Annex P

Canadian Pandemic Influenza Plan *for the Health Sector*

Pandemic Influenza Psychosocial Annex

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Summary of significant changes:

- This is a new Annex.
- The Annex outlines a suggested planning framework for addressing the psychosocial implications of a pandemic influenza or any large-scale public health emergency.
- The Annex identifies key activities to be undertaken to prevent/mitigate, prepare for, respond to and recover from the psychosocial consequences of a pandemic influenza.
- The Annex is not prescriptive in structure; rather it is based on the assumption that activities will be undertaken in accordance with local organizational structures and arrangements.

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1.0 Introduction

This document outlines a suggested planning framework for addressing the psychosocial implications of a pandemic influenza or any large-scale public health emergency and is intended for, but not limited to, planners at all levels of government and non-governmental organizations.

It begins by providing the rationale for applying a psychosocial lens in pandemic influenza planning and goes on to describe the major components of psychosocial health emergency planning assessment, identification of vulnerable individuals/populations, development and delivery of support services, program evaluation and modification, as well as the need for comprehensive and timely communication and information sharing within all levels of government, non-governmental organizations, the public and the media.

A suggested planning framework is outlined detailing pandemic phase-specific activities. These are based on current research on the psychosocial dimensions of disasters, including lessons learned from the severe acute respiratory syndrome (SARS) outbreak in 2003, the public health response to the anthrax incidents in 2001 and professional consensus regarding best practice in psychosocial disaster response.

The scope and nature of the specific plans developed using this framework will vary and reflect the wide range of planning roles, responsibilities and resources that exist among pandemic planning partners at all levels of government.

The range of issues associated with psychosocial planning is broad (e.g. workforce resiliency, mental health and illness, social cohesion, public trust) involving all levels of government and multiple planning partners. Effective psychosocial pandemic planning will need to be coordinated and be collaborative across multiple systems if it is to result in plans that truly enhance Canada's pandemic response capacity. As a result, this process is likely to place substantial and additional demands on planners in health, mental health and other social service systems. It will be particularly challenging for organizations or communities in which the availability of or access to planning resources (human, financial, material) is limited (e.g. rural, geographically remote or dispersed). Not addressing the psychosocial dimensions of pandemic planning, however, could have a cascading effect, derailing the country's overall response capacity, exacerbating other pandemic-related issues (e.g. economic downturns, workforce shortages), and undermining business and community viability and continuity in the short and long term.

Anticipated impact on the Canadian health care system using U.S. CDC FluAid software & attack rates (according to the Public Health Agency of Canada):

- 4.5-10.6 million Canadians would become clinically ill and unable to attend work or other activities for at least 0.5 days;
- 2.1-5.0 million would require outpatient care; and
- 34,000-138,000 would require hospitalization and would recover, and there would be 11,000-58,000 deaths, with hospitalizations and deaths occurring in a relatively short (6-8 month) period – pandemic waves.

Estimates range anywhere from 10% to 25% of the population who will lose working days because of illness or caregiving responsibilities (US Department of Health and Human Services, 2005, Public Health Agency of Canada and Canadian Federal Department of Finance). A predicted economic impact of direct/indirect health outcomes was estimated to be between CAN $10 and $24 billion in 1999 and does not include other societal impacts (e.g. tourism, trade).

Comparative health care usage rates between an interpandemic and pandemic year using Canadian data (Alberta):

- 3.7 times as many outpatient visits;
- 3.9 times as many hospitalizations; and
- 8.2 times as many deaths.[1]

1.1 Rationale: The Importance of Pandemic Influenza Psychosocial Planning

The consequences of an influenza pandemic may far exceed those associated with any disaster we have yet encountered. In addition to posing a physical health threat, the secondary consequences of an influenza pandemic will be substantial. Illness, death, caregiving responsibilities and fear of infection will place extreme demands on the health care system and contribute to sudden and significant shortages of personnel and resources in all sectors. High rates of absenteeism, public health measures and fears of infection may result in the disruption of many normal business activities, contributing significant economic downturns particularly in tourism and other service-related industries. There may be extended and multiple periods of time when community members will not be able to engage in the routines of school, work and many leisure activities while simultaneously coping with the ongoing uncertainty of the threat and the grief of losing friends, family and colleagues.

Although disasters can often have positive secondary consequences, particularly during the response and the immediate recovery periods (e.g. increase in altruism, volunteerism, enhanced sense of social cohesion), public health measures (e.g. social isolation strategies) and the prolonged and extensive nature of an influenza pandemic may diminish some of this potential and exacerbate the social cleavages and breakdowns also common in the aftermath of disasters.[2] The multiple secondary consequences of the pandemic, along with the primary (medical) consequences, have significant implications for the psychological, emotional, behavioural or psychosocial well-being of individuals and communities.

One has only to look at the literature emerging from the research on the SARS outbreak in 2003 to understand the critical importance of psychosocial planning. Analysis of the long-term psychosocial impact of SARS on health care workers (HCWs) indicates significantly higher levels of burnout, psychological distress, post-traumatic stress and behavioural consequences (e.g. reduced patient contact and work hours) in HCWs who worked in hospitals that treated SARS patients compared with those in hospitals that did not.[3]

> In a study of how people in the U.S. might respond to an outbreak of smallpox, approximately 40% of those surveyed indicated that they would not get vaccinated even if vaccinations were made compulsory.
>
> Compliance with public health measures during a public health emergency cannot be assumed. Understanding the behavioural consequences of a pandemic is therefore not only a critical aspect of supporting social and individual resilience but also has implications for the ability of governments to enact public health and emergency response strategies.
>
> From the Redefining Readiness Study (available at: http://www.redefiningreadiness.net/)

SARS also caused disproportionate economic and social disruption given the relatively limited rates of infection (approximately 10,000 globally) and mortality (approximately 1,000 globally).[4] The global macroeconomic impact, for instance, is estimated to have been between 30 and 100 billion dollars.[5] Similarly, reviews of the anthrax incidents in the United States (U.S.) in 2001 suggest that the response capacity of the US public health network (e.g. US Centers for Disease Control and Prevention [CDC], public health departments) was "frail" and "highly stressed" by events that resulted in only 22 actual cases[6] and in which the number of those prescribed antibiotics outnumbered the actual cases by a factor of more than 1,300.[7] The psychosocial footprint of a pandemic is likewise anticipated to far outweigh the medical footprint, which will itself be substantial. Some of the psychosocial implications for individuals and families include the following:

- Emotional and financial strain associated with short and possibly long-term economic downturns and employment issues (e.g. job loss, underemployment, worker shortages);
- Increased incidence of mental health problems (e.g. stress, fear, anxiety, depression, complex grief);
- Increased role/emotional strain for particular family members (e.g. increased caregiving for children and the elderly, difficulty accessing health care and material goods, loss of income);
- Increased family violence, substance abuse, and other antisocial behaviours as a result of increased stress and decreased supports and resources;
- Occupational issues, including role and/or work overload, stress associated with non-routine roles, responsibilities, and worksites;
- Social challenges, including increased and mutually reinforced levels of uncertainty and fear, increased disputes associated with intra-community tensions;
- As a result of fear of infection and social distancing measures, breakdown of social support networks, social customs and community support mechanisms (e.g. volunteering, sporting and cultural groups) associated with individual and community belonging and resiliency;
- Increased stress, fear and anxiety associated with stigma and social exclusion;

- Emotional and behavioural health issues associated with disruption of routine activities; and
- Increased stress and distress resulting from real or perceived differences in access to and availability of psychosocial support and other health resources based on geographic location; social, economic and other forms of marginalization; and various individual factors (e.g. ability, sex, pre-existing health conditions).

Although governments and health systems around the world have been applying significant resources to pandemic influenza planning activity, very little of this activity has focused on the management and mitigation of or response to the psychosocial dimensions. Although psychosocial pandemic planning may place additional demands on planning processes that are already stretched for resources, not addressing these concerns could have a cascading effect that derails existing plans. If left unaddressed, the psychosocial responses of individuals and families to the pervasive and prolonged emotional and psychological demands of a pandemic may undermine Canada's entire pandemic response capacity. Those who feel unsupported or overwhelmed by stress or grief may be less willing to comply with public health measures. Unaddressed psychological and emotional issues may result in behavioural responses (e.g. surges on health care facilities, unwillingness to work) that exacerbate other pandemic-related issues (e.g. economic downturns, workforce shortages) and undermine business and community viability and continuity in the short and long term.

A comprehensive and multi-pronged psychosocial response to people's emotional, psychological and behavioural reactions to an influenza pandemic can mitigate or prevent some of these adverse outcomes and enhance not only the nation's response capacity but also its long-term recovery process. The focus in psychosocial pandemic planning is to maximize personal and social resilience, occupational performance and the likelihood of people's compliance with public health measures. This will require a multisectoral, collaborative and holistic planning process that supports and enhances alliances within health (e.g. medical, public, mental and Aboriginal health) and across other systems (e.g. social services), and integrates the expertise of those already providing psychosocial support and engaged in psychosocial disaster planning. As with all disaster and emergency planning, the process of planning is at least as significant as if not more significant than the plan it produces. Effective emergency response capacity rests on the quality of relationships (i.e. sense of trust, cooperation and collaboration) and the contributions of those who are directly and indirectly affected by and are the subject of plans.

Addressing the psychosocial impacts of a pandemic is closely aligned with the practice of risk communications. Risk communications is the development, exchange and dissemination of appropriate information to enable authorities responsible for managing risk situations and stakeholders (those affected by the risk or those who perceive themselves at risk) to make well-informed decisions. It focuses on facilitating dialogue and exchanging essential information between stakeholders and the authorities. It can be a vital public health intervention because it advocates the preparation of communications and risk mitigation strategies that are grounded in the social, cultural and political realities of the situation. The mitigation of the psychosocial impacts of a public health emergency is therefore a key outcome of effective risk communications.

1.2 Pandemic Influenza Psychosocial Planning Assumptions

The Canadian Pandemic Influenza Plan (CPIP) is based on a set of planning assumptions outlined earlier in the body of the CPIP. Although best planning practices in emergency management tend to focus on an all-hazards approach, there has been an acknowledgement that planning for an

influenza pandemic and other large-scale public health disasters (e.g. terrorist attack involving chemical, biological, nuclear, radiological or explosive agents) presents some unique challenges (e.g. intact infrastructure but high rates of absenteeism and a prolonged duration).

The planning assumptions guiding this framework flow from current professional consensus regarding the human response to extreme stress and large-scale emergencies. They also acknowledge that effective psychosocial response requires a contextualized response* addressing the influence of social, cultural, economic and personal factors,[8] and an analysis of the psychosocial implications of the planning assumptions guiding the CPIP framework. For example, the CPIP is based on an assumption that a standard dose of antiviral medication will be available to all who need early treatment. The psychosocial implication of this assumption is a general sense of reassurance and trust in the equity and efficacy of the government's response to the early threats of an influenza pandemic.

However, should the required dose need to be increased, it is unclear whether this kind of universal availability will be possible in the early stages of an outbreak. How decisions are made about who is prioritized in this scenario and how this is communicated to health care staff and the public will prompt other psychosocial responses. Similarly, there is an assumption that the demand on health care resources and facilities will outstrip their availability, requiring the prioritization of treatment strategies. There may be several responses to either of these scenarios:

- Fear and fear-based behaviours (e.g. surge on hospital facilities, anger at those who have received medication);
- An increase in moral stress and anxiety for those responsible for making and implementing decisions regarding treatment prioritization;
- The potential stigmatization of these decision-makers or those who are perceived to have differential access to health treatment and/or medication;
- Increased fear, anxiety, anger and possibly grief for those who perceive inequities and/or who lose loved ones as a result of such treatment decisions; and
- A decrease in the public trust that undermines compliance with other public health or emergency measures. (See Appendix A for an overview of other psychosocial implications of major pandemic planning assumptions.)

Effective psychosocial planning would anticipate and plan for these possible responses through:

- Public education and staff training;
- Consideration not only of the content of public communication but also the process (the how and the who of communication); and
- The development and implementation of strategies to support workers and the public more generally and to more effectively manage their stress and fear, and the emotional and behavioural responses of others.

