Buzz

American Red Cross

Disaster Mental Health Guidance for Influenza Pandemic Planning (4/29/09)

Overview

It's difficult to imagine a disaster that would provoke more fear and distress across the nation than when an influenza outbreak raises concerns about pandemic influenza (panflu) or when an actual influenza pandemic occurs. Disaster Mental Health (DMH) workers will play an integral role in helping American Red Cross workers and communities cope with unprecedented stress resulting from panflu challenges such as:

- Infected people may be ***isolated***, which means that they are separated from healthy people to reduce the chances of spreading the flu;
- ***Social distancing*** is a practice imposed to limit face-to-face interaction in order to prevent exposure and transmission of a disease;
- People who have been exposed to the virus may be ***quarantined***--the physical separation of healthy people who have been exposed to the influenza virus from those who have not been exposed;
- Many things may shut down or be canceled, including public transportation, gathering places, events, schools and businesses;
- Community services and utilities may be disrupted; and
- Health care services could become overwhelmed.

(Adapted from the CrossNet Fact Sheet on Coping and Emotional Well-Being): https://crossnet.redcross.org/every/initiatives/flu_planning/pan_flu_coping_emotional well-being.pdf;

Adding to the above challenges, a pandemic flu event will severely limit the deployment of Red Cross national assets and may require chapters and their local partners to be the primary service providers.

DMH workers can assist their chapters now in preparing for a pandemic flu event by helping to: 1) implement workforce support strategies; 2) ensure accurate and appropriate messaging; and 3) develop unique service delivery protocols that are designed around limited or no face-to-face contact with clients. Many of these strategies will be of value now in helping to strengthen the chapters' capacity to respond to all types of disasters.

Strengthen the Chapter Work Force

DMH workers can assist their chapters in strengthening and growing its staff and volunteer workforce by promoting a chapter "culture" that views worker ***force health protection*** as the first, necessary step to providing the best possible services to clients. Force health protection strategies are organization-wide activities which support workers and facilitate self-care. Activities include:

- Training all chapter staff and volunteers in psychological first aid;
- Working with chapter leadership to ensure that adequate time and resources are dedicated to volunteer recruitment, support and retention efforts;
- Consulting with chapter leadership to help establish worker resilience building activities and force health protection strategies. For example, chapter leaders should divide work into mission critical and non-mission critical elements and designate self-care as mission critical;
- Preparing protocols to support supervisors and workers challenged by: 1) a workforce reduced by absenteeism; and 2) job assignment decisions that may be difficult due to varying levels of risk (e.g., chapter or community activities vs. in-home telephonic support); and
- Providing emotional support to chapter workers by increasing the integration of DMH workers into chapter activities and teams (e.g., pair DMH workers with ERV drivers in bulk distribution and feeding efforts).

Ensure Accurate and Appropriate Messaging

Accurate and appropriately messaged information is a well-known and critical component of helping people cope with stress. DMH workers should assist their chapters in the following tasks:

- Ensuring that all chapter workers, volunteers, clients and community partners understand the scope and limits of Red Cross service delivery. Chapter workers and volunteers should have quick access to the most current Red Cross pandemic flu service delivery guidance. The most comprehensive guidance is summarized in Pandemic Flu Guidance #2 (3/10/06) at: https://crossnet.redcross.org/chapters/connections/2006-006.pdf.
- Forming chapter cross-activity communication groups that, at a minimum, include leadership from the following activities: Emergency Services, Human Resources, Disaster Health Services (HS), DMH, Mass Care, Partner Services, Public Affairs and Government Liaison. This will ensure that chapter messaging is internally consistent and externally consistent with local public health information and guidance issued by National American Red Cross national, including our partners at the U.S. Department of Health and Human Services and the Centers for Disease Control. Collaborative

messaging will also ensure that clients receive information that is as comprehensive and precautionary as the information provided to Red Cross staff and volunteers.

