Template for State Level Mental Health Pandemic Response Plan

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DRAFT For Review

Introduction

This chapter addresses the behavioral health and psychosocial issues emanating from an influenza pandemic. A twenty-first century Influenza Pandemic will cause a high level of infectious disease morbidity and mortality leading to a surge in health care usage. In addition to complex health and societal effects, pandemic influenza will translate into unprecedented acute and chronic mental health consequences and behavior challenges. The purpose of this effort is to build greater resiliency through expanding the capacity to promote and respond to the mental health effects of a pandemic influenza.

The proposed project pro-actively addressing the range of mental health and behavioral consequences holds the promise to enhance the resilience of the public and mitigate the surge on health care facilities, attenuate economic impact, and protect the public's mental health from an influenza pandemic.

As a function of phase/stage and severity of a pandemic, there are two primary mental health and behavioral foci:

1. The first is protecting the public from adverse psychological consequences with special attention to "at-risk" populations
2. The second focus is to promote *timely* behavioral adherence by the public to recommended or mandatory public health actions to maximize community containment and other strategies.

The two-pronged mental health and behavioral response strategy:

To address these issues, a two-pronged mental health and behavioral response strategy will be used:

The proposed "UCLA Personal Resilience System" is a continuum of care spanning coping with fears to severe disorders providing virtually unlimited surge

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capacity and efficient allocation of professional resources to those in greatest need (Schreiber, 2006, 2007). The UCLA Personal Resilience System (UCLA PRS) is composed of elements to:

1. Mitigate fears and concerns proactively at the population level.
   - Accomplished by development of a "coping with fear" public information module supplementing risk communications that will provide concrete phase specific coping strategies (see Table I and Appendix 1 for details)
2. For those at lower risk, a menu of web-based strategies will support natural coping (e.g., engaging social supports and self-care) strategies for those not needing definitive care. In this way, limited direct service mental health capacity would be preserved for those with life-threatening mental health emergencies or otherwise at high risk for complex psychological outcomes.
3. For the sub-set of those "at risk" for clinical disorders (such as depression and PTSD) and given the potential surge needs, the UCLA PRS platform would use existing, evidence based internet treatments (e.g., PTSD and depression) to achieve virtually unlimited surge capacity and safety in a contagious/social distancing context of care.
4. Specialized resilience coping packages for health care workers would also be included.

Mental Health Triage and Incident Management System

1. From common distress to severe disorders, the strategy coordinates surge mental health needs by providing a triage driven continuum of mental health interventions. Facilitating the continuum of care will be a novel mental health incident coordination system that links first responders, general health care providers, and local public and private mental health practitioners into a locally coordinated approach. This permits rational alignment of resources and services to "at risk" populations first. With the mental health triage system, a menu of interactive web-based treatments will help to preserve the traditional direct service care for those with the most acutely severe needs. This system matches those at high risk for disorder (e.g., PTSD, depression) with evidence-based Internet treatments and in person care (as needs and capacity allows). In a context of extreme surge demand and contagion, web-based treatments hold the promise to reach and serve the large numbers at high risk whom otherwise could not be assisted given current capacities.
2. This mental health triage and incident coordination system component would adapt an "off the shelf" evidence-based mental health incident coordination system known as PsySTART, that has already been successfully included in training for the American Red Cross, States of New York and Ohio, National Disaster Medical System and US Public Health Service Response Teams. The PsySTART system is also being customized for LA County Emergency departments. The approach here would encourage local entities (counties, regions) to also customize the

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PsySTART approach to their local needs and resources but still enabling a coordinated NIMS approach.

Goals

1 Promote resilience, coping and manage the mental health consequences of an influenza pandemic.
2 Promote success of the public health response by facilitating timely adherence to community containment strategies by the public.
3 Promote the functionality and maximize efficient use of public and private health care and mental health care resources.

