BRITISH COLUMBIA
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British Columbia's Pandemic Influenza Response Plan (2012)

Community Pandemic Influenza Psychosocial Support Plan

Adapted from the Canadian Pandemic Influenza Plan for the Health Sector, Annex P: Pandemic Influenza Psychosocial Annex

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1. INTRODUCTION

This document outlines a suggested planning framework for addressing the psychosocial (i.e., psychological, social, emotional) implications of a pandemic influenza or any large-scale public health emergency. 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. 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.

Civic infrastructure (e.g., community-based, non-governmental and faith-based organizations) and citizens have an important and necessary role to play in mitigating the potential harm from a pandemic and increasing the resilience of communities as they meet the demands of pandemic. The scope and nature of the specific plans developed using this framework will vary, reflecting the unique cultural, social and economic make-up of individual communities and regions, the range of available resources (human, fiscal and material) and the identified needs of community members. The issues associated with psychosocial planning include workforce resiliency, mental health and illness, social cohesion and public trust, and these demand the collaboration, coordination and cooperation of all levels of government and multiple community-based partners.

A pandemic influenza outbreak is likely to place substantial and additional demands on community-based and non-governmental organizations and those working in health, mental health and other social service systems (World Health Organization, 2003). However, failure to anticipate and address the psychosocial dimensions of a pandemic may result in a cascading effect, derailing the province's overall response capacity and undermining business and community viability and continuity in the short- and long-term.

1.1 Rationale: The Importance of Psychosocial Pandemic Influenza Planning

Although governments and health systems around the world have been applying significant resources to pandemic influenza planning activity, most of this has focused on the medical consequences of pandemic. The physical health threat is associated with a range of secondary consequences (e.g., widespread absenteeism causing social and business disruption, economic downturns, etc.) that are likely to be substantial. Illness, death, caregiving responsibilities and fear of infection may place extreme additional demands on health care providers and social service systems and contribute to sudden and significant shortages of personnel and resources in all sectors. Higher rates of absenteeism may be disruptive even in a "normal" flu season. In a virulent and severe novel influenza outbreak, 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 (Public Health Agency of Canada, 2003; US Department of Health and Human Services, 2005).

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 (Kaniasty & Norris, 1999). 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.

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 (Seynaeve, 2001). 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 those engaged in psychosocial disaster planning.

As with all disaster and emergency planning, the process of planning is at least as significant—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 subject of these 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 measure 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 then potentially a key outcome of effective risk communications.

2. 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 the capacity of individuals to go on with their lives by addressing their social, emotional, psychological and material 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. The specific objectives are to:

1. Provide information about the psychosocial implications of an influenza pandemic (or other infectious outbreak) and of the various pandemic protocols and action strategies (e.g., use of social isolation strategies to control infection spread).

2. Identify and outline specific pandemic-related issues and factors contributing to the personal and occupational stress and psychological distress of citizens.
3. Outline strategies for the rapid and ongoing assessment of the psychosocial capacity and vulnerability of the general population.
4. Identify and assess the specific needs and vulnerabilities of those who may be at greater risk of experiencing adverse psychosocial outcomes because of functional disabilities, chronic health or employment problems, other socio-economic and/or cultural factors.
5. Outline evidence-informed psychosocial support mechanisms and strategies to promote the psychosocial resilience and functioning of citizens and to mitigate the short- and long-term adverse psychosocial consequences (e.g., health or employment issues resulting from chronic stress, complicated grief or trauma).
6. Outline strategies for integrating psychosocial planning into existing disaster planning processes, plans and protocols.

3. PSYCHOSOCIAL PLANNING PRINCIPLES

The guidelines for managing a psychosocial response to a pandemic reflect core humanitarian principles (e.g., valuing of human rights, equity and the principle of doing no harm).

