16. Community Health Services

For purposes of OHPIP, community health services include:

- *community care access centres, home care providers, and community support services*
- *community mental health and addiction services*
- *other community-based health services.*

The 2008 edition of OHPIP includes the plan for community mental health and addiction services. Plans for home care services and other community-based health services are still under development.

For primary care services, see Chapter 11; for long-term care services, see Chapter 19.

16.1 Community-based Mental Health and Addiction Services

> [The pandemic] kept people apart … It took away all your community life, you had no community life, you had no school life, you had no church life, you had nothing … It completely destroyed all family and community life. People were afraid to kiss one another, people were afraid to eat with one another, they were afraid to have anything that made contact because that's how you got the flu …There was an aura of constant fear that you lived through from getting up in the morning to going to bed at night.
>
> *The Great Influenza*, John M. Barry

An influenza pandemic will threaten the health of people with mental health and/or addiction problems. It will also disrupt the services they rely on to manage their health.

During a pandemic, the primary responsibilities of agencies and organizations that provide community-based mental health and addiction services will be to:

- help clients access the mental health, addiction and other essential health and social services they need
- support as many clients as possible in the community to reduce the need for hospitalization and free up more beds for influenza care
- educate clients about how to reduce the risk of acquiring influenza and where to go for care
- help clients with flu symptoms connect with flu centres and get the care they need
- slow the spread of influenza in their settings.

In addition, community-based agencies and organizations that provide residential programs and services – such as supportive housing programs, group homes, Homes for Special Care and residential treatment programs – will need to provide some direct care for residents who develop influenza but do not require hospitalization.

This chapter is designed to provide a framework that community-based mental health and addiction agencies can use to prepare for an influenza pandemic.

16.1.1 Objectives

- To help community-based mental health and addiction services prepare for an influenza pandemic.
- To maintain essential community-based mental health and addiction services during a pandemic.
- To make effective use of mental health knowledge, skills and services during a pandemic.
- To slow the spread of influenza within community-based mental health and addiction service settings.

16.1.2 Implications of an Influenza Pandemic

For People with Mental Health and/or Addiction Problems

Increased Vulnerability

Many clients with severe mental illness will be vulnerable to influenza because their health may already be compromised.

Many clients live in congregate living settings (e.g., homeless, shelters,

supportive housing, Homes for Special Care) where – because of space restrictions, crowding and the overall health of the population – the risk of being exposed to influenza will be higher.

Some clients may find it difficult to comply with public health measures designed to slow the spread of influenza (e.g., voluntary isolation, social distancing, cough etiquette).

Any disruption in the supply of alcohol or illegal drugs could lead to an increase in crime and demands on law enforcement and/or push people with addictions into withdrawal, and increase the demand for treatment services.

Clients in residential programs may have less interaction with family and friends, which could affect their mental well-being.

Problems Accessing Services

Hospitals providing care for influenza patients may restrict access to mental health outpatient clinics and detox or withdrawal programs. These restrictions occurred during the SARS outbreaks and made it very difficult for clients with mental health and addiction problems to get the treatment (including medications) they needed.

Hospitals providing care for influenza patients may discharge mental health patients to the community, increasing the demands on community services. They may also be hard-pressed to meet the demand for outpatient services, including services that are essential for other parts of the health care system, such as psychogeriatric outreach to long-term care homes.

For Agencies and Organizations Providing Mental Health and Addiction Services

Increased Demand for Services

Community-based agencies will be under pressure to provide as much care as possible for people with severe mental illness, reducing the need for hospitalization. They may also be asked to assist in providing outpatient services.

Many people with mental health and addiction problems do not have a primary care provider, and may turn to community-based mental and addiction agencies for care and advice on influenza.

Residential and group living settings, such as group homes, supportive housing units, Homes for Special Care and residential addiction treatment programs, provide housing services and can anticipate having clients with influenza who are not sick enough to require hospitalization. Staff in these settings may need to provide a basic level of medical care, but may not have appropriate knowledge or skills.

Community-based programs that provide both mental health and primary care services may see an increased demand for primary care, assessment and influenza-related treatment services.

Workforce Disruption

At the peak of the pandemic, as many as 20 to 25% of the mental health and addictions workforce may be unavailable – due to illness, family responsibilities or other demands in the health care system.