Objectives

1. Preserve the functionality of health care systems by supporting the mental health needs of first responders, the health care workforce, and the general population.
2. Decrease population level psychological morbidity associated with the pandemic and for "at-risk" populations (children, those with traumatic loss of parents, special health care needs, health care workforce, etc).
3. Promote timely adherence with non-pharmaceutical community containment measures:
   Including mass prophylaxis directives, movement restrictions/social distancing strategies, hygiene, self-care and appropriate seeking of health care services (i.e., decrease non-indicated surge of Emergency Departments, acute/primary care settings).
4. Promote efficient alignment of public and private mental health resources based on evidence based, objective risk indicators by establishing the "Disaster Mental Health Triage Incident Management System".
5. Use the triage system to rapidly identify sub-populations at the greatest level of mental health risk and focus delivery of programs that promote effective coping strategies early on before entrenched disorder develops in "at-risk" individuals.
6. Encourage resilience and the use of positive coping skills for all members of the population, including responders and providers through establishing a novel, integrated "Personal Resilience Strategy".
   The "UCLA PRS" model adapted for the state will promote the enhancement of a range of culturally relevant coping strategies, reinforce the use of natural support systems and teach new coping strategies specific to pandemic phases and level of individual risk (i.e. fearful vs. experienced loss vs. developed PTSD).
   The "UCLA PRS" system will create pathways to positive personal coping protective measures for both citizens and providers
7. Utilize existing and/or develop training methodologies and delivery systems to prepare first responders, volunteers, healthcare providers and the mental health care workforce for the specialized functions of delivering crisis psychological support, triage and treatment.

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Assumptions and Planning Principles

Magnitude:

There will be a continuum of mental health effects from transitory distress in many and, depending on the level of morbidity and mortality, minimally 30-40% or more of those directly effected (i.e. traumatic loss of loved ones) will develop new, diagnosable mental disorders notably Posttraumatic Stress Disorder (PTSD), depression and/or substance abuse.

Risks for first responders:

There where will be significant mental health consequences on emergency response workers including public health and medical system providers.

New incidence psychological disorders:

1 Traumatic grief, depression and PTSD) will continue to become more prevalent in successive waves of a pandemic as the loss of loved ones and secondary effects spread, overwhelming the capacity of traditional in-person care or “usual crisis response” approaches. Individuals requiring care will be those with new incidence mental health disorders (e.g. depression, PTSD)
2 Traumatic loss of loved ones from pandemic will result in complicated/traumatic grief effects at a population level and will be associated with significant psychosocial consequences (notably depression) extending for years after the pandemic for large numbers of the public.

Pre-existing mental health conditions will worsen:

1 Public and private mental health care systems will experience unprecedented exacerbation of pre-existing mental health disorders resulting from the pandemic
2 Pandemic will differentially impact “at risk” groups such as children, those with special health care needs, health care workers, those with prior traumatic loss and still others that will surface during varied pandemic phases

All community systems will be stressed and stretched:

1 The mental health consequences will put added burden not only on the mental health system, but also on medical, public health, commercial institutions, and critical infrastructure as well.
2 Non-pharmaceutical and community containment measures benefit from high levels of public adherence to maximize their impact
3 Undesirable public behaviors can be reduced

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Need for new systems of mental health care

1 Surge numbers and fears of contagion/social distancing will severely limit applicability of the traditional mental health care as usual for crisis response.
2 Traditional mental health service delivery systems and approaches will not be able to absorb new incidence psychological disorders either in the acute phase (World Health Organization Phases 5/6), multiple waves of influenza, or extended course of recovery (WHO post pandemic phase).

Psycho-educational coping strategies to help "inoculate" the population.

1 Behavioral health resilience, common in many disasters will be less common in pandemic influenza unless specific supports are built in at the population level
2 In the early phases of a pandemic, population-level behavioral health resilience is supported by novel psycho-educational coping strategies to help inoculate against fears.
3 Population level behavioral resilience and coping can also be enhanced by supporting natural social support systems by facilitating and encouraging the *continuity* of natural coping in a context of community containment measures (with possible social distancing for extended periods) using novel electronic social support (e.g. instant messenger, "face book","myspace", etc.)
4 Population-level behavioral resilience can be enhanced by creating the mechanisms for, supporting and conducting bi-directional communications between the people and public health officials in "near real-time" as the event unfolds and the public health impacts and strategies evolve.
5 Enhancing population resilience may reduce the surge demand on all goods and services delivery systems.

