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British Columbia's Pandemic Influenza Response Plan

Pandemic Influenza Psychosocial Support Plan for Health Care Workers and Providers

September 2012

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EXECUTIVE SUMMARY

There is global recognition of the need for comprehensive planning and capacity building in anticipation of a pandemic such as the anticipated influenza or flu pandemic.¹ As a result there has been significant investment of resources into pandemic planning throughout health sectors. The resilience and well-being of health care workers and providers² (HCWP) is a critical component of health service delivery, surge capacity and pandemic response capacity.

Increasingly, HCWP find themselves on the front line of Canada's response to disasters and public health emergencies. The outbreak of Severe Acute Respiratory Syndrome (SARS) demonstrated not only the economic and social costs of serious infectious diseases but also the human costs, particularly to HCWP and their families. As the world prepares and plans for a pandemic there is a growing sense of urgency regarding the need to develop and implement plans and strategies that will help protect HCWP and, ultimately, increase the capacity of the health sector to respond to such a public health emergency.

The purpose of this document is to outline the non-medical issues and consequences of an influenza pandemic and provide a planning framework for the development of workforce resiliency programs and support strategies to address the psychological and social (psychosocial) needs of HCWP. It is intended for a broad audience that includes health emergency planners, senior management and concerned frontline HCWP in BC's health

authorities and affiliated institutions, organizations and private contractors.

In considering the recommendations outlined and described in this report it is important to recognize that the planning process is as important an outcome as the actual plan. Emergency planning involves more than the development of a plan; it can be more accurately thought of as an ongoing and iterative process that becomes a cornerstone of the health system culture. Increasing organizational and HCWP resilience is based on an ongoing commitment to the development, implementation and maintenance of individual and systemic practices and behaviours that increase resilience and the adaptive capacity of the entire health system.

This document utilizes World Health Organization (WHO) and Canadian Pandemic Influenza standards for organizing the response according to three periods: Inter-pandemic, pandemic alert and pandemic period. It provides a planning template that identifies relevant psychosocial support issues that human resources and business continuity planners should consider when creating pandemic-specific support mechanisms for staff. It also provides a general overview of what support mechanisms are required, including the phase in which they should be implemented. This document should be read as a planning framework to guide the development of psychosocial plans rather than a prescriptive plan.

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² In this document, the umbrella term of health care workers and providers (HCWP) is used to signify and include medical and non-medical staff employed or contracted by or on behalf of the province's health authorities. This would include private-practice physicians, registered nurses, licensed practical nurses, nurse practitioners, physicians, social workers, psychiatrists, psychologists, continuing care assistants/personal care workers/home support workers, pharmacists, public health officials and nurses, ambulance services, paramedics, cleaning staff in hospitals and other health care facilities, medical and non-medical staff in community-based health and social service facilities, and administrative and/or support staff in hospital and community-based sites.

Key Recommendations

1. Acknowledge and prioritize the need for psychosocial planning in health authorities pandemic plans by establishing targets, indicators of progress towards those targets, identifying and tasking individuals with the authority and responsibility for planning processes, and assigning resources (human, financial and material).
2. Where possible, support the development of, and/or participate in, interagency regional and local psychosocial pandemic planning committees or groups. Such groups benefit from the involvement of representatives from a cross-section of HCWP and focus on the identification of needs, resources, gaps in resources, and the collaborative development of strategies and programs to support workforce resiliency.
3. Develop, implement and integrate psychosocial workforce resiliency activities into day-to-day human resource management practices, in order to build capacity in advance of a health care emergency/disaster. Such programs and activities should build on/enhance existing resources and draw on evidence-informed disaster mental health and psychosocial planning resources, tools and techniques. (See Section 3 and Appendix A for additional web-based resources)
4. Adapt or develop, and implement training and education in psychological first aid, stress management, and personal and family preparedness planning.
5. Adapt or develop, and implement relevant training and education specific to management and leadership regarding psychosocial programs, support and building resilient organizations/workforces.
6. Prepare or adapt psychosocial support and education materials in multiple formats and languages for HCWP and their families.
7. Work with human resources and occupational health (where available) to develop plans for potential employment issues in a pandemic.
8. Develop psychosocial support plans that address short-term and long-term response needs and the extended recovery period.

1. INTRODUCTION

Effective psychosocial pandemic planning will need to be coordinated and collaborative across multiple systems and regions if it is to result in plans that truly enhance British Columbia's (BC) health sector pandemic response and recovery capacity.

This document begins by providing a rationale for applying a psychosocial lens to health emergency planning for a pandemic and goes on to describe a general psychosocial planning framework and the major components of a workforce resiliency plan. Pandemic phase-specific activities are suggested and a range of prevention and intervention strategies are

1.1 Purpose

The purpose of this document is to outline the non-medical issues and consequences of an influenza pandemic³ and provide a planning framework for the development of workforce resiliency programs and support strategies to address the psychological and social (psychosocial) needs of health care workers and providers (HCWP).⁴ It is intended for a broad audience that includes health emergency planners, senior management and concerned frontline HCWP in BC's health authorities and affiliated institutions, organizations and private contractors.

briefly described. Where possible, reference is made to other resources that provide greater elaboration, relevant materials that can be adapted or other relevant information. Key psychosocial issues and population-specific vulnerabilities are discussed. The recommended actions are based on current research on the psychosocial dimensions of disasters, including lessons learned from the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003, the public health response to the anthrax incidents in 2001, and professional consensus regarding best practice in psychosocial disaster response.

The scope and nature of the specific plans developed using this framework will vary given the wide range of roles, responsibilities and organizational contexts HCWP may occupy and the differential availability and access to planning resources (e.g., human, financial, material).

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1.2 Background

The Psychosocial Implications of an Influenza Pandemic

The consequences of an influenza pandemic will likely exceed those associated with any disaster we have yet experienced. The medical footprint alone is expected to be enormous, including high rates of illness and death among the general population. The psychological, emotional, behavioural and social—or psychosocial—footprint associated with the physical health consequences and the secondary consequences (e.g., economic downturn, social disruption, high rates of absenteeism) will be even more substantial, impacting every aspect of society (Conference Board of Canada, 2003). Those providing critical health care and other health services may be vulnerable to experiencing higher than normal levels of occupational stress resulting from a range of primary and secondary consequences and the conflicts they may experience as they juggle their work and family responsibilities.

High rates of illness and death in the general population will contribute to sharp surges in demand for services while simultaneously contributing to sudden and significant shortages of personnel and resources, adding to the stress on those HCWP who are able and willing to continue working. Even those HCWP not directly impacted by the illness will share some or all of the psychosocial consequences of a pandemic, including the real potential of significant economic downturns and the interruption of normal supply chains and public services. Temporary or long-term closures of normal social and recreational activities may make self-care and family care more challenging. The stress, the ongoing uncertainty of the event, and the threat or actual loss of family members, friends and colleagues may cause unusual emotional strain and contribute to or exacerbate pre-existing psychological disorders (e.g., depression, anxiety, complicated grief).

Stress has long been identified as a determinant of health and well-being tied to employment issues (e.g., job performance, absenteeism, job satisfaction and willingness to work), physical health (e.g., hypertension, cardiovascular disease) and mental health (e.g., depression, anxiety, substance abuse) (Brunner, 1997; Jackson, 2002). Experience and research also suggest that the psychological impact of response on responders can be significant, with lasting mental and physical health consequences (Benedek, Fullerton, & Ursano, 2007; Hobfoll & de Vries, 1995; Norris, Friedman, & Watson, 2002), and may result in a complex and not always successful adaptation process (van der Kolk et al., 2005). For most HCWP, the occupational stresses experienced during and following a pandemic will be more extreme and differ at times in scope from those stresses faced during their day-to-day work lives. Although research on specific psychosocial interventions is not definitive in terms of the effects, there is growing evidence in support of the positive effects of organizational culture and leadership (e.g., shared vision, effective communication, high levels of trust) and organization-wide approaches to stress management on resilience, occupational performance and retention (Seville et al., 2006; van der Hek & Plomp, 1997). This research also suggests that resilience strategies and programs must be integrated into the culture of organizations and systems well in advance of a crisis if they are to be effective during a crisis.

Lessons Learned from Previous Infectious Disease Outbreaks

Beyond the general rationale for the benefits of addressing occupational stress, the rationale for addressing this issue in pandemic planning is based on research on the psychosocial consequences of recent and not so recent infectious disease outbreaks. The combined research on the 1918 influenza pandemic in the United States, and the Severe Acute Respiratory Syndrome (SARS) outbreak in Toronto in 2003

presents a disturbing picture. Immense patient loads, coupled with shortages of health care workers (including physicians, nurses, pharmacists) and medical supplies placed enormous demands on those who were working; in fact, many endangered their own health in order to meet the demands of care. During the SARS epidemic, health care providers reported experiencing high levels of stress and distress related to (a) risk of infection; (b) intense and highly stressful working conditions, including having to work while wearing protective equipment; (c) balancing work demands with family concerns about infection; and (d) longer hours and extended shifts (Amaratunga et al., 2008; Nickell et al., 2004; Tansey et al., 2007).

SARS caused economic and social disruption well beyond what might have been anticipated by the relatively small number of cases and low mortality rates (Conference Board of Canada, 2003; WHO, 2003). Similarly, reviews of the 2001 anthrax incidents in the United States suggested that the response capacity of the American public health network (e.g., the United States Centers for Disease Control and Prevention, health departments) was “frail” and “highly stressed” by an incident that resulted in only 22 actual cases (Gursky, Inglesby, & O’Toole, 2003).

Health sector performance during a pandemic will be critically dependent on the commitment and motivation of HCWP, their personal resilience and professional performance, and their willingness to work. The factors influencing workforce motivation are complex, involving a web of individual, organizational and socio-cultural dimensions and factors (Franco, Bennett and Kanfer, 2002). A recent study of nurses involved in the SARS response in Canada has detailed significant structural and systemic barriers to their willingness to work in the event of another public health disaster. Some of these relate to differences in employment status (e.g., full-time versus part-time or casual; self-employed) that impact access to sick benefits in the event they or a

Estimated Impacts of Pandemic Influenza on Canada’s Health Care System

Using United States Centers for Disease Control and Prevention FluAid software and an anticipated attack rate of 25 per cent, the Public Health Agency of Canada has estimated the impact of pandemic influenza on the Canadian health care system as follows:

- 4.5–10.6 million Canadians would become clinically ill and be unable to attend work or other activities for at least 0.5 days.
- 2.1–5.0 million would require outpatient care.
- 34,000–138,000 would require hospitalization and recover, with 11,000–58,000 deaths. Hospitalizations and deaths would occur in a relatively short period of time.

Conservative estimates state that 10 per cent of the population would lose working days due to illness or caregiving responsibilities. Economic impacts of direct/indirect health outcomes were estimated to be between \$10–24 billion CDN in 1999, not including other societal impacts (e.g., tourism, trade).

Research drawing on Canadian population and health care data from Alberta results in the following comparative health care usage rates between an inter-pandemic year and the pandemic:

- 3.7 times as many outpatient visits.
- 3.9 times as many hospitalizations.
- 8.2 times as many deaths (Schopflocher et al., 2003).

family member become ill, and the right to refuse work (Amaratunga et al., 2008).

Work/life balance issues were also identified as a major obstacle, particularly as the majority of HCWP are women with caregiving responsibilities for dependent children and/or parents.

