New York State Office of Mental Health
Infection Control Manual for Public Mental Health System Programs

September 16, 2022

Note: The situation regarding the COVID-19 pandemic is ever changing, as is our knowledge of this new disease. The guidance in this document is based on the best information currently available. Visit the New York State Department of Health and The Centers for Disease Control and Prevention for more information.
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Infection Control Practices for Programs Based in Article 28 Hospitals, including CPEP and Inpatient Units (and any ambulatory programs located in and/or run by Article 28 Hospitals)

- CPEP Crisis Beds (2600)
- CPEP Crisis Intervention (3130)
- CPEP Crisis Outreach (1680)
- CPEP Extended Observation Beds (1920)
- Inpatient Psychiatric Unit of a General Hospital (3010)
- Ambulatory Programs and other mental health programs run by and located in or in proximity to an Article 28 General Hospital

Program medical leadership must meet regularly and develop infection control policies and procedures that are consistent with guidance for healthcare settings (not for the general public) issued by the CDC, NYSDOH, and the Article 28 Hospital’s Infection Control Department. The NYS DOH continues to require that all psychiatric inpatient units and CPEPs maintain requirements for all staff and clients to wear a mask https://coronavirus.health.ny.gov/system/files/documents/2022/09/2.60-determination-9.7.22.pdf .

Departmental and program medical leadership should consider obtaining consultation from colleagues in the Infection Control or Infectious Diseases Departments. Policy and procedures must be individualized for each program and take into considerations the particular needs of the population served (i.e. rate fully vaccinated, rates of medical comorbidities, etc), the physical plant, particulars of the staff (i.e. rate fully vaccinated), and the biology of the SARS-CoV-2 virus (i.e. asymptomatic transmission, spread by aerosolized droplets, etc).


Infection Control Practices for Ambulatory Treatment, Support, Crisis, and Forensic Transition Programs, including Mobile and Community-Based Services

- CORE Community Psychiatric Support and Treatment (CPST) (4720)
- Adult BH HCBS Education Support Services (ESS) (4660)
- CORE Empowerment Services - Peer Supports (4650)
- CORE Family Support and Training (FST) (4690)
- Adult BH HCBS Habilitation (4700)
- Adult BH HCBS Intensive Supported Employment (ISE) (4620)
- Adult BH HCBS Ongoing Supported Employment (OSE) (4610)
- Adult BH HCBS Pre-Vocational Services (4640)
- CORE Psychosocial Rehabilitation (PSR) (4710)
- Adult BH HCBS Self-Directed Care (4740)
- Adult BH HCBS Transitional Employment (4630)
- Adult Home Supportive Case Management (6820)
- Advocacy/Support Services (1760)
- Affirmative Business/Industry (2340)
- Assertive Community Treatment (ACT) (0800)
- Assisted Competitive Employment (1380)
- CASES Homeless Forensic Case Management Program
- CFTSS: Children’s Mental Health Rehabilitation Program (4960)
- CFTSS: Community Psychiatric Support and Treatment (CPST) (4950)
- CFTSS: Family Peer Support Services (FPS) (4900)
- CFTSS: Mobile Crisis Intervention (CI) (4910)
- CFTSS: Other Licensed Practitioner (OLP) (4940)
- CFTSS: Psychosocial Rehabilitation (PSR) (4930)
- CFTSS: Youth Peer Support and Training (YPS) (4920)
- Children and Youth Assertive Community
Agencies and programs should consider every clinical encounter, whether in-person or virtual, as an opportunity to encourage vaccination and boosting for individuals who are not fully protected and for education on infection control practices.

Assertive Community Treatment (ACT), Community Oriented Recovery and Empowerment (CORE) services, Mobile Crisis, Forensic Transition Programs, and other specialty services that rely on home and off-site visits are specifically designed to serve vulnerable, high-risk individuals.
who have not been able to engage in traditional outpatient services. These clients are at high risk of disengaging from care in a transition to virtual services. ACT and similar programs must meet with each client and conduct an informed analysis to review each client’s risk and capacity to engage in and benefit from telehealth to determine when telehealth encounters are an acceptable alternative to in-person encounters (see considerations above). These services should aim to resume in-person visits for all clients as possible.