- DMH should review chapter messaging to ensure that it: 1) is factual and not overly optimistic or pessimistic); 2) promotes a sense of hope by detailing the extensive chapter and community efforts to keep people safe and to deliver services; 3) periodically includes tips to parents to use with their children; 4) is culturally and linguistically appropriate to diverse populations; and 5) is accessible to people with medical disabilities and other special needs.

Unique Service Delivery Strategies

Chapters should design service delivery strategies that eliminate or significantly reduce person-to-person contact. Chapter DMH teams can prepare now by engaging in the following activities:

- Developing partnerships, Memorandums of Understanding (MOUs) and remote communication links with local public health departments, Medical Reserve Corps, community mental health providers, local Voluntary Organizations Active in Disaster (VOAD) and faith-based and other community organizations. DMH can assist in clarifying Red Cross service delivery limitations;

- Designing new DMH service delivery methods to be used during quarantines and social isolation. These strategies may include the provision of emotional support and psycho-education via the telephone and internet;

- Customizing DMH messaging and homebound resilience-building activities for those most vulnerable to quarantines and social isolation (e.g., children and people with medical disabilities and other special needs); and

- Developing plans to provide DMH support to clients in the event that a disaster occurs during a pandemic flu event (e.g., if a tornado strikes, DMH may provide telephonic support to clients being sheltered in non-congregate housing). Any such plans should be in accordance with guidance and directives from local public health officials.

Summary

ARC chapters should always be prepared for a pandemic flu event. DMH workers are well positioned to assist their chapters in the preparedness efforts described above. Moreover, each one of the three strategies outlined above can provide immediate dividends to chapters as they seek to support their work force and build their capacity for disasters of all types, large and small.

TOPIC: INTERIM GUIDANCE FOR DISASTER HEALTH AND DISASTER MENTAL HEALTH SERVICES IN SHELTERS DURING H1N1 (SWINE FLU) OUTBREAK

INTRODUCTION

Operations Updates will be issued periodically, and each Operations Update is effective immediately. If no end date is provided in the text of the document, the guidelines and procedures described in this document are not applicable after December 31, 2009.

AUDIENCE

This guidance is intended for chapter leadership, program managers and relief operations workers with responsibilities for sheltering, mental health or health services. This includes Disaster Action Team (DAT) members, chapter staff, and others conducting activities which may initiate or impact congregate care in shelters during an outbreak of H1N1 influenza.

PURPOSE

This guidance is intended to assist chapters offering Disaster Health and Mental Health Services in shelters opened as a result of disasters such as tornadoes, hurricanes, floods, or other "traditional" disasters that occur during the H1N1 (Swine) Flu outbreak. This document reinforces current Disaster Health and Mental Health Services procedures and activity guidance and emphasizes the importance of community health activities that will ensure the continued wellness of shelter populations. During a public health emergency such as the current outbreak of H1N1 influenza, guidance is expected to change as more is known about the incident or situation. Additional Operations Updates will be released as needed.

KEY POINTS

Following are the key points of this document. Each of these key points is explained in greater detail in the Guidance section of this document.

1. Sheltering during an outbreak of H1N1 will require extra diligence in monitoring the population and workforce.
2. Make every effort to have qualified Health Services workers involved in operations with sheltering activities.
3. Immediately notify the Lead Health Services Manager if clients have acute respiratory illness and fever.
4. At all times, emphasize shelter hygiene and standard precautions for contact with clients and workers.
5. Use the Client Health Record (Form 2077), Health Services Morbidity Report Form (Form 2077C), and aggregate summary sheets of the Client Health Records to track health-related issues in shelters on a daily basis.

GUIDANCE

During a public health emergency or a pandemic, American Red Cross shelter operations must follow all applicable state and local public health requirements as well as federal and state guidance. To ensure that shelters are operated in an appropriate manner during an H1N1 (swine flu) outbreak, every effort should be made to have qualified Health Services workers involved in operations with sheltering activities. Ideally, every shelter should have assigned nursing staff during this period. If resources do not allow for such assignment, every effort should be made to arrange for daily visits by qualified Health Services workers or nurses, or cooperative arrangements should be made with local public health or medical reserve corps members. If you are unable to assign nursing staff or to make cooperative arrangements, please contact the DOC to discuss alternative solutions. This guidance will remain in effect until the Department of Health and Human Services (HHS) declares that the nation is no longer in a public health emergency phase.

