Major Research Paper:

Applying a Health Justice Framework to Examine Visitation Policies in Canadian Federal Penitentiaries and Psychiatric Facilities During the COVID-19 Pandemic

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November 2021

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Abstract

The COVID-19 pandemic has illuminated inequities in policy development and implementation of emergency intervention strategies. This study addresses the equitable access to visitation in COVID-19 emergency intervention strategies between comparable total institutional settings. This multiple-case design encompassed two selected custodial environments and was compared using the implemented emergency policies surrounding visitation. In comparing the institutionalized settings of psychiatric hospitals and federal penitentiaries in Ontario, it draws appraisals for equity and health justice-based analysis. These emergency intervention policies focused on visitation vary based on institutional influence, interests, and ideas that are consequently highlighted within this study. The findings of this study reflect a lack of consistency in emergency response surrounding visitation policies across psychiatric facilities and federal penitentiaries located within Ontario and uncover discrepancies in policies within the various Ontario psychiatric facilities. These findings lead to an analysis rooted in the framework of human rights and social justice that propel a unique discussion surrounding health justice in the context of Canadian institutionalized settings. The study concluded by considering health justice as a framework in practical and theoretical policy development and implementation to promote health equity and the approach to social justice from a health and equity perspective.

Introduction

The Coronavirus pandemic (COVID-19) has resulted in variations in emergency interventions and policy responses in Canada. These emergency interventions and policy responses have been generated as a means to combat the spread of the virus across social, political, and economic institutions. Emergency intervention strategies have encompassed case management practices, closures of businesses and services, physical distancing measures, state of emergency orders and the development of public health information guidelines (Canadian Institute for Health Information [CIHI], 2021). Emergency intervention policies and practices were implemented with the goals of controlling community spread, improving public health and safety, and improving health outcomes associated with COVID-19 by Canadian jurisdiction (CIHI, 2021). These specific interventions vary depending on the jurisdictional level of governance of the specific intervention.

For the purpose of this study, the institutionalized settings of Canadian federal penitentiaries and psychiatric facilities and visitor policies will be discussed and examined. In Canada, there are federal penitentiaries and provincial penitentiaries. The federal penitentiaries in Canada are governed by Correctional Service Canada (CSC), which is an entity responsible for federally incarcerated individuals. The term “penitentiary” will be used in this study to refer to federal prisons managed by the CSC. Federal penitentiaries are designated for offenders who are serving a sentence of two years or more, whereas provincial penitentiaries, not discussed in the context of this study, are for offenders sentenced to two years less a day or a lesser sentence (Correctional Service Canada, 2019). In contrast, psychiatric facilities in Canada are a public health responsibility of provinces and territories, as these facilities are intended for providing

healthcare services to individuals within provincial/territorial jurisdictions (Detsky & Bogoch, 2020; Hardcastle, 2019).

This study is focused on federally incarcerated individuals and people in select Ontario psychiatric facilities as institutionalized individuals. The conception of institutionalized individuals refers to people residing in a facility that provides all necessary means of life within the physical boundaries of the facility and from which the individual is unable to freely remove themselves. These facilities are referred to frequently in this paper as total institutions as they both hold strong characteristics of total control over the daily life of individuals within the bounds of the facilities (Goffman, 1968). Furthermore, for the context of this paper, a custodial setting refers to a total institution that by order of the state becomes the governing body of an individual's autonomy.

The policies associated with the institutions of corrections and healthcare, range in emergency intervention strategies across federal and provincial jurisdictions to focus on case management, distancing, public health information, and closures (CIHI, 2021). Visitation policies, an aspect of many policy interventions, have evolved in response to COVID-19 and public health concerns in Canada. Visitation, for the purpose of this study, will be operationalized as the physical act of an external support person, with any type of social connection to the institutionalized individual, attending in-person sessions to see, speak with, or spend an interval of time with the individual who is unable to leave the physical confines of the facility (Bales & Mears, 2008). Visitation is of significant importance to the mental health and well-being of institutionalized individuals (Turanovic & Tasca, 2019). Therefore, the emergency intervention policies considering visitation at selected facilities have an impact on the well-being of individuals. Using a health justice lens, this study will examine the policy responses to

visitation across select correctional and psychiatric institutions within the context of the COVID-19 pandemic in Ontario to analyze the equity implications of different approaches to emergency interventions.

Visitation and Institutionalized Individuals

Visitation within institutionalized facilities is a significant factor contributing to the well-being of institutionalized individuals (Turanovic & Tasca, 2019). The prospect of visitation offers institutionalized individuals the opportunity to maintain social ties with their loved ones outside of the institution, which leads to more positive situational outcomes for these individuals (Turanovic & Tasca, 2019). For example, social ties aid incarcerated individuals specifically in coping with the struggles associated with imprisonment, as well as finding housing, employment, and other supportive mechanisms upon their release (Turanovic & Tasca, 2019). Furthermore, visitation keeps people engaged with external support networks (Turanovic & Tasca, 2019). Incarcerated individuals tend to be less disgruntled with their physical environment when they are actively involved with visits from loved ones (Turanovic & Tasca, 2019). Visitation offers a distraction from the struggles of imprisonment and consequently serves as a form of institutional management (Turanovic & Tasca, 2019). Visitation is used as an incentive, based on acceptable and institutionally expected behaviour, to maintain social bonds beyond the confines of the penitentiary for institutionalized individuals (Turanovic & Tasca, 2019). Fostering and maintaining strong connections with loved ones through visitation aids in delaying and reducing recidivism rates (Bales & Mears, 2008; Beckmeyer & Arditti, 2014). Moreover, when institutionalized individuals have access to visitation, they are statistically less likely to experience significant grievances associated with the institutionalized setting (Turanovic & Tasca, 2019). These grievances of institutionalization stem from discontent with the physical and

emotional settings of these facilities; however, the maintenance of social bonds via visitation allows for alleviation of these afflictions (Bales & Mears, 2008; Beckmeyer & Arditti, 2014; Turanovic & Tasca, 2019).

Social supports have a vital impact on incarcerated individuals and their mental health outcomes (De Claire & Dixon, 2016; De Motte, Bailey & Ward, 2012). It is important for policymakers, whether through the development of emergency policies or otherwise, to recognize the impacts that visitation policies have on institutionalized individuals. Institutionalized individuals can face increased levels of loneliness and isolation (Turanovic & Tasca, 2019). The removal of social supports perpetuates these experiences of social exclusion and eliminates the connection to the social supports for incarcerated individuals, which may, itself, be considered a form of punishment (Travis, 2002).

According to the Ministry of the Solicitor General of Ontario (2020), visits from family, friends, and loved ones improve morale and contribute to the rehabilitation and successful community reintegration of incarcerated individuals. However, during the first, second, and third waves of the COVID-19 pandemic in Canada, the CSC, the governmental body responsible for all federally run penitentiaries, removed visitation for incarcerated individuals and restricted visitation for individuals in psychiatric facilities (Correctional Service of Canada, 2019).

Visitation Policies: Penitentiaries and Psychiatric Facilities

In this study, two cases of total institutions are examined: penitentiaries and psychiatric facilities. The CSC functions under the authority of the *Corrections and Conditional Release Act* (Correctional Service Canada, 2019). The *Corrections and Conditional Release Act* provides a legislative framework that shapes policy development by the CSC (Correctional Service Canada, 2019). In addition, the CSC is bound by acts and regulations that serve as principles for the

governance, control, and management of incarcerated individuals (Correctional Service Canada, 2019).

Psychiatric facilities, on the other hand, are categorized into two distinct types within Ontario. The first category includes designated psychiatric facilities under the *Mental Health Act (MHA).* This refers to the care and treatment of individuals experiencing a mental illness (Ontario Ministry of Health, 2013). Admission and treatment under the *MHA* of Canada can be voluntary or involuntary while a person is experiencing a mental health crisis. The *MHA* is legislation that outlines the rights of individuals regarding their own mental health within the context of hospitalization, treatment, detention, and other legal considerations. The second category of psychiatric facility is designated under Part XX.1/Mental Disorder of the *Criminal Code* and refers to facilities that admit and treat patients with mental disorders under the Criminal Code (Ontario Ministry of Health, 2013). Part XX.1 of the Criminal Code addresses mental disorders and covers topics such as the interpretation of terms, assessment orders and reports of individuals with mental illness, protected statements, fitness to stand trial, verdicts of not criminally responsible on the account of a mental disorder (NCRMD), review boards and disposition hearings (*Criminal Code*, 1985). The process of entering the criminal legal system, from facing a criminal charge through to a potentially imposed sentence, is complex and must follow considerations under Part XX.1 of the *Criminal Code*. Understanding this complex process is vital to accurately expressing the rights of individuals, regardless of their extant charges (Mental Health & the Law Service, 2017). It is within this process that an individual can be sentenced to a penitentiary or a psychiatric facility depending on the procedural outcomes (see Table A1. *Ontario Psychiatric Hospitals Under Part XX.1/Mental Disorder of the Criminal Code* in Appendix A). The distinction between types of facilities allows for differentiation in

protocol, policies, and regulations within the facilities that meet the differing needs of the populations in each type of institution. Both categorizations of facilities are the responsibility of the Minister of Health in Ontario; however, these two categories require different considerations, and for the purpose of this study, facilities that admit and treat individuals under the Criminal Code will be the focus of analysis. Forensic mental health is a balance between individual rights and the needs of and duty to the public (Bettridge & Barbaree, 2008). This balance is addressed when considering the *MHA* with section XX.1 of the Criminal Code to weigh individual rights compared to the public good as such to protect themselves and public safety (Bettridge & Barbaree, 2008).

Coronavirus Disease 19: A Pandemic and Institutional Response

Countries around the world have been dealing with containing the COVID-19 pandemic. COVID-19 is a highly communicable disease, particularly in congregate living and institutional settings, where the risk and rate of transmission is increased due to the built structural and physical environments of these facilities (Franco-Paredes et al., 2020). While the physical conditions of congregate living and custodial settings vary depending on the facility, there are significant concerns common to all congregate settings related to overcrowding, insufficient sanitation, poor ventilation, and inadequate access to and distribution of healthcare services (Franco-Paredes et al., 2020). The COVID-19 pandemic revealed deficiencies in policies and procedures associated with congregate living settings. These settings became the most vulnerable sectors of the community, with significant proportions of COVID-19 related deaths originating in congregate settings (Detsky & Bogoch, 2020).

Public health in Canada is managed by federal, provincial/territorial, and municipal governments, and there are variations in COVID-19 responses based on jurisdictional differences

(Detsky & Bogoch, 2020). While the pandemic has allowed for significant collaboration between federal and provincial governments, most public health responsibilities for containment and mitigation of the virus have been left to the provincial governments, with the federal government concerned with large-scale policies such as vaccine procurement (Detsky & Bogoch, 2020). According to CIHI (2021). Between March 2020 and September 2021, Canada and its provinces experienced three waves of the COVID-19 pandemic. The first wave pattern for Ontario represents a rise and fall of positive COVID-19 cases from mid-March 2020 to mid-May 2020. The second Ontario wave occurred from approximately October 2020 through to February 2021, and finally, the third wave from mid-March 2021 through to May 2021 (CIHI, 2021; Ontario Agency for Health Protection and Promotion, 2021). This study examines visitation policies during the time period from March 1, 2020, to June 1, 2021, encompassing the first three waves.

Significance of the Study

This study examines the equity issues that arise as a result of changes to visitation policies of Canadian federal penitentiaries during the first, second, and third waves of the COVID-19 pandemic in Ontario. Equity issues were explored by comparing the visitation policy response within federal penitentiaries in Ontario to the visitation policy responses within selected Ontario psychiatric facilities. The two cases were chosen due to the similarities in mental health services needed of the people institutionalized and the comparable congregate and custodial settings of these facilities in Canada.

The research was conducted using a case study method with a multiple-case design, where institutionally similar custodial settings were compared using the implemented emergency policies surrounding visitation, which is a vital aspect of total institution life. Visitation is a well-established social support for institutionalized individuals as it connects people to their support

networks beyond the total institution setting (Turanovic & Tasca, 2019). This study addressed the equity-centered consequences of eliminating visitors from Canadian federal penitentiaries and select psychiatric facilities during the COVID-19 pandemic for institutionalized individuals.

Context and Literature Review

Canadian Correctional Systemic During the COVID-19 Pandemic

Mass incarceration refers to incarcerated groups of individuals on a large scale. Mass incarceration is facilitated by policies that target groups of the population and exclude them from society based on social constructions of the law and acts deemed criminal (Ingram, Schneider & DeLeon, 2019; Tubex, 2014; Rafter, 1990). The correctional system fosters inequities stemming from these policies, disproportionately targeting marginalized groups within the population that perpetuate the mass incarceration crisis (Tubex, 2014). The aims of incarceration have been historically centered around deterrence, incapacitation, retribution and rehabilitation (Banks, 2009). However, in recent years with a cultural shift towards individualism and materialism as the objective of social, political, and economic life, there too has been a shift in the definition of rights and how incarceration encompasses those rights (Banks, 2009; Kneen, 2009). The shift towards incapacitation as the fundamental aim and justification of incarceration is evident in the criminal legal policies and practices that restrict the actions of select groups of people (Zimring & Hawkins, 1997). For example, policies that target the cultural or societal practices of a marginalized group of people can be the subject of criminal legal policies and laws to target these individuals. Consequently, incapacitation is enforced as a penal policy via incarceration (Wermink et al., 2013). Policies that promote mass incarceration are built on incapacitation to foster a system of societal labelling and marginalization (Auerhahn, 2003). Systematic labeling

fuels incapacitation by generating mass discrimination of groups of people in society isolating them further from the greater population.

Incapacitation can be carried out via collective or selective incapacitation (Auerhahn, 2003). Collective incapacitation is where sentences increase in severity and affects all offenders, while selective incapacitation prospectively identifies an individual dangerous offender and strives to detain them for longer lengths of time (Auerhahn, 2003). Increasingly, penitentiaries focus on collective incapacitation while psychiatric facilities target selective incapacitation. The differences in incapacitation methods stem from systemic human-made differences in the admissions process and procedural objectives of these two facility types. Consideration must be given to both collective and selective incapacitation practices that can be seen in present-day criminal legal policies. However, collective incapacitation fosters the culture of mass incarceration as the policies target entire groups of the population. Mass incarceration threatens social, political, and economic structures on federal, provincial, and municipal levels; however, there are detrimental impacts of mass incarceration on an individual basis as well. These detrimental impacts associated with mass incarceration have become most evident with the emergence and spread of COVID-19 in the year 2020 (Franco-Paredes et al., 2020).

The correctional system was, and continues to remain, ill-prepared for both proactive and reactive solutions resulting from the consequences of the COVID-19 pandemic. Facilities in the Canadian correctional system are custodial settings that are at a heightened risk for serving as epicenters for infectious disease due to the presence of high-risk individuals, poor ventilation, and unsanitary conditions (Franco-Paredes et al., 2020; Kinner et al., 2020). Furthermore, the overcrowding of penitentiaries due to mass incarceration policies perpetuate this detrimental cycle of recurrent mass incarceration (Haney, 2012). Highly communicable diseases, like

COVID-19, are easily transmissible in these custodial settings as the design of the facilities leads to limited infection control (Kinner et al., 2020). The confined conditions of prison allow for the virus to spread rapidly within the walls of penitentiaries generating pandemic conditions for increased risk of disease transmission (Franco-Paredes et al., 2020). Furthermore, the lack of personal protective equipment (PPE) for incarcerated individuals and poor sanitation practices puts the people living in penitentiaries in a position of increased vulnerability (Kinner et al., 2020). The lack of sanitation equipment and practices threatens the autonomy of incarcerated individuals to make informed and equitable decisions about their health and well-being.

The consequences of incarceration on an individual's physical and mental health and well-being have been established in the literature (Haney, 2012). Incarcerated individuals experience environmental stress associated with the prison environment which has been cited to result in psychological distress (Haney, 2012). Furthermore, the strict environment can exacerbate underlying mental health conditions due to the stress endured by incarcerated individuals (Haney, 2012).

Incarcerated individuals face inadequate access to healthcare services which, when coupled with the restrictive physical environment of the carceral facilities, leads to poor health outcomes (Franco-Paredes et al., 2020). According to Bernier and MacLellan (2011), correctional facilities in Canada produce adverse physical and psychosocial health outcomes for incarcerated individuals. Poor physical conditions of carceral facilities can exacerbate the mental health issues for incarcerated individuals and further marginalize them in society pre-and-post release (Bernier & MacLellan, 2011). The negative health consequences associated with the physical burden of incarceration coupled with the mental health and well-being implications of isolation, stigmatization, and mental stress are a threat to incarcerated individuals (Yi, Turney &

Wildeman, 2017). This notion of isolation and stress has been linked to the presence, or lack, of social supports for incarcerated individuals. Social supports and social relationships have protective influences for incarcerated individuals and contribute to more positive outcomes for individuals (De Claire & Dixon, 2016; De Motte, Bailey & Ward, 2012).

Psychiatric Facilities

Psychiatric facilities, as designated by the Criminal Code, operate differently than acute care or other healthcare facilities as the patients are deemed to have different needs (Rovers et al., 2020). Patients in psychiatric facilities are in an additionally vulnerable position in comparison to patients in non-psychiatric hospital departments due to several compounding factors related to organizational and facility characteristics that serve as additional layers of vulnerability (Rovers et al., 2020). Psychiatric facilities are susceptible to the spread and outbreak of COVID-19 due to the nature of the patient population themselves, the practice of healthcare workers, infection control policies, and facility infrastructure. Patients with severe mental illness face increased susceptibility to pulmonary infections and other infectious diseases; furthermore, it is difficult to address physical illness in a setting where mental health is the primary focus (Rovers et al., 2020). This difficulty is due to increased communication barriers associated with a patient's mental illness, symptom confusion associated with a patient's mental illness, or negative effects associated with medications the patient is taking (Rovers et al., 2020). In the circumstance of psychiatric facilities, immunization remains the strongest defense against infectious diseases for a population that face significant individual and collective barriers to infection control (Fukuta & Muder, 2013). The second concern is with the healthcare workers as social distancing measures, PPE procedures, and infectious disease prevention policies cannot always be strictly followed due to emergency circumstances (Fukuta & Muder, 2013; Rovers et

al., 2020). Staff additionally should be immunized to mitigate the spread of infection within these facilities (Fukuta & Muder, 2013). Finally, there is a lack of familiarity with infection protocol due to the potential lack of acute care given in select facilities (Rovers et al., 2020).

Rapidly developing policies are difficult to follow and implement due to the lack of policy continuity which increases the susceptibility of a COVID-19 outbreak in these facilities (Rovers et al., 2020). As previously mentioned, psychiatric facilities are not commonly acquainted with infectious disease protocol; therefore, there are additional barriers to the implementation of emergency policies due to the lack of routine capacity and experience in infectious disease protocol and management (Rovers et al., 2020). Facilities with affiliations to acute care hospitals or external healthcare partners may additionally benefit from the expertise of infection prevention professionals; however, not all facilities have access to these resources due to the independent nature of some psychiatric facilities (Fukuta & Muder, 2013). Finally, infrastructure is another consideration, as many psychiatric facilities are not built with infection containment and mitigation in mind (Rovers et al., 2020). The congregate living settings of psychiatric facilities, combined with poor ventilation systems, allow for the rapid spread of COVID-19 (Franco-Paredes et al., 2020; Rovers et al., 2020). When considering the potential for COVID-19 spread, policy surrounding visitation has developed as a means to control the spread of the virus within institutionalized settings.

The Visitation Debate

There is significant evidence to support the notion that visitation is positive social support for institutionalized individuals; it often promotes positive institutional behaviours and fosters social ties; however, there are other outcomes of visitation to consider (Turanovic & Tasca, 2019). Visitation outcomes are shaped by a variety of situational factors like the relationship of

the visitor to the institutionalized individual, the frequency of visits, environmental and sociodemographic factors (Turanovic & Tasca, 2019). Visitation can also be the source of significant distress and turmoil for incarcerated individuals (Turanovic & Tasca, 2019). The physical environment is not only taxing on the individuals living within the institution but the people visiting as well (Turanovic & Tasca, 2019). The punitive atmosphere of penitentiaries and restrictive rules add a complex layer to visitation as it can be a source of distress for individuals outside of the institutional walls to experience (Turanovic & Tasca, 2019). Furthermore, the realistic relationships individuals have with their loved ones can be strained, and grievances are frequently the topic of discussion instead of supportive communications that are required for positive institutional outcomes (Turanovic & Tasca, 2019). However, while there are circumstances of negative visitation experiences, there is an established pattern associated with these visits. For example, with each negative visit, visitation sessions become less and less frequent allowing for distance and decreased physical tension (Turanovic & Tasca, 2019). In addition, research has highlighted that negative visitation outcomes are also associated with a lack of adjustment from the physical environment of incarceration that is projected onto the visitation experience (Turanovic & Tasca, 2019).

Administrative Jurisdiction and Equity Considerations

In accordance with this research, administrative jurisdiction must be considered and addressed. The penitentiaries that will be the focus of the research are under the responsibility of the federal government of Canada as they are federally managed (Correctional Service Canada, 2019). The Commissioner of the Correctional Service reports to the Minister of Public Safety in Canada (Correctional Service Canada, 2019). It is important to note that the Ministry of the Solicitor General of Ontario does not further specify protection measures in the corrections

policies and guidelines surrounding visitation regardless of active emergency orders (Ministry of the Solicitor General of Ontario, 2020). Therefore, incarcerated individuals are at the mercy of the CSC's policies, working collaboratively with the federal Ministry of Public Safety and Emergency Preparedness. However, the psychiatric facilities in Canada are monitored and managed provincially by their respective Ministries of Health. There are no regulations regarding the continuity of care for these provincially governed institutions (Ministry of Health and Long-Term Care, 2016). This discrepancy results in variations of patient diagnosis and health outcomes due to the discrepancies in services available and provided to patients in each community (Ministry of Health and Long-Term Care, 2016). During the first, second, and third waves of the COVID-19 pandemic, psychiatric facilities and penitentiaries worked with the provincial emergency framework to follow the emergency intervention protocols. The lack of overarching regulations may be a contributing factor leading to discrepancies in policy development and implementation that can be seen between these two types of facilities during the first three waves of the pandemic in Ontario.

The equity concerns that arise surrounding visitation for incarcerated individuals are similar to the equity concerns for people living in psychiatric facilities. Both populations live in institutional settings that remain as total institutions. Total institutions break down the barriers surrounding daily life and combine them into a single setting (Goffman, 1968). Total institutions schedule and structure the activities of individuals in the institution with limited personal autonomy (Goffman, 1968). Research has shown that incarcerated individuals have the same level of mental distress as psychiatric patients, but higher levels of mental distress than forensic mental health patients (Otte et al., 2017). This statistic is indicative of the turmoil that

incarcerated individuals face at a disproportionate rate in comparison to their counterparts in psychiatric facilities.

The contemporary literature on this topic highlights the relative importance of visitation for people in institutionalized settings and the positive impacts that visitation can have on these individuals' mental health and well-being (De Claire & Dixon, 2016; De Motte, Bailey & Ward, 2012). Visitation, mobilized as a reward for proper institutional behaviour, can foster circumstances that lead to more positive institutional outcomes such as reduced recidivism and community reintegration (Turanovic & Tasca, 2019). With consideration of the current literature, this study examines the emergency COVID-19 policy responses to visitation across selected total institutions in Ontario. The analysis of these policies through a health justice lens explores the impact of different approaches to emergency interventions in the established institutions with a focus on equity across select Canadian total institutions.

Theoretical Framework

The Human Rights Framework

The human rights framework offers an entitlement approach to basic rights and freedoms that every person is deemed to possess based on their humanness for the entirety of their lives (Freeman, 2017). Rights, however, are not inherently present. Rather, rights must be advocated, and are necessary, for the realization of access to human necessities (Kneen, 2009). The concept of human rights is dynamic in nature and has, and continues to be, developed over time and across various societies to produce continually evolving standards and understandings of entitlement (Freeman, 2017). The language of human rights is Western in its origins, aiming to transform human necessity into a legal claim, ultimately requiring a fragmented advocacy for the

realization of individual rights when not otherwise positively granted by the state (Kneen, 2009). The realization of rights requires both formal recognition of rights by the state and the formal provision of access to the substance of those rights, though the act of merely granting a right does not guarantee the that the duty bearer will undertake any positive action for the provision of any specific level of quality or quantity of that right for the rights holders (Kneen, 2009).