Depending on their competencies, some mental health professionals – particularly doctors, nurses and counsellors – may be asked to provide influenza-related services (e.g., provide counselling for health professionals dealing with stress),

and may not be available to provide community-based mental health and addiction services. Agencies and organizations that provide community-based services may have to rely on other types of providers and volunteers to maintain their programs.

Need for New Knowledge and Skills
Mental health and addiction settings are not necessarily knowledgeable about infection prevention and control, and may not have the systems, policies and equipment to slow the spread of influenza in their congregate living facilities or office-based programs.

Staff in congregate living settings may not have the skills to provide basic care for residents with influenza.

To be prepared, community-based mental health and addiction agencies should develop plans to maintain essential services during a pandemic.

16.1.3 Planning

Review and Update Emergency Plans
Every community-based mental health and addiction agency should develop a plan for an influenza pandemic, which should be reviewed and updated annually or more frequently if required. These plans should be based on the business continuity and emergency plans already in place in mental health and addiction agencies, modified to reflect the potential severity of an influenza pandemic. (See Chapter 16A for a planning checklist.)

Coordinate Planning with Other Health Organizations
Because an influenza pandemic will affect the whole community, mental health and addiction services cannot plan in isolation. They should:

- connect with the local public health unit, which is responsible for coordinating local pandemic health plans
- work with other health organizations in the community, including other mental health and addiction agencies, hospitals, community care access centres (CCACs), home care providers, primary care providers, emergency medical services, local public health units, pharmacies, social services and police services, to plan for the needs of people with mental health and addiction problems during a pandemic. For example, flu assessment centres will need staff with the skills to manage disadvantaged populations (i.e., people with mental health or addiction problems, people who are homeless)
- familiarize themselves with other organizations' plans and functions during a pandemic
- identify possible scenarios and how they would be handled by the system (e.g., if the hospital has to discharge psychiatric patients, how will the community provide care? If hospitals limit access to out-patient services, who will dispense medications and how will clients access their medications or be monitored for side effects? If hospital-based outpatient programs are no longer able to provide psychogeriatric services for long-term care homes, how will the mental health needs of the homes be met? If the community experiences a large number of influenza cases and deaths, how will the system provide counselling and psychological support? How will the community meet the needs of highly vulnerable people, such as people who are homeless or street-involved? Given that 40 to 50% of people who use

shelters have mental health problems, how will the community ensure that shelters or other emergency services continue to operate throughout a pandemic?)

- identify opportunities to collaborate/ share resources during a pandemic. For example, mental health drop-in centres or withdrawal management centres (particularly those not on a hospital site) could be used to deliver some influenza-related services or to provide services for vulnerable populations, such as people who are street-involved or Aboriginal peoples living off-reserve
- collaborate/consult with hospitals about any plans the hospitals are developing to curtail or change mental health services managed by hospitals (e.g., withdrawal management services, outpatient programs) to ensure that decisions do not have unintended negative consequences (e.g., increasing the number of people seeking mental health services in hospital emergency departments).
- work with partners, such as acute care hospitals and community psychiatrists, to develop criteria for mental health and addictions clients who will be admitted/maintained in hospital and those who will be cared for in the community
- work with partners to develop criteria and procedures for managing clients in congregate living settings who develop influenza (e.g., who will provide care? when should they be transferred to another setting?)
- work with police to plan how to manage safe beds and provide mobile crisis services during a pandemic
- determine whether community-based mental health and addictions staff will be asked to work in other parts of the system during a pandemic and/or whether some hospital staff currently working in mental health will be available to work in the community (e.g., mental health nurses, psychiatrists)
- identify services that may be in greater demand during a pandemic (e.g., counselling and support to address pandemic-related fear, anxiety, refusal to work, non-compliance with public health measures, grief and loss; practical support), and how they will be delivered
- help shape public messages to reduce fear and reinforce coping mechanisms.

16.1.4 Assess Clients' Needs

Community-based mental health and addiction services should assess clients' care needs in order to identify:

- clients whose mental health and addiction services must be maintained at all times (e.g., clients who require safe beds, clients being served by ACT teams, clients on methadone)
- clients who require acute care services and those whose needs can be met in the community
- clients whose needs can be met in non-traditional ways (e.g., counselling by phone)
- clients who will need assistance with practical needs, such as food and transportation
- clients who will need assistance obtaining medication and/or adhering to antiviral therapy if they fall ill with influenza

- clients whose needs can be met by family members with some support from professionals – including clients in congregate living settings who could be discharged home
- clients whose care can be safely delayed or deferred
- clients at highest risk of complications from influenza. The assessment should include plans to limit their risk of exposure.

