

had received some sort of compensatory kit consisting of a mattress, a 20 kg sack of rice and some clothes. Others received nothing. All had lost relatives or friends, some their entire family. As well as trying to cope with all of the loss, they are also now expected by UNICEF to contribute to the fight by caring for children orphaned by Ebola. The problem is that these children have been so stigmatised, no person nor community wants to care for them. Many of the people who come forward to receive Ebola survivors congratulate them not with joy on their faces, but with an immense weariness.

Recently, I heard of an entire, small rural community in Koinadugu that had fled and sought refuge in the jungle, leaving the village completely deserted. They had abandoned their homes after a sample taken from a corpse was found to be positive. Who could be surprised when there is so little attention paid to increasing awareness and understanding of the disease, the measures taken to combat it and to counteract the endless rumours?

Meanwhile, back in Europe you would think rationality and scientific evidence would dominate, but you also find the 'travellers dance' occurring here. If you are returning from an area labelled a risk region, such as Sierra Leone, you cannot go back to your regular job and have to remain under observation for three weeks, taking your temperature morning and afternoon with recommended moderate confinement to prevent febrile illness. When you ask expert epidemiologists, they confirm that Ebola can only spread at the time of massive viraemia,<sup>1</sup> but you had better do the 21 day quarantine 'just in case'.

<sup>1</sup> Viraemia is a medical condition where viruses enter the bloodstream, thereby gaining access to the rest of the body.

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## Mental illness and health in Sierra Leone affected by Ebola: lessons for health workers

***Peter Hughes***

*Sierra Leone is currently going through the worst Ebola epidemic on record, creating anxiety and anxiety related, somatic symptoms. Additionally, increased psychiatric morbidity could be expected as a result of the adverse social and psychological consequences of the epidemic, exposing the country's weak, poorly resourced mental health services and highlighting the need for psychosocial interventions and development of psychiatric interventions.*

*Countrywide, there are 20 psychiatric nurses and 150 community health workers trained in the mental health Gap Action Programme and Psychological First Aid. However, in order to strengthen their capacity to deliver psychosocial and psychiatric interventions and to create a potential resource for psychiatric interventions during a major humanitarian crisis, ongoing training and supervision will be essential.*

**Keywords:** Ebola, mental health Gap Action Programme, psychiatric disorders, psychiatry, psychological first aid, psychosocial, Sierra Leone

## **Introduction: background context**

Sierra Leone has a population of 5.9 million. It is one of the poorest countries in the world. Many of the indicators of poverty are among the worst in Sierra Leone, such as literacy and maternal and infant mortality rate. Life expectancy is 47 years old. There has been significant illicit drug problems with the subsequent psychiatric complications.

There are very few health workers trained in mental disorder care, now only 20 psychiatric nurses and 150 community health workers for the entire country. Psychiatric care is focused in the capital, at the Kissy Psychiatric Hospital. There is a faith based drug unit, the City of Rest, which also takes mentally ill patients. People often go first to traditional healers or to religious leaders.

### **Ebola: some facts**

Ebola was first reported in Sierra Leone in May 2014 in the Kailahun district.

Currently, there 1,510 fatalities from Ebola and double that in cases (end October figures UN Mission for Ebola Emergency Response [UNMEER] situation report). All 14 districts of Sierra Leone are now affected and some areas are under quarantine (UNMEER Report November, 2014).

Ebola is a highly contagious virus and lethal. The virus has led to wide scale socio-cultural changes. There is now a culture of no touching and it was announced there should be at least one metre social distance, but I have not observed this happening. Children are unable to go to school, because the schools are closed, and they exhibit stress responses on radio call-in programmes. Entertainment centres are closed as well, but churches and mosques remain in use. Due to the many deaths, the areas in quarantine, the no

touching rule and the fear, the economy is sliding and productivity slipping. Health workers have been heavily hit by Ebola, also many traditional healers have died since they are usually the first point of health care contact. Moreover, Ebola not only directly causes many deaths, but also due to the reduced capacity of hospitals and fear of going to hospital, non Ebola illness is causing many deaths as well.

