Mental Health

Pandemic Influenza sub plan

2015
Purpose

This sub plan to the South Australian Pandemic Influenza Plan addresses how Mental Health Services (MHS) will respond to situations as they relate to Pandemic Influenza (PI).

The Office of the Chief Psychiatrist (OCP) is responsible for periodically reviewing and updating this plan to ensure that information contained within the document is consistent with current knowledge and changing infrastructure. While this sub plan serves as a guide specifically for influenza intervention activities during a pandemic, the judgment of Department of Health (DH) leadership, based on knowledge of the specific virus, may alter the strategies that have been outlined.

The role of MHS will be to provide mental health information, consultation and support consistent with, and in support of the general principles of the management of an influenza pandemic. These principles include:

> minimising serious illness and death;
> maintaining essential services; and
> minimising social disruption.

Associated aims of the health response to such a pandemic will be to minimise exposure to infection and delay the peak of infection rates to enable an optimal health response. Mental Health information, consultation and support, at state and regional levels, will be pivotal in achieving these aims.

Primary areas of Mental Health (MH) involvement will include:

> communications (strategic, professional, public and media);
> leadership and organisation;
> public health and emergency response;
> mental health surveillance and clinical service provision; and
> workforce education and training.

Specific mental health preparedness activities relating to these areas, at the varying stages of response are set out in table format herein. Priorities of MHS during an influenza pandemic will be to ensure the continuation and delivery of essential mental health services while providing for the emergency mental health needs of the population.

Overview

In recognition of the fact that the occurrence of a PI can easily overwhelm or damage the capability of local mental health resources to meet community needs, the purpose of the Mental Health sub plan is to create the necessary structure and process to enable the DH to support local and regional efforts to meet community, and regional human services needs in a collaborative, organised, effective, and culturally competent manner.

The MH sub plan describes systems that will be implemented to address the psychological consequences of a PI in South Australia (SA). The MH sub plan provides a comprehensive state wide approach to preparedness and pandemic planning for mental health services by providing information to guide regional and local planning groups. The phased planning and response approach prepares responders to be ready with the appropriate actions at the appropriate time.

The planning for mental health interventions assumes that, while everyone will be affected to some extent, some groups are more vulnerable than others. The planning and implementation of mental...
health interventions during an influenza pandemic will consider the special needs and circumstances of particular affected populations. Interventions will be tailored to people ill with influenza, those who have been exposed, first responders, and vulnerable or hard-to-reach populations.

The MH sub plan is designed to promote resilience, unity, and recovery, and to minimise the negative psychological effects of a pandemic on individuals, families, communities, service systems, and the emergency response as a whole.

**Roles and Responsibilities**

At the State level, the emergency response to a PI will be coordinated through the Health and Medical Functional Service.

In the event of a pandemic, the role of the OCP is to convene and coordinate the local response to SA’s MH needs, in collaboration with other agencies. To achieve this, the Chief Psychiatrist will be designated to act as the decision making and policy direction body on mental health matters; operational support; internal and external communication; planning and analysis of incoming data; and administration and financial matters.

The Mental Health sub function of the South Australian Department of Health’s Pandemic Influenza Plan (referred to as Health’s PIP) applies to all victims of the disaster as well as personnel assigned to emergency operations within South Australia. MHS will operate within the established incident command structure.

The MH sub plan is based on a coordination and collaborative approach among all stakeholders as they work together to ensure continuation of their mission critical business and support of the pandemic response.

At the regional and local level, regional health services and other organisations are, in consultation with the appropriate stakeholders, responsible for developing their own specific pandemic influenza plans.

**Challenges**

**Community Emergency Response**

An influenza pandemic will constitute a health emergency in South Australia. Typically, emergencies have been perceived as disasters (e.g. plane crashes, bushfires, cyclones, floods, or other phenomena) that may last hours or days. They may result in many casualties creating a onetime demand on health services.

A health emergency such as a PI however, can be expected to be prolonged with two or more successive waves creating multiple demands on multiple sectors. The resulting impact on human resource infrastructure can potentially be staggering. Addressing MH needs will help the public cope in a pandemic, supporting the effective implementation of medical and non-medical public health measures.