Agencies should keep client assessments up-to-date based on the criteria listed below.

Identify Services that must be Maintained and Services that Could Be Curtailed

During a pandemic, community-based mental health and addiction services will likely be short staffed, and will need to use limited resources to deliver essential services. Agencies will identify:

- services that MUST be maintained
- services that could be reduced or curtailed (e.g., offered once every two weeks instead of once a week), or delivered in different ways (e.g., smaller groups, by phone instead of in person).

The criteria to determine services to be maintained would include:

- the service is required to prevent/ reduce danger to self or others
- lack of or delay in treatment will have a serious negative impact on client's health
- the ability of the service to reduce demands on other parts of the health care system
- the ability of the service to slow the spread of influenza
- increased need for the service during a pandemic.

Table 16.1.1 suggests the types of mental health and addiction services that should be maintained and those that could be curtailed or adapted.

Note*: the need to reduce or curtail services will depend on the severity of the pandemic. If the pandemic strain is mild (i.e., <.5% of deaths in population), agencies may be able to maintain almost all services; if the pandemic is severe (i.e., >2% of deaths in population), it will be much more difficult to maintain services, and many will have to be reduced or stopped.* For more discussion of pandemic severity, see Chapter 6.

Storage and Tracking Systems for Antivirals

With the exception of ACT teams and some residential programs, it is not likely that community-based mental health and addiction agencies will be storing or distributing antivirals for treatment; however, if it is appropriate or necessary for them to do so, they will be given instructions by the local public health unit.

16.1.5 Infection Prevention and Control/Occupational Health and Safety

To slow the spread of influenza in community-based mental health and addiction settings, agencies should comply with the *Occupational Health and Safety Act*, and adopt the hierarchy of controls approach (see Chapter 7). The type and level of controls will vary depending on the nature of the setting and type of services being provided.

Table 16.1.1 Maintaining Mental Health and Addiction Services

Program/Service	Maintain or Increase	Reduce or Delay
Acute in-patient services	**Maintain as long as possible; if it is necessary to move patients out of hospitals, identify other ways to deliver services (e.g., community-based mental health agencies or services, home care, by phone, in other residential settings)**	
Hospital-based psychiatric programs (e.g., eating disorders)	**Maintain but provide services at another site or in other ways (e.g., by phone)**	**Postpone admission of new clients on a case by case basis; identify other ways to provide support**
Forensic services and safe beds	**Maintain**	
Assertive Community Treatment (ACT) Teams, case management programs, and other services for severe mental illness	**Maintain or increase depending on the capacity of hospitals to provide in-patient care**	
Outreach, including crisis services, peer programs and psychogeriatric outreach to long-term care homes	**Maintain services as long as possible** **When providing face-to-face service, screen clients for flu symptoms and take appropriate steps (e.g., referring clients to a flu centre, social distancing, and taking other precautions)**	
Drop-in centres, including peer programs	**Maintain services as long as possible** **Screen clients for flu symptoms and take appropriate steps (e.g., referring clients to a flu centre, social distancing, and taking other precautions)** **Adapt functions to implement social distancing strategies to prevent spread of flu in setting (e.g., limiting number of people in a given space, providing some services outside, bag meals)**	
Supportive housing, and other residential MH services	**Maintain**	**Postpone admission of new clients on a case-by-case basis**
Access to stabilizing medication, including methadone, and other harm reduction supplies (e.g., needle exchange programs)	**Maintain or increase to compensate for any disruptions in supply from other usual sources (e.g., hospital or community pharmacies)**	
Outpatient mental health or addiction counselling services	**Maintain but provide services in different ways (e.g., less frequently, by phone)**	**Postpone admission of new clients on a case-by-case basis; identify other ways to deliver services**
Residential addiction treatment services – including withdrawal management services	**Maintain existing clients through course of treatment** **Consolidate services on fewer sites to compensate for staff shortages**	**Postpone admission of new clients on a case-by-case basis or identify other ways to deliver services** **Reduce group size**
Non-residential mental health or addiction services, including peer programs, employment supports/ alternative businesses, day treatment programs, and community withdrawal management programs	**Maintain existing clients through course of treatment, provide services in other ways (e.g., by phone, Internet)**	**Postpone on a case-by-case basis for new clients**

Environmental Controls: Changes to the Physical Environment

Agencies and organizations should make every effort to create physical environments that will reduce the spread of influenza, and protect staff, clients and visitors (e.g., hand sanitizer stations at the doors, plexiglass barriers between receptionists and clients, enough space in waiting areas that clients can stay about two metres from one another, an entrance designated for people with flu symptoms).

