



# Correctional Health Care

**Pat Hamilton R.N OHN BHScN**  
**Julie Pickering R.N CPMH(c)**

Picture removed



Picture removed



# Vision

**“Enhance community safety through effective offender supervision, care, custody and intervention, thereby influencing positive behavioural change and reintegration of offenders into the community as productive citizens.”**



# Mandate

**“To create an environment in which offenders may achieve changes in attitude and behaviour by providing training, rehabilitative treatment and services designed to provide opportunities for successful personal and social adjustment in the community.”**



# Adult Institutional Services

- Provides secure custody and rehabilitative programs for adult offenders serving sentences of up to two years less one day.
- Provides detention for adults awaiting court proceedings, such as trials and immigration hearings.
  - 21 Jails / Detention Centres;
  - 10 Correctional Centres/Complexes/Treatment;
    - 1 Correctional Centre for women (Vanier Centre);
    - Ontario Correctional Institute;
    - St. Lawrence-Valley Treatment Centre;
    - Algoma Treatment Centre.



# HEALTH CARE TEAM

- Nurses
- Mental Health Nurses
- Doctors
- Social Workers
- Pharmacists, Pharmacy Technicians
- Psychiatrists
- Psychologists, Psychometrists
- Dentists, Dental Assistants
- Physiotherapists, Occupational Therapists
- Midwives
- Mobile X-ray & Ultrasound



Picture removed



Picture removed



# Nursing Responsibilities

- Assess offender conditions
- Assist in developing & implementing health care treatment plans
- Observe, assess, record and report offender's health care treatment, condition and behaviour
- Provide health care crisis intervention/management & health care counselling/education
- Identify health care services and resources for offenders, advocating on their behalf



Institution:		Admission Date (MM/dd/yyyy)		<input type="checkbox"/> Young Person <input type="checkbox"/> Adult Client	
Name (Last/First/Middle):		Date of Birth (MM/dd/yyyy)		Health Number:	
Client Identification No:		Previous Incarceration: Where:		When (MM/dd/yyyy)	
Vital Signs: Pulse:		Resp.	Temp.	B/P	Diet <input type="checkbox"/> Regular <input type="checkbox"/> Vegetarian <input type="checkbox"/> Diabetic _____cal <input type="checkbox"/> Other
* Notify MD if 100 or greater and client is withdrawing from alcohol/drugs					
Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> YES		Specify:			
Current Medication No <input type="checkbox"/> Yes <input type="checkbox"/>		Pharmacy/MD: Tel # & Location		5.	
See D sheet for additional meds <input type="checkbox"/>		1.		7.	
		2.		8.	
		3.		9.	
		4.		10.	
Current Injuries: No <input type="checkbox"/> Yes <input type="checkbox"/>		<input type="checkbox"/> Laceration <input type="checkbox"/> Abrasion <input type="checkbox"/> Swelling	<input type="checkbox"/> Redness <input type="checkbox"/> Tenderness <input type="checkbox"/> Bruising	Specify	
Current Suicidal Ideation: No <input type="checkbox"/> Yes <input type="checkbox"/>		Are you thinking about hurting yourself? No <input type="checkbox"/> Yes <input type="checkbox"/> Do you have a plan? No <input type="checkbox"/> Yes <input type="checkbox"/> Previous attempts? No <input type="checkbox"/> Yes <input type="checkbox"/>		Specify	
History of Treatment for Psychiatric Problems: No <input type="checkbox"/> Yes <input type="checkbox"/>		Were you ever admitted to a psychiatric hospital? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, what did they say you have?		Specify	
History of Cardiac / Chest pain: No <input type="checkbox"/> Yes <input type="checkbox"/>		<input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Hospitalization <input type="checkbox"/> CVA	<input type="checkbox"/> Angina <input type="checkbox"/> MI <input type="checkbox"/> Other	Specify Last episode	
History of Shortness of Breath related to: No <input type="checkbox"/> Yes <input type="checkbox"/>		<input type="checkbox"/> Asthma <input type="checkbox"/> Smoking <input type="checkbox"/> Cardiac	<input type="checkbox"/> Chronic Lung Disease <input type="checkbox"/> Other	Specify Last episode	
History of Diabetes: No <input type="checkbox"/> Yes <input type="checkbox"/>		<input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Non-Insulin Dependent <input type="checkbox"/> Diet Controlled		Specify Blood sugar	
History of Seizures / Epilepsy: No <input type="checkbox"/> Yes <input type="checkbox"/>		<input type="checkbox"/> Unknown etiology <input type="checkbox"/> Birth <input type="checkbox"/> Result of accident / injuries		Specify Last episode	
History of Other Illness/ or Infection: No <input type="checkbox"/> Yes <input type="checkbox"/>		<input type="checkbox"/> Skin <input type="checkbox"/> Thyroid <input type="checkbox"/> Kidney/Liver	<input type="checkbox"/> TB <input type="checkbox"/> STI <input type="checkbox"/> Other	Specify	
Physical Disability or Prosthesis: No <input type="checkbox"/> Yes <input type="checkbox"/>		<input type="checkbox"/> Ocular Prosthesis <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Other	<input type="checkbox"/> Dentures - lower <input type="checkbox"/> - upper <input type="checkbox"/>	Specify Last episode	