It is the intent of the MH sub plan that organisations responsible for providing essential MH services plan for operations during the pandemic period.
Special Needs Populations

Comprehensive pandemic influenza planning must prepare for the mental health concerns of populations with special needs. MHS will help ensure that tailored services are provided to the greatest extent possible to these vulnerable populations. Groups with special needs may include:

- children, adolescents, and the elderly;
- people with mental or physical disabilities, including:
  - those who live in long-term-care facilities;
  - those who depend on outpatient services;
- individuals living in congregate settings, including:
  - students;
  - prisoners;
- people in inpatient health care facilities;
- people who live in nursing homes and other long-term care facilities, such as homeless shelters;
- hard to reach populations, including:
  - Indigenous communities;
  - homeless not utilising shelters;
  - homebound;
  - immigrants;
- individuals with special language needs; and
- community groups with special cultural needs.

Assumptions

Human Impact

The effects of natural disasters and other public health threats and emergencies can place enormous stress on the coping abilities of even the healthiest people, be they victims, survivors, family members, emergency responders, community leaders, or public officials.

The need for an understanding and “normalisation” of ordinary human reactions to these extraordinary events is not widely understood, but it is of great importance in meeting the needs and respecting the dignity of people in crisis. Many people who need help in coping with this stress may not seek or accept help if it is presented in terms of “mental health services” or “substance abuse services,” for fear of the stigma associated with the conditions that those services are traditionally designed to treat.

In a large-scale public health emergency, both the emergency and the response process itself can engender chaos and confusion, destabilising survivors and crisis workers alike. Disaster situations may also leave some survivors with long-term stress disorders and other mental illnesses, in numbers that the pre- and post-crisis health services are not equipped to address.

- For people with pre-existing mental illness, substance use disorders, disabilities, or higher levels of vulnerability to emotional stress (e.g. children, older adults), crisis situations can bring about psychological and/or behavioural symptoms that are both painful to the individual and disruptive to the crisis response process.
The medical stability, survival, and dignity of people with pre-existing mental, developmental, and substance-related illnesses and disabilities are also jeopardised when emergency conditions disrupt their patterns of care. In addition, older adults and people who require significant health care support can be greatly affected.

In public health threats involving the spread of communicable disease, people can experience considerable stress whether or not they have been exposed to the agents, because of the “invisible” nature of these microscopic threats. The fear that can take place in some public health emergencies (e.g. those involving infectious agents and quarantine procedures) can also create isolation and dismantle the sense of community that is so essential to mental health and resiliency.

The pre-incident mental well-being and resilience of individuals, families, and communities is perhaps the strongest factor in mitigating the psychological impact of public health threats and emergencies. Recovery of individuals in a community will not be complete until the resiliency and cohesiveness of the community itself is restored, a process that can take several years.

A number of factors play a significant role in mitigating the effects of disasters and other public health threats and emergencies, including:

- planning, preparedness and response efforts designed to promote community resilience and unity;
- normalisation of disaster-related stress reactions and the presentation of programs and services in non-labelling, non-stigmatising terms;
- well planned and coordinated responses to the special needs of people with mental illness, substance use disorders, disabilities (including visual and hearing impairment), age-related challenges, language or cultural barriers, those who live in congregate settings, hard-to-reach populations, such as the homeless and the homebound, etc.

In coordination with the individual, local or regional plan, responders may collaborate in providing the local human services response, including disaster crisis counselling, stress management, problem-solving, logistical support, screening and referral, and other forms of human service assistance, as needed and appropriate.

Health, Emergency and Community Workers

Individuals psychologically impacted upon often include those involved in treating the physical casualties. In fact, disaster responders, including medical personnel, are a high-risk group for developing trauma-related disorders. Certain members of the workforce (e.g. healthcare workers) may be at increased risk of infection.

