MSF Holland

Peace of mind: MSF program proposal on mental health, Sierra Leone

Kaz De Jong

Ashley Shearer

Maureen Mulhern

1999
This program proposal was developed by MSF Holland based on a three-week assessment of mental health needs in Sierra Leone. The team assessed what resources, systems and structures exist in the country, as well as what the psychosocial needs are. The latter include training in psychiatric treatment and case management for nurses and medical doctors; the development and implementation of primary mental health care services at a health post level; and increased co-operation between NGOs working in the field. The overall objective of the planned intervention by MSF is to create community based mental health services for the population which will be achieved by 1) developing a community mental health centre in Freetown and 2) training health workers in primary mental health care. The involvement of the Ministry of Health and WHO is essential to the successful implementation of the proposal.
# Contents

Introduction 6

The needs in perspective: a system approach in the emergency phase 7  
What is present? 9  
What is needed? 9

MSF program proposal: capacity building and emergency support 10  
Objectives 12  
Freetown Community Mental Health Training Centre 12  
Pilot program on community based mental health services 13  
Input of Ministry of Health and WHO 14

Notes 17

**Appendices**

Appendix 1: Overview of mental health NGOs, activities and requests 18
Peace of mind: MSF program proposal on mental health, Sierra Leone
Introduction

MSF (Medecins Sans Frontieres) has been present in Sierra Leone for the past five years. At various points in time MSF has tried to implement mental health programs in Sierra Leone. None have succeeded due to insecurity and the resultant tragic developments in Sierra Leone. The recent peace accord has enabled MSF to complete a thorough three weeks assessment in Sierra Leone (Freetown, Bo, Kenema). The proposal is the result of the assessment. Our program ideas have been discussed with the relevant partners, most notably: the representatives of the Sierra Leonian ministries of Health and Social Welfare, WHO (World Health Organisation), UNICEF (United Nations Children's Fund) as well as representatives of FAWE.

The scale of need combined with the absence of an organised mental health system means that co-operation among NGOs, WHO (World Health Organisation) and Sierra Leonian authorities is essential. Collaboration is a prerequisite for the creation of a standardised quality support for those who have suffered mentally from their experiences during the recent years of conflict.

Mental Health is defined in this proposal as a continuum, ranging from psycho-social problems, psychological complaints to psychiatric disorders. Defined as such effective mental health interventions are not restricted to the health system. Not all mental health problems are the result of psycho-pathology, nor to be defined as disorders. Some complaints are a normal reaction to abnormal circumstances. To effectively deal with the mental health effects of violence, the social and educational system have to be included for a successful intervention.

When reading this document one should keep in mind that MSF (Medecins Sans Frontieres) is a health organisation and analyses the problems from this perspective. We realise the limitations this imposes, as well as we realise that Western approaches to mental health problems are not necessarily the solution for mental health problems in Sierra Leone. In order to implement services, the training of national staff is essential to create a common approach with Sierra Leonians. The approach has to result in services and interventions that are perceived by the inhabitants as effective, relevant and in line with their cultural concepts of coping, their cultural methods of integrating the past events, their ways of accepting reality and their cultural ways of creating a future perspective.

Providing mental health support is only one of the tools in the process of giving meaning to the past events and to create a better future. We try to facilitate this process through creating services in which local people can help their own local people. MSF is aware of its modest role in this process.
The needs in perspective: a system approach in the emergency phase

The assessment revealed clear mental health needs within the population of Sierra Leone. Mental health needs which have been provoked by the past violence, but also structural needs caused by the absence of a (minimal) mental health system. Therefore a future mental health intervention should not focus just on the issue of traumatic stress but also incorporate other problems in the mental health continuum. The combination of high needs and the absence of basic mental health services justify the conclusion of a catastrophic situation which will even further deteriorate when peace sustains and the population switches from survival behaviour to (re)settling.

What is present?

The community level is possibly the best organised and the most effective. Over the past years many national grass root initiatives were started, and continued, even during the highest levels of insecurity. These initiatives were partly supported by various international NGOs who provided training in basic counselling skills and basic psycho-education in various parts of the country. Since the recent crisis the activities of the grass root organisations have been adversely affected. The activities, in rural areas particularly, have been eradicated because most of the population have fled.

Mental health services have never been present as part of the primary health care services. In the reconstruction of the primary health care services the opportunity should be taken to include mental health services. A strong link between the community grass root services (part of the social system) and the primary mental health care services (health system) is essential to provide immediate relief for those that are suffering. Early intervention reduces suffering. A strong first line of mental health care also decreases the strain on other levels of the mental health system.

In the district hospitals (secondary level) treatment for more severe mental health disorders should be available. Except for the Bo district (1 medical doctor with certificate in psychiatry) no district has these services available. Immediate investment on this level is vital.

Sierra Leone has only one mental health institution: the Kissy Mental Hospital. The infrastructure of the building is appalling. Both the government and MSF are doing basic reconstruction. The living conditions in this institution are inhumane despite the brave efforts of a few dedicated national staff under guidance of the only psychiatrist in Sierra Leone: Dr Nahim. The only treatment available is chlorpromazine. At present the psychiatric patients share the institution with IDPs.

What is needed?

Firstly, the dire mental health situation in Sierra Leone has to be acknowledged by both the government of Sierra Leone and WHO as a priority area of intervention. The well intended efforts of NGOs are barely sufficient to build a basic support capacity on community and primary mental health care level. The referral system for those suffering from severe mental health disorders is of vital importance to reduce human suffering of a very vulnerable group which is in need of intensive treatment. This group is expected to increase significantly when the peace process continues. The acknowledgement of mental health as a priority area should be materialised through immediate emergency action. To realise basic mental health services on tertiary and secondary level on the short term 22 nurses (2 in each district) and 11 medical doctors should be trained in psychiatric treatment and case management. Training resources are available in Nigeria and entail 18 months training (diploma level). The regular delivery of basic drugs has to restart. Furthermore, the basic living conditions in the Kissy institution have to improve on the short term.
At the primary health care level activities should focus on training and implementing primary mental health care services on health post level. The present medical staff have to focus on addressing the physical needs, therefore, the mental health services can only be effective and professional when a special function, for instance a community-based mental health worker, is created within the health post. The interventions would entail individual or group counselling, crisis intervention, outreach in the communities, training of medical staff and referral to secondary and tertiary level. The interventions do not include drugs prescription. The community-based mental health workers can be recruited from people that have received counselling training in the past and have gained experience in grass root organisations, local and international NGOs