**Infection Control Practices for OMH-Licensed Clinic Treatment Programs (2100)**

Agency leadership must follow COVID-19 guidance issued by the NYS Department of Health (DOH) and the Centers for Disease Control and Prevention (CDC) for healthcare settings; and must meet regularly and develop policies and procedures for clinic programs. Policy and procedures must be individualized for each clinic and take into considerations the particular needs of the population served (e.g. rate fully vaccinated, rates of medical comorbidities), the physical plant, particulars of the staff (e.g. rate fully vaccinated), and the biology of the SARS-CoV-2 virus (i.e. asymptomatic transmission, spread by aerosolized droplets, etc). Policies and procedures should address pre-appointment screening, testing requirements, distancing requirements, size and length of therapeutic and rehabilitative groups, waiting room etiquette, and whether companions are permitted to accompany clients. Clinics must require masking in a manner that is consistent with NYS DOH requirements: [https://coronavirus.health.ny.gov/system/files/documents/2022/09/2.60-determination-9.7.22.pdf](https://coronavirus.health.ny.gov/system/files/documents/2022/09/2.60-determination-9.7.22.pdf) (see page 3).

**Infection Control Practices for OMH-Licensed Partial Hospitalization Programs (2200)**

Agency leadership must follow COVID-19 guidance issued by the NYS Department of Health (DOH) and the Centers for Disease Control and Prevention (CDC) for healthcare settings; and must meet regularly and develop policies and procedures for Partial Hospitalization Programs (PHPs). Policy and procedures must be individualized for each PHP and take into considerations the particular needs of the population served (e.g. rate fully vaccinated, rates of medical comorbidities), the physical plant, particulars of the staff (e.g. rate fully vaccinated), and the biology of the SARS-CoV-2 virus (i.e. asymptomatic transmission, spread by aerosolized droplets, etc). Policies and procedures should address pre-intake screening, testing requirements, distancing requirements, size and length of therapeutic and rehabilitative groups, waiting room etiquette, and whether companions are permitted to accompany clients. PHPs must require masking in a manner that is consistent with NYS DOH requirements: [https://coronavirus.health.ny.gov/system/files/documents/2022/09/2.60-determination-9.7.22.pdf](https://coronavirus.health.ny.gov/system/files/documents/2022/09/2.60-determination-9.7.22.pdf) (see page 3).

**Infection Control Practices for Congregate Residential Programs**

- Adult BH HCBS Intensive Crisis Respite (4670)
- Adult BH HCBS Short-term Crisis Respite (4680)
- Community Residence for Eating Disorder Integrated Treatment Program (6110)
- Crisis Residence (0910)
- Crisis/Respite Beds (1600)
- Apartment/Support (7080)
- Children & Youth Community Residence (7050)
- Congregate/Support (6080)
- Congregate/Treatment (6070)
- Family Care (0040)
- Respite Services (0650)
- Intensive Crisis Stabilization (1710)
Agency leadership must meet regularly and develop policies and procedures for residential programs that are consistent with guidance for the general population. Policy and procedures must be individualized for each program and take into considerations the particular needs of the population served (e.g. rate fully vaccinated, rates of medical comorbidities), the physical plant, particulars of the staff (e.g. rate fully vaccinated), the CDC COVID-19 Community Level, and the biology of the SARS-CoV-2 virus (i.e. asymptomatic transmission, spread by aerosolized droplets, etc). Policies and procedures should address room assignment, use of common areas, masking requirements, distancing requirements, size and length of educational or rehabilitative groups, and visitor screening/vaccination requirements. There is no statewide requirement that all residential programs require masking, but based on the risk factors mentioned above, agency leadership may determine to require masking for staff and/or clients in particular programs when there is an outbreak. Continued mask wearing by staff and clients remains strongly recommended. Agencies may not make admission conditional on COVID-19 vaccination, although programs should continuously educate staff and residents on the importance of getting vaccinated and staying fully vaccinated with boosters.

