Mental Health and Psychosocial Support in Ebola Virus Disease Outbreaks

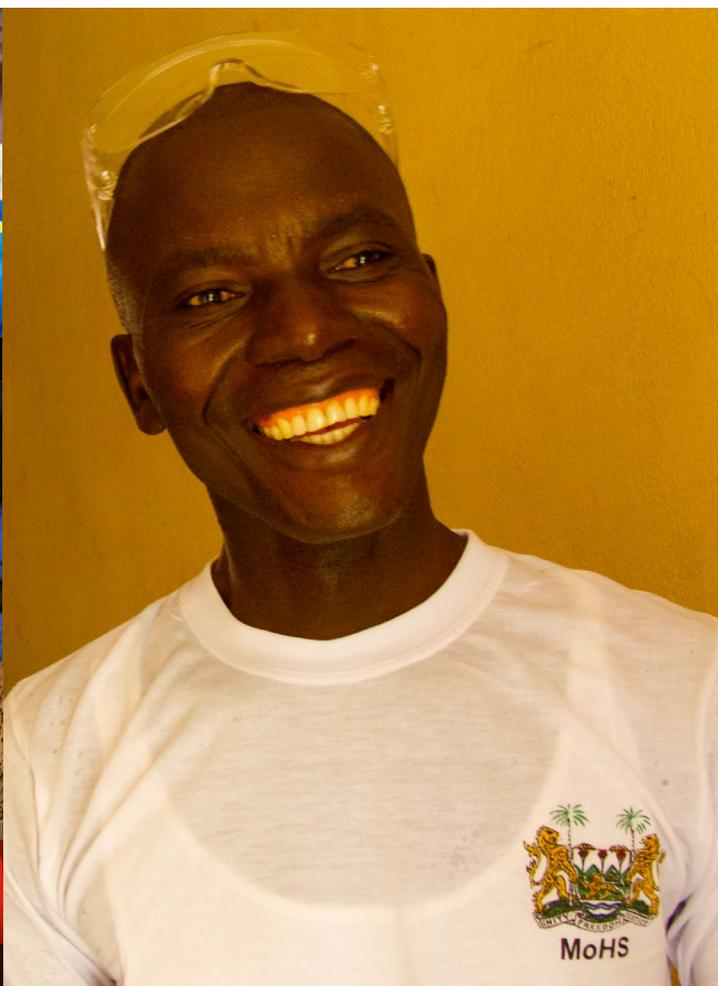## A Guide for Public Health Programme Planners

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Background

This document provides information to strengthen preparedness and response plans with regards to the mental health and psychosocial consequences of an Ebola virus disease (EVD) outbreak.

EVD outbreaks lead to significant mental and psychosocial effects in a number of ways (1):

- Fear of the virus is associated with the experience of intense distress (Box 1).
- Exposure to any severe stressor is a risk factor for a range of long-term mental and psychosocial problems (including anxiety and mood disorders as well as acute stress and grief reactions).
- Physical isolation of individuals, families or communities exposed to the Ebola virus is a further risk for psychosocial problems.
- Social problems may emerge after a population is exposed to the virus and the EVD response: for example, breakdown of community support systems, and social stigma and discrimination associated with EVD.
- There is likely to be a drastic decline of income generation within communities due to travel and work restrictions, loss of family and community members and the collapse of businesses.

The mental health of specific groups requires special consideration, including those who have recovered from the disease and those who are living with the consequences of the epidemic, such as orphans and other family members (Box 2), as well as health care staff and other frontline support workers (Box 3). Support offered to such groups should be targeted and integrated into community-wide interventions to avoid reinforcing stigma.

At the same time, when faced with an emergency, community members may show great altruism and cooperation, and people may experience great satisfaction from helping others.

During an EVD outbreak, it is common to observe a reduction in the use of health services. People may believe that they will contract the disease by seeking health care. They might also be afraid of the consequences (e.g. quarantine) if they arrive at a health care facility with EVD-related symptoms. Likewise, health care workers may avoid reporting for duty out of fear of becoming infected with EVD, and health facilities may close.

Mental health and psychosocial considerations must be integrated adequately into public health assessment, preparation and response and recovery plans. All too often, there is neglect of, or even resistance to, the involvement of mental health professionals in a public health response during an acute crisis (2). This may be because an infectious disease outbreak is perceived to require a physical health response, without adequate recognition of mental health and psychosocial concerns. However, arguably mental health and psychosocial support staff have key skills that may be critical during an outbreak, such as experience of working with angry, violent or resistant individuals and communities and helping health staff to cope. They may provide useful support to other health staff in dealing with such problems. An essential part of preparing for a public health response is affirming beforehand the essential role of mental health and psychosocial support expertise throughout the emergency (3).