Part A – A & D Assessment Continues on Page 2...

CSD 010-009 (01/05)

**CAUTION: THIS RECORD CONTAINS INFORMATION ABOUT A YOUNG PERSON WHICH IS SUBJECT TO THE YOUTH CRIMINAL JUSTICE ACT!**

Information about a young person as defined in the Youth Criminal Justice Act is subject to publication, use and access restrictions set out in the Act to protect the privacy of the young person. The penalty for violation may result in imprisonment for up to 2 years.



**Health Care Record - Part A  
(Health Assessment continued)**

If more space is required, utilize Part D.

Name (Last/First/Middle):		Client Identification No:	Institution:
Travel Out of Country within the last 4 weeks No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:			
Hospitalization within the last 6 months No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:			
Respiratory Symptoms Check:		If present check symptoms:	
None <input type="checkbox"/>		<input type="checkbox"/> Recent fever <input type="checkbox"/> Cough <input type="checkbox"/> Blood tinged sputum <input type="checkbox"/> Recent weight loss <input type="checkbox"/> Night sweats <input type="checkbox"/> Headache	
Street Drug Use:	(Type/Amount/Frequency)	Withdrawal History:	
No <input type="checkbox"/> Yes <input type="checkbox"/>			
Alcohol Consumption:	(Type/Amount/Frequency)	Withdrawal History:	
No <input type="checkbox"/> Yes <input type="checkbox"/>			
Interim Nursing Plan:			
Name of R.N. (Print)		Signature of R.N.:	Date Time:

**Part A – Section 2 (complete when Mantoux given)**

Height cm	Weight kg	Urinalysis (if not complete indicate why)	Vision Unaided <input type="checkbox"/>	Vision Aided L <input type="checkbox"/> R <input type="checkbox"/>	Glasses Status:	Contact Lenses Status:
Date of Immunizations: (MM/dd/yyyy)	Booster:	Hepatitis B Vaccine	Hepatitis A Vaccine	Tetanus Vaccine		
HIV test date & results:		Chlamydia test date & results				
Hepatitis test date & results:						
Did they have Flu Vaccine this Year No <input type="checkbox"/> Yes <input type="checkbox"/>		(Please be sure to record all dates as MM/dd/yyyy)				
Offered No <input type="checkbox"/> Yes <input type="checkbox"/>		If Flu Vaccine Administered, Record on Part D				
Client <input type="checkbox"/> Refused <input type="checkbox"/> Accepted						
Family Physician:	Address	Telephone #	Last Visit			
Female Health History	Last menstrual period (MM/dd/yyyy)	Para	Gravida	Birth Control		
Current Physical & Emotional Health: (describe current health concerns, mental status)						
Name of R.N. (Print)		Signature of R.N.:	Date (MM/dd/yyyy)	Time:		

**Mantoux Record (Please be sure to record all dates as MM/dd/yyyy)**

Mantoux Date	Signature	Date Read	Results (mm)	Signature	Chest x-ray Date
					Results
2 <sup>nd</sup> Step Mantoux Date	Signature	Date Read	Results (mm)	Signature	



