Principles for designing and delivering psychosocial and mental healthcare

Richard Williams,1 V Kemp2

ABSTRACT
The development of the UK’s military policy includes the potential for military organisations to deploy in support of humanitarian aid operations. This paper offers an overview of the risks to people’s mental health of their exposure to emergencies, major incidents, disasters, terrorism, displacement, postconflict environments in which humanitarian aid is delivered, and deployments to conflict zones. It summarises the psychosocial approach recommended by many contemporary researchers and practitioners. It differentiates the extremely common experience of distress from the mental disorders that people who are affected may develop and introduces the construct of psychosocial resilience. The authors recognise the importance of trajectories of response in separating people who are distressed and require psychosocial care from those who require mental healthcare. Finally, this paper summarises a strategic approach to designing, planning and providing psychosocial and mental healthcare, provides a model of care and outlines the principles for early psychosocial interventions that do not require training in mental healthcare to deliver them.

INTRODUCTION
The context
The development of the UK’s military policy includes the potential for military organisations to deploy in support of humanitarian aid operations. As part of this, the Defence Medical Services (DMS) are required to prepare and train to respond to the psychosocial and mental health impacts of all kinds of emergencies, major incidents, disasters and postconflict environments in the province of humanitarian aid, and deployments to conflict (shortened to emergencies hereafter). This requires the DMS to prepare for serious communicable illnesses, natural disasters, care of refugees, terrorist events and assaults on aid projects. Plans, and the services required to deliver them, should be integrated into wider arrangements for mounting emergency responses to events that require humanitarian relief.

Work to research how best to facilitate people’s psychosocial recovery following emergencies and military mobilisation is continuing. But, some historical developments continue to influence current practice, including the proximity, immediacy and expectancy approach adopted by the military.1 The principles that are informed by evidence and experience are covered in a paper provided by the The Royal College of Psychiatrists,2 and in other pertinent publications.1–3

As the military engages in support for humanitarian aid, the requirements of other governmental and societal organisations impact on doctrine. Priority 4 of the Sendai Framework for Disaster Risk Education 2015–2030, for example, calls on states “To enhance recovery schemes to provide psychosocial support and mental health services for all people in need.”

The psychosocial approach
The authors have adopted the North Atlantic Treaty Organization’s (NATO) approach that recognises people’s psychosocial experiences and needs and differentiates them from their needs for mental healthcare.7 The adjective ‘psychosocial’ refers to the emotional, cognitive, social and physical experiences of people in the context of particular social, cultural and physical environments. Mental healthcare refers to delivering biomedical interventions from which people with disorders may benefit. This approach, informed by Patel,8 describes the following:

► It distinguishes people who are distressed from those who require biomedical interventions.
► It bases distinctions between the two sorts of conditions on trajectories of people’s stress levels and dysfunction.
► It commends providing assistance for the greater number of distressed people through lower intensity psychosocial care.

HOW PEOPLE BEHAVE DURING AND AFTER EMERGENCIES
Understanding how people behave and their psychosocial and mental health needs before,
Review

Table 1 Indicators of distress

<table>
<thead>
<tr>
<th>Emotional experiences</th>
<th>Cognitive experiences</th>
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<tbody>
<tr>
<td>Numbness</td>
<td>Impaired memory</td>
</tr>
<tr>
<td>Fear and anxiety</td>
<td>Impaired concentration</td>
</tr>
<tr>
<td>Helplessness and/or hopelessness</td>
<td>Confusion or disorientation</td>
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<tr>
<td>Fear of recurrence</td>
<td>Invasive thoughts</td>
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<tr>
<td>Guilt</td>
<td>Dissociation or denial</td>
</tr>
<tr>
<td>Anger</td>
<td>Reduced confidence or self-esteem</td>
</tr>
<tr>
<td>Anhedonia</td>
<td>Hypervigilance</td>
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<table>
<thead>
<tr>
<th>Social experiences</th>
<th>Physical experiences</th>
</tr>
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<tbody>
<tr>
<td>Regression</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Hyperarousal</td>
</tr>
<tr>
<td>Irritability</td>
<td>Headaches</td>
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<tr>
<td>Intercpersonal conflict</td>
<td>Somatic complaints</td>
</tr>
<tr>
<td>Avoidance</td>
<td>Reduced appetite</td>
</tr>
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<td></td>
<td>Reduced energy</td>
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During and after emergencies is crucial to planning and delivering responses. There is a broad spectrum of ways in which people who are directly or indirectly involved react emotionally, cognitively, socially, behaviourally and physically. Their reactions have many influences including their: genetics; epigenetics; experience of stress; past experiences and health; relationships, group and team memberships; support; and effective leadership.