In addition to considering the psychosocial implications of other pandemic planning assumptions, this framework is founded on specific psychosocial assumptions:

- The emotional, behavioural and social (psychosocial) consequences of an influenza pandemic will be widespread, given that the clinical attack rate is estimated to be between 15% and 35% of the population with predicted absenteeism rates of 10% to 25% during peak pandemic periods;

* For a comprehensive articulation of operational guidelines for psychosocial support in mass and other emergencies see Seynaeve.[8]

- As a new and "invisible" threat of sustained duration (i.e. multiple waves of infection over a period of 12-18 months), an influenza pandemic will generate a good deal of uncertainty, anxiety and stress resulting in prolonged exposure to extraordinary and chronic stress. The size of the psychosocial "footprint" of a disaster is often much larger than the "medical" footprint;[7]
- Exposure to extreme and/or prolonged stress is likely to significantly and adversely compromise immunity, healing and recovery, and overall health and/or illness states. Such stress is a risk factor for physical, mental and social health problems and is associated with a variety of physical ailments (e.g. heart disease), chronic conditions, and mental and social health disorders (e.g. post-traumatic stress, depression, anxiety, substance abuse, domestic violence);
- People are generally resilient and have developed individual mechanisms and skills to cope with stress that are more or less effective and reflect greater or lesser availability and access to resources (e.g. personal, emotional, cognitive resources; social support networks; economic and material resources). By their very definition, although disasters do not rob people of these they can overwhelm them. The novel and sustained nature of the challenges of a pandemic disaster will likely overwhelm some individuals' and/or groups' ability to cope effectively; and
- Sharing common experiences can enhance a sense of belonging, mutuality and support but can also exacerbate feelings of helplessness, disempowerment and other difficult emotions, and contribute to an emotional sense of being overwhelmed.
- Psychosocial consequences will vary across a spectrum of severity and duration (from brief to long-term) and may include the following:
    - An increase in the development of psychiatric disorders and/or the exacerbation of pre-existing psychiatric disorders (i.e. depression, anxiety and substance abuse);
    - Fear-driven behaviours and impaired decision making;
    - Impaired cognitive, social and family functioning; and
    - Decreased workplace and school performance.
- Any of these psychosocial consequences, including psychiatric/psychological disorders, may develop:
    - In individuals who are not physically/medically affected by influenza;
    - Concomitant with physical illness or injury, or in response to illness or injury in someone else; and
    - In response to social, economic and other secondary consequences of a pandemic.
- The development of comprehensive psychosocial support plans and workforce and social resiliency programs will mitigate the severity of the adverse psychosocial consequences of the pandemic;
- Absentee rates may affect psychosocial planning and response activities;
- Effective psychosocial support is based on an understanding that knowledge is empowering and a critical component of stress reduction. An effective risk communication approach considers stakeholders' values in decision-making processes and tailors communications strategies (content and process) to their perceptions and understanding of risk. This approach is based on the principle that transparency will increase trust and empowerment and facilitate cooperation in carrying out pandemic response and recovery strategies; and

- Effective psychosocial support is based on an understanding that individuals and communities have unique capacities, needs and vulnerabilities requiring creativity and flexibility in the development and delivery of services. Effective psychosocial response is based as much as possible on evidence-informed practices and the engagement in planning and delivery of services of those with front-line psychosocial disaster planning and response experience.

1.3 Goals of Pandemic Influenza Psychosocial Planning

The primary objective of a psychosocial response to any disaster or public health emergency is to restore and increase individuals' capacity to go on with their lives by addressing their social, emotional, psychological and physical needs. It includes supporting and strengthening social systems (e.g. social support networks) and helping individuals to regain a sense of control, diminish psychological arousal, effectively manage stress and improve adaptive coping strategies. There a number of specific goals:

- Protect and promote psychosocial well-being and resilience;
- Mitigate, prevent or treat the mental and/or behavioural health issues that arise for individuals in response to the disaster and/or the process of recovery from that disaster;
- Support or restore a sense of confidence, competence, efficacy and trust;
- Support or enhance individuals' adaptation to the stress and distress and their capacity to respond to the adverse impacts of a disaster through a sense of empowerment and responsibility, and an action orientation;
- Support workers' willingness and ability to continue to work;
- Improve support of and adherence to other public health measures;
- Support the development of plans that will include rapid assessment of psychosocial needs, mapping of resources and vulnerabilities, including the identification of those with specific vulnerabilities, and the ongoing evaluation of the effectiveness of support programs and strategies; and
- Augment Canada's capacity to respond effectively over time to disasters and public health emergencies.

1.4 Psychosocial Planning Principles

The guidelines for planning and managing a psychosocial response to a pandemic reflect core humanitarian principles (e.g. valuing of human rights and equity). Psychosocial planning should maximize fairness in terms of the availability and accessibility of mental health, psychiatric and psychosocial support services in affected populations across workplaces, languages and various individual factors (e.g. sex, age, ethnicity, geographic location):

- Effective psychosocial support is based on the fundamental value of participation, and the need for different groups to have some control over decisions affecting their lives and to develop local ownership. Every effort should be made to include in the planning process representatives of people who experience specific dimensions of vulnerability (e.g. impaired mobility, impaired cognitive ability, dependency on dialysis or medical equipment/processes) or who experience specific barriers to accessing information and/or resources or acting on that information (e.g. sex, age, language issues, poverty, geography);

- Programs and interventions should build on and mobilize the local capacities and resources of individuals, families and communities. They should support and enhance existing resources (e.g. social service agencies, family support resources, counselling and mental health programs) and sustainability;
- Psychosocial support and care for individuals and communities address highly sensitive issues, including cultural values and competencies, but lack the extensive scientific evidence available in some other disciplines. Because of this, psychosocial programming should draw on research evidence and lessons learned from other disasters and emphasize a coordinated, collaborative approach that minimizes gaps and the unnecessary duplication of services;
- By its very nature, psychosocial support is multidimensional and needs to integrate multiple strategies. As such, it requires a planning process that is collaborative, coordinated and inclusive. It should reflect both the variance in roles, responsibilities and access to resources across planning partners, and the simultaneous need for consistency of planning goals and access to psychosocial support and resources;
- The majority of affected people seeking help will look for social, practical and financial support, not mental health or counselling interventions, but the former actions can have positive or negative mental health consequences. Effective psychosocial response in disasters and public health emergencies requires a proactive, integrated approach in order to reach a wider range of people, minimize stigma associated with mental health services and maximize sustainability;
- Psychosocial support addresses different types of needs, including basic psychosocial care, specialized treatment of mental health problems and/or psychiatric/psychological disorders, family and community support, education and training in stress management, and specialized services for responders and the public (e.g. psychological first aid);
- Psychosocial programs should integrate continuous review of plans and services by assessing both direct health effects and indirect consequences, such as social and economic impacts, and should allow for plans to be updated as required to incorporate lessons learned and recommended improvements; and
- Effective psychosocial planning and response requires clearly designated leadership, roles and responsibilities for the guidance and provision of psychosocial support. Further, psychosocial support must be clearly linked to and included inother public health and medical emergency functions.

2.0 Psychosocial Planning

The specific dimensions of psychosocial pandemic planning will differ across levels of government to reflect the various roles and responsibilities. Generally speaking, however, there are four major components: psychosocial assessment, identification of specific at-risk populations, development and delivery of support services, and program evaluation and modification. Comprehensive psychosocial programming draws on but differs from traditional mental health or counselling interventions and approaches. The latter tend to be focused specifically on assessing and treating psychiatric/psychological disorders, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*[9] or the *International Statistical Classification of Diseases and Related Health Problems*,[10] whereas the former is based on an assumption of resiliency* and focuses on providing a broad range of support strategies.

* Resiliency refers to the ability of individuals and communities to take action that will improve their own capacity to respond effectively to stressful circumstances. It is not a static quality; it is a process that can be developed and strengthened over time through the active involvement at the individual and community level.

Those engaged in psychosocial pandemic planning will need to consider their own specific context, organizational culture, roles and responsibilities and the nature of their workforce in order to tailor the psychosocial programming to the specific needs, capacities and vulnerabilities of those for whom they are planning. The effectiveness of any plan, however, will rely on the degree of coordination and consistency with other emergency plans, procedures, and partnerships with F/P/T, local, and non-governmental organizations (e.g. faith-based community organizations) that support collaborative development and implementation.

2.1 Key Planning Steps

Psychosocial planning begins with an acknowledgement of the psychological, emotional and behavioural consequences of an influenza pandemic (e.g. decreased trust, increased stress, lack of cooperation with public health measures). This includes an awareness of the potential for risk amplification through the media and the "contagion" of fear as a result of misinformation or lack of information. Key steps in the planning process are as follows:

- Conducting assessments relating to space and site resource inventories to determine the availability of staff at shelters, schools, gymnasiums, nursing homes, day care centres and other potential sites for aggregate psychosocial care and identify existing or potential providers of psychosocial support services;
- Assessing related psychosocial needs of the community, individuals and their families, and emergency and health care workers and their families in cooperation with local/regional health centres;
- Developing and delivering programs that promote awareness and training in psychological first aid and resilience for individuals and their families as well as emergency responders, health care workers and community organizations (e.g. faith-based, cultural);
- Training individuals in psychosocial support; identifying and training multidisciplinary teams that could provide outreach, a hotline and institutional services during a pandemic;
- Developing culturally sensitive, multilanguage and multimedia educational materials and communication strategies that address the information needs of multiple stakeholders; these should be sensitive to cultural differences and their impact on health and self-care practices and barriers to accessing information, including access to technology and cultural and linguistic requirements;
- Developing the material and means to provide accurate information on an ongoing basis to workers and the public about the spread of infection, response strategies and how to effectively manage fear, anxiety, stress and other emotional, behavioural reactions to an influenza pandemic. This includes a consideration of the content and the "how" and "who" of delivery in order to maximize trust and the uptake of this information;
- Educating health care providers, psychosocial responders and the public about the psychosocial consequences of an influenza pandemic and strategies for reducing these (e.g. psychological first aid, stress management). This should include discussing the effects of stress on decision-making processes, relationships and communication;
- Educating health care providers and the public about the rationale for and potential benefits and risks of all interventions, including pharmaceutical, medical and psychosocial interventions;

- Developing strategies and resources that will sustain the capacity of communities and relevant organizations to provide psychosocial support information and education using traditional (e.g. seminars, training) and non-traditional (e.g. on-line, psychosocial information lines – warm lines) means in multiple languages and over a prolonged period (during and following a pandemic);
- Developing, integrating and implementing workforce resiliency programs in order to help front-line (e.g. first responders and receivers) and other workers manage emotional stress during the response to an influenza pandemic and to resolve related personal, professional and family issues;
- Training psychosocial and other health care staff and emergency responders on how to provide immediate symptom-relevant and culturally sensitive psychosocial support, triage and assessment for more serious psychological issues requiring more specialized intervention, and to make appropriate referrals. Training should acknowledge varying levels of prior training and the differences between providing disaster psychosocial support and traditional mental health/counselling/psychiatric and other interventions;
- Training and integrating into plans potential community-based partners who can offer guidance to psychosocial support providers (e.g. counsellors, psychologists, social workers, faith-based organizations); and
- Developing pandemic psychosocial recovery plans that address pandemic phases and the long-term recovery process.

Tips for facilitating the integration of psychosocial planning with other emergency planning processes

- Outline the organizational/community government emergency management structure during a crisis in ways that highlight the integration of psychosocial measures. Psychosocial plans should address the interface between local, regional, F/T/P governments and public health authorities so that resources and services are outlined and unnecessary duplication is eliminated.
- Consult with neighbouring communities/organizations to assess resources and build psychosocial plans that are consistent and coordinated, again minimizing unnecessary overlap and maximizing shared resources.
- Assess and support training for employees that will contribute to their resilience (e.g. stress management) and training that is specifically designed for those providing psychosocial interventions (e.g. psychological first aid, crisis communication).
- Develop contingency plans that include mutual aid/support agreements between health, social service and other agencies/organizations involved in psychosocial response. Consider regional plans that can mitigate the effects or duration of potential service delivery interruptions likely to affect access to mental health services, receipt of social/economic support, food delivery and other community services.
- Ensure that a continuous process of evaluation is in place to allow for the assessment of training and interventions and for their improvement and adaptation over time and in the context of other planning frameworks as necessary.

2.2 Phase-Specific Planning Steps*

Each phase of the influenza pandemic will require specific action steps and activities that meet the unfolding psychosocial demands and needs. The following framework provides some suggested phase-specific planning steps that are consistent with the World Health Organization (WHO) pandemic phases.