The 2003 Public Health Agency of Canada report (the Naylor report) suggested that strained infrastructure and a lack of coordination and collaboration among different levels of government could make the outbreak of a more virulent infectious disease such as an influenza pandemic result in disastrous

outcomes. This sentiment was echoed in the aforementioned study of nurses involved in the SARS response, which indicated that many nurses believe the health care system to be already operating at maximum capacity with little to no room for surge capacity (Amaratunga et al., 2008). Similarly, findings from the 2007 National Physician Survey (NPS) indicate that many Canadian physicians believe health system capacity is inadequate to meet the demands of an aging population and the increasing demand for care for chronic medical and mental health conditions.

The success of any of the health sector's current or future pandemic plans will rest on the foundation of its human resources and their faith in the system's capacity to provide adequate support and professional resources to allow them to meet the increased demands a pandemic would place on them. Successful management of the risks associated with a pandemic will rely on HCWP's willingness and availability to work, which in turn will rest on HCWP's knowledge, resilience and capacity prior to an influenza outbreak. In order to increase the likelihood that HCWP will be able and willing to continue working in a pandemic and following a pandemic, HCWP must trust that they and their families will be cared for, that their work environments will be made as safe as possible, that their voices and concerns will be heard and addressed as issues arise, and that they will have access to the resources they need to ensure they can effectively and safely perform their professional responsibilities.

Although governments and health systems around the world have been applying significant resources to pandemic influenza planning activity, very little of this activity thus far has focused on the management, mitigation and response to the psychosocial implications of the

pandemic. However, planning for the psychosocial implications is currently occurring in BC, and the health sector needs to apply human, material and financial resources to the immediate development and implementation of workforce resiliency programs and activities designed to enhance and support the natural resilience of HCWP.

In order to be successful, planning will rely on effective alliances between all health authorities and their community partners and the allocation of resources to develop, integrate and implement effective support strategies and plans throughout the health sector in both well-resourced and under-resourced contexts. Psychosocial pandemic planning for HCWP is a critical aspect not only of preparing for the next epidemic, but also for ensuring that the health sector has the capacity to protect and promote the health of all Canadians today and in the future.

Potential Psychosocial Pandemic Scenarios

The following scenarios illustrate some of the wide range of psychosocial issues HCWP may face during and following a pandemic. These issues will include such things as role conflict; the degradation of services throughout the health sector; caregiver fatigue; cultural and other impediments to HCWP's capacity to fully participate in the pandemic response; the impact of the public's emotional and behavioural responses to the pandemic; and the differential access to and availability of required resources in rural, remote and isolated communities or organizations. These scenarios invite a consideration of the challenges HCWP will face, and provide a context for understanding the importance of psychosocial pandemic planning.

<p>Scenario 1: Family Physicians – The Community Front Line</p>	<p>Dan is one of several physicians practicing family medicine in a walk-in community clinic. In the months preceding the pandemic outbreak, he and his family have been looking forward to his imminent retirement. When the pandemic hits, Dan and his clinic partners are quickly overwhelmed as they and other primary health providers in the community struggle with a huge surge in demand for services. They extend their clinic hours and attempt to serve patients as best they can although they are exhausted and at times are in despair due to their inability to offer the standard of care they would wish. The clinic’s receptionist has succumbed to illness and medical supplies are in short supply because of interruptions in the normal supply chains.</p> <p>As the pandemic crisis continues, Dan’s family begins pressuring him to leave his practice as planned, arguing that his health and their health are more important than staying. Leaving the practice will increase the strain on his colleagues and the other clinic staff and will likely compromise their capacity to meet the demands for service. On the other hand, staying increases not only the health risks for Dan and his family, but also the risk of the break-up of his family.</p>
<p>Scenario 2: The Secondary Consequences of the Pandemic</p>	<p>There is growing pressure on the limited number of respiratory therapists. Pinder is a respiratory therapist in her local hospital and she has been working 16-hour days for the past 6 days. She is exhausted and overwhelmed but she is also aware of the great need for her services. She lives with her two children, her husband and his parents. Her husband and in-laws have been pressuring her not to go to work for fear of increased risk of infection for her and her children. The conflict has recently escalated to threats that Pinder will not be allowed home if she continues to work.</p>
<p>Scenario 3: Work/Life Conflict and Caregiver Fatigue</p>	<p>For the past number of years, Big City General Hospital (BCGH) has been operating at or beyond 100 per cent of its allotted capacity. Nursing and bed shortages often mean wards are understaffed, surgeries are delayed, and morale is low. Cathy is a single mother of two dependent children and has been nursing at BGGH for 15 years. She commutes from the suburbs, an approximate 1.5-hour drive. By the time the first wave of the pandemic hits Cathy’s home community, one-third of the scheduled nurses at BGGH are absent.</p> <p>Very quickly her “normal” sense of exhaustion at work is exacerbated by the acute care needs and the workload increases due to absenteeism. She has been working longer shifts and has received multiple calls requesting that she take on additional shifts. Over the course of the pandemic outbreak Cathy is faced with multiple challenges as she decides whether or not to continue working. Some situations Cathy faces over the course of the pandemic are:</p> <ul style="list-style-type: none"> • Her children’s school decides to close in an effort to slow down infection rates and Cathy has no alternative arrangements for child care. • Her carpool will no longer accept Cathy’s participation because of fear of disease transmission. • Food is in short supply and she has heard that her local grocery store is expecting a shipment on the morning of her next shift and she must decide whether to work or buy food for her family. • She is exhausted, notices herself yelling at her children and is involved in escalating conflicts at work. She feels torn by her duty to care, her responsibility as a parent and her own need for self-care. • One of her children becomes ill and she experiences guilt because she believes she has increased the risks for her family.
<p>Scenario 4: The “Graceful Degradation” of Services</p>	<p>Staff absences in all areas of the hospital following the first wave, and prior to the second wave, have been as high as 22 per cent: some due to illness, some due to staff recovering from extended shifts during the first wave, and some due to staff addressing family issues that have arisen as a result of the first wave (e.g., partners’ lost wages due to the economic downturn; emotional impact on children of losing a parent, being ill themselves, disrupted routines). If vaccines are not available as the second wave hits, hospitals will quickly run out of staff, space and medical equipment. Although the community has established a protocol for triaging access to hospital-based medical services, many community members are either unaware of these plans or non-compliant and they begin showing up at the hospital in large numbers. The news media quickly picks up the story, fuelling the public’s fears that there are not adequate health care resources available.</p>

Scenario 5: Care of the Caregivers in Under-Resourced Communities	<p>Maricel, a recently widowed single parent of one young child, is the nurse practitioner in her small, remote Aboriginal community. The first wave of the pandemic has caused extensive illness and death throughout the region, and Maricel and the small nursing station she runs have been overwhelmed with the demand for medical care. Physician visits and transportation via air ambulance have been disrupted, medical supplies have been severely limited, and alternative arrangements are not yet in place to provide Maricel with additional support. Her children, already struggling with grief from the loss of their father, have lost friends and relatives to the influenza and have suffered further because of Maricel’s absences due to her extended work hours.</p> <p>Public health officials are racing to produce enough vaccine to stop a second wave before the start of the traditional flu season, but Maricel, faced with the untenable and unsustainable situation at home and at work, must decide how to proceed. Although she is working with a group of lay volunteers, she has no immediately available colleagues to consult with or to provide peer support, guidance or relief.</p>
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1.3 Roles and Responsibilities

The specific roles and responsibilities and organizational capacity for developing and implementing psychosocial pandemic plans will vary depending on the setting. Successful planning will include anticipating both the short- and long-term psychosocial implications of a pandemic and working closely and effectively with health and other planning partners to identify and assess capacity and

resources; define clear roles, responsibilities and accountability structures (i.e., planning and performance indicators) including shared leadership roles; pooling resources and creating collective work-products wherever possible. All health authorities and institutions are responsible for developing and integrating psychosocial planning into their pandemic and/or all-hazard plans.

1.4 Goals and Objectives

The goal of this document is to guide senior management and health emergency planners in early and thoughtful psychosocial pandemic planning and the development of workforce resiliency programs throughout the health sector. Given the range of roles and responsibilities, and the differences in access to and availability of resources, specific planning processes and the plans and programs they produce will vary across health authorities and from organization to organization. The goals and objectives of the planning processes, however, will be common throughout the health sector:

- Protect and/or promote the psychosocial well-being and resilience of HCWP.
- Mitigate, prevent or treat the mental and/or behavioural health issues that arise in HCWP in the context of the pandemic.

- Support HCWP’s willingness and ability to continue working.
- Improve HCWP’s support of and adherence to risk management measures.
- Augment the health care system’s capacity to respond effectively over time to the pandemic crisis.

Objectives

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 physical needs. It includes supporting and strengthening social systems (e.g., social support networks), and helping individuals to regain a sense of control, diminish psychological arousal, effectively

manage stress and improve adaptive coping strategies. The specific objectives are to:

1. Provide information to HCWP about the psychosocial implications of an influenza pandemic and of the various pandemic protocols and action strategies (e.g., use of personal protective equipment, distribution of antiviral medication and vaccines, shift and job reassignments).
2. Identify and outline specific pandemic-related issues and factors contributing to the occupational stress and psychological distress of HCWP.
3. Outline strategies for the rapid and ongoing assessment of the psychosocial capacity and vulnerability of HCWP and the efficacy of workforce resiliency plans and programs.
4. Outline evidence-informed psychosocial support mechanisms and strategies to promote organizational and workforce resiliency. The goal of such strategies should be to enhance the resiliency of HCWP, support and protect their capacity to deliver critical services, and minimize the short- and long-term psychosocial implications for HCWP of the primary consequences (e.g., medical) and secondary consequences (e.g., social, economic) of an influenza pandemic or other large-scale infectious disease outbreak or public health emergency.
5. Outline strategies for integrating psychosocial planning into existing pandemic planning processes, plans and protocols.

1.5 Psychosocial Planning Assumptions and Guidelines

Psychosocial Planning Assumptions

This document reflects the general planning assumptions of the BC Ministry of Health Services 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 (Ministry of Health, 2007; Seynaeve, 2001) and a consideration of the possible psychosocial consequences of an influenza pandemic. The assumptions include the following:

1. The emotional, behavioural and social—or psychosocial—consequences of an influenza pandemic will be widespread given the clinical attack rate is estimated to be between 15–35 per cent of the population with predicted absenteeism rates of 10–25 per cent during peak pandemic periods. The size of the psychosocial “footprint” of a disaster is often much larger than the medical footprint (Shultz et al., 2003).
2. The demand for health care services can be expected to increase sharply simultaneous to workforce shortages, placing increased occupational and personal stress on HCWP.
3. HCWP may face risk to their own health as a result of their occupational roles. The level of acceptable risk that HCWP should tolerate may be perceived differently depending on social, professional and institutional norms and expectations and personal and occupational circumstances.
4. As a threat of sustained duration (i.e., multiple waves of infection over a 12 to 18-month period), an influenza pandemic will generate much uncertainty, anxiety and stress, resulting in prolonged exposure to extraordinary and chronic stress for HCWP.
5. Exposure to extreme and/or prolonged stress may adversely affect the overall health of HCWP. Such stress is a risk factor for physical, mental and social health problems and is associated with a variety of mental and social health