1. Psychosocial response should maximize fairness in terms of the availability, relevance and accessibility of mental health, psychiatric and psychosocial support services among affected populations in ways that address differences in need, ability, access and capacities across demographic factors (e.g., gender, age, ethnicity, language, geographic location), functional disabilities (e.g., impairment related to mobility, cognition, hearing, sight), and socio-economic status.
2. Participation, inclusivity and empowerment are core values guiding psychosocial planning. Affected populations should be provided with meaningful opportunities to participate in planning and decision-making processes.
3. Programs and interventions should build on, mobilize and support the sustainability of local resources and services and the individual and shared capacity of citizens.
4. Programs and interventions engage with individuals and communities regarding highly sensitive issues, including cultural values and competencies, and should draw on both research evidence (where available) and lessons learned from other disasters.

4. Pandemic-Specific Planning Assumptions

This document reflects the general planning assumptions of the *BC Ministry of Health Pandemic Influenza Plan* and a set of psychosocial-specific planning assumptions. These latter assumptions are based on nationally and internationally recognized objectives and principles of psychosocial disaster planning (Seynaeve, 2001; Ministry of Health, 2007) and a consideration of the plausible psychosocial consequences of an influenza pandemic. They include:

1. The size of the psychosocial "footprint" of a pandemic (e.g., fear-driven behaviours; impaired decision making; social and family functioning; psychological disorders; decreased workplace and school performance; and acute or chronic stress) is likely to be much larger than the "medical" footprint (Shultz et al., 2003).
2. As a new and "invisible" threat of sustained duration (i.e., multiple waves of infection over a period of 12-18 months), the psychosocial footprint of the pandemic virus will reflect the nature of the threat (e.g., new, "invisible" threat of sustained duration), severity of the consequences (clinical attack rate of 10 to 20%) and breadth of secondary consequences (e.g., absenteeism level of 10 to 20% during peak periods, if the vaccine supply arrives in a timely fashion).
3. Those adversely impacted by a pandemic will include not only individuals who become ill themselves or whose loved ones become ill and/or die, but also those who are not themselves physically or medically affected, but who experience adverse social, economic and other secondary consequences.
4. 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.

5. Mental and Behavioural Health

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?). As a microbiological threat, pandemic influenza presents British Columbians with an invisible enemy—one that cannot be seen but which can be passed on between people and cause, at least in the initial stages, an unspecific set of symptoms that could be associated with a potentially deadly infection or a relatively innocuous illness (e.g., cough and headache could indicate a pandemic virus or the common cold).

Many, if not 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, behavioural consequences (e.g., increased use of drugs and alcohol as coping mechanism or increased family conflict and violence) and surges in demand for psychosocial support.

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 gender and other developmental, social, economic and personal factors can contribute both to resilience and to increased vulnerability to the psychosocial consequences of a pandemic. Careful attention to and consultation with the particular needs of a given client or client group will help determine what support measures or interventions, if any, are appropriate. For most people, the symptoms of stress, fear and loss will gradually decrease over time. People should be encouraged to use existing coping strategies if they find them effective but also to seek out and access additional support as needed.

6. PSYCHOSOCIAL PLANNING FOR COMMUNITY

Psychosocial planning groups should involve as wide a range of relevant stakeholders as possible and include representatives from various levels of government (e.g., local, regional and provincial), health emergency management, non-governmental and community-based organizations, and representatives from groups who may experience extraordinary vulnerability during a pandemic as a result of disabilities, ethnicity, culture or poverty.

6.1 Establish a Psychosocial Planning Group

Developing an inclusive and interdisciplinary planning group in the early stages of planning will enhance the likelihood of a more integrated, coordinated, and effective psychosocial pandemic plan.