Primary and secondary stressors

Primary stressors arise directly from untoward events. People who are affected directly or indirectly by emergencies, and their relatives, are highly likely to suffer distress. Secondary stressors are events, circumstances or policies that are not inherent in events, which include failure of infrastructure recovery, gaps in services, failures in rebuilding and problems with insurance. Often, they persist for longer than the emergencies.

Indicators of distress in the immediate aftermath

Table 1 summarises the experiences that people may have in the immediate aftermath of disasters. Distressed people have a mix of some of them.

Distress shortly after emergencies is very common. In most cases, it is transient and not associated with dysfunction. Distress that is more severe, more disrupting or associated with mild limitations of function may be called acute stress or post-traumatic stress. The latter should be differentiated from post-traumatic stress disorder (PTSD), which consists of a particular constellation of symptoms that may persist, or worsen into the medium and long term. Box 1 summarises the potential impacts of emergencies on people’s psychosocial needs and mental health.

The proportion of people who require supporting interventions to assist them to cope with distress consequent on emergencies is large despite the majority not being likely to develop a mental disorder. Many may be psychosocially resilient despite their distress, but, intervening early can reduce the risks of their developing disorders later. While evidence is limited, the majority of people affected by disasters may benefit from lower level psychosocial care. Before diagnosis, consideration should be given as to whether or not sufferers of persisting stress, which lasts more than several weeks or is more incapacitating, are experiencing secondary stressors that are sustaining their distress.

Most people do not require access to specialist mental healthcare, but a substantial minority might. Displaced people, children and survivors of terrorist attacks are at particular risk.\(^{11,12}\) A small proportion of affected persons requires long-term mental health services in response to their needs. Therefore, a proportion of survivors thought to be at particular risk require assessment and monitoring over time.

Psychosocial resilience

Most people cope well and recover after emergencies if social support from relatives, friends and colleagues is available. While the general term ‘resilience’ is used universally and, often, without definition, there is increasing evidence about the term ‘psychosocial resilience’. This term describes how people, groups of people and communities may return to effective functioning, given adequate social support, after becoming distressed by emergencies and adversity.\(^{11}\) Williams and Kemp\(^1\) warn the following:

Psychosocial resilience is not a synonym for resistance to the impact of events, absence of short-term distress after untoward events, or
Psychosocial resilience is an interactive, dynamic concept that describes interpersonal processes and the attributes of people by which they act singly and/or together to mitigate, moderate and recover from the effects of stressful events through exercising adaptive capabilities. Norris et al define it as ‘a process linking a set of adaptive capacities to a positive trajectory of functioning and adaptation after a disturbance.’ The adaptive capacities that enable psychosocial resilience are genetic, psychological, social and environmental in origin. While resilience is common, it should not be assumed.

Trajectories of people’s responses

‘The trajectory of people’s stress and dysfunction over time is an important feature of their reactions to threats or adversity. Several recent research studies show differing patterns of how people respond over time.’4 Table 2 summarises broad patterns.4 15

These generalisations suggest that the severity of stress and dysfunction that people experience in the period before and after events and how they progress over time are ways of separating people who should be offered lower level psychosocial interventions alone from those who also require specialist mental healthcare.

