Incorporating Mental Health into Pandemic Flu Preparedness and Response

While there have been relatively few large outbreaks to inform an appropriate response to a potential flu pandemic, the existing data on infectious disease outbreaks, data from natural disasters and public mental health principles can be brought to bear on the development of such a response. Public mental health measures must address numerous areas of potential distress, health risk behaviors, and psychiatric disease. In anticipation of significant disruption and loss, promoting health protective behaviors and health response behaviors will be imperative. Areas of special attention include: (1) the role of risk communication; (2) the role of safety communication through public/private collaboration; (3) psychological, emotional, and behavioral responses to public education, public health surveillance and early detection efforts; (4) preventing and responding to panic (5) psychological responses to community containment strategies (quarantine, movement restrictions, school/work/other community closures); (6) health care service surge and continuity; and (7) responses to mass prophylaxis strategies using vaccines and antiviral medication. Attention needs to be focused both on global-level and community issues, such as the possibility of panic and other crowd or mob mentalities and reactions, and personal health related issues that focus on individuals.

Therefore, APHA recommends that:

1. Leadership preparation activities be carried out, including ensuring that public officials understand which members of the population will be most vulnerable and who will need the highest level of health services, including mental health services.
2. Community leaders, spokespersons, and natural emergent leaders be identified who can affect community and individual behaviors and who can endorse and model protective health behaviors.
3. Uncomplicated, empathically informed information on normal stress reactions be disseminated widely, which can serve to normalize reactions and emphasize hope, resilience, and natural recovery.
4. The public be informed about the rationale and mechanism for distribution of limited supplies (e.g., Tamiflu).
5. Community rituals (e.g. speeches, memorial services, funerals, collection campaigns, television specials) be used as important tools for managing the community-wide distress and loss and coping with such situations as deaths of important or particularly vulnerable individuals (e.g., children), new unexpected and unknown risk factors and shortages of treatments.
6. Federal, state and local public health partners plan at societal, local and individual levels for the psychological and behavioral responses of the health demand surge, the community responses to shortages, and the early behavioral interventions after identification of the pandemic, and especially during the time frame prior to availability of vaccines.
7. A sense of community be maintained to manage community and organizational distress and untoward behaviors, especially as in-person social supports may be hampered by the need to limit movement or contact due to concerns of contagion. Virtual contact — via Web, telephone, television, and radio — will be particularly important at these times.
8. Officials plan for mass fatality and management of bodies, as well as the community responses to such situations and activities, including taking into consideration various religious rituals of burial and disseminating public health announcements addressing (if known) how long the virus remains in the corpse and what should be done with the bodies.
9. Good safety communication be disseminated, as promoting clear, simple and easy-to-do measures can be effective in helping individuals protect themselves and their families.
10. Care for first responders be provided to maintain their function and workplace presence, including providing assistance to ensure the safety and care of their families.
11. Mental health surveillance, at both the societal and individual level, be conducted in tandem with disease surveillance. Such surveillance should address PTSD, depression and altered substance use, psychosocial needs (e.g. housing, transportation, schools, employment), and loss of critical infrastructure necessary to sustaining community function or which might foster panic.