Note: *OHPIP recommends the use of alcohol-based hand sanitizer. Some community-based mental health and addiction agencies may be concerned about the use of alcohol-based sanitizers in environments where many clients smoke (i.e., because alcohol-based sanitizer is flammable) or have addictions to alcohol. In those cases, agencies should explore alternatives to alcohol-based sanitizers with their local public health unit or develop additional safety procedures for how alcohol-based sanitizer is distributed (e.g., controlled by staff).*

Administrative and Work Practices: Changing the Way Agencies Work

Community-based mental health and addiction agencies should establish policies and practices to reduce the spread of influenza, including:

- an immunization policy, encouraging all staff, clients and volunteers to have the annual flu shot (Note: this will not reduce the individual's chance of getting the pandemic flu virus but does help keep the person in good general health.)
- hand hygiene policies and procedures, and cough etiquette
- strategies to help staff, clients, volunteers and visitors comply with hand hygiene and other protective measures

> **Screening, Surveillance and Care in Residential and Group Living Settings**
>
> **During a pandemic, agencies operating residential programs should monitor clients for symptoms of influenza-like illness. Clients with symptoms should be taken/referred to a Flu Centre to be assessed. and referred to the appropriate level of care.**
>
> **Depending on the attack rate and severity of the pandemic, people with influenza are only likely to hospitalized if their illness is life-threatening (i.e., requires intensive care). Otherwise, they will be cared for where they live.**
>
> **For assistance with infection control procedures, residential settings should contact their Regional Infection Control Network, local public health unit or the infection control department at the local hospital or long-term care home.**

- a screening / surveillance procedure to assess staff, clients, volunteers and visitors for flu symptoms, and implement appropriate precautions (e.g., asking clients with flu symptoms to sit in a separate waiting area or wear a surgical mask)
- encouraging staff, volunteers and visitors to stay home when ill
- social distancing procedures to be followed by staff in congregate living settings, such as sitting people about two metres apart at meals, organizing two seating times for meals, cancelling social activities, feeding people who have the flu in their rooms, cohorting people with flu in the same room, grouping residents with flu symptoms in one part of the facility; asking residents with influenza-like illness to wear a surgical mask. ***Note****: droplets from a coughing or sneezing person can be expelled a distance and may be inhaled by someone who is within two metres of the coughing or sneezing person.*

- cleaning more frequently and following environmental guidelines for cleaning (see Chapter 7)
- delivering certain services by phone or Internet, or in smaller groups.

Occupational Health and Safety Tip Box

Employers have developed and implemented appropriate measures, procedures and training for the protection of workers in consultation with Joint Health & Safety Committees (JHSC) or Health and Safety Representatives and Infection Prevention and Control resources. See measures in Chapter 7 for more information.

Some examples of controls community health services include:

- hand hygiene and cough etiquette signage
- appropriate IPC housekeeping practices
- hand hygiene
- education and training for workers and supervisors
- personal protective equipment (based on risk assessment)

Web resources: http://www.labour.gov.on.ca; http://www.ricn.on.ca; http://www.osach.on.ca; http://www.whsc.on.ca

For more information on Occupational Health and Safety Measures and Infection Prevention and Control in Health Care Settings consult the OHPIP Chapter 7.

Personal Protective Equipment

Community-based agencies that are NOT providing direct care for clients who have influenza or working closely with vulnerable populations (i.e., homeless clients, people with severe mental illness who might have to be restrained) will require only basic personal protective equipment, such as a supply of surgical masks and hand sanitizer. Masks would be worn only when staff have to be within three feet of a client who has flu symptoms (i.e., coughing, sneezing). Whenever possible, the mask would be worn by the symptomatic client.

Community-based agencies that are providing some level of care for clients with influenza (e.g., residential programs) or outreach to vulnerable populations may require a higher level of personal protective equipment. See Chapter 7.