Those workers at increased risk of infection are an especially vulnerable group due to a real or perceived increased risk of becoming infected themselves, and/or transmitting infection to their friends and families. In addition to assuring access to personal protective equipment, vaccination (when available) and prophylactic treatments for first responders and frontline health care workers, organisations need to direct attention to mitigating the stress-related psychological effects of disaster response on these individuals.

Impact on Mental Health Services

Mental health is a key component in the essential services response to a pandemic.

During a pandemic there may be an increase in demand on mental health services, as well as for appropriate locations and adequate equipment to facilitate the provision of care.

Acute and community mental health services require plans that will address what will be done if the health care system is becoming overwhelmed. Care will need to be provided by persons, both health
care workers and volunteers, doing work which is not normally part of their daily activities, and potentially in settings not usually used for mental health care provision.

Issues to be considered during planning:

> a substantial proportion of the workforce will not be able to work for some period of time due to personal illness or ill family members;
> service capacity is likely to be already limited and could be further challenged;
> care protocols may change and standards of practice for “normal” operating conditions may need to be adapted to meet emergency needs;
> essential services in communities may be disrupted;
> widespread illness in the community could increase the likelihood of sudden and potentially significant shortages of personnel in other sectors who provide critical public safety services (e.g. police, fire, etc.);
> a clear understanding of the roles and responsibilities of the various responders is required; and
> effective and streamlined communication processes will be required at the local, state and federal levels.

**Communications**

Communication is an integral part of all emergency planning responses. Communication serves as a vehicle to ensure that appropriate messages and information reaches the appropriate target groups.

The communication goals of this plan include:

> effective distribution of information, i.e. information packages to the health community, response agencies, the media and the public (public communication);
> rapid transfer of information (from local, to regional, to state levels and vice versa) and updates (internal communication); and
> creating the ability to assimilate rapid information such as illness, adverse events etc. (internal communication).

**Internal Communications**

Effective internal communications provides the backbone for a coordinated mental health response during a PI. A wide range of stakeholders will need to share accurate, timely and consistent information relating to service delivery at each stage of a pandemic.

Internal stakeholders involved in information sharing could include:

> government departments;
> non-government agencies;
> health care professionals;
> infectious disease experts;
> regional health services; and
> the network of SA Health Emergency Management.
Public Communications

The Department of Health has developed a Public Information Communications Plan. DH Communications Plan will link with the SA Health communications plan and will be consistent with the overarching principles of the Commonwealth Department of Health and Ageing Communications Plan.

The key mental health messages in the PI Communications Plan are promoting community and self-resilience and managing psychosocial distress.
Response Stage

This section addresses activities that occur in the different stages of the Pandemic.

It is expected that an influenza pandemic will occur in the stages listed below. In actual practice, the distinction between the various phases of pandemic influenza may be blurred or occur in a matter of hours, underscoring the need for flexibility.

Preparation Stage

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<thead>
<tr>
<th>Planning Element</th>
<th>Responsibility</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td><strong>Strategic</strong></td>
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<tr>
<td>Develop partnerships for collaboration (federal, state, and local).</td>
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<td>Identify major gaps in current ability to effectively respond to an influenza pandemic. Explore possible avenues for addressing and resolving gaps.</td>
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<tr>
<td>Facilitate and support regional PI planning efforts, including review of plans in relation to MHS provision during a PI.</td>
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<tr>
<td>Identify private and public sector responding partners in the planning process. Foster coordination and participation among private and public sector partners in the planning process.</td>
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<tr>
<td>Monitor and evaluate selected groups to maintain up-to-date information on SA’s MH disaster response capacity and capability, including:</td>
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<tr>
<td>&gt; monitor and evaluate MHS’ readiness to respond to the MH needs generated by disasters, including influenza pandemic</td>
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<tr>
<td>&gt; survey and monitor the response capacity of MH responders</td>
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<tr>
<td>&gt; monitor other agencies active in disaster MH response.</td>
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<tr>
<td>As appropriate, monitor the extended health care provider community’s (e.g. primary health care providers) readiness to adequately respond to the MH needs generated by a PI.</td>
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## Mental Health Pandemic sub plan 10