- disorders (e.g., post-traumatic stress, depression, anxiety, substance abuse, domestic violence).
6. The sustained nature of the challenges of a pandemic disaster will likely overwhelm the ability of some individual and/or groups of HCWP to cope effectively. This assumption is based on an understanding that although people are generally resilient and have developed individual mechanisms and skills to cope with stress, they can become overwhelmed.
 7. A range of coping and stress management strategies exist that are more or less effective in any given situation, and which reflect the greater or lesser availability and access to relevant resources (e.g., personal, emotional, cognitive resources; social support networks; economic and material resources). Whereas any individual HCWP may cope in one situation, changes in the situational, personal and professional contexts may prevent or lessen his/her ability to cope.
 8. Sharing common experiences can enhance a sense of belonging, mutuality and support but can also exacerbate feelings of helplessness and disempowerment, and intensify other difficult emotions.
 9. Psychosocial consequences will vary across a spectrum of severity and duration (from brief to long-term) and may include
 - a. An increase in the development of psychiatric disorders and/or the exacerbation of pre-existing psychiatric disorders (e.g., depression, anxiety and substance abuse).
 - b. Fear-driven behaviours and impaired decision-making.
 - c. Impaired cognitive, social and family functioning.
 - d. Decreased workplace and school performance.
 10. Any of these psychosocial consequences, including psychiatric/psychological disorders, may develop
 - a. In individuals who are not physically/medically affected by influenza.
 - b. Concomitant with physical illness or injury or in response to illness or injury in someone else.
 - c. In response to social, economic and other secondary consequences of a pandemic.
 11. The development of comprehensive psychosocial support plans, and the institutionalizing of workforce and social resiliency programs, will enhance workforce resiliency and mitigate the severity of the adverse psychosocial consequences of the pandemic.
 12. Effective psychosocial support is based on an understanding that knowledge is empowering and a critical component of stress reduction. An effective risk communication approach considers stakeholders' values in decision-making processes and tailors communications strategies (content and process) to their perceptions and understanding of risk. This approach is based on the principle that transparency will increase trust and empowerment, and facilitate cooperation in carrying out pandemic response and recovery strategies.
 13. Effective psychosocial support is based on an understanding that individuals and communities have unique capacities, needs and vulnerabilities, requiring creativity and flexibility in the development and delivery of services. Effective psychosocial response is based as much as possible on evidence-informed practices and the engagement in planning and delivery of services of those with frontline psychosocial disaster planning and response experience.

Guidelines for Managing a Psychosocial Response

The guidelines for managing a psychosocial response to a pandemic reflect core humanitarian principles (e.g., valuing of human rights, equity, principle of doing no harm). Psychosocial support should maximize fairness in terms of the availability and accessibility of such supports, including mental health, psychiatric and behavioural support services to HCWP across workplaces, languages, cultural norms and various individual factors (e.g., gender, age, ethnicity, geographic location) and systemic factors (e.g., organizational size, resource allocation).

1. Effective psychosocial support is predicated on an acknowledgment of the fundamental psychological and social value of participation and maximizing the potential for different sub-groups to retain or resume control over decisions affecting their lives and develop local ownership. Every effort should be made to include HCWP in the planning process, particularly those representatives of individuals who may experience specific dimensions of vulnerability (e.g., increased exposure to the virus, pre-existing health conditions, limited or inadequate peer support, disabilities) or who experience specific barriers to accessing information and resources or acting on that information (e.g., language, casual employment, geographic or other isolation).
2. Programs and interventions should build on and mobilize existing capacities and resources within health authorities.
3. Psychosocial support and care engages with individuals and communities regarding highly sensitive issues, including cultural and professional values and competencies, and lacks the extensive scientific evidence available in some other disciplines. Because of this, psychosocial programming should draw on research evidence and lessons learned from other disasters.
4. Psychosocial support is multidimensional and needs to integrate multiple strategies. As such, it requires a planning process that is collaborative, coordinated and inclusive, that minimizes gaps and the unnecessary duplication of services, and that reflects both the variance in roles, responsibilities and access to resources across planning partners, and the simultaneous need for consistency of planning goals and access to psychosocial support and resources.
5. The majority of affected people (including HCWP) seeking psychosocial support will look for social, practical and financial support, not mental health or counselling interventions. Such interventions, however, can have both positive and negative mental health consequences. Effective psychosocial response in disasters and public health emergencies requires a proactive, holistic approach that acknowledges the stigma associated with mental health services and maximizes resiliency and people's willingness and capacity to access relevant support.
6. Psychosocial support addresses multiple levels of need by providing basic psychosocial services and support, care and specialized treatment of mental health problems and/or psychiatric/psychological disorders; family and community supports; focused, non-specialized supports (e.g., education and training in stress management); and specialized services to responders and the public (e.g., psychological first aid).
7. Psychosocial planning and programming should integrate continuous appraisal of the global situation over the long term and evaluation of the effectiveness of plans, interventions and recovery strategies. This should include individual and collective follow-up of the direct impacts (e.g., health consequences) and indirect impacts (e.g., secondary consequences including economic and social disruption), and

integration of lessons learned as the pandemic unfolds, in order to improve services during and following the pandemic.

8. Effective psychosocial planning and response requires clearly designated leadership, roles and responsibilities for the guidance and provision of psychosocial support. Further, psychosocial support must be clearly linked to and be within other public health and medical emergency functions.

2. PSYCHOSOCIAL PLANNING

2.1 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 addresses: (1) coordination and collaboration; (2) assessment – the identification of specific at-

risk populations, service needs and gaps in existing services; (3) development and implementation of workforce resiliency programs; (4) program evaluation – the ongoing evaluation and modification of services and plans.

Completed	In Progress	Not Started	
Coordination and Collaboration			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	There is recognition of the potential human, social and economic impact of a pandemic on health care workers within your plans.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The relevant stakeholders (e.g., management, HCWP, unions, professional associations) have committed to the psychosocial pandemic planning process and there is a way for them to actively engage and be involved in this process.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Planning partners (e.g., private-practice physicians, counselling and mental health providers and their organizations, pharmacists, those providing chaplaincy services) and allied partner organizations (e.g., churches, volunteer and not-for-profit social service agencies) are aware of their roles and responsibilities in the psychosocial pandemic plan, and their contributions and needs have been identified and integrated into your plans.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	There are mechanisms in place to convey the ethical framework clearly to workers, and where relevant, to patients/clients and the public.
Assessment of Resources, Vulnerabilities, Service Needs			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	An assessment process and protocols have been developed and implemented that would identify specific gaps in psychosocial support resources and services, and the specific needs of HCWP and their families covered by this psychosocial pandemic plan and workforce resiliency program.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	There is an audit plan in place that can effectively identify and support collaborative planning with individuals and/or groups with specific vulnerabilities or service needs. These vulnerabilities or specific service needs may be associated with work role and responsibilities, abilities (e.g., mobility, vision, hearing), age, gender and other socio-cultural and economic factors.

Completed	In Progress	Not Started	
Development and Implementation of Workforce Resiliency Plans/Programs			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	There is a framework in place for the development and implementation of workforce resiliency and psychosocial support programs that are responsive to the shifting resources and needs of individual workers and their families as identified through an ongoing assessment process.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	There is a framework in place for the development, adaptation and delivery of education and training to support the psychosocial resilience of individual workers and their families. This framework addresses issues such as pre-pandemic education and training in psychosocial resilience; the psychosocial implications of education and training in occupational safety and infection control measures; and pre-training and just-in-time training that address potential changes in roles, responsibilities and worksites.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	There is a framework in place in the workforce resiliency plan for the development and delivery of relevant education and training to staff, volunteers and community-based providers of psychosocial support services.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	There is an effective risk communication plan that will address the ongoing information needs of HCWP and their families and client/patients in the context of the disruption that a pandemic is likely to create.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 HCWP.
Ongoing Program Evaluation and Revision			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	There is a framework in place for the ongoing assessment of the impact of various pandemic-related factors on the psychosocial well-being and mental health of HCWP and their families, and on HCWP's willingness and ability to work. Assessment strategies address possible changes in the availability of and access to resources over time; the emotional impact of long-term uncertainty; changes in levels or perceived levels of risk of infection; rates of illness and death in HCWP population and general population; depletion or loss of social infrastructure; and rates of absenteeism.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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.

2.2 Phase-Specific Psychosocial Planning Activities

In this section, recommendations for specific goals and planning action steps are outlined as a guide for each of the WHO pandemic phases. These action steps are intended as a guide for whoever is initiating the process of developing psychosocial pandemic plans. In some instances this will be senior management, while in others the initiative will come from those on the front line who recognize that a need and/or gap in planning exists. Throughout this section, the action steps attempt to reflect this variety and the range of possible planning contexts (e.g., hospitals, private practice clinics, private and public care facilities), providing general guidelines that will need to be adapted depending on the specific context. The steps have been organized to reflect the various suggested components or considerations in workforce resiliency programming.

This section begins with the current phase (Pandemic Alert - Phase 3) and a focus on the development and establishment of workforce resiliency programs. The goals and actions outlined for this phase would also apply in

future to the inter-pandemic phases. With the very real possibility of a pandemic on the horizon, building systemic capacity and resiliency within the health sector is a priority. Being ready for the crisis is critically important to reduce the adverse economic, human and social impacts. Now is the time in pandemic planning for the development and integration of workforce resiliency frameworks and programs throughout the health sector, in order to build resiliency skills before the crisis.

Planning for the pandemic and post-pandemic periods focuses on the delivery of pandemic-specific psychosocial support services, the ongoing maintenance of workforce resiliency programs and the provision of up-to-date occupational health information and effective risk communication. The recommendations made for these phases are intended to assist in the planning and development of services that will help HCWP manage psychological and emotional stress and distress, and resolve related personal, professional and family issues.

Current Phase: Pandemic Alert Phase 3

Goal: Develop, integrate and implement workforce resiliency programs and ensure effective communication channels and processes with planning partners.

Coordination and Collaboration

A critical first step in psychosocial planning is to recognize the occupational, personal and family stress consequences of a pandemic and to bring this awareness of the psychosocial implications of a pandemic into all health sector pandemic plans and planning processes. Health authorities, health sector organizations and providers should develop and/or participate in psychosocial pandemic planning processes (e.g., multi-stakeholder planning committees) based on a coordinated, collaborative approach and focused on the development and integration of workforce resiliency programs. The suggested

components of such programs are outlined in Section 3.

In disaster planning, effective response relies on relationships characterized by trust, clearly defined roles and responsibilities, and effective communication. Psychosocial planning groups should involve as wide a range of relevant stakeholders as possible and include representatives from health authorities, health care institutions (e.g., emergency planners, occupational health and safety, human resources), public health emergency planners, health sector employee and family assistance programs, and a wide range of HCWP. Special attention should be paid to include representatives of groups often overlooked in health sector emergency planning, including private-practice physicians, private and public mental health service providers, and the voluntary health sector.

ACTION STEPS

- 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.
- Identify and recruit planning partners, addressing the need for both local (specific to the particular initiating entity) and collaborative (common initiatives across agencies and sometimes sectors) and, in some instances, regional plans and initiatives:
 - Identify who has the authority and responsibility for undertaking psychosocial pandemic planning within your organization and/or region (e.g., senior management, administrators, emergency planners).
 - Identify and foster relationships with potential planning partners within and outside the public health care system. Likely partners include: private and public care facilities; human resource and occupational health departments; governmental organizations (e.g., Ministries of Housing and Social Development, Children and Family Development) Health Authority units such as Community Mental Health; non-governmental organizations and institutions (e.g., community-based counselling, social service agencies, multicultural support agencies); private-practice physicians, psychologists and counsellors; and faith-based organizations.
 - Clearly identify resources, roles and responsibilities and develop plans and strategies for information sharing and ongoing communication.
- Review all relevant emergency legislation, mandates and existing protocols.
- Engage in research (formal and informal) to ensure that planning decisions and plans are based on the best available information.
- Develop and establish a mandate for the planning group that is based on likely pandemic scenarios and addresses the need to integrate the psychosocial implications of a pandemic throughout all pandemic plans.
- Encourage all participants to assign and train alternates for all key positions to ensure continuity in the event of illness or death.
- Identify specific triggers for the implementation of psychosocial plans.
- Develop and establish common ethical principles and frameworks to guide the planning process and the delivery of services.
 - Ethical decision-making process for the allocation of psychosocial support resources.
 - Confidentiality and information-sharing agreements that minimize bureaucratic barriers to information sharing while also protecting HCWP's individual rights.