There are equally theoretical and practical applications of human rights, especially when considering the health of institutionalized individuals (Cohen & Ezer, 2013). The theoretical application of human rights considers human rights on the basis of domestic legislation, international law, and scholarly frameworks, while practical applications represent the practice and implementation of these frameworks. States and state agencies are to act as guarantors of human rights for citizens (Kneen, 2009). The CSC, as a federal state agency and guarantor, is, therefore, responsible for upholding the rights of individuals incarcerated within the CSC's facilities.

The human rights framework considers rights under the generalized language of rights. The human rights framework within Canada functions within the bounds of Canadian legislation, such as the *Canadian Charter of Rights and Freedoms* [*Charter*] (1982) and the *Canadian Human Rights Act* (Ontario Human Rights Commission [OHRC], 2020), and is also informed by international declarations onto which Canada has signed as a member. The rights of Canadians are enumerated in its *Charter* (see Figure A3. *Canadian Charter of Rights and Freedoms* in Appendix A). These rights apply to all Canadians, protecting Canadians from the potential violations and harms in the context of government action. The *Charter* does not apply to private interactions between citizens or corporations. *Charter* rights comprise fundamental freedoms and democratic, mobility, legal, equality, official language and minority language educational rights

(*Charter*, 1982). These rights and freedoms become restricted and have historically faced lesser protection for people who become institutionalized in institutions, such as Canadian penitentiaries (Parkes, 2007). Incarceration limits individuals' *Charter* rights to liberty, freedom of association, expression, and assembly (Correctional Investigator of Canada [CIC], 2013). However, this restriction of rights is not intended to be total deprivation or complete surrender of individuals' rights. Incarcerated persons are entitled to the rights that affirm their treatment with dignity and respect (CIC, 2013). Incarcerated individuals retain their rights to the safety and security of the person, the right to be treated humanely and be free from torture, degrading or inhuman punishment (CIC, 2013). These actors include federal penitentiaries and psychiatric facilities in accordance with this study. This scope of selected total institutions in this study allows for the inclusion of a broader range of institutionalized individuals under Canadian law.

Historically, the standard of rights outlined within Canadian legislation were not present or upheld up well into the 19th century for people in penitentiaries (Parkes, 2007). In society, incarceration was referred to as "civil death" as people lost all civil and property rights (Parkes, 2007). Ahead of the *Charter of Rights and Freedoms*, incarcerated people were granted limited individual rights and were recognized as having residual liberty (Parkes, 2007). Residual liberty refers to an incarcerated individual's remaining freedoms and liberties whilst experiencing the deprivation of liberty associated with the penitentiary setting (*R. v. Miller*, 1985).

The Universal Declaration of Human Rights is a foundational document in the rights of people across the globe. Article 25(1) of the Universal Declaration of Human Rights outlines that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family" (The United Nations, 1948, art. 25). This article includes right to a standard of living related to fundamental aspects such as food, housing, medical care, necessary social

services, etc. (The United Nations, 1948, art. 25). Article 25 then incorporates the right to health in the standard of living as a standard of living promotes and protects health (Meier, 2010).

Utilizing the human rights framework addresses the responsibility of the state and the criminal legal system in upholding and protecting the rights of incarcerated individuals. The CSC manages federally incarcerated individuals, therefore, it is the duty of this state actor, as the guarantor, to provide healthcare and necessary health needs (Mariner & Schleifer, 2013). As guarantor, the state is held responsible for ensuring, upholding, and verifying that the rights of citizens are addressed, including the right to health (Mariner & Schleifer, 2013). This study considers mental health to be an important component and determinant of health and well-being. Significantly, literature has supported this conceptualization of positive mental health outcomes as associated with the maintenance of social bonds through visitation for institutionalized individuals (Bales & Mears, 2008; Beckmever & Arditti, 2014; Turanovic & Tasca, 2019).

The human rights framework allows for the examination of systemic issues while considering state responsibility for those issues (Cohen & Ezer, 2013). As the CSC is responsible for the health services of incarcerated individuals, it is vital for the CSC to address these individuals as patients and consumers of healthcare services. Incarceration has negative impacts on the mental and physical health and well-being of individuals experiencing institutionalization, including, but not limited to imprisonment, which can lead to a breach in the rights of institutionalized individuals (Brinkley-Rubinstein, 2013; Mariner & Schleifer, 2013). In accordance with the right to health for this subset of the population, there is an opportunity to go further than patient rights to address patient care rights (Cohen & Ezer, 2013). Patient rights address the surface level of the right to health and the right to access services, whereas patient care rights mobilizes concepts of justice for individuals (Cohen & Ezer, 2013). Human rights in

patient care mobilizes justice via advocacy for the patient's rights to a standard of living, encompassing standard of health, that is not reflected in patient rights (Cohen & Ezer, 2013). A human rights framework exceeds the quality of care a patient receives, and is centered around human dignity, which considers patient safety, bioethical standards, and equity objectives (Cohen & Ezer, 2013). The concept of dignity then allows for further considerations to incorporate social justice into the human rights approach (Yamin, 2015).

The Right to Health

While every Canadian has the right to health, which encompasses their mental health, regardless of their social position or criminal record, the meaning of the term "rights" has evolved over the last several hundred years within social institutions (Kneen, 2009; Mariner & Schleifer, 2013). The concept of rights has been camouflaged by a culture of individualism that has fostered the demise of the ultimate universality of human rights (Kneen, 2009). While incarcerated individuals are guaranteed the right to life, the right to be free from cruel, inhumane or degrading punishment, and to right to be treated with humanity and respect, there are rights that can be restricted through imprisonment (Mariner & Schleifer, 2013). The right to health and well-being is vital to Canadians, and according to international human rights laws, incarcerated individuals are entitled to their fundamental rights and freedoms (Mariner & Schleifer, 2013). There are several federal and provincial powers that aid in the advocacy of this right to health (Hardcastle, 2019). According to the Supreme Court of Canada case, *Schneider v. The Queen* [*Schneider*],

> Health concerns are directly raised by the jurisdiction attributed to Parliament by s. 91(11) of the *Constitution Act* and may also be raised by s. 91(7) and perhaps sub. (2) as well. In sum "health" is not a matter which is subject to specific constitutional assignment but

> instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question. (*Schneider v. The Queen*, 1982, p. 143).

Schneider emphasizes the fluid nature of the topic of health within the social and political Canadian context. When considering the rights of incarcerated individuals, there are so-called "positive" and "negative" rights (Mariner & Schleifer, 2013). Individuals who are incarcerated face the deprivation of their liberty due to physical imprisonment and have lost their ability to make certain decisions about their health, such as selecting their own health care or the impact that their physical environment has on their health (Mariner & Schleifer, 2013). However, institutionalized and incarcerated individuals remain entitled to their highest attainable mental and physical health (Mariner & Schleifer, 2013).

The conditions surrounding incarceration threaten to violate individuals' rights. It is the duty of the CSC, as the guarantor, to provide healthcare and necessary health needs for federally incarcerated individuals (Mariner & Schleifer, 2013). A failure to provide these necessities arguably constitutes a standard of torture, or cruel, inhumane, and degrading treatment in accordance with international law (Yamin, 2016). It has been established in the literature that healthy living conditions are encompassed within one's right to health and, therefore, falls under the jurisdiction of the CSC (Mariner & Schleifer, 2013). Healthy living conditions is broad in definition and incorporates physical capacity levels of facilities, sanitation practices and ventilation standards (Franco-Paredes et al., 2020; Mariner & Schleifer, 2013). Research explicitly states that incarceration hampers a person’s mental health status (Hardcastle, 2019). The CSC, a state actor, as the guarantor, has historically been unable to provide the adequate level of physical conditions, which threatens the rights of individuals incarcerated within

Canadian penitentiaries. This right to health extends to mental health as well. A failure to provide adequate mental health services has been established as cruel, inhumane, or degrading punishment and is a violation of the rights of incarcerated individuals (Mariner & Schleifer, 2013). Therefore, healthy living conditions for institutionalized people encompasses both physical and mental conditions associated with institutionalization.

Social Justice Framework

The human rights framework can be considered as a launchpad for the social justice framework (Marks, 2005). The social justice approach features aspects of the human rights framework, particularly through its analysis of the structural social inequalities in society, which parallel discussions of systemic inequities faced by incarcerated and institutionalized populations (Brown, 2004). Justice can be achieved through highlighting inequities, addressing them directly, and offering recommendations for change. According to Marks (2005), the human rights lens can be carried out by applying social justice theory. Critical social justice theory addresses the way in which dominant classes can silence and dehumanize groups of people, labelling them as "others" and, consequently, removing them from view of functioning society (Brown, 2004). This removal from society alienates groups of individuals from participating and being engaged actors in their own lives and as citizen decision-makers within society. This pattern of labelling and dehumanization is explored in literature that highlights institutionalized individuals and their historical oppression and mistreatment (Walmsley, 2005). The oppression of institutionalized individuals has served as a method of removing individuals from society as a means of social control (Garland, 2002; Walmsley, 2005).

Social control as the objective of institutionalization, then alters perceptions of social cohesion and connectivity, creating barriers between certain groups in society. These barriers can

be illustrated by assigning to individuals distinct labels, including “criminal” and “mentally ill,” where society’s institutions seek to marginalize and delegitimize individuals (Garland, 2002). When people are dehumanized and delegitimized as individuals, there may be a shift in the expectation of the standard of treatment provided to the ‘othered’ individuals, which may lead to violations of human rights. According to Goffman and Helmreich (2007), the mortification of self, defined as the loss or breakdown of individual identity, occurs in total institutions, such as penitentiaries and psychiatric hospitals, where individuals’ habitual routines and social behaviours are immediately interrupted and caused to transition to the institutions’ schedule and behaviours in an instant. This process is purposefully perpetuated within these types of institutions as a means of punishment and control (Goffman & Helmreich, 2007).

Rights-based language is furthered by social justice considerations as the language contributes notions of individualization and privatization of society (Green, 1996; Kneen, 2009). Systemic individualization perpetuates a culture of alienation and oppression (Walmsley, 2005). The language of rights can disguise reality as the language shifts into ill-defined concepts that are not fully understood or put into meaningful forms of practice. These ill-defined concepts can be seen through institutional forms of mortification of self (Kneen, 2009). This mortification of self within total institutions furthers the individualization and culture of alienation as people are stripped of their rights and identities as citizens as they are seen to be inherently ‘other.’ The protection of people’s rights decreases the less inherently human they appear, and the more inherently ‘othered’ they become (Kneen, 2009). Therefore, a culture of exclusion, or ‘othering’, by stripping people of their identities facilitates opportunities for the continued potential for unjust human rights violations.

Human Rights & Social Justice: A Combined Approach using Health Justice

A combined human rights and social justice framework is well-suited for exploring the equity implications of COVID-19 visitation policies because it lends itself to the discussion of fairness within the Canadian institutional setting. Fairness in the context of this human rights and social justice-based approach to institutionalization considers dignity, humanity, and substance of one's rights. When considering the combination of human rights and social justice within the context of health, a broader approach can be considered. This broader approach contextualizes health within the social determinants of health to consider the impacts that social structures and systemic issues have on people's health. According to the World Health Organization (2018), there is social injustice in the preventable systematic differences in health on a global scale. These global scale injustices can be applied locally and nationally as they can too be mitigated at this level (World Health Organization, 2018).

> Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. Putting right these inequities—the huge and remediable differences in health between and within countries—is a matter of social justice… Social injustice is killing people on a grand scale. (World Health Organization, 2018, p. 4).

When focusing on social justice within the context of a rights-based framework, there is opportunity to address what is fair and just for individuals. In the context of this study, the comparison of federal penitentiaries and psychiatric facilities lends itself effectively to the discussion of social justice as these are two groups of institutionalized individuals in parallel facilities, as health is intrinsically connected to the notion of social justice through the mechanisms of human rights and policy (Rioux, 2010).

The analyses presented in this study are informed by a complimentary human rights and social justice framework. The social justice framework aims to fuel the analysis as a means to address the disjointedness within the human rights framework when considering select institutionalized individuals in Canada. Universal human rights are based on the notion of equal dignity for all people (Yamin, 2015). Dignity requires self-governance, equitable considerations and respect for humanity within a specific social context (Yamin, 2015). The right to health can be situated within these multidimensional frameworks to achieve a holistic view of health, both physical and mental, in Canadian institutions.

Canadian Healthcare Structure

To adequately situate the right to health in Canada, the structure of healthcare in Canada must be considered. When analyzing the basic healthcare structure system in Canada, there is a strict division of power (see Figure A4. *Basic Structure of Canada's Healthcare System* in Appendix A). This division of power is related to the constitutional responsibility for health (Hardcastle, 2019). Sections 91 and 92 of Canada's *Constitution* define the distribution of legislative powers as between the federal and provincial governments (Hardcastle, 2019). Throughout the COVID-19 pandemic, the federal government has worked collaboratively with provincial and territorial governments to ensure supports are available for a unified response plan to the pandemic (Public Health Agency of Canada, 2020). Each province and territory is typically responsible for the provision of health care services; nevertheless, the federal government oversees select populations like federally incarcerated individuals (Public Health Agency of Canada, 2020). The federal government is responsible for immediate health organizations and health-related regulatory departments and agencies (Hardcastle, 2019).

However, the provincial government further divides powers between regional health authorities, health care providers, and provincial programming (Hardcastle, 2019).

The CSC is a federally managed agency and is internally responsible for the health of people who are incarcerated, while psychiatric facilities are considered hospitals and are provincially governed (Hardcastle, 2019). Provincial laws regulating psychiatric facilities address issues such as funding, maintenance and inspection, management procedures, treatment standards and practices, the rights of patients and health care workers, licensing, governance structures, health staffing requirements, and the creation, retention, and confidentiality of health records (Hardcastle, 2019). However, the CSC operates under and is regulated by the federal government; therefore, it is responsible for the health and health services of this population as well (Hardcastle, 2019). The exceptions to this division of power are activated in situations of national emergency where federal and provincial governments work collaboratively. The division of power is significant, as while the *Constitution* is the ultimate law, the provincial or federal law has the ability to be modified on the grounds of the *Charter* violations (Hardcastle, 2019). The peace, order, and good government clause (POGG) in s. 91 of the *Constitution* outlines the federal government's power to regulate relations in times of national concern, such as a public health emergency like COVID-19, where federal emergency intervention strategies were implemented (Hardcastle, 2019).

Equity and Health Justice

In considering the human rights and social justice frameworks, the conceptualization of equitable circumstances can be applied within this context. Equity refers to the fairness and impartiality of a circumstantial outcome. Equity can be applied within the context of the right to health and the comparison between the parallel facilities studied, as what is considered to be fair

and just is not confined to a singular system. Social justice and equity are intrinsically linked within society, specifically within the criminal legal system.

Incarceration allows for a segment of the population to be denied certain rights, or for their entitlement and access to rights to be limited. When people are denied the opportunity for health, they are consequently denied the ability to exercise their rights under democratic principles (Benfer, 2015). Health inequity and social justice are interdisciplinary and multifaceted in nature, focusing on public health, human rights and the law (Benfer, 2015). The social location of incarcerated individuals places them in a state vulnerable to discrimination, exclusion, and dehumanization. This discrimination remains unjust.

Within the context of the right to health, incarcerated individuals have the right to mental and physical well-being. The health justice framework can effectively be applied to incarcerated individuals as a means to protect and advocate for their rights to health, further the interests of justice, and promote equity. “Health justice” is a framework that considers the principles of health equity and the approach to human welfare to produce a cohesive approach to justice regarding health (Benfer, 2015). Health justice requires the development of policies that prevent health inequity; therefore, visitation policies, and their policymakers, are in a position to promote equity and foster health justice (Benfer, Mohapatra, Wiley & Yearby, 2020). The health justice framework then can be applied to analysis of the institutional consequences arising from the COVID-19 pandemic. The effects of the COVID-19 pandemic within these institutions is a circumstance of inequitable health outcomes perpetuated by the unjust functionality of the social determinates of health (Benfer, Mohapatra, Wiley & Yearby, 2020).

Health justice is determined by the social determinants of health – specifically, structural and intermediary determinants of health (Benfer, Mohapatra, Wiley & Yearby, 2020) (see Figure

A2. *The Health Justice Framework* in Appendix A). The structural and intermediary determinants of health are the target of legal and policy responses (Benfer, Mohapatra, Wiley & Yearby, 2020). An analysis of the structural determinants of health allows for an exploration of the forms of systemic discrimination that foster inequitable health outcomes as a result of differential treatment at the institutional level (Benfer, Mohapatra, Wiley & Yearby, 2020). In contrast, intermediary determinants of health are the material and environmental factors that impact health outcomes, such as health care, physical environment, and social support networks (Benfer, Mohapatra, Wiley & Yearby, 2020). Incarcerated individuals, historically labelled and discriminated against, are penalized under further structural determinants of health that limit their individual capacity to support their individual health such as socioeconomic status and societal context (Benfer, Mohapatra, Wiley & Yearby, 2020). Research has highlighted the poorly detailed approach that healthcare facilities took to record data during the COVID-19 pandemic is reflected of lack of collected racial and ethnic statistics (Benfer, Mohapatra, Wiley & Yearby, 2020). In society, disparities have come to the forefront due to the pandemic's discriminatory targeting of minority population groups through poor structural and intermediary determinants of health. This lack of individual control and systemic oppression coupled with material and environmental stress and deprivation of resources, associated with institutionalization, leads to disparities in health outcomes. These factors consequently contribute to the objective of this study which is the equitable access to visitation across the select institutionalized settings.

Methodology

Case Study Method

Case study method using a multiple case study design was selected to address the research questions of this study. As this study examined the policy responses to visitation across select correctional and psychiatric institutions within the context of the COVID-19 pandemic in Ontario to analyze the equity implications of different approaches to emergency interventions in association with access to visitation. A case study is a social science research method that investigates a contemporary phenomenon in a practical context (Yin, 2017). The multiple case study method was chosen for this research question as it allows for the exploration of equitable policy decisions in a real-world context, and more specifically it allows for the equity-based comparison of visitation policies Canadian federal penitentiaries to the case comparator, psychiatric facilities (Yin, 2017). Directing attention to the visitation policies of these two parallel settings illuminates patterns in the findings and addresses the policies in a practical context that considers equity and applicability (Yin, 2017).

Case Definition: The cases were defined as "visitor policies implemented during the first three Ontario waves of the COVID-19 pandemic in selected total institutions within the Canadian context". The two cases selected for comparison were the Correctional Service of Canada visitation policies within federal prisons and the visitation policies of designated psychiatric facilities under the *Criminal Code and Youth Justice Act* in Ontario. These two types of facilities are comparable in forensic admissions, or admission into a total institution on the ground of a criminal event or interaction with the criminal legal system, making them viable for policy comparisons (see Figure A1. *Forensic Mental Health and Criminal Legal Flow Chart* in Appendix A).

Case Selection: The primary case was the Correctional Service of Canada's emergency intervention strategy regarding the elimination of visitors implemented during the COVID-19 pandemic. The Correctional Service of Canada (CSC) is responsible for the management of 43 institutions across Canada. These institutions include six maximum security, nine medium security, five minimum security and twelve multilevel security facilities (Correctional Service Canada, 2021b). As mentioned previously, all facilities under the jurisdiction of CSC were analyzed as the policies apply to the institutions as a collective; however, considering the objective of this study, Ontario located CSC penitentiaries were the specific focus.

The case comparator was another similar institutional setting: psychiatric facilities in the Canadian province of Ontario. In Ontario, there are two distinct categories of these facilities: (1) designated psychiatric facilities under the *MHA* and, (2) designated hospitals under Part XX.1/Mental Disorder of the Criminal Code (Ontario Ministry of Health, 2013). This study focused on the designated hospitals under the Criminal Code as individuals who commit crimes under the Criminal Code have the potential of entering the corrections system or these designated facilities depending on their mental health status. This distinction makes the comparison between these two custodial settings possible. There are ten facilities listed in Ontario under the second designation. They are as follows: Brockville Mental Health Centre, St. Joseph's Healthcare Hamilton, Providence Care Centre: Mental Health Services Site, North Bay Regional Health Centre, Royal Ottawa Mental Health Centre, Waypoint Centre for Mental Health Care, Southwest Centre for Forensic Mental Health Care, Thunder Bay Regional Health Sciences Centre, Centre for Addiction and Mental Health, and Ontario Shores Centre for Mental Health Sciences (Ontario Ministry of Health, 2013).

Case Boundaries: Cases in this study were bounded by limitations to the time period, geographic locations, and included groups (Yin, 2017). Policy and documentary data were included in the study if created and published between March 1st, 2020, to June 1st, 2021. This date range was selected as it included Ontario's recorded first, second, and partial third waves of the pandemic. Furthermore, this interval allowed for all immediate emergency interventions to be included in the case study. The geographic boundaries of the case study were the Canadian context.

The choice to isolate the geographic location to one province for psychiatric facilities allowed for a more in-depth analysis, which is required for a case study (Yin, 2017). As psychiatric facilities are provincially managed, selecting one province was required to yield valid result for equitable comparisons. The choice to use psychiatric facilities as the comparator to CSC for this study was due to the following shared characteristics: (1) total institution setting; (2) individuals can potentially take similar routes through the legal system to enter both types of institutions, and (3) the custodial underpinning associated with both types of facilities. Psychiatric facilities, while they are not penitentiaries, are potential institutional outcomes for people involved in the criminal legal system. While not everyone in these facilities is involved in the criminal legal system, admission to a psychiatric facility is a possible outcome of a forensic event. Moreover, both groups of institutionalized individuals face similar stigma and exclusion from society (Peternelj-Taylor, 2004).

Inclusion and Exclusion Criteria

The inclusion criteria incorporated policies that centered around visitation from the primary case and comparator case defined previously. The selected policies included those that mentioned visitation, visitors, and visiting the facilities. The policies included were the most recent and up-to-date policies in accordance with the time frame of this research. Data collection

occurred on June 1st, 2021 to allow for the policies to be updated throughout the first, second, and third waves of the COVID-19 pandemic to emphasize less of the emergency implementation of the policies and more focus directed on the formulated visitation policies. The June 1st date also signified the last date that would be considered in this research to allow for continuity in the results and analysis of the policies.

Exclusionary criteria comprised any visitation policy and published study outside of the date range of March 1st, 2020 to June 1st, 2021. According to the Government of Ontario Newsroom (2020), the first reported COVID-19 case in Ontario occurred on January 25th, 2020; however, the first wave of the pandemic in Ontario commenced in mid-March 2020, which is the reason for the March 1st start date (CIHI, 2021). In contrast, June 1st, 2021, marked a case count milestone of over 700 in Ontario and the date of final data collection for this research paper (Ontario Agency for Health Protection and Promotion, 2021).

Accessing Policies

The research was conducted using publicly available policy documents from a variety of sources. The search strategy involved searching publicly available facility-specific and institutional web pages for these policies. The Canadian Institute for Health Information was a source for emergency intervention strategies surrounding COVID-19 in penitentiaries in Canada and hospitals/psychiatric facilities in Ontario.

Psychiatric hospitals in Ontario: Psychiatric hospitals were identified via manual internet searches. Manual Google searches were conducted to select the homepage URL for each facility, then exploratory research was conducted on each webpage. The objective of this exploratory policy search was to determine the most effective process of policy selection. Each independent

facility required different click processes to access the visitation policy (see Table A4. *Visitor Policy Accessibility* in Appendix A).

Federal penitentiaries in Canada: The CSC website was used as a policy source as it is the centralized institution responsible for federally incarcerated individuals, encompassing the Ontario region. The protocol for visitation was unanimous across all federal penitentiaries in Canada; however, the CSC provided a chart outlining all facilities and the status of visitation (see Table A2. *CSC Facilities in the Ontario Region* in Appendix A).

Table Development

A series of data collection tables were developed to organize and categorize the policies and documentary data collected and analyzed in this study.