Section A: Triage and Surveillance Procedures

Shelters operated during an H1N1 (swine flu) outbreak must employ surveillance to ensure that proper safeguards are in effect to ensure the health of shelter clients and staff. Surveillance takes two primary forms: syndromic surveillance and behavioral health surveillance.

Disaster Health Services – Syndromic Surveillance

Syndromic surveillance is defined by the Centers for Disease Control and Prevention (CDC) as "observation using health-related data that precede diagnosis and signal a sufficient probability of a case or an outbreak to warrant further public health response." In effect, it is gathering and analyzing information to predict an illness event or an outbreak.

The Disaster Health Services (HS) worker and Staff Health (SW) worker should assess and monitor the shelter clients and staff for Influenza Like Illness (ILI), as defined by CDC in its interim guidance for H1N1 (Swine Flu). The *Initial Intake and Assessment Tool* should be used to screen clients coming into the shelter to identify any acute febrile (accompanied by fever) respiratory illness. Particular attention should be given to answers to question 3 ("Do you have a medical or health concern or need right now?").

When operating a shelter during an outbreak, sheltered client triage/assessment should occur at the following times:
- Upon arrival/admission to the shelter,
- Once a day; and
- When referring individuals to a health care facility.

Shelter clients should be assessed every 24 hours and should be encouraged to self-report symptoms between assessments. Encourage shelter staff to report symptoms of infectious diseases between screenings.

Shelter Practices

To further ensure a safe environment, a number of other precautions should be used. First, strategically locate hygiene posters (see links in the bullets below) around the shelter. Also, observe the following infection control strategies:

- Correct hand washing techniques (http://www.health.state.mn.us/handhygiene/wash/index.html)
- Use hand sanitizers (http://www.health.state.mn.us/handhygiene/clean/index.html)
- Cough and sneeze etiquette (http://www.cdc.gov/flu/protect/covercough.htm)
- Disposal of tissues
- Daily cleaning of environmental surfaces (http://www.apic.org/Content/NavigationMenu/EmergencyPreparedness/SurgeCapacity/Shelters_Disasters.pdf)
- Daily cleaning of communal toys

HS Disaster Health Services (HS) workers should follow standard precautions for contact with all clients and workers in shelters, which include the following:

1. Wear appropriate personal protective equipment (PPE) when exposure to blood, body fluids, secretions or excretions of individuals is anticipated.
2. Remove all PPE in the room/area in which it was used.
3. Perform hand hygiene before and after physical contact with each sheltered individual.
4. Follow respiratory etiquette:
    a. Provide tissues for coughing individuals
    b. Instruct individuals to cough or sneeze into the crook of their elbow or sleeve, or into a tissue
    c. Separate potentially infectious individuals (by at least six feet) from other persons
5. Coordinate with the Shelter Manager to ensure that all sleeping areas are configured so that individuals are appropriately separated by:
    a. Ensuring three feet of space between individual sleeping areas (or cots)
    b. Using head to toe sleeping configurations

The results of the formal assessments/triage (i.e., active surveillance) and passive surveillance (self-reported symptoms between screenings) should be reviewed by the HS worker and reported to the HS Supervisor at the shelter. The HS Supervisor must immediately notify the Lead HS Manager of clients with acute respiratory illness and fever.

Disaster Mental Health Services – Behavioral Health Surveillance

The term *behavioral health surveillance* applies to observation using behavioral-health related data that precede diagnosis and, on an aggregate basis, signal a sufficient probability of significant distress that would warrant further public mental health response (Galea S., et. al., 2006). In effect, it is gathering and analyzing information that indicates increased risk of developing sustained or significant distress.