### PREPAREDNESS STAGE

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<tr>
<th>Planning Element</th>
<th>Responsibility</th>
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<tr>
<td><strong>Populations with Special Needs</strong></td>
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<tr>
<td>Ensure planning and activities to meet the demand for expanded MH services tailored for populations with special needs include:</td>
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<tr>
<td>➢ considering the specific MH needs of vulnerable populations in all pandemic influenza MH planning and response;</td>
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<td>➢ educating health and MH care providers about vulnerable populations, their special needs during pandemic influenza and the providers' role in addressing those needs;</td>
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<td>➢ providing MH specific needs assessment of vulnerable populations;</td>
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<td>➢ developing need-specific web-based and public health education material;</td>
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<td>➢ providing support and consultation to agencies regarding MH services to vulnerable populations;</td>
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<tr>
<td>➢ collaborating with community and faith-based organisations to ensure that MH planning, preparedness, and response is culturally appropriate.</td>
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<tr>
<td><strong>Maintenance of Services</strong></td>
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<tr>
<td>Develop guidelines for prioritising MH care needs and service delivery, accessing resources, and implementing infection control measures during a pandemic.</td>
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<tr>
<td><strong>Communications</strong></td>
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<tr>
<td>Develop key messages, strategies and guidelines for Department of Health (DH) and SA Health communications through all pandemic stages.</td>
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<tr>
<td>Increase awareness of potential mental health implications of an influenza pandemic:</td>
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<tr>
<td>➢ with the assistance of the DHA Communications Department, identify and develop pandemic influenza-specific educational tools and materials regarding the signs of distress, traumatic grief, coping strategies, and building and sustaining personal and community resilience;</td>
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<tr>
<td>➢ maintain an updated Web page containing information about pandemic influenza-related MH issues.</td>
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<tr>
<td>Develop a system for rapid activation of interagency communication for MH assessment and resource mobilisation.</td>
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<tr>
<td>Involvement of key MH management and clinical staff in inter-agency, whole-of-government workshops, ‘table-top’ scenarios and exercises to develop and test response plans and capacities at State, Area and local levels. Active involvement of the media in these exercises and the establishment of media contacts to support the provision of routine health information regarding influenza.</td>
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**Education & Training**

| Provide information and educational materials about psychosocial health during a PI to health care providers: |                |           |           |
| > educate MH professionals (social workers, psychologists, psychiatrists, and mental health nurses) about the importance of self-care, and prepare them to provide adequate psychological support to patients and hospital staff during stressful circumstances. |                |           |           |

| Ensure that individuals who are not MH professionals (e.g. GPs, general health professionals, emergency workers, community leaders, leaders of faith based organisations, educators, etc.) but who may be expected to provide psychological support during a pandemic are well informed, well educated, and well trained in: |                |           |           |
| > anticipation of the range of potential psychosocial effects that might occur in the phases of Pandemic Influenza; |                |           |           |
| > recognition of the signs and symptoms of mental illness; substance use disorders; and the full range of disaster-related conditions, including shock, panic, trauma, grief, depression, and acute and chronic post-traumatic stress disorder; and |                |           |           |
| > effective outreach to communities, families, and individuals, including the use of non-stigmatising terminology and the normalisation of common reactions to disaster, threat, and emergency conditions. |                |           |           |
Local Health Network Planning (LHN) Planning

Local Health Networks (LHNs) are responsible for developing contingency plans (inclusive of a Business Continuity Plan) for the delivery of health services in the event of a pandemic. This planning should be in conjunction with other stakeholders in the community to ensure a coordinated response. Due to the expected demand for services, LHNs are responsible to estimate the potential impact of pandemic influenza by:

- evaluating the ability to cope with increased demand and the existing resources (facilities/capabilities);
- evaluating the ability to operate the service on reduced staffing levels and increased demand for care;
- adopting the infection control guidelines for health care services; and
- considering homeless, vulnerable populations and identifying strategies for delivering care and information to these groups.