Triage system

1. The PsySTART rapid mental health triage and incident management approach, adapted for pandemic disaster mental health triage incident management is required to rationally align and coordinate available mental health resources using a NIMS/NIMS common operational picture focused on managing the event at the local level and in helping the public obtain customized care they will require.
2. The projected surge of mental health resources will require new programs. As the pandemic evolves, coping packages can be established specific to the triaged needs of the individual.

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Pandemic Response Action Steps

WHO Phase 1 and Phase 2

Inter-pandemic period: No novel influenza subtypes have been detected in humans, but a novel subtype that has caused human infection may be present or circulating in animals.

Pandemic Alert Period: WHO Phase 3

Human infections are occurring with a new sub-type, but no human-to-human spread or at most, rare instances of spread to a close contact

An established partnership made up of public and private Mental Health Professionals, Mental Health institutions, and important stakeholders, in collaboration with State Departments of Mental and Public Health, will:

1. Establish the preparedness component "Personal Resilience System"(UCLA PRS-see details in Appendix 1) to foster "stress inoculation" for potential pandemic impacts.
2. Develop the "UCLA PRS" Phase 1 program to support basic ("all hazards") psychosocial preparedness and resilience via preparedness coping information. The PRS will serve the public, public health workforce and medical providers with customized stress inoculation strategies and coping information specific to phase
    - Establish a "UCLA PRS" page on a public health website (along with other health information)
    - Develop specific pre-event psychological preparedness modules containing psychosocial support self care (including at risk children and families and schools) based on the existing national best practices (i.e. the UCLA/Center for Public Health and Disasters /Ready.gov "Listen, Protect and Connect", one available form of Psychological First Aid).
    - Develop media messages and delivery systems that encourage Individuals to speak to and liaison with employers, schools, public health, personal health care providers about emergency response plans; pandemic response specifically and any personal protective behaviors (respiratory hygiene, hand washing).
    - Design, develop, and/or adapt a standardized disaster mental health triage incident management system to prioritize available mental health resources, coordinate response across incident command system/National Incident Management System levels

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and recommend individual/population-level interventions.

- Design a system which will use behavioral health epidemiological information derived from the standardized disaster mental health triage system to help craft customized targeted coping messages.
- Design training methodologies and delivery systems or adapt existing systems to prepare first responders, volunteers, healthcare providers, and the mental health care workforce for the specialized functions of delivering crisis psychological support, triage and treatment.
- Design performance evaluation systems to enable the Pandemic Influenza crisis mental health system to plan for continuous quality improvement as the pandemic emerges.

WHO Phase 4

Pandemic Alert Period: Small clusters of human infection with limited human to human transmission but spread is highly localized.

An established partnership made up of public and private Mental Health Professionals, Mental Healthl institutions, and important stakeholders, in collaboration with Departments of Mental and Public Health will:

1. Continue with all actions in previous pandemic phases
2. Extend the "UCLA Personal Resilience System" to "Phase/component 2"(see table 1 and Appendix 1)
3. Extend "Coping with Pandemic" resilience modules from Phase 1 with broader penetration via multimodalities, engaging key stakeholders, community-based organizations, local public health departments and schools via additional formats (i.e. Public Service Announcementcustomized stakeholder partnerships releases, briefings, sample community presentations for stakeholders)
4. Develop a focused *"Coping with Pandemic"* module (see table 1):
   (Coping with fears of acquiring illness, altered standards of care, scarce resources, community-based activity restrictions (e.g., social distancing, school dismissals, limited availability of antiviral, vaccine or other pharmaceuticals) and potential secondary consequences at work, school, etc.)
5. Identify specialized strategies for "at risk" populations: children/families, those with pre-existing behavioral health and special health care needs, those living alone and other high risk populations specific to the unfolding

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event including the public health workforce and their families

6. Publish and distribute focused coping information related to managing illness and potential traumatic loss of loved ones and other anticipated stressors using currently available materials.