Risk factors

Williams and Kemp state the following in terms of risk factors:

The differences in how people respond to disasters are influenced by their: personal characteristics; developmental and life experiences; training; family, team and group memberships; and the leadership and social support they are offered. People who are at greater increased risk of dysfunctional distress and social and mental health problems following disasters include: women; children and adolescents; older people; people who have pre-existing health problems and disorders; socially disadvantaged people and staff of rescue and responding services.

Williams and Kemp also summarise people’s circumstances and experiences that place them at greater risk of developing a mental disorder. They include people who:

► perceive they have experienced high threats to their lives;
► are physically injured;
► face circumstances of low controllability and predictability;
► live with the possibility that disaster might recur;
► experience disproportionate distress;
► experience multiple losses of relatives, friends, colleagues and property;
► were exposed to dead bodies and grotesque scenes;
► endure higher degrees of community destruction;
► perceive that they have limited social support;
► have been displaced;
► were previously exposed to a major traumatic event;
► have had a mental disorder previously.

The implications for the military supporting humanitarian operations

Knowledge of how people cope with emergencies and military deployments identifies the importance of their relationships, leadership and social care, and this should inform all plans.13 16 17 This evidence-informed knowledge gives rise to the five key messages for military organisations that deploy to conflicts and also in support of humanitarian aid operations, which appear at the head of this paper.

The recommended approach is to provide briefings as a component of psychosocial care that is intended to prepare people before disasters strike, and then support their coping in the immediate aftermath of events and through their medium-term recovery. Support also endeavours to prevent people from developing serious mental disorders. While a number of early interventions lack evidence of effect, there is some evidence that high levels of perception of social support are protective and associated with lower rates of PTSD.10 13 Despite best endeavours, a minority of people are at risk of developing new mental disorders and more may experience exacerbations of previous disorders. People in these groups require timely mental healthcare.

A STRATEGIC FRAMEWORK

‘Disasters test civil administrations’ and health services’ capacity to act in a flexible but well-coordinated manner because each disaster is unique and poses unusual challenges.19 Each disaster poses particular challenges requiring customised responses to best meet people’s needs. The humanitarian and health responses required differ according to: the nature of each emergency; communities’ infrastructures; the cultures and geographical spread of people who are affected; and the resources available to provincial and national communities.

A generic approach to delivering psychosocial and mental health responses to emergencies enables the responsible agencies to develop, train and test responses and engage with communities in advance of events. It reduces the time required for preparation when particular events are forecast or arise unpredictably. But, a single plan is unlikely to be best adapted to all emergencies. This paper offers a generic, flexible framework for healthcare strategists and clinicians to use for planning, designing, delivering and evaluating services that meet the psychosocial and mental health needs of people who are affected by emergencies and, importantly, adjust them iteratively. It is consistent with policies of: NATO; countries in Britain; the Inter-Agency Standing Committee; and The European Network for Traumatic Stress (TENTS).7 20–22

The main components of the strategic framework are:

► A knowledge base: Knowledge of how people cope with emergencies and deployment provides the basis for generic planning, training, rehearsal and testing.
► Core principles: Evidence-informed and values-based principles inform planning, designing and delivering the services required.2 23
► Information gathering and evaluation: It is imperative to have health intelligence that offers strategists and clinicians the information they require to adjust generic plans as events evolve.

Table 2: Patterns of trajectories of people’s responses

<table>
<thead>
<tr>
<th>Resilient responses</th>
<th>Deteriorating responses</th>
<th>Initial high stress responses</th>
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<tbody>
<tr>
<td>Depending on the nature of events, around 70% or more people are psychosocially resilient. They suffer distress, usually mild or moderate, that reduces in severity if they receive support they perceive as adequate.</td>
<td>Around 10%–20% of people may experience stress that is initially of low severity, but which becomes more severe and/or associated with dysfunction over time. About half of this group may recover later while others develop chronic problems.</td>
<td>Around 10% of people may have high levels of stress before and immediately after events. The symptoms, signs and dysfunction of about one-half may prove chronic, while others improve.</td>
</tr>
</tbody>
</table>

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A model of care: A model of care enables comprehensive services to be titrated against people’s needs in efficient and effective ways.