# Health Care Concerns

- Addictions
- Mental Health
- Suicidal Ideation
- Hepatitis and HIV
- Infections
- Tuberculosis
- Undiagnosed pre-existing health conditions
- Prenatal Care & Postnatal Care



## Intensive Management Assessment & Treatment Unit

- Psychiatrist
- 4 Mental Health Nurses
- 3 Psychologists
- 1 Operational Manager
- 2 Mental Health Social Workers
- Correctional Officers With Mental Health Training



Picture removed



# Day Room & Cell

Picture removed

Picture removed



# Pregnancy care

- All inmates assessed by an RN on Admission (often pregnancy testing is done at this time)
- Pregnancy check list initiated (see next slide)
- Seen By M.D next clinic
- M.D will initiate medical plan e.g blood work, ultrasound
- Referred to Community Obstetrician @ 6 months
- Inmate referred to high risk medical center if indicated
- Midwives visit weekly
- Birth plan is prepared by Social Worker



## VCFW- PREGNANCY CHECK LIST

I/M NAME \_\_\_\_\_ OTIS# : \_\_\_\_\_ D.O.B: \_\_\_\_\_

EDC: \_\_\_\_\_ GRAVIDA: \_\_\_\_\_ PARA: \_\_\_\_\_

	DATE	SIGNATURE
CONFIRMED PREGNANCY-URINE/BLOOD		
ANY ILLICIT DRUG/ ALCOHOL/METHADONE USE, NOTIFY MD		
DIET FORM TO KITCHEN		
PRENATAL VITAMINS RX		
ADD TO MIDWIVES LIST		
NOTIFY UNIT SOCIAL WORKER		
PLACE ON NEXT VCFW DR'S CLINIC		
CONSENT FORM SIGNED		
MEMO TO A&D		
PRENATAL BLOOD WORK ORDERED BY VCFW DR		
PREGNANCY ULTRASOUND ORDERED		
OB/GYN CONSULT AS PER VCFW DR		
INCLUDE BLOOD/ULTRASOUND RESULTS WITH CONSULT		

THIS PACKAGE CONTAINS: CHECK LIST

DIET SHEET  
 CONSENT FORM  
 MEMO FOR A&D

PLACE ON I/M FILE UPON COMPLETION.