Disaster Mental Health (DMH) workers should assess and monitor the shelter community, which includes assessing shelter clients and shelter staff. As is consistent with current DMH shelter monitoring activities, this individual assessment should be documented on the Client Health Record (Form 2077) and conducted on all sheltered individuals and shelter staff identified by DMH workers as having acute mental health symptoms and/or syndromes. Aggregate summary sheets of the Client Health Records (how many clients and staff have which symptoms and syndromes) should be sent to the Lead DMH Manager on a daily basis.

DMH workers should conduct behavioral health surveillance using the Psychological Simple Triage and Rapid Treatment (PsySTART) evidenced-based, exposure-based triage system. The aggregate risk factors for clients and staff should be noted as they report their aggregate DMH contacts on a daily basis. DMH workers should continue to encourage all disaster workers who are trained in Disaster Psychological First Aid (which includes training on PsySTART) to use the exposure based risk factors to make appropriate referrals to DMH.

The *Initial Intake and Assessment Tool* will continue to be used by shelter registration workers in the initial entry assessment to determine whether an individual can be safely accommodated in the shelter, and referrals to DMH for further mental health assessment will arise from this process.

Section B: Suspected or Confirmed Case Responsibilities/Process

Disaster Health Services

When an individual in the shelter is identified as having Influenza Like Illness (ILI), he/she will be socially distanced (separated from the general population shelter) and referred to the next level of medical care for a diagnostic work up. This encounter should be documented on the Client Health Record (Form 2077). The CDC Health Services Morbidity Report Form (Form 2077C) should also be completed at this time. When symptoms warrant, the HS worker in collaboration with the HS supervisor will consult with local public health to determine if the individual should remain in the shelter. If public health determines that the individual should not remain in the shelter, the HS Supervisor will contact the Lead HS Manager and work the issue to resolution through the Disaster Relief Operation (DRO) headquarters.

Disaster Mental Health Services

Aggregate summary sheets of the Client Health Record (symptom-based) and aggregate PsySTART (exposure-based) data collected at each site will be sent to the DMH lead manager at the DRO headquarters. This data will inform: 1) the deployment of DMH resources (to sites with higher risk clients); 2) the identification of appropriate community resource providers for client referrals; 3) the development of appropriate public mental health messaging; 4) the coordination of service delivery with local, state and federal mental health partners; and 5) the identification of evolving behavioral health trends that may illuminate continued disaster and/or secondary stressors and which can then be addressed in service delivery planning.

FOR FURTHER INFORMATION

If there are questions about the information provided in this document, please contact the Disaster Operations Center at 202-303-5555 or via email at DOC@ usa.redcross.org.

Additional reference information can be found at the following links or documents:

American Red Cross. (2006). Individual Client Services: Disaster Mental Health. https://crossnet.redcross.org/chapters/services/disasters/follow_dis_svc_prog_guidance_activities.asp

American Red Cross. (2006). Individual Client Services: Disaster Health Services. https://crossnet.redcross.org/chapters/services/disasters/follow_dis_svc_prog_guidance_activities.asp

Centers for Disease Control and Prevention. Interim Guidance for Infection Control for Care of Patients with Confirmed or Suspected Swine Influenza A (H1N1) Virus Infection in a Healthcare Setting. http://www.cdc.gov/swineflu/guidelines_infection_control.htm

Galea A., Resnick H., and Vlahov. D. (2006). "Post traumatic stress symptoms in the general population after a disaster: Implications for Public Health," in 9/11 Mental Health in the Wake of Terrorist Attacks, Eds. Neria. Y, Gross R., Marshall R. and Susser E.

Rebmann, Terri. (2007/2008). Infection Prevention and Control for Shelters During Disasters. Washington D.C.: Association for Professionals in Infection Control and Epidemiology (APIC) Emergency Preparedness Committee.

In addition, the Centers for Disease Control and Prevention provides updated guidance at http://www.cdc.gov/swineflu/