Assessment of Resources, Vulnerabilities, Service Needs

Developing or enhancing workforce resiliency programs requires an assessment of existing resources, gaps in resources and specific vulnerabilities that may require specialized attention. Those responsible for planning should be encouraged to identify and utilize existing resources, tools and strategies and to continue to develop and improve upon these resources. This requires a collaborative and comprehensive assessment process to determine not only what is already there, but also its effectiveness in addressing the day-to-day psychosocial needs of HCWP and the

potential for addressing HCWP's needs in a crisis on the scale of a pandemic. The assessment process also includes identifying potential sites and the material and human resources necessary for the provision of psychosocial support, identifying gaps in the availability and readiness of these resources, and assessing the current and pandemic-specific psychosocial resources and needs of HCWP. This in turn, relies on the adoption of a gender-, cultural-, and abilities-sensitive analysis to identify specific vulnerabilities that may influence the availability of, access to, and resilience of, psychosocial resources in the event of a pandemic.

ACTION STEPS

- Identify and foster coordination among existing organizational resources, identifying and building on their knowledge and experience. Potential resources include critical incident stress management programs (CISM), employee family assistance programs (EFAP), human resources, and occupational health and safety.
 - Assess space and site resource inventories relevant to the delivery of psychosocial support to HCWP.
 - Identify and establish relationships with potential psychosocial support providers.
 - Identify education, training and support needs required for those providers to deliver relevant workforce support services during and following a pandemic.
- Identify and foster relationships with potential external resources, programs and services that may be available to support HCWP and their families with health (medical and mental) issues (e.g., BC Ministry of Health Services Disaster Psychosocial Services Network – formerly Disaster Stress and Trauma Response Services). It will be particularly important to address the additional challenges and barriers to accessing support during a pandemic (e.g., HCWP who are deployed to non-traditional work sites, those working in isolated or resource-poor communities).
- Collaborate with HCWP to assess relevant psychosocial resources, vulnerabilities and needs for themselves and their families.
- Assess and identify individuals or groups that may need additional psychosocial support, including
 - HCWP in close contact with acutely ill/dying patients, particularly children.
 - HCWP working in isolation because of geographic, professional, cultural or social barriers.
 - HCWP who may experience specific work-related (e.g., part-time, casual workers who may not have adequate access to employee benefits), cultural, communication (e.g., language, hearing and vision), mobility, or other barriers to accessing support.
- Identify potential providers of psychosocial support services. Knowing evidence-informed, disaster mental health intervention protocols is necessary but not adequate to being effective as a psychosocial responder in a disaster or crisis. Psychosocial responders must be able to step into situations that often require them to work outside of familiar contexts (e.g., frontline contexts, outreach, working within multi-disciplinary teams). To be accepted within an institution or existing response team, psychosocial responders must be able to establish rapport and present themselves as well-organized professionals who are aware of and are able to operate within the parameters of organizational/response culture.

Development and Implementation of Workforce Resiliency Plans

An effective workforce resiliency plan and program evolves from the involvement, buy-in and support of leaders at all levels and the participation of frontline workers. 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 and programs will differ across the health sector and will be tailored to the specific resources and needs of the target health care organization and its HCWP. Some dimensions and major components, however, will be common, reflecting the shared need for training and education. These components are outlined more specifically in Section 3.

ACTION STEPS

- Develop and deliver programs that promote awareness of the need for psychosocial pandemic planning, workforce resiliency and support programs, and individual HCWP/family disaster and pandemic preparedness plans.
- Plan for a long-term response, anticipating short- and long-term needs (i.e., more than one year) during a pandemic, and the long-term recovery process (multiple years).
- Review the EFAP contracts that provide employee assistance programs with social support services for HCWP and their families, to ensure that the programs have the capacity and skills to address their needs during a pandemic and the recovery period. This would include having the capacity to offer virtual support options through telephone and web-based systems. Professional peer support programs should also be consulted (e.g. Physician Health Program of the BC Medical Association).
- Access/Utilized pre-pandemic briefing, education and training materials, including
 - Hard copy and/or web-based descriptions of roles and responsibilities during and following the pandemic.
 - Cross-training and just-in-time training materials to address the potential need for HCWP to fulfil unfamiliar roles during a pandemic. Research indicates that being prepared, trained and informed supports resilience.
 - Common questions and answers regarding possible concerns (e.g., infection risks, personal protective equipment and procedures, isolation and/or quarantine strategies, communication plans, family issues, personal health, employment benefits/payment concerns).
 - Information about where and how to access local and virtual (e.g., web-based) educational and support resources.
- Develop and implement protocols and processes (and, where relevant, training) to support the ongoing assessment of cognitive, physiological, behavioural and emotional symptoms of chronic and/or acute stress, burnout, compassion fatigue and severe mental disturbance in HCWP. The goal would be to have processes in place that support early detection in order to provide early intervention.
 - Exit interview strategies and protocols designed to assess HCWP concerns and readiness to return to work.
 - Training for managers in identifying signs and symptoms of stress and effective stress management, conflict resolution strategies, self-care and mutual care.
 - Develop and implement education and training to upgrade the skills of program administrators, supervisor, managers, union personnel and human resources on how to provide support in ways that respect cultural differences, autonomy and the principle of doing no harm; the effect of stress on decision-making; self-care and actions to safeguard physical and emotional health; and how to maintain a sense of control and self-efficacy in crisis.
- Develop protocols and processes designed to address some of the secondary consequences of a pandemic on HCWP, including:
 - Employment issues related to illness (e.g., benefits, sick pay, compassionate leave, staff rotation).
 - Work issues related to disrupted public services and infrastructure (e.g., provision of on-site or close-to-site elder care and child care to facilitate HCWP's ability to work; alternate transportation if public transit is unavailable).
 - High rates of absenteeism.
 - Benefits, additional training and other needs specific to casual and part-time HCWP.
- Develop and implement components of a workforce resiliency program, including protocols and processes to conduct ongoing assessment of the efficacy and relevance of services, service gaps, and changes in availability and access to relevant resources.

Pandemic Alert Phases 4 and 5

Goal: Continue preparedness planning and activities; Clear and open communication with partners; Early activation of workforce resiliency and psychosocial support plans and strategies and ongoing assessment and monitoring.

Planning activities during the ongoing alert phases focus on the continued development, implementation and maintenance of partnerships, core planning activities, and workforce resiliency programs.

ACTION STEPS

- Ensure all psychosocial planning partners are aware of Pandemic Alert Phase 4 (small clusters of human-to-human transmission of new influenza subtype).
- Encourage HCWP and planning partners to monitor bulletins and websites of relevant agencies (Public Health Agency of Canada, BC Centre for Disease Control, and the World Health Organization) regarding clinical updates, as appropriate.
- Review and update pandemic influenza psychosocial response and contingency plans and partnership agreements, ensuring clarity regarding leads, roles, responsibilities and mandates.

Pandemic Phase 6

Goal: Activate pandemic-specific psychosocial plans; assess and monitor HCWP health and wellness; disseminate, maintain and/or modify workforce resiliency programs.

Activation of Psychosocial Support Services for the Pandemic Period

Health authorities, health care institutions, organizations and agencies must have in place and be ready to mobilize and make full use of their ongoing workforce resiliency plans and pandemic-specific psychosocial support strategies, resources and risk communication tools. Implementing and maintaining these programs should be a priority, in order to help HCWP manage emotional stress and family

issues, foster and maintain cohesion and morale and apply effective coping and resilience skills during the pandemic response. Effective implementation of these plans will rest in part on accurate and ongoing assessment and surveillance plans that provide an accurate picture of the evolving capacities, vulnerabilities, extent and nature of HCWP's psychosocial needs. Feedback loops must be in place to ensure that HCWP can both receive and provide information regarding the effectiveness, relevance, availability and accessibility of support resources. Effective communication channels will help ensure that psychosocial support can flexibly and responsively meet changing demands and resources.

ACTION STEPS

- Activate pandemic-specific psychosocial support plans (e.g., buddy system) and strategies.
- Activate schedules that reflect the need to phase out workers gradually from high to medium to low stress areas/roles and initiate voluntary emotional defusing for HCWP as they go off-shift and/or take breaks.
- Assess HCWP workforce resiliency programs and determine which components to maintain and which to suspend based on psychosocial demands on HCWP, availability of resources, mandates etc.
- Activate systematic assessments of HCWP psychosocial well-being (in collaboration with occupational health services, human resources, unions and others as applicable), monitor effectiveness of psychosocial programs/strategies to respond to emergent surges in demand, address gaps and reallocate resources as needed.
- Assess the need for additional psychosocial support strategies. These may include psychological first aid, critical incident stress management strategies, and referrals to mental health professionals. Services should be considered for HCWP (including managers, supervisors, leaders) and their families.

ACTION STEPS

- Institute alternate transportation strategies for HCWP as needed (e.g., carpooling or mini-bus) and alternate child/elder care plans.
- Activate “rest and recuperation sites”, on location, where staff can go to get respite, back-up clothing (for those wearing infection control masks etc.), information, nutrition, relaxation materials and access to emotional support.
- Provide psychosocial support personnel and materials at sign-in/sign-out location (and in the rest and recuperation site if different from sign-in/sign-out location).
 - Personnel may include chaplains, counsellors, massage therapists.
 - Support strategies can include physical relaxation, comfort, nutrition and hydration, and emotional support.
 - Consider shift “exit interviews” (check-outs to address lingering operational concerns, issues and workers’ intention to return).
 - Materials (print and web-based) should provide information on signs and symptoms of stress, burnout, compassion fatigue and stress management; where and how to access psychosocial support, including confidential telephone support lines staffed by mental health professionals (see Section 3 for more information on support materials).
- Implement and sustain psychosocial programming.
- Activate pandemic communication plans including:
 - HCWP family communication plans, including HCWP access to telephones while at work to allow regular communication among family members.
 - Provision and dissemination of educational and support materials (e.g., pamphlets/web-sites providing information regarding signs and symptoms of stress, stress management).
 - Provision of regular updates regarding infection control measures, rate of spread, etc. (access to accurate and timely information is a powerful component of effective stress management).
 - Provision of information for commuters. HCWP may require alternative transportation and scheduling (e.g. carpooling, employer-provided private transportation, alternate work schedules during off-peak hours) to address service interruptions and avoid exposure to large groups of potentially infected persons.

Pandemic Subsequent Waves

Goal: Monitor and provide ongoing assessment; mitigate chronic stress, burnout, compassion fatigue and complicated grieving responses; amend psychosocial strategies and reallocate resources as needed.

ACTION STEPS

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

Post-Pandemic Recovery Period

Goal: Support short- and long-term recovery through the maintenance of workforce resiliency programs and implementation of post-pandemic recovery activities; assess and address ongoing psychosocial or mental health needs of HCWP.

The disaster recovery period is typically much longer than the disaster itself and is often cited by survivors as the most stressful part of the disaster experience. It may involve a complex web of stressors for HCWP, who may already

be fatigued as a result of extended work hours and responsibilities, who may be grieving lost family, friends and colleagues, and who, like other members of society, may face ongoing challenges due to workforce and resource shortages, economic downturns, and a host of financial, emotional, relational and social challenges. The development and provision of psychosocial support during the short- and long-term recovery process is a critical aspect of pandemic psychosocial planning.