ACTION STEPS

1. Identify and recruit planning partners, addressing the need for local (specific to the particular initiating entity), collaborative (common initiatives across agencies and sometimes sectors) and, in some instances, regional plans and initiatives.
2. Develop and prioritize the most likely pandemic scenarios (i.e., define risks), identify current and potential emergent needs of existing clients and communities, and anticipate resources and services required to meet those needs.
3. Have organizations self-define their pandemic roles and responsibilities internally (i.e., to their clients) and externally (i.e., within larger community plan)
4. Identify capabilities, overlaps and gaps in services and resources among community planning partners.
5. Develop contingency plans to address emergent needs and gaps.
6. Identify specific individual and collective triggers for the implementation of psychosocial plans.
7. Develop risk communication strategies that support ongoing communication within and between partner agencies during all phases (planning, response, recovery).
8. Develop and establish common ethical principles and frameworks to guide planning, response and recovery processes:
   - Ethical decision-making process for the allocation of psychosocial support resources.
   - Confidentiality and information-sharing agreements that minimize bureaucratic barriers to information sharing among planning partners while maximizing the rights of clients/community members.

6.2 Psychosocial Planning Foundations

Psychosocial planning for the community relies on three simultaneous and interconnected planning tracks:

1. Planning to sustain business continuity and workforce resilience within psychosocial planning partner organizations and agencies.
2. Planning to support resilience in existing clients and their families in response to pandemic-specific emergent needs.
3. Planning in support of broader social or community resilience that may involve an adaptation of existing services and/or the delivery of services and support to new clients or new client groups.

Regardless of which track, 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' (e.g., workers, clients) values in decision-making processes and tailors communications strategies (content and process) to their perceptions and understanding of risk. This approach is fundamentally based on the principle that transparency will increase trust and empowerment, and facilitate cooperation in carrying out pandemic response and recovery strategies.

Business Continuity

The foundation of any robust disaster planning process is business continuity. The purpose of business continuity planning is to ensure timely and orderly continuation or resumption of key operations when business is impacted by unplanned or unanticipated incidents or events. In the case of a pandemic, this could include higher than normal absenteeism due to illness and or caregiving responsibilities, reductions in other community services, disruptions of supply chains, and surges in demand for services. All planning partners need to be able to responsively and flexibly adapt to the sudden changes in human and material resources, infrastructure and physical environment.

Issues include succession and delegation processes; alternate work locations; alternate human resources and work assignments; alternate practices and technologies; intentional redirection of resources to address emergent needs and the potential degradation of other services and infrastructure on which the organization depends; and the maintenance of critical systems, processes and resources internal to the organization.

ACTION STEPS
Each partner should 1. Establish and convene a business continuity planning committee to develop and/or review business continuity plans in the context of the specific constraints and demands of a pandemic. 2. Conduct a risk analysis in order to develop a prioritized list of potential risk scenarios. 3. Conduct a business impact analysis to identify, inventory and rank order an organization's mission-critical resources/ services (including human resources and critical dependencies); costs (tangible/intangible) associated with the loss of these resources; and the estimated amount of acceptable downtime before resources/services are restored. 4. Provide appropriate training and education so that employees understand and can implement business continuity measures when required. 5. Engage in joint planning with pandemic psychosocial planning partners to identify and address critical interdependencies and mutual support.

Organizational and Workforce Resilience

An integral aspect of business continuity is workforce resiliency. A pandemic will likely cause extraordinary occupational stress for many workers as a result of increased workload demands, workforce shortages, shifts in roles and responsibilities, the potential need to work in non-traditional sites, increased risk of infection, and exposure to a large number of distressed clients (Benedek, Fullerton & Ursano, 2007). Organizational leaders must be willing to mentor effective stress management, lead by example, and support the creation of an environment in which self- and mutual care is possible. The details of workforce resiliency plans will be tailored to the specific resources and needs of that organization.