Ontario Psychiatric Hospitals: A table was created listing the ten psychiatric facilities in Ontario categorized under the Mental Disorders section of the Criminal Code. Columns were added to specify data that would contextualize the policies and analysis for this study:

- Facility name.
- Facility location by city.
- Type of facility (Psychiatric hospital or psychiatric unit). The type of the facility was a consideration when analyzing the data as several of the psychiatric facilities were independent psychiatric hospitals or psychiatric units within an acute care facility (Woogh, Meier & Eastwood, 1977). This differentiation is notable as visitation policy can differ depending on the facility's settings.
- Number of beds associated within each facility. The inclusion of this header provided context regarding the size and capacity of each facility, and thus the number of individuals affected.

- Visitation status associated with the facility. This column stated whether the facility was open to visitors, if it remained closed to outsiders or had restricted visitation regulations.

CSC Facilities in the Ontario Region: A table was created that outlined the CSC facilities within the Ontario region with columns to reflect the details of each of the facilities.

- Facility name.
- Facility location by city. This column contextualized the facility location and offered a mode of comparison to psychiatric facilities.
- Security level of each facility. The security level ranged from minimum, medium, to maximum level facilities for additional context.
- The capacity of each facility. The inclusion of this header provided context regarding the size and capacity of each facility, and thus the number of individuals affected.
- Visitation status associated with the facility. This column states whether the facility was open to visitors, if it remained closed to outsiders or had restricted visitation regulations.

Visitor Policy Accessibility: A table was created to document the process of accessing each visitation policy associated with the facility inquiry. The table included all ten psychiatric facilities and the CSC as an entity to address the accessibility of each visitation policy. The columns were defined as follows:

- Facility name/type.
- Website URL link associated with the homepage of each facility for data collection purposes. This inclusion aimed to ensure replicability in the data collection by providing the homepage as a baseline for the research into visitation policies.
- Clicks from the homepage. This provided a brief outline of the accessibility of the visitor policies on each website, clarifying the number of clicks it takes from the website

homepage to the visitation policy. The subsequent columns were numbered one through five to illustrate the process of each click and stage from the homepage to policy for easy replicability.

Policy Analysis using Institutions, Interests, and Ideas Framework: 3I: Finally, an analytical table was developed based on the "3 I" framework to organize and analyze the selected policies. This conceptual framework explores how policy choices and policy development are shaped by institutions, interests and ideas (National Collaborating Centre for Healthy Public Policy, 2014). Institutions refer to formal or informal rules or organizational factors that shape policy and political behaviours (National Collaborating Centre for Healthy Public Policy, 2014; Pomey, Morgan, Church, Forest, Lavis, McIntosh, Smith, Petrela, Martin & Dobson, 2010). Similarly, interests refer to the agendas of policymakers, societal groups, elected officials and researchers (National Collaborating Centre for Healthy Public Policy, 2014; Pomey et al., 2010). The interests of a policy consider the various actors involved and the goals these actors hold for the policy adoption and implementation (National Collaborating Centre for Healthy Public Policy, 2014). Finally, the framework of ideas considers how evidence, values, and beliefs influence policy choices and development (National Collaborating Centre for Healthy Public Policy, 2014). Different ideas shape how different actors define a problem and attempt to solve it via policy decisions. These three factors influence policy development and aid in fostering interpretive perspectives to the various visitation policies selected for the purpose of this study.

Policy and communication theory can help to uncover how particular policy topics are framed (McCombs et al., 2013). During the policy analysis process there were three emergent themes related to policy tone that aided in the author's synthesis of the materials. The author defined tone of the policy as an indication of the policy direction and inherent objectives and

noted that policies fell within one of three categories: formal, informal, and cooperative. Therefore, using the 3 I framework to analyze the visitation policies, a conceptual framework was developed by the author to categorize each policy by tone. A policy with a formal tone strongly reflects and follows the institutional influences such as governmental lockdown measures and Ministry of Health implemented guidelines. While an informal policy tone echoes select or weak institutional influences wherein there is a limited delivery of policy information and flexibility for individuals interacting with the policy, such as patients, staff, and families. Consequently, policies with a cooperative tone function as the marriage between institutional influences, interests, and ideas to produce a more comprehensive policy. Policies with a cooperative tone consider a range of interests and ideas in accordance with institutional influences. A tone criteria checklist was developed by the author to allow for replicability and structure in analyzing the policies (see Table A3. *Tone Criteria Checklist* in Appendix A).

Findings

The psychiatric facilities in this study included all ten facilities under Part XX.1 of the Criminal Code and varied in location across Ontario ranging from the northmost facility, Thunder Bay Regional Health Sciences Centre, to the southmost facility, Southwest Centre for Forensic Mental Health Care, St. Joseph's Health Care London. While the geographic location of these facilities varied in relative proximity, for the purpose of this study they are presented in accordance with the facility organization obtained from Ontario Ministry of Health (Ontario Ministry of Health, 2013). At the time of this study, each facility had differing visitation policies ranging from complete closures (no visitation permitted) to restricted visitation policies (see Table A1. *Ontario Psychiatric Hospitals Under Part XX.1/Mental Disorder of the Criminal*

Code in Appendix A). In comparison, there were seven CSC facilities within the provincial boundaries of Ontario assessed in this study. These penitentiaries similarly ranged in geographic location and proximity to each other. These penitentiaries varied in security level from minimum to maximum security with combination security levels within some facilities as well. While the CSC outlined the visitation status of each of these facilities independently on the CSC website in a chart format, all CSC facilities included in this study were closed for visitation during the time of data collection (see Table A2. *CSC Facilities in the Ontario Region* in Appendix A).

Accessing Visitor Policies

Accessing the visitor policies for each of the facilities required various approaches and a search method that was conducive to the variability of access with each facility. The process of visitor policy accessibility is outlined in the table titled, Visitor Policy Accessibility (see Table A4. *Visitor Policy Accessibility* in Appendix A). The search process began at the homepage of each institution and followed a process of manual searches to achieve the most direct route to the policy. Seven of the psychiatric facilities required three or fewer clicks from the homepage to access the visitation policies, and these facilities included: Providence Care Centre, North Bay Regional Health Centre, Waypoint Centre for Mental Health Care, Southwest Centre for Forensic Mental Health Care, Thunder Bay Regional Health Sciences Centre, Centre for Addiction and Mental Health, and Ontario Shores Centre for Mental Health Sciences. At the same time, Brockville Mental Health Centre, Royal Ottawa Mental Health Centre, St. Joseph's Healthcare Hamilton, and CSC facilities all required four or more clicks from the homepage to access the visitation policies.

Analyzing Visitation Policies

The findings of this study are presented using the 3 I's framework in the chart titled, 3 I's Chart – Data Effective of June 1st, 2021 (see Table A5. *3 I's Chart – Data effective of June 1st, 2021 (3rd wave lockdown)* in Appendix A). The policy analysis considered the institutional influences of organizational policies and government legislation shaping the development and implementation of the visitation policies, including emergency intervention strategies and provincial government directives. The interests of the policies, as per the 3 I's framework, considered the people or groups of people that are invested in the policy's development and implementation. Interests in the content and outcome of the policy varied from the patients and staff within the facility to the facility itself. The ideas embedded within the visitation policies focused on the values of the individual facilities and society. These values embedded within the policies discussed the importance of visitation having therapeutic value and as a part of rehabilitation, as well as prioritizing visitation hours/days and alternatives to in-person visitation as a means to actively endorse the importance of visitation within the facilities for institutionalized individuals.

The Royal Mental Health Centre, Brockville and Ottawa locations, shared a visitation policy as they are a part of the same corporation. The policy explicitly framed the governmental directives of a province-wide lockdown as informing policy content in stating, "Ontario is entering into a province wide lockdown due to rapidly increasing rates of infection and unsustainable hospital capacity; The Royal will suspend visitors for the next two weeks" (The Royal, 2020, p. 1). The policy considered the well-being and interests of patients within the facility by citing COVID-19 health concerns for patients and visitors while recognizing the potential benefits of visitation on mental health. However, the overall tone of the policy was

formal as it addressed the well-being of patients within the facility in accordance with visitation yet remained rigid in the decision to halt visitation, prioritizing adherence to provincial public health directives. The policy did not explicitly consider the interests (patients, staff, visitors) or prioritize the therapeutic benefit of visitation at The Royal as the policy cited the benefits of visitation but offered no alternative or compensation in the policy. Moreover, the policy had no explicit information on visitation provisions, dates to reopen visitation, or consideration of other alternatives to in-person visitation for patients needing social support network access.

St. Joseph's Healthcare Hamilton West 5th Campus had a visitation policy that made the claim to caregivers/support people that the facility was safe, but it was the visitors' responsibility to keep the facility safe. The tone of the policy was cooperative. The importance of visitation was operationalized in their protocol to make virtual visits with patients and loved ones available as a visitation option. "We understand that some people do not feel safe coming to the hospital, and these are good alternatives. This is another good option for those who are not listed as one of the two visitors on the patient's list" (St. Joseph's Healthcare Hamilton, 2021, p. 1). The visitation policy was detailed in specifying types of visitors permitted for each department of the facility, offering a comprehensive outlook on the facility's expectations of visitors and the policy's targeted objectives.

The visitation policy for Providence Care Centre: Mental Health Services Site was a cooperative policy as the facility included considerations of institutions, interests, and ideas to produce an inclusive visitation policy. For instance, the implementation of safety measures in accordance with the provincial-wide shut and structures of designated visitor types followed provincial guidelines while considering the social support aspect of visitation. The facility's visitation policy was titled, "Family presence & visitor restrictions at Providence Care sites"

(Providence Care, 2021). This title expressed the consideration of social support presence for individuals within the facility as it articulated family attendance, as opposed to the mere visiting of family. This word choice illustrates the interests of patients within the facility being at the forefront of the policy with consideration of the interests of the well-being of patients. The policy's word choice focused on rehabilitation, which also illustrates the importance placed on therapeutic patient support and growth by the facility.

The visitation policy of North Bay Regional Health Centre was consistent with an informal tone. It addressed the necessary information for visitation, including hours and dedicated care partner definitions in accordance with physical distancing measures. However, the mention of emergency intervention strategies merely addressed physical distancing, with no discussion of health and safety protocol or governmental directives. The policy did not provide additional information past the basic information requirements of visitor type categorizations, visitation hours, and interests of vulnerable patients for visitation. An informal tone within the policy was explicit in defining the bounds of visitation encompassing interests and institutional values. Given that the policy was aligned with provincial directives, it was mainly influenced by scientific evidence surrounding infectious disease, offering limited flexibility and adaptability in the policy's framework.

Waypoint Centre for Mental Health Care had a cooperative visitation policy. The policy functioned within the bounds of the provincial lockdown measures and with regional partners to generate the visitation policy for the facility. It considered the importance of visitation for patients regarding their well-being while simultaneously addressing emergency intervention strategies. The policy outlined the opportunity for other forms of visitation including video visitation and deliveries for patients to improve their mental health status and overall well-being.

The policy additionally recognized exceptions to visitor restrictions on compassionate grounds such as palliative or end of life circumstances illustrating the cooperative tone of the policy.

The visitation policy of the Southwest Centre for Forensic Mental Health Care was formal in tone. The policy provided an in-depth consideration of visitation types and protocol surrounding visitation while situating the facility's commitment to the well-being of the patients. Emphasis was placed on the government's response framework and remaining true to these provincial policies. The policy covered a comprehensive range of topics, including visitor terminology and visitation hours associated with institutional values while likewise addressing the coloured stages of provincial guided closures. However, the policy neglected to consider the interests past the facility and facility stakeholders, such as the patients and staff.

Thunder Bay Regional Health Sciences Centre's visitation policy provided information, resources and contacts for patients, visitors, and staff to connect with individuals within the context of visitation. The tone of this policy was informal. The policy detailed interventions that contribute to protecting health and safety, offering educational resources for visitors, including PPE applications and risks associated with being a care partner in the facility. The policy linked to the facility's policy on this designated type of visitor. This essential care partner policy stated,

> "An essential caregiver is a person identified and designated by the patient/resident – a family member, friend, neighbour – who provides important personal, social, psychological and/or physical support, assistance and care. An essential caregiver does not have to be living with the person they are supporting or biologically related to the patient/resident" (St. Joseph's Health Care London, 2021, p. 1).

In addition, the policy offered alternative visitation options including visits via FaceTime and Skype. While the policy emphasized emergency intervention strategies as shaping the protocol

for visitation, it lacked consideration of other institutional influences on policy development and implementation.

The visitation policy for the Centre for Addiction and Mental Health (CAMH) was formal. While the policy referenced Toronto Public Health for health guidelines and directives, it lacked consideration of interests and ideas regarding facility values. The policy made no mention of the mental health benefits of visitation in accordance with social support networks or institutional values associated with patient well-being. The policy included detailed case counts within the facility to ensure infection control was maintained and considered within the policy. While CAMH published comprehensive COVID-19 data related to case numbers within the facility, the visitation policy lacked consideration of the patients within the facility and the mental health benefits associated with visitation for patients.

Ontario Shores Centre for Mental Health Sciences' visitation policy had an informal tone as there was no mention of facility values or mental health impacts of visitation or benefits of social support via visitation. Furthermore, the policy lacked a strong institutional influence from the provincial government and Ministry of Health. While emergency intervention strategies shaped the policy, there was no discussion of the provincial directives and lockdown measures. The policy's first sentence supported this as it stated, "Everyone is requested to wear a procedure mask while inside the hospital. Thank you for your cooperation" (Ontario Shores Centre for Mental Health Sciences, 2021). The policy failed to address the interests of parties impacted by the policy such as patients and visitors of patients. The policy concluded with an extensive inventory of emergency intervention strategies including health screening, PPE and social distancing with a broad statement deficient of consideration for patients or visitors of patients. "Thank you for your understanding as we continue to deliver compassionate care while

protecting the health and safety of everyone at Ontario Shores and our community" (Ontario Shores Centre for Mental Health Sciences, 2021). This concluding statement was evidence to the informal tone of the policy that lacked greater considerations.

While the visitation policies for psychiatric facilities were outlined individually, the visitation policy for all of CSC's penitentiaries was shared. Although the CSC is responsible for all federal penitentiaries, visitation availability varies depending on the province and provincial guidance. The CSC policy was formal in tone as it focused on the directives of government and emergency intervention strategies; however, it had no consideration of the interests of stakeholders beyond the CSC facilities themselves. The COVID-19 visitation policy of CSC stated the objective as "keeping our institutions safe and healthy" (Correctional Service Canada, 2021c). The interests of the facilities were the concentration of the policy and the values embedded within the policy were centred around the evidence related to infectious disease transmission and public health guideline adherence.

Factors Influencing Visitation Policies

The 3 I's framework highlights the main factors that influence the visitation policies of the select facilities. The findings of this study, in accordance with the data collection chart, have been analyzed for themes and patterns across the framework (see Table A6. *Thematic 3 I's Chart* in Appendix A). Patterns in policy development and implementation have been illuminated as a result of this analysis.

Institutional Influence

The institutional influences present in the visitation policies highlighted themes of province-wide lockdowns, emergency intervention strategies, and regional partner continuity. The reference to province-wide lockdown was in accordance with the Ontario government's

mandate for a province-wide lockdown/shutdown. This was quoted in five of the visitation policies across the selected facilities as the reason or factor contributing to the policy development and implementation. Furthermore, emergency intervention strategies were implemented as directed by governmental requirements to offer additional guidance to these policies. These intervention strategies implemented were outlined as vaccination, case finding and management (e.g., screening), openings and closures of businesses and services, physical distancing, health workforce capacity, health services, travel restrictions, and public information (e.g., personal protective equipment) (CIHI, 2020). While these interventions can be explicitly or implicitly stated, they remained vital in influencing and directing visitation policies in all eleven of the study's selected facilities. Finally, additional institutional influences shaping these policies were the directives of regional partners to create facility continuity and consistency in visitation policies across the healthcare sector. The visitation policy for Waypoint Centre for Mental Health Care is evidence of the institutional influences involved within policy development and implementation,

> "With the announcement of another lockdown across the province, escalating case numbers, and out of an abundance of caution, the hospital has made the difficult decision to restrict visitors once again. This is consistent with our regional partners. Some exceptions will continue to apply for essential care partners and end of life or palliative circumstances" (Waypoint Centre for Mental Health Care, 2021, p. 1).

This approach to the visitation policies promotes a range of institutional influences addressing provincial lockdown measures, emergency intervention strategies, and regional partner continuity engineering the foundation for equitable policy development and implementation.

Merely two of the facilities referred to creating a unified approach for visitation policies across the province, public health units, and regional health authorities, and healthcare facilities.

Interests

The development and implementation of visitation policies in this study's selected facilities represented a diversity of interests. The interests of patients within the facility, vulnerable patients within the facility, the facility itself, and staff were represented to varying degrees across the policies. The interests of patients within the facility were supported through a direct consideration of the patient's mental health, well-being, and safety in the visitation policy. Six of the policies analyzed for this study cited the importance of social support networks and/or the benefits supports can have on a patient's mental well-being. These considerations for social support networks include such statements as that included in the visitation policy of The Royal.

> "There is a therapeutic value to involving your family members, significant others, friends and supporters so visitors are encouraged during your treatment at The Royal. Your treatment team can assist you to connect or reconnect with family, friends and community supports" (The Royal, 2020, p. 1).

Four policies furthered this consideration of patients to address the interests of vulnerable patients within the facility by acknowledging the difference in needs between patients and vulnerable patients. Vulnerable patients varied in definition; however, the policies that supported the interests of vulnerable patients referred to those living with a developmental or intellectual disability or experiencing end of life. The interests of the facility as a separate entity were also represented in the policies through a focus on sustainable hospital capacities or ensuring hospital safety with regard to visitation policy directives. "Our hospital is safe. However, it is your responsibility when you are in the hospital to help keep it safe. (St. Joseph's Healthcare

Hamilton, 2021, p. 1). This statement from St. Joseph's Healthcare Hamilton visitation policy illustrates the focus on the interest and safety of the facility as an entity. Six out of the eleven policies referenced these interests of the facility within the provisions of the visitation policy. Finally, the interests of the staff were represented in three visitation policies in emphasizing an explicit need to protect facility staff from COVID-19.

Ideas

Ideas are values, beliefs, and evidence that influence and inform visitation policies to varying degrees. These ideas stem from society and from within the organizations employing the policies. The ideas and values affecting visitation policy development and implementation encompassed the therapeutic value of visitation, restriction of visitation days/hours, and alternatives to in-person visitation. These ideas were grounded in evidence from the literature supporting visitation and variations of visitation having a therapeutic value for institutionalized individuals. The presence of designated visitation days/hours in the policies may indicate that an organization had the belief that visitation in restricted time frames were sufficient for the patient needs. Furthermore, restricted visitation hours and days may be grounded in evidence from public health strategies that support social distancing (CIHI, 2021). Finally, there was a notable belief that alternatives and substitutions to in-person visitation was adequate for institutionalized individuals. Virtual visitation opportunities, including Skype and Facetime, were frequently referenced in policies as a substitution or alternative to in-person visitation. These alternatives made reference to institutional influences and interests within the policy as the decision to seek substitutions for the standard practice of in-person visitation.

Visitation can be seen as positive events and beneficial in the construction of mental health and well-being for institutionalized individuals which reflect the values of the

organizations that implement the policies. Five of the policies analyzed in the study mentioned the association between visitation and social supports. The policies appreciated the valuable impact that social support networks provide for patients and the generation of more positive mental health outcomes. The impact of social supports is inherent in society and rooted in many of the organization's policies displaying a continuity of beliefs across societal and systemic bounds. This value is evident in the St. Joseph's Healthcare Hamilton visitation policy that outlines the importance of a "caregiver/support person," in stating, "Caregiver/Support people can be a family member, partner, friend or neighbor that play a critical role in providing physical, emotional, and occasionally translation support to our patients" (St. Joseph's Healthcare Hamilton, 2021, p. 1). This focus on social supports as a value was a strategic highlight of many visitation policies. Furthermore, many organizations expressed ideas and values associated with visitation through the policies addressing restricted hours/days of visitation. The choice to restrict days and hours of visitation has been referenced in policy as a means to promote safety and follow public health measures, while other policies reference the visiting days/hours as merely facility protocol (CIHI, 2021). "Each inpatient may have one dedicated care partner (plus a designated alternate) for the patient's length of stay between the hours of 11 a.m. and 1 p.m. or 5 and 8 p.m. (only one entry and one exit each day)" (North Bay Regional Health Centre, 2021). These outlined visiting hours are frequently cited in policies in accordance with emergency intervention strategies, such as,

> "To continue to reduce the risk of COVID-19 transmission and protect our most vulnerable people, NBRHC visitor restrictions are still in place at all its sites. We are now moving to a +1 for inpatients—this direction is based on availability of space to allow for physical distance" (North Bay Regional Health Centre, 2021, p. 1).

This is evidence of institutional values in reference to following the beliefs of emergency intervention practices or the importance of the social connection and cohesion. Regardless of the objective of restricting hours/days to visitation it does not remove visitation completely allowing for patients within the facility to connect with their social supports at some capacity, whatever that may be. Finally, four facilities present in their visitation policies additional forms of visitation, other than in-person, such as virtual visitation or other technology-based alternatives. Four policies highlighted alternatives to visitation for individuals within the studied facilities through promoting technology-based alternatives. Furthermore, this presents the societal dependence on technology as an alternative to in-person interactions. The use of technology to aid in visitation also compliments the promotion of emergency intervention strategies, such as the importance of social distancing (CIHI, 2021). This recognizes the importance of social support and social connection while offering alternatives to in-person visitation that may be restricted or eliminated for other COVID-19 related reasons.

Key Findings

The purpose of this study was to gain a comprehensive understanding of the comparative policy responses to COVID-19 visitation policies across select total institutions in Ontario and uncover possible equity implications. The results highlight three major themes, or factors shaping policy formulation, across the selected policies and illustrate the variations in the development and implementation of visitation policies during COVID-19 in select facilities, leading to inequitable access to visitation. Overall, policy formulation varied between CSC and psychiatric facilities, as well as between psychiatric facilities, resulting in differences in access to visitation. Moreover, there was inconsistency in consideration of vulnerable people within penitentiaries and their visitation needs, as well as variability in how facilities prioritized

visitation as having therapeutic value for incarcerated individuals. Some facilities appeared to prioritize the importance of provincial directives, infection control measures, and public health measures (institutional influences) when developing their policies, while others prioritized the needs of patients and families (interests) and the evidence supporting the therapeutic value of visitation to an individual's rehabilitation (ideas).

Analysis

Contextualizing the Findings

This study has demonstrated that institutional influences, including formal legislation, government emergency intervention strategies, and organizational policies, can profoundly impact equitable access to health-related services, specifically visitation. Thus, these institutional influences ought to be balanced with other considerations that attend to the needs of individuals impacted by these policies. The right to health is a multidimensional concept upheld by human-made institutions that control how, when, and why rights are afforded to various groups of people (Kneen, 2009). In this study, individuals in penitentiaries and psychiatric hospitals experienced reduced access to visitation, an important service related to health and wellness, as a result of human-made institutional factors. This conceptualization of rights is supported further by the notion of social justice and health equity that permit health justice modalities (Marks, 2005). When considering human rights and social justice, the framework of health justice can then be mobilized to address policy-level concerns by suggesting solutions to prevent health inequities, namely addressing policy formulation to reduce variations in access to visitation (Benfer, Mohapatra, Wiley & Yearby, 2020).

The findings of this study are consistent with previous research in the fields of institutionalization and visitation. According to Munshi et al. (2021), family and essential caregivers are vital to patient-centred care; and overarching restrictive visitation policies are associated with potential harm for patients within these facilities. Visitation has significant impacts on the mental health and well-being of institutionalized individuals (Turanovic & Tasca, 2019). The importance of and therapeutic value of visitation for institutionalized individuals is reflected in only a subset of policies analyzed in this study (see Table A6. *Thematic 3 I's Chart* in Appendix A). Moreover, the policies analyzed in this study varied in consideration and prioritization of therapeutic visitation as necessary to individuals' wellness. In fact, this is illustrated by the CSC visitation policy that does not consider the therapeutic value of visitation in their policy formulation, and thus removed access to visitation. In contrast, most psychiatric facilities addressed the importance of visitation by offering some form of visitation or virtual alternatives. Notably, all of the psychiatric hospital policies that acknowledged the therapeutic value of visitation in their policy development also addressed at least one or more other policy formulation criteria identified within the 3 I framework analysis. This attention to all aspects of the 3 I framework (ideas, interests, and institutions) during policy development creates a comprehensive approach to visitation policies that address the needs of a broad range of stakeholders or interests. However, it is important to note that taking a comprehensive approach to policy development was not observed across all psychiatric facilities or comparable total institutions in this study.