In line with the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (4), the composite term *mental health and psychosocial support* (MHPSS) is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Although the terms *mental health* and *psychosocial support* are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches. Aid agencies outside the health sector tend to speak of supporting psychosocial well-being. Health sector agencies tend to speak of mental health, yet historically have also used the terms *psychosocial rehabilitation* and *psychosocial treatment* to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organizations, disciplines and countries.

Furthermore, we use the terms *acute emergency phase* and *post-emergency phase*. For the purpose of this document, we define the acute emergency phase as a period during which fewer than 42 days have passed since the last confirmed case has tested negative twice for the Ebola virus on blood samples. This period is followed by a post-emergency phase. There is overlap in the needs of populations across these phases.

Box 1. Possible experiences of fear in an EVD outbreak

Exposure to a life-threatening disease is frightening to most people. However, fear is even more likely when infectious agents like viruses (or bacteria) are involved. The most terrifying component for many people is that viruses are invisible, and they cannot fully rely on their own senses to determine physical exposure. Feelings of fear and helplessness are common when a virus can be spread by person-to-person contact, creating a situation in which health providers, family members, friends and neighbours may be sources of illness. As a result, safe health care and social support may not be readily available, at a time when they are most needed. A contagious virus may induce problems such as social stigma, isolation and quarantine, including the separation of children from their parents, and fear of infecting loved ones.

Lack of knowledge about the Ebola virus increases fear, especially when there is a lack of clarity about how long it will take to manage or control the disease. Rumours, inconsistent reporting by the media and conflicting expert opinions and public health recommendations worsen public anxiety.

People in affected communities may misattribute physical effects of anxiety as evidence of infection. Such signs and symptoms are normal among frightened persons and include muscle tension, palpitations, rapid breathing, vomiting, sweating, tremors and a sense of foreboding. Thus, frightened but physically healthy individuals experiencing symptoms that may be mistakenly attributed to infection may overwhelm health services, even if they do not have fever.

(Sources: 1, 12, 14, 20, 21)

General principles

WHO has proposed principles for public mental health activities in emergencies (5) and specific guidance for outbreaks of lethal viruses (6); these principles are also valid for situations involving an EVD outbreak. These principles, in addition to others collected from MHPSS experts who have worked in EVD outbreaks, are summarized here.

All phases of the emergency

- Allocate resources to support MHPSS activities associated with emergencies throughout the phases, including pre-emergency (preparation), the acute phase and the post-emergency phase.
- Employ the highest ethical principles and international standards for interventions and research (see the IASC *Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings* (7)).
- Consider medium- to long-term planning at all phases of the emergency.

Preparation before an emergency

National and local preparation plans should be developed in collaboration with government, community representatives and other key MHPSS stakeholders. Such plans should involve:

- Mapping of resources (in terms of current availability and human resources): both mental health care resources and resources for community psychosocial interventions (e.g. women's groups, child welfare committees, children's programmes, survivor networks, social services, etc.);
- A comprehensive list of MHPSS practitioners trained and locally available to offer appropriate advice and to participate in a response to an infectious disease outbreak, such as EVD. The list should ideally cover competencies and areas of expertise, as well as identify gaps in MHPSS human resources;
- A vulnerability analysis (to identify potential scenarios, weaknesses in public mental health and social support systems during a crisis, needs and capability, and resources needed to respond);

- A strengths inventory (to identify community and system strengths across care delivery systems);
- Local community advisory groups that can be rapidly contacted and are included in decision-making from the very beginning;
- A coordination plan which specifies focal persons responsible within each relevant sector and agency in each relevant administrative region;
- Contingency plans to prepare for an adequate MHPSS response (including adapting tools to the local context);
- Prepared and pre-tested MHPSS communication plans that are integrated into the broader EVD communication plan;
- Realistic training of relevant personnel in MHPSS interventions (including awareness-raising on the relevance of such interventions);
- An up-to-date desk review of literature related to MHPSS and relevant sociocultural aspects in the country (see Template for Desk Review of Pre-Existing Information Relevant to Mental Health and Psychosocial Support in the Region/Country in *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide* (8));
- MHPSS guidelines/standards of practice adapted to the context (including for people with delirium and severe mental disorders infected by the virus and admitted into Ebola treatment units (ETUs) and psychosocial support for the discharge and follow-up of patients).

Overall, preparation plans for MHPSS should be integrated into general national health emergency response planning, and should indicate priorities for the allocation of limited resources. Engaging community members in the disaster planning process is vital to facilitate intervention if an outbreak occurs.

In general, countries with mental health services that are community-based and integrated with general health services will be better prepared for a mental health response in outbreaks of life-threatening diseases. Health systems that centre on large psychiatric institutions as the only service for mental health problems impede effective disaster response in an emergency. Prioritizing the development of community mental health services – integrated with general health services – is thus essential to prepare for a mental health response during and after emergencies.