At the same time, maximizing personal, social and workforce resilience across planning partners and the community will require collaborative and holistic planning frameworks. To be effective, these plans must address the gendered nature of formal (over 90 per cent of nurses are female; see Amaratunga et al., 2008) and informal (traditional gender roles continue to mean that most in-home caregivers are female) caregiving. Enhanced instrumental, informational, psychological and emotional support strategies that acknowledge the gendered nature of many service professions and associated work/family conflicts are required to enhance workforce resiliency and mitigate the adverse effects of occupational stress on employees and the sustained 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 with access to 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 workforce resiliency. Comprehensive workforce resiliency and psychosocial support programs will also include the ongoing, professional assessment of need for individual workers to transition to longer term, specialized, mental health interventions as needed. As with most planning, involving staff in the planning process can help ensure the relevance and effectiveness of the workforce resilience plans and implementation strategies.

ACTION STEPS
1. Develop and implement "buddy" systems so that workers can support each other in monitoring stress levels and offering mutual help in coping.
2. Provide respite sites in workplace settings (e.g., staff kitchen). 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 provisioned with healthy snacks, relaxation materials (e.g., music, relaxation tapes, comfortable seating) and educational materials (e.g., stress and coping pamphlets).
3. Develop the means and mechanisms to provide up-to-date and accurate pandemic information and advice to workers and their families.
4. Determine what resources are required and available to provide psychosocial assistance, support and information to workers and their families (e.g., employee assistance programs, peer-support programs) including on-the-scene support and stress management; critical incident stress management interventions, and family support.
5. Implement flexible work arrangements and benefits as needed (e.g., working from home or flexible hours to address child/elder/family care issues; flexible use of medical leaves or vacation time).

6.3 Community Psychosocial Planning and Interventions

The goal of psychosocial interventions is to support an affected individual's or group's resilience and their natural ability to cope. It is based in the underlying ethical principle of do no harm, which in turn relies on respecting the unique and idiosyncratic needs, capacities and resources of any individual.

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

People should be encouraged to follow their natural inclination with regards to coping (e.g., how much and to whom they talk) and measures should be considered to facilitate basic coping strategies, such as connecting and talking with friends, family and other natural supports, in the context of social isolation and other public health measures, and people's fear of infection (e.g., use of Internet, phone and other virtual social networks).

ACTION STEPS

1. Involve people in planning and preparedness activities prior to a pandemic through an inclusive planning process and an effective risk management/risk communications strategy.
2. Find ways to support people articulating their basic needs and concerns (e.g., for medical care, emergency shelter, food, clothing, etc.) and developing plans for meeting those needs.
3. Provide repeated, simple and accurate information 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. Information is key in helping them to "help themselves" and retain or regain a sense of competence and control over their lives and helps build, maintain or restore public trust.
    a. These messages should be delivered throughout preparedness, response, and recovery phases using multiple media (e.g., radio, televised public information announcements, radio, pamphlets, webcasts/blogs) and using the major languages of a community/organization.
    b. Examples of content include cognitive, emotional and behavioural responses to stress and fear and techniques for coping; family communications plans; available workforce support services; employment issues related to illness, sick pay, essential service mandates, shift rotations, family concerns).
4. Provide support with problem-solving and practical assistance to enable people to meet those needs (e.g., assist people in accessing food, medical care, child and elder care, other emergency assistance programs).
5. Psycho-educational and peer-support groups are an effective means of disseminating information to the general public about what to anticipate in terms of the emotional and behavioural consequences of an influenza pandemic. They can also provide an opportunity during and following a disaster for processing some of these experiences. A 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.
6. Educate employees, clients and the general public about stress management strategies. This would include fairly basic interventions (e.g., developing opportunities to informally debrief distressing experiences with colleagues, friends or family, or to 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 *Psychosocial Response Workbook – Disaster Stress and Trauma Response Services*, BC Ministry of Health at: http://www.health.gov.bc.ca/emergency/dstrs.html).
7. Consider providing training within organizations and/or the community in Psychological First AID (PFA). PFA is an evidence-informed intervention designed to assist children, families and adults in the aftermath of disasters and other crises. The core actions of PFA can be applied within days or weeks following a potentially traumatic event. (For more information on PFA, see the document *Psychological First Aid – Field Operations Guide* (2nd edition), on the National Center for Posttraumatic Stress Disorder website, at http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/smallerPFA_2ndEditionwithappendices.pdf).
8. Anticipate the potential spike in demand for grief and bereavement support, 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, long-term physical health, employment, and other social issues during the recovery process.
    a. Particular attention should be paid to the potential that unusual arrangements 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 severe pandemic waves.