Checklist for Regions

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<tr>
<th>Planning Element</th>
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<tr>
<td><strong>Strategic</strong></td>
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<tr>
<td>Identify major gaps in current ability to effectively respond to an influenza</td>
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<tr>
<td>pandemic.</td>
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<td>Explore possible avenues for addressing and resolving gaps.</td>
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<td>Participate in LHN PI Steering Committees.</td>
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<td>Estimate pandemic needs.</td>
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<td>Identify additional and alternative care locations and resources</td>
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<td>Identify strategies to ensure adequate human resources.</td>
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<td>Identify strategies to ensure adequate material resources.</td>
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<td>Prepare comprehensive plans with reasonable contingencies that anticipate</td>
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<td>sustained high volume health care needs.</td>
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<tr>
<td><strong>Maintenance of Services</strong></td>
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<tr>
<td>Adopt infection control guidelines in terms of their relevance to mental health services.</td>
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<td>Prepare to implement established pandemic guidelines.</td>
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<td>Assess clinical capacity.</td>
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<td>Plan for triage.</td>
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<td>Develop contingency plans for existing Mental Health clients re ongoing care.</td>
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<td><strong>Communications</strong></td>
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<tr>
<td>Develop MHU/local communications networks.</td>
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<td>Define communications roles and responsibilities.</td>
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<tr>
<td>Develop regional communication strategies. Prepare to communicate DH messaging in regional context.</td>
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Business Continuity Planning considerations

Standby Stage

During the pandemic standby period, a dramatic increase in news coverage of global influenza will be expected. The psychological effects of the increased media coverage, as well as of the public health measures introduced, may require the limited, situation-appropriate activation of the MH sub plan.

Psychological issues requiring MH intervention during this phase may include:

- increased, but not excessive, levels of the general publics’ and individuals’ anxiety;
- increased, but not overwhelming, health care-seeking behaviour;
- stigmatisation of the sick and those assumed to have been exposed;
- psychological support of suspected cases placed in isolation and quarantine;
- psychological support of those caring for the sick, including health care providers and family members.

Potential Stage-Specific Activities

Strategic

- Enhanced monitoring and frequent meetings of responsible committees.
- Formal enactment of operational plans.
- Address MH issues associated with individual and community containment measures:
  - MHS will ensure the provision of immediate and ongoing psychological support to alleviate the stress associated with isolation, quarantine and/or social distancing.
  - Activating the system for interagency collaboration to assess MH needs and mobilise resources.
- Assessing MH needs specific to community containment measures by:
  - assessing the psychological needs of people and their family members in isolation and quarantine, and determining the extent and type of MH support they need;
  - assessing the psychological well-being and functioning of caretakers working with patients in isolation and quarantine to determine their need for MH support;
  - assessing the MH needs of populations affected by isolation and quarantine; and
  - assessing the MH needs resulting from community control and containment measures, such as cancelled public events and school closures.

Maintenance of Services

Implementation of clinical/organisational management plans including:

- management of the interface between primary care and hospital Emergency Departments:
- initial surge;
- outpatient triaging and psychosocial support;
- implementation of psychosocial support programs for emergency / health personnel with fatigue and exposure to potentially traumatising events;
- assist agencies caring for the sick and those quarantined;
- mobilising and deploying MH responders (with due consideration of the risks of infection);
- assist MH contracted agencies;
as appropriate, mobilise volunteer agencies to provide MH support;
> support and triaging of clients with pre-existing mental health presentations or exacerbations;
> implement contingency plans for existing mental health clients and new clients;
> ensure that a mechanism exists for psychological assessment at the end of the isolation/quarantine and, if needed, that referral to additional MH support is available.

Communications
Providing MH information specific to community containment measures, such as:
> common psychological reactions to isolation and quarantine, and tips for coping;
> how and where to obtain professional MH and other assistance;
> identifying, developing, and distributing tools to prevent stigmatisation;
> establish public enquiry contact numbers and media lines;
> distribute and if needed, develop new informational materials that appropriately reflect the current situation to educate the public about MH issues. This may include updating Web sites, distributing leaflets and brochures;
> identify translation resources for addressing the psychological consequences of the pandemic in a culturally appropriate manner;
> consideration of the needs of special groups and implementation of planned interventions (e.g. cultural and linguistically diverse groups (CALD), indigenous communities etc.).