ACTION STEPS

- Anticipate and prepare for a long recovery period, including anticipating significant dates (e.g., anniversaries of peak waves when mortality rates were highest) and the ongoing stress for HCWP associated with the continuing need for services while they are engaged in their personal recovery and the health sector recovery processes.
- Assess capacity to resume normal functions given current resources (including human resources).
- Continue to provide and revise workforce resiliency plans and programs in order to meet the long-term recovery needs of HCWP, and to enhance and sustain their capacity and willingness to continue working during the long-term recovery process.
- Continue psychosocial outreach to ensure that HCWP who may be less visible (e.g., home support workers; casual and part-time workers, community health nurses) continue to receive adequate support.
- Continue to provide psychosocial supports to families who have lost loved ones who were HCWP.
- Consider ways to facilitate team and community building within the health sector and empowerment strategies to support HCWP's positive involvement in the recovery process.
- Develop and implement strategies that validate HCWP contributions during a pandemic.
- Assess specific worker groups and/or individuals and implement psychosocial recovery support programs that address specific emotional, psychological, professional, financial and social issues that may impact HCWP well-being and resilience.
- Engage HCWP in recovery planning and the ongoing assessment and identification of needed resources and programs.
- Engage HCWP in a comprehensive evaluation of pandemic psychosocial programs and modify the pandemic psychosocial contingency plans based on lessons learned.

3. WORKFORCE RESILIENCY PROGRAM

Comprehensive workforce resiliency⁵ and psychosocial programming draws on but differs from traditional mental health or counselling interventions and approaches. The latter tends to be focused specifically on assessing and treating psychiatric/psychological disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IVR; American Psychiatric Association, 2000) or the International Statistical Classification of Diseases and Related Health Problems (ICD -10; World Health Organization, 1992); the former is based on an assumption of resiliency and focuses more broadly on providing a range of support strategies. During a pandemic, workers are likely to experience greater stress on the job because of increased workloads due to absenteeism, fear of infection and/or transmission, managing work/life balance in the face of school closures, family illness and child and/or elder care.

The goal of a workforce resiliency program is to support and enhance HCWP's ability to cope effectively with occupational stress and maximize professional performance. A workforce resiliency program requires the development, implementation and integration of resiliency strategies and policies into non-crisis activities; establishing a culture of resiliency will not only optimize HCWP's resilience during a pandemic but has the additional benefit of increasing everyday capacity. During a disaster, additional psychosocial support strategies will be necessary to support HCWP's ability to meet the exceptional and unique demands associated with the disaster. Such strategies will focus on maximizing workers' ability to function at work, at home and in the community by more effectively managing and/or mitigating the stress and distress associated with a disaster.

HCWP who do not believe that their families are safe are less likely to be able and willing to work. Therefore, workforce resiliency and pandemic psychosocial support strategies need to adopt an ecological perspective that addresses HCWP's concerns about their own safety and well-being, that of their families, and ultimately of their communities. The term "disaster health" has been coined and will be used in the following description of workforce resiliency programs to describe the outcome of "optimal, health human functioning within family, community and occupational roles during extreme events" (Shultz et al., 2003).

A cultural competence and gender sensitive lens should be adopted in the development and delivery of all such programs and strategies. Cultural competence is the ability to understand and respond effectively to the cultural and language needs of individuals and families affected by a disaster (Marsella & Christopher, 2004). Cultural and/or gender differences can be apparent in the way groups define disaster and loss, express their grief, as well as how they seek assistance. Different cultures may ascribe different meanings to an event based on their beliefs and values. In this way, cultures also serve as a source of protection by furnishing people with a shared sense of identity, life meaning and continuity that they may rely on to carry themselves through difficult times.

The following sections outline the key components of workforce resiliency programs and some pandemic-specific psychosocial support strategies. The suggested components have been organized into separate but often overlapping categories. Whereas the range and breadth of programming will depend on funding and resources, each of these categories should be considered in the psychosocial pandemic planning process and addressed in some way.

⁵ Resiliency refers to the ability of individuals and communities to take action that will improve their own capacity to respond effectively to stressful circumstances. It is not a static quality; it is a process that can be developed and strengthened over time through active involvement at the individual and community level.

3.1 Resources and Programming

- Identify, develop and support an ongoing education and training program (e.g., seminars or brown-bag luncheons) that provide HCWP with regular opportunities to provide input and to be involved in briefings on the pandemic planning process and plans and to learn and/or upgrade skills that will support resilience during a pandemic. (For more specifics, see Section 3.2).
- Develop and implement a workplace buddy system that allows HCWP to support each other in monitoring stress levels, and to offer mutual help in coping during a crisis. This might include plans for peer mentorship by those who have recovered from influenza or another infectious disease (e.g., SARS).
- Develop contingency plans that address:
 - Flexible work arrangements that may be implemented as needed. These can include remote work options where possible, alternatives to face-to-face meetings (e.g., teleconference, couriers), and flexible hours to address child/elder/family care issues. Although it may be desirable and possible to have managers/administrators working remotely (e.g., from home) such decisions need to be weighed against the potential perception that frontline staff are being asked to put themselves in situations that carry greater risk of infection while senior administrators/leaders are not.
 - The needs of casual workers and those in lower paying positions (e.g., addressing issue of no or limited benefits) in order to maximize the potential of them continuing to work. Creative solutions might include banked holiday and sick-day benefit pools where employees can contribute benefits that they do not need themselves in order to create a pool for those in greater need (e.g., they have been ill and recovered in a previous wave)
- Non-punitive sick leave provisions – policies requiring documentation from a physician may not be appropriate or even possible during an influenza pandemic.
- Alternate arrangements for transportation should public transportation systems be disrupted; on- or near-site day care facilities for HCWP with dependent children and/or adults requiring day care should public schools and day care centres be closed.
- The psychosocial needs of those HCWP deployed to non-traditional roles or worksites, quarantined or ill at home.
- Identify and re-establish relationships with retired HCWP, who may be able to step back into active roles, and/or provide mentorship or support during a pandemic. Consider engaging such individuals through sponsored training and networking events.
- Identify and develop respite sites in workplace settings, and policies/procedures that ensure regularly scheduled breaks, in order to provide workers with the physical/temporal space to remove themselves from the immediate environment 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).

- Develop and train (or ensure training has been provided) worker support teams that can be deployed to provide critical stress interventions, psychosocial assistance, support and information. In order for such teams to be effective, they must be integrated into the culture of an organization, establish trust and respect, and have the confidence of HCWP that support will be professional (e.g., evidence-informed, confidential, voluntary) and will be provided in ways that are consistent with professional, organizational and individual cultural issues.
- Anticipate the challenges HCWP may face in fulfilling the everyday tasks of living (e.g., buying groceries, paying bills) while they are deployed and/or working extended shifts or living in quarantine. Consider developing disaster concierge services (i.e., individuals or programs that can aid employees in addressing these issues) to support HCWP and their families to maintain family functioning and care.
- Apply infection control measures to minimize the risk of transmission and/or allay workers fears of transmission. HVAC systems, shared telephones, and other equipment used by multiple users can be a source of additional stress for workers worried about infection. Although changing HVAC filters may not be relevant in a pandemic, acknowledging this fear, providing information and being proactive will signal concern and caring.
- Plan for the provision of psychosocial support during the post-pandemic recovery period. Given the potential primary and secondary consequences of a pandemic, and based on existing literature on SARS and disasters more generally, the long-term recovery will be characterized by economic and other stressors, accumulated fatigue in the workforce (individually and systemically), and the real possibility of attrition of the workforce. Providing ongoing support, advice and services (e.g., non-interest loans that could be paid back over time through payroll deductions) to workers will contribute to their resilience and that of the system over the long term.

3.2 Training and Education

Psycho-educational groups, brown-bag lunch series and topic-specific forums (e.g., web-based groups) can be effective means of disseminating information and providing opportunities for HCWP to engage in mutual support. Such educational and training opportunities can also provide an opportunity during and following a disaster for HCWP to discuss and process their experiences, identify common concerns/issues and share positive coping strategies and support. Because the use of personal protective gear such as masks, fears of transmission and the sheer volume of work may limit the potential for in-person groups or information seminars, thought should be given to ways of facilitating group training, education and connection during a pandemic through the use of virtual environments.

Educational and training materials may be adapted from existing resources (see Appendix A) and should address cultural, language and other differences in the workforce. Consider also providing educational materials for distribution to employees and their families on the human response to disaster, with a particular emphasis on aspects that are unique to a pandemic (e.g. concerns about infection, stigmatization, scope and duration of the pandemic, widespread economic disruption and social consequences). This material should also include age-appropriate (e.g., children, youth, adults, older adults) information on stress and stress reduction, self-care strategies and psychosocial pandemic planning information for families.

- Provide or support the involvement of HCWP in ongoing education and training (e.g., mini-training and information sessions) about pandemic plans, disaster health, individual and organizational resilience, stress management and coping. Specific topics might include:
 - Information on distribution and use of vaccines, antiviral medication, potential side-effects, and other medical resources (this information can reduce anticipatory stress and anxiety and ensure a smoother transition to pandemic status).
 - Guidance on distinguishing between psychological disorders (e.g., depression, anxiety) and common and expected psychological, emotional, behavioural and cognitive responses to extreme and/or prolonged stress in adults and children.
 - Psychosocial impacts specific to anticipated extreme events (e.g., mass fatalities during a pandemic).
 - Effective resilience skills, stress management and coping strategies.
 - Cultural competence (e.g., the influence of culture, age, gender, abilities, etc. on stress response and coping strategies, delivery of health care, perception of illness, death, authority).
 - Details regarding what psychosocial support resources are or will be available (in-house and community-based), including contingency plans regarding safety (e.g., use and availability of personal protective equipment and medical supplies), employment issues (e.g., staff rotations, use of non-traditional worksites, anticipated shift coverage, sick pay, death and disability benefits, benefits for casual or part-time staff, use of benefit time) and other disaster-specific resources (e.g., financial assistance, psychosocial support programs that supplement existing workforce resiliency programs).
 - Buddy systems and other workforce resiliency strategies.
 - Family preparedness planning, including family communication plans that will help families maintain ongoing contact during work or other related separations (e.g., quarantines).
 - Strategies for managing conflict and highly agitated patients, and for working with special populations (e.g., children) in times of crisis.
 - Crisis decision-making and the effects of stress on the decision-making process.
 - Strategies for working to support patients' adherence to medical and public health measures without causing undue anxiety or alarm.
 - Strategies for supporting those who feel they may have been infected.
 - Guidance for managing exposure to larger than normal numbers of acutely ill and dying patients, persons with unusual disease symptoms and anticipated scenarios entailing challenging ethical issues.
- Provide training in psychosocial support to those workers (internal and external) who might be able and willing to provide psychosocial support services during a pandemic. Identify and exercise multi-disciplinary teams who might provide outreach, hotline and institutional psychosocial support services during a pandemic.