To determine which workers need access to personal protective equipment and the type of equipment they require, agencies should conduct a risk assessment (see Chapter 7).

Staff Training and Education

Staff should have appropriate training and education in infection prevention and control techniques – particularly staff working in congregate living programs. Education programs should be developed in consultation with the Joint Health and Safety Committee or representatives, and should include:

- the agency's influenza pandemic plan and policies
- any procedures or programs that will change during a pandemic
- risks, benefits, and myths of seasonal influenza immunization
- the benefits of screening/surveillance
- the importance of hand hygiene and proper hand hygiene technique
- cough etiquette
- appropriate use of personal protective equipment
- caring for someone with influenza-like illness – including infection prevention and control measures (for staff working in residential or congregate living programs only)
- information/education for clients/residents, and strategies to encourage compliance.

16.1.6 Supplies and Supply Chains

Community mental health and addiction agencies should identify the type and quantity of supplies they will need during a pandemic wave, as well as potential suppliers. They should purchase and stockpile a four-week supply of personal protective equipment. (See Chapter 10 for a supplies and equipment template.) They should also have contingency plans in case traditional supply chains are disrupted. For example, clients may not be able to access methadone or other medications through hospital pharmacies so agencies will have to arrange another way to obtain prescriptions and medications (e.g., through arrangements with physicians and a local pharmacy).

Congregate living programs should make arrangements with suppliers to maintain supplies of food, cleaning supplies and other materials.

When agencies are serving clients who are dependent on food banks, they should work with the food banks to ensure that clients will continue to be able to get food during a pandemic.

16.1.7 Develop an HR Plan

During a pandemic, community-based agencies may experience staff and skill shortages. The Ontario Health Plan for an Influenza Pandemic (OHPIP) supports a skills-based approach (for more information, see Chapter 8). As part of their planning, mental health and addiction agencies should identify:

- skills required to meet clients' needs
- staff who have those skills or could be trained to take on more responsibilities within their scope of practice
- strategies that could be used to increase capacity (e.g., redeploying hospital-based staff to programs in the community, contracting staff from external agencies, extending working hours, calling staff back to work)
- other staff (e.g., clerical) who could be trained to assist with care
- volunteers and family members who could be trained to assist
- other organizations in the community that might be able to provide workers with the appropriate skills
- any labour (i.e., union), insurance or liability issues to be addressed
- the supports that staff and other workers may need to be able to work (e.g., transportation, accommodation, assistance with child care and other family responsibilities).

Agencies should engage the Joint Occupational Health and Safety Committee or representative in pandemic planning to ensure plans include appropriate practice, communication and education.

16.1.8 Communicate with Staff, Clients, Families and Volunteers

Most community-based mental health and addiction agencies will already have established plans and procedures for communicating with staff, clients, families and volunteers during an emergency. These plans should be reviewed to ensure that they will be appropriate during a pandemic. Agencies should maintain up-to-date contact lists for staff, clients and families.

To help ensure that all staff, clients and the public receive consistent messages

from all parts of the health care system, mental health and addiction agencies should use influenza fact sheets and other materials provided by the local public health unit or the MOHLTC, including Important Health Notices.

In addition, agencies should communicate with staff, clients and visitors about how services will be delivered during a pandemic, such as:

- encouraging clients/visitors to phone rather than come into the agency
- informing clients/visitors about any change in services or work practices
- providing as many services as possible by phone or other ways that reduce the need for people to congregate
- directing staff, clients, volunteers and visitors who have flu symptoms to appropriate services (e.g., Telehealth, flu centres) – and, if possible, discouraging them from entering mental health and additions settings.

This information should be communicated on the agency's voice mail and web site, and through clear signs on the doors.

Directives

During a pandemic, the Ministry of Health and Long-Term Care may issue directives about care, infection control or other issues. Information will be provided on how and when to apply these directives in community-based mental health and addiction settings.

16.1.9 Next Steps

The community-based mental health and addiction workforce has skills that will be valuable in helping manage the personal and social impact (i.e., fear, anxiety) of a pandemic. Representatives from this sector will work with the MOHLTC to develop a strategy for psychosocial support. The sector will also address outstanding issues, including:

- procedures, equipment, training and support required to maintain outreach and other essential community-based mental health and addiction services to highly vulnerable populations (e.g., homeless)
- the capacity of small community-based agencies to prepare for a pandemic
- a training strategy for the mental health and addictions workforce.