Response Stage

Phase-Specific Mental Health Planning Principles and Assumptions
MH needs during this stage may exceed available resources, requiring prioritisation in distribution.

Given limited supplies and prioritisation of treatment with antiviral drugs, and with vaccine not likely to be available for 6 to 9 months after a pandemic strain is identified, stress levels are expected to be high, potentially undermining public trust and cooperation.

If establishing Community Flu Clinics (CFC) becomes necessary, considerable psychological and physical stress can be expected among visitors and staff. MHS will assess, monitor, and address the MH needs at CFC by mobilising its MH first responders, and by close collaboration with the local service providers.

Isolation, quarantine and social distancing, whether voluntary or involuntary, and whether in hospitals, single homes, or entire neighbourhoods, can have a significant effect on psychological well-being.

In mass fatality situations due to pandemic influenza, individuals may have to face, in addition to personal loss, restrictions that limit their freedom to mourn for and bury their dead in a timely fashion according to their cultural/religious beliefs. MHS will lead the effort to provide appropriate and culturally-sensitive MH support to individuals and their communities.

Potential Phase-Specific Activities

Strategic
> As needed, the MHU will monitor and support the provision of MH services at sites caring for influenza patients, including hospitals, community-based primary care centres, and temporary health care facilities.
> Collaborating with MH RHS as per Business Continuity Plans by:
> maintaining communication with RHS and individual hospitals and hospital networks to obtain updates on functionality of services and capacity to provide MH services; and
> obtaining regional reports on surge capacity and working with services to ensure that underutilised MH staff are relocated to services experiencing surge.
> Identify state resources if the estimated need for MH support is greater than locally available resources.
> Support the effective operation of Influenza Clinics by providing MH support, including:
> assessing specific needs for MH support; and
> mobilising and deploying MH responders.
> Address psychological consequences in the event of mass fatalities:
> communicate with SAPOL and the Coroner's Office to determine the extent and type of MH needs generated by mass fatalities, and the actions required to address those needs; and
> if required, mobilize MH staff to accompany staff for death notifications when death occurs outside of a hospital setting.
> Support the MH needs of communities:
> assess unmet needs; and
> develop strategies to support communities to meet those needs.

Maintenance of Services
> Provide MH support at health care sites.
> Support hospitals’ efforts to address the MH needs of those in isolation and those caring for them.
> Mobilise and deploy MH responders and identify additional MH response resources as required.
> Address psychological needs in the event of mass vaccination.

Communications
> Assisting health care providers, through increased public education, to reduce anxiety-induced health care-seeking behaviour.
> Educating health and MH care providers about patients’ and their own psychological needs and how to address them.
> Support the general risk communication effort by providing MH-specific information in close collaboration with the DH Communications Division.
> Prepare and distribute appropriate psychological support information.
> Maintain an updated Web page.
> Support vaccination specific risk communication by preparing and providing information and tip sheets (both online and on-site) about the psychological effects of mass prophylaxis, including:
> normal and abnormal stress reactions, coping and self-care tips;
> for groups with special needs; and
> where and how to seek professional help and assistance.

Second or Subsequent Waves
> Continue all activities listed under the response stage.
> Review, evaluate and modify as needed, the local pandemic response.
Monitor MH resources and staffing needs.

Post-pandemic period

- Assess state and local MH service capacity to resume ‘normal’ behavioural health functions.
- Assess fiscal impact of pandemic response on MH resources.
- Modify the pandemic influenza response and contingency plans based on lessons learned.

Operationalisation and Recovery

- Continue to develop and modify PI Plans as new information becomes available. During the pandemic, ongoing evaluation of the response will occur to determine if any changes need to be made so PI plans can be adapted and refined as required.

The Recovery Phase will involve:

- deactivating the response activities;
- reviewing their impacts; and
- using the lessons learned to guide future planning.