- Undertake HCWP leadership training focusing on the skills and knowledge necessary for the development and maintenance of a healthy, supportive working environment.
- Educate staff about contingency plans (e.g., alternate transportation arrangements should disruption of public transit occur, onsite day care during school closures).
- Consider establishing a regular forum in which HCWP can access peer support and relevant information, and address concerns and questions. Consideration should be given to formats that improve accessibility (e.g., multiple modalities) and that can be maintained during a pandemic (e.g., online forums). Possible forum topics include
 - Information regarding workforce resiliency and pandemic-specific psychosocial support plans and programs (internal and external resources).
 - Information and answers to questions about infection control practices, use and availability of personal protective equipment, sick leave and compassionate leave during a pandemic, sick pay, staff rotation strategies, support to family members.
- Consider developing incentives for retired employees to attend training days every six months (e.g., offering a catered lunch) to maintain skills and engagement, and to enhance the likelihood that they will be available to augment the workforce during a pandemic.
- Develop and educate staff on confidentiality policies regarding employee illness, what will or will not be shared, and other contingency plans to address extraordinary employment issues.
- Develop written instructions and/or just-in-time training for re-deployed staff on the essential tasks of their new position for those HCWP who may be called upon to fill in for sick colleagues and perform unfamiliar tasks.

3.3 Information and Communication

Given the uncertainty that is characteristic of a new strain of any infectious disease, there will be an exceptional need for open lines of communication in the health care system. This will include the need for continual, timely access to up-to-date and accurate information about the spread of infection, risk management strategies (i.e., infection control measures, personal protective equipment), and changes in shifts, work roles and responsibilities, or contexts. Access to this information must be available to HCWP throughout the health sector. This will require successfully addressing potential barriers to effective communication that may result from wearing personal protective devices, public health infection control strategies, the disruption or loss of

communication infrastructure (e.g., as a result of absenteeism and workforce shortages) and HCWP's separation from their families during work and/or quarantines.

In order to address evolving needs for information and to provide HCWP an opportunity for feedback, health care facilities should consider establishing mechanisms for information exchange on employee questions and concerns (e.g., public meetings, forums, online question-and-answer sheets, etc.). Reputable weblinks (e.g. World Health Organization website) should be highlighted, including recommended websites providing information on self- and mutual-help in disasters (e.g., indicators of stress, compassion

fatigue, coping strategies, family emergency planning, how to support children in disasters). A variety of delivery modalities are likely to be required. These will include face-to-face individual and group briefings, pandemic and psychosocial support websites, hotlines (for up-to-date pandemic information) and warmlines (for psychosocial support and information), written information and broadcast media (television and radio).

- Develop or adapt information pamphlets (print and web-based resources in multiple languages as needed) on critical disaster health topics including
 - Signs of distress.
 - Traumatic and cumulative grief.
 - Psychosocial aspects related to natural death surge.
 - Stress management and coping strategies.
 - Strategies for building and sustaining personal resilience.
 - Behavioural and psychological support resources.
 - Strategies for helping children and families in times of crisis.
 - Strategies for working with highly agitated patients, families and colleagues.
 - Providing medical care to colleagues.
 - Issues related to the ethical dilemmas and psychological impacts of triage.
 - Working outside traditional roles.
 - Strategies for self-assessment.
- In coordination with risk communication/information/communications officer develop strategies to ensure accurate, timely dissemination of

information to staff. It may be necessary to provide “virtual” psychosocial support via telephone hotlines, Internet/intranet. This will include employee updates (e.g., shift briefings that address changes in risk management/infection control strategies).

- Develop organization-specific telephone hotlines (e.g., 1-800 lines), websites and/or newsletters that can provide pandemic information and advice to HCWP and their families.
- Anticipate the need for HCWP to stay in touch with their families during extended shifts and/or isolation measures. This could include providing cell phones or wireless communication devices and developing and educating employees about plans that support regular communication.
- Include in risk communication plans ways of providing HCWP with up-to-date, accurate information regarding:
 - International, national, and local progress of the pandemic and relevant, reliable websites.
 - Availability and use of vaccines, antiviral drugs and personal protective equipment.
 - Infection control practices as conditions change.
 - Notification of employee illness at a work site.
 - Staff rotations, use of non-traditional worksites and anticipated shift coverage.
 - Actions to address understaffing or depletion of personal protective equipment and medical supplies.
 - Expert advice and answers to questions about disease control measures, self-care, stress management, family support, etc.

3.4 Stress Management

The cornerstone of any workforce resiliency program is the development and enhancement of workers' ability to effectively manage and cope with stress. In a pandemic, all health care workers, including management and administrative staff, can be considered to be on the front line of response and are likely to benefit from training that supports the recognition of signs of stress, burnout and compassion fatigue, and gives effective coping strategies. In addition, organizations can develop and implement a range of interventions to mitigate occupational stress and enhance workers' stress resilience. These strategies include fairly basic interventions such as providing the opportunity for workers/individuals to informally debrief with colleagues, friends or family, and to engage in exercise and pleasurable activities, and other interventions that require the guidance of someone with more formal training including cognitive-behavioural reframing strategies, mindfulness training and relaxation meditation.

Other interventions include the development and implementation of peer support programs. Such programs often involve encouraging mutual support by the strategies listed earlier, and augmenting that support with peer support

teams who have received advanced training in stress management strategies and who are able to assess the necessity to refer someone to a more experienced mental health professional. This advanced training should be provided by a qualified mental health professional who is familiar with the organizational culture and is capable of providing ongoing supervision and follow-up with the group leads. The advantages of internal peer support teams are a greater likelihood of acceptance and first-hand knowledge of the work environment and culture; the disadvantage is that team members can themselves be part of the response and therefore be unavailable because of other responsibilities and/or be at risk of burnout. Additionally, peers can, at times, be too close to colleagues and incidents to provide effective service. This is another reason for peer support teams to work closely with a professional who can provide ongoing supervision, training and support to the peers themselves.

(For more detailed description of specific interventions see: *Psychosocial Response Workbook – Disaster Stress and Trauma Response Services*, BC Ministry of Health Services at: <http://www.health.gov.bc.ca/emergency/dst.html>).

3.5 Additional Pandemic Psychosocial Support Strategies

Psycho-Educational Groups

Psycho-educational groups can be an effective means of disseminating information and providing opportunities for mutual support. They can also provide an opportunity during and following a disaster for HCWP to discuss and process their experiences, identify common concerns/issues, and share positive coping strategies and support. Thought should be given to a variety of ways of facilitating group training, education and connection, including developing virtual environments when necessary or useful.

Psychological First Aid and other Disaster Health Frameworks

Psychological First Aid is an evidence-informed intervention designed to assist children, families and adults in the aftermath of disasters and other crises. The core actions of Psychological First Aid can be applied within hours, days or weeks following a potentially traumatic event. These actions are:

- **Contact and Engagement:** To initiate and respond to contacts by survivors in a non-intrusive, compassionate and helpful manner.
- **Safety and Comfort:** To enhance survivors' sense of safety and security by meeting their physical and emotional needs.
- **Stabilization:** To calm, reassure and comfort emotionally distraught survivors.
- **Information Gathering:** To identify the immediate physical, social and emotional needs of survivors.
- **Practical Assistance:** To ensure that survivor's practical needs for health services, shelter, food, clothing and other basic needs are addressed.
- **Connection with Social Supports:** To reduce isolation and enhance self-help among survivors by reuniting and keeping families together, establishing contacts with primary support persons and linking survivors to community assistance resources.
- **Information on Distress Reactions and Coping:** To provide information about stress reactions and coping techniques in order to reduce distress and enhance positive coping.
- **Linkage with Services:** To ensure survivors know of and are linked to available disaster assistance, health and social services programs.

There are a number of training programs in Psychological First Aid, and consideration should be given to making these available so that all HCWP have access to the knowledge and have an opportunity to develop skills that will be useful for self-care, mutual care to colleagues and supporting family members. Those providing or likely to provide psychosocial services during a pandemic and those whose work may put them at higher risk for experiencing the psychosocial consequences of a pandemic should be prioritized for such training. For more information on Psychological First Aid, 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.

The Miami Center for Disaster and Extreme Event Preparedness (DEEP) provides similar training in what they describe as Safety, Function, Action (SFA). SFA is another framework for the provision of disaster health support and resiliency training focused on responder self-care and the provision of support to survivors. For more information on SFA see the Safety Function Action Support Center on the DEEP website at <http://www.deep.med.miami.edu/x239.xml>.

Family Support Strategies

Workers' willingness and ability to remain on the job will be enhanced by a sense of confidence that their families are safe and cared for. Psychosocial programming should include strategies to support the ability of workers to plan with their families for some of the challenges an influenza pandemic will pose. This includes family communication plans, psychosocial support for family members including children, and strategies to address some of the anticipated disruption to routines and supply chains. Services may include

- Providing psychosocial outreach services to families (information/support), taking into consideration cultural issues, age-appropriate information, languages.
- Providing instrumental help (e.g., assistance obtaining food, medical supplies).
- Assessing the need for and providing assistance with elder care and child care.
- Assistance with other issues related to parenting and child care. A model to consider is that of a concierge who supports workers to stay at work by providing

practical support to workers and their families.

- Developing feedback mechanisms (e.g., web-based feedback or designated voice mailboxes) that allow families/community members to provide anonymous feedback and suggestions for improvement of services.
- Developing amendments to existing benefit packages so that psychosocial support can be provided to family members of HCWP who are infected as a result of exposure to the pandemic through work. Amendments would address extended illness or death (e.g., scholarship funds, outreach psychosocial support, funds for burial).

Grief and Bereavement Support

Although in general people will find their own ways to mark the loss of family and friends, psychosocial pandemic plans should consider the need for additional support in this regard for HCWP who may be exposed to extraordinary rates of acute illness, uncertainty and death at work and in their communities. Some HCWP may benefit from specific psychosocial support to manage their grief,

particularly as normal social support networks may be unavailable or disrupted. Particular attention should be paid to those who are exposed to the death(s) of child(ren) and employees who have experienced a loss in their immediate family or the loss of a close colleague. Some workers may experience long-term health (mental and/or physical) problems, and employment and other social issues as a result of their experiences during a pandemic influenza. The volume of dead and the increased need for coroners, mortuary and burial services may necessitate changes to normal burial/funeral arrangements; in turn, this may cause increased stress and/or complications in the grieving process. Psychosocial plans should include, or partner with those involved in their delivery, spiritual and religious care and support to mitigate this stress on workers and their families.

For more information on approaches to complicated grieving read the article: Kersting, K. (2004). A new approach to complicated grief, *Monitor on Psychology*, available at <http://www.apa.org/monitor/nov04/grief.html>.

3.6 Assessment, Triage and Referral

Many HCWP may be reluctant to seek out psychosocial support services because of the general stigma associated with mental health and concerns regarding the impact that seeking out such help could have on their professional reputation or employment. It is consistent with disaster mental health to presume that most people will not actively seek out such support and to develop outreach strategies. For organizations this issue can be addressed through education and training to a large extent, and by providing well developed policies regarding confidentiality, employee rights, etc. Current best practice in the provision of disaster psychosocial support suggests that

outreach programming is often the most effective method of support. This should include an ongoing, systematic process of assessment (as opposed to a single event), including (1) appraisal of general stress levels; (2) nature and degree of demand for psychosocial support services among HCWP and specific subpopulations of HCWP; (3) trends and patterns in identified needs, issues and concerns and, in particular, trends that may anticipate a sharp increase in the demand for services; and (4) monitoring and evaluation of the efficacy of psychosocial interventions and monitoring.

Assessment strategies can include:

- Informal assessment through discussions and scans during outreach.
- Incorporating stress assessment in the provision of psychosocial services.
- Employing occasional questionnaires, surveys or interviews on psychosocial well-being.
- Monitoring the volume and nature of calls or requests for help either in person or on HCWP-specific hotlines/warmlines.
- Monitoring people's reasons for seeking assistance.
- Monitoring waitlists and referrals to EFAP and other services.
- Working with planning partners (e.g., private-practice physicians and mental health clinicians) to develop a systematic reporting of trends and identified needs for service.
- Using virtual suggestion boxes (through e-mail, confidential phone lines) for feedback and suggestions for additional services from employees and their family members.
- Developing and integrating regular and ongoing operational debriefings and other formal and informal assessment strategies with HCWP (e.g., at shift exit interviews) and with providers of psychosocial services. This can provide general and specific information about developments that may indicate the need for revision of what and/or where services are provided.