WHO Phase 5 and Phase 6

(5) Pandemic Alert Period with Substantial Pandemic Risk: Larger clusters but still limited human- to- human transmission;

(6)Pandemic Period: Sustained community transmission in general population

An established partnership made up of public and private mental health professionals, MH institutions, and important stakeholders, in collaboration with the State Departments of Mental and Public Health will:

1. Use *Phase/Component 3* "Personal Resilience System". Phase 3 UCLA PRS will enable on-going coping with pandemic fears, managing confusion about health information, community containment measures, illness, social disruption and particularly coping with traumatic loss of loved ones.
2. Use the PsySTART disaster mental health triage incident management system to allocate available public and private professional mental health resources to those at greatest risk (parents or children with traumatic loss or complicated bereavement, special health care needs, adults living alone, etc.) in a coordinated approach
3. Using triage level, guide lower risk to the "UCLA PRS" menu of web-based interventions, access /develop of virtual natural social support networks and provide family-to-family member psychosocial support (i.e. "Listen, Protect and Connect" package (See Appendix 1)
4. Provide specialized web-based coping intervention strategies on the "UCLA PRS" system for health care workers, first responders, and other critical infrastructure resources and their families
5. Provide training in basic psychosocial support and triage to key "disaster systems of care" providers (including public health workforce, primary care and emergency department providers)
6. Implement training methodologies and delivery systems to prepare first responders, volunteers, healthcare providers, and the mental health care workforce for the specialized functions of delivering crisis psychological support, triage and treatment.
7. Conduct performance evaluations to enable the pandemic influenza crisis mental health system to plan for continuous quality improvement as the pandemic emerges

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WHO POSTPANDEMIC Period

1 Continue with behavioral health recovery based on evidence-based triage needs\
2 Re-establish basic psychosocial preparedness foci.

Table 1: * Behavioral countermeasures based on level of novel influenza activity and risk of human transmission and projected psychosocial impact*

(developed by M. Schreiber, Ph.D., UCLA Center for Public Health and Disasters)

Level of Influenza Activity	Response	Rationale
WHO Pandemic Phase 3 Circulation of a novel influenza virus subtype in animals and animal to human transmission resulting in isolated human infections or at most, rare instances of human to human transmission.	(**Public and Health Care Workers) Establish the "UCLA PRS"** (**Personal Resilience System**) Strategies provide *stress inoculation** by providing *coping strategies* with evolving event information management strategies, particularly as related to desired preparedness behaviors *Stress inoculation involves discussion of the event and possible coping strategies and resources to manage fears	**Public**: In anticipation of unfolding of the event, develop basic psychosocial coping information using established stress management protocols with pandemic-specific preparedness content. The goal is to "inoculate" against anticipated anxiety/fear in advance of further pandemic development. This approach may also enhance adherence to community containment strategies and thus to contain or slow disease spread (via enhanced public preparedness and understanding of response strategies. (i.e., Individuals liaison with employers, schools, public health, personal health care providers about pandemic response plans and personal protective actions) **HCW**: Enhanced HCW (Health Care Worker) and HCW family preparedness and resilience efforts for stakeholders and self
WHO Pandemic Phase 4 Limited novel influenza virus transmission abroad; all local cases (e.g. in State or the US)	**UCLA PRS* (Personal Resilience System)** Evolving Psychosocial Coping information	**Public:** In anticipation of unfolding of the event, provide basic psychosocial coping information using established stress management protocols with