In addition, mental health housing programs should consider the following additional efforts to protect clients and staff in these programs:

1. Obtaining the COVID vaccine is the best way for individuals to protect themselves and their communities. It is strongly encouraged for all individuals in residential programs, staff and clients, to be fully vaccinated against COVID-19.
2. Socializing among individuals who live in the residence should preferably occur outdoors or in large, well-ventilated spaces.
3. Socializing with individuals who do not live in the program should occur outdoors as much as possible.
4. Prior to entering the residence, visitors should be asked if they have any COVID-19 symptoms (see appendix), if they recently tested positive for COVID-19, or if they recently came into contact with anyone with COVID-19. If any of these are present, the visitor should not be allowed into the residence. If the program has a thermometer, then the visitor’s temperature should be checked at the door. Preferably, programs will only allow indoor visitors who can present proof of being fully vaccinated or a negative test within the last 24 hours.
5. All staff who work in congregate residential programs should always wear a mask when at work unless alone in their own office with the door closed. High-quality, securely-fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks.
6. Upon returning home, residents and any accompanying staff should immediately wash their hands with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer with at least 60% alcohol. Cell phones and other frequently handled items should be sanitized daily. All residents should be reminded to avoid touching their faces.
7. Congregate residential programs are permanent or long-term homes to many individuals. It is not an expectation that people wear a mask at home with their families, housemates, and roommates. It is important to preserve the home-like atmosphere in residential programs, but it must not be forgotten that any congregate setting can pose a risk of infection, illness, and death if appropriate infection control precautions are not maintained.
8. Please see below for guidance when a new resident is admitted to a program.
9. Frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks) should be disinfected daily.
10. Clients and staff should be instructed to report symptoms as soon as possible. Staff specifically should ask all clients daily about COVID-19 symptoms.

11. Agencies should encourage their clients to access primary care and obtain an influenza vaccine.

12. Programs should work with local health departments, local healthcare providers, and pharmacies to access COVID testing if there is concern of a possible exposure or outbreak.


Infection Control Practices for Psychiatric Hospitals and Residential Treatment Facilities

- Residential Treatment Facility - Children & Youth (1080)
- Private Inpatient Psychiatric Hospital (2010)

Inpatient and RTF programs must follow COVID-19 guidance issued by the NYS Department of Health (DOH) and the Centers for Disease Control and Prevention (CDC) for healthcare settings. This includes the masking determination from DOH: https://coronavirus.health.ny.gov/system/files/documents/2022/09/2.60-determination-9.7.22.pdf.

Agencies should consider the following additional efforts to protect clients and staff in these programs:

1. Obtaining the COVID vaccine is the best way for individuals to protect themselves and their communities. It is strongly encouraged for all individuals in residential programs, staff and clients, to be fully vaccinated against COVID-19.

2. Socializing among individuals who live in the residence should preferably occur outdoors or in large, well-ventilated spaces.

3. It is strongly encouraged for all residents to wear a mask in common areas unless actively eating, drinking, or showering.

4. All visitors two years of age and older and able to medically tolerate a mask, must wear a mask regardless of vaccination status.

5. High-quality, securely-fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks.

6. Socializing with individuals who do not live in the program should occur outdoors as much as possible. Masks should be worn by all whenever clients are socializing with individuals who do not live in the residence.

7. Prior to entering the residence, visitors should be asked if they have any COVID-19 symptoms, if they recently tested positive for COVID-19, or if they recently came into contact with anyone with COVID-19. If any of these are present, the visitor should not be allowed into the residence.

8. Prior to entering the residence, visitors should be screened for COVID-19 symptoms (see appendix) or recent contacts with individuals sick with COVID-19. If yes, the visitor should not be allowed into the residence. Programs should also require proof of vaccination or negative test within 24 hours for all visitors.

9. All staff who work in RTFs or hospitals must always wear a mask when at work unless alone in their own office with the door closed.

10. Upon entering the facility, all clients and staff should immediately wash their hands with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer with at
least 60% alcohol. Cell phones and other frequently handled items should be sanitized daily. All residents should be reminded to avoid touching their faces.