ACTION STEPS

   b. Publicly orchestrated events (commemorations, public memorial ceremonies) can provide citizens with an opportunity to mourn collectively and recognizes 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.

9. Implement confidential telephone and/or web-based support services staffed by mental and behavioural health care professionals who can provide expert advice and answers regarding psychosocial support (e.g., resources and services, self- and mutual care, and family care).
10. Deploy multi-disciplinary 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.
11. Consider ways of facilitating community discussions (e.g., identifying and brainstorming solutions to common issues, sharing tips/advice and information, and offering each other support) through direct (e.g., face-to-face) and virtual (e.g., wiki's, non-urgent support lines, crisis lines).

6.4 Assessment, Triage and Referral

Most people are reluctant to seek out mental health services and support, often only accessing help 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 capacity and vulnerability over time, particularly when working with populations who are more likely to experience specific dimensions of vulnerability (e.g., mobility, hearing, dependency on others).

Assessment is a process rather than a single event and requires a multi-pronged, 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. 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.

ACTION STEPS

1. Develop and employ 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 clients and client groups, and the broader community.
2. Monitor the volume and nature of calls requesting help on psychosocial-specific or mental health crisis lines.
3. Monitor people's reasons for seeking assistance within partner organizations.
4. Monitor wait lists and referrals to mental health professionals and providers (e.g., psychologists, counsellors, mental health workers), employee family assistance programs agencies and programs, substance abuse programs and mental health services
5. Implement a reporting procedure whereby family physicians, community-based and non-governmental organizations can share ongoing information about needs and demands for service.
6. Conduct ongoing evaluation of psychosocial well-being and health of employees and their families, and clients using existing formal (e.g., mental health and disaster psychosocial tools) and informal (e.g., interviews) assessment measures to assess current levels and anticipate 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).
7. Develop and integrate regular and ongoing operational debriefings among planning partners in order to share general and specific information about shifts in needs, efficacy of effectiveness and relevance of psychosocial resources, developing trends (while respecting confidentiality) and addressing gaps in planning and service delivery.

7. PSYCHOSOCIAL PLANNING CHECKLIST

The psychosocial planning checklist provides a general framework for engaging with and assessing progress in the development of a comprehensive psychosocial plan. The psychosocial planning process address: (1) Coordination and collaboration; (2) Assessment of resources, vulnerabilities and service needs (the identification of specific at-risk populations, service needs, gaps in existing services); (3) Development and implementation of psychosocial plans within partner agencies; (4) Development and implementation of community-wide psychosocial support plans; and (5) Ongoing program evaluation and revision through pandemic phases.

Completed	In Progress	Not Started	
			Coordination and Collaboration
☐	☐	☐	There is recognition of the potential emotional, psychological, spiritual and social impact of a pandemic or large-scale infectious disease outbreak on community members covered by your plans.
☐	☐	☐	The relevant governmental (e.g., local, regional, provincial), non-governmental and community-based (e.g., mental health, social service, community service and faith-based) organizations have been engaged as planning partners.
☐	☐	☐	Planning partners are aware of their own and each others' roles and responsibilities in the psychosocial pandemic plan, and their contributions and needs have been identified and integrated into community plans.
☐	☐	☐	There is a communication framework in place to support the ongoing collaboration and coordination of planning, psychosocial support service delivery, and the evaluation and revision of services as needed.
☐	☐	☐	The ethical aspects of psychosocial policy and planning decisions have been considered and outlined to provide a framework for decision-making during the response that addresses the psychosocial implications of making and implementing those decisions.
☐	☐	☐	There are mechanisms in place to convey this ethical framework clearly to those working in partnering agencies/organizations and to the public.
			Assessment of Resources, Vulnerabilities, Service Needs
☐	☐	☐	A needs and capabilities assessment process has been developed and implemented that would identify existing and emergent psychosocial support needs, resources and services over the course of a pandemic (i.e., planning, response, recovery).
☐	☐	☐	An audit plan is in place that can effectively identify and support collaborative planning with individuals and/or groups with specific vulnerabilities or service needs associated with work roles, disabilities (e.g., mobility, vision, hearing), age, gender, and other socio-cultural and economic factors.