29/07/05



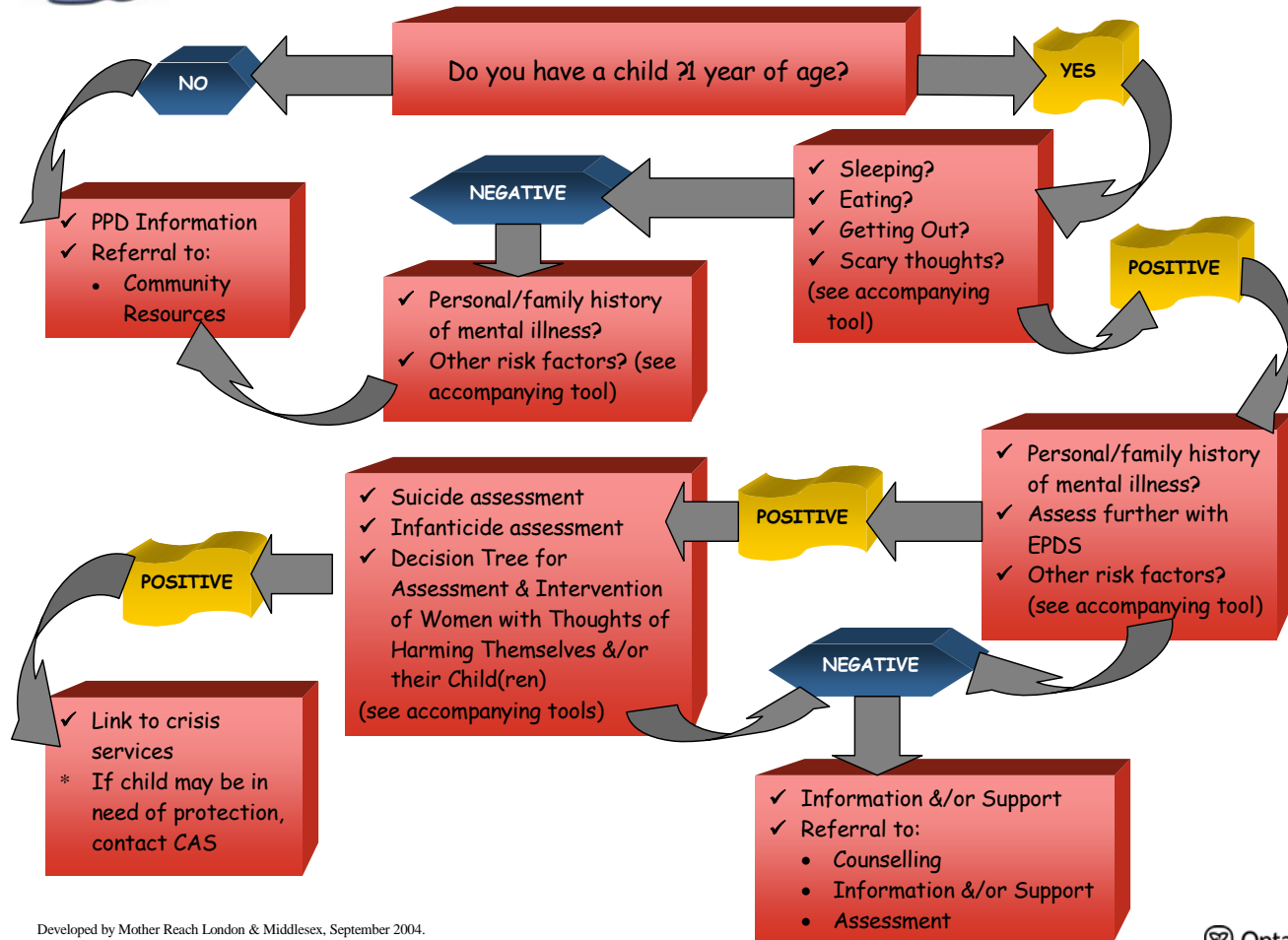


# Post Natal Care

- Inmate seen by RN post hospital discharge nursing plan developed
- See MD next clinic
- Social worker involved
- IMAT referral if needed
- Medication management
- Community liaison
- Discharge planning
- Parenting courses
- Referral to Community Agencies