2.2.1 Phases 1-3. Goal: Develop, Test and Update Psychosocial Preparedness and Response Plans, Build Capacity/Resilience, Establish Communication with Partners, and Assess and Monitor

The specific activities that should take place during phases 1-3 include the following:

- Where possible, establish a multidisciplinary, inter-agency/multisectoral psychosocial planning group or task force. Developing an inclusive planning group/task force in the early stages of planning will ensure that a more integrated and comprehensive plan is developed and there is buy-in and cooperation of a broader range of partners. Membership can include representatives from various health care facilities (e.g. group homes, long-term and critical care facilities, hospitals), social service and mental health provider agencies/organizations, and professional associations (e.g. Canadian Psychological Association, Canadian Counselling Association):
    - Identify and recruit planning partners within local government, health organizations/ authorities and prominent community mental health, social service and counselling agencies and associations;
    - Ensure that representatives of key ethnic, cultural, work or other subgroups (e.g. key vulnerable/high risk groups, spiritual communities within the community, system or institution) participate;
    - Develop a mandate that integrates the psychological, behavioural and social effects of a pandemic holistically in all pandemic/emergency plans;
    - Ensure that key stakeholder in the psychosocial plans know their roles and responsibilities, have an opportunity to exercise plans, and integrate psychosocial concerns into other community or organizational pandemic exercises; and
    - Encourage all those who participate to assign and train alternative participants for all key positions in order to safeguard continuity in the event of illnesses and/or deaths.
- Review emergency preparedness legislation and plans;
- Engage in research (formal and informal) to ensure that planning decisions are based on the best available information;
- Identify specific triggers for implementation of psychosocial programs;
- Integrate organizations and agencies with existing pools of volunteers into the planning process, as volunteers will be an important resource during a pandemic;

* Given ongoing modifications of the World Health Organization pandemic plans, this section should be revisited and updated to determine what, if any, changes to the phases have been adopted in the Canadian Pandemic Influenza Plan.

- Identify and foster coordination with disaster psychosocial service partners, including relevant government departments, representatives from non-governmental and community-based health care partners (e.g. hospitals, primary care physicians, community mental health, public health, long-term care facilities) and those who may be called on to provide disaster psychosocial services;
- Advise health care institutions and authorities to consider incorporating psychosocial support services into occupational health and emergency preparedness planning for an influenza pandemic; and
- Consider needs for information sharing with emergency planners in other local/regional health organizations/authorities, schools, law enforcement agencies and local businesses.
- Develop specific psychosocial support plans that address:
    - Contingency plans for likely psychosocial scenarios during response and recovery;
    - Coordination of planning with provincial, regional and local partners, including agencies, non-governmental organizations and community-based organizations already engaged in training and/or delivery of psychosocial support;
    - Development/implementation of psychosocial training of mental health professionals (e.g. social workers, psychiatrists, registered and psychiatric nurses, psychologists, counsellors) and/or community members who can be available to support staff/ community experiencing grief, stress, exhaustion, anger and fear during an emergency;
    - Where possible, provision of similar training for other workers (e.g. primary care clinicians, emergency department staff, medical/surgical staff, safety and security personnel, behavioural health staff, chaplains, community leaders, staff of cultural and faith-based organizations);
    - Development and institutionalization of workforce resiliency plans (e.g. ensuring that policies, procedures and performance indicators are in place and that administrators, managers and supervisors, and workers are familiar with and encouraged to use support resources for themselves and their families);
    - Development of strategies to provide workers (particularly essential service and health care workers) with practical support with child- and elder-care responsibilities and other special needs that might affect their ability/willingness to come to work during a pandemic;
    - Identification, development and distribution of relevant educational, training and planning materials, including workforce support materials; and
    - Performance of a vulnerability and capacity audit in order to identify and address gaps in current psychosocial response capacity and planning.
- Initiate communication with relevant stakeholders (employees, community members, institutional and community partners) to ensure that they are aware of pandemic phase 3 (human infections with a new influenza subtype);
- Designate an official contact person to receive and provide updates.

2.2.2 Phase 4. Goal: Continue Preparedness Planning, Ensure Communication with Partners, and Assess and Monitor

If there is activity in Canada or your jurisdiction, follow bullets under phase 5.

If there is no activity in Canada or your jurisdiction:

- Ensure that all psychosocial health/community partners are aware of Phase 4 (small clusters of human-to-human transmission of new influenza subtype);
- Encourage ongoing monitoring of bulletins from the Public Health Agency of Canada (PHAC), CDC and WHO regarding clinical updates, as appropriate; and
- Review and update pandemic influenza response and contingency plans and partnership agreements to ensure that there is clarity regarding leads, roles, responsibilities and mandates.

2.2.3 Phase 5. Goal: Communicate with Partners, Activate Resiliency and Preparedness Strategies, Assess and Monitor

- Ensure that all relevant stakeholders (e.g. employees, providers, community members and planning partners) are aware of pandemic influenza in your jurisdiction to safeguard the adequacy of the psychosocial response;
- Continue to review pandemic influenza response and contingency plans, activation strategies and communication channels for large-scale public health disasters;
- Activate workforce resiliency programs (if not already activated; and
- Monitor bulletins from relevant government/health agencies (e.g. CDC, WHO and PHAC) regarding clinical updates as appropriate.

2.2.4 Phase 6. Goal: Mitigate Acute Stress, Disseminate Information and Implement Workforce and Social Resiliency Plans

- Implement plans for large-scale public health disasters and fully activate psychosocial plans;
- Ensure that the designated contact is available to receive updates from relevant government bodies (e.g. WHO, CDC and PHAC) as well as other partners, stakeholders and non-governmental organizations;
- Activate assessment/surveillance strategies in order to assess the effectiveness of psychosocial programs/strategies, emergent surges in demand, gaps etc., and reallocate resources as needed;
- Work with planning partners to coordinate implementation of available psychosocial resources during pandemic, including private, public and volunteer resources;
- Assess the effectiveness of the local response and available local capacity;
- Pay particular attention to the specific needs of those providing essential services, including those providing psychosocial support services; and
- Monitor bulletins from relevant government/health agencies (e.g. CDC, WHO and PHAC) regarding clinical updates as appropriate.

2.2.5 Post-Peak (Second or Subsequent Waves). Goal: Monitor and Conduct Ongoing Assessment, Mitigate Chronic Stress and Complicated Grief Response, Redesign Strategies as Needed

- Continue, as required, activities listed under Pandemic Phase 6;
- Review, evaluate and modify, as needed, the psychosocial pandemic response with particular attention to the emotional, behavioural and physical health of workers providing essential services and in high-risk positions, those working in non-traditional roles and those working in areas/programs where demand for services is high and/or rates of absenteeism are high; and
- Monitor resources and staffing needs.

2.2.6 Postpandemic Period. Goal: Support Short- and Long-Term Recovery, Assess and Evaluate (Lessons Learned)

- Assess capacity to resume normal functions;
- Initiate psychosocial recovery plans;
- Assess and plan for the need for transition to specialized mental health, psychiatric and/or counselling services for those who may continue to need such support during the longer-term recovery process;
- Assess the financial impact of the pandemic response; and
- Modify the pandemic influenza response and plans based on lessons learned.

Psychosocial support during recovery is as essential as that offered during the response. Recovery from any disaster can be complex and frustrating, involving multiple bureaucratic processes (e.g. access to government financial aid). It is a long-term process that many affected individuals find more stressful than the disaster or emergency event itself. Support strategies during recovery include the following:

- Continue to promote workforce resiliency and stress management programs as workers and organizations recover;
- Assess the need for ongoing professional support (e.g. psychiatric, counselling, mental health) during the long-term recovery process;
- Continue to ensure that the content and delivery of psychosocial support services is inclusive by addressing differences in developmental needs (e.g. children, older adults), physical and mental abilities, cultural and ethnic values, languages and other aspects of diversity;
- Use psychosocial outreach services to identify vulnerable individuals/groups and provide ongoing community stress management programs and bereavement support;
- Through psychosocial planning, help communities to develop memorial ceremonies;
- Redesign pandemic information websites and hotlines to provide recovery information;
- Engage the community in economic and social recovery planning and interventions as a way of confirming the relevance of these services and increasing social cohesion, stabilization and recovery; and
- Anticipate the longer-term recovery needs, including addressing significant dates (e.g. anniversaries of peak waves when mortality rates were highest) and the ongoing stress associated with rebuilding (e.g. economic, employment, social) individually and collectively.

3.0 Psychosocial Interventions

The goal of psychosocial interventions is to support an affected individual or group's resilience and their natural ability to cope. It is based on ethical principles such as respecting the unique and idiosyncratic needs, capacities and resources of any individual.

Psychosocial support requires careful assessment of capacities and vulnerabilities, particularly when it involves working with populations who are more likely to experience specific dimensions of vulnerability (e.g. mobility, hearing, dependency on others).

Not all psychosocial programming requires the involvement of mental health professionals; however, their expertise may be required in order to avoid doing harm either through intervention or lack of intervention.

Psychological assessment and referral may be required for individuals who experience an exacerbation or the onset of a mental health disorder as a result of their exposure to extraordinary stressors, critical incidents and/or death associated with an influenza pandemic. It involves a range of interventions:

- Coordination;
- Ensuring that basic needs are met;
- Public awareness, education and media relations;
- Normalizing daily living;
- Education and training;
- Stress management;
- Psychological first aid;
- Workforce resiliency;
- Support to families and communities;
- Bereavement and grief support;
- Assessment, triage and referral; and
- Program monitoring, evaluation and modification.

Effective psychosocial support and disaster mental health is more practical than psychological – i.e., meeting people's basic needs, restoring a sense of safety, providing accurate, timely information and guidance, problem solving, and supporting coping and resiliency. It is based on an active, outreach model focused on support of coping and resiliency and addressing specific psychological and behavioural health implications.

3.1 Mental and Behavioural Health Implications

Uncertainty and unknowns characterize the very nature of an influenza pandemic (e.g. When will it happen? How severe will it be? Who will be most affected? How long is it likely to last?). The pandemic will also be associated with potentially dramatic changes in the individual and shared lives of Canadians. Answers to these questions will not be immediately available when the emergency begins and will contribute to uncertainty regarding which health measures will be most effective. As a microbiological threat, pandemic influenza presents Canadians with an invisible enemy, one that cannot be seen but that can be passed on between people and cause, at least in the initial stages, a nonspecific set of symptoms that could be associated with

a potentially deadly infection or a relatively innocuous illness (e.g. cough and headache could indicate pandemic or the common cold).

Most people find any uncertainty and change stressful. Research has shown that humans are better able to adapt to acute, short-term stress rather than long-term, chronic stress. The prolonged nature and uncertainty of an influenza pandemic is likely to result in levels of chronic stress that, for some, will be associated with psychological and physiological health and social problems. During and following a pandemic, this stress may contribute to symptoms that include:

- Increased sadness and/or irritability;
- Exhaustion;
- Sleep and appetite disturbances;
- Other signs of distress (e.g. impaired cognitive and social functioning);
- Increased incidence of psychological disorders, including depression and anxiety;
- Caregiver burnout; and
- Compassion fatigue.

Behavioural consequences may include:

- Increased use of substances (e.g. alcohol, drugs, tobacco);
- Increased family/relationship violence;
- Social stigmatization and/or exclusion of those who are infected or may be perceived to be at higher risk of infecting others (e.g. health care workers);
- Surges in the demand for medical and psychological services; and
- Voluntary withdrawal from the workforce.

Symptoms may be in reaction to primary health concerns (e.g. illness, health complications associated with infection) or secondary consequences (e.g. loss of income and/or employment, inadequate medical assistance, interruption of routines and predicted futures), or they may arise in response to the prolonged uncertainty, fear and chronic stress. There may also be an increased potential for complicated grief responses resulting from the number and nature of deaths (e.g. of young children), and changes to burial and mourning rituals as a result of demand and workforce shortages (e.g. those providing coroner, funeral, spiritual care services). The recovery process once the threat has passed may continue to place increased demands and stress on everyone but in particular those providing medical, mental health and social services.

The severity and nature of the mental and behavioural health consequences for individuals will depend on a variety of factors:

- Level of exposure to primary (health) consequences, including death of family member(s), friends, colleagues;
- Individual factors (e.g. age, sex, ability, history of trauma and loss);
- Social factors (e.g. income, position, nature and degree of secondary consequences);
- Cultural factors (e.g. norms regarding social gathering/family living arrangements/religious or spiritual practices and meanings);

Caregiver stress significantly dampens antibody response to influenza and other vaccines.[11,12]

- Institutional factors (e.g. work-related risk exposure, perceived level of institutional material and emotional support for workers); and
- Degree of personal, family, institutional and social preparedness.

Those providing critical health care and other services are particularly vulnerable to experiencing higher than normal levels of stress, anxiety, fear and anger resulting from increased workloads; shifts in roles, responsibilities and work sites; higher personal risks to themselves and potentially their families; increased family fears for their safety at work, including potential pressure not to return to work; social stigma resulting from fears of infection or differential access to vaccines and antiviral drugs; and perceived or actual lack of training, safety equipment or information that would increase risks. Those at higher risk in this regard include not only health care workers and public health officials but also all emergency response and public safety personnel (e.g. police, 911 dispatchers, correctional facility staff, coroner and mortuary service workers), utility workers (e.g. hydro, gas, water, sewage and other waste disposal), transportation workers (e.g. fuel, water, food, medical supplies, public transportation) and telecommunications/information technology workers.

Careful attention to and consultation with the particular needs of a given client or client group will help determine what interventions, if any, are appropriate. For most people the symptoms of stress, fear and loss will gradually decrease over time. Although disaster psychosocial support is based on an assumption of resilience, there is also an assumption that individual and collective coping capacity can be overwhelmed by the sheer extent or novel nature of the demands. People should be encouraged, therefore, to use existing coping strategies if they find them effective but also to seek out and access additional support as needed. People should be encouraged to follow their natural inclination with regard to coping (e.g. how much and to whom they talk). To facilitate basic coping strategies, measures such as connecting and talking with friends and family, and other natural supports should be considered. In the context of social isolation, other public health measures and people's fear of infection, the following are examples of coping methods: use of the Internet, telephone and other virtual social networks.

3.2 Diversity and Dimensions of Vulnerability

As with all disasters, an influenza pandemic will not affect all citizens equally. Post-disaster health outcomes reflect pre-existing patterns of social, economic and political inequalities and their influence on access to resources, division of labour, general health, resiliency of social support networks and influence in decision making. Although psychosocial support is premised on an assumption of resilience, individual and collective resilience is dependent on the availability and accessibility of relevant resources and a consideration of specific potential areas of vulnerability or reduced capacity. Variables such as sex and developmental, social, economic and personal factors can contribute both to resilience and increased vulnerability to the psychosocial consequences of a pandemic. Although no assumptions of vulnerability should be made, an outline of some of the potential dimensions follows.

3.2.1 Sex

As a primary organizing principle of life, sex is recognized as one of the most critical determinants of disaster-related vulnerability:

- Women and children are disproportionately affected by disasters, reporting higher rates of stress-related health problems (e.g. post-traumatic stress, anxiety and depression), an increased risk of sexual and domestic violence, greater economic marginalization and substantial increases in their emotional and material work due to their role as the primary caretakers within their

families and communities. Moreover, persisting gender inequities in formal (e.g. nursing) and informal (e.g. parenting) caregiving may place women at greater risk and in need of psychosocial support to address caregiver burnout, role overload and compassion fatigue; and

- Men, because of their socialization as providers, may experience greater stress and distress connected to loss or interruption of employment, unfamiliar roles and responsibilities (e.g. unanticipated increases in caregiving or parenting roles) or a sense of helplessness in the face of widespread illness and social disruption.

3.2.2 Economic Marginalization

Those living in poverty or relying on contingent employment tend to be at greater risk because they have less financial stability and fewer resources to weather economic and employment disruptions. They may also be more susceptible to infection as a result of crowded living conditions and a lack of adequate sanitation and/or the ability to adopt social isolation strategies.

3.2.3 Social Marginalization

Ethnicity, immigration status and occupational status of individuals are some of the social variables that may contribute to greater risk and/or vulnerability as a result of language and cultural issues, reduced access to resources and barriers to accessing information or appropriate technology (e.g. Internet, telephones). Furthermore, the overlap between social and economic marginalization is associated with limited access to financial credit, and less robust social networks (formal and informal) and other forms of assistance that people rely upon during crises.

3.2.4 Physical and Mental Disabilities, Medical and Mental Health/ Psychiatric Needs

Those relying on medical equipment or aides, or other support services may be at greater risk because of the impact of worker attrition on the availability and accessibility of services and resources, including public transportation, personal care attendants and the potential disruption caused by the illness, death or increased caregiving responsibilities of those on whom they rely for support. Those with pre-existing mental health issues, including psychological disorders, dementia and chronic stress (e.g. burnout) may be overwhelmed by additional stressors associated with an influenza pandemic, experience greater difficulty coping or accessing coping resources and experience an intensification of pre-existing symptoms.

Additionally, the information and resource requirements of those with pre-existing mobility, communication, physical or mental health issues may not be fully understood or adequately addressed by first responders, emergency health personnel or other support providers unfamiliar with their specific needs, issues and concerns, their presentation styles (e.g. behaviours, communication styles) or their idiosyncratic response to stress and/or fear.

Women may be at greater risk when they are pregnant because of mobility issues or medical needs and because they may put themselves at risk out of concern for their unborn child.

3.2.5 Special Language or Communication Needs

Individuals who have special language requirements or communication needs (including newcomers to Canada, those who are deaf or hard of hearing) may be at greater risk because they may have difficulty in learning of and responding to warnings, acquiring information about emergency health services and psychosocial assistance, and communicating their needs to emergency personnel.

3.2.6 Age

Age can contribute to both capacity and vulnerability in a number of ways:

- Older individuals may be at greater risk if they experience age-related infirmity (either physical or cognitive), are functionally limited because of reduced mobility, have become socially isolated or experience substantial disruptions that add to the "multiple losses" that characterize later life. Older persons are also less likely to respond to warnings and are slower to respond to losses by seeking assistance and support;
- Adolescents may be at greater risk because they have not yet developed coping strategies as effective as those of adults. Developmentally, adolescents are in a period of complex physical, psychological and social transition and thus may experience a greater sense of disruption should the pandemic significantly interrupt the functioning of their family and community (e.g. illness and/or death in the family, school closures and other social isolation strategies designed to limit infection spread, loss of friends). Adolescents may also be more affected by exposure to traumatic events, either directly or through excessive exposure to media coverage;
- Adolescents may also experience increased vulnerability if parents or caregivers become ill or die. This may include having to adopt age-inappropriate responsibilities, receiving inadequate care and supervision, increased risk of homelessness, increased likelihood of turning to high-risk behaviours as a means of coping and increased vulnerability to violence and sexual exploitation; and
- Children are dependent upon others for care, and anything that disrupts this dynamic has the potential for a significant psychosocial impact. As a result, children may experience a greater sense of disruption as a result of illness and/or death in their families, the closure of schools and other public buildings, the impact of social isolation strategies and emotional/psychological vulnerability through proximity to traumatic events directly and indirectly through the media. Illness and/or death of caregivers may leave a large number of children in need of emergency shelter and care. Developing the capacity to respond is limited for children; instead the caregiver and community are required to take this on for them. This magnifies the strain on the community and caregiver since there is not only a need to respond on a more general public and perhaps "adult" focused level but there is also a need to develop capacity to respond to the unique considerations of a child; a "one-size fits all response" may not necessarily fit adults and children in this situation, heightening anxiety, risk and impact. The community may also need to intervene if the caregiver is unable to take on the care and respond on behalf of the child, which shifts the burden.

  Because of their cognitive and emotional development, very young children may be more likely to believe that they are somehow responsible for the occurrence of a crisis or disaster and may have fears of being separated from their parents and/or left alone. Because children depend upon adults for their emotional, psychological and physiological needs, they are particularly sensitive to parents' fears and distress as well as disruptions to the structure

and consistency in family life. Both children and youth may also experience increased vulnerability and stress if parents or primary caregivers become ill or die. This may include children being thrust into or having to assume greater than normal caregiving roles and other age-inappropriate responsibilities, receiving inadequate care and supervision, and being at increased risk of homelessness because of the secondary financial and employment impacts of the pandemic. On the basis of research into children's and young people's responses to family disruption and upheaval, there may be an increased threat of children and youth turning to high-risk behaviours as a means of coping and an increased vulnerability to violence and sexual exploitation.

3.2.7 Caregivers

Those in primary caregiving roles professionally and/or personally are faced with increased and persistent demands for support and nurturance that may overwhelm coping resources and contribute to compassion fatigue and burnout.

3.2.8 Occupational Groups

Some occupational groups may be at greater risk of adverse psychosocial impacts during an influenza pandemic because of the degree and duration of their exposure to highly stressful events. These groups include but are not necessarily limited to health care workers or first receivers, public health officials, first responders (e.g. police, fire and ambulance), laboratory workers and all those involved in providing essential services during and after a pandemic. The specific challenges will differ among the various occupational groups. Special efforts should be made to identify and support hospitals and other health care organizations and facilities, public health agencies, first-responder organizations and employers of essential service workers in order to enhance their resiliency, mitigate the potential for adverse physical and mental health outcomes, and support the professional performance of these workers and their capacity and willingness to work.

3.2.9 Sole Health Care or Social Service Providers

In some rural and remote communities, there may be only one formal health care or social service provider. In a non-pandemic situation professional isolation and lack of peer support can result in role overload, burnout, compassion fatigue, and other health and social issues for that individual. Virtual peer support networks can mitigate some of this isolation, but care and attention should be paid in psychosocial pandemic planning to address the limitations and challenges these individuals and their communities will face. Many of the recommendations for planning (e.g. multidisciplinary/multisectoral committees) and preferred practices for workforce resiliency (e.g. peer support, shift rotation and shift debriefings) will either not be available or will involve some creative sharing and development of resources in order to be accomplished.

3.3 Coordination and Meeting Basic Needs

The ability of people to meet their basic needs is fundamental to maintaining a sense of personal control and well-being. The influenza pandemic, like the SARS crisis in Toronto, may interfere with people's ability to meet their basic needs either as a direct result of illness or social isolation strategies, or through the disruption of supply chains.

Ensuring that people can continue to meet their basic living needs throughout a pandemic is the first step to enhancing self-sufficiency and resiliency, and re-establishing a sense of control and well-being. This can be facilitated by:

- Finding ways to help people to articulate their basic needs and concerns (e.g. for medical care, emergency shelter, food, clothing) and developing plans for meeting those needs; and
- Providing support with problem-solving and practical assistance to enable people to meet their needs (e.g. in accessing food, medical care, child and elder care, other emergency assistance programs).

3.4 Public Awareness, Education and Media Relations

Providing access to accurate and timely information during a pandemic or any emergency is important to the psychosocial well-being of people and cannot be overstressed. Lack of information fuels rumours, uncertainty and misinformation and can quickly exacerbate fear, distress and social panic. A lack of relevant, clear and compassionate messages from leaders can undermine the public's confidence in local government or health authorities and their capacity and willingness to endorse and implement recommended infection control strategies. Providing people with timely and accurate information is key to helping them to "help themselves" and retain or regain a sense of competence and control over their lives; as well, it helps build, maintain or restore public trust. Some examples of information to provide are cognitive, emotional and behavioural responses to stress and fear, and techniques for coping; family communications plans; a list of available workforce support services; details of employment issues related to illness (sick pay, essential service mandates, shift rotations, family concerns).

Both internal (e.g. organizational newsletters) and external (e.g. public service messages, websites) delivery methods should be considered in addition to the infrastructure and social network requirements to support the ongoing dissemination of accurate information in the midst of potential work and service interruptions. Addressing not only what is relevant but how that relevant information will be made available to particular groups of workers, organizations or community subgroups will have practical, psychological and behavioural consequences. Knowledge is power, and through empowerment the workforce becomes more resilient and the public more capable of effective decision making and personal preparedness.

The following are some examples of how to keep people informed:

- Involve people in planning and preparedness activities before a pandemic through an inclusive planning process and an effective risk management/risk communications strategy;
- Provide repeated, simple and accurate information throughout preparedness, response and recovery phases to support people's capacity to make informed decisions about their health before, during and after a pandemic;
- Inform and educate people about how they can help themselves, options for action, available services and how to access them, and other resources for support;
- Inform and educate people about the emotional, behavioural and physical impacts of the pandemic influenza and its secondary consequences in ways that emphasize the normalcy of their reactions and provide tips for healthy coping; and

- Ensure that all materials and messages (e.g. televised public information announcements) are generated in the major languages of a community/organization and disseminated using multiple media strategies (e.g. television, radio, websites, email).

See Appendix C, Psychosocial Communication Planning Tips, for more information.

3.5 Normalizing Daily Living

So-called "normal" life may be moderately or severely disrupted during an influenza pandemic. Routines may be disrupted by short- or long-term closures (e.g. schools, community centres, daycare centres), and work roles may either be extended or disrupted as a result of closures, absenteeism and the economic impacts. Some family members may be dislocated from loved ones as a result of work demands (e.g. essential service workers), and many families will experience the illness and/or death of one or more loved ones. This in turn will have implications for the strength and availability of social networks and supports, and community activities. Although during pandemic waves normalcy may not be possible, individual and social resiliency will be enhanced by supporting people's capacity to engage with family, friends and social support networks, maintain or re-establish a sense of connectedness and mutual support, and engage in as many routine activities as possible in order to experience some sense of stability and hope.

It is important to work with those directly affected to determine strategies that support daily routines and maximize involvement, self-determination and engagement. Age, sex, cultural norms and ability should be considered in determining and designing such strategies. Adopting a participatory approach is also more likely to result in relevant and effective programming. Communities and workers can be involved throughout all phases of pandemic planning and response by creating opportunities for open dialogue, participatory decision making and an inclusive climate that encourages the involvement of those who are more vulnerable and/or marginalized.

3.6 Staff Education and Training

Research has shown that feeling adequately prepared, trained and experienced supports resiliency and, in the context of work, productivity and effectiveness. Training in the emotional and behavioural consequences of disasters, and more specifically public health emergencies, should be provided to volunteer and professional service providers. This can include signs and symptoms of trauma, stress and unresolved and/or complicated grief, as well as intervention strategies such as psychological first aid, critical incident stress management interventions and voluntary group or individual debriefings, worker care and other appropriate intervention strategies. Psychosocial teams can and should involve individuals from different fields (e.g. social work, psychology, counselling) and with different levels of training and education. Even those with extensive training in providing mental health services require an orientation to the differences between traditional service provision and disaster-specific services and interventions.

The content of educational material should outline the following:

- Stressors related to pandemic influenza;
- Cognitive, behavioural and emotional signs of distress;
- Traumatic grief;

- Psychosocial aspects related to management of mass fatalities;
- Stress management and coping strategies (including self-care at work and at home);
- Cultural differences (e.g. ethnic, professional, geographic) that can affect signs of distress and communication;
- Strategies for building and sustaining personal resilience;
- Strategies for home care of infected individuals;
- Behavioural and psychological support resources;
- Differential impact of a pandemic on special populations (e.g. children, ethnic or cultural groups, older adults, persons with disabilities);
- Strategies for helping children and families in times of crisis;
- Strategies for working with highly agitated patients; and
- Family preparedness planning, including family communication plans.

Psycho-educational groups are an effective means of disseminating information to the public and to groups of employees about what to anticipate in terms of the emotional and behavioural consequences of an influenza pandemic. They can also provide an opportunity during and after a disaster for processing some of these experiences. The pandemic will pose challenges in terms of bringing groups together, and so thought should be given to how to facilitate group training and education through virtual training environments. Such groups can provide opportunities for:

- Creating a safe and supportive environment for emotional expression;
- Cognitive reframing;
- Providing information about signs and symptoms of stress and other emotional responses;
- Identifying and reinforcing resiliency and positive coping styles;
- Mitigating long-term stress reactions; and
- Developing community-based networks of support and/or planning.

Cultural competence is another essential ingredient of effective psychosocial plans and programs. Cultural competence is the ability to understand and respond effectively to the cultural and language needs of individuals and families affected by a disaster.13 Cultural differences can be apparent in the way groups define disaster and loss and express their grief, as well as how they seek assistance. Different cultures may ascribe different meanings to an event according to their beliefs and values. In this way, cultures also serve as a protective system by furnishing people with a shared sense of identity, life meaning and continuity that they may rely on to carry themselves through difficult times.

Language, limited financial resources, limited social supports, lack of familiarity with community support systems and differences in cultural norms regarding accessing outside help may put some individuals and families at greater risk. Integrating a cultural competence lens into training, education and the development of information packages can mitigate some of these risks. The planning and delivery of services should involve consultation with and leadership from representatives of specific ethnic, religious and other groups (e.g. new immigrants, persons with disabilities, women-serving organizations).

3.7 Stress Management Programs

When dealing with an extraordinary incident, it is normal for people to show various signs and symptoms of acute and chronic stress. Although there is no single way to effectively cope with chronic stress, recognizing the signs of acute and chronic stress is an important first step in accessing support to develop more effective coping strategies and, if the symptoms become too intense or if they persist or interfere with an individual's ability to function, to access professional help. All workers likely to be on the front line of the pandemic response (e.g. health care and other essential service workers, emergency responders) should receive training in stress management in order to manage their own stress and recognize the needs for stress management generally.

Effective psychosocial programming can and often does include peer support teams/groups, and those involved in facilitating these programs should receive advanced training in stress management strategies. This training should be provided by a qualified mental health professional who is familiar with the organizational culture and who can provide ongoing supervision and follow-up with the group leads. The advantage of peer support groups is a greater likelihood of acceptance and first-hand knowledge of the work environment and culture. The disadvantage is that team members can themselves be part of the response and therefore at risk of burnout themselves, and can at times be too close to colleagues and incidents to provide effective service, including the skills and ability to assess the need for referral to a more experienced mental health professional. Peer teams should work closely with a professional who can provide ongoing supervision, training and support to the peers themselves.

Other stress management strategies include fairly basic interventions, such as providing the opportunity for workers/individuals to informally debrief with colleagues, friends or family and engage in exercise and pleasurable activities; and interventions that require the guidance of someone with more formal training, including cognitive-behavioural reframing strategies, mindfulness training and relaxation meditations.

(For a more detailed description of specific interventions see the *Psychosocial Response Workbook*.[14]) The following table identifies various signs and symptoms of acute and/or chronic stress.

Physical Reactions	Emotional Reactions	Cognitive Reactions	Behavioural Reactions
· Increase in blood pressure · Fatigue · Nausea · Trembling · Perspiration · Increase in heart rate · Hyperventilation · Headache · Shivering · Gastrointestinal distress · Pain · Indigestion · Disorientation · Decrease in coordination · Chest pains · Sleep disturbance · Appetite disturbance	· Anxiety · Fear · Withdrawal · Resentment · Searching for scapegoat · Guilt · Feelings helpless · Sorrow · Decrease in activity · Anger · Despondency · Despair · Feeling abandoned · Depression	· Inability to perform calculations · Confusion · Memory loss · Difficulty making decisions · Obsession with details · Poor concentration · Difficulty thinking · Memory flashes · Loss of interest in regular activities	· Isolation · Withdrawal · Alcohol use increase · Drug use increase · Aggressive behaviour

In general, it is a good idea for psychosocial teams to develop networks that include individuals with varying levels of training, skills and experience in mental health assessment and service provision, and a knowledge of community resources in order to make meaningful, relevant and accessible referrals over the course of a pandemic. An influenza pandemic will not be "business as normal". Nor does it constitute a "typical" disaster (e.g. lack of a clear beginning and end). Because of this, more individuals than usual may require additional psychosocial support and help in managing the psychosocial implications of the pandemic and its impact on their work, family environments and community.

3.8 Links Between Communication, Information and Stress

There is a clear link between access to accurate information, communication styles and stress. It is important, therefore, that the psychosocial implications of who provides what information in what way and at what time are taken into consideration when developing pandemic communication plans and strategies (e.g. advice on infection control measures). This includes working with the media to develop effective communication channels and working relationships. It also includes considering how and when daily briefings are given regarding response objectives, time schedules and changes in roles, responsibilities and safety measures. Effectively managing media and facilitating continued communication with family and members of natural support networks are also components of an effective work-related stress reduction and management program.

There is some research evidence and a good deal of self-reported support for the efficacy of stress management programs, but in many cases the scientific evidence for the effectiveness of particular stress management strategies is minimal or equivocal. Rather than see this lack as a reason not to implement stress management programs, it should be viewed as a reason for continued evaluation and updates on evidence-based interventions; as well, such programs can provide access to specialist professional treatment for those who identify a need for it or are identified as requiring further assessment.

3.9 Psychological First Aid

Psychological first aid is an evidence-informed intervention designed to assist children, families and adults in the aftermath of disasters and other crises. The core actions of psychological first aid can be applied within days or weeks after a potentially traumatic event:

- **Contact and engagement:** To initiate and respond to contacts by survivors in a non-intrusive, compassionate and helpful manner;
- **Safety and comfort:** To enhance survivors' sense of safety and security by meeting their physical and emotional needs;
- **Stabilization:** To calm, reassure and comfort emotionally distraught survivors;
- **Information gathering:** To identify the immediate physical, social and emotional needs of survivors;
- **Practical assistance:** To ensure that survivors' practical needs for health services, shelter, food, clothing and other basic needs are addressed;
- **Connection with social supports:** To reduce isolation and enhance self-help among survivors by reuniting and keeping families together, establishing contacts with primary support persons and linking survivors to community helping resources;

- **Information on distress reactions and coping:** To provide information about stress reactions and coping techniques to reduce distress and enhance positive coping; and
- **Linkage with services:** To ensure that survivors know of and are linked to available disaster assistance, health and social services programs.

There are effective training programs in psychological first aid, and consideration should be given to making these available so that all health care teams have access to psychological first aid (and other psychosocial supports), to those providing or likely to provide psychosocial services during a pandemic, and to those whose work may put them at higher risk of experiencing the psychosocial consequences of a pandemic.

(For more information on psychological first aid see the National Center for PTSD [Post-traumatic Stress Disorder]: http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/smallerPFA_2ndEditionwithappendices.pdf.)

3.10 Workforce Resiliency Programs

Research on the SARS outbreak in 2003 suggests that there should be more attention given to developing effective workforce resiliency support programs, particularly for those who are working in high risk and high stress environments. The pandemic will likely cause extraordinary occupational stress for many workers but particularly for those working in health care. Extraordinary stressors are likely to arise from increased workload demands, workforce shortages, shifts in roles and responsibilities, work in non-traditional health care sites, increased risk of infection and exposure to a large number of acutely ill and dying patients. Health care workers, those involved in public health and safety (e.g. police, fire) and a range of workers providing essential services (e.g. utilities, sanitation, public safety, corrections) will be on the front line of what is anticipated to be an extremely challenging and prolonged response. Extreme and prolonged stress is associated with a variety of physical ailments (e.g. heart disease), chronic conditions, and mental and social health disorders (e.g. post-traumatic stress, depression, anxiety, substance abuse, domestic violence).[15] A critical first step in psychosocial planning is to recognize the occupational, personal and family stress consequences of a pandemic for everyone, but in particular for those workers central to the response capacity locally and nationally.

Research on the impact of SARS on nurses has identified gaps in risk communication, effective leadership strategies and psychosocial support.[16] This same research has suggested that many of those working in the health care system, particularly women, experience role conflict between their professional and family lives and report that family concerns may prevent them from reporting for work in the event of another highly contagious disease outbreak, such as an influenza pandemic. The high numbers of casual and part-time workers in the health care workforce and other gendered professions will pose additional challenges (e.g. lack of sick benefits, inadequate training and integration into pandemic planning) (for specific recommendations see Amaratunga et al.[16]).

Comprehensive plans are required to address the human resource dimensions of health and other essential service delivery during the pandemic. Maximizing personal and social resilience and professional performance will require preparedness planning based in a multisectoral, collaborative and holistic planning framework. To be effective, these plans must address the gendered nature of formal caregiving (over 90% of nurses are female[16]) and informal caregiving (traditional gender roles continue to mean that most in-home caregivers are female). Enhanced instrumental, informational, psychological and emotional support strategies that acknowledge the gendered nature of many professions and work/family conflict are required to enhance

workforce resiliency and mitigate the adverse effects of occupational stress on both the health of workers and the Canadian pandemic response capacity.

Effective stress management in stressful work environments can include providing respite options for workers wherein they have access to quiet, safe and relaxing spaces, healthy food, support, should they seek it, and some time away from their work demands. Critical incident stress management programs can include a range of organizational and individual level strategies to support work force resiliency. Comprehensive workforce resiliency and psychosocial support programs will also include the ongoing professional assessment of the need for individual workers to receive longer-term, specialized mental health interventions as needed.

During a pandemic, workers are likely to experience greater stress on the job because of increased workloads due to absenteeism; fear of infection; and management of the work-life balance in the face of school closures, family illness and child and/or elder care. The goal of a workforce resiliency program is to address this additional stress in ways that are empowering and that improve workers' ability to cope and manage in the context of these additional pressures. Workforce resiliency programs improve worker well-being and health, and increase the likelihood of workers remaining on the job.

In addition to support programs, psychosocial plans should include ways to ensure that workers have adequate preparation and training for the various roles they will have to undertake during a pandemic. The psychosocial implications of being trained and educated in advance include mitigating uncertainty and confusion, supporting competence and a sense of effectiveness, and the possibility of rotation of workers between higher and lower stress positions to avoid burnout. Planning should include opportunities to:

The latest reports from the Canadian Nurses Association on nursing shortages in Canada predicted a shortage of 78,000 registered nurses by 2011. During a 1957 influenza pandemic in Liverpool, up to 10.4% nurses were absent during the first month of the epidemic.

Estimates are that as of June 2003, SARS had cost the Ontario health care system $945 million. The Canadian Tourism Commission estimated the financial costs of SARS to the Canadian economy to be $519 million for 2003 and $722 million for 2003-2006.[17]

For many, the psychosocial recovery of those directly infected with SARS was much slower than their physical recovery. A prospective study of patients 1 year after infection indicated that the majority had not been able to return to pre-infection work levels, 33% continuing to experience significant decrements in their mental heath.[18]

Similarly, studies of health care workers providing direct care to SARS patients reported increased psychological distress, greater stigmatization and higher levels of concern about contagion to family members.[19,20]

- Help staff to learn about the structures and functions of other organizations or units within organizations;
- Involve staff in determining training needs, logical cross-over positions;
- Review the existing curriculum to identify modules that might be used for cross-training purposes;
- Develop "just-in-time" training packages that outline core competencies, tasks and lines of authority for delivery during a pandemic; and
- Develop leadership reserves that can address loss of key leaders to illness or death and the secondary impacts on themselves and their families.

3.10.1 Key Components of Workforce Resiliency Programs

- Offer regular briefings and training on behavioural health, resilience stress management and coping;
- Develop and implement management and supervisor leadership training focused on improving the ability to maintain a healthy, supportive working environment;
- Develop and implement "buddy" systems so that workers can support each other in monitoring stress levels and offering mutual help in coping;
- Provide respite sites in workplace settings. The goal of these sites is to provide rest, relief and ventilation for those wearing masks. Mandated and regularly scheduled breaks should provide workers with a space to get away from the immediate environmental or function-related stressors of their work. These sites can be supplied with health snacks, relaxation materials (e.g. music, relaxation tapes, comfortable seating) and educational materials (e.g. stress and coping pamphlets);
- Develop organizational-specific telephone hotlines providing pandemic information and advice to workers and their families;
- Deploy worker-care teams to provide psychosocial assistance, support and information on-site and/or in the community, including on-the-scene support and stress management, critical incident stress management interventions and family support;
- Provide cell phones or wireless communication devices to allow regular communication among family members;
- Implement flexible work arrangements as needed (i.e. working from home, flexible hours to address child/elder/family care issues);
- Provide up-to-date and accurate pandemic information through websites or hotlines; and
- Provide worker/stress care at tele-health/nurses hotlines etc.

3.10.2 Workforce Support Suggestions

- Provide respite areas, back-up clothing (for those wearing infection control masks etc.), nutritious food, time to eat properly;
- Rotate teams, and encourage teams to share with each other;
- Phase out workers gradually from high to medium to low stress areas;
- Provide opportunities for voluntary defusing for all workers as they go off duty or take breaks;
- Provide shift "exit interview" (check-outs to address lingering concerns, issues) when requested; and
- Encourage effective self-care during and after shifts.

Psychosocial support within an institution or response team depends on the support of leaders at all levels, including their willingness to mentor effective stress management and lead by example. Knowing intervention protocols is not enough to be effective. Psychosocial responders must establish rapport and be seen as well organized, aware of and able to operate within the parameters of organizational/response culture, and professional if they are to be accepted within an institution or existing response team. Psychosocial responders can also play an important role in encouraging organizations to solicit the help of internal departments or external supportive agencies in identifying sources of worker stress and reducing that stress.

Psychosocial responders who are not already part of an existing team or institution may experience some resistance associated with the stigma of mental health interventions and the general tendency to ignore or accept high levels of stress as a normal part of the job. Some measure of this kind of response is adaptive; however, these barriers can sometimes mean that serious signs of burnout and cognitive and behavioural symptoms of acute and chronic stress are ignored. Institutionalizing workforce resiliency programs (e.g. having a presence on an ongoing basis, "pitching in" where appropriate) can help psychosocial responders integrate into the response/work teams.

Psychosocial responders are also workers and will themselves require ongoing support and assessment for signs of stress and/or burnout. Cross-team or peer support programs, critical incident stress management programs and ongoing monitoring for burnout and/or compassion fatigue are a necessary component of psychosocial planning and service delivery. Many of those who will be providing psychosocial support may be doing so in multiple locations (e.g. in a specific hospital, the community, at home) and should be encouraged to self-assess and seek additional support and advice to safeguard their health, well-being and capacity to sustain delivery of service to others.

3.11 Support to Families and Communities

Workers will be more willing and able to remain on the job if they are confident that their families are safe and cared for. Services and support should be considered for families of workers who may be working long hours to cover absent colleagues or who are sequestered to guarantee continuity of essential services.

Family Support Services

- Providing psychosocial outreach services to families (information/support). Consider various technological options;
- Providing instrumental help (e.g. assistance obtaining food, medical supplies);
- Assessing the need for and providing assistance (information/instrumental) with elder care and child care;
- Assisting (information/instrumental) with other issues related to parenting and child care. A model to consider is that of a concierge who supports the ability of workers to stay at work by providing practical support to workers and their families; and
- Developing evaluation feedback mechanisms (i.e. web-based feedback or designated voice mailboxes) that allow families/community members to provide anonymous feedback and suggestions for improvement of services.

3.11.1 Community Psychosocial Support Strategies

The overall psychosocial well-being of community members will be a critical component of an effective community response to a pandemic. Providing reliable and timely information and addressing some of the emotional consequences of a pandemic improve community morale and contribute to the ability of public health authorities to implement infection control and intervention strategies.

Promoting self-help and mutual aid strategies among people affected by a disaster is an important component to restoring people's sense of control and self-sufficiency. Self-help and mutual aid groups can serve as a natural setting for people to find emotional support and help

problem-solve practical issues – which often become their main source of distress – through advice giving, information sharing and mutual assistance. During a pandemic, people may be understandably reluctant to gather in groups, but self-help and mutual help groups can be offered as part of a virtual community (i.e. through Internet chat rooms and facilitated Internet conversations).

3.11.2 Community-Based Strategies for Maximizing Resiliency

- Implement confidential telephone and/or web-based support services staffed by mental/behavioural health care professionals who can provide expert advice and answers regarding infection mitigation, self-care and family care;
- Deploy multidisciplinary health and psychosocial outreach teams to provide information, assistance and support within the community. These teams could include (1) those trained in psychological first aid and psychosocial support strategies, (2) those trained in grief and bereavement issues, (3) public health nurses trained to provide pandemic-specific health information and interventions and (4) social services workers trained to support families addressing pandemic-related family/parenting/life-work issues;
- Offer practical support and websites where community groups can establish virtual communities that allow people to discuss common issues, solve problems, share advice and information, and offer support; and
- Consider alternative ways of providing information to those who might not/cannot access websites. This could include 1-800 pandemic stress lines or so called "warm" lines (non-urgent support), or integrating psychosocial service providers into existing hotlines (e.g. nurses and crisis lines).

3.12 Bereavement and Grief Support

Although in general people will find their own ways to mark the loss of family and friends, some may need some specific psychosocial support to manage their grief, particularly in the face of multiple losses and the uncertainty of more, the absence or disruption of social support networks and, in the case of a child, the loss of a parent or primary caregiver. Further, some survivors of a pandemic influenza may be faced with long-term physical health, employment and other social issues that give rise to a grief reaction.

Psychosocial planners should work closely with those engaged in the planning for and delivery of coroners' and mortuary services (death care industry) in order to establish an integrated response to the needs of bereaved individuals and families. Particular attention should be paid to the potentially unusual arrangements that may need to be employed to address a lack of adequate resources (human or material) to deal with the volume of dead and the increased need for coroners', mortuary and burial services that is likely during pandemic waves. The extent of the demand may interfere at times with the burial and service wishes of the bereaved, which in turn may generate complications in the grieving process. Psychosocial teams should include or partner with those involved in the delivery of spiritual and religious care and support.

Publicly orchestrated events (commemorations, public memorial ceremonies) can provide citizens an opportunity to mourn collectively, and these events recognize both the shared individual and collective or social impacts of the pandemic. Such events can enhance the psychosocial healing process for individuals, organizations and communities.

3.13 Assessment, Triage, and Referral

Most people are reluctant to seek out mental health services and support, often accessing help only when the coping and emotional difficulties they are experiencing reach crisis proportions. Current best practice in psychosocial disaster support involves outreach and an ongoing process of assessment and surveillance of psychosocial needs, issues and trends. This should include the assessment of individual and collective psychosocial needs, the monitoring and evaluation of the efficacy of psychosocial interventions, and monitoring of trends that may indicate a sharp increase in the demand for services.

Monitoring and assessing the scope, extent and nature of psychosocial needs and the effectiveness of resources provides another strong argument for integrating psychosocial planning into overall emergency planning for a pandemic. Assessment is a process, not a single event, and requires a multi-pronged approach that supports a continuous appraisal of stress levels, demand for psychosocial support care and services, mental health issues (e.g. burnout, depression) and the relevance and efficacy of current interventions and psychosocial resources.

3.13.1 Psychosocial Assessment Goals

As with all psychosocial planning and support, assessment requires a multidisciplinary approach in which multiple levels of monitoring and evaluation are developed and initiated. The goal of assessment includes the following:

- Assessing the key psychosocial factors that affect the public as a whole and specific subpopulations (e.g. occupational groups, specific ethnic communities, frail elderly, caregivers);
- Identifying and anticipating future trends in demands based on shifts in psychosocial demands (e.g. changes in dominant stressors, duration of pandemic, evolving impact on specific populations and occupational groups);
- Assessing the evolving capacities and vulnerabilities of specific subpopulations, including psychosocial care providers;
- Addressing the need at times for professional (e.g. psychological/psychiatric) assessment of symptoms indicative of more serious mental health issues and referral to appropriate mental health resources; and
- Assessing the ongoing effectiveness and relevance of psychosocial support plans and specific interventions, and identifying and addressing gaps in planning and service delivery.

3.13.2 Psychosocial Assessment Strategies

There are a number of formal assessment processes and tools that might be used or adapted for use in the psychosocial planning process and service delivery. These include tools and processes developed specifically for disaster psychosocial and mental health assessment, including those that assess stress (acute, post-traumatic and chronic), compassion fatigue, resilience and caregiver burnout. Development of psychosocial assessment plans would benefit from the involvement of qualified disaster psychosocial and mental health professionals in order to develop, identify or adapt relevant psychosocial indicators and assessment tools, and triage and referral strategies. Formal assessment can be augmented by informal assessment strategies, for example, monitoring for signs and symptoms of stress or burnout by friends, family or colleagues. This depends on the development and provision of an education program for caregivers, staff and the public more

generally on common stress reactions, signs of mental health problems, how to offer support, and how and whom to refer to if problems are identified.

Assessment strategies can include:

- Developing and employing information-gathering networks and outreach strategies that can be used to scan the psychosocial status (e.g. stress levels, demands for service, sense of trust, social cohesion) of communities and specific organizations/institutions (e.g. schools, hospitals and clinics, labour organizations regarding grievances, occupational health and safety, social assistance, unemployment assistance centres). This can involve community/organizational leaders, clergy and others in direct contact with the affected population or occupational group;
- Incorporating stress assessment in the work of psychosocial support/care, occupational health and safety, and employee and family assistance programs (EFAP);
- Employing individual questionnaires or surveys of psychosocial well-being;
- Monitoring the volume and nature of calls accessing help on psychosocial-specific or mental health crisis lines;
- Monitoring people's reasons for seeking assistance;
- Monitoring wait lists and referrals to counselling and EFAP agencies and programs, substance abuse programs and mental health services;
- Implementing a reporting procedure whereby family physicians and other health professionals can provide ongoing information about needs and demands for service;
- Using virtual suggestion boxes (through email, confidential phone lines) for feedback and suggestions for additional services from employees and their family members;
- Conducting ongoing evaluation of the psychosocial well-being and health of employees and their families using existing formal mental health and disaster psychosocial tools, and informal assessment measures (e.g. interviews);
- Developing and integrating regular and ongoing operational debriefings and other formal and informal assessment strategies with psychosocial providers. This can provide general and specific information about shifts in needs, efficacy of resources and developing trends (while respecting confidentiality) and can also be used to monitor the well-being and evolving capacity of psychosocial providers; and
- Monitoring mental health/community counselling/EFAP wait lists to assess developing trends in demand for services.

3.13.3 Psychosocial Triage, Screening and Referral

In some circumstances, such as a surge in demand for services at a hospital or other health care facility, psychological triaging may be necessary. This kind of assessment involves deciding who is at risk of psychological trauma and other psychological disorders and then referring to appropriate mental health professionals and services.

Psychological triaging in disasters is based on a number of guidelines, which include assessing the psychological and emotional proximity of an individual to an event, his or her history of previous trauma and/or loss, the presence of acute stress reactions or the proportionality of the response, any history of psychopathology, and access to and availability of resources. Such triaging should be conducted by appropriate professionals or para-professionals trained in psychological assessment, trauma and crisis intervention. Those identified as being at risk should be closely monitored to assess their need for referral and/or immediate intervention.

More extensive screening of the entire presenting population should be conducted after triaging has identified all individuals at greatest risk as a result of their exposure or other risk factors. This screening involves observing for signs of distress or acute/chronic stress and can involve care providers (formal and informal), those close to the affected person (e.g. family, friends, teachers) and/or psychosocial providers on site. An effective psychosocial plan will include education for staff, care-providers and the public more generally about reactions to loss and stress, including signs and symptoms of acute, chronic or post-traumatic stress. This education should also include information about potential resources and assistance, and the process of self-referral or referring others to these resources.

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Appendix A – Psychosocial Implications and Pandemic Planning

Pandemic virus is expected to be in Canada within 3 months after it emerges elsewhere in the world (or sooner), to spread quickly with the first peak of illness occurring within 2-4 months, and to spread in two or more waves in the same or successive influenza seasons with each wave lasting 6-8 weeks.

Based on current predicted attack rates (35%) assume 25% of the population (current population based on 2006 Census information – 31.6 million) will be clinically ill in the first wave; up to 50% of the ill will seek outpatient care; depending on severity, 1%-2% will be hospitalized and recover; 0.4%-2% will be fatal cases

Challenges anticipated during a pandemic	**Psychosocial implications**	**Responses to be addressed in psychosocial plans**	**Outcome**
Surge in demand for health care services during an influenza pandemic Increased demand for psychosocial & mental health services – rates likely to increase around peak wave periods and during recovery	Public: increased stress, anxiety, anger as a result of difficulties accessing resources (e.g. antivirals) or services Health care workers and other essential service employees: stress, anxiety, uncertainty, overwhelmed Role overload for primary care physicians and other health care/social service providers Need for training and education in assessing and mitigating basic mental health issues (e.g. anxiety, depression, stress)	Development of multidisciplinary and community-based planning committees to involve relevant stakeholders (e.g. employees of an institution, general public) in planning process Development of collaborative, multidisciplinary psychosocial support teams and community resources (e.g. 24/7 pandemic psychosocial support lines; public service messaging re signs and symptoms; behavioural & cognitive strategies for mitigating; community-based mental health resources)	Build trust & rapport Develop and practice communication channels Clarify roles, responsibilities, mandates Increase buy-in and relevance of strategies developed
Perceived or actual differences in access to relevant health care resources and services	Need for information regarding rationale for public health decisions and measures	Development of culturally sensitive information in multiple media (print, radio, television, web-based) and languages, with phase-relevant dissemination strategies (e.g. community meetings pre-pandemic; radio, web, TV during pandemic) Identification and relationship building with community leaders from different subpopulations	Reduction in uncertainty; more informed public = more empowered & more likely to comply

Increased workload, shifts, shifts in roles and responsibilities to address absenteeism Sustaining essential services	Role overload, increased stress & anxiety, decreased attendance	Development and institutionalizing of psychosocial support services, including stress management, self-care, personal and family preparedness, extension of EFAP services to include crisis response Development of cross-training and just-in-time training modules Staff education, training and exercising of • Pandemic/health emergency plans • Clinical decision making • Work-from-home strategies for staff • Building communication capacity and alternatives to support virtual connection (e.g. fax, email, Internet, compatible software for sharing electronic medical and other records)	Increased human resource capacity and resilience
Implementing influenza control measures	Anxiety, fear, anger Stigma and social exclusion associated with infection, risk of infection Increased home-care responsibilities (especially for women who remain primary caregivers) for children, elders, sick family members	Public and employee education and training in • Public health pandemic plans • Infection risk management at work & home • Stress – signs, symptoms, management across developmental spectrum • Strategies for mitigating and managing stigma/ social exclusion Planning support for employees, families regarding; • Self-care and home-care of influenza-infected family members • Development of social support networks (friends, neighbourhoods) Community development of contingency plans for child care and elder care	Reduced anxiety Increased individual and social resilience Increased resilience, decreased demand for institutional services Reduced likelihood of serious mental health problems

An estimated absenteeism rate of 20%-25% during a peak 2-week period with lower rates before and after each peak (average during normal winter 8%) is used for planning purposes.

Absenteeism may result from illness or increased caregiving responsibilities of ill family members or those requiring home-care as a result of institutional closures (e.g. in the event of closures of schools, daycare centres, elder-care facilities).

Absenteeism rates are likely to vary among communities and work sites, and may be exacerbated by workplace avoidance. Although not a critical factor in previous pandemics, workplace avoidance should be considered with estimates based on a framework in which employees balance perceived relative risk with the cost of an absence; such absenteeism could be highest in education services, health care and social assistance, public administration.

Challenges anticipated during a pandemic	**Psychosocial implications**	**Responses to be addressed in psychosocial plans**	**Outcome**
Increased absenteeism	Increased work overload for those remaining on the job Increased stress & uncertainty arising from non-traditional roles, responsibilities, work sites, risk Economic and social implications (job loss, changes in family finances, stress within family, illness & death) Stigma associated with higher-risk occupation Uncertainty regarding family safety	Ensuring that workforce resiliency programs providing a range of on-the-scene, pre- and post-shift, follow up, and family support services are institutionalized Customizing business continuity plans to address staffing contingencies, safe and flexible working hours, family care plans for staff, early psychosocial support for staff and patients, and to minimize payroll disruption Ongoing assessment of workforce emotional and behavioural health, and evaluation and refinement of interventions Cross-training and just-in-time training to ensure that workers have a greater sense of efficacy and competence in new roles Communication strategies that address employees' need for information (e.g. safety measures) and employees' families' needs for information (e.g. precautions, communication with individual, child-care and elder-care strategies)	Improved workforce resiliency Reduced likelihood of absenteeism Reduced likelihood of serious mental health issues, long-term health issues related to stress

Anticipated social disruptions resulting from economic impacts, social distancing strategies and disruption of supply chains. Social consequences may last longer than actual pandemic.			
Challenges anticipated during a pandemic	**Psychosocial implications**	**Responses to be addressed in psychosocial plans**	**Outcome**
Social disruption	Breakdown in community support networks, including volunteers, cultural, social, recreational groups and activities Role conflict & stress related to child care, elder care, family care more generally Intra-community tension and conflict	Assessing community needs by engaging community in planning Developing and implementing non-traditional venues at which community members can connect (e.g. virtual networks, telephone support) Developing & disseminating information packages regarding psychosocial consequences, coping strategies Developing strategies to address additional homecare responsibilities & anticipating & addressing the impact of this on workforce availability Anticipating & addressing ongoing need for support in accessing resources (e.g. financial aid, material and health resources)	Improved mutual-aid opportunities Mitigation of long-term effects and facilitating recovery Empowerment of individuals and families – increasing sense of competency, self-efficacy, resilience

Appendix B – Psychosocial Issues for Essential Service Workers

Providing psychosocial support to health care and other essential service workers will be a critical component of an effective psychosocial pandemic plan. This will be particularly true for workers who, because of their work, are at increased risk of infection or exposure to those who are acutely ill and/or who die as a result of influenza. Some of the specific issues to consider are outlined below.

Psychosocial issues for health care and other essential service workers

- Extreme occupational stress due to:
    - Surge in demand for service;
    - Working with large numbers of ill/agitated persons and their families;
    - Wearing hot and uncomfortable personal protective equipment;
    - Concerns for personal safety (e.g. receiving vaccines and/or antivirals); and
    - Stigma and social isolation.
- Burnout/compassion fatigue associated with performing multiple caregiving roles (e.g. caring for dependent children/aging parents);
- Role conflict between personal and professional caregiving roles, exacerbated by potential school and other institutional closures (e.g. adult day care facilities);
- Illness and death among colleagues and family members;
- Fear of contagion and/or transmitting disease to others;
- Shock, numbness, confusion or disbelief; extreme sadness, grief, anger, guilt, exhaustion, frustration;
- Sense of ineffectiveness and powerlessness;
- Difficulties maintaining self-care activities (e.g. getting sufficient rest, connecting with family);
- Prolonged separation from family;
- Concerns about children and other family members; and
- Constant stress and pressure to perform.

Contributing factors

- Lack of reliable/consistent information (e.g. about protective measures);
- Perceived lack of effective leadership;
- Loss of faith in employers/institutions or governments;
- Death of immediate supervisors, colleagues, leaders in the response efforts;
- Death or illness of family members;

- Mass illness and deaths among children;
- Economic collapse or acute shortages of food, water, electricity or other essential services and supplies;
- Restrictions on civil liberties perceived to be inequitable (e.g. right to refuse work);
- Infection control measures (including personal protective equipment) that limit personal contact, hinder communication, interfere with normal personal/professional support systems;
- Concerns about children and other family members; and
- Rumours and misconceptions.

Appendix C – Psychosocial Communication Planning Tips

The psychosocial impacts of emergencies, particularly something on the scale of a pandemic, are a fundamental part of effective strategic communications with the public and media. Filling the knowledge gap with useful, accurate, consistent information is absolutely critical to helping manage the demand for information. Those planning to deliver effective psychosocial services and communications professionals must work closely together to support emergency management activities. Involving the public in planning efforts from the beginning and throughout all phases of a pandemic is also important:

- Create unambiguous, facts-based, consistent, comprehensive but also easily understandable messages;
- Update information on a regular basis, even if the update only signals that nothing has changed;
- Create messages that reflect and/or address local cultural sensitivities, public beliefs and opinions, local geographic considerations (i.e. remote communities, rural issues);
- Create messages that empower action, outlining what people can do to protect and prepare themselves and their families;
- Establish the transparency of the process by providing ongoing briefings about government and public health plans and decisions;
- Consider communication networks or information relays that are specifically targeted to particular groups of workers (e.g. health and social service providers) or that are designed to keep the public informed and aware. Such networks can effectively support delivery of information and key messages throughout the community and also receipt of that information or feedback from the community throughout the process;
- Assess and determine special equipment/systems needs, including cell 'phones, dedicated 'phone lines and message centres, in order to support the capacity of workers and their families to stay in touch and have up-to-date pandemic information specific to their work/organization/community;
- Designate and train specific individuals in crisis and risk communication strategies in order to minimize misinterpretations and to ensure, as much as possible, that they are experienced as caring and accessible, and are associated with reliable information. People who are afraid or stressed can easily misinterpret or miss pertinent details;
- Pre-prepare emergency messages, including ones tailored to non-English language speakers and those with special needs (i.e. literacy issues, limited access to web and other electronic resources); and
- Consider a psychosocial health support hotline: provide information on strategies for coping with stress and grief, and identify available community/organizational resources and services. Such lines can involve trained mental health care providers (i.e. psychologists, counsellors, clinical social workers and trained peer and crisis counsellors) in providing psychological first aid, support and information.