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are either imported or have clear epidemiological links to other cases	management strategies, protective preparedness and personal coping skills	pandemic-specific preparedness content. The goal is to “inoculate” against anticipated anxiety/fear in advance of further pandemic development. This approach may also enhance adherence to community containment strategies and serve to contain or slow disease spread (via enhanced public preparedness and understanding of response strategies. (i.e., Individuals liaison with employers, schools, public health, personal health care providers about pandemic response plans and personal protective actions). Reduce impact of potential further event stress. **HCW:** Improve HCW compliance with emerging responsibilities based on “just in time” personal and family preparedness/resiliency plans **“At Risk” populations:** as above
WHO Pandemic Phase 5 Limited novel influenza virus transmission in the area (e.g. within State or the US), with either a small number of cases without clear epidemiological links to other cases or with increased occurrence of influenza among their close contacts	**UCLA PRS* (Personal Resilience System**) Strategies for coping with complex health information and coping with phase specific stressors Activate mental health triage incident management system for behavioral health surge Use information obtained from behavioral epidemiology assessments derived from mental health triage to help protect population from specific stressors and risk factors.	**Public**: Facilitate adherence and improved resilience via UCLA PRS using triaged risk factors/stressors. Engage residents @ state, regional, and county levels using established community outreach mechanisms described in WHO Pandemic Phase 3 rationale for public engagement. **HCW**: Facilitate adherence to emergency role and personal/family resilience, reduce secondary stress related to HCW role **“At Risk” populations:** Tailored strategies based on triaged risk indicators
WHO Pandemic Phase 6 Sustained novel influenza virus transmission in State, with a large number of cases without clear epidemiological links to other cases; control measures aimed at individuals and groups appear effective	**UCLA PRS (Personal Resilience System)** Provide evolving event information management and coping strategies adapted to *Phase 6 specific* features. Continue activation of	**Public**: To increase adherence with evolving risk communications, protective action guidelines (desired personal protective behaviors) implementation of social distancing, movement restrictions or other public health recommended strategies for this phase

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	behavioral health triage incident management system, including self-triage for those affected by traumatic or complicated loss, social distancing/movement restrictions, school closures, coping with ill friends, self or family seeking care Based on behavioral epidemiology of triaged needs, adapt the "UCLA PRS" to address coping with triage indicated stressors and risk factors evolving with phase of pandemic	Reduce secondary psychological effects of morbidity and mortality by matching triaged risk to indicated coping interventions via traditional or novel service delivery strategies **"At-Risk" populations:** Support behavioral health self care management of acute loss. Mitigate risk for long-term psychological effects (tied to exposure, traumatic loss, social). Link to available professional mental health resources **HCW:** Support adherence to job function and personal/family resilience. Reduce secondary psychological effects of morbidity and mortality, mass casualty. Link triaged needs to coping interventions via traditional or novel service delivery strategies
WHO Pandemic Phase 6 Sustained novel influenza activity in State, with a large number of cases in persons without identifiable epidemiological link evaluate. Individual control measures are believed to be ineffective	UCLA PRS* (Personal Resilience System). Provide of phase-specific event information coping strategies, triage including use of self-triage to the UCLA PRS. menu of coping interventions for individuals/family. Provide psychological first aid(neighbor to neighbor, parent-child versions) Link high-risk individuals to traditional mental health care system. Use PsySTART Rapid mental health triage system to facilitate behavioral health incident management response with linkage to a three-stage service delivery strategy:	_As above plus:_ **Public**: Promote adherence with recommended evolving/remaining public health or evolving personal protective behaviors and search for new strategies to combat pandemic Support behavioral health self care management of acute loss Mitigate risk for long-term psychological effects(tied to exposure, traumatic loss, social disruption) Preserve functionality of the behavioral health system via stepped triage to care model **Health Care Workers**: Support HCW's to better manage their experiences with high morbidity/mortality, personal threat perceptions, potential lack of effective treatments, personal/family risk, etc. **"At-Risk" populations:**

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	1 Promote traditional basic psychosocial support strategies. 2. Customize web-based coping and treatment interventions for at risk subpopulations (i.e. traumatic loss or depression care) 3. Allocate available traditional mental health services to those triaged at significant high-risk(public and private resources as available)	Use self-triage to link to available traditional mental health care. Provide basic psychosocial support to self, family and co-workers

Reference: Schreiber, 2006

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