Psychosocial and mental healthcare for responders: Responders are exposed to stress either directly or indirectly and require particular consideration.

An integrated emergency management cycle: A management cycle is important to: (A) planning, designing, delivering and adjusting the services that people require; (B) ensuring integration of psychosocial and mental healthcare within the broad spectrum of services.

A strategic, stepped model of care
This model of care is intended to enable planners to link the impacts of events and timeline with the components of psychosocial and mental healthcare that populations and communities require. Table 3 summarises the seven cumulative steps that comprise the model.

IMPLEMENTATION: PRINCIPLES FOR INTERVENING
General principles for early psychosocial intervention
The general principles for psychosocial intervention soon after events include:14,5:
1. Provide early intervention for everyone involved: Early interventions in communities after disasters should consist of social support and community development rather than psychological treatments.
2. Provide practical interventions:
   – in proximity to where people are
   – as soon as possible
   – with expectancy that people will recover
   – as simply as possible.
3. Base interventions on four core principles (developed from Hobfoll et al15):
   – Help people normalise their experiences while being aware that some people develop mental disorders.
   – Enable people by providing social support.
   – Help people restore their agency.
   – Enable people to seek further help.
4. Develop people’s social connectedness and access to social support through:
   – effective leadership
   – restoring families and community groups
   – reopening schools
   – restoring work opportunities.

Psychological first aid
These principles predict core psychosocial interventions in the immediate aftermath that are gathered together within psychological first aid (PFA).25 PFA is not a single intervention but its components are intended to reduce people’s distress in the

| Table 3 | The strategic, seven-step model of community care |
|------------------|----------------------------------|------------------------------|--------------------------|
| **Step** | **Action** | **Nature of action** | **Purpose** | **Timetable** |
| 1 | Strategic planning, mitigation and preparation | Comprehensive multiagency planning, preparation, and training of the full range of service responses are required in advance of events. | Preparedness, prevention, risk communication and mitigation before events occur to prepare services and staff, and reduce risks of distress and mental disorder through developing the resilience of all nature to community | Before events and continuing afterwards |
| 2 | Public prevention programmes to develop communities | Whenever possible, prevention services intended to develop the psychosocial resilience of communities, families and workplaces are planned and delivered in advance. | Universal interventions are offered to everyone affected. | Immediately after events begin and continue thereafter |
| 3 | Universal and selective psychosocial interventions | Families, peers and communities are supported in providing programmes of response to people’s psychosocial needs in the aftermath based on the principles underpinning psychological first aid (PFA) | Universal interventions are offered to everyone affected. | Immediately after events begin and continuing thereafter |
| 4 | Community support and development | Interventions include activities intended to sustain communities, restore their cohesion and develop their abilities to deliver social support through, for example, leadership, and restoring activities in schools and communities. Families and communities should be provided with routes by which they can draw the attention of health and social care services to people in need. | Delivering public welfare, social and public mental healthcare paradigms of response to meet groups and communities’ psychosocial needs as soon as events occur and restore their agency | |
| 5 | Monitoring and signposting for people in need to welfare, health and social care services | Services are established to initiate mental health assessments and monitoring to identify, after the immediate aftermath of events, unmet needs of people whose distress is sustained by secondary stressors and people who need personal assessments in case they have emerging or recurrent mental disorders.21 | Personal health assessment to identify people with unmet needs: | After 4–6 weeks and continuing into the medium and longer terms |
| | | | – whose distress is sustained by secondary stressors; | |
| | | | – who require continuing monitoring; | |
| | | | – who need referral for personalised services and provision of indicated psychosocial interventions or mental healthcare, as appropriate. | |
| 6 | Augmented primary health and social care | Primary health and social care services are augmented in the aftermath and medium term after disasters to provide assessment, monitoring and intervention services for people who do not recover from immediate and short-term distress or develop problems later. | Delivering personalised psychosocial, health and social care paradigms of assessment and interventions for people who need or may need primary mental healthcare or specialist mental healthcare | Medium and longer terms (ie, from 4 weeks) |
| 7 | Specialist mental healthcare | Healthcare strategists should ensure there are routes that are negotiated with and promulgated to primary healthcare, surgical care and education services for people who require specialist mental healthcare to be referred with minimum delay. | | Medium and long terms |
immediate aftermath of disasters and foster adaptive functioning by encouraging them to adapt to the sources of stress. It consists of activities to: promote sense of safety; provide affected people with effective communications, connectedness and reconnect them with family members; ensure they are offered social support; restore their agency (their perceptions of self-efficacy and collective efficacy); and begin restoring communities. PFA is a good vehicle for initiating psychosocial care and its principles should underpin all levels of care.

