarités et de la santé	France	Recommandations applicables en phase de déconfinement à l'organisation des prises en charge en psychiatrie et en addictologie	https://solidarites-sante.gouv.fr/IMG/pdf/covid-19_consignes_services_psychiat-rie.pdf
Mental Health Commission of Ireland	Ireland	Mental Health Commission welcomes safeguards for involuntary patients during Covid-19 crisis	https://www.mhcirl.ie/File/PR_300320.pdf
Inter-Agency Standing Committee	Worldwide	Addessing mental Health and Psychological Aspects of COVID-19 Outbreak	https://interagencystandingcommittee.org/system/files/2020-03/IASC%20Interim%20Briefing%20Note%20on%20COVID-19%20Outbreak%20Readi-ness%20and%20Response%20Oper-ations%20-%20MHPSS_0.pdf

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United Nations	Worldwide	Advice of the Subcommittee on Prevention of Torture to States Parties and National Preventive Mechanisms relating to the Coronavirus Pandemic (adopted on 25th March 2020)	https://www.ohchr.org/Documents/HRBodies/OPCAT/AdviceStateParties CoronavirusPandemic2020.pdf
Mental Welfare Commission for Scotland	United Kingdom	Covid-19 faqs for practitioners (version 8, 7 May 2020)	https://www.mwcscot.org.uk/sites/default/files/2020-05/Covid-19%20advice%20note%20v8%207%20May%202020_0.pdf
National Association of Psychiatric Intensive Care Units	United Kingdom	Managing acute disturbance in the context of COVID-19	https://napicu.org.uk/wp-content/uploads/2020/03/COVID-19_guidance_appendix.pdf
National Health Service England	United Kingdom	Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0454-mhlda-spec-comm-legal-guidance-v2-19-may.pdf
National Health Service England	United Kingdom	Supporting patients of all ages who are unwell with coronavirus (COVID-19) in mental health, learning disability, autism, dementia and specialist inpatient facilities	https://www.england.nhs.uk/coronavirus/publication/letter-responding-to-covid-19-mental-health-learning-disabilities-and-autism/
National Health Service England	United Kingdom	Workforce guidance for mental health, learning disabilities and autism, and specialized commissioning services during the coronavirus pandemic	https://www.england.nhs.uk/coronavirus/publication/letter-responding-to-covid-19-mental-health-learning-disabilities-and-autism/
Parliament of the United Kingdom	United Kingdom	Coronavirus act	http://www.legislation.gov.uk/ukpga/2020/7/pdfs/ukpga_20200007_en.pdf
Royal College of Psychiatrists	United Kingdom	COVID-19: Ethical considerations	https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/covid-19-ethical-considerations
Royal College of Psychiatrists	United Kingdom	Covid-19: personal protective equipment (ppe)	https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/personal-protective-equipment-ppe

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Royal College of Psychiatrists	United Kingdom	COVID-19: Secure hospital and criminal justice settings	https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/secure-hospital-and-criminal-justice-settings
Royal College of Psychiatrists	United Kingdom	Legal matters - COVID-19 guidance for clinicians	https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/legal-covid-19-guidance-for-clinicians
Royal College of Psychiatrists	United Kingdom	COVID-19: Guidance for community and inpatient services	https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services
Royal College of Psychiatrists	United Kingdom	Prison transfers and remissions to and from mental health inpatient hospitals in relation to COVID-19	https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/secure-hospital-and-criminal-justice-settings
Scottish Gouvernment	United Kingdom	Restricted patients and covid-19	https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Restricted-Patients-and-Covid-19-guidance-legislative-25-March-2020.pdf?x82981
Social Care Institute for Excellence	United Kingdom	Mental Capacity Act (MCA) and the COVID-19 crisis	https://www.scie.org.uk/care-providers/coronavirus-covid-19/mca