In some countries, the majority of mental health care workers are employed

in large psychiatric institutions. In such cases, it can be important to create a memorandum of understanding with the institutions and the Ministry of Health for the release of key mental health professionals to participate in the emergency response (3).

Speciality mental health care, including hospitals that offer acute or long-term care, should be included in infection prevention and control planning, training and service delivery strategies. They must also receive all relevant supplies, and should not be shut down or made inaccessible for people in need.

Assessment

Interventions in both the acute and post-emergency phases should be preceded by careful planning and rapid assessment of the local context (e.g. setting, culture, history and nature of problems, local perceptions and expressions of distress and illness, ways of coping, community needs and resources, etc.).

A literature review of secondary (existing) data on sociocultural aspects of mental health can be very helpful in cases where a review has not already been conducted as part of preparation for an emergency. Such a review can reduce the burden of collecting data during the rapid assessment (see Template for Desk Review of Pre-Existing Information Relevant to Mental Health and Psychosocial Support in the Region/Country in *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide* (8)). Gaps in the literature should be filled first by rapid assessment and then by more in-depth assessment. Overall, the assessment should include local perceptions and social factors that are specific to EVD and important for its transmission (e.g. burial practices, beliefs about death and dying, existing beliefs about EVD and people affected by it) (see *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide* (8)).

Such assessments should be carried out collaboratively with local stakeholders and staff members, and in an interdisciplinary manner, in order to maximize understanding of the situation and to develop and implement effective interventions.

A population-based assessment of the prevalence of mental disorders is difficult, resource-intensive and typically unhelpful in developing disaster response plans. To plan for interventions in the post-emergency phase, it is recommended to mainly assess available mental health and social supports/services and resources, including an assessment of the number, functions and location of human resources who can deliver relevant interventions (input indicators). When assessment uncovers a broad range of

needs that are unlikely to be met, assessment reports should specify the urgency of needs, local resources and potential external resources.

Collaboration and coordination

Coordination of MHPSS should be intersectoral – involving both health and non-health agencies – as many important activities occur outside the health sector (e.g. education, water and sanitation, protection sectors). Government authorities need to be supported by an appropriate, knowledgeable public mental health adviser (or team of advisers) who will ensure that MHPSS aspects are given appropriate consideration and that organizations working on MHPSS collaborate with each other and with the general health and social services sector. Interventions should involve consultation and collaboration with governmental and both local and international nongovernmental organizations (NGOs), as well as with relevant community-based organizations (CBOs) in the area.

Intersectoral MHPSS coordination groups bring together all of the key MHPSS stakeholders (including government ministries and institutes, user and family associations, associations of people who have survived EVD, local and international organizations and UN agencies) and build upon existing MHPSS coordination structures. Coordination groups may serve to gather information (including keeping up-to-date information on who does what, where, when), compile and share situation analyses and coordinate activities.

The MHPSS coordination group must be represented at the national EVD emergency response management level. Representatives from the MHPSS coordination group should also attend sectoral coordination groups (health, protection, etc.) to ensure the integration of MHPSS activities into different sectors.

Where possible, the creation of multiple coordination bodies with duplication in roles and terms of reference should be avoided. In settings where the outbreak is spreading across borders, it is relevant to communicate and share tools with coordination groups in neighbouring countries.

Where a multitude of agencies are operating independently and without coordination, it leads to waste of valuable resources and duplication of efforts in some areas, while other areas are neglected. Clear leadership that is knowledgeable of MHPSS issues as well as humanitarian response is critical to maintaining effective

relationships between organizations and aligning efforts to create a unified and effective response.

Integration into all levels of health care

Mental health care interventions should be carried out within general health services (including primary health care (PHC), district general hospitals and outpatient facilities). Such interventions should also be organized in other pre-existing structures in the community, such as schools, community centres, youth and senior centres and places of worship. Care by families and active use of resources within the community (for example, where appropriate, religious leaders) should be maximized. Clinical on-the-job training and thorough supervision and support of PHC workers by mental health specialists are essential components for successful integration of mental health care into the general health system. A tool for integrating mental health care into non-specialized health care exists (see *mhGAP Humanitarian Intervention Guide (mhGAP-HIG) (9)*).

In some settings, traditional health systems play a strong role in the care of community members. If feasible and appropriate, collaborate and share information with traditional healers and other traditional groups (for detailed guidance, see Action Sheet 6.4 in *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (4)*).

Recognizing and using social support networks and community resources

The most important first points in seeking help in any crisis are immediate family and friends. In addition, all communities have people and systems that support those who are having particular problems (whether emotional, social or financial). These might be religious institutions, community groups or traditional healers. Such systems understand local needs and how to respond sensitively.