The study findings revealed the absence of a consistent visitation policy approach across facilities studied. Variations in policy approach to visitation were observed between different psychiatric facilities, and variation was also observed when comparing psychiatric facilities and

CSC facilities. In fact, when comparing psychiatric hospital visitation policies to CSC visitation policies, a mere three policy influencing factors were identified in both facility types (see Table A6. *Thematic 3 I's Chart* in Appendix A). The lack of policy continuity between comparable total institutions is exemplary of the larger governmental and systemic inequities between institutionalized populations. Inequities in the development and implementation of these policies are representative of the "othering" and stigmatization faced by incarcerated individuals (Brown, 2004).

As expected, an overwhelming number of visitation policies within psychiatric hospitals and CSC considered the interests of the facility as an important factor in shaping visitation policy but did not explicitly consider the needs of the staff or have an emphasis on vulnerable individuals living within these total institutions. A small subset of psychiatric hospitals made direct reference to vulnerable patients who required additional social supports, thus prioritizing the interests of these vulnerable patients, including the needs of ill or end-of-life individuals. While not every facility referenced this smaller group of the institutionalized population, it was a common theme among hospital-type facilities studied. In contrast, the CSC makes no mention of vulnerable individuals. This policy consideration for vulnerable individuals may reflect a societal shift toward offering additional support for individuals in increasingly difficult social positions – in other words, an effort to address issues of equity through a health justice approach.

This study demonstrated that inconsistent, variable, and incomplete approaches were taken to policy development and implementation for visitation between different psychiatric facilities and between psychiatric facilities and CSC facilities. It is these variations in policy approaches that can then lead to the following inequities: (1) inequitable access to visitation; and (2) potential inequitable health and wellness outcomes. These results represent the first direct

demonstration of equity considerations for visitor restrictions in select total institutions during the COVID-19 pandemic in Ontario.

Health Justice in the Context of this Study

This study addresses the inconsistencies in COVID-19 visitation policies across comparable institutions, which coincides with variations in mental health and well-being due to the previously cited benefits of visitation. This notion of mental well-being associated with visitation policy formulates health justice considerations. “The combined principles of health, equity, and justice are the keystone to a functional, thriving society. Yet, these principles go unfulfilled when they do not apply equally to all members of society” (Benfer, 2015, p. 350). Therefore, health justice is only achieved when the policies embody these principles effectively to reduce health inequities (Benfer, 2015).

Health justice is not achieved via disparities in policy formulation between parallel institutions or within facilities of the same category. Institutionalized individuals are a segment of the population that are denied an opportunity to achieve a standard of living that promotes health (Benfer, 2015). However, this study has illuminated that in comparison to psychiatric hospital patients, incarcerated individuals may experience additional health inequities as a result of facility policies. People incarcerated in federal penitentiaries in Ontario experience reduced access to visitation due to institutional influences, interests, and ideas incorporated (or not incorporated) in the visitation policy development and implementation by the CSC (see Table A6. Thematic 3 I’s Chart in Appendix A).

In addressing the inequities and systematic issues, health justice can be achieved through legislative decision-making, policy development, and policy implementation that includes the amalgamation of health equity and social justice priorities (Benfer, 2015). An important part of a

health justice approach is to address aspects of the legislation that negatively affect the health and well-being of individuals, particularly marginalized populations such as those institutionalized (Benfer, 2015). This study has showcased the various discrepancies between visitation policies at select total institutions, and whether deliberate or inadvertent, further disadvantage comparable groups of people by restricting equitable access to visitation. Whether policy decisions were influenced by institutions, select interests, or the ideas and beliefs of actors, there is clear health injustice facing incarcerated individuals in Canada.

Policy Equity within Psychiatric Facilities

Interestingly, this study uncovered significant discrepancies in the institutional influences, interests, and ideas within the Ontario psychiatric facilities' policies as direction, directives, and motivation vary in origin depending on the psychiatric facility. While many of these hospital policies represented the interests of patients, many hospitals chose to omit this critical aspect of patient care in their policy formulation, citing the interests of facility or staff safety as a priority. The institutional influences from government-directed lockdowns and regional partner continuity varied in frequency, while emergency interventions remained a consistent influencing factor in policy development. Finally, variations occurred with regard to the ideas and beliefs incorporated into policies by each different facility. These variations in these policy frameworks led to disparities in policy outcomes. Policies ranged in length, detail and overall tone. The tone of the policies contributed to the comprehensiveness of the documents. Policy variation within select psychiatric hospitals raises equity concerns as it does not support continuity of care for individuals, nor does it foster a just setting for patients in the various facilities.

Policy Equity between Psychiatric Facilities and CSC Facilities

In contrast to policy equity between individual psychiatric facilities, there were significant inequities between the two comparable facilities of psychiatric hospitals and CSC facilities. Although psychiatric hospitals and CSC penitentiaries are two distinct types of facilities, they shared similar admissions requirements, processes, and procedural objectives. In consideration of these comparable institutional settings, it was found that CSC shared a mere three policy influencing factors with any one given psychiatric hospital. CSC policy formulation shared institutional influences from provincial-wide lockdowns and emergency intervention strategies and consideration of facility and organizational interests within their policy formulation. This stark approach to visitation policy formulation was a departure from the approach observed by the selected psychiatric hospitals that included other factors within the 3 I framework as part of their policy formulation.

Discussion

The study's findings highlight the series of equity considerations associated with the visitation policies and strongly implies there is variation in the development and implementation of visitation policies in the CSC in comparison to select psychiatric hospitals in Ontario, thus creating inequitable access to visitation. Furthermore, the results demonstrate that the institutional influences, interests, and ideas expressed in CSC visitation policies differ from those included in psychiatric facility policies. CSC visitation policies overwhelmingly prioritize institutional influences, while psychiatric facilities are varied in the prioritization of institutional influences, ideas, and interests in their policy development. It is noteworthy that these results

outline the differences in visitation policies associated with groups of people experiencing similar forensic events.

A compelling explanation for the findings comes from the consideration of the right to health and health justice. Incarcerated individuals are deemed as others and excluded from society (Garland, 2002). This state of social exclusion and labelling of "others" may allow for limited, or no, consideration of individual needs related to visitation that would not be accepted in the hospital setting. Additionally, the difference between the concepts of patient rights and patient care rights may provide an additional explanation for the inconsistencies in visitation policies across select institutions (Cohen & Ezer, 2013). The patient care rights mobilize the concepts of justice associated with patient rights, such as the right to health and access to services (Cohen & Ezer, 2013). This mobilization of justice is evident in psychiatric facility policy formulation as the policies take a more comprehensive approach to considering aspects of visitation during the first, second, and part of the third wave of the COVID-19 pandemic in Ontario. However, within penitentiaries, this mobilization of justice is not present as the policies of these facilities do not address the comprehensive approach to policy development and implementation. Patient care rights are not brought forth in penitentiary policies which is evident in the institutional focus of the policies.

Another interpretation of these findings reflects the influence of individualization and privatization of society (Green, 1996; Kneen, 2009). Individualization perpetuates a rights-based language that recognizes a culture of alienation and oppression within institutions (Walmsley, 2005). As the CSC visitation policy places emphasis on the interests of the facility over the interests of individuals living within the facility and staff, it is evidence of the unbalanced power dynamics within this total institution setting. The dehumanization of "criminals" allows for

society and organizations to increase punitive institutional and stakeholder influence while dismissing positive approaches to ideas for visitation. Hence, the visitation policy of CSC neglects the consideration of the idea of the therapeutic value of visitation, restricted hours/days of visitation, and alternatives to in-person visitation methods. The mortification of self essentially flourishes in penitentiaries as individualization dominates the criminal legal system (Kneen, 2009). People are ostracised for their labelled criminality, and the lack of balance between the criminal legal system aims and the objectives of imprisonment fosters (Kneen, 2009; Zimring & Hawkins, 1997). This ostracization is evident in the visitation policies in this study that disregard and overlook the needs of these institutionalized individuals, namely the CSC policies and some of the psychiatric facility policies. While the psychiatric facilities in this study do not demonstrate comprehensive and consistent policy formulation with the 3 I framework to address equitable standards of health justice – they do model a more inclusive approach to visitation policies that consider a broader range of institutional influences, interests, and ideas as a whole.

Study Limitations

This study situates visitation as a positive influence and impact on institutionalized individuals; however, there are negative implications associated with visitation. According to Turanovic & Tasca (2019), visitation causes significant distress and perpetuates circumstances of sorrow for incarcerated individuals in particular. This study does not consider the negative implications of visitation in the context of visitation policies beyond recognizing that these effects are possible outcomes. The present literature addresses visitation as a positive aspect of mental health and well-being with considerations of the negative associations (Munshi et al., 2021; Turanovic & Tasca, 2019). For this study, in particular, the negative associations were not

present in selected visitation policies furthering the choice not to address them in the study. In addition, the negative impacts related to infectious disease and COVID-19 transmission associated with in-person visitation were not addressed. In-person visitation may potentially be associated with poor infectious disease control and increased rates of COVID-19 transmission, particularly in facilities with poor infection control measures and infrastructure.

Furthermore, the study is limited in scope to Ontario facilities; a more comprehensive analysis would come from a national scope of psychiatric facilities and all CSC facilities. However, for the purpose of this study, this scope was defined as appropriate due to the nature of the study's restricted timeframe. Select limitations of this study can be addressed in future research within this field.

Additionally, the analysis considers the explicit language and content of the policies; however, how the policies were enacted in practice cannot be verified. Accordingly, while each policy outlined the procedure and rules associated with visitation – whether the policies were referenced in practice or enacted fully cannot be determined within the scope of this study. Moreover, this study's analysis was constructed based on policy-shaping factors that were explicitly stated in the policies. This analysis of explicit factors is a limitation of the study as it did not consider implicit, or unseen, factors that may have shaped policy formulation but were not stated in the policy narrative.

A final limitation to this study is the policy accessibility and complex multilevel approach to the development of the visitation policies by selected facilities. Due to the rapidly evolving COVID-19 pandemic, policies surrounding visitation developed at a swift pace which led to complications in collecting data. The visitation policies were constantly evolving and changing daily; therefore, ensuring that versions remained consistent was essential for the

replicability of the study. Moreover, the multilevel approach that many facilities took to visitation policies added a complexity factor to data collection and analysis. Visitation policies were not complete documents as the policies were obtained via publicly accessible channels and frequently required the researcher to follow a path of webpage links to obtain various aspects of a whole policy.

Study Implications

Despite the limitations addressed in this study, the results suggest theoretical and practical implications for visitation policies. A significant theoretical contribution relates to the application of the health justice framework to a case study policy analysis. This study's methodology can be applied to a range of congregate living settings, including group homes and long-term care homes, to further the research on this topic and similar topics related to equitable access to health and healthcare in a systemic manner, such as access to COVID-19 vaccinations. Likewise, the theoretical framework of this study can be used to foster analysis of findings and the basis for future research to further explore health justice in systemic and institutionalized structures. The practical implications associated with this study are strategies and policy formulation considerations that can be undertaken to address inconsistencies and inequities in visitation policies. Meaningful policy changes can arise from considering the thematic findings and the health justice approach to policy change (Benfer, 2015).

Policymakers at the government level and within psychiatric facilities should consider a more consistent approach to policy development and implementation to generate more equitable access to visitation, and consequently, other aspects of institutionalized life. This can manifest as the development of a process to ensure that policies within a jurisdiction or geography are integrated and developed collaboratively. A more consistent approach would promote health

justice by improving equitable access and considering policy as a means to achieve social justice. The CSC should consider the inequities in visitation access that incarcerated individuals face across institutionalized settings to advance policies. Health justice requires these considerations of policy changes to address inequities that can be achieved within CSC facilities. Additionally, the CSC should consider all factors of policy-shaping outlined in this study, including mechanisms to ensure regional partner continuity with psychiatric facilities to offer incarcerated individuals an equitable level of access. Another necessary component to visitation policy formulation to ensure equitable access to visitation would be to include the needs of individuals within the facility, vulnerable individuals within the facility and staff members. Finally, more emphasis should be placed on the therapeutic values of visitation, select visitation hours/days, and alternatives to in-person visitation when developing a comprehensive visitation policy to achieve health justice.

This study supports the equitable access to visitation for institutionalized individuals by suggesting strategies for visitation policy formulation that would reduce variation. Furthermore, the study highlights the inequitable access to visitation facing federally incarcerated individuals compared to individuals in psychiatric institutions. This study has allowed for policy recommendations to be illuminated as a means to generate equitable policies in these select institutionalized settings. A health justice framework supports policy changes that are directed towards more equitable outcomes surrounding access to visitation for institutionalized individuals. The findings of this study support a shift in policy development and implementation to ensure comprehensive and consistent policies between total institutional settings with a focus on regional continuity. Visitation policies developed through a health justice framework are

required to consider more than an infection control imperative to adequately address the policy's impact on mental health and well-being outcomes.

Directions for Future Research

In terms of future research, extending the current findings by examining other total institution and congregate living settings as case comparators, such as provincial penitentiaries, has significant benefits for the findings of this study. Examining this study on a larger scale would offer more comprehensive results through a national approach to inequities in select total institutional settings. These alternative case comparators would allow the research to make comparisons within the institutional and governmental boundaries of the criminal legal system. Moreover, future research could use the multiple case study design and frameworks to analyze other policies within these comparable institutions. Variations in policy selection for future research could involve policies directed towards the social determinants of health, including policies around recreational activity access and time.

Research can also be propelled in the future via using this study as the foundation for policy development surrounding equitable emergency intervention strategies nationwide. This study offers a foundation for supplementary policy development and implementation as it addresses the flaws and inequities within CSC’s COVID-19 visitation policy during the first, second, and part of the third wave of the pandemic in Ontario. This exploration would concentrate research in the field of law and human rights while approaching the topic of visitation policy with social and health justice considerations. This study's framework of health justice would offer grounds for equitable visitation policies, as social justice, health, and equity are presented at the forefront of policy decisions. Further research must be conducted to establish the extent of visitation as a positive mental health factor, specifically in the context of the

COVID-19 pandemic; however, the health justice framework would offer a basis for the research to be conducted.

This study represents the first attempt to address these equity and social justice concerns. Further research examining these limitations may shed light on additional circumstances of inequity and injustice. Beyond the current COVID-19 pandemic scope, considering how visitation policies are developed and implemented going forward in total institutions post-pandemic is a potential area for further exploration as health justice and be applied to these topics.

Concluding Remarks

In considering the limitations of this study and the associated implications, this research has produced significant findings in the field of policy and equity for institutionalized individuals. This research generates connections between visitation policy formulation and equitable access to visitation in COVID-19 emergency intervention strategies for psychiatric patients and incarcerated individuals. Based on the research conducted for this study, this connection has not been directly cogitated in literature to date. Despite the limitations highlighted in this study, the relationship between the visitation policies of comparable facilities, psychiatric hospitals and federal penitentiaries, illustrated the inequitable access to visitation as a result of policies developed under COVID-19 emergency intervention strategies. The future of research in this area is hopeful in strengthening the relationship between health justice and institutionalization in Canada.

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Appendix A

Table A1

Ontario Psychiatric Hospitals Under Part XX.1/Mental Disorder of the Criminal Code

Designated Psychiatric Hospital under Part XX.1/Mental Disorder of the Criminal Code	Location of Facility	Type of Facility	# of Facility Beds	Visitation Status
Brockville Mental Health Centre – Member of the Royal Ottawa Health Care Group	Brockville, ON	Psychiatric hospital	161[1]	Closed (two-week closure)
Royal Ottawa Mental Health Centre – Member of the Royal Ottawa Health Care Group	Ottawa, ON	Psychiatric hospital	286[1]	Closed (two-week closure)
St. Joseph's Healthcare Hamilton: West 5th Campus	Hamilton, ON	Psychiatric unit	715[2]	Restricted
Providence Care Centre: Mental Health Services Site	Kingston, ON	Psychiatric unit	270[3]	Restricted
North Bay Regional Health Centre	North Bay, ON	Psychiatric unit	389[4]	Restricted
Waypoint Centre for Mental Health Care	Penetanguishene, ON	Psychiatric hospital	301[5]	Restricted
Southwest Centre for Forensic Mental Health Care, St. Joseph's Health Care London	St. Thomas, ON	Psychiatric hospital	89[6]	Restricted
Thunder Bay Regional Health Sciences Centre	Thunder Bay, ON	Psychiatric unit	375[7]	Restricted
Centre for Addiction and Mental Health	Toronto, ON	Psychiatric hospital	?[8]	Closed (opens June 30, 2021)
Ontario Shores Centre for Mental Health Sciences	Whitby, ON	Psychiatric hospital	329[9]	Closed (opens June 2, 2021)

[1] The Royal. (2020). *Vision, mission and values*. The Royal Mental Health: Care & Research. https://www.theroyal.ca/vision-mission-and-values
[2] St. Joseph's Healthcare Hamilton. (2013, February 1). *St. Joseph's healthcare Hamilton: An overview*. https://www.joinstjoes.ca/our-people-culture/who-we-are/vital-statistics.pdf
[3] Providence Care Hospital. (2020, January 3). *Providence care hospital*. Providence Care. https://providencecare.ca/providence-care-hospital/
[4] North Bay Regional Health Centre. (2021, May 13). *About us*. NBRHC. https://nbrhc.on.ca/about-nbrhc/
[5] Waypoint Centre for Mental Health Care. (2015). *About us*. https://www.waypointcentre.ca/about_us
[6] St. Joseph's Health Care London. (2020, August 31). *Mental health care: Forensic program*. https://www.sjhc.london.on.ca/areas-of-care/mental-health-care/mental-health-care-forensic-program
[7] Thunder Bay Regional Health Sciences Centre. (2021). *About*. https://tbrhsc.net/tbrhsc/
[8] No data found
[9] Ontario Shores Centre for Mental Health Sciences. (2019). *Strategic plan*. https://www.ontarioshores.ca/UserFiles/Servers/Server_6/File/PDFs/Strategic_Plan_2011.pdf

Table A2

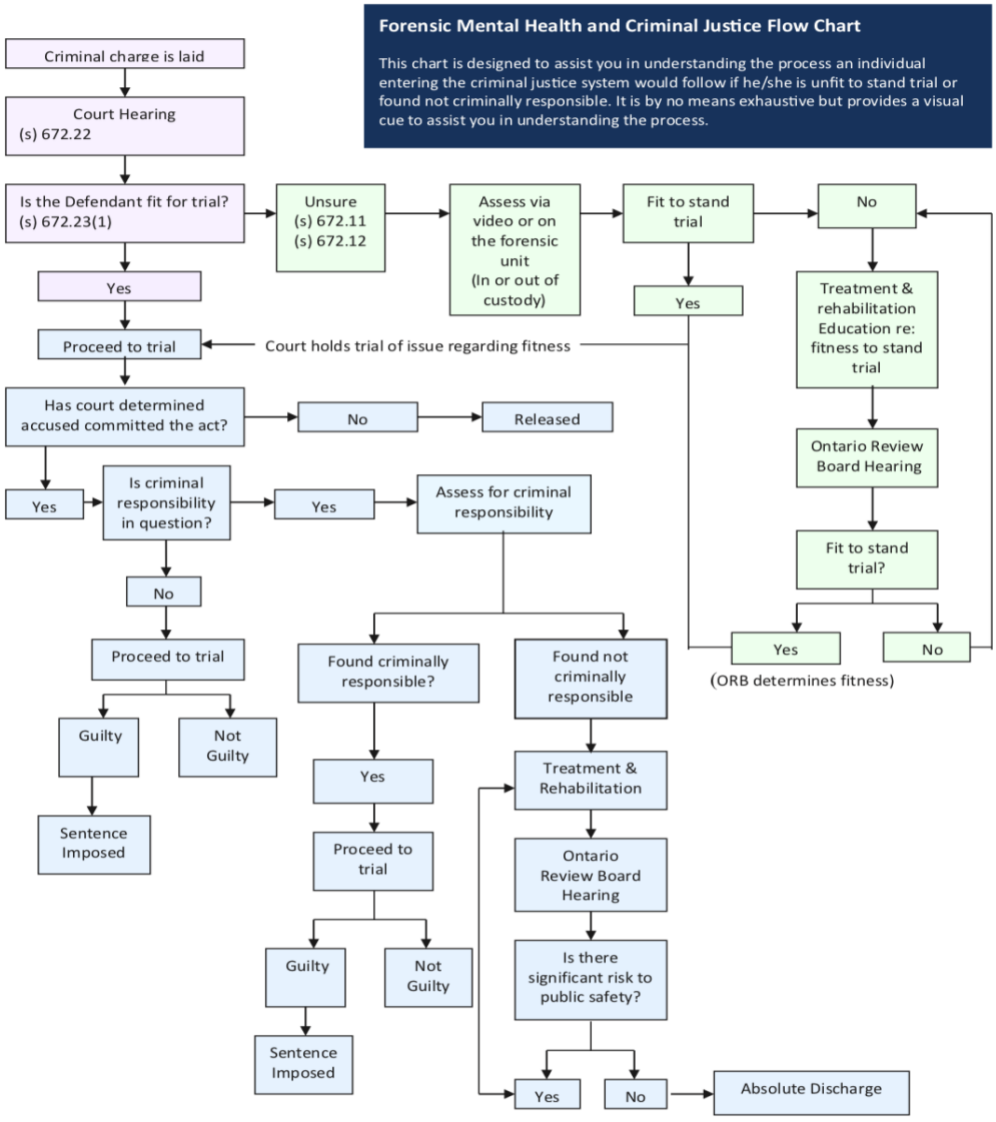
CSC Facilities in the Ontario Region

CSC Facilities	Location of Facility	Security Level of Facility	Facility Capacity	Visitation
Bath Institution	Bath, ON	Medium	516	Closed
Beaver Creek Institution	Gravenhurst, ON	Minimum/Medium	201/516	Closed
Collins Bay Institution	Kingston, ON	Minimum/Medium/Maximum	182/482/96	Closed
Grand Valley Institution for Women	Kitchener, ON	Minimum/Medium	215	Closed
Joyceville Institution	Kingston, ON	Minimum	752	Closed
Millhaven Institution	Bath, ON	Maximum	496	Closed
Warkworth Institution	Campbellford, ON	Medium	537	Closed

(Correctional Service Canada, 2021a).

Figure A1

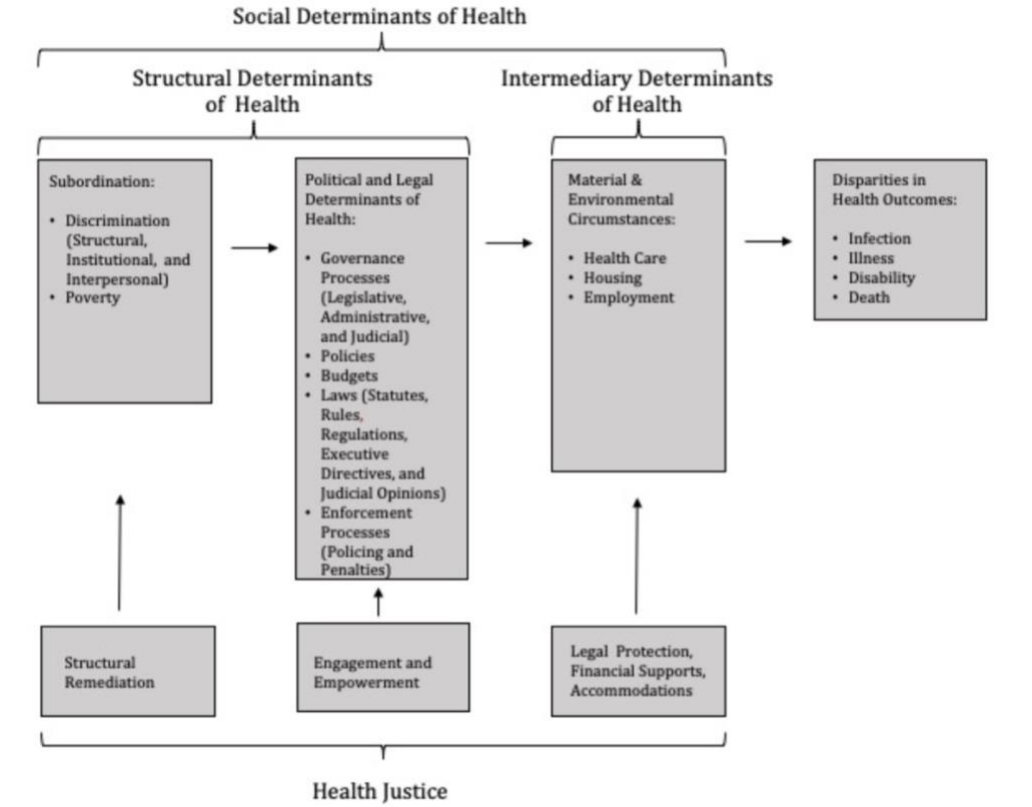
Forensic Mental Health and Criminal Legal Flow Chart



(Mental Health & the Law Service, 2017).