Practical implications
There is a great deal that family members, colleagues and practitioners can do in the preparedness and response phases to alleviate people’s suffering, accelerate their adaptation and recovery, and endeavour to prevent them from developing mental disorders in the medium and longer terms by offering social support and contributing to community development. The Royal College of Psychiatrists Occasional Paper OP94 indicates the importance of:

► Actions, interventions and service responses promoting a realistic sense of safety, calm, hope, empowerment, physical and social support, and access to welfare services.

► Efforts made to identify appropriate sources of support (eg, families, friends, communities, schools).

► Enabling people to contact their relatives and reunite families.

► Explicitly basing services on people’s human rights.

► Services facilitating appropriate communal, cultural, spiritual and religious healing practices in conjunction with the people who have been affected.

► Local community leaders being involved in planning psychosocial and mental healthcare.

► Responders identifying people who have serious mental disorders as early as possible.

► Recognising that events may affect people who do not live where incidents occur. Healthcare staff local to where affected people live should be made aware of possible psychopathological sequelae.

► Responding organisations providing access to specialist psychological and mental health assessments and intervention when required.

► Long-term planning. Authorities should be funded to deliver extra services to augment existing primary and specialist mental health services for several years following disasters. Certain interventions, such as single-session individual psychological debriefing, however should not be provided.

CARING FOR RESPONDERS
These principles apply equally to staff of the responding agencies who routinely require peer support, leadership, training and supervision.

The extent and frequency of the psychosocial and mental health impacts of emergencies on rescuers, the staff of emergency services, and health and social care agencies fall between assessments of the impacts on people who are directly involved and people who are not involved. Drury et al and Williams and Greenberg offer further general information. Core to supporting people who respond are the necessities of ensuring that they are well briefed, well led and offered effective social and peer support.

The social and occupational factors associated with deployed persons’ psychological distress and disorder have been systematically reviewed. Persons who are responsible for deploying and leading staff should be aware of these factors and the signals from research on deployment lengths and altering them.

Deployed personnel may be assisted by mental health briefings. Trauma Risk Management is a method for monitoring responders’ stress levels. Peer support, and leadership, cohesion and good relationships between leaders, employees and military personnel play vital roles in sustained responders. OP94 contains checklists of actions for leaders and responders when preparing, while working in a disaster area and to assist them to recover afterwards.

CONCLUSION
While there remains much to learn from continuing research, there is now sufficient evidence to inform policy for caring for the majority of people, including responders, who have psychosocial needs and the fewer, though substantial, numbers of people who reach diagnostic thresholds for mental disorders. This paper embeds this knowledge into a framework for planning, designing, preparing and delivering services at the time that events occur and the medium and longer terms. Evaluation of services using similar principles is crucial.

Contributor
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REFERENCES
Review