4. OPERATIONAL CONSIDERATIONS

The availability and access to psychosocial support and health resources will vary across organizational contexts (e.g., independent family physician practices versus hospitals) and employment contexts (e.g., full-time versus casual workers). This variability must be taken into consideration as a system-wide concern if the health sector is to function as a whole during and following an influenza pandemic

4.1 Coordination and Liaison

Given this variability, and the range and diversity of the concerns and issues that fall under the category of workforce resiliency and psychosocial planning, effective planning for HCWP will rely on system-wide collaboration and coordination. As much as possible, planning processes should involve or seek input from a diverse group of stakeholders including health authorities, public health agencies, medical and mental health institutions and agencies, professional associations and unions, and a range of health care workers and providers. Psychosocial pandemic planning and coordination involves the following activities:

1. Identifying and securing the active participation of planning and service delivery partners (including health authorities, primary care, mental health services, emergency social services, counselling agencies and associations, non-governmental and community services).

4.2 Timing

The pandemic psychosocial planning process should start immediately; thoughtful planning, including establishing trusting and effective working relationships among partnering agencies, institutions and service providers will take time and is not likely to happen in the

outbreak. Other factors related to personal dimensions (e.g., age, health), occupational roles (e.g., degree and risk of exposure), social factors (e.g., stigmatization, availability of other care-related services including school and child/adult day care) and economic issues (e.g., loss of work) will also play a significant role in the well-being of health care workers during and following a pandemic.

2. Determining coordination mechanisms, roles and responsibilities at local, regional and national levels and facilitating the ongoing development, discussion and adaptation of plans to reflect evolving psychosocial resources and concerns.
3. Establishing agency and inter-agency policies, protocols and procedures for referral and information exchange with services that constitute the network of care and support for HCWP.
4. Securing financial and human resources for psychosocial planning and implementation.
5. Collaboratively developing and implementing education and training packages to ensure that psychosocial support providers are trained, prepared and sensitized to workplace cultures and protocols.

midst of an emergency. The specific timing for activating psychosocial support services will depend on an ongoing assessment of the local pandemic phase and site-specific assessment of needs, but should follow the general guidelines provided in previous sections of this report.

5. NEXT STEPS OR FUTURE RECOMMENDATIONS

The long-term goal of psychosocial pandemic planning should be to assess and address the psychosocial implications of all aspects of planning and response within existing plans, as each aspect of pandemic planning has psychosocial implications.

Key recommendations from this document for psychosocial planning are as follows:

1. Acknowledge and prioritize the need for psychosocial planning in health authorities pandemic plans by establishing targets, indicators of progress towards those targets, identifying and tasking individuals with the authority and responsibility for planning processes, and assigning resources (human, financial and material).
2. Where possible, support the development of, and/or participate in, interagency regional and local psychosocial pandemic planning committees or groups. Such groups benefit from the involvement of representatives from a cross-section of HCWP and focus on the identification of needs, resources, gaps in resources, and the collaborative development of strategies and programs to support workforce resiliency.
3. Develop, implement and integrate psychosocial workforce resiliency activities into day-to-day human resource management practices, in order to build capacity in advance of a health care emergency/disaster. Such programs and activities should build on/enhance existing resources and draw on evidence-informed disaster mental health and psychosocial planning resources, tools and techniques. (See Section 3 and Appendix A for additional web-based resources)
4. Adapt or develop, and implement training and education in psychological first aid, stress management, and personal and family preparedness planning.
5. Adapt or develop, and implement relevant training and education specific to management and leadership regarding psychosocial programs, support and building resilient organizations/workforces.
6. Prepare or adapt psychosocial support and education materials in multiple formats and languages for HCWP and their families.
7. Work with human resources and occupational health (where available) to develop plans for potential employment issues in a pandemic.
8. Develop psychosocial support plans that address short-term and long-term response needs and the extended recovery period.

6. RESOURCE IMPLICATIONS

As with all aspects of the pandemic planning process and implementation, psychosocial planning and support programs will require human and financial resources. Planning for the psychosocial dimensions of disasters is relatively

new and reflects a cultural shift within the health sector that increasingly acknowledges the importance of mental and behavioural health for the effective functioning of the health care system in a crisis.

7. RELEVANT PSYCHOSOCIAL PANDEMIC INFLUENZA PLANNING RESOURCES

The Ministry of Health Services Emergency Management Branch has initiated a Disaster Psychosocial Project. The Disaster Psychosocial Project is working collaboratively with health and community partners to support the production of comprehensive psychosocial response plans for individuals, families and responders in the event of a disaster in British Columbia. Whereas it is incumbent on all health agencies and institutions to develop psychosocial pandemic plans, the Disaster Psychosocial Project is one of a number of resources available to assist health institutions and agencies to develop the resources and capability, with best practices in mind, to

provide a full range of psychosocial services during a pandemic and/or other infectious outbreak or disaster.

Disaster Psychosocial Services (DPS) is a voluntary response group made up of registered professional clinicians including clinical counsellors, psychologists and social workers. The number of volunteers involved in DPS is approximately 1,000 and the service has been activated roughly 12 times since 2001.

See Appendix A for a list of other relevant web-based planning resources.

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APPENDICES

Appendix A: Disaster Psychosocial Planning Web-based Resources

Canadian Pandemic Planning Websites

Resource	Website
Canadian Government Pandemic Influenza website One-stop access to information from Government of Canada departments and agencies on pandemic, seasonal and avian flu.	http://www.influenza.gc.ca
Public Health Agency of Canada pandemic preparedness website	http://www.phac-aspc.gc.ca/influenza/pandemic_e.html
<i>Canadian Pandemic Influenza Plan for the Health Sector</i> This plan is the product of extensive dialogue and collaboration within the Pandemic Influenza Committee. It was created in 2001, by the Public Health Agency of Canada.	www.phac-aspc.gc.ca/cpip-pclcpi/
<i>Influenza Pandemic: Psychosocial Care Planning</i> , by Environmental and Workplace Health, Health Canada	http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/pandemic-plan-pandemic/index-eng.php

Disaster Mental Health and Psychosocial Planning Tools

Resource	Website
Public Health Agency of Canada Emergency Preparedness and Response website	http://www.phac-aspc.gc.ca/ep-mu/index.html
World Health Organization publications on mental health and psychosocial support in emergencies	http://www.who.int/mental_health/emergencies/en/
<i>Pandemic Influenza Planning: Guide for Individuals and Families</i> (2006), by the United States Department of Health and Human Services Comprehensive guide that outlines what a pandemic is, its anticipated effects, questions/answers about vaccines, etc., a checklist for planning for individuals and families.	http://www.hss.energy.gov/healthsafety/guidepandemic.pdf
Québec Pandemic website A guide for employers and workers to prevent psychosocial impacts	http://msssa4.msss.gouv.qc.ca/en/document/publication.nsf/4b1768b3f849519c852568fd0061480d/eb4470cd63c91575852575b40068bcfe?OpenDocument
<i>Psychosocial Support in Situations of Mass Emergencies – European Policy Paper</i> (2001) A comprehensive guide to psychosocial concerns and interventions in a broad range of mass emergencies.	http://ec.europa.eu/environment/civil/pdfdocs/cpact03h-en.pdf
Public Health Agency of Canada Pandemic Preparedness Information for Health Care Professionals Primarily technical rather than psychosocial information.	http://www.phac-aspc.gc.ca/influenza/hcp-ps-eng.php
<i>Mental Health Practitioners Guide: Guidelines for Psychological Service Practice</i> (2003), by Emergency Management Australia	http://www.preventionweb.net/english/professional/publications/v.php?id=1997

Workplace Planning

Resource	Website
<i>Influenza Pandemic: Psychosocial Care Planning</i> , by Environmental and Workplace Health, Health Canada	http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/pandemic-plan-pandemie/index-eng.php
Vancouver Coastal Health Pandemic Influenza Plan (Chapter 8 Human Resources)	http://www.vch.ca/media/Coastal%20Pademic%20Plan_web.pdf
<i>Caring for Nurses in Public Health Emergencies: Enhancing Capacity for Gender-Based Support Mechanisms in Emergency Preparedness Planning</i> (2008), a Canadian Policy Research Networks report, by C. Amaratunga et al. Detailed research and recommendations for enhancing the resiliency of human resource dimension of health services with particular attention to gender issues (e.g., role conflict for HCWP, many of whom are women, between professional and family responsibilities; addressing needs of casual employees).	http://www.cprn.org/documents/49473_EN.pdf
<i>HHS Pandemic Influenza Plan Supplement 11 Workforce Support: Psychosocial Considerations and Information Needs</i> , by the US Department of Health and Human Services	www.hhs.gov/pandemicflu/plan/sup11.html

Disaster Health Resources and Materials

Although many of the following resources are American and focused more generally on natural disasters, they provide an excellent range of resources, materials and information on disaster health and psychosocial support that can be adapted and modified for use in a pandemic or all-hazards context. Additionally, most of these sites provide links to other reputable and useful disaster psychosocial planning information and resources.

Resource	Website
Trauma and Disaster Mental Health Resources, from the Centers for Disease Control and Prevention	http://www.bt.cdc.gov/mentalhealth/
David Baldwin's Trauma Information Pages – Disaster Mental Health Includes disaster-related links and materials, including handouts focused on adults, families and children, and disaster responders. These may need to be modified for the pandemic context.	http://www.trauma-pages.com/disaster.php
US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration – Emergency Mental Health and Traumatic Stress website	http://store.samhsa.gov/home

Resource	Website
<p>US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration – Publications on mental health and disaster issues</p> <p>Provides links to a range of documents including</p> <ul style="list-style-type: none"> • A guide to managing stress in crisis response professions. • Communicating in a crisis: risk communications guidelines for public officials. • Managing stress: tips for emergency and disaster response workers. • Mental health all-hazards disaster planning guidance. • Psychological first aid for first responders. • Psychosocial issues for children and families in disasters: a guide for the primary care physician providing information on managing stress for response professionals, mental health all hazards planning guides, psychosocial issues for specific populations (e.g., children). 	<p>http://store.samhsa.gov/home</p>

Workforce Support for First Responders

Resource	Website
Physician Health Program British Columbia website	http://www.physicianhealth.com
<i>Tips for Managing and Preventing Stress: A Guide for Emergency and Disaster Response Workers</i> , by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration	http://store.samhsa.gov/home
<i>HHS Pandemic Influenza Plan Supplement 11 Workforce Support: Psychosocial Considerations and Information Needs</i> , by the US Department of Health and Human Services	www.hhs.gov/pandemicflu/plan/sup11.html
Patel, M.S., et al. (2008). General practice and pandemic influenza: A framework for planning and comparison of plans in five countries. <i>PLoS ONE</i> , 3(5), E2269.	http://www.pubmedcentral.nih.gov/articlerender.fcgi?to=pubmed&pubmedid=18509538

Signs and Symptoms of Stress and Age-Appropriate Intervention Strategies

Resource	Website
US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration – Emergency Mental Health and Traumatic Stress website, Tips for Talking About Disasters	http://store.samhsa.gov/home
<i>HHS Pandemic Influenza Plan Supplement 11 Workforce Support: Psychosocial Considerations and Information Needs</i> , by the US Department of Health and Human Services	www.hhs.gov/pandemicflu/plan/sup11.html
<i>The Emotional and Behavioural Consequences of CBRN Events and Other Complex Public Health Emergencies: Part II</i> (2006), by S.M. Crimando.	http://www.bigmedicine.ca/stevencrimando.htm#The-Emotional-and-Behavioural-Consequences-of-CBRN-Events-and-Other-Complex-Public-Health-Emergencies-Part-II