## Post-Partum Mental Health Assessment Flow Chart

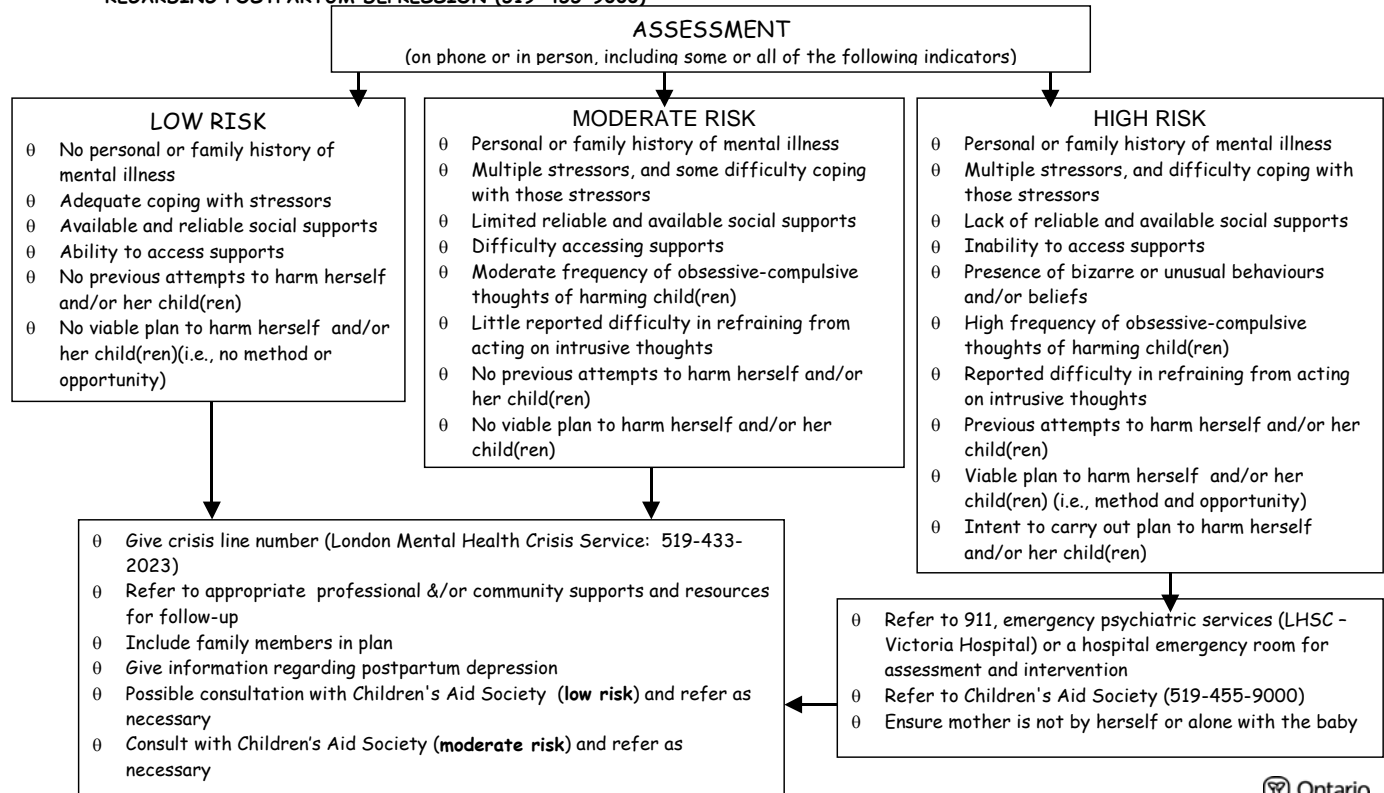


Developed by Mother Reach London & Middlesex, September 2004.  
Revised 2007.



## Decision Tree for Assessment & Intervention of Women with Thoughts of Harming Themselves &/or their Child(ren)

This decision tree is a guideline to inform your practice with postpartum women. Your professional judgement is a critical element in its use. You may identify one or two "red flag" signs/symptoms and may directly move to intervention without completing the entire assessment, or you may identify factors of concern that are not included below. **IF AT ANY TIME YOU ARE UNCERTAIN OF A WOMAN'S LEVEL OF RISK, CONSULT WITH A CHILDREN'S AID SOCIETY INTAKE SOCIAL WORKER WITH EXPERTISE REGARDING POSTPARTUM DEPRESSION (519-455-9000)**





## FOUR KEY QUESTIONS

### ARE YOU ABLE TO SLEEP WHEN THE BABY SLEEPS?

This question will identify mothers who are sleeping all the time and those who cannot sleep at all (i.e. those with racing thoughts). Difficulties can be an indicator of possible postpartum depression (PPD). Was this the mother's normal sleep pattern before her baby's birth? Don't assume that sleeping is a problem because of a crying baby. Find out what this mother does when her baby is sleeping.

### ARE YOU GETTING OUT?

This question will pick up anxiety, depression, agoraphobia (fear of going out), exhaustion and inability to cope. Remember that PPD includes anxiety symptoms. Women are not always going to look depressed and are experts at disguising their symptoms. Ask questions. Women experiencing PPD will often isolate themselves. Find out if they are still socializing.

### ARE YOU EATING AND, IF SO, WHAT ARE YOU EATING?

This question will identify severe anxiety i.e. feeling like she has a rock in her stomach, no appetite (in some cases diarrhea and vomiting), or over-eating, especially carbohydrates. Some women will describe a feeling of having something stuck in their throats. It is key to find out if these were patterns before the birth of the baby or if they are unusual for this woman.

### ARE YOU HAVING SCARY &/OR REPETITIVE THOUGHTS?

Mothers sometimes experience obsessive thoughts about their baby and/or themselves. Asking this question may open lines of communication, but do not expect that a woman will confide at this point. She may be afraid that telling someone may lead to her baby being removed from her by child welfare. Reassurance that other new mothers also have had scary and repetitive thoughts can be helpful.