### **Myths about Ebola in Sierra Leone**

There is a high level of myths about Ebola. Examples include: chlorine can give you Ebola; the thermometer gun can take your soul; and that it is a punishment from God. There is a lot of rumour and scaremongering even among health workers. Some health workers believed that stress could cause a rise in temperature, rendering this determination useless. During one training, a senior health worker said that stress could cause fever. As a result, an important part of the work in Sierra Leone is debunking these myths. Another issue is stigma, which impacts health workers, families affected by Ebola and survivors. The *Psychological First Aid (PFA) Guidelines on Ebola* (see *Announcement*, this issue) can help in counteracting rumour and stigma. The implications being that through the passing on of knowledge, people can reduce their level of fear as they understand that Ebola can be avoided by simple measures. Therefore, we ensure in our trainings that participants have good knowledge of Ebola.

### **The response to Ebola**

The key ministries involved in mental health and psychosocial support (MHPSS) are the Ministry of Health and Sanitation (MOHS) and Minister of Social Welfare, Gender and Children's Affairs (MSWGCA). However, they see their remit differently; mental health is the focus of the MOHS and psychosocial support is the focus of the MSWGCA. This can lead to some difficulties, as different ministries also have different responsibilities. For

example, one ministry may deal with human rescues and the other service delivery. So, it can be a challenge to coordinate between these differing perspectives, as well as delay programme development.

The government leads on the Ebola response with the support of partners United Nations (UN) and nongovernmental organisations (NGOs). UNMEER is the UN umbrella organisation that covers Ebola related activities with a new regional base in Accra. The Sierra Leone National Ebola response team has had frequent changes of personnel and structure, with increasingly higher government control and prioritisation. The national Ebola response team directs and relates to all these organisations. It is a complex, but mostly balanced and coordinated system.

The coordination mechanism is chaired by MSWGCA and UNICEF jointly, but government led under the auspices of National Ebola response team.

The contact number to access emergency Ebola response is 117. The 117 operators face a lot of criticism as there are often delays in mobilising ambulances and burial teams.

The response team have identified key groups of psychosocial pillars as being at high risk and in need of PSS. These groups are: health workers; the burial teams; children; and emergency line 117 operators. There were 21 nurses trained in mental health. One of the 21 key psychiatric nurses died in October, and in November another doctor died in Kenema district.

There is little research or evidence on the psychosocial effects of Ebola, either direct effects on the person, or how society copes. Regardless, I will share in this paper my reflections on what health workers might need to know and key issues.

### **Developing a psychosocial response**

There has been a flurry of trainings in Sierra Leone by the various psychosocial agents. WHO concentrated on training health and allied workers on PFA and the

#### ***Box 1: WHO mental health Gap Action Programme (mhGAP)***

The WHO mental health Gap Action Programme (mhGAP) was launched by WHO in 2008 to address the lack of care, particularly in low and middle income countries, for people suffering from mental, neurological and substance abuse disorders. In this approach, non specialised health workers can manage most mental health problems with the possibility of referral to a secondary care specialist when necessary, and to have ongoing supervision and training support. One of the main tools of this programme is the *Intervention Guide*. This is an evidence based guide for assessment and management of mental, neurological and substance use disorders using diagnostic algorithms. The guide enables a number of psychosocial management skills.

stress module of the mental health Gap Action Programme (mhGAP) (see Box 1). Currently about 300 health workers have been trained in delivering health informed by psychosocial awareness. These trainings need to be supported by refresher sessions and by supervision.

There are various different strands of work that are included in Ebola MHPSS policy development, such as: training of health workers, staff support and development of district level nurse led clinics to provide a community focus of psychosocial work.

It is also necessary to support people who do jobs that directly and indirectly lead to psychosocial difficulties.

One strand of this work was developing an Ebola *psychosocial* response. This was accomplished with many partners coordinating with the government. We based our policy on the principles of the Inter-Agency Standing Committee (IASC) pyramid. At the

top of the pyramid are the specialised services, however, we felt that in the current situation in Sierra Leone and the low capacity of the health care system, it was not realistic to concentrate efforts on specialised care in secondary care centres. The (primary) tools of implementation are training courses and supervision, public health messages and supporting existing community supports.

Health and psychosocial messages, in particular, can be at every strata and part of social health care. These messages can be verbal by a health worker at a clinic or dispensary, such as via media (radio or television), or in churches. The messages on Ebola protection are imperative, but can also be complemented by psychosocial messages.

### **Psychiatric nurses**

There is a main psychiatric unit in Freetown, which thankfully has had no Ebola cases so far. About 60% of their cases are as a result of drug use. They are preparing for Ebola and have a holding unit. We have not, yet, seen a surge of cases of psychiatric disorder referred to this unit. There is another faith based unit for drug and alcohol rehabilitation, which we visited. Similarly they did not have a great increase of cases. This suggests that a psychosocial response should focus on the immense psychological distress in the community, rather than on psychiatric disorders. However, there is an urgent need to improve mental health care in Sierra Leone. Therefore, in our work with psychiatric nurses, we trained them in following the mhGAP model of care (see Box 1).

This is delivering mental health at a primary care level using the *mhGAP Implementation Guide*<sup>1</sup> and supported by supervision. Health workers should be advised to refer any cases of psychiatric disorder to the psychiatric nurses or community health officers.

### **Health workers**

The next level of the pyramid is about supporting health through interventions by health

workers. This is where the tools of mhGAP and PFA come to the fore. MhGAP is more technically oriented, but PFA is more common sense and anyone in health or social care can use it. Basic needs need to be met at a lower level of pyramid. People need shelter, opportunities to earn their livelihood and community. This is where problem solving can be important. All of the above pyramid levels need to be considered by health workers, from specialised care to basic needs.

### **Coordination**

There were over 30 organisations delivering PFA training in Sierra Leone and ensuring coordination of activity amongst the UN, NGOs, government and other organisations was essential to produce synergy of effect. The key to coordination was the psychosocial pillar which was, as mentioned earlier, jointly chaired by MSWGCA and UNICEF, but led by government. Members included the UN organisations, social and mental health NGOs (both local and international), and the Mental Health Coalition. All information was pooled and actions based on this pool of information. Trainings were coordinated nationally. Information on livelihood opportunities, shelter and gender based violence was shared and a map quickly developed of who was doing what, where and for how long in the country (the 4Ws). This was a strong system, and those few NGOs who were missing were communicated with outside of the meeting to ensure all psychosocial players were working together, unlike previous disaster experiences. This experience has shown it is possible to work together, even in the most difficult environments, and avoid the mistakes of the past.

### **Content of training courses**

The mainstay of our work in Sierra Leone was the *PFA Guide* (see *Announcement*, this issue) for field workers (2011). The government of Sierra Leone has produced The Sierra Leone Training Manual: *Psychosocial Support for Ebola affected communities in Sierra*

Leone, produced by the MSWGC. This covers PFA, as well as staff support, resilience and survivor issues.

Trainings were focussed on PFA, a stress module and a communications skills session. Sessions were highly interactive with role play, group work and practice in skills of communication, with a focus on the 3 Ls of PFA: look, listen and link, as well as a knowledge base on Ebola. There was sessions on problem solving, relaxation and local, culturally appropriate coping skills, which included religious practice. There were sections on stigma, looking after yourself, protecting yourself and your family from Ebola, and working in health facilities where one might see Ebola.

The 20 nurses also needed to be future trainers with skills on managing and coping with anxiety and stress, emphasising normalising not pathologising what is normal, even if distressing, and psychiatric disorders also included. Their training level was higher than general health care workers, as they had had an mhGAP training previously.

The focus of the training for general health workers was on PFA. Humane, caring work where people are vigilant for emotional problems and empathic. We did not provide PFA for overseas volunteers, but there is a programme of Skype staff support using these principles planned through a Kings College London/ Sierra Leone link.

It is too early to speak about the effect of these training courses on the psychological health of the community. We know that the messages on Ebola, social distance and safe burials are still having a limited impact, so one can assume the same for messages of psychological wellbeing.

However, it is still highly important to have accurate factual knowledge of the virus in order to dispel myths and provide clear, objective advice. Much of my knowledge on Ebola came from WHO orientations and from being around infectologists and epidemiologists at the hotel where I stayed. Knowledge is power, and especially for

Ebola. Some of this information is included in Box 2 below, such as the fragility of the virus, its lethality and hopes for recovery. Hope is a key part of PFA.

### **Supporting health and other Ebola related workers**

It is important to know that there is a disproportionately high rate of Ebola among health workers. Many doctors and nurses have died. This is understandable as they are closest to active Ebola cases. This also makes being a health worker a very dangerous occupation, with added anxiety, resilience and burn out. It is, therefore, important to consider the psychological needs of health workers.

Others who also have a particularly dangerous role are the burial team workers, cleaners of health facilities and those responsible for waste disposal. These groups also need to be supported to avoid psychological distress, burn out and resultant (potentially fatal) mistakes leading to Ebola.

Wearing personal protective equipment (PPE) is physically draining and directly affects the rapport one can have with a patient. You cannot really hug someone in PPE, or have any direct human contact. Volunteers see people die who might have survived in the west with more resources. There is also the ongoing personal fear of contracting Ebola. Methods to deal with these fears include mandatory rest periods, limited work time and supervision.

### **Local workers**

There have been strikes in Sierra Leone among health workers. This is in response to poor pay or not getting salary regularly. It is also likely due to the stress of working in such difficult environments, with so many health workers succumbing to Ebola. Their burden needs to be acknowledged, both nationally and by international partners and positively regarded. It is also important to understand that national staff may live in overcrowded areas with Ebola cases

**Box 2: The medical facts**

Ebola has taken on such a totemic place as a deadly disease, which causes agonising bloody infections and death that it is important to get some accurate information to counter this image.

The Ebola virus is easy to avoid and very easy to catch. It is a fragile filovirus and can be destroyed by something as simple as chlorine, or other cleaning materials.

Chlorine can save lives. Washing hands properly saves lives. In Sierra Leone, one washes one's hands countless times per day and especially after any contact with any surface. There is a no touch principle in the country, so there is no reason to actually have human contact with another, but it does happen and drives one rushing to rinse in chlorinated water for one minute or longer.

The other pillar of keeping sane in Sierra Leone is temperature keeping. Ebola is infectious when there is a temperature rise and not before. Needless to say, there are boundless rumours and myths that Ebola can be droplet spread or infectious without a temperature. For all practical purposes, the key message is that a person is safe if they have no temperature. This is a positive message. Taking my temperature twice a day reassured me each time. From an anxiety management point of view this is a powerful means of anxiety control; give people a thermometer to check themselves. The knowledge that the virus is so fragile is not something widely known, and this also gives a positive message. Dead bodies are the most dangerous things of all in terms of Ebola. A dead body can hold live Ebola virus for weeks. This is an important public health message that saves lives. Funerals are dangerous places and a lot of consideration is in place about how to have safe burials. In my time, I saw the burial teams taking bodies away, but was not sure if there were culturally specific ways of honouring the dead that were accepted by the community. There are many stories of contagion from the dead, through entrenched practices such as washing the dead, both for Christians and Muslims. Even the water used has been taken to bathe others in a symbolic way with lethal consequences.

Knowledge about body fluids is essential to protect and manage anxiety. Ebola is in all body fluids, including sweat. It is in the highest concentrations in faeces, vomit and then blood, but also in breast milk and semen. It is important for people to know that Ebola stays in semen for 3 months in survivors of Ebola.

nearly. Therefore, they live with this direct fear, whereas international staff might not face Ebola so directly where they stay.

**Overseas volunteers**

Overseas volunteers live in a place where they have their temperature checked at least twice a day and plenty of chlorine and water to wash their hands frequently. However, they also need support. For them, the work stress may become overwhelming. Dealing with the high death rate is upsetting, with the deaths of children particularly painful,

as has been reported by many overseas volunteers. In addition, stress is caused by delayed blood tests, mistakes in Ebola blood testing results and lack of equipment and other resources. The WHO ensures that volunteers have a psychological assessment before and after their mission, as well as a health check-up.

**Supporting Ebola survivors**

Health workers need to know that surviving Ebola is not the end of the story. By the time someone gets out of the treatment unit they

may have lost family and friends, and may still have family in treatment. They have often lost their job. They may be seen as evil, witches, affected or concealing their status and still infectious. They may find that they cannot return to their own families who are alive, due to stigma and fear. Some treatment centres now have a survivor triage to assess any psychosocial vulnerabilities. They will be guided to counselling or practical support. This has occurred in a very patchy way so far. Some NGOs have set up these clinics, but there is a wide geographic variation. What is clear is the importance of adequate psychosocial support for people who have survived Ebola who may be depressed, grief stricken, have survivor guilt and be at risk of maladaptive coping methods, such as substance abuse. There is an aspiration for all survivors to have some psychosocial support at the time of discharge and reintegration back into community.

Apart from practical support, some Ebola survivors may need to talk about the sometimes dehumanising care they have received. Some survivors mentioned that, during their stay in the hospital, their food was *'thrown at them'*. While they were in treatment units or holding centres, they were terrified. To quote a survivor from memory, *'it was a trauma being in a treatment centre. The staff are frightened and stay away from you. They don't see you as a person and don't even call you by your name. They don't treat you as a person.'*

Children may also be affected. They have insomnia, changes in patterns of behaviours, clinginess and aggressive behaviour. For this, both children and their parents might also need support.

### **Psychiatric disorders**

The mainstay of mental health care has been traditional healers and this is likely to continue, although the traditional healers have been significantly affected by Ebola with many deaths among them. Hope resides in the 20 psychiatric nurses to lead on nurse led clinics in the districts and in the

community health workers. This will facilitate an environment of identification, management and sensitisation in the community. Outreach is a key part of this. Drugs and alcohol abuse may be picked up through the outreach process. Epilepsy can be managed by physicians, but the psychiatric nurses can address the psychosocial aspects.

### **Effect of Ebola**

We still do not know yet what the effect of Ebola will be in terms of psychiatric cases. Ebola infection does cause a neurological abnormality by affecting the brain. People with Ebola can become delirious, which is a neuropsychiatric condition. Anxiety and fear is a normal feeling of those diagnosed with Ebola. What we see in the psychiatric hospital is that there hasn't been a significant rise in admissions, but this may be complicated by other factors, such as fear of going to communal areas where Ebola might spread and general stigma. However, it would be inconceivable that there would not be a rise in psychiatric morbidity in the future in Sierra Leone, precipitated by the ongoing stress of Ebola. Another aspect is that there is such a current preoccupation with Ebola that conditions such as depression may be missed, or seen as an understandable reaction to the effect of Ebola on society and appropriate treatment missed. An element of diagnosis of psychiatric disorder is functional impairment and people can be so incapacitated by anxiety and fear that function is affected by understandable anxiety, as well as psychiatric disorder.

### **Anxiety**

The level of anxiety, depression, health anxiety and defences has not been researched in Sierra Leone since the arrival of Ebola. However, what one sees is a lot of anxiety and depressed mood under the surface. On direct questioning, for example, at staff support sessions we see that there are a lot of problems that are not spoken of

spontaneously. People work hard at their façade of social functioning. There is insomnia, fear of contracting Ebola on a daily basis, enormous health anxiety and fear that any symptoms can be a sign of Ebola. People describe having sore throats, feeling hot, headaches, dizziness and symptoms that are similar to Ebola. This is a reflection of their fears of Ebola and hidden preoccupations. This would not come under a formal diagnostic category under the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Statistical Classification of Diseases (ICD), but is widely prevalent.

It should be remembered that anxiety is an understandable and protective emotion in response to Ebola. Every day one wakes up to the realisation that Ebola is still there and everything that day must be prised through it, there is the stress of constant tension and vigilance. Anyone who is in Sierra Leone will understand what this is like, every time one walks on the road, goes anywhere where there are people, there is risk of contracting Ebola. Every time one touches a wall, a car or a window, there is a fear, the anxiety is unrelenting.

This anxiety extends beyond just the physical to social as well, and for good reason. The psychiatric nurses are well placed to have a broad view of people's lives in relation to Ebola, including the effect on their psychological, social and occupational lives. Ebola causes businesses and schools to close, social distance means people shouldn't get close to one another, social outlets are closed and people can be bored with little diversionary activities available to them.

People react to Ebola anxiety in different ways. There are some who have maladaptive coping and ignore the safe Ebola practices of safe social distance and safe burials. It is hard to know if this is mere ignorance or wilfulness. There are some who say that God will protect them and ignore safe Ebola practice. These are dangerous people, especially when they

are health workers. People may feel depressed, but this does not constitute clinical depression when interviewed.

### **Grief and issues of posttraumatic stress**

What is more clear is the overwhelming grief that people experience. One only has to talk briefly to anyone in Sierra Leone to see the loss and tragedy of the situation. Every family has been affected by Ebola. What is staggering is the amount of loss. Families have multiple deaths, which is entirely understandable when one considers this unforgiving virus. However, there is a strong imperative to carry on with life and that is also what one sees. Life goes on as normal it seems in Freetown and other centres, but the pain of grief is not far from the surface. What I cannot say is how that knowledge can help health workers, apart from understanding the context of people's lives. What strikes me is the resilience, but there may be displaced psychological issues. It may be a change of behaviour that shows that the person may not be coping well, such as gender based violence, or it might be social difficulties or substance use, or it may be that the stress reactions might be manifest in the children, rather than the adults in the family. Additionally, we might run the risk of an over diagnosis of posttraumatic stress disorder (PTSD) in these situations.

The *mhGAP Implementation Guide* has a rigorous definition of PTSD. PTSD is an issue that does come up in all the trainings as very much associated with disasters. In trainings cases are discussed and gone through using the algorithm. In our trainings, we heard descriptions of PTSD, but in relation to car crashes and sexual assaults rather than Ebola.

With Ebola one might expect PTSD, but technically it may be the out of the ordinary stress that is ongoing and unrelenting. This makes PTSD diagnosis difficult and technically impossible. In a way this is helpful, as it avoids pathologising the understandable psychological reactions to an intolerable

situation. It is important for health workers to concentrate on resilience and positive coping methods rather than looking for diagnoses such as PTSD.

### **Communities under stress**

There are some reports of increase of violence in some communities, especially quarantined communities. What is unclear is if there is an increase of drug and alcohol use, which one might suspect. The secondary care hospitals in Freetown report no increase in these issues, which were high even before Ebola. Communities under stress can lead to increased stigma, discrimination against survivors and family contacts of Ebola sufferers. So far, there are anecdotal reports of all these problems. The survivors speak of these problems, as do contacts of Ebola cases. Health workers need to be vigilant to the potential effects of communities under stress and ask about problems that may not be volunteered by people in the community. It is important to ask about substance abuse, psychiatric disorders, violence and sexual violence. It is also important to see if any survivors, or their families, are being marginalised and try and support them. In training, these scenarios are prepared through a highly interactive facilitative approach, which is based on participants own experiences and shared knowledge.

### **Conclusion and things health workers need to know in Ebola areas**

PFA seems effective from the feedback of those who have been trained. However, further, more formal evaluation is needed. Those we trained were going out with knowledge of Ebola, relaxation methods and very importantly, the knowledge of when to get more help, such as for psychiatric disorders, as well as practical support, advice on contact addresses and numbers, livelihood advice and methods of reuniting families. These trainings were important for building skills, knowledge, staff morale

and demonstrating the value they had in the health system. PFA training appears to be an effective tool for enhancing direct, humane, emphatic, pragmatic, solution focussed psychosocial care.

Additionally, relaxation exercises are demonstrably effective in states of anxiety and fear and were rehearsed and repeated frequently with good effect. The mhGAP training was also an effective way of supporting health workers in managing psychiatric disorders such as acute stress reaction, PTSD and children's stress disorders, such as bed wetting.

### **Things health workers need to know in Ebola areas**

- It is likely that with the stress of the current Ebola crisis that there will be an increase of psychiatric disorder. Health workers need to remain vigilant for signs of anxiety, depression, substance abuse and stress reactions, such as insomnia, irritability, impaired social and occupational functioning. Health workers who have been trained in PFA may be able to see when things are not right, but it is through the *mhGAP Implementation Guide* that psychiatric disorders can be screened and managed. Health workers need to know that there are some mental health resources and contacts in Sierra Leone, including the 20 psychiatric nurses, community health officers and the Psychiatric Hospital at Kissy in Freetown.
- Stop stigma through education and advocacy. Everyone is human, even when suffering with Ebola and deserves dignity in care. Psychosocial activities should cut across every health and social arena. Human rights violations are happening to mentally ill people. Health workers must not accept nor condone this. Spend time with people and use the principles of PFA: humane, listening and helping with solutions. Problem solving and psycho-education are important tools in the psychosocial Ebola response for stress

conditions and psychiatric disorders. This does need some training and monitoring.

- Even if people are smiling and appear to carry on as usual, there may be distress and anxiety, but don't make anxiety and normal distress an illness. Self-help is mainstay of resilience. There is a very immediate and important need to support self-help such as relaxation, diversionary activities, and reinstatement of usual social repertoire, as much as possible. This is helpful for anxiety and the somatic associations. At the same time, do not forget that religion is important to people, as well as traditional healers. They are part of the community and it is important to be open to their role.
- It is important to look at family and community systems, rather than an individual in isolation. There is no such thing as just a patient, there is a patient and family/community. Don't forget the children; ask about the children and how they are doing. Be aware that survivors can be victims as well, listen to their situation and feelings and ask about losses and any relatives currently in treatment.
- It is always important to give an honest message, but also try and instil hope as much as possible.

### Lessons learned

- Psychological first aid seems to be an effective tool to train and disseminate skills in reducing psychosocial distress.
- mhGAP is a useful tool to use to screen and manage mental disorders. It is evidence based and very positive feedbacks from field work (yet still more evaluative work needs to be conducted to prove its use).
- Even one staff support session can be very helpful in reducing background staff anxiety and depression
- People in Sierra Leone value a psychosocial aspect to care that encompasses

culturally appropriate local supports and religion, because Sierra Leoneans are deeply religious.

- Even with the stress of Ebola, the people of Sierra Leone are demonstrating remarkable resilience. We are seeing cases of individuals continuing to maintain their families, change jobs and survive great numbers of family deaths. In spite of the fear invoking nature of Ebola, life does go on as normal on the streets with market trading, traffic, attendance at church and mosque. People don't give up and die, but fight Ebola.

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<sup>1</sup> See: <http://www.who.int/mentalhealth/publications/mhGAPinterventionguide/en>.

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