Completed	In Progress	Not Started	
			Development and Implementation of Disaster Psychosocial Plans Within Partner Agencies
☐	☐	☐	Business continuity plans are in place and implemented within planning partner agencies and organizations that address the potential for higher than normal demand for services, impact of widespread absenteeism, and the potential disruption of critical or civic infrastructure.
☐	☐	☐	Workforce resiliency programs are in place and implemented within planning partner agencies and organizations. Such programs are responsive to the shifting needs, capabilities and resources of individual workers and their families as identified through an ongoing assessment process.
			Development and Implementation of Community-Wide Psychosocial Support Plans
☐	☐	☐	A community-wide psychosocial planning framework has been developed and implemented to ensure the development and delivery of relevant education and training for those providing disaster psychosocial support services.
☐	☐	☐	A community-wide psychosocial planning framework has been developed and implemented to ensure the development, adaptation, coordination and implementation of public education strategies to enhance awareness of psychosocial issues and services that directly and indirectly support social and individual resilience within the community.
			A community-wide psychosocial planning framework has been developed and implemented to ensure the development, adaptation, coordination and implementation of psychosocial support to prevent, mitigate or repair physical and/or mental health effects of long-term uncertainty and stress; actual or perceived levels of risk; higher than normal rates of illness and death; and the depletion or loss of social infrastructure during peak infection periods.
			A community-wide psychosocial planning framework has been developed and implemented to ensure the development, adaptation, coordination and implementation of services to address the specific needs of community members whose social, economic or cultural location, functional disability, age or gender may increase their vulnerability in regards to need for psychosocial support.
			There is an effective risk communication plan that will address the public's ongoing need for accurate, timely and relevant information even during peak pandemic periods when normal services may be disrupted.
			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 citizens.
			Ongoing Program Evaluation and Revision
☐	☐	☐	Program assessment processes and protocols are in place to address possible changes in the availability and access to resources over local waves of infection and the short- and long-term community recovery process.
☐	☐	☐	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.

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APPENDICES

Appendix A: Risk Communication Tips

Involve the public in planning efforts from the beginning and throughout all phases of a pandemic.

- 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, and 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.
- Ensure transparency of 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 (i.e., health and social service providers), or that are designed to keep the general public informed and aware. Such networks can effectively support delivering information and key messages throughout the community and also receiving 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 staying in touch and having 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, accessible and associated with providing reliable information. People who are afraid or stressed can easily misinterpret or miss pertinent details.
- Pre-prepare emergency messages including ones tailored for non-English language speakers and those with special needs (i.e., literacy issues, limited access to web and other electronic resources).
- 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, trained peer and crisis counsellors) in providing psychological first aid, support and information.
- Identify and advertise reliable sources where the public can access up-to-date, accurate information on the pandemic, progression of disease spread, and public health and emergency response measures.

Appendix B: Business Continuity Planning Steps

Step 1. Establish the scope, objectives and priorities of business continuity planning in BCCDC, and the activities or "program" required to deliver these objectivities.

Step 2. Conduct a thorough hazard, risk and vulnerability assessment in which hazards, the likelihood of their occurrence, and the vulnerability of people (staff and public), property, environment, and the organization itself are identified and prioritized.

Step 3. Conduct a thorough Business Impact Analysis.

Step 4. Design and develop recovery plans detailing Recover Time Objectives, critical activities and resources for each individual function, program and division.