Developed by Postpartum Adjustment Support Services of Canada (PASS-CAN)



## OTHER RISK FACTORS

Although all women are susceptible to developing depression following childbirth, women who have one or more of the following factors have a significantly increased risk of experiencing postpartum depression.

### Strong to Moderate Risk:

- Depression during pregnancy
- Anxiety during pregnancy
- Stressful recent life events
- Lack of social support (either perceived or received)
- Previous history of depression

### Moderate Risk:

- High levels of childcare stress
- Low self-esteem
- Neuroticism
- Difficult infant temperament

### Small Risk:

- Obstetric & pregnancy complications
- Cognitive attributions
- Quality of relationship with partner
- Socioeconomic status

### No effect:

- Ethnicity
- Maternal age
- Level of education
- Parity
- Gender of child (within Western societies)

From Robertson, E., Celasun, N., and Stewart, D.E. Risk factors for postpartum depression. In Stewart, D.E., Roberson, E., Dennis, C.-L., Grace, S. L., & Wallington, T. (2003). *Postpartum Depression: Literature review of risk factors and interventions*. Toronto: Toronto Public Health.



### SUICIDAL IDEATION



Some women have thoughts or images about harming themselves  
 Begin the discussion with:  
**“Often when women are depressed, they have negative thoughts about harming themselves.”**

Proceed through the following questions.  
**In the past month, did you:**

	NO	YES	Points
Think that you would be better off dead or wish you were dead?			1
Want to harm yourself?			2
Think about suicide?			6
Have a suicide plan?			10
Attempt suicide?			10
<b>In your lifetime:</b>			
Did you ever make a suicide attempt?			4

Is at least 1 of the above coded YES?  
 If YES, add the total number of points for the answers checked  
 “YES” and specify the level of suicide risk as follows:

CURRENT SUICIDE RISK:	
1-5 points	Low
6-9 points	Moderate
?10 points	High

Source: Sheehan, D.V., Lecrubier, Y., Harnett-Sheehan, K., Amorim, P., Janvas, J., Hergueta, T., Baker, R. & Dunbar, G. (1998). The Mini International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic interview. *Journal of Clinical Psychiatry*, 59(suppl 20), 22-33.

### INFANTICIDAL IDEATION



Some women have thoughts or images about harming their baby, especially when holding a knife or bathing the baby. Women who have guilt feelings about harming their infants may also have suicidal thoughts and be suffering from Major Depression. Women who have no guilt feelings related to the infanticide ideation and are being compelled to act on their thoughts may have a psychosis.

Begin the discussion with:

**“Often when women are depressed, they have negative thoughts about the baby.”**

1. Have you had any negative **thoughts** or **ideas** about harming your baby?
2. If yes, have you made any **plans** to harm your baby? Can you give me more details?
3. Have you ever made an **attempt** to harm your baby? If yes, when? How?
4. Do these thoughts **disturb** you?

**NOTE: Any woman who states she has plans to harm her baby, or who has attempted to harm her baby, MUST be reported immediately to the Children’s Aid Society (519-455-9000). The woman must be informed of the report.**

Adapted from British Columbia Reproductive Care Program Guidelines for Perinatal Care. (2003). *Identification and Assessment of Reproductive Mental Illness during the Preconception and the Perinatal Periods*. As viewed August 10<sup>th</sup>, 2004 (and reviewed February 16<sup>th</sup>, 2007) at <http://www.bcrmh.com>



# Issues

- Increase in female offender population is over 16% year 2007 vs 1.5% in male offenders
- More female offenders remanded into custody for shorter periods of time and at various stages of pregnancy. Often without prenatal care and serious Addiction & Mental Health issues.
- Minimal education resources for such a transient population.
- Educational need fulfillment for nursing staff in OBS/GYN



# Thank you

[Patricia.Hamilton@ontario.ca](mailto:Patricia.Hamilton@ontario.ca)

[Julie.Pickering@ontario.ca](mailto:Julie.Pickering@ontario.ca)