Figure A2

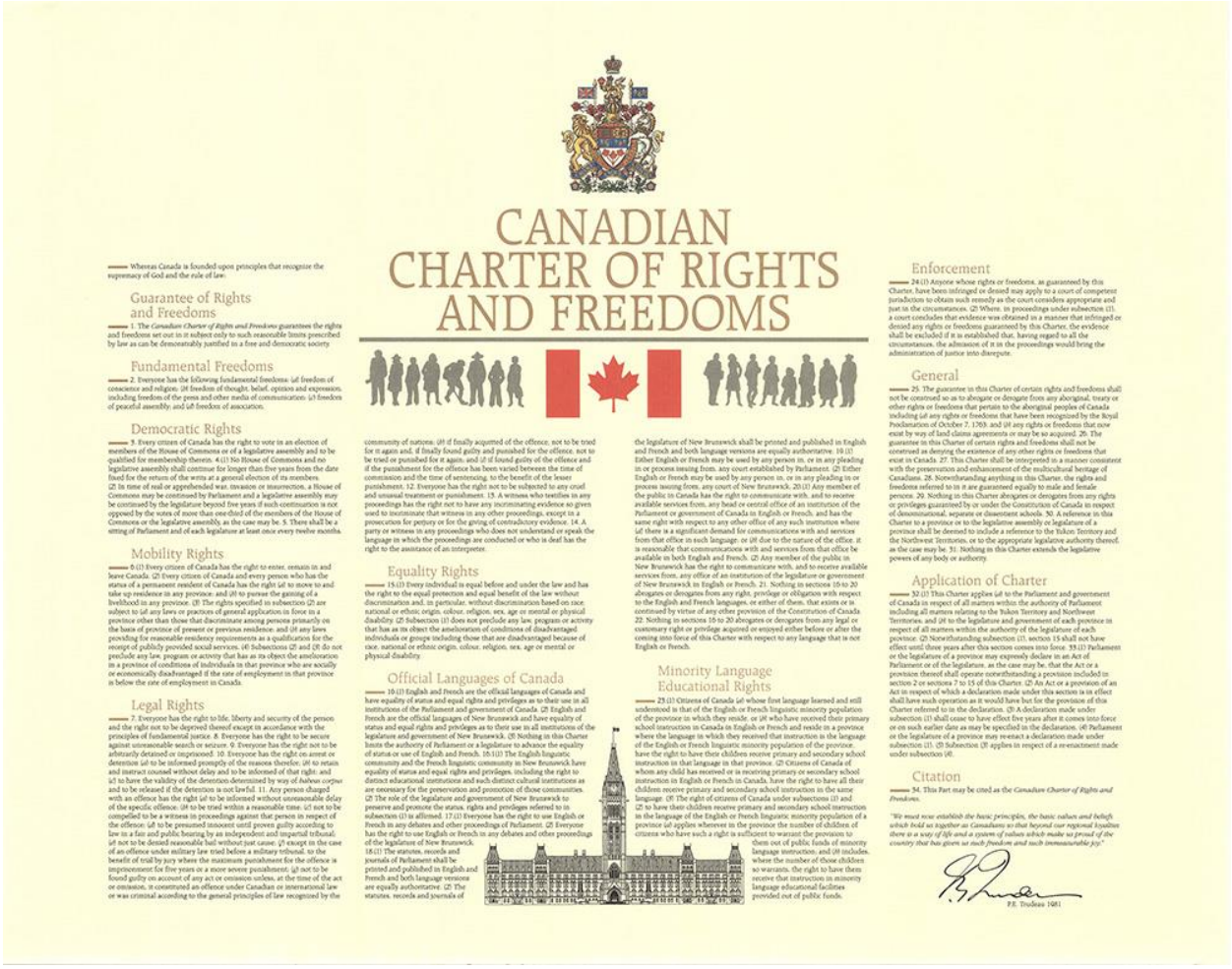
The Health Justice Framework



(Benfer, Mohapatra, Wiley & Yearby, 2020).

Figure A3

Canadian Charter of Rights and Freedoms



CANADIAN CHARTER OF RIGHTS AND FREEDOMS

Whereas Canada is founded upon principles that recognize the supremacy of God and the rule of law:

Guarantee of Rights and Freedoms

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society

Fundamental Freedoms

2. Everyone has the following fundamental freedoms: (a) freedom of conscience and religion; (b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication; (c) freedom of peaceful assembly; and (d) freedom of association.

Democratic Rights

3. Every citizen of Canada has the right to vote in an election of members of the House of Commons or of a legislative assembly and to be qualified for membership therein. 4.(1) No House of Commons and no legislative assembly shall continue for longer than five years from the date fixed for the return of the writs at a general election of its members. (2) In time of real or apprehended war, invasion or insurrection, a House of Commons may be continued by Parliament and a legislative assembly may be continued by the legislature beyond five years if such continuation is not opposed by the votes of more than one-third of the members of the House of Commons or the legislative assembly, as the case may be. 5. There shall be a sitting of Parliament and of each legislature at least once every twelve months.

Mobility Rights

6.(1) Every citizen of Canada has the right to enter, remain in and leave Canada. (2) Every citizen of Canada and every person who has the status of a permanent resident of Canada has the right (a) to move to and take up residence in any province; and (b) to pursue the gaining of a livelihood in any province. (3) The rights specified in subsection (2) are subject to (a) any laws or practices of general application in force in a province other than those that discriminate among persons primarily on the basis of province of present or previous residence; and (b) any laws providing for reasonable residency requirements as a qualification for the receipt of publicly provided social services. (4) Subsections (2) and (3) do not preclude any law, program or activity that has as its object the amelioration in a province of conditions of individuals in that province who are socially or economically disadvantaged if the rate of employment in that province is below the rate of employment in Canada.

Legal Rights

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. 8. Everyone has the right to be secure against unreasonable search or seizure. 9. Everyone has the right not to be arbitrarily detained or imprisoned. 10. Everyone has the right on arrest or detention (a) to be informed promptly of the reasons therefor; (b) to retain and instruct counsel without delay and to be informed of that right; and (c) to have the validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful. 11. Any person charged with an offence has the right (a) to be informed without unreasonable delay of the specific offence; (b) to be tried within a reasonable time; (c) not to be compelled to be a witness in proceedings against that person in respect of the offence; (d) to be presumed innocent until proven guilty according to law in a fair and public hearing by an independent and impartial tribunal; (e) not to be denied reasonable bail without just cause; (f) except in the case of an offence under military law tried before a military tribunal, to the benefit of trial by jury where the maximum punishment for the offence is imprisonment for five years or a more severe punishment; (g) not to be found guilty on account of any act or omission unless, at the time of the act or omission, it constituted an offence under Canadian or international law or was criminal according to the general principles of law recognized by the community of nations; (h) if finally acquitted of the offence, not to be tried for it again and, if finally found guilty and punished for the offence, not to be tried or punished for it again; and (i) if found guilty of the offence and if the punishment for the offence has been varied between the time of commission and the time of sentencing, to the benefit of the lesser punishment. 12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment. 13. A witness who testifies in any proceedings has the right not to have any incriminating evidence so given used to incriminate that witness in any other proceedings, except in a prosecution for perjury or for the giving of contradictory evidence. 14. A party or witness in any proceedings who does not understand or speak the language in which the proceedings are conducted or who is deaf has the right to the assistance of an interpreter.

Equality Rights

15.(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Official Languages of Canada

16.(1) English and French are the official languages of Canada and have equality of status and equal rights and privileges as to their use in all institutions of the Parliament and government of Canada. (2) English and French are the official languages of New Brunswick and have equality of status and equal rights and privileges as to their use in all institutions of the legislature and government of New Brunswick. (3) Nothing in this Charter limits the authority of Parliament or a legislature to advance the equality of status or use of English and French. 16.1(1) The English linguistic community and the French linguistic community in New Brunswick have equality of status and equal rights and privileges, including the right to distinct educational institutions and such distinct cultural institutions as are necessary for the preservation and promotion of those communities. (2) The role of the legislature and government of New Brunswick to preserve and promote the status, rights and privileges referred to in subsection (1) is affirmed. 17.(1) Everyone has the right to use English or French in any debates and other proceedings of Parliament. (2) Everyone has the right to use English or French in any debates and other proceedings of the legislature of New Brunswick. 18.(1) The statutes, records and journals of Parliament shall be printed and published in English and French and both language versions are equally authoritative. (2) The statutes, records and journals of the legislature of New Brunswick shall be printed and published in English and French and both language versions are equally authoritative. 19.(1) Either English or French may be used by any person in, or in any pleading in or process issuing from, any court established by Parliament. (2) Either English or French may be used by any person in, or in any pleading in or process issuing from, any court of New Brunswick. 20.(1) Any member of the public in Canada has the right to communicate with, and to receive available services from, any head or central office of an institution of the Parliament or government of Canada in English or French, and has the same right with respect to any other office of any such institution where (a) there is a significant demand for communications with and services from that office in such language; or (b) due to the nature of the office, it is reasonable that communications with and services from that office be available in both English and French. (2) Any member of the public in New Brunswick has the right to communicate with, and to receive available services from, any office of an institution of the legislature or government of New Brunswick in English or French. 21. Nothing in sections 16 to 20 abrogates or derogates from any right, privilege or obligation with respect to the English and French languages, or either of them, that exists or is continued by virtue of any other provision of the Constitution of Canada 22. Nothing in sections 16 to 20 abrogates or derogates from any legal or customary right or privilege acquired or enjoyed either before or after the coming into force of this Charter with respect to any language that is not English or French.

Minority Language Educational Rights

23.(1) Citizens of Canada (a) whose first language learned and still understood is that of the English or French linguistic minority population of the province in which they reside, or (b) who have received their primary school instruction in Canada in English or French and reside in a province where the language in which they received that instruction is the language of the English or French linguistic minority population of the province, have the right to have their children receive primary and secondary school instruction in that language in that province. (2) Citizens of Canada of whom any child has received or is receiving primary or secondary school instruction in English or French in Canada, have the right to have all their children receive primary and secondary school instruction in the same language. (3) The right of citizens of Canada under subsections (1) and (2) to have their children receive primary and secondary school instruction in the language of the English or French linguistic minority population of a province (a) applies wherever in the province the number of children of citizens who have such a right is sufficient to warrant the provision to them out of public funds of minority language instruction; and (b) includes, where the number of those children so warrants, the right to have them receive that instruction in minority language educational facilities provided out of public funds.

Enforcement

24.(1) Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances. (2) Where, in proceedings under subsection (1), a court concludes that evidence was obtained in a manner that infringed or denied any rights or freedoms guaranteed by this Charter, the evidence shall be excluded if it is established that, having regard to all the circumstances, the admission of it in the proceedings would bring the administration of justice into disrepute.

General

25. The guarantee in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada including (a) any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and (b) any rights or freedoms that now exist by way of land claims agreements or may be so acquired. 26. The guarantee in this Charter of certain rights and freedoms shall not be construed as denying the existence of any other rights or freedoms that exist in Canada. 27. This Charter shall be interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canadians. 28. Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons. 29. Nothing in this Charter abrogates or derogates from any rights or privileges guaranteed by or under the Constitution of Canada in respect of denominational, separate or dissentient schools. 30. A reference in this Charter to a province or to the legislative assembly or legislature of a province shall be deemed to include a reference to the Yukon Territory and the Northwest Territories, or to the appropriate legislative authority thereof, as the case may be. 31. Nothing in this Charter extends the legislative powers of any body or authority.

Application of Charter

32.(1) This Charter applies (a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and (b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province. (2) Notwithstanding subsection (1), section 15 shall not have effect until three years after this section comes into force. 33.(1) Parliament or the legislature of a province may expressly declare in an Act of Parliament or of the legislature, as the case may be, that the Act or a provision thereof shall operate notwithstanding a provision included in section 2 or sections 7 to 15 of this Charter. (2) An Act or a provision of an Act in respect of which a declaration made under this section is in effect shall have such operation as it would have but for the provision of this Charter referred to in the declaration. (3) A declaration made under subsection (1) shall cease to have effect five years after it comes into force or on such earlier date as may be specified in the declaration. (4) Parliament or the legislature of a province may reenact a declaration made under subsection (3). (5) Subsection (3) applies in respect of a reenactment made under subsection (4).

Citation

34. This Part may be cited as the *Canadian Charter of Rights and Freedoms*.

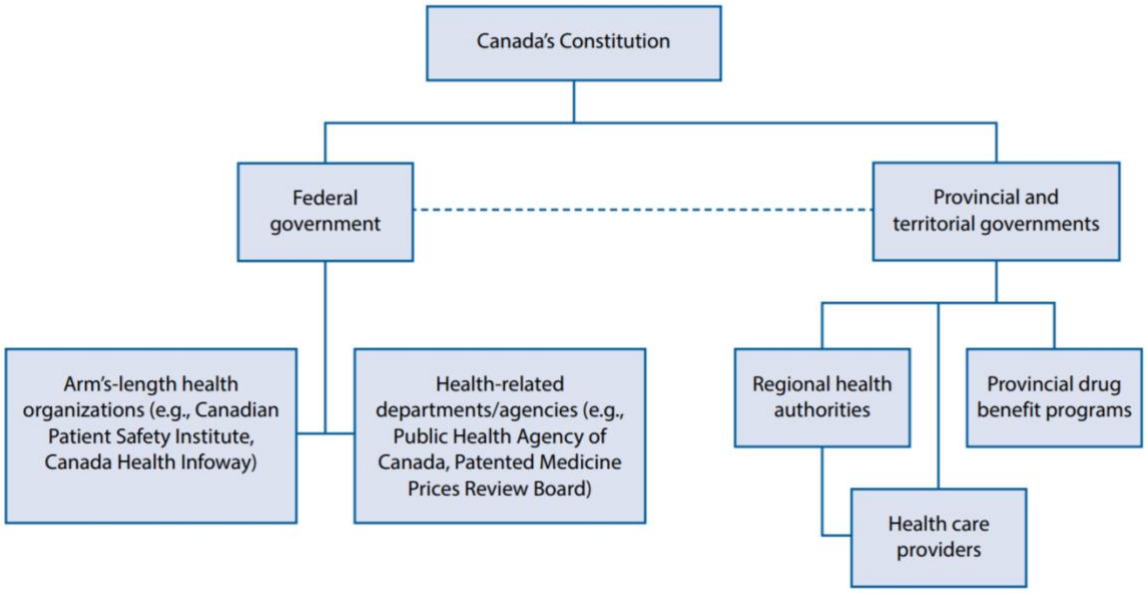
"We must now establish the basic principles, the basic values and beliefs which hold us together as Canadians so that beyond our regional loyalties there is a way of life and a system of values which make us proud of the country that has given us such freedom and such immeasurable joy."

P.E. Trudeau 1981

(*Charter*, 1982).

Figure A4

Basic Structure of Canada's Healthcare System



(Hardcastle, 2019, p. 7).

Table A3

Tone Criteria Checklist

Tone	Criteria 1	Yes/No	Criteria 2	Yes/No
Formal	Must meet a maximum of 5/10 theme criteria outlined in Thematic 3 I's Chart (Table A6)		At least two thematic criteria from the institutional influences section OR one thematic criterion from the institutional influences section with all thematic criteria from the ideas section satisfied	
Informal	Must meet 5 (or less) of the 10 thematic criteria outlined in Thematic 3 I's Chart (Table A6)		Only one thematic criterion from the institutional influences section	
Cooperative	Must meet at least 6/10 theme criteria outlined in Thematic 3 I's Chart (Table A6)		At least 1 theme from each section (institution, interests, ideas) OR fully satisfy two thematic criteria sections in Thematic 3 I's Chart (Table A6)	

Table A4

Visitor Policy Accessibility

Facility (name/type)	Website URL Homepage	Clicks from Homepage	Click 1	Click 2	Click 3	Click 4	Click 5
Brockville Mental Health Centre	https://www.theroyal.ca	4	Select "Patient Care & Information"	From the drop-down menu at the top of the page under the subheading "COMING TO THE ROYAL"	Select "Visiting Hours and Parking" from the menu	Then select the link titled, "COVID information page" under the visiting hours subheading for visitor information	
Royal Ottawa Mental Health Centre	https://www.theroyal.ca	4	Select "Patient Care & Information"	From the drop-down menu at the top of the page under the subheading "COMING TO THE ROYAL"	Select "Visiting Hours and Parking" from the menu	Then select the link titled, "COVID information page" under the visiting hours subheading for visitor information	
St. Joseph's Healthcare Hamilton	https://www.stjoes.ca	5	Select "Patients & Visitors"	Scroll down to the page and click the left-hand sidebar under "COVID-19" that states "Info for Patients and Visitors"	Scroll down and click the "Visitor Info" icon halfway down the middle of the page	From the drop-down menu, select "Visitor Policy"	Click the link to the latest visitor policies for the facility
Providence Care Centre: Mental Health Services Site	https://providencecare.ca	2	Click the link from the pop-up message that states, "Click here for information about visiting the hospital"	Then click "Guidelines for Designated Visitors"			
North Bay Regional Health Centre	https://nbrhc.on.ca	2	Select from the menu "Patients & Visitors"	From the drop-down menu under the "Visiting Us" subheading, click "Visitor Information"			

Waypoint Centre for Mental Health Care	https://www.waypointcentre.ca	2	Select "Patients & Families" from the menu bar at the top of the home page	From the drop-down menu, click "Visiting a patient"			
Southwest Centre for Forensic Mental Health Care	https://www.sjhc.london.on.ca/patients-and-visitors/our-locations/southwest-centre-forensic-mental-health-care	2	Click on the link at the top of the page in a highlighted box that states "COVID-19 information"	From the left-hand menu on the side of the page under "COVID-19 pandemic information for patients, families and visitors," the reader can click the subheading "Essential (designated) caregiver presence and general visiting" to be directed to additional visitation information			
Thunder Bay Regional Health Sciences Centre	https://tbrhsc.net	2	From the home page, scroll midway down the page and click "COVID-19 Updates: Keeping you Safe"	From the four highlighted options on this new page, select the fourth option: "Information for Patients, Essential Care Partners and Care Partners During COVID-19 Pandemic"			
Centre for Addiction and Mental Health	https://www.camh.ca/	1	Click the link in the yellow warning notification bar at the top of the homepage titled "COVID-19 Pandemic: Important information for patients and visitors of CAMH" with the link "Read more"				
Ontario Shores Centre for Mental Health Sciences	https://www.ontarioshores.ca	3	Click "Patients & Families" from the menu bar on the homepage	Then click "Information for Visitors"	From the highlighted box at the top of the page titled "COVID-19 Update," click the link "Coronavirus Screening Practices at our		

					Entrances and updates for visitors"		
CSC Facilities Note: All CSC institutions in Canada follow these visitation policies; however, Ontario region CSC facilities will be the focus of this research. Bath Institution, Beaver Creek Institution, Collins Bay Institution, Grand Valley Institution for Women, Joyceville Institution, Millhaven Institution, Warkworth Institution	https://www.csc-scc.gc.ca	5	Select English as the language of choice	Then scroll midway down the page to find the subheading "Services and Information," under this subheading, select the link "Information for friends and families of offenders"	From the blue highlighted box at the top of the page, click "Find out if an institution is open for visits and plan your visit"	Scroll down the page to the subheading "Planning your visit," this provides detailed bullet points regarding all requirements for visitation	For facility specific information select the second bulleted link titled "Find out if a facility is currently accepting visitors"

Table A5

3 I's Chart – Data effective of June 1st, 2021 (3rd wave lockdown)

Designated Psychiatric Hospital under Part XX.1/Mental Disorder of the Criminal Code	Institutions (organizational policies, government, institutional influence shaping the policy)	Interests (person or group of people that have something invested in the policy)	Ideas (values or facts to inform the policy)	Policy Tone
Brockville Mental Health Centre	**Ministry of Health policies shape facility policy response.** The facility follows the guidance of province-wide lockdown measures and public health information and closures[10]. The policy cites the increasing rates of infection within the province, demonstrating influence from province emergency orders that focus on case management[10].	Patients with mental health concerns in the facility have been deemed a priority by the facility. The mental health of patients is references in accordance with the positive impact of social supports. The policy considers the interests of facility safety in accordance with provincial emergency intervention strategies over all other considerations.	Addresses the therapeutic value and importance of visitation for patients within the facility. However, the policy is heavily influenced by directives of the provincial government which are grounded in scientific evidence surrounding infectious disease. The increasing rates of infection within the province are referenced within the policy as an influencing factor in the policy's structure and implementation.	Formal – the policy addresses the well-being of patients yet remains rigid in following the guidelines of the provincial lockdown by not allowing visitors into the facility.
Royal Ottawa Mental Health Centre	**Ministry of Health policies shape facility policy response.** The facility follows the guidance of province-wide lockdown measures and public health information and closures[10]. The policy cites the increasing rates of infection within the province, demonstrating influence from province emergency orders that focus on case management[10].This policy is following the emergency intervention strategies of the province directly influencing the policy decisions.	Patients with mental health concerns in the facility have been deemed a priority by the facility. The mental health of patients is references in accordance with the positive impact of social supports. The policy considers the interests of facility safety in accordance with provincial emergency intervention strategies over all other considerations.	Addresses the therapeutic value and importance of visitation for patients within the facility. However, the policy is heavily influenced by directives of the provincial government. The increasing rates of infection within the province are referenced within the policy as an influencing factor in the policy's structure and implementation.	Formal – the policy addresses the well-being of patients yet remains rigid in following the guidelines of the provincial lockdown by not allowing visitors into the facility.

[10] (CIHI, 2021)

St. Joseph's Healthcare Hamilton	**Departments use evidence and contextual factors to shape department-specific policies.** Visitors are restricted within the hospital; however, visitation differs based on department. The visitation in the psychiatric department is at the discretion of the unit manager. Direction for this policy taken from consideration of social support research and public health guidelines; however, no direct mention of governmental (federal, provincial, or municipal) policies influence.	The policy reflects the interests of patients within the facility. Patients' physical, emotional, and mental well-being are considered and protected within the policy. The policy is structures around protecting the interests of facility stakeholders by outlining direct guidelines for visitation in regard to each department.	Policy considers the critical roles that caregivers/support people and visitors provide patients and for the overall health of patients in the facility. The policy presents the notions of facility health and safety, as well as all individuals within the facility. The importance of visitation is carried through in their protocol to have virtual visits with patients and loved ones.	Cooperative – the policy is detailed in nature and relies on the directives of public health while comprehensive in its targeted objectives.
Providence Care Centre: Mental Health Services Site	**Ministry of Health policies shape facility policy response.** The facility's policy on visitation references the providence-wide shut down. This shutdown is in alignment with the governmental directives during the province wide shut down[10].	The policy supports the interests of patients within the facility with a focus on mental and emotional well-being associated with visitation. The policy title, "Family presence & visitor restrictions at Providence Care sites." expresses the consideration of social support presence for individuals within the facility.	The policy supports the mental well-being of patients by emphasizing the benefits of visitation. Visitors are prioritized by type to ensure a focus on rehabilitation with designated visitors for social, care, and essential purposes. This policy focus on rehabilitation illustrates the facility's projected values of patient support and growth.	Cooperative – this policy considers the Ministry of Health policies while considering the needs of patients within the facility.
North Bay Regional Health Centre	**Ministry of Health policies shape facility policy response.** This facility's policy cites the potential for change in policy depending on internal and external factors relating to COVID-19 activity within the community and health care settings. The policy takes influence from government directives on physical distancing[10].	The policy reflects the interests of the facility itself and the stakeholders responsible for the facility. It directs attention towards the safety of the facility as an entity when referring to visitation of COVID positive patients.	The policy does not explicitly reflect identifiable values as there is no mention of benefits of visitors or overall mental well-being of patients experiencing the lockdown within the facility. Given that the policy is aligned with provincial directives, it is mainly influenced by scientific evidence surrounding infectious disease	Informal – this policy is inconsistent in the delivery of information, offering limited flexibility and adaptability in the policy's framework.