Step 5. Test and exercise the plan using well-defined test objectives, methods and documentation procedures. Amend the plan as needed.

Step 6. Maintain the plan by incorporating test results into an evolving version of the recovery plan document. Once a business continuity plan is in place, the agency should continually cycle through the process of assessment, testing and revision.

Step 7. Execute the plan. During a disaster, the business continuity plan should be used by all functions/programs/divisions in order to maintain focus on recovery tasks and objectives. Daily status reports should be issued to senior management as a means of monitoring progress.

Appendix C: Overview of Psychosocial Risk Factors and Supportive Mechanisms

	RISK FACTORS Contributing to psychological distress	DISTRESS Related to the individual	DISTRESS Related to family and community	DISTRESS Related to work environment	SUPPORTIVE MECHANISMS Contributing to psychosocial resiliency		
					Informational	Emotional	Instrumental
Emotional	• Child deaths • Multiple/mass casualties and deaths • Deaths of supervisors and/or leaders in the response effort • Family and colleague illness or deaths	• Shock, grief, frustration, confusion, anger, guilt, exhaustion, and fear (e.g. fear of contagion and death; fear of short and/or long term income loss because of death or disability; etc.)	• Fear of transmitting disease to family and community; fear of death • Domestic pressures caused by school closures, disruptions in day care or family illness • Emotional reactions of family member(s) whose occupation is in health care • Worry about family members' health and well-being as well as loss of income	• Stress of working with sick or agitated persons and their families and /or with communities under quarantine restrictions	• Adequate comprehensive pre-event training; i.e., psychological first aid, exercising of pandemic plans, potential non-traditional roles and responsibilities, delivery of services in non-traditional sites • Education and information re: shift rotation strategies • Education re stress and stress management, grief, complicated grieving • Accurate and timely risk communication and infection control and status reports	• Having opportunity to share experiences with others in a respite area or through organized group process sessions; Internet/intranet sites • Opportunities to debrief particularly difficult medical outcomes – individually or in a group; i.e. more formalized group process sessions; one-on-one support personnel	• Having opportunity to take breaks away from front line; i.e., respite area • Adequate staffing (including use of students) and shift rotations that allow for slow rotation away from "hot" or high-risk situations • Good infection control practices. • Accessibility of self-help activities that will help to safeguard workers' physical and emotional health (e.g. dedicated space for "downtime", physical exercise, relaxation, sharing, information, nutrition, etc.)
Physical	• Economic collapse within community • Acute shortages of medicine or any other essential services(s) • Restrictions of civil liberties (e.g. quarantines, etc that may limit personal contact/hinder communications) • Illness	• Limited interpersonal contact due to physical isolation associated with use of infection control measures	• Limited contact with family due to quarantine, extended hours and/or shifts; concern about children and other family members • Difficulty communicating on a reliable and regular basis • Isolation, stigmatization and discrimination associated with being perceived as a source of contagion	• Illness and death of colleagues and patients • Fatigue and exhaustion	• Involvement in pandemic preparedness planning and exercising. • Access to reliable, current, and accurate information (e.g., epidemiological info, distribution and status of antivirals/vaccines, human resource decisions) • Information re how to support children (e.g., age-appropriate stress intervention, bereavement support, managing stigma)	• Opportunities to share and debrief (formally and informally) with colleagues • Availability of psychosocial support to self and family during illness	• Availability and accessibility of physical space, breaks, equipment and materials to support self-help activities while at work (e.g., dedicated respite areas and on-site work-out/gym, nutritious food) • Access to phones/long-distance cards (where applicable) in order to facilitate contact with family