During an EVD outbreak, however, social support networks can become fragmented. In collaboration with communities, humane interventions that account for this disruption and work around the challenges created by the virus need to be developed (e.g. speaking with others from a distance or bringing meals/essential supplies to the perimeter of houses when unable to touch others or visit quarantined homes).

One of the most important things in an emergency response is to recognize and support these community resources so that they can function effectively. For example, support should be provided to families who have taken in children of relatives who have died, and 'do no harm' approaches to child care should be promoted.

Training and supervision

During the acute emergency phase, non-professional caregivers and responders (medical teams, contact tracers, social mobilization teams, burial teams and emergency phone teams) may be rapidly trained to provide psychological first aid (PFA) (for more information about PFA, see below). They should also be trained to provide feedback to family members of people with EVD (e.g. on the status and condition of the patient or giving notice of death) and to create a reliable system that enables better tracing of patients to avoid them being 'lost'. Given the sensitivity required in such discussions, and that such discussions may be important in reducing transmission of the virus, training may incorporate an element of ongoing support or supervision by MHPSS professionals.

For provision of effective clinical mental health care, short training without follow-up supervision is unlikely to be adequate. Continuous in-service training and ongoing supervision are essential to instil new clinical skills.

With respect to capacity-building for clinical skills, training and supervision should be focused on the development of skills of health care workers who have had short training in MHPSS. They should be supervised by mental health specialists – or be under their guidance – for a substantial amount of time to ensure lasting effects of training and responsible care. Workshops on supervision skills, and ongoing support, should be offered by and to mental health specialists providing supervision to health care workers.

As much as possible, agencies should use local trainers to conduct training. Training initiatives should take into consideration national social and health care systems so as to avoid creating parallel systems of care. Coordination between governmental and nongovernmental agencies should take place when planning training so that content is consistent, roles are clearly defined and use of resources is maximized.

Long-term perspective

After a population has been exposed to severe stressors, it is preferable to focus on medium- and long-term development of community-based mental health services and psychosocial interventions (see *Building Back Better* (10)). Unfortunately, while impetus and funding for MHPSS programmes are highest during or immediately after acute emergencies, mental health and psychosocial effects tend to last much longer than the acute crisis phase. The development of services within a long-term perspective focuses on establishing sustainable access to mental health services for the whole community and is not restricted to sub-populations identified on the basis of exposure to a virus. However, services delivered within a single integrated, community-based system can, when necessary, be tailored to address the needs of different sub-populations. Examples include support groups specifically for bereaved families in the event of deaths and the provision of outreach services/awareness programmes to vulnerable affected communities or marginalized groups who are reluctant or unable to attend clinical services.

Stigma and discrimination

Social stigma and discrimination can be associated with EVD, including towards persons who have been infected, their family members and health care and other frontline workers (1, 11, 12, 13). Steps must be taken to address stigma and discrimination at all phases of an EVD emergency response. Care should be taken to promote the integration of people who have been affected by EVD without over-targeting (i.e. without increasing stigma by drawing attention to them). Health and social services, for example, should, if at all possible, be available to all community members rather than just those affected by EVD. However, it should be noted that outreach can be essential, as some people who have survived EVD may isolate themselves due to prevailing stigma. Community members and leaders (including traditional healers and religious leaders as well as mental health service users and associations of people who have survived EVD) should be engaged to understand the sources of stigma and the steps that can be taken to dispel any unnecessary fears and misconceptions. At the same time, it should be recognized that empowerment of those who have survived and are affected by EVD is essential to overcoming stigma, including self-stigma, and discrimination.

Monitoring indicators

Activities should be monitored and evaluated through indicators that need to be determined, if possible, *before* starting the activity. Indicators should focus on inputs (available resources, including pre-existing services), processes (aspects of programme implementation and utilization) and outcomes (e.g. distress, functioning of beneficiaries, livelihoods).

Acute emergency phase

During the acute emergency phase of an EVD outbreak, the public health system will focus much of its resources on risk management: (a) surveillance; (b) hazard prevention and control procedures; (c) protecting responders and health care workers from physical exposure; (d) case triage (i.e. initial reception, assessment and prioritization of casualties); and (e) physical health care to save lives. These general public health interventions are essential and should be complemented with a range of mental health and psychosocial interventions and supports.

Social/community interventions can address important factors (determinants) influencing mental health. Therefore, general health and mental health professionals should advocate and work in partnership with colleagues from other sectors (e.g. communication, education, community development, disaster coordination, child protection, police) to ensure that relevant interventions are fully implemented.

Communication

- Health professionals should work with risk communication experts to establish and disseminate a reliable flow of credible and easily understandable information about: (a) the nature of the risk and the exact recommended prevention methods of reducing risk; (b) the availability of medical evaluation and treatment and how and where to obtain these; and (c) information on any other relief efforts, including what governmental organizations and NGOs are doing and how they may be contacted. Such risk communication is essential not only for disease control but also for the reduction of anxiety and the facilitation of access to care.

- Vaguely reassuring messages or messages asking the public not to panic are unhelpful (14), as is continuous negative messaging. Messages should be positive (e.g. 'Early treatment helps you to survive'), rather than showing graphic pictures of patients with symptoms or dead bodies being collected by teams in personal protection equipment (PPE), as such pictures may lead to feelings of hopelessness and non-engagement with treatment, as the disease is seen as being fatal.
- Messages should be shared in relevant languages and should be accessible (to those who are not literate, have sensory disabilities, are generally not mobile or are in neglected situations such as prisons, special schools or institutions), empathetic (showing understanding of the situation), adapted to the audience (e.g. children) and culturally relevant.
- Messages should evolve with the context and stage of community preparedness. They should address key dilemmas faced by community members (e.g. if a loved one falls sick, a tendency to deny reality and interpret it as another illness).
- In situations where the outbreak is approaching country borders, the sharing of messages across borders should be promoted.
- Brief, non-sensationalistic, non-blaming press releases, radio programmes, posters and leaflets may be valuable in educating the public. Public education should emphasize positive but realistic expectations of hope, resilience and natural recovery.
- Recruit people who are considered important and who are trusted within the community to share information and key messages on EVD.
- Brief EVD responders in the areas of health and social welfare regarding issues of fear, grief, disorientation and the need for active community participation, in addition to training in communication skills.
- Provide community members with clear explanations and facilitate discussions regarding EVD as a disease, the introduction of interventions and services (e.g. ambulances, ETUs, contact tracing). Convey the process for isolation and treatment to communities, including what to expect when a person with EVD is picked up for admission to a facility or upon admission to a facility for treatment. Helping communities understand that it is possible to survive EVD is important in reducing stigma and discrimination against people who have survived EVD in the long term.
- To the extent possible, employ MHPSS staff in the ETU system to offer support and promote communication between patients, families and staff.
- Set up communication systems so that people with EVD can be traced and relatives

of patients can be informed. Create a comprehensive feedback system for families and individuals who are contacts, suspected cases or confirmed cases as they enter the system for surveillance and care. The system should be initiated as soon as a person enters an ETU and should begin with providing a phone or another way for families to communicate with and about their loved ones. Families and communities can better support individuals who have EVD, or who are suspected of having it, if they are in contact with them. Feedback should be given upon arrival at a facility, and daily until discharge. This system should include communication between health care teams and families to promote transparency and trust.

- Ensure that people who have survived EVD have access to information on what to expect after recovering. Such information should include physical and mental health information, as well as information about reintegrating into the community.
- Establish a clear channel of communication with lines of authority consistent with national laws on the transmission of sensitive information such as death notification and post-mortem information flow to families.
- Where possible, establish post-discharge referral and liaison between the ETU MHPSS focal person and the MHPSS focal person in the community.
- Set up a system for communication to relevant protection authorities for children and other vulnerable individuals.

Community intervention and mobilization

- Engage with community leaders and existing structures to develop community-focused interventions. Empower the community to develop and implement their own response plan, as appropriate, including the identification of isolation areas and roles and responsibilities.
- Include a mental health and psychosocial awareness component – including communication skills – in the training of teams going door-to-door in communities (e.g. contact tracers) to avoid the under-reporting of EVD symptoms amongst people with mental health problems (3).
- Employ strategies that provide information on ETUs (e.g. open houses and visits by community representatives to ETUs before they are operational).
- Establish a system for tracking vulnerable individuals (e.g. unaccompanied children, persons with disabilities and the elderly).

Box 2. The needs of persons who have survived EVD

The experiences and needs of persons who have survived EVD are far from being completely understood. There is limited documentation currently available and there is a great need to increase the evidence base on how to best support persons who survive the disease.

In the 2014/15 outbreak in West Africa, there were accounts of physical side effects from Ebola infection. Individuals described severe headaches, joint and muscle pain (especially in the arms, legs and back), cramps, weakness, numbness, loss of hair and disruption of menstrual cycles. Ophthalmological problems (blurred sight, uveitis, blindness) were also commonly observed. In terms of mental health, experiences of depression, anxiety and unexplained psychosomatic symptoms were reported.

While some persons who survived EVD were welcomed home from ETUs, many more experienced stigma, discrimination and rejection by their communities. Some individuals were deserted by their spouses and other family members. Stigmatization was faced not only by individuals but by families and whole communities, resulting in people losing their jobs and even their homes. Similar experiences have been reported in previous outbreaks of Ebola and related diseases.

Children, whether they have recovered from EVD themselves or have been cleared after a family member contracted the disease, can also experience significant disruption to their social supports, with changes to friendship/peer supports, social isolation and stigma and subsequent challenges in being able to re-engage in education.

Coordination groups have been formed to address the needs of persons who have survived EVD. In Sierra Leone, for example, the Survivor's Comprehensive Care Working Group has been developed to look at how to provide health services (including mental health) to persons who have survived. All agencies involved in supporting persons who have survived EVD are working together in this group, including MHPSS stakeholders. In Liberia, a Survivor Clinical Network has been established that includes the main health actors working with persons who have survived EVD, as well as people who have survived EVD themselves.

While it is important to address the specific needs of persons who have survived EVD in the emergency phase, in the long term it will be necessary to incorporate these groups into mainstream services. If services are seen as being equally distributed, the risk of continued stigma against persons who have survived EVD will decrease.

(Sources: 1, 22)

Death and body management

- The bereaved need to have the opportunity to mourn. This involves safe and dignified burial if possible. If this is not possible, find dignified alternatives to safe burials and funerals/mourning ceremonies/rituals that do not involve the body itself, e.g. enabling rituals to be conducted within safe distances. Dead bodies carry a very high risk of transmission of the Ebola virus; therefore, everyone must be aware that they should not touch bodies, and the burial of bodies must be done in collaboration with a trained burial team and must follow strict safety precautions (see *Field Situation: How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola virus disease* (15)).

- Engage with community members, including religious/traditional leaders, as soon as possible during the outbreak to promote acceptance of the need for safe burials and to reach consensus on how to bury bodies in a manner that is culturally acceptable and safe.

- Ensure that burial teams include community members who are normally responsible for burials. For example, depending on the local context, this might include individuals who are responsible for religious burial ceremonies or other culturally significant individuals.

- Locally appropriate death certificates (possibly with photographs of the deceased) need to be organized to avoid unnecessary financial and legal consequences for relatives, and if possible relatives should know where their relatives are buried so they have a place to mourn in future. If appropriate, mark burial sites at least with the name of the person buried (and dates of birth and death), so that individuals can be respected and families can find burial sites.

- Develop a system for death notification that is in compliance with the law, is supportive and sensitive to relatives and loved ones and provides post-mortem support.

- To the extent that the activity is safe (i.e. it does not violate infection prevention and control (IPC) procedures), encourage the re-establishment of normal cultural and religious events and practices (including grieving rituals in collaboration with spiritual and religious practitioners) and, if culturally appropriate, the recognition of significant anniversaries in relation to those who have died.

Restoring normality

- Encourage activities that facilitate the inclusion of social networks of the bereaved, people who have survived EVD, orphans, widows and widowers or those without their families within social networks (once quarantine or infection control measures such as reducing public gatherings have been taken into account).
- Encourage the organization of normal recreational activities for children and encourage (re)starting schooling, even partially, once it is safe to do so.
- Encourage activation of local child protection systems to follow up and ensure the well-being of vulnerable children, particularly those living in alternative care arrangements. Provide support to adoptive families taking care of orphans.
- Involve adolescents, adults and older adults in concrete, purposeful, common interest activities.
- EVD outbreaks can have significant impacts on community livelihoods. Encourage economic development initiatives which incorporate psychosocial support as soon as possible. Promote the integration of people who have survived EVD and adoptive parents of orphans into community-wide livelihood activities.
- Encourage families to remain together.
- Encourage peer support of people affected by EVD. This can be done by collaborating with and building the capacity of mental health advocacy groups.

Child protection

- Link with social services and community-based protection networks that seek to reduce emergency-induced rights violations, especially those affecting children, such as child labour, early marriage and sexual abuse.
- Collaborate to establish a well-documented referral system for organizations focused on child protection, where mental health referrals may need to be made. Monitor the care offered in observational interim care centres (OICCs) for children and promote the improvement of OICC services when necessary.
- Ensure that the full range of needed physical and mental health services are available in OICCs.
- Establish transitional homes with staff trained to work with children, if needed, for children who need to transit back to their homes from OICCs, ETUs or other environments.

- Ensure that the full range of children's rights are protected and observed in OICCs, ETUs or other facilities, including the need for caregiver/parental consent when media or public information is involved.

Psychological first aid

- PFA is basic, natural social support, and can be taught quickly to health professionals and lay people in the community (e.g. teachers). PFA should be made available in the community at general health care facilities where exposed people seek help.
- As far as possible, acute distress should be managed without medication following the principles of PFA (i.e. listen, convey compassion, assess needs, ensure that basic physical needs are met, do not force talking, provide or mobilize company preferably from family or significant others, offer or encourage but do not force social support, provide accurate information, link with services, protect from further harm) (16).
- PFA should also be made available to grieving relatives and to responders (medical teams, ambulance drivers, contact tracers, social mobilization teams, burial teams and emergency phone teams) at emergency care facilities. An essential component of PFA is protection, which is important because intense acute distress may occasionally lead people to behave irrationally in ways that put themselves and others at risk. Supervision and emotional support of staff providing this form of aid is important to ongoing delivery of PFA. *Psychological first aid for Ebola virus disease outbreak* is a manual specifically adapted for people helping others during EVD outbreaks (16).
- Assuming the availability of volunteer/non-volunteer community workers, organize outreach and non-intrusive emotional support in the community by providing, when necessary, PFA and referral.
- Because of possible negative effects, it is not advised to organize forms of single-session psychological debriefing if these are done in a way that pushes people to share their personal experiences beyond what they would naturally share or feel comfortable with. In contrast, creating *natural* opportunities for individuals to share their concerns and support each other may be helpful.
- Orient responders to PFA. Ensure that responders know the limits of their capacity based on a very brief orientation, and are aware of referral mechanisms (including for mental health care).

Box 3. Mental health and psychosocial support for health care and other frontline support workers

During an EVD outbreak, large numbers of health care workers are called upon to offer care to people diagnosed with Ebola. In addition, a great number of workers are needed for other tasks including contact tracing, quarantine monitoring, driving ambulances, burying bodies and cleaning Ebola treatment centres (among others). All of these roles involve potential exposure to EVD and require vigilance if workers are to stay healthy.

In the 2014/15 EVD outbreak in West Africa, it was observed that attention was placed primarily on the welfare of patients and their families. In some countries, there was some attention to the need to support frontline health workers; however, limited attention was given to the welfare of other support workers, despite high levels of recorded infection and mortality.

Health care and other support workers reported high levels of stress, as did those providing other services, due to the threat to their own lives as well as working excessive hours. Workers in ETUs and burial teams struggled emotionally with the scenes they witnessed. They also faced a high degree of stigma – for example, some workers were deserted by their spouses. Members of burial teams described experiencing recurring mental images of dead bodies for months afterwards and also experienced rejection by their families and communities. Mental health staff felt a great deal of pressure to support others in need.

Addressing the MHPSS needs of health care and other support workers is a delicate matter. The stigma associated with mental health problems creates additional fear and reluctance to seek support.

To address these challenges, one approach is to offer group support sessions for health care and other support workers. Group settings can offer a safe place for people to describe how they are feeling and to share successful coping mechanisms. Individuals experiencing greater degrees of distress can be offered one-on-one support.

Additional approaches need to be considered and documented.

(Sources: 1, 2, 3, 12, 23)

Mental health interventions

- Integrate MHPSS into the guidelines for case management in the EVD response. Refer to national guidelines (17).

- Protect people in institutions (e.g. children, people with disabilities, older adults or people with mental or neurological disorders) from physical exposure to the virus by screening staff and new admissions. Ensure that staff working in institutions are trained in IPC and PFA.

- Manage urgent psychiatric and neurological complaints (e.g. delirium, psychosis, severe depression) within emergency or general health care facilities. Appropriate staff may need to be deployed to these locations and, when time permits, staff capacity in MHPSS increased (see selected modules of the *mhGAP Humanitarian Intervention Guide (mhGAP-HIG)* (9)).

- Ensure availability of essential, generic psychotropic medications at all levels of health care. Persons with long-term psychiatric complaints or epileptic seizures will need continuous supplies of medication, and sudden discontinuation should be avoided.

- Adapt and implement protocols on how to manage EVD patients with delirium, psychosis, severe depression and other priority mental health conditions in ETUs. Protocols should include how to help patients with such conditions feel more at ease when seeing health care staff wearing PPE, as well as empowering all ETU staff to work with people with these conditions. Each ETU should have at least one person available at any given time who can address the mental health and psychosocial needs of patients. Health workers should avoid routine prescription of benzodiazepines to treat acute anxiety. Over-prescription of benzodiazepines is common in emergencies and is associated with potential dependence.

If the acute phase is protracted, start training and supervising PHC workers and community workers in mental health care and community-based self-help support groups (for a description of these activities, see below).

Post-emergency phase

After the risk of Ebola has been contained, the public health system should focus on implementing ongoing disease surveillance and risk assessment procedures as well as ongoing long-term care. At the same time, a range of standard MHPSS interventions (described below) are recommended in the aftermath of emergencies, including after community exposure to an EVD outbreak and response.

Community interventions in the post-emergency phase

- Continue relevant interventions, as outlined above in the acute phase section.
- Inform and educate the public about risks for persons who have survived EVD (e.g. timeframe for possible sexual transmission of EVD), which fears are unnecessary, how important it is to accept people back into the community and social support systems.
- Facilitate the creation of inclusive, community-based self-help support groups. The focus of such groups is typically problem sharing, brainstorming on solutions or more effective ways of coping (including traditional ways), generation of mutual emotional support and sometimes development of community-level initiatives or income generation opportunities. Community healing dialogues – a form of support adapted from sociotherapy (18) – apply these concepts and have been used to support community recovery during an EVD outbreak (19).
- Share and encourage the application of pre-existing and new positive, appropriate ways of coping. Information should emphasize positive expectations of natural recovery and should avoid medicalizing normal grief reactions. At the same time, information should increase people's willingness to seek help if they are experiencing severe symptoms.
- Work at both community and national levels to create opportunities to mourn and achieve closure as a country, acknowledging key actors in overcoming the outbreak and recognizing affected communities (e.g. a national moment of silence, rituals for celebration of the end of the emergency).
- Contribute to efforts to rebuild trust in social structures and medical systems. Empower communities to create mechanisms to fill gaps created by the breakdown of social support networks. This is important for managing the placement of

orphans. Use community resources such as child welfare committees.

- Communicate clearly which norms established in the EVD response are still helpful (e.g. hand washing) and which are not needed any more (e.g. avoidance of physical contact). Encourage the re-establishment of cultural and religious events and practices (including grieving rituals, if appropriate, in collaboration with spiritual and religious practitioners).
- Provide supportive activities for children and adolescents that allow them to understand what has happened, why adults have been full of fear and why everything has changed.
- Encourage economic development initiatives which incorporate psychosocial support as soon as possible. Promote the integration of persons who have survived EVD and adoptive parents of orphans into community-wide livelihood activities.
- Build a case management system, creating linkages to social and health services.

Mental health care interventions in the post-emergency phase

- Work towards proper and relevant national mental health and social welfare policies and plans for care of people with mental disorders. The long-term goal is a functional public health system with mental health and psychosocial support systems as a core element (see *Building Back Better* (10)).
- Train and supervise PHC workers in basic mental health knowledge and skills (e.g. assessment, provision of appropriate psychotropic medication, PFA, supportive counselling, working with families, suicide prevention, management of medically unexplained somatic complaints, substance use issues, referral) (see *mhGAP Humanitarian Intervention Guide (mhGAP-HIG)* (9)).
- Train and supervise community workers (support workers, counsellors and, if available, social workers) in general principles of care to assist PHC workers with increased caseloads. Community workers may be volunteers, paraprofessionals or professionals, depending on the context. Community workers need to be thoroughly trained and supervised in a number of core skills: assessment of perceptions of problems by individuals, families and groups, PFA, providing emotional support, stress management, problem-solving counselling, mobilizing family and community resources and referring and linking to other services and support.

- Educate community workers as well as community leaders (e.g. village heads, teachers, religious leaders) in core psychological care skills (e.g. PFA, emotional support, providing information, answering frequently asked questions, encouraging practical ways of coping, recognizing core mental health and substance misuse problems, key messages about things to say or not to say) to raise awareness and strengthen community support and to refer persons to PHC services when necessary.
- Establish a referral and treatment system for children and adolescents with mental health needs.
- Establish a referral and treatment system for alcohol and substance misuse, as prevalence might increase due to self-medication.
- Train and support mental health specialists as part of a comprehensive stepped care approach, including the capacity-building of national mental health trainers and of leaders in public mental health.
- Ensure the continuation of medication for people with severe mental disorders or epilepsy who may not have had access to relevant medication during the acute phase of the emergency.
- If feasible and appropriate, collaborate with traditional healers, traditional birth attendants and other traditional groups. A working alliance with traditional practitioners may be possible in certain contexts.
- Link mental health care with social services to ensure the provision of basic needs among communities affected by EVD.

Conclusion

A public health approach is necessary to address the mental health and psychosocial consequences of an EVD outbreak. Many mental and psychosocial consequences are similar to those in other emergency situations. Nonetheless, delirium, fear and social stigma are particularly likely in emergencies involving an EVD outbreak. The EVD response interrupts common norms and social support systems by creating physical distance between people, especially when people get sick or family members die. This can lead to conflicts and breakdowns of relationships, undermining existing coping mechanisms. Many of the interventions proposed here do not require a high level of specialized skill to be implemented, but if used effectively they can significantly reduce widespread suffering.

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**This document is for public health programme planners
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and non-governmental organizations.**

**This document gives an overview of essential knowledge
that public health programme planners should have about
mental health and psychosocial support (MHPSS) in EVD
outbreaks. The document highlights general principles,
as well as specific MHPSS considerations during the preparedness,
acute and post emergency phases of an EVD outbreak.**

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