11. Please see below for guidance when a new resident is admitted to a program.

12. Frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks) should be disinfected daily.

13. Clients and staff should be instructed to report symptoms as soon as possible. Staff specifically should ask all clients daily about COVID-19 symptoms.

14. Agencies should provide an influenza vaccine to all clients.

15. Programs should work with local health departments, local healthcare providers, and pharmacies to access COVID testing if there is concern of a possible exposure our outbreak.

16. Free-standing Article 31 hospitals should implement surveillance rapid testing of all staff:
   a. Surveillance testing should be implemented twice per week for staff who work where that have been active COVID-19 cases in patients or staff in prior two weeks
   b. Surveillance testing should be implemented once a week for staff who work in settings where there are NO active COVID-19 patient or staff cases
   c. Surveillance testing should be increased to twice a week for unvaccinated staff when the county COVID-19 positivity is greater than 3%
   d. Hospitals may apply for multi-site Limited Service Laboratory Certificate to do onsite rapid COVID-19 testing. [https://www.wadsworth.org/regulatory/clep/limited-service-lab-certs. Competency evaluations for testing is necessary.](https://www.wadsworth.org/regulatory/clep/limited-service-lab-certs)

17. Free-standing Article 31 hospital administrators must implement Part 557 on vaccination requirements for staff: [https://omh.ny.gov/omhweb/policy_and_regulations/emergency/557-vaccination.pdf](https://omh.ny.gov/omhweb/policy_and_regulations/emergency/557-vaccination.pdf)


**Accepting New Clients (ALL Congregate Programs)**

1. Programs accepting new clients may require a COVID-19 diagnostic PCR test within 72 hours prior to transfer from another institutional setting. Staff should screen all new arrivals for symptoms or recent exposures.

2. For clients who previously tested positive for the COVID-19 virus, diagnostic PCR tests may remain positive for many weeks after the client is no longer at risk of transmitting COVID. Programs do not need to request a new PCR diagnostic test if there is evidence the client recovered from a COVID-19 infection within the prior 3 months. The program should confirm that 10 days have passed since the first COVID-19 symptom (or positive test result if the individual was asymptomatic), that the individual has been fever-free for at least 24 hours without the aid of fever-reducing medications, and that the individual’s symptoms have significantly improved. There is no need to wait for test results to become negative prior to accepting the client.

3. If a program accepts a client without a negative PCR test or proof of recent recovery from COVID-19, the program should arrange for the client to be tested right away. Alternatively, the client should remain in their room as much as possible during the first 14 days and maintain six feet of distance from all other clients and staff to the extent practicable and wear a high-quality, securely-fitting mask.

**Responding When Client Develops Symptoms (ALL Congregate Programs)**

1. When a client in the residential program develops symptoms of a COVID-19
infection, the client should be asked to stay in their room. If possible, the client should be assigned a single room. The client must be asked to wear a mask. Meals should be taken in the room.

2. High-quality, securely-fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks. It is strongly recommended that when working with clients with known or suspected COVID-19, staff wear N95s that have been fit-tested to them.

3. All clients in the program should always wear a mask when in proximity of individuals who are showing symptoms of COVID-19.

4. Ventilation in common rooms, bathrooms, and bedrooms should be maximized. If possible, leave windows open to allow air circulation with the outside of the building. Electric fans close to open windows may enhance circulation. Programs with sophisticated HVAC systems should modify settings to ensure that air from within the residence is channeled outside, and not to other parts of the building.

5. Programs who have at-home testing kits should test clients and staff exposed to clients showing symptoms twice weekly until all infections resolve and everyone completes their isolation periods. Congregate residential programs without in-house testing capacity must work with their local health departments and local provider networks to plan for testing for the affected client as soon as possible. Other residents in the program and staff should also be tested, preferably twice per week until all cases resolve.

6. If a client with COVID-19 requires close support from a staff member (within six feet), the staff member and client must wear a tight-fitting, high-quality mask and the staff member must also wear gloves and eye-protection. Outer clothing that becomes soiled or possibly soiled with a client’s saliva, urine, blood, or stool should be removed immediately and set aside until washed.

7. Roommates should be moved to another room, if possible. Roommates should, if possible, have their own rooms for 14 days or for two negative tests three days apart. If they remain symptom-free or have two negative tests, they can then share a room with another.