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					Informational	Emotional	Instrumental
Social Behavioural	• Restrictions on normal behaviour or any imposed change that reduces social interactions and support (e.g., illness, quarantine) • Limited family or friendship support • Overworking and over-functioning for long periods of time	• Constant need to take special precautions to avoid exposure to the pandemic virus and difficulty maintaining self-care (e.g., sleep, nutrition, exercise, etc.) • Irritability • Burnout • Mental health symptoms	• Struggle to manage roles in family and professional commitments • Breakdown in family relationships • Disorientation • Lack of concentration • Memory issues	• Increased difficulty in performing crucial tasks and functions as the number of severely ill patients increases and health care staff and medical/ infection control resources decline • Fractured relationships with colleagues	• Paper (e.g., pamphlets) and online information support for family and community/ neighbourhood preparedness planning • Response and recovery hotlines for HCWP and their families, for public regarding pandemic infection control and status information, psychosocial support, recovery strategies	• Being part of a broader collegial community that supports learning and development of resilience abilities • Being part of a community or neighbourhood that actively addresses disaster response (e.g., neighbourhood safety plan) • Facilitation of connections with family and community	• Provision or facilitation of provision of alternate care arrangements for dependent family members (e.g., children, aging parents, family members with mental or physical disabilities or pre-existing mental/physical health issues)
Cognitive	• Rumours, misconceptions or conspiracy theories • Belief that medical resources are not available or fairly distributed • Lack of accurate information	• Sense of ineffectiveness and powerlessness • Ability to think clearly and make sound decisions	• Comprehension issues for family members (and public) regarding the virus and issues around protection and quarantine	• Maintaining focus on primary duties • Adapting to a new or different work assignment • Struggling with lack of control and knowledge base	• Education/validation regarding areas of difficulty (e.g., death of children, working outside area of expertise, recognition and acceptance that it is not possible to be 100% prepared for what will happen) • Availability of timely, accurate and candid information • Clear and open lines of communication between all levels of care within the organization	• Opportunities for peer-to-peer and professional psychological/ emotional support • Institutional recognition and validation of HCWP accomplishments and contributions during pandemic and recovery	• Multidisciplinary HCWP support teams that could provide pre-, during-, and post-event planning support • On-site psychosocial support • Wallet cards regarding stress signs and symptoms and simple coping strategies • Effective leadership
Spiritual	• Loss of trust in health institutions, employers or government leaders • Loss of faith in a just world	• Search for meaning; shattered assumptions	• Presence (or not) and influence of faith-based beliefs, coping and support system(s)	• Moral distress around decision-making regarding who is saved or not	• Pre-event education regarding possible spiritual meaning • Information regarding available spiritual support services (e.g., chaplains)	• Peer or professional-based psychosocial intervention strategies that acknowledge and address spiritual aspect of pandemic consequences	• Membership in faith-based communities that may provide physical shelter and emotional support.

	RISK FACTORS Contributing to psychological distress	DISTRESS Related to the individual	DISTRESS Related to family and community	DISTRESS Related to work environment	SUPPORTIVE MECHANISMS Contributing to psychosocial resiliency		
					Informational	Emotional	Instrumental
Ethical	• Lack of clear guidance and triage decisions • Uncertainty in decision-making framework • Inter-professional teams that are not adequately integrated to address individual support needs • Limited family or friendship support	• Ethical dilemmas and moral distress, etc., whether or not to go to work; concerns about receiving vaccines or antiviral drugs before other people	• Presence (or not) and influence of adequate supports; i.e., vaccine availability to worker and not family, tension between work roles and family expectations	• Moral distress around decision-making regarding who is saved or not	• Accurate information pre-event and during-event regarding ethical decision-making framework, decisions regarding availability and distribution of antivirals and vaccines, duty to care and ethical obligations of HCWPs, triaging that affects quality of care	• Opportunities to discuss ethical decision-making in interdisciplinary fashion • Ongoing opportunities to debrief (formally and informally) the emotional dimensions and consequences of decision-making	• Clearly delineated protocols and procedures regarding ethical decision-making • Health care decision-makers having access to ethics advice • Non-punitive ethical review boards to provide advice and "lessons learned" information to improve practice during response and recovery