Waypoint Centre for Mental Health Care	**Ministry of Health policies shape facility policy response.** **Regional government policy responses inform organizational policy.** The facility made the policy decision to restrict visitors due to provincial lockdown, it addresses the importance of consistency with regional partners on visitor policy. This demonstrates the influence of the regional governments on the outcome of the policies at this facility.	Considers the patient's mental health within the facility. Furthermore, consistency and equity across the region is cited within the policy, with regard to health partners and their visitation policies. This demonstrates a political interest in consistency among governed provincial facilities. As an independent facility, the policy attempts to set out guidelines for facility protocol following other regional partners.	Policy highlights the notion of visitation as a part of patient mental health recovery. The policy clearly outlines the opportunity for video visitation and deliveries for patients to improve their mental health status and overall well-being. Furthermore, the policy recognizes exceptions to visitor restrictions on compassionate grounds such as palliative or end of life circumstances.	Cooperative – this policy functions within the bounds of the Ministry of Health and other regional partners while considering the patient's mental health in accordance with access to social support networks.
Southwest Centre for Forensic Mental Health Care	**Ministry of Health policies shape facility policy response.** The facility aligns with government directives for emergency lockdown and reopening plan, emergency intervention strategies of the province[10].	Interests of patients are limited in scope within the policy. The interests reside in the government and stakeholders of the facility as they promote the governmental colour-coded framework for COVID-19 response.	The policy expresses the facility's commitment to the patient's mental health and well-being within the facility. Value is placed on the government's response framework and remaining true to these provincial policies.	Formal – this policy considers in-depth protocol and practice measures and providing a detailed emergency framework yet lacking consideration of interest's parties beyond the facility as an institution.
Thunder Bay Regional Health Sciences Centre	**Ministry of Health policies shape facility policy response.** The facility references personal protective equipment (PPE), physical distancing practices, public health information, and case management are addressed within the policy, in reference to provincial emergency interventions[10].	The interests expressed through this policy are of patients, visitors, and staff alike. The policy focuses on guides for patients and essential care partners to address the processes of visitation and education of COVID-19 risk.	The ideas of the facility are evident in the detailed visitation policy. The policy offers educational resources for visitors, including PPE application and risks associated with being a care partner in the facility. Furthermore, it offers options for virtual visits via FaceTime and Skype.	Informal – policy details interventions that contribute to protecting health and safety, however restricted in institutional influences beyond the scope of basic policy development.

Centre for Addiction and Mental Health(CAMH)	**Ministry of Health policies and local public health guidelines shape facility policy response.** The facility implemented facility specific policies regarding visitation protocol with donning PPE and active screening. These protocols consider public health information and guidelines that are provincial emergency interventions[10]. Furthermore, CAMH addresses the direction of policy from the municipal government and public health department of Toronto.	Interests stem from the facility itself. The policy has an overarching tone of hostility which discussing visitation. The detailed policy lacks the interest considerations of patients within the facility, their mental health and well-being, or the benefit of social supports associated with visitation.	The policy considers visitation as the mere act of visiting. No discussion of mental health benefits or institutional values. It highlights aspects such as deliveries and permissions of certain groups of visitors however does not provide institutional ideas and value sets as basis of policy.	Formal – policy takes directives from Ministry of Health and local Toronto public health guidelines yet lack the appropriate consideration of parties beyond the facility itself.
Ontario Shores Centre for Mental Health Sciences	**Ministry of Health intervention strategies shape the facility policy response.** The facility is influenced by the policies presented by the province. The policy states screening practices, PPE, social distancing practices, and case management protocol[10].	The policy is structures on the notion of facility safety. The interests of the facility are brought forth in this policy as it highlights the importance of the "safest environment possible." Furthermore, the policy states that these detailed practices are to ensure visitors, patients, and staff safe.	Visitation is limited to an hour length visit with a patient in the facility. Furthermore, according to the policy each patient is restricted to one visitor every other week with the exception of essential visitors. The policy makes a designation of essential visitors.	Informal – the policy lacks strong institutional influence and fails to address the interests of parties impacted by the policy.

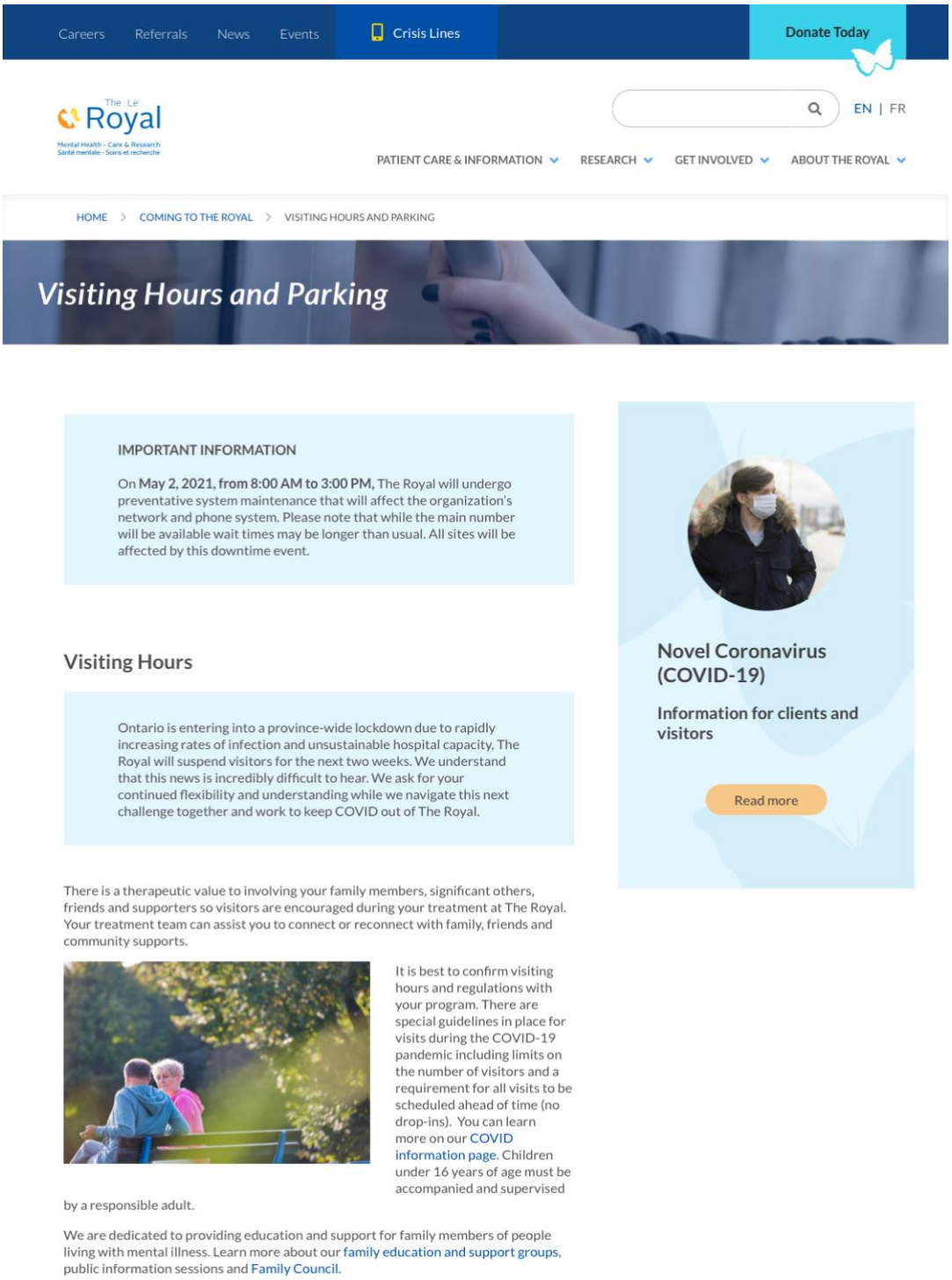
Table A6

Thematic 3 I's Chart

3 I's framework	Factors affecting policy choice	Description of how factor influences the policy decision	Brockville Mental Health Centre	Royal Ottawa Mental Health Centre	St. Joseph's Healthcare Hamilton	Providence Care Centre	North Bay Regional Health Centre	Waypoint Centre for Mental Health Care	Southwest Centre for Forensic Mental Health Care	Thunder Bay Regional Health Sciences Centre	Centre for Addiction and Mental Health	Ontario Shores Centre for Mental Health Sciences	CSC	# of policies addressing factor
Institutions	Province-wide lockdown	Province-wide lockdown in accordance with the Ontario government's province-wide lockdown.	●	●		●		●					●	5
	Emergency intervention strategies	Vaccines, case finding and management (eg/ screening), openings and closures, physical distancing, health workforce capacity, health services, travel restrictions, public information (eg/ personal protective equipment) (CIHI, 2020).	●	●	●	●	●	●	●	●	●	●	●	11
	Regional Partners Continuity	Directives of regional partners to produce facility continuity and equity across the healthcare field regarding visitation policies.						●			●			2
Interests	Patients within the facility	Consideration of the interests of the patient's mental health, well-being, and safety in the visitation policy.	●	●	●	●		●	●					6
	Vulnerable patients within the facility	Recognize difference of interests between patients and vulnerable patients within the facility (eg/ living with a developmental or intellectual disability or end of life event).			●	●	●	●						4
	Facility	The interests of the facility. For example, interests of sustainable hospital capacity or ensuring hospital safety with regard to visitation policy directives.	●	●	●			●				●	●	6
	Staff	Visitation policy considering the interests of staff.					●	●			●			3
Ideas	Therapeutic value of visitation	Facility's ideas and presented value set evident in visitation policy via the consideration of the therapeutic value associated with visitation and social support it offers patients institutionalized.	●	●	●	●			●					5
	Restricted visitation hours/days	The facility's ideas of visitation within the policy are presented in restricted hours/day of visitation. The facility emphasis of support networks is addressed via the outlined hours/days of visitation, as opposed to the closure of visiting days/hours fully.			●	●	●		●			●		5
	Alternatives to in-person visitation	The facility's ideas present in the visitation policy in deliberating other forms of visitation, other than in-person, such as virtual visitation or other technology-based alternatives.			●		●		●	●				4

Appendix B

The Royal Ottawa Health Care Group (Brockville Mental Health Centre & Royal Ottawa Mental Health Centre)



If you have a fever, cough, runny nose, sore throat, rash, vomiting, diarrhea or any other sign of a communicable disease, we ask that you not visit The Royal until you have been symptom free for at least 48 hours.

Parking

Ottawa

- Pay parking is at the main entrance, lower visitors parking lot and along the ring road that circles the campus at 1145 Carling Avenue.
- The daily parking rate is $3.25 for a half hour with a maximum daily rate of $13.25. Parking passes are available from the Cashier's Office or the Volunteer Café, located in the Winter Garden (Atrium area) on the second floor. Packs of 5-visit or 16-visit passes ($26 or $84.35 at the time of printing) are also available. The Cashier's Office is open Monday to Friday from 9 -11:30 a.m. and the Volunteer Café from 11:30 a.m. to 4:00 p.m.
- For longer-term inpatient parking, please speak with your treatment team, who will contact the parking department on your behalf.
- Geriatric client pick up and drop off: 2 spots at main entrance. 15 minute time limit.
- Client pick-up and drop-off: 2 spots at main entrance. 15 minute time limit.
- Accessible parking: 8 spots available at main entrance. These are part of the pay parking.

Brockville

- Parking at the Brockville Mental Health Centre is free and available throughout the campus.

St. Joseph's Healthcare Hamilton: West 5th Campus

- ▷ Support Services
  - ▷ Library Services
  - ▷ Redevelopment
  - ▷ Infection Prevention & Control
    - ▷ Update on COVID-19
  - ▷ Hospital Security
  - ▷ Emergency Preparedness
- ▷ Patient Relations
- ▷ Patient, Family, & Community Engagement
  - ▷ Resources
  - ▷ How to Get Involved
  - ▷ Becoming a Patient and Family Advisor
  - ▷ Patient and Family Advisor Structure
  - ▷ Families Matter
  - ▷ Accomplishments
- ▷ Privacy & Information Security
  - ▷ Privacy at St. Joe's
- ▷ Patient Education
  - ▷ A - E
  - ▷ F - J
  - ▷ K - O
  - ▷ P - T
  - ▷ U - Z

Pages visited today

What you need to know before coming to the hospital
Visitor Information
Information for patients and visitors
Patients & Visitors
Home

Quick Help

Maps and Directions

Contact

Charlton Campus
King Campus
West 5th Campus

Limited exceptions exist for allowing more or additional visitors to inpatient areas, including:

- Compassionate grounds for palliative patients
- Patients in labour: One support person is permitted.
- Patients staying overnight with a newborn on the Mother Baby Unit: One support person is permitted.
- Parents or caregiver of babies admitted to the Special Care Nursery: One parent or caregiver is permitted at a time.
- Other special needs as determined by the care team

One Caregiver/Support Person allowed to accompany patients in the Emergency Department, Psychiatric Emergency Service and Urgent Care Centre

Caregivers and Support Persons are essential partners in care and play a critical role in providing physical, emotional, and occasionally translation support to a family member, partner, friend or neighbour in need.

With the higher volumes of patients presenting to our Emergency Department and Urgent Care Centre, caregiver/support person presence will continue to be limited to prevent community spread of infection and to support the requirements for physical distancing.

Virtual visits

We encourage to continue **virtual visits**. We understand that some people do not feel safe coming to the hospital, and these are good alternatives. This is another good option for those who are not listed as one of the two visitors on the patient's list.

Questions or concerns

Where can visiting take place? For the Charlton Campus, we encourage visiting to take place in the patient's room. For the West 5th Campus, this will be left up to the discretion of the unit manager.

Can caregiver/support person move around the hospital OR go outside of the hospital? We are asking you to limit moving throughout the hospital as much as possible. The intent is to have the caregiver/support person go directly to visit the patient, and leave the hospital after the visit.

How long can visitors stay? This will be determined in partnership with the healthcare team.

Who can I contact if I have questions or concerns about the visitor policy? Please speak with the manager of the unit and if you have additional questions, please contact Patient Relations at 905-522-1155 ext. 33838 or by email at **PatientRelations@stjoes.ca**. (Visiting hours are between 9 a.m. – 9 p.m.)

For more information, click here.

Our hospital is safe. However, it is your responsibility when you are in the hospital to help keep it safe.

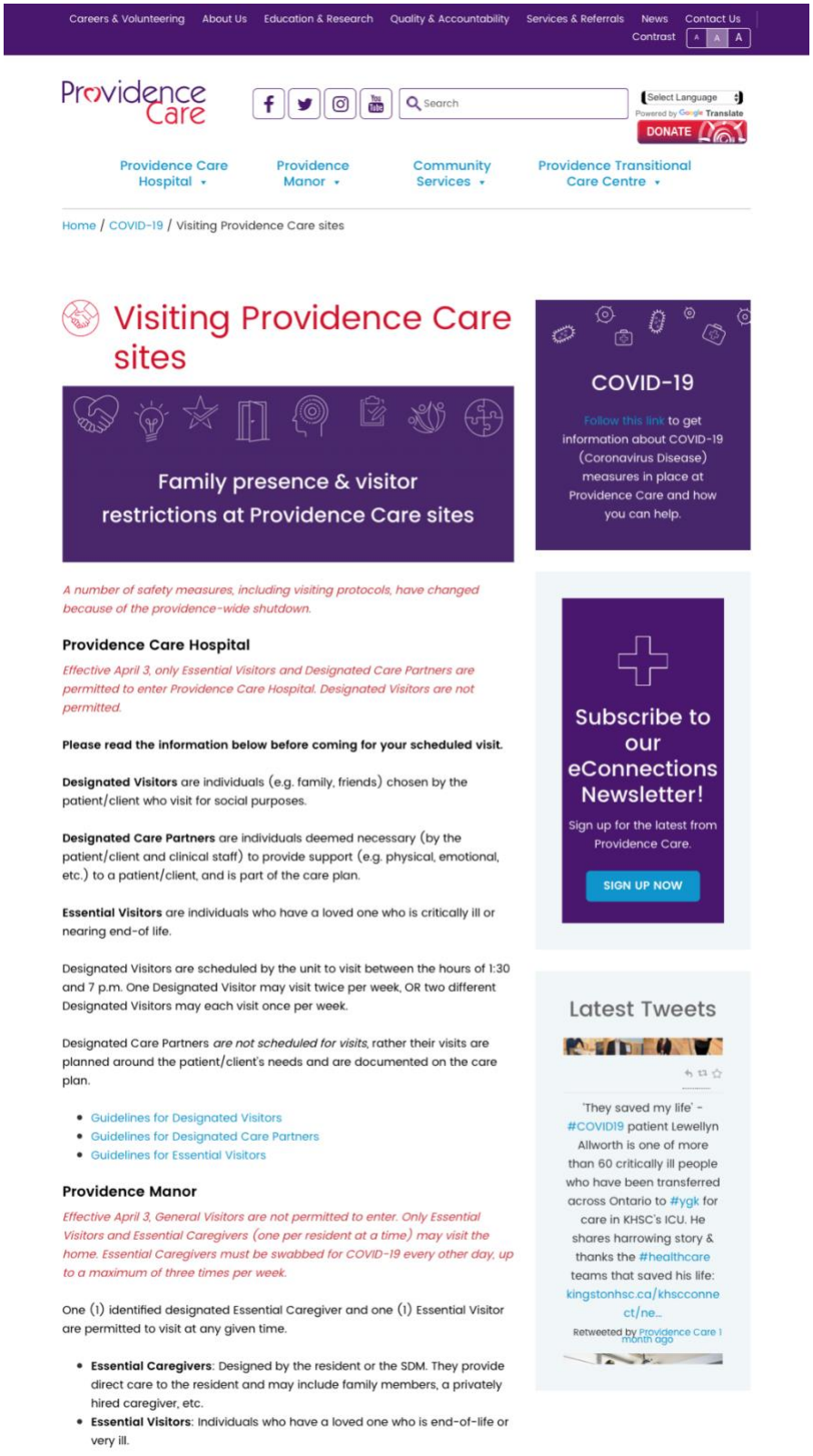
- All visitors must be screened before entering the hospital. (Go to **sjhhscreening.com** to use your phone and get through screening faster)
- Visitors must use designated entrances (Go to **stjoes.ca/coronavirus** for location of designated entrances)
- **Hospital visitors will be asked to wear the blue surgical masks provided for them when they enter the hospital**, and will no longer be allowed to wear cloth masks. This will ensure alignment and universality of wearing a three-layer mask.
- Please practice good hand hygiene when entering and leaving the hospital and entering and leaving the hospital unit.
- Please practice physical distancing in all public areas.

Click here for frequently asked questions.

If you have any questions about visiting your loved one, please contact your care team.

For more information about St. Joseph's Healthcare Hamilton's services during the pandemic, please visit stjoes.ca/coronavirus.

Providence Care Centre: Mental Health Services Site



Essential Caregivers and Essential Visitors will be screened upon arrival.

Please read the Visiting Guidelines carefully for NEW information regarding Outdoor Visits for General Visitors.

All Essential Caregivers and Essential Visitors must wear a mask and eye protection for the duration of their visit. This includes when you are inside your loved one's room. Do NOT remove your mask to eat or drink.

Please answer our screening questions truthfully. If you do not pass screening, your visit will be postponed.

Community Services

Effective April 3, teams are modifying services to ensure client safety and alignment with government directives during the provincial shutdown.

All clients and visitors are asked to bring a mask/face covering to wear at any Providence Care Community Services location. If you don't have a face covering of your own, you will be provided a mask to use. Masks/face coverings must be worn for the duration of your visit. Do NOT remove your mask to eat or drink.

All clients/visitors will be screened before they are allowed to enter a Community Services site. You must pass screening. All clients/visitors must also sign in during screening and provide their name, as well as a contact number.

Clients receiving services in their homes or areas outside of Providence Care facilities are strongly encouraged to wear a mask when receiving care.

Click here to learn more about protective measures in place at our Community Services locations.

Sharing is caring!

Share Tweet Pin Share Mail Share

Providence Care
more than healthcare

Providence Care Hospital
752 King St. West
Kingston, ON K7L 4X3

Providence Manor
275 Sydenham St.
Kingston ON, K7K 1G7

Providence Transitional Care Centre
340 Union St. Kingston,
ON K7L 4E6

Community Locations

STAFF LINKS:

Clinical Tools

Staff Webmail

KnowledgeNow

Staff Intranet

Board Portal

Employee Self Service

Employee & Family Assistance Program

Sponsor Foundation

Founder Funder

Partners

Privacy Statement | Access to Information | Terms of Use | Accessibility Plan | Sitemap

TOP

North Bay Regional Health Centre

NBRHC | Accountability | Foundation | Strategic Plan

North Bay Regional Health Centre / Centre régional de santé de North Bay

Français | Search | Donate Now | Our Hospital 50/50

Home | About Us | Patients & Visitors | Join Our Team | Programs & Services | Contact Us

Home » Patients & Visitors » Visiting Us » Visitor Information

- Care Providers
- Patient Information
- Staying With Us
- Visiting Us
  - Accessibility
  - Amenities & Services
  - COVID-19 (Coronavirus)
  - Directions
  - NBRHC is Tobacco-Free
  - North Bay Regional Pharmacy
  - Parking
  - Visitor Information
  - What to Expect in Emergency

Visitor Information

Limited entry in place

As we continue to monitor the COVID-19 activity in our community, we are asking for your help to ensure we can continue to safely support Care Partner visits at NBRHC.

Care partner access is subject to change based on a number of internal and external factors including COVID-19 activity in the community and Health Centre and the individual patient's progression of care.

Please note that for the safety of everyone, **in-person visits are not allowed for COVID-19 suspected or positive patients.** In these cases, the unit will help accommodate virtual visits using technology such as iPads.

More Information:

- Contact Us
- Directions
- Parking
- Floor Plan

To continue to reduce the risk of COVID-19 transmission and protect our most vulnerable people, NBRHC visitor restrictions are still in place at all its sites. We are now moving to a +1 for inpatients—this direction is based on availability of space to allow for physical distance.

Each inpatient may have one dedicated care partner (plus a designated alternate) for the patient's length of stay between the hours of 11 a.m. and 1 p.m. or 5 and 8 p.m. (only one entry and one exit each day)

Children could be a dedicated care partner. A care partner who is a child (a young caregiver, defined as children and youth as young as 8 years old) has to be accompanied by one parent, guardian or family member.

Two dedicated visitors are allowed in the building at one time to provide end-of-life support to a patient. These visitors are also not restricted to the two-hour limit and could be different people each day. Everyone must be able to appropriately physically distance.

PREVIOUS RESTRICTIVE ENTRY IS STILL IN PLACE IN OUTPATIENT AREAS (Emergency Department, Outpatient Clinics).

Up to one person may remain with an inpatient or outpatient at all times and is not restricted to the two-hour time limit if they are:

- support for a vulnerable patient (under the age of 18, cognitive impairment, significant developmental and/or intellectual disability, unable to effectively communicate)
- support for a patient experiencing a life altering event (end of life, critically ill, trauma)

We appreciate the community's cooperation with this direction and recognize that it is difficult not to visit with friends and family—these are necessary steps for the safety and protection of our patients, staff and physicians.

To learn more about the restrictive entry, please visit our COVID-19 page.

Accommodations with Hospital Preferred Rates

For a complete list please click here.