Planning for Populations with Special Needs

Resource	Website
BC Ministry of Public Safety and Solicitor General, Provincial Emergency Program Website provides various general disaster preparedness resources, including information on preparedness for people with disabilities and a link to the BC Pandemic Influenza Preparedness Plan.	http://www.pep.bc.ca/publications/publications.html
<i>Interim Emergency Management Planning Guide for Special Needs Populations</i> [Draft], by the US Federal Emergency Management Agency. This guide contains links to other special service resources (primarily American), which could be adapted.	http://www.apic.org/Content/NavigationMenu/EmergencyPreparedness/SpecialNeedsPopulations/Special_Needs.pdf
<i>CDC Disaster Planning Goal: Protect Vulnerable Older Adults</i> , by the US Centers for Disease Control and Prevention, Healthy Aging	http://www.cdc.gov/aging/pdf/disaster_planning_goal.pdf

International Plans and Planning Guides

Resource	Website
Pandemic Influenza Preparedness and Response: a WHO guidance document (2009), by the World Health Organization Global Influenza Programme and the World Health Organization.	http://whqlibdoc.who.int/publications/2009/9789241547680_eng.pdf
<i>Explaining Pandemic Flu: A Guide from the Chief Medical Officer</i> (2005), by UK Department of Health.	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121751
UK Health Departments' Influenza Pandemic Contingency Plan (2005), by UK Department of Health	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121735
<i>Public Health Pandemic Influenza Plan – Attachment I: Behavioral Health Support</i> (2006), by the Oregon Department of Human Services.	http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Influenza/Documents/oregonfluplan.pdf

Ethical Issues in a Pandemic

Resource	Website
Thompson, A.K., Faith, K., Gibson, J.L., & Upshur, R. (2006). Pandemic influenza preparedness: an ethical framework to guide decision-making. <i>BMC Medical Ethics</i> , 7, 12.	http://www.biomedcentral.com/1472-6939/7/12
John Hopkins – Berman Institute of Bioethics	http://www.bioethicsinstitute.org

Planning Considerations for First Nations Communities

Resource	Website
Canadian Pandemic Influenza Plan for the Health Sector, Annex B: Influenza Pandemic Planning Considerations in On Reserve First Nations Communities (2009), by the Public Health Agency of Canada	http://www.phac-aspc.gc.ca/cpip-pclpci/ann-b_e.html

General Psychosocial Issues for Disaster and Emergency Planning

Resource	Website
Amaratunga, C. A., O'Sullivan, T., (2006). In the path of disasters : Psychosocial Issues for preparedness, response, and recovery. <i>Journal of Prehospital and Disaster Medicine</i> , 21(3), 149–155.	http://pdm.medicine.wisc.edu/Volume_21/issue_3/amaratunga.pdf
Redefining Readiness Research Reports, at the Center for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine	http://www.cacsh.org
Van Ommeren, M., Saxena, S., & Saraceno, B. (2005). Mental and social health during and after acute emergencies: Emerging consensus. <i>Bulletin of the World Health Organization</i> , 83, 71–77,	N/A

Appendix B: Summary of Psychosocial Issues for HCWP

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

Contributing factors could include:

- Lack of reliable/consistent information (e.g., about protective measures).
- Perceived lack of effective leadership.
- Loss of faith in employers/institutions or governments.
- Death of immediate supervisors, colleagues, leaders in the response efforts.
- Death or illness of family members.
- Mass illness and deaths among children.
- Economic collapse or acute shortages of food, water, electricity or other essential services and supplies.
- Restrictions on civil liberties perceived to be inequitable (e.g., right to refuse work).
- Infection control measures (including personal protective equipment) that limit personal contact, hinder communication, interfere with normal personal/professional support systems.
- Rumours and misconceptions.

Appendix C: Providing Psychosocial Support: Tips for Family Physicians and Staff

Purpose

The purpose of this document is to provide an easily accessible, brief document for family physicians on how to provide psychosocial support to their staff, and care for themselves, during a pandemic influenza. This document briefly outlines a few resilience based “next steps” to prepare.

Objective

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 physical needs. It includes supporting and strengthening social systems and helping individuals to regain a sense of control, diminish psychological arousal, effectively manage stress and improve adaptive coping strategies.

This document highlights some of the basic steps in providing psychosocial support to physicians and staff, and it recognizes that people may be experiencing different stressors at different times as they respond to a pandemic influenza.

Office management matters such as engineering and administrative approaches, personal protection, infection control procedures and human resources policies are available in the *Pandemic Influenza Response Plan* and on the government’s website entitled Pandemic Influenza Preparedness under Clinical Care (<http://www.health.gov.bc.ca/pandemic/response/clinical.html>).

First Steps in Providing Support for Family Physicians and Staff

The following are some simple steps to provide support to staff who will be dealing with an extreme event:

1. Designate the responsibility of worker care to an appropriate person.
This designated person, with best practice in mind, will then form a small internal team and work to establish peer support within the office environment. In the case of solo practices, this could mean a buddy system with other offices where you can share the support and information needs.
2. Provide emotional, information and instrumental support
Physicians or designated worker care person can provide emotional, informational and instrumental support to address fear, stress and anxiety, manage expectations and assist with normalizing.

Pamphlets or articles on managing stress can be found on the Public Health Agency of Canada website at www.phac-aspc.gc.ca/publicat/oes-bsu-02/comm-eng.php, and on the Ministry of Health Services website at <http://www.health.gov.bc.ca/pandemic/planning.html>.

Examples of emotional, informational and instrumental support are:

Emotional	Informational	Instrumental
<ul style="list-style-type: none"> • Acknowledge the stress and added demands. • Provide stress management tips and training in adaptive coping. • For larger offices, set up a staff Hotline number for information and support in dealing with stress and anxiety and/or for small practices identify local crisis line or Healthlink website addresses and numbers • Establish a buddy system so staff can watch out for one another. 	<ul style="list-style-type: none"> • Ensure clear, honest and frequent communication. • Provide written notices, using language that indicates care strategies for the workforce. • Provide communication feedback loops such as regular ‘brown bag’ sessions and e-mails to give staff a chance to ask questions, offer suggestions and be part of the process. • Ensure proper and timely follow-up as staff raise questions and suggestions. • Ensure staff members are equipped with the proper information or have links/access to information. • In absence of internet, distribute guidelines in hard-copy. 	<ul style="list-style-type: none"> • Develop a process for clear communication, contact with and updates for loved ones. • Address staff’s physical needs (e.g., food, transportation, child/elder/pet care, medication, equipment). • Establish respite space/centers for staff, with healthy snacks, and telephone and computer access, especially when long hours of work are occurring. • For solo/small practices identify space away from the desk and office that will provide respite/relief, e.g. a buddy office, a local café, park space.

And, also very importantly...

3. Maintain a sense of humour!

Self-Care and Psychosocial Prevention

Things primary care physicians can do to take care of themselves during an emerging disaster or pandemic include:

- Taking time to rest and relax.
- Avoiding overload of information; seeking information only once a day.
- Talking about your thoughts and feelings with family, friends, co-workers, spiritual advisors or health professionals.
- Distracting yourself with other activities (e.g., exercise, reading, creative activities).
- Balancing what is important.
- Maintaining as normal a routine as possible.
- Avoiding the use of alcohol or drugs to numb your feelings.
- Trying to eat well and get a good night’s sleep.

What to Watch Out For

All people become concerned when their health is at risk.

The extra work required by disaster protocols can be a significant disruption to many workplaces, including those of primary care physicians. The more severe a problem becomes, the bigger the problem for society, health care workers and the health care system. Patients and staff with anxiety conditions, including exposure to prior traumatic events, will have more difficulty coping.

Behaviours and behavioural changes to be aware of during stressful times include

- Sleep disruption or fatigue.
- Disturbance of daily eating (over- or under-eating).
- Avoidance of others or certain patients.
- Feeling anxious, depressed or having panic attacks.
- Being easily startled.
- Elevated resting heart rate.
- Crying.
- Drinking more alcohol or taking more prescription drugs.
- Being more easily moved to anger.
- Reluctance to rest or return to home after working long hours or days.

Who Can Help?

Stressors such as the risk of illness associated with a pandemic will affect all people differently. Stressors that are beyond our personal control are especially difficult to cope with well. During these times, seek the help of:

- People with whom you are close.
- Peer supports and/or your buddy.
- Counsellors, spiritual care.
- Hotlines, distress centres and government websites.

If you change your daily or professional routine more than you need to, if symptoms persist or if they are too strong for you to handle, consult a health professional, such as your own family physician, nurse, psychologist or social worker.

Appendix D: 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	<ul style="list-style-type: none"> • Child deaths • Multiple/mass casualties and deaths • Deaths of supervisors and/or leaders in the response effort • Family and colleague illness or deaths 	<ul style="list-style-type: none"> • 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.) 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Stress of working with sick or agitated persons and their families and /or with communities under quarantine restrictions 	<ul style="list-style-type: none"> • 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 & timely risk communication and infection control and status reports 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Limited interpersonal contact due to physical isolation associated with use of infection control measures 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Illness and death of colleagues and patients • Fatigue and exhaustion 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Opportunities to share and debrief (formally and informally) with colleagues • Availability of psychosocial support to self and family during illness 	<ul style="list-style-type: none"> • 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

	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
Social Behavioural	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Struggle to manage roles in family and professional commitments Breakdown in family relationships Disorientation Lack of concentration Memory issues 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Rumours, misconceptions or conspiracy theories Belief that medical resources are not available or fairly distributed Lack of accurate information 	<ul style="list-style-type: none"> Sense of ineffectiveness and powerlessness Ability to think clearly and make sound decisions 	<ul style="list-style-type: none"> Comprehension issues for family members (and public) regarding the virus and issues around protection and quarantine 	<ul style="list-style-type: none"> Maintaining focus on primary duties Adapting to a new or different work assignment Struggling with lack of control and knowledge base 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Opportunities for peer-to-peer and professional psychological/emotional support Institutional recognition and validation of HCWP accomplishments and contributions during pandemic and recovery 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Loss of trust in health institutions, employers or government leaders Loss of faith in a just world 	<ul style="list-style-type: none"> Search for meaning; shattered assumptions 	<ul style="list-style-type: none"> Presence (or not) and influence of faith-based beliefs, coping and support system(s) 	<ul style="list-style-type: none"> Moral distress around decision-making regarding who is saved or not 	<ul style="list-style-type: none"> Pre-event education regarding possible spiritual meaning Information regarding available spiritual support services (e.g., chaplains) 	<ul style="list-style-type: none"> Peer or professional-based psychosocial intervention strategies that acknowledge and address spiritual aspect of pandemic consequences 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Ethical dilemmas and moral distress, etc., whether or not to go to work; concerns about receiving vaccines or antiviral drugs before other people 	<ul style="list-style-type: none"> • Presence (or not) and influence of adequate supports; i.e., vaccine availability to worker and not family, tension between work roles and family expectations 	<ul style="list-style-type: none"> • Moral distress around decision-making regarding who is saved or not 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Opportunities to discuss ethical decision-making in interdisciplinary fashion • Ongoing opportunities to debrief (formally and informally) the emotional dimensions and consequences of decision making 	<ul style="list-style-type: none"> • 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