8. If more than one client has a positive test, then these individuals can share a room if the program has shared bedrooms.

9. Clients who test positive or develop COVID symptoms may be taken off isolation when:
   a. The person has had no fever for at least 24 hours without the use of fever-reducing medications; AND
   b. There is a significant improvement of symptoms; AND
   c. At least 10 days have passed since symptoms first appeared (or, if asymptomatic and never developed symptoms, since the date of COVID-19 test collection) OR the client has a negative rapid test at least 7 days after the start of isolation.

10. In clients who are severely immunocompromised (see https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html#definitions) for definition, isolation may be discontinued when:
    a. The person has had no fever for at least 24 hours without the use of fever-reducing medications; AND
    b. There is a significant improvement of symptoms; AND
    c. At least 20 days have passed since symptoms first appeared (or, if asymptomatic and never developed symptoms, since the date of COVID-19 test collection).
Guidance for Child and Youth-Serving Residential Programs
Home-time leaves should continue to occur as appropriate. The following should also be considered:

1. Programs should facilitate vaccination for their clients.
2. Programs should encourage family members and guardians to obtain the COVID-19 vaccine.
3. The youth and family must agree that the home-time leave is appropriate and safe. Staff should ask families whether anyone at home has COVID-19 symptoms or is in a high-risk category.
4. Programs are encouraged to obtain testing before and after home visits.
5. Information on general infection control strategies should be provided to the youth and parents/guardians.
6. Any youth in quarantine or isolation may not leave the program site for community or home-time leave.

Infection Control Practices for Scatter-Site Residential Programs

- Apartment/Treatment (7070)
- Shelter Plus Care Housing (3070)
- Supported Housing Community Services (6060)
- Supported/Single Room Occupancy (SRO) (5070)
- SRO Community Residence (8050)

1. Programs should encourage all staff and residents to obtain the COVID vaccine and booster.
2. Programs should educate all clients about their CDC COVID-19 Community Level and help clients take appropriate masking precautions in medium or high level communities. Staff should also educate clients about practicing appropriate hand hygiene, avoiding touching their faces, and practicing basic disinfecting at home.
3. When visiting a client, staff should use alcohol-based sanitizer prior to entering the client’s home and should wear a mask. If the client has confirmed or suspected COVID-19, staff should also wear a face shield if an in-person visit is unavoidable.
4. High-quality, securely fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks. Staff should avoid using cloth masks when visiting clients.
5. Staff should keep at least six feet away from the client during the visit.
6. Staff should use alcohol-based sanitizer immediately upon leaving the client’s building.

Guidance for Staff
Agencies should follow guidance issued by DOH and the CDC for healthcare personnel:

4. High-quality, securely fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks. Staff may need to be advised that facial hair or large piercings/jewelry may prevent tight seal to form and negate benefit of high-quality masks. Staff should avoid wearing cloth masks.

Guidance on Non-Emergent Transportation

1. When transporting clients in a vehicle, all individuals are strongly encouraged to wear a mask.
2. High-quality, securely fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks.
3. Whenever possible, have no more than two individuals, including the driver, in a sedan or three individuals in a van.
4. If client or staff is in any way immunocompromised (chemotherapy, AIDS, other), do not have more than two people in vehicle and all must wear masks.
5. To maximize safe air circulation, client should sit directly behind the driver. Open the driver’s window (front left) and the rear window opposite the passenger (rear right).
6. If using heating or air-conditioning, NEVER use the recirculation setting. Always have air come into vehicle from outside.
7. Disinfect all high contact inside surfaces after every trip, in front and rear seats. Ensure hand sanitizer is available in vehicle for staff and client use.
8. Staff who have COVID-19 must isolate away from work until isolation period ends. These individuals should never be in a vehicle with clients.
9. If a client has COVID-19 and needs transportation, both staff and client must wear masks, no more than two people should be in vehicle, ensure windows are open as described above, if possible, use a van to maximize distance between client and staff.

Appendix: COVID-19 Symptoms

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

When to Seek Emergency Medical Attention:
- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone