

DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE
ABUSE SERVICES
Pandemic Influenza Response

PURPOSE

The behavioral health response appendix to the North Carolina Pandemic Influenza Response Plan describes activities that will be implemented to address how the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) will respond to the psychological consequences of a pandemic influenza in the state of North Carolina.

DMH/DD/SAS is responsible for periodically reviewing and updating this plan to ensure that information contained within the document is consistent with current knowledge and changing infrastructure. While this appendix serves as a guide specifically for influenza intervention activities during a pandemic, the judgment of public health leadership based on knowledge of the specific virus may alter the strategies that have been outlined.

Priorities of DMH/DD/SAS during pandemic influenza will be to assure the continuation and delivery of essential behavioral health services while providing for the emergency behavioral health needs of the population.

Visit the DMH/DD/SAS web site located at the end of this document for the complete disaster preparedness, response and recovery plan.

SCOPE OF OPERATIONS

This sub function applies to all victims of the pandemic influenza as well as personnel assigned to emergency oriented missions within North Carolina.

DMH/DD/SAS will operate within the established incident command structure.

SITUATION AND ASSUMPTIONS

1. An influenza pandemic in North Carolina will present a massive test of the emergency preparedness system. Advance planning for North Carolina's emergency response could save lives and prevent substantial economic loss.
2. A pandemic will pose significant threats to human infrastructure responsible for critical community services due to widespread absenteeism.
3. Many geographic areas within North Carolina and its neighboring jurisdictions may be affected simultaneously. Localities should be prepared to rely on their own resources to respond. The effect of pandemic influenza on individual communities will be relatively prolonged (weeks to months) in comparison to other types of disasters.

4. North Carolina's healthcare and behavioral healthcare systems will be strained to the breaking point by staff attrition and increased demand for services. Healthcare workers and other first responders may be at higher risk of exposure and illness than the general population further straining the healthcare system.
5. Widespread illness in the community could increase the likelihood of sudden and potentially significant shortages of personnel in other sectors that provide critical public safety services.
6. An effective response to an influenza pandemic will require the coordinated efforts of a wide variety of organizations, both private and public.
7. In an influenza pandemic, preparing for a surge in behavioral health casualties as well as attending to those who believe themselves to be infected is crucial. Disasters, by their inherent conditions, produce the need for behavioral health response. Responding to the psychological and emotional impact of disasters for all people involved is an integral part of a comprehensive and effective disaster response and recovery strategy. Hence, a behavioral health response should be made available to individuals at various venues such as home, school, shelter, hospital, and isolation/quarantine areas.
8. Individuals psychologically impacted often include those involved in treating the physical casualties. In fact, disaster responders, including medical personnel, are a high-risk group for developing trauma-related disorders. Certain members of the workforce (e.g. healthcare workers) may be at increased risk of infection. Those workers at increased risk of infection are an especially vulnerable group due to a real or perceived increased risk of becoming infected themselves, and/or transmitting infection to their friends and families. In addition to assuring access to personal protective equipment, vaccination and prophylactic treatments for first responders and frontline health care workers, health care organizations need to direct attention to mitigating the stress-related psychological effects of disaster response on these individuals. Hence, there is a particular need for sensitivity to personal concerns and obligations when workers, for instance, may be separated from their families and loved ones for long hours and even days.
9. An influenza pandemic may pose substantial short-term and long-term physical, personal, social, and emotional challenges to individuals and/or the community at large.
10. In an influenza pandemic, there may be short and/or long term effects on the behavioral health of individuals due to direct experience with sick and dying loved ones, and on the population as a whole. The particular behavioral health needs of marginalized populations such as homeless people also need to be considered.
11. Critical to planning for pandemic-related behavioral health care within a community includes assisting individuals with pre-existing behavioral health needs. This population may become more vulnerable and may experience increased anxiety, depression, or substance use when their support system is impacted. The need to access medications and psychosocial supports will be a priority as the community support infrastructure deteriorates. Planning for a decline in the emotional status of individuals currently identified as "at-risk" for behavioral health needs includes increased behavioral health counseling, medication management, and support groups.

CONCEPT OF OPERATIONS

DMH/DD/SAS will organize behavioral health response into a comprehensive network to conduct Emergency Support Function #8 - mitigation of the psychosocial impact of any mass casualty incident in coordination with Local Management Entities (LMEs), Red Cross, interfaith agencies, DMH/DD/SAS cadre of volunteers, and private partners. Provision of local behavioral response will be administered as available resources permit.

Because some or all of the state-level resources may quickly be exhausted, DMH/DD/SAS may need to request assistance from Federal Emergency Management Agency (FEMA), the National Disaster Medical System (NDMS) and other states through the Emergency Management Assistance Compact. NDMS consists of the Disaster Medical Assistance Team, the Disaster Mortuary Operation Response Team, Medical Support Unit, Behavioral Health and Stress Management teams, and the Veterinary Medical Assistance Team.

To prepare for a pandemic, DMH/DD/SAS will:

1. Conduct a county-wide space and site resource inventory to determine the availability of staff at shelters, schools, gymnasiums, nursing homes, day care centers, and other potential sites for aggregate care.
2. Assess related behavioral health needs of community, victims, families, behavioral health consumers, emergency workers and their families.
3. Provide oversight and coordination of State response by promoting psychological first aid and resilience for victims and their families as well as coordinating with NC Critical Incident Stress Management to ensure Critical Incident Stress Management is available for first responders and healthcare workers.
4. Provide LME staff and community response partners with literature and educational materials for community-wide distribution, on the human response to disaster, stress reduction and self-help information, and support Public Health community education efforts.
5. Staff will be mindful of the “contagion” factor. Staff is working with public affairs staff to develop messages on this issue. Staff will be prepared and trained to address this issue through the media.
6. Educate healthcare providers, behavioral health responders and the public of the side effects of antivirals. (Side effects may include nervousness, anxiety, difficulty concentrating, lightheadedness and insomnia, dizziness, behavioral changes, delirium, hallucinations, agitation and seizures).
7. Provide assistance to the Office of Citizen Services’ CareLine that will:
 - Provide information and education via phone line for the community
 - Assure behavioral health consumers’ concerns are addressed
 - Provide information in Spanish

8. Work with Office of Minority Health and Health Disparities, Office of Rural Health and Community Care, and different communities within the state (e.g., ethnic, racial, and religious groups; most vulnerable; special needs; language minorities) to ensure people are identified and can be reached with appropriate behavioral health resources. Identify resources, such as culturally competent and multilingual providers, that could assist in provision of disaster services.
9. In the event of a Presidential Declaration of Disaster, initiate the application process for federal funding. If needed, apply for all FEMA-funded disaster crisis counseling assistance grants. Prepare mandated reports for the federal government.
10. Institutionalize psychosocial support services in order to help workers manage emotional stress during the response to an influenza pandemic and to resolve related personal, professional and family issues.
11. Train behavioral healthcare staff and first responders on how to:
 - Help victims of a disaster emergency deal with the trauma directly associated with an emergency or disaster
 - Provide immediate support
 - Set up rest stations to allow space for psychological first aid to be administered
 - Recognize self limitations
 - Make appropriate referrals for continuing services
12. Train non-behavioral health professionals (e.g., primary-care clinicians, safety and security personnel, community leaders, and staff of cultural and faith based organizations) in basic psychological first aid.
13. With the assistance of DHHS Public Affairs Office, identify and develop pandemic influenza specific education tools and materials regarding the signs of distress, traumatic grief, coping strategies, and building and sustaining personal and community resilience.
14. Create a plan for continuity of operations in case of increased workload or staff losses during a pandemic.
15. Develop and implement table-top exercises focused on behavioral health disaster issues.
16. If there are mass casualties, individuals may have to face, in addition to personal loss, restrictions that limit their freedom to mourn for and bury their dead in a timely fashion according to their cultural/religious beliefs. DMH/DD/SAS will assist community response partners to provide appropriate and culturally-sensitive support to individuals and communities.
17. Guidance will also be needed for coping with psychosocial issues such as irrational stigmatization and grief, ethical dilemmas, managing stress when familial roles change, economic hardships, and managing feelings of frustration, anger, and helplessness. Support will be needed for dealing with exhaustion, anger, and fear in patients, peers and self and learning how to take measures to care for self, peers, and family.

(Refer to US DHHS Pandemic Influenza Plan, *Supplement 11: Workforce Support* for more information on psychosocial considerations and information needs for healthcare workers).

RESPONSE PHASES

It is expected that an influenza pandemic will occur in the phases listed below. In actual practice, the distinction between the various phases of pandemic influenza may be blurred or occur in a matter of hours, underscoring the need for flexibility. DMH/DD/SAS' response is detailed in each phase.

World Health Organization Phases

Interpandemic Phases 1 and 2

- Identify private and public sector responding partners in the planning process. Foster coordination and participation among private and public sector partners in the planning process.
- Work within agencies to develop contingency plans for large scale public health disasters like an influenza pandemic.
- Coordinate planning with federal and other neighboring states.
- Provide education and planning guidance to responding partners and community on preparing for and responding to an influenza pandemic.
- Prepare and distribute education materials for workforce and community support to promote resilience.
- Identify major gaps in current ability to effectively respond to an influenza pandemic. Explore possible avenue for addressing and resolving gaps.

Pandemic Alert Phase 3

- Notify LME and community partners of the pandemic alert phase 3 (human infections with a new influenza subtype).
- Designate an official contact person to receive updates.

Pandemic Alert Phase 4

- Update LME and community partners of pandemic alert phase 4 (small clusters of human-to-human transmission of new influenza subtype).
- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate.
- Review and update pandemic influenza response and contingency plans.

Pandemic Alert Phase 5

- As appropriate, activate response partners and intensify activities described in phases 1-4.
- Notify LME and community partners of the potential for an influenza pandemic in North Carolina to ensure adequacy of behavioral health response.
- Continue to review pandemic influenza response and contingency plans for large scale public health disasters.

- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate.

Pandemic Phase 6

- Implement contingency plans for large-scale public health disasters.
- Ensure designated agency contact available to receive updates from DMH/DD/SAS.
- Provide regular updates to LMEs and community partners of gaps in agency services.
- Coordinate use of available resources during pandemic, including private, public and volunteer resources.
- Coordinate activities with other stated and federal health agencies.
- Assess effectiveness of local response and available local capacity.
- Monitor response of DMH/DD/SAS during pandemic, re-allocate resources as needed
- Apply for FEMA grants as needed.
- Monitor bulletins from CDC, WHO, and HAN regarding clinical updates as appropriate.

Second or Subsequent Waves

- Continue all activities listed under Pandemic phase 6.
- Review, evaluate and modify as needed, the local pandemic response.
- Monitor resources and staffing needs.

Post pandemic Period

- Assess state and local capacity to resume normal behavioral health functions.
- Assess fiscal impact of pandemic response.
- Modify the pandemic influenza response and contingency plans based on lessons learned.

Special Needs Population

Comprehensive pandemic influenza planning must prepare for the behavioral health concerns of populations with special needs. People who depend on frequent appointments for medical care or behavioral health services are vulnerable to the loss of these services due to staff shortages and breakdown in community infrastructure and support system. DMH/DD/SAS will help to ensure that services are provided to the greatest extent possible to these vulnerable populations. Groups with special needs may include:

- Children, adolescents, and the elderly
- Individuals with emotional, cognitive, or physical disabilities
- Individuals with substance use issues
- Individuals living in congregate settings
- Individuals in inpatient health care facilities
- Individuals in state operated facilities
- Individuals who are Deaf or Hard of Hearing
- Individuals who are blind or visually impaired
- The homeless
- The homebound
- Undocumented individuals
- Immigrants
- Groups with special language/cultural needs

Planning and activities to meet the demand for expanded behavioral health services for populations with special needs include:

- Encourage providers to develop a Continuity of Operations Plan for delivery of essential services to special needs populations.
- Educate health and behavioral health care providers and Local Management Entities about vulnerable populations, their special needs during pandemic influenza and the providers' role in addressing those needs.
- Ensure staff and individuals in state operated facilities are considered in planning, preparedness, and response activities.
- Develop need-specific web-based education materials.
- Collaborate with community and faith-based organizations to ensure that behavioral health planning, preparedness, and response activities are culturally appropriate.

REFERENCES

Center for Mental Health Services. (2004). *Mental Health Response to Mass Violence and Terrorism: A Training Manual*. HHS Pub. No. SMA 3959. Rockville, MD.

National Institute of Mental Health (2002). *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practice*. NIH Publication No. 02-5138, Washington, C.C.: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2005). *Pandemic Influenza Preparedness and Response Plan*. Washington, D.C.

World Health Organization. (2005). *Responding to the Avian Influenza Pandemic Threat. Recommended strategic actions*. Communicable Disease Surveillance and Response Global Influenza Programme. Geneva, Switzerland

WEBLINKS

NC DMH/DD/SAS www.dhhs.state.nc.us/mhddsas/disasterpreparedness/disasterplan04-05.pdf

American Psychiatric Association. www.psych.org/disasterpsych

American Psychological Association Help Center www.apahelpcenter.org

National Center for PTSD, Department of Veterans' Affairs www.ncptsd.va.gov/

National Child Traumatic Stress Network www.nctsnet.org