North Bay

50 College Drive,
P.O. Box 2500
North Bay, ON
P1B 5A4
Tel: 705-474-8600

Sudbury

680 Kirkwood Drive,
Sudbury, ON
P3E 1X3
Tel: 705-675-9193
Fax: 705-675-6817

Floor Plans

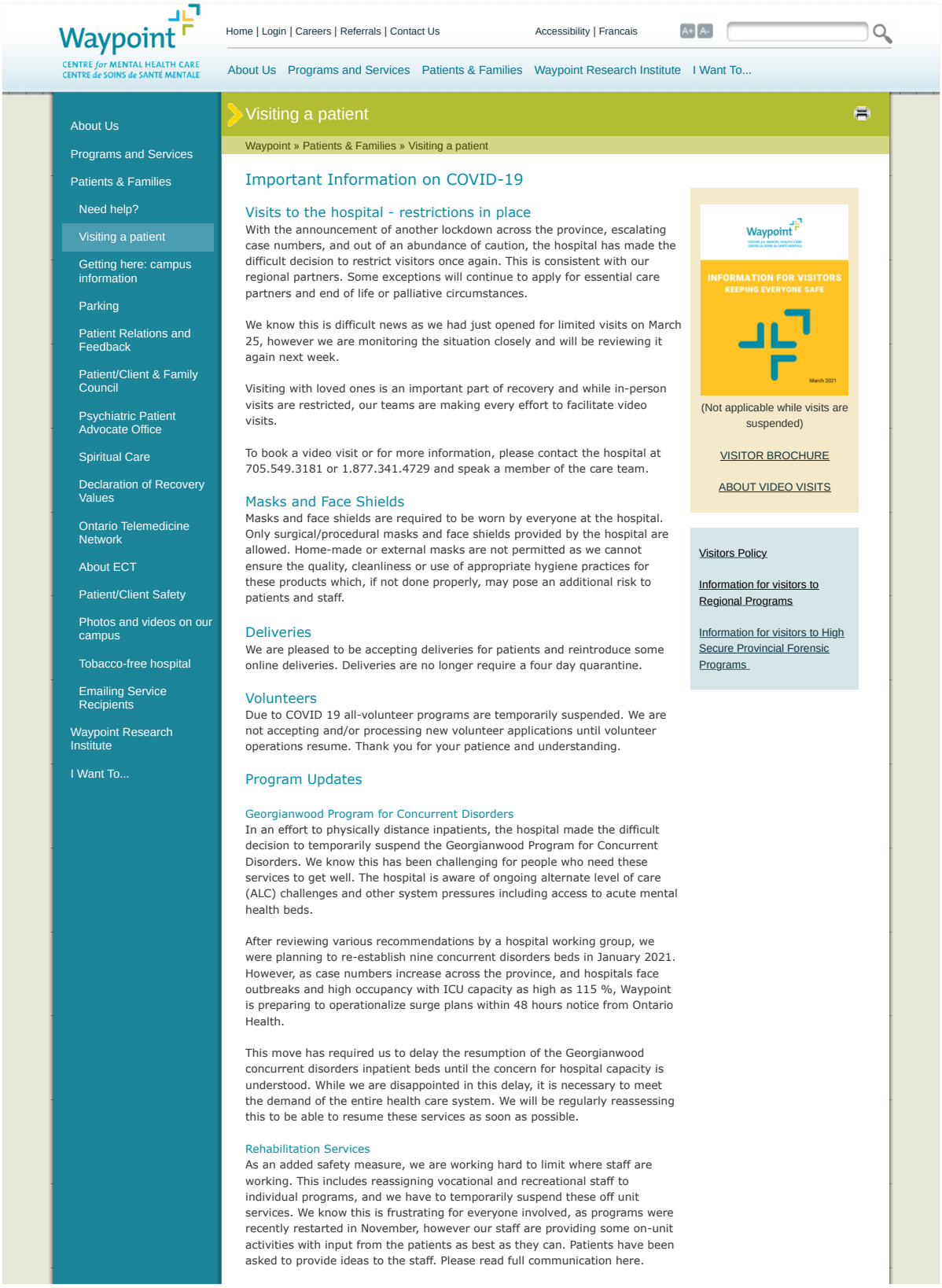
Let us guide you to where you need to go.

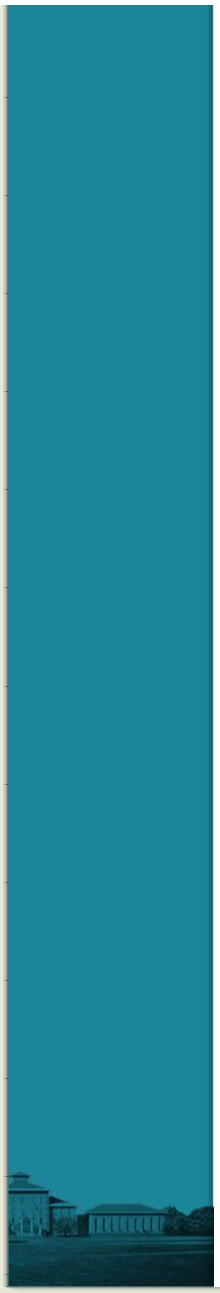
Visitors Guide

NBRHC | Accountability | Foundation | Strategic Plan | COVID-19 (Coronavirus) | Health Care Provider Forms | Privacy & Terms of Use | Pay Now

Ontario
North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

Waypoint Centre for Mental Health Care





Paid Parking

Paid parking is in effect at Waypoint. Visitors remain exempt from paid parking however are required to park in the marked Visitor Parking spaces available on the campus (**see map**). Visitor Parking spaces are marked in green. Parking Lot A has the largest number of visitor spots so this may be where you want to check first. You do not require a tag if you are in a Visitor Parking space

If you arrive at Waypoint and all Visitor parking spots across the campus are in use, please visit security staff at the Toanche building main desk to obtain a visitor parking tag to display in your vehicle.

Contacting Waypoint

705 549-3181 or toll free 1 877 341-4729

* Confidential patient/client information requests: ext. 2597 / Fax 705.549.3778
* Communications and Fund Development: ext. 2073 / info@waypointcentre.ca - This email is for general info or media inquiries only
* Human Resources: careers@waypointcentre.ca
* For more information on video visiting, or to schedule a video visit, please email telemedicine@waypointcentre.ca

Getting to Waypoint

* Directions by car
* Coming by bus - The Midland / Penetanguishene transit stops right in front of Waypoint's main entrance. For more information on this service including hours of operation, please visit:
  - Town of Midland website
  - Town of Penetanguishene website

Food and Beverage

The Bay Café is open for breakfast and lunch Monday through Friday serving a variety of hot food choices, a salad bar and daily soup options. We also offer two canteen outlets, one in the Administration Building and one in the Atrium Building for your convenience. As the hours vary in both sites, it is recommended you speak with the treatment team.

Photography on our grounds

Waypoint's location on the beautiful shores of Georgian Bay makes it an ideal place to take pictures; however, protecting patient privacy is one of our highest priorities and we ask that you also respect the privacy of those around you. Prior permission must be obtained from Waypoint's Communications staff before any photography, audio or video, including drones, can take place on any Waypoint property or building. Consent, verbal and written, must also be obtained from the people who will be included in all photos, video or audio.

You may be asked to stop taking a photo, video or audio recording and delete any recordings taken if you do not have prior approval or if your actions interfere with care or services being provided.

For inquiries regarding photography, video or audio, including drones, please contact Communications and Fund Development at info@waypointcentre.ca or 705.549.3181, ext. 2073.

Scents

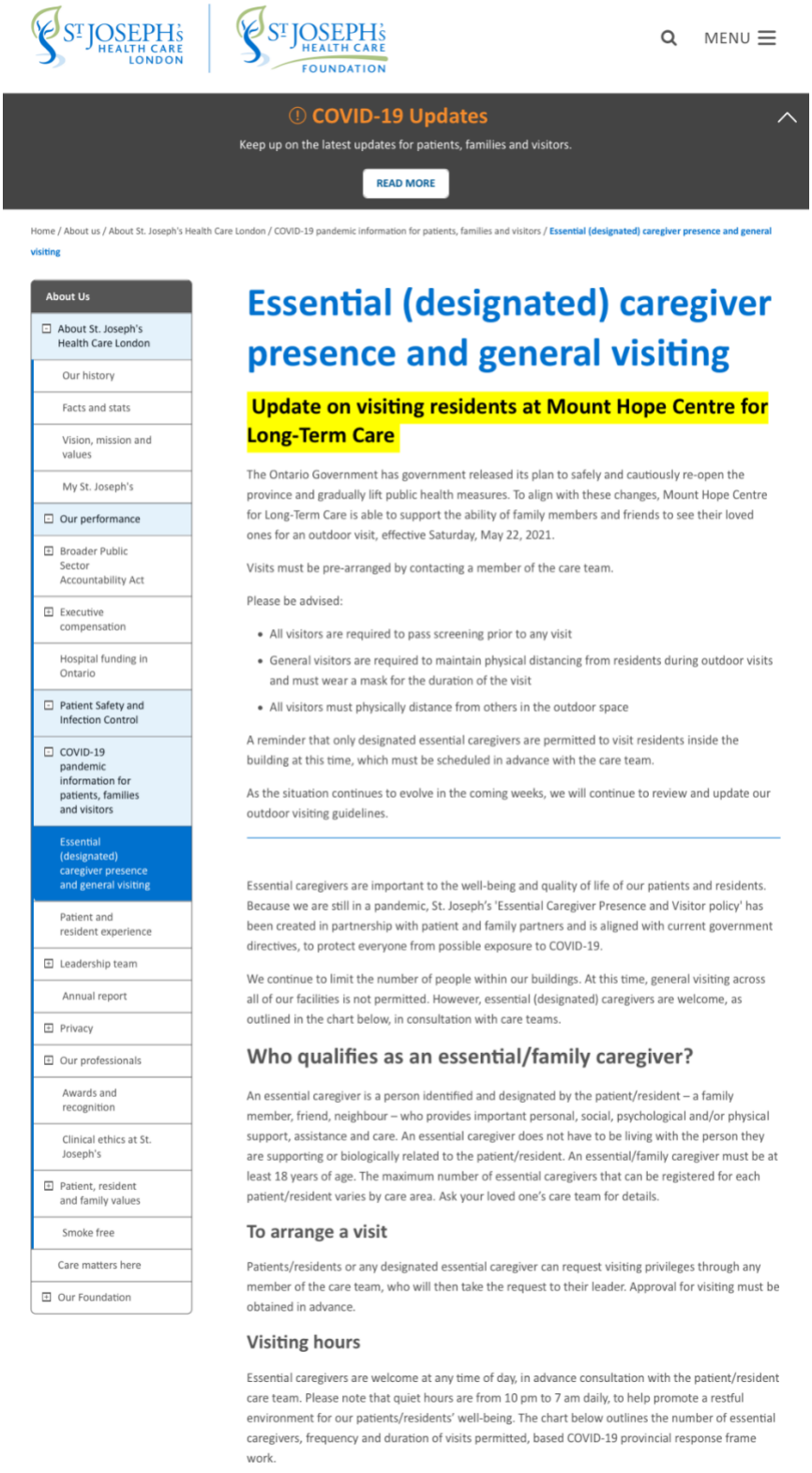
Waypoint is a scent sensitive and tobacco-free hospital. Staff and visitors are asked to avoid scented aftershave lotions, hairsprays, or other scented personal
products while at work. Scented products contain chemicals that can cause serious problems for people with asthma, allergies, migraines and environmental illness.

The Gift Shop

Waypoint's Gift Shop is located in the lobby and open to the public. It is volunteer-run and the hours vary. All proceeds go to patient programming and activities.

Waypoint Centre for Mental Health Care
500 Church Street, Penetanguishene, ON. L9M 1G3
Tel: 705-549-3181

Southwest Centre for Forensic Mental Health Care, St. Joseph's Health Care London



ST JOSEPH'S HEALTH CARE LONDON | ST JOSEPH'S HEALTH CARE FOUNDATION

MENU

COVID-19 Updates

Keep up on the latest updates for patients, families and visitors.

READ MORE

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Essential (designated) caregiver presence and general visiting

Update on visiting residents at Mount Hope Centre for Long-Term Care

The Ontario Government has government released its plan to safely and cautiously re-open the province and gradually lift public health measures. To align with these changes, Mount Hope Centre for Long-Term Care is able to support the ability of family members and friends to see their loved ones for an outdoor visit, effective Saturday, May 22, 2021.

Visits must be pre-arranged by contacting a member of the care team.

Please be advised:

- All visitors are required to pass screening prior to any visit
- General visitors are required to maintain physical distancing from residents during outdoor visits and must wear a mask for the duration of the visit
- All visitors must physically distance from others in the outdoor space

A reminder that only designated essential caregivers are permitted to visit residents inside the building at this time, which must be scheduled in advance with the care team.

As the situation continues to evolve in the coming weeks, we will continue to review and update our outdoor visiting guidelines.

Essential caregivers are important to the well-being and quality of life of our patients and residents. Because we are still in a pandemic, St. Joseph's 'Essential Caregiver Presence and Visitor policy' has been created in partnership with patient and family partners and is aligned with current government directives, to protect everyone from possible exposure to COVID-19.

We continue to limit the number of people within our buildings. At this time, general visiting across all of our facilities is not permitted. However, essential (designated) caregivers are welcome, as outlined in the chart below, in consultation with care teams.

Who qualifies as an essential/family caregiver?

An essential caregiver is a person identified and designated by the patient/resident – a family member, friend, neighbour – who provides important personal, social, psychological and/or physical support, assistance and care. An essential caregiver does not have to be living with the person they are supporting or biologically related to the patient/resident. An essential/family caregiver must be at least 18 years of age. The maximum number of essential caregivers that can be registered for each patient/resident varies by care area. Ask your loved one's care team for details.

To arrange a visit

Patients/residents or any designated essential caregiver can request visiting privileges through any member of the care team, who will then take the request to their leader. Approval for visiting must be obtained in advance.

Visiting hours

Essential caregivers are welcome at any time of day, in advance consultation with the patient/resident care team. Please note that quiet hours are from 10 pm to 7 am daily, to help promote a restful environment for our patients/residents' well-being. The chart below outlines the number of essential caregivers, frequency and duration of visits permitted, based COVID-19 provincial response frame work.

Essential caregivers accompanying outpatients

Those accompanying outpatients attending a clinic appointment or the Urgent Care Centre will only be permitted to enter the building if deemed essential based on the needs of the patient. Otherwise, caregivers will be asked to wait outside of the building.

To reduce the number of people in our buildings and minimize the risk of exposure to COVID-19, essential caregivers are required to:

- Follow the permitted number of essential caregivers/visit frequency as outlined in the chart below;
- Obtain approval from a member of the patient's care team in advance. Visits must be pre-arranged. Patients or designated essential caregivers can request a visit through any member of the care team;
- Stay home if feeling unwell, have symptoms of COVID-19, or have been exposed to someone with COVID-19;
- Pass all screening criteria for signs and symptoms of illness upon entry at designated entrances; if an essential caregiver fails screening, they will not be permitted to enter and visit at that time;
- Follow established Infection control measures including continuously wearing the provided personal protective equipment (PPE), performing hand hygiene as directed and practicing safe physical distancing from other patients and staff;
- Not visit anyone other than the intended patient/resident and access designated visiting/care presence area(s) only;
- Adhere to any time restrictions as required (outlined in the below chart);
- Consider and explore with your loved one's care team the opportunity for virtual visits as a way of reducing in-person visits;
- Inform the patient's/resident's care team immediately if symptoms develop either during or following a visit.

*Essential caregiver presence may be revoked as a result of ignoring or defying the requirements or policy guidelines, as it is essential that St. Joseph's protects the safety and health of all patients, residents, staff and essential caregivers.

Essential Caregiver Presence Guidelines

The chart below outlines the number of essential care providers, frequency and length of visits permitted across St. Joseph's, based on the COVID-19 provincial response frame work (control zones by color).

COVID-19 Response Framework					
Patient Population	**Green: Prevent**	**Yellow: Protect**	**Orange: Restrict**	**Red: Control**	**G L**
Inpatient stay: less than or equal to 90 days (excluding palliative care and short stay surgeries)	Two essential caregivers once/day for up to two hours, three times/week			One essential caregiver once/day for up to two hours, two times/week Additional visits in consultation with the care team	O fc A w
Inpatient stay: greater than 90 days	Two essential caregivers once/day for two hours up to three times/week: caregiver selection can be changed in consultation with the care team			One essential caregiver once/day up to two hours, two times/week; caregiver selection can be changed in consultation with the care team	O u s c
Outpatient appointment/procedure	One essential caregiver for duration of appointm				
Urgent Care Centre (UCC) patients	One essential caregiver for duration of UCC visi				
Short stay surgery (Estimated length of stay less than 3 days)	Two essential caregivers in consultation with the care team			One essential caregiver in consultation	
Palliative Care	No limit on number of essential caregivers; no limit on frequency; maximum numbe consultation with the care team				
Actively dying	No limit on number of essential caregivers; no limit on frequency; maximum numbe determined with the care team				
*Long Term Care and Veterans Care Program ***(When unit is not in outbreak and resident is not self isolating or symptomatic)***	Two essential caregivers per resident at a time Two general visitors per resident at least once/week; must be screened before entry			One essential caregiver per reside General visiting is not permitted	
*Long Term Care and Veterans Care Program ***(When unit is in outbreak and/or resident is self isolating or symptomatic)***	One essential caregiver per resident at a time General visiting is not permitted				

As the pandemic evolves, St. Joseph's will continually review our visiting processes and make changes to better accommodate our patients, residents, veterans and families as permitted. We thank you for your patience and understanding.

Thunder Bay Regional Health Sciences Centre

Home About News Programs and Services Research Education Regional Partners Join Our Team

Français

Before you Visit our Hospital

Guide for Patients During COVID-19

- Entering our Hospital
  - The use of non-medical masks (cloth masks) when physical distancing of 2 meters cannot be maintained may help reduce the spread of COVID-19 by pre-symptomatic and asymptomatic people. All patients, staff and care partners are required to wear a mask when entering the Hospital, including satellite locations and will be asked to don a new procedure mask every time they enter after performing hand hygiene. For an example of how to use a mask, watch this video: https://youtu.be/yMiGto8Iq5Y
  - Patients must enter through the West Entrance (to the left of the revolving door, following the arrows on the window).
  - Emergency Department patients must enter through the Emergency Entrance.
  - Labour and Delivery patients must enter through the Labour and Delivery Entrance (down to the right of the Emergency entrance).
  - All individuals who enter our Hospital must pass through screening. If you have a scheduled appointment and are feeling unwell, please call the department of your appointment to see if you should continue with the appointment or should reschedule.
  - If able, please bring this completed screening form to give to the screening staff upon entry
- PCS 21 (Updated Version Dec 22 2020)

Guide for Essential Care Partners and Care Partners

- Guidelines for Care Partners
- Guidelines for Women and Children Program

Appeals Process

- When a request for Essential Care Partner (ECP) / Care Partner (CP) exception is unresolved through discussions between the patient, essential care partner and manager and/or director of the care unit, please fill out the Appeals Form.
- Send completed form to the Patient and Family Centered Care office at PFCC@tbh.net.

Know Your Risk and Your Role

- Essential Care Partners and Care Partners: Know your risk of spreading or getting COVID-19 at the hospital
- How to Self-Monitor
- How to Self-Isolate

What You Need to Know as an Essential Care Partner/Care Partner

- How to Enter
  - ECPs/CPs must enter through the West Entrance (to the left of the revolving door, following the arrows on the window).
- Screening
  - ECPs/CPs must pass the Hospital's COVID-19 screening to be allowed entrance into the building.
  - ECPs/CPs must have identification on them and keep their Care Partner pass (once issued) to re-enter the Hospital on a different day until patient is discharged.
- Other Instructions
  - All ECPs/CPs must wear a procedure mask for the duration of their time at the Hospital. New procedure masks will be given upon entry to the Hospital
    - How to Care for a Procedure Mask
    - If a gown is required, you will be instructed to put a gown on at the unit/department you are visiting.
  - ECPs/CPs are not to wander the Hospital. They may stop into common areas (Robin's, Season's Gift Shop, the Cafeteria) only prior to going to the in-patient's unit or when exiting the Hospital. CPs may not visit common areas and return to the in-patient's unit.
- ECP Risk Brochure

Staying Connected

Our Hospital provides virtual visits through FaceTime, Skype or OTN applications:

- Please bring your own device (cell phone, tablet, etc.) and the appropriate chargers to stay connected with loved ones during this time.
- There is free access to bedside telephone and internet access.
- If you do NOT have your own device or need assistance to request virtual visits, please contact the Telemedicine Department at 684-6711 or by email at telemedicine@tbh.net.

Thunder Bay Regional Health Sciences Centre
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980 Oliver Road
Thunder Bay, Ontario,
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tbrhsc@tbh.net

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COMPLIMENTS AND COMPLAINTS

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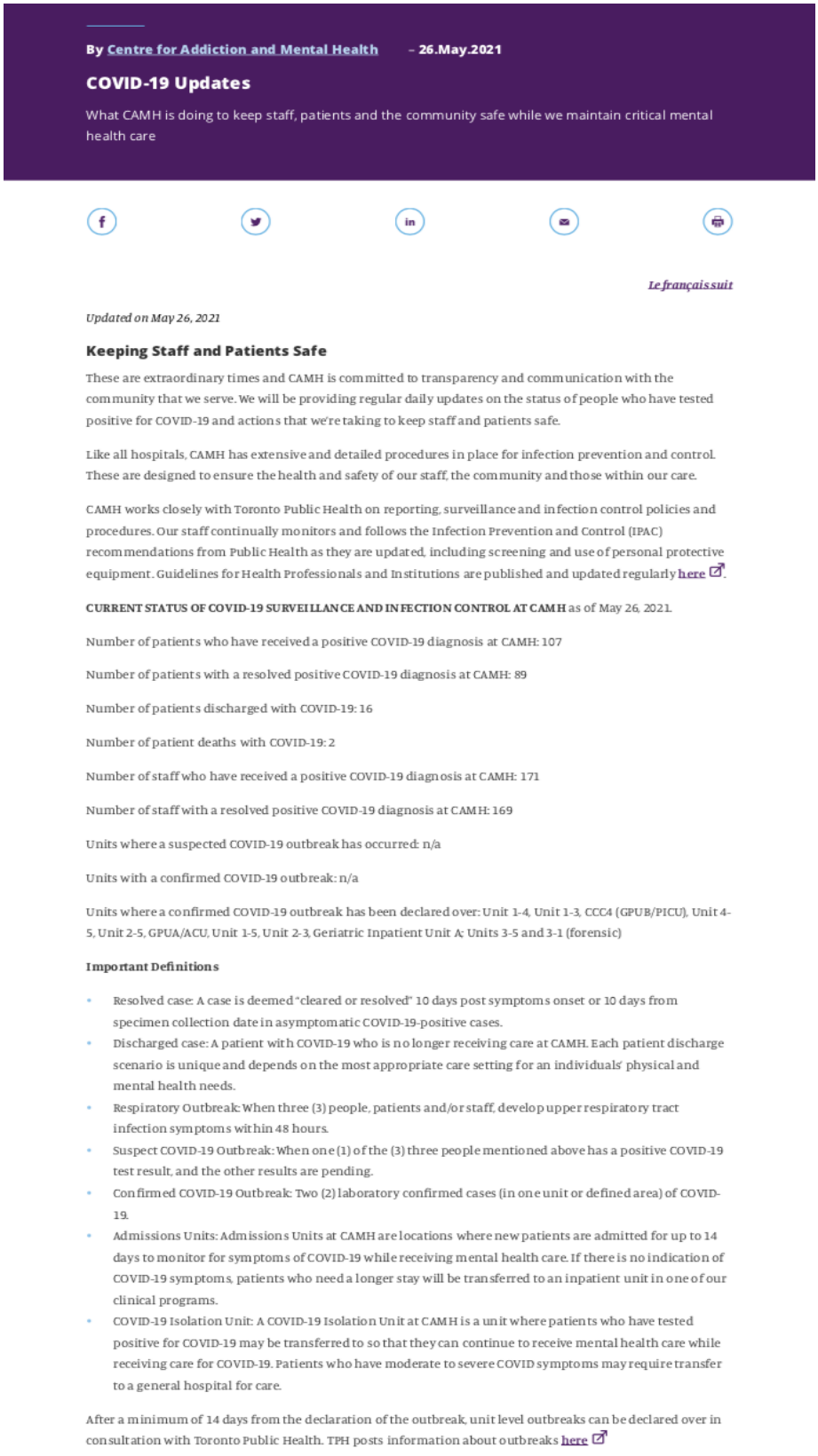
Centre for Addiction and Mental Health



By Centre for Addiction and Mental Health – 26.May.2021

COVID-19 Updates

What CAMH is doing to keep staff, patients and the community safe while we maintain critical mental health care

Le français suit

Updated on May 26, 2021

Keeping Staff and Patients Safe

These are extraordinary times and CAMH is committed to transparency and communication with the community that we serve. We will be providing regular daily updates on the status of people who have tested positive for COVID-19 and actions that we're taking to keep staff and patients safe.