Appendix D – Web-based Planning Resources

Canadian Pandemic Planning Websites

1. Canadian Government Pandemic Influenza website – one stop access to information from Government of Canada departments and agencies on pandemic, seasonal and avian flu: http://www.influenza.gc.ca
2. Public Health Agency of Canada (PHAC) pandemic planning website: http://www.phac-aspc.gc.ca/influenza/pandemic_e.html
3. Canadian Pandemic Influenza Plan for the Health Sector (PHAC) website: www.phac-aspc.gc.ca/cpip-pclcpi/ (product of extensive dialogue and collaboration within the Pandemic Influenza Committee (PIC). Created in 2001, Public Health Agency of Canada)
4. Safe Canada pandemic website: http://www.safecanada.ca/link_e.asp?category=10&topic=193
5. City of Ottawa, Are you ready? – Influenza Pandemic Passport website: http://www.ottawa.ca/residents/health/emergencies/pandemic/passport_en.html
6. Canadian Centre for Occupational Health and Safety Pandemic Planning website: http://www.ccohs.ca/pandemic/subject/governmentalpandemicplann.html

Disaster Mental Health and Psychosocial Planning Tools

1. Public Health Agency of Canada Emergency Preparedness website: http://www.phac-aspc.gc.ca/ep-mu/index.html
2. The US Department of Health and Human Services Pandemic Influenza Planning: Guide for Individuals and Families is a comprehensive guide that outlines what a pandemic is, its anticipated effects, questions and answers regarding vaccines etc., a checklist for planning for individuals and families
3. Quebec Pandemic website – A guide for employers and workers to prevent psychosocial impacts : http://www.pandemiequebec.gouv.qc.ca/en/news/advice-enterprises.aspx?p=impacts
4. EU Psychosocial Support in Situations of Mass Emergencies is a comprehensive guide to psychosocial concerns and interventions – covers a range of mass casualty emergencies: ec.europa.eu/environment/civil/act_prog_rep/psychosocial_aftermath.pdf

Workplace

1. Health Canada – Environmental & Workplace Health : Influenza Pandemic : Psychosocial Care Planning : http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/pandemic-plan-pandemie/intro-eng.php
2. Vancouver Coastal Health Pandemic Influenza Plan – Chapter 8 Human Resources: http://www.vch.ca/pandemic/

3. Canadian Policy Research Network – Caring for Nurses in Public Health Emergencies – Enhancing Capacity for Gender-based support mechanisms in Emergency Preparedness Planning. Detailed research and recommendations for enhancing the resiliency of the human resource dimension of health services with particular attention to gender issues (e.g. role conflicts experienced by HCWs as a result of multiple caregiving roles). Available at: http://www.cprn.org/

Signs and Symptoms of Stress & Age-Appropriate Intervention Strategies

1. Substance Abuse and Mental Health Services Administration (SAMHSA - US Government) website: http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/after.asp
2. United States Department of Health & Human Services; Pandemic Influenza Plan, 2005; Supplement 11 Workforce Support: Psychosocial Considerations and Information Needs. Available at: www.hhs.gov/pandemicflu/plan/sup11.html
3. Crimando SM (MD), 2006. The emotional and behavioural consequences of chemical, biological, radiological and nuclear events and other complex public health emergencies: Part II. Available at: http://www.bigmedicine.ca/stevencrimando.htm.

Special Needs Populations

Federal Emergency Management Agency, Emergency Management Planning Guide for Special Needs Populations - currently available in interim form at: http://www.fema.gov/pdf/media/2008/301.pdf.

Workforce Support for First Responders

1. Tips for Managing and Preventing Stress: A Guide for Emergency and Disaster Response Workers – SAMHSA website: http://mentalhealth.samhsa.gov/publications/allpubs/tips/disaster.pdf
2. The US Department of Health and Human Services Pandemic Influenza Plan Supplement 11 Workforce Support: Psychosocial Considerations and Information Needs: http://www.hhs.gov/pandemicflu/plan/sup11.html
3. Patel MS, Phillips CB, Pearce C, Kljakovic M, Dugdale P, Glasgow N. (2008). Primary health care planning – general practice and pandemic influenza: A framework for planning and comparison of plans in five countries. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=18509538
4. Emergency Management Workforce Protection Guidelines – US guidelines for to protect EMS and 9-1-1 workforce and their families during an influenza pandemic. Available at: www.nhtsa.gov/people/injury/ems/PandemicInfluenzaGuidelines/Task61136Web/PDFs/Section6.pdf

Other

Redefining Readiness Study. Available from: http://www.redefiningreadiness.net/rrstudy.html

International Plans

World Health Organization (WHO) Global Influenza Preparedness Plan; Department of Communicable Disease, Surveillance and Response, Global Influenza Programme; World Health Organization 2005. Available at: www.who.int/entity/csr/resources/publications/influenza/GIP_2005_5Eweb.pdf

Ethical Issues in Pandemics

1. Thompson AK, Faith K, Gibson JL, Upshur REG. Pandemic influenza preparedness: an ethical framework to guide decision-making. Available at: http://www.biomedcentral.com/1472-6939/7/12
2. Johns Hopkins – Berman Institute of Bioethics. Various documents concerning ethical decision making related to an influenza pandemic. Available at: www.bioethicsinstitute.org

Planning Considerations for First Nations Communities

The Public Health Agency of Canada's pandemic website, Annex B: http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-b_e.html

Appendix E – Tips for Linking Psychosocial Planning with Emergency Management

- Review all aspects of existing pandemic plans with an eye for the emotional, behavioural and social implications of response and recovery actions and strategies.
- Outline the organizational/community government emergency management structure during a crisis in ways that highlight the integration of psychosocial measures.
- Develop alliances across disciplines (e.g. health, social services, emergency management) in order to build trust, improve communication and enhance response capacity through the development of interdisciplinary teams and collaborations.
- Ensure that workers and community members are informed regularly of structural/procedural changes associated with emergency plans. Plan for and communicate the potential for shifts in roles and responsibilities and integrate these possibilities into existing plans, education and training.
- Psychosocial plans should address the interface between local, regional, F/T/P governments and public health authorities so that resources and services are outlined and unnecessary duplication is eliminated.
- Consult with neighbouring communities/organizations to assess resources and build psychosocial plans that are consistent, again minimizing unnecessary overlap and maximizing shared resources.
- Develop contingency plans that include mutual aid/support agreements between health, social service and other agencies/organizations involved in psychosocial response that can mitigate the effects or duration of potential interruptions to delivery or access to mental health services, receipt of social/economic support, food delivery and other community services.

Appendix F – Psychosocial Planning Checklist

The following psychosocial planning checklist* addresses a range of planning considerations that are likely to affect the psychological, behavioural and social well-being of individuals, families and communities. The specific relevant points may vary across jurisdictional and organizational mandates.

1. Plan for the psychosocial impact of an influenza pandemic			
Completed ❑	**In Progress** ❑	**Not Started** ❑	Identify and develop a multisectoral psychosocial planning group with the authority to design, maintain and implement a psychosocial preparedness and response plan for pandemic influenza.
❑	❑	❑	Determine the potential psychosocial consequences in your jurisdiction/organization & develop contingency plans.
❑	❑	❑	Develop and deliver training to address shifts in roles, absenteeism and just-in-time training needs.
❑	❑	❑	Use exercises, drills & community/worker input to continually refine psychosocial plans.
2. Communicate with and educate staff, volunteers and other community members about the health and psychosocial consequences of a pandemic			
Completed ❑	**In Progress** ❑	**Not Started** ❑	Develop & distribute materials with basic information about psychosocial consequences, stress management, individual and family preparedness for secondary consequences of pandemic.
❑	❑	❑	Develop and integrate psychosocial resiliency education and information sessions into staff training and public meetings/gatherings.
❑	❑	❑	Develop communication strategies and tools that will support the ongoing dissemination of resiliency/stress management information using multiple media.
❑	❑	❑	Ensure that you address diversity issues (including culture, language, cognitive and physical ability, age, literacy) in the development and dissemination of plans, messages and materials. Includes participation of diverse stakeholders.
3. Plan for the physical, social, emotional and economic impact on your workers/community by institutionalizing psychosocial and worker resiliency programs			
Completed ❑	**In Progress** ❑	**Not Started** ❑	Plan for staff/volunteer absenteeism during a pandemic due to personal and/or family illness, quarantines and social distancing interventions (i.e. closure of schools, businesses, public transportation, public gatherings).
❑	❑	❑	Develop and implement workforce resiliency programs.
❑	❑	❑	Anticipate psychosocial impacts of secondary consequences on your organization/community.
❑	❑	❑	Identify, evaluate and enhance capacity of the availability of mental/behavioural health and social services likely to be available to staff, volunteers and community members during a pandemic.

❑	❑	❑	Provide training in disaster mental and behavioural health to relevant personnel (i.e. social workers, psychologists, counsellors, mental health workers, psychiatrists, other relevant health personnel).
❑	❑	❑	Identify potentially vulnerable or at risk populations or individuals in your community/organization. Plan for their psychosocial needs.

4. Establish policies and procedures for use during a pandemic			
Completed ❑	**In Progress** ❑	**Not Started** ❑	Develop policies and procedures for non-penalized staff absences/ leaves for personal/family illness during a pandemic. Encourage community businesses to do the same.
❑	❑	❑	Develop mandatory sick-leave policies for staff suspected to be ill, or who become ill at the workplace.
❑	❑	❑	Develop strategies and policies for flexible work hours and working from home. Consider technological needs to support these arrangements.
❑	❑	❑	Develop policies/protocols for addressing psychosocial impact of loss of services/workplaces that are closed as part of infection control measures.
❑	❑	❑	Consider developing alternative strategies for service delivery for use during peak wave periods.
❑	❑	❑	Designate persons responsible for assessing the psychosocial well-being of workers/community and for providing additional psychosocial support as needed.
❑	❑	❑	Develop and establish procedures for activating your response plan when a pandemic is declared by public health authorities.
5. Development and implementation of workforce resiliency plans			
Completed ❑	**In Progress** ❑	**Not Started** ❑	There is a framework in place for the development and implementation of workforce resiliency and psychosocial support programs that are responsive to the shifting resources and needs of individual workers and their families, as identified through an ongoing assessment process.
❑	❑	❑	There is a framework in place for the development, adaptation and delivery of education and training to support the psychosocial resilience of individual workers and their families. • pre-pandemic education and training in psychosocial resilience; • psychosocial implications integrated into occupational safety and infection control measures; and • pre- and just-in-time training that addresses potential changes in roles, responsibilities and worksites.
❑	❑	❑	There is a framework in place for the development and delivery of relevant education and training to staff, volunteers and community-based providers of psychosocial support services included in your workforce resiliency plan.
❑	❑	❑	There is an effective risk communication plan that will address the ongoing information needs of the health care workers and their families and client/patients in the context of the disruption that a pandemic is likely to create.

❑	❑	❑	There are contingencies in place to support the ongoing provision and revision of psychosocial support services following a pandemic. These take into account the shifting situational factors and long-term needs of health care workers.
❑	❑	❑	There are mechanisms and processes in place that will facilitate the ongoing coordination, evaluation and sustainability of workforce resiliency programs, including the ongoing integration of lessons learned.
6. Coordinate with psychosocial planning partners in organization/community locally and regionally			
Completed ❑	**In Progress** ❑	**Not Started** ❑	Understand the plans, roles and responsibilities of federal, provincial/territorial, regional and local governments, public health authorities and emergency response organizations.
❑	❑	❑	Develop planning networks with local and regional counterparts. Share plans, develop mutual aid plans and detail contributions of each. Identify and assign a point of contact and communication strategies to maximize communication between key stakeholders.
❑	❑	❑	Develop plans to enhance capacity of existing resources (i.e. churches, community emergency management teams).

*Adapted from the faith-based community checklist for pandemic 'flu: http://www.pandemicflu.gov/plan/faithcomchecklist.html