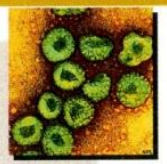
Cross-Border Psychosocial Considerations Before, During and Following a Communicable Disease Outbreak

Jason P. Madrano, BSN, RN, Randal D. Beaton, PhD, EMT, Robin Cox, PhD, Meredith Li-Vollmer, PhD, Mark Oberle, MD, MPH

Proposed Policies Addressing Psychosocial Issues in an Infectious Disease Outbreak or Pandemic



1. Mental health considerations need to be **included** as a component of preparedness for, response to and recovery from an infectious disease outbreak and pandemic affecting the Pacific Northwest
2. Public health and emergency management authorities and personnel in Washington State and British Columbia need to **collaborate and coordinate** their mental health planning for every stage of an infectious disease hazard affecting the region
3. Special planning needs to be undertaken to ensure that the mental health needs of **health care workers and other vulnerable populations** in an infectious disease outbreak and pandemic are addressed.
4. **Innovative and best practice** approaches to meeting the mental health needs of the general public and vulnerable populations in response to infectious disease hazards need to be identified, adopted and mounted for all stages of a communicable disease outbreak and pandemic.
5. Agencies need to provide **consistent and congruent guidance** regarding measures to be employed during each stage of an infectious disease outbreak or pandemic such as priority groups for available vaccines, school closures and infection control in healthcare settings.
6. Authorities in Canada and the USA should adopt the same policies and protocols regarding **cross-border travel and screenings** of citizens entering or leaving either country.
7. Authorities should collaborate to identify in advance evidence-informed mental health interventions that address the psychosocial support needs of groups for each phase of an infectious disease outbreak. Development of **parallel systems** to deliver needed care should be simultaneously undertaken and should include less conventional methods of service delivery (e.g., internet counseling, social media supported peer-to-peer and group support).

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Innovative Mental Health Treatment During a Communicable Disease Outbreak or Pandemic

1. Accessible **educational multimedia** addressing a variety of mental health topics. These multimedia could include webinars, facebook pages, and other social media, in addition to traditional media outlets. As well, it is important to place an emphasis on culturally-appropriate content, and provide media in a variety of languages.
2. Following an outbreak in a particular community, **counseling** can safely be provided by telephone, text messaging, or via the internet with instant messaging and email chat, in addition to traditional face-to-face counseling.
3. **Social media** such as Facebook and Twitter could serve as forums for group discussions and provide social support for various segmented and potentially isolated populations.
4. **Crisis lines**, while not necessarily innovative, should be made widely available to the public, and especially tailored to provide specialized support and information to front line workers. These lines could be provided via text messaging, social media, and traditional telephone.
5. Targeted mental health treatment **protocols** and approaches need to be developed for special at risk groups including health care providers and those potentially quarantined during an outbreak or pandemic. Exemplar: North York General Hospital developed a SARS Psychological Team including social workers, psychiatric crises nurses, psychiatrists and infectious disease specialists (Loutfy, 2004).

Risk Communication for a Communicable Disease Outbreak or Pandemic

BEFORE:
1. Establish communication **roles** - agencies should discuss what communications they will be responsible for in case of emergencies.
2. Determine order of **notification** - agencies should discuss priority and order of notifications in case of emergencies.
3. **Template** for initial information release - agencies should use the same policies and protocol for the initial release of information to the public.

DURING:
1. **Consistency** of message- Establish a Joint Information System to share and coordinate information between US & Canadian entities.
2. **Timeliness**- Proactive about announcing information
3. **Openness**- maintain transparency in communications and include contact info for all public information officers (PIOs) and potential spokespeople
4. **Acknowledge** emotions - commiserate with public about pandemic
5. **Two-way** communication - encourage social networking and flow of information between agencies and public.

Psychosocial Lessons from SARS and H1N1 Research Investigations

SARS

In 2003, more than 8000 individuals were affected by the SARS pandemic worldwide, resulting in 774 deaths. Approximately one-third to one-half of those experiencing SARS-related mortality and morbidity were **healthcare workers**. In addition to the physical symptoms and after-effects of SARS, SARS took a toll on the psychological well-being of survivors. (Mak et al, 2009a). At the very least, hospital staff were affected by not unreasonable fears of contracting and transmitting this novel disease; and SARS patients experienced stress due to their isolation, fear of dying as well as other adverse mental health outcomes. (Loutfy, 2004). Many health care workers including physicians and nurses were emotionally **traumatized** during the SARS outbreak with reported PTSD rates of 20% for health care workers two months following the outbreak at one affected hospital in Hong Kong (Chan and Huak, 2004). Another published study examined the psychosocial effects of SARS on hospital staff in a large tertiary care institution in Toronto. (Nickell et al, 2004). This study found that two-thirds of hospital staff responding reported SAR-related concern for their own or their family's health.

Another issue that surfaced during the SARS outbreak was that of **stigmatization**. Stigma can be defined as an attribute linking a person to a set of undesirable characteristics that may lead to prejudice and discrimination. Infectious diseases such as HIV/AIDS, TB and SARS are considered stigmatizing. Stigma causes psychological suffering in affected individuals and families and, in the case of stigmatizing diseases, may delay treatment seeking. Perceptions of stigma associated with SARS was documented to persist for at least several years following the outbreak in Hong Kong (Lam et al, 2009; Mak et al, 2009b; Siu, 2008)

H1N1

In 2009, H1N1 became a global influenza pandemic within a few months after emerging. One result of this novel infectious outbreak was the widespread **fear** that it caused in those populations affected. For example, a study of Malaysian citizens in the Summer of 2009 reported that nearly three-fourths (73.2%) reported that they were either fearful or slightly fearful (Wong and Sam, 2011). They concluded that reported fear levels predicted health protective and avoidance **behaviors** in their sample (n=1,050).

Another lesson from the H1N1 pandemic is the difficulty in **predicting** what groups will be affected. For example, the H1N1 virus primarily affected children, young adults and pregnant women, especially those with an underlying lung or cardiac disease condition. This has implications for **targeted** psychosocial interventions. (Murray, 2009).

Additional lessons learned from the H1N1 outbreak include the need for improved two-way information sharing between front-line service providers and policy makers, and the importance of public engagement in policy and planning.

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