Like all hospitals, CAMH has extensive and detailed procedures in place for infection prevention and control. These are designed to ensure the health and safety of our staff, the community and those within our care.

CAMH works closely with Toronto Public Health on reporting, surveillance and infection control policies and procedures. Our staff continually monitors and follows the Infection Prevention and Control (IPAC) recommendations from Public Health as they are updated, including screening and use of personal protective equipment. Guidelines for Health Professionals and Institutions are published and updated regularly here.

CURRENT STATUS OF COVID-19 SURVEILLANCE AND INFECTION CONTROL AT CAMH as of May 26, 2021.

Number of patients who have received a positive COVID-19 diagnosis at CAMH: 107

Number of patients with a resolved positive COVID-19 diagnosis at CAMH: 89

Number of patients discharged with COVID-19: 16

Number of patient deaths with COVID-19: 2

Number of staff who have received a positive COVID-19 diagnosis at CAMH: 171

Number of staff with a resolved positive COVID-19 diagnosis at CAMH: 169

Units where a suspected COVID-19 outbreak has occurred: n/a

Units with a confirmed COVID-19 outbreak: n/a

Units where a confirmed COVID-19 outbreak has been declared over: Unit 1-4, Unit 1-3, CCC4 (GPUB/PICU), Unit 4-5, Unit 2-5, GPUA/ACU, Unit 1-5, Unit 2-3, Geriatric Inpatient Unit A; Units 3-5 and 3-1 (forensic)

Important Definitions

- Resolved case: A case is deemed "cleared or resolved" 10 days post symptoms onset or 10 days from specimen collection date in asymptomatic COVID-19-positive cases.
- Discharged case: A patient with COVID-19 who is no longer receiving care at CAMH. Each patient discharge scenario is unique and depends on the most appropriate care setting for an individuals' physical and mental health needs.
- Respiratory Outbreak: When three (3) people, patients and/or staff, develop upper respiratory tract infection symptoms within 48 hours.
- Suspect COVID-19 Outbreak: When one (1) of the (3) three people mentioned above has a positive COVID-19 test result, and the other results are pending.
- Confirmed COVID-19 Outbreak: Two (2) laboratory confirmed cases (in one unit or defined area) of COVID-19.
- Admissions Units: Admissions Units at CAMH are locations where new patients are admitted for up to 14 days to monitor for symptoms of COVID-19 while receiving mental health care. If there is no indication of COVID-19 symptoms, patients who need a longer stay will be transferred to an inpatient unit in one of our clinical programs.
- COVID-19 Isolation Unit: A COVID-19 Isolation Unit at CAMH is a unit where patients who have tested positive for COVID-19 may be transferred to so that they can continue to receive mental health care while receiving care for COVID-19. Patients who have moderate to severe COVID symptoms may require transfer to a general hospital for care.

After a minimum of 14 days from the declaration of the outbreak, unit level outbreaks can be declared over in consultation with Toronto Public Health. TPH posts information about outbreaks here

Actions in Response to Respiratory Outbreaks

In keeping with standard infection prevention and control procedures in any respiratory outbreak scenario, CAMH has put in place the following procedures:

- Closed confirmed or suspected COVID-19 outbreak units to admissions and transfers (Unit 1-4 February 22, Unit 1-3 on February 19, Unit 4-5 on November 23, Unit 2-5 on November 11, ACU/GPUA on October 26, Unit 2-3 on October 23, Unit 1-5 on October 21, Unit 1-4 on October 18, Unit 3-1 on March 26, Unit 3-5 on April 3 and GAUA as of April 5),
- Placed all patients on outbreak units on "contact and droplet precautions" — meaning that all staff are wearing personal protective equipment when interacting with patients
- Enhanced cleaning and disinfection processes at every CAMH building
- Provided patients with supports to stay in their rooms and to ensure physical distancing (for example, meals are provided in patient bedrooms)

CAMH has opened two isolation units to facilitate transfer of patients who test positive for COVID-19, and we have taken a number of additional precautionary measures:

- Visitors were significantly limited as of March 17, 2020,
- Only staff supporting essential patient care remain on site,
- All community passes for forensic patients ceased as of March 18, 2020 (community passes are a part of a supervised, graduated, community reintegration program),
- Essential staff that remain are being actively screened in all buildings, and must pass screening protocols to enter,
- Staff an all outbreak units are being asked to monitor twice daily for the development of symptoms.

CAMH is deeply grateful to staff and physicians who are working to deliver mental health care to those in need, to our community who supports us in this important work, and to Toronto Public Health for their leadership and partnership in fighting the spread of COVID-19.

CAMH Daily COVID-19 Updates:

March 2021

- March 26, 2021
- March 24, 2021
- March 17, 2021
- March 16, 2021
- March 15, 2021
- March 12, 2021
- March 10, 2021
- March 9, 2021
- March 8, 2021
- March 6, 2021
- March 5, 2021
- March 4, 2021
- March 2, 2021
- March 1, 2021

Additional Precautions to Keep Staff and Patients Safe

Updated Visitors Policy

On Tuesday, June 30, CAMH will allow essential visitors for some patients, including those admitted to our Emergency Department, those who require support to access critical ambulatory services, and those on inpatient units. Visiting hours will be 8 a.m. to 8 p.m. daily.

All visitors must register with the patient's care team before 2 p.m. one day in advance of their planned visit. In addition, all visitors will be actively screened at entrance points to CAMH buildings, and will be required to strictly adhere to infection prevention and control measures, including self-monitoring for symptoms, performing proper hand hygiene, and donning personal protective equipment ("PPE") where appropriate, at the direction of CAMH personnel.

Patients admitted to an inpatient unit will only be permitted one visit from their designated visitor each day, with a maximum length of one hour. However, depending on scheduling of other visits and unit acuity, daily visits for **every patient** may not be possible. In most cases, visitors will be required to remain in the patient's bedroom, as long as physical distancing can be maintained.

For more information, please call the Family Information and Support Centre telephone line at 416-535-8501 ext. 33472.

Patients, families, staff, and the public can continue to connect with the Family Resource Centre by telephone and email (although they are currently closed to all walk-ins). Contact info: familyengagement@camh.ca or 416-535-8501 ext. 33202.

Deliveries

Package delivery is once again permitted for CAMH patients. Whenever possible, deliveries should be coordinated with the patient's clinical team in advance. Third-party food deliveries are also now permitted (e.g. via UberEats or restaurant delivery services). Patients are required to work with their clinical teams when placing orders, as COVID-19 restrictions in place require cashless payment methods and delivery to screening stations. For this and other family-related information, please contact the Family Information & Support Centre.

Families

The Family Information and Support Centre telephone line is now active. This line is intended as an information and support resource for CAMH families. It includes a recorded message on CAMH policies at this time and where to find more information on a variety of topics. Callers can also leave a voicemail message with inquiries about services and supports. Please dial 416-535-8501 ext. 33472.

The Family Resource Centre is currently closed to all walk-ins. Staff continue to respond to call and emails. Patients and families, staff and the public can continue to connect with the Centre at familyengagement@camh.ca or 416-535-8501 ext. 33202.

Volunteers

Due to COVID 19 all-volunteer programs are temporarily suspended. We are not accepting and/or processing new volunteer applications until volunteer operations resume. Thank you for your patience and understanding.

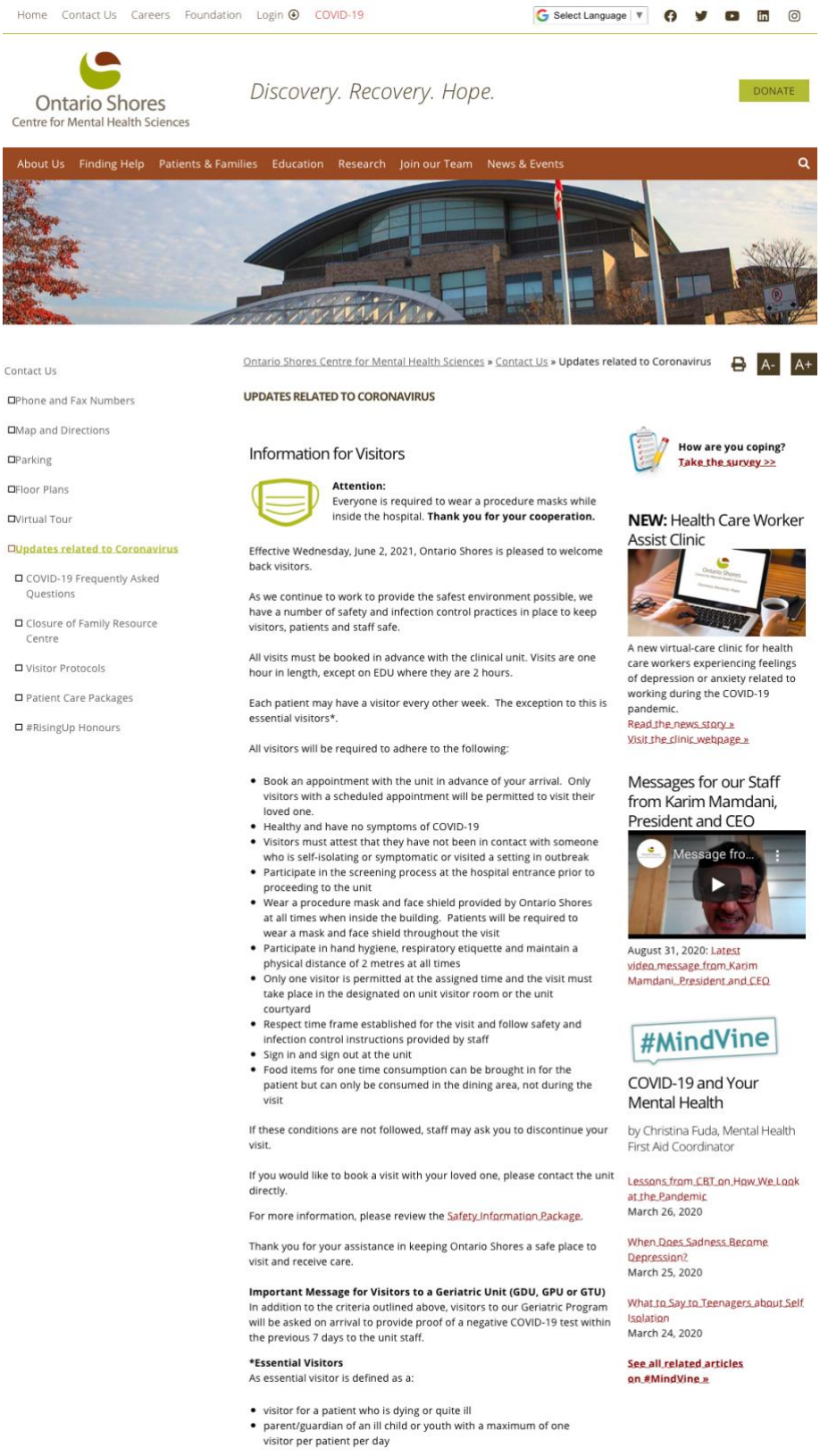
Active Screening

Active screening protocols are in place for all people entering CAMH. Symptom-based screening will be performed for presence of:

- Cough
- Shortness of breath
- And/or fever

Anybody presenting with the above symptoms will receive further instructions.

Ontario Shores Centre for Mental Health Sciences



Updated Visitor Protocols
Ontario Shores is pleased to welcome back visitors. As we continue to work to provide the safest environment possible, we are implementing a number of safety and infection control practices to keep visitors, patients and staff safe.

- Details of the updated visitor protocols »
- Safety Information Package for patients and visitors (.pdf) »
- Frequently asked questions for visitors »

Screening Practices

Entry to the building is limited to:
- Building 5 (Main Entrance - green) from 6:00 a.m. to 11:00 p.m.
- Building 2 (Admitting Entrance - yellow) from 6:00 a.m. to 7:30 p.m.

Those entering the building will participate in a mandatory screening process that will ask a series of questions (public screening, staff screening) related to symptoms, travel and contacts. Everyone entering the building will be required to have their temperature checked, and will be provided with a protective face mask.

Thank you for your understanding as we continue to deliver compassionate care while protecting the health and safety of everyone at Ontario Shores and our community.

Staff are encouraged to complete online screening before entering the building.

Screening Setup at Building 5 Entrance

2019-Novel Coronavirus (COVID-19) Frequently Asked Questions

We are maintaining a list of frequently asked questions here about 2019-Novel Coronavirus (COVID-19).

Patient Care Packages

At this stage, we are grateful to be able to accept Care Packages on behalf of our patients. See details.

Personal Protective Equipment Needed

We are accepting donations of gloves, ear-loop masks, and hand sanitizer Monday through Friday, 8:00 a.m. to 4:00 p.m. at our loading dock. PPE donation details »

Information for Patients and Families

Family Services
In order to comply with Public Health directives, The Family Resource Centre (FRC) will be temporarily closed until further notice, and related FRC programs temporarily suspended until further notice.

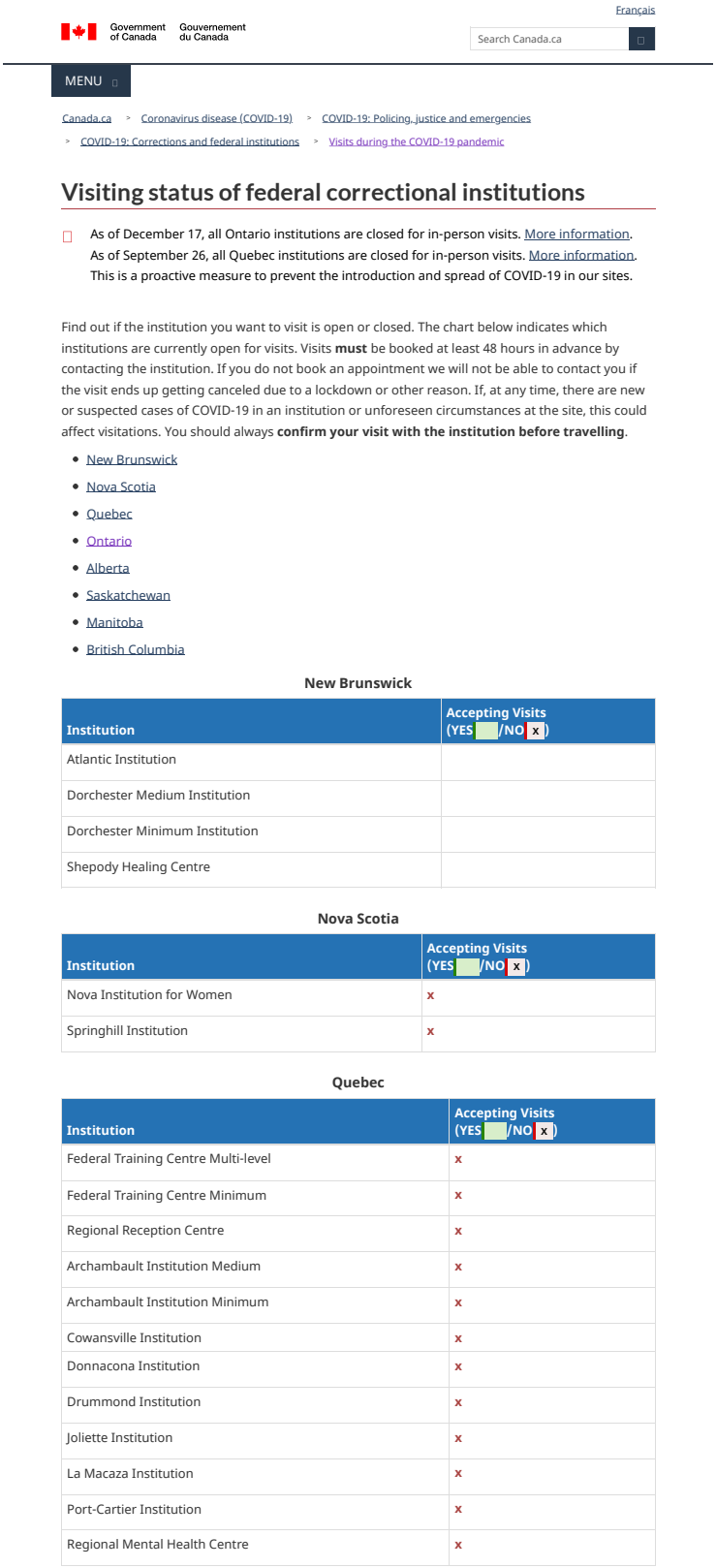
Online Patient Portal - My Health, My Way
My Health, My Way is our online patient portal which allows patients and caregivers to access lab results, check appointment dates, update personal information and message clinicians. It is a safe option when everyone is being asked to limit pubic outings and ensure social distancing.
Learn more about My Health, My Way »

Patient E-transfers
We are working with our patients who wish to receive funds via email money transfers from family and friends.

To send money to patient in our care, please email etransfers@ontarioshores.ca to note your intent to transfer funds to a patient's client trust account. The email should include patient name, unit (if known), amount of transfer and password for accepting the transfer.

E-transfers can then be sent to etransfers@ontarioshores.ca through your respective financial institution.

CSC Facilities



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Visiting status of federal correctional institutions

As of December 17, all Ontario institutions are closed for in-person visits. More information.
As of September 26, all Quebec institutions are closed for in-person visits. More information.
This is a proactive measure to prevent the introduction and spread of COVID-19 in our sites.

Find out if the institution you want to visit is open or closed. The chart below indicates which institutions are currently open for visits. Visits **must** be booked at least 48 hours in advance by contacting the institution. If you do not book an appointment we will not be able to contact you if the visit ends up getting canceled due to a lockdown or other reason. If, at any time, there are new or suspected cases of COVID-19 in an institution or unforeseen circumstances at the site, this could affect visitations. You should always **confirm your visit with the institution before travelling**.

- New Brunswick
- Nova Scotia
- Quebec
- Ontario
- Alberta
- Saskatchewan
- Manitoba
- British Columbia

New Brunswick

Institution	Accepting Visits (YES /NO x)
Atlantic Institution	
Dorchester Medium Institution	
Dorchester Minimum Institution	
Shepody Healing Centre	

Nova Scotia

Institution	Accepting Visits (YES /NO x)
Nova Institution for Women	x
Springhill Institution	x

Quebec

Institution	Accepting Visits (YES /NO x)
Federal Training Centre Multi-level	x
Federal Training Centre Minimum	x
Regional Reception Centre	x
Archambault Institution Medium	x
Archambault Institution Minimum	x
Cowansville Institution	x
Donnacona Institution	x
Drummond Institution	x
Joliette Institution	x
La Macaza Institution	x
Port-Cartier Institution	x
Regional Mental Health Centre	x

Ontario

Institution	Accepting Visits (YES /NO x)
Bath Institution	x
Bath Regional Treatment Centre	x
Beaver Creek Medium Institution	x
Beaver Creek Minimum Institution	x
Collins Bay Maximum Institution	x
Collins Bay Medium Institution	x
Collins Bay Minimum Institution	x
Collins Bay Regional Treatment Centre	x
Grand Valley Institution for Women	x
Joyceville Institution	x
Joyceville Minimum Institution	x
Millhaven Institution	x
Millhaven Regional Hospital	x
Millhaven Regional Treatment Centre	x
Warkworth Institution	x

Alberta

Institution	Accepting Visits (YES /NO x)
Bowden Institution	x
Drumheller Institution – Minimum Security	x
Drumheller Institution – Medium Security	x
Edmonton Institution	x
Edmonton Institution for Women	x
Grande Cache Institution	x
Grierson Centre	x
Pê Sâkâstêw Centre	x

Saskatchewan

Institution	Accepting Visits (YES /NO x)
Okimaw Ohci Healing Lodge	x
Regional Psychiatric Centre	x
Saskatchewan Maximum Penitentiary	x
Saskatchewan Medium Penitentiary	x
Saskatchewan Minimum Penitentiary	x
Willow Cree Healing Lodge	x

Manitoba

Institution	Accepting Visits (YES /NO x)
Stony Mountain Maximum Institution	x
Stony Mountain Medium Institution	x
Stony Mountain Minimum Institution	x

British Columbia

Institution	Accepting Visits (YES /NO x)
Fraser Valley Institution	x
Kent Institution	x
Kwìkwèxwelhp Healing Lodge	x
Matsqui Institution	x
Mission Medium Institution	x
Mission Minimum Institution	x
Mountain Institution	x
Pacific Institution	x
Pacific Regional Treatment Centre	x
Pacific Regional Reception and Assessment Centre	x
William Head Institution	x

Visiting correctional institutions during the COVID-19 pandemic

Certain measures are in place to protect inmates, staff and visitors during the COVID-19 pandemic. Find out whether an institution is open for visits, use our screening questions to see if it is safe to visit, and learn what you must do before and after your visit.

- Planning your visit: Find out how to prepare to visit a CSC institution.
- Travel advisories to consider when planning visits that require inter-provincial travel.
- Public health authorities: Information about local public health authorities in specific locations across Canada.
- During and after your visit: There are certain guidelines you must follow during, and after, your visit.
- Frequently asked questions addresses specific questions that visitors might have about the process for visiting during COVID-19.
- Visiting status of an institution identifies which institutions are currently open for visits.

Planning your visit

You must be registered on the inmate's authorized visitors' list. Visits **must** be booked at least 48 hours in advance by contacting the institution. If you do not book an appointment we will not be able to contact you if the visit ends up getting canceled due to a lockdown or other reason.

- Find contact information for institutions.
- Find out if an institution is currently accepting visitors.
  - *Please be aware that at any given time a range of an institution could be closed which could affect your ability to visit an inmate. The institution may show as open but an inmate may not be able to have visitors.
- Infographic: Visiting an institution during COVID-19 explains how to prepare for a visit and what to expect during your visit

You will be asked a series of questions at the time of booking:

- COVID-19 screening questions

Additional measures may be put in place to prevent the spread of COVID-19. Please note measures are evolving based on public health advice and community transmission.

A maximum of three visitors are permitted at a time, which can include up to two children.

Due to reduced capacity, normally only one visit per week per visitor will be permitted (though some sites may be able to accommodate more than one visit a week).

Masks are mandatory. It is recommended that you bring your own or one will be provided. Please ensure you know how to properly wear a mask.

- COVID-19: How to wear a non-medical mask or face covering properly

You cannot bring food, beverages, or personal belongings into the institution. Exceptions may be made for accessibility reasons. Exceptions may also be made for small children that require diapers, bottles and other items.

Visits will be limited to 1.5 hours.

Monitor your health and know the symptoms of COVID-19:

- Coronavirus disease (COVID-19): Symptoms and treatment

Do not come to the institution if you are sick. If you are not sure, take this assessment:

- on-line self-assessment

During your visit

In addition to regular security protocols, all visitors will be screened upon arrival:

- COVID-19 screening questions

All visitors will have their temperature taken by a non-touch thermometer. If you have symptoms, you will not be permitted to enter.

Visitors will be required to wash their hands for 20 seconds and wear a mask during their entire visit.

- Learn more about hand washing

Vending machines will not be available.

Play areas will be closed and toys will not be permitted.

Physical distancing is proven to be one of the most effective ways to reduce the spread of illness during an outbreak.

- Learn how physical distancing helps reduce the spread of COVID-19

After your visit

- Each visitor table will be provided with disinfecting wipes.
- Locations where visiting occurs are disinfected before and after each visit, including visitor washrooms.
- Remember to wash or disinfect your hands.

Please do your part in keeping our institutions safe and healthy.

Infographic: Visiting an inmate at a CSC institution during COVID-19 is a printable version of what to do Please do your part in keeping our institutions safe and healthy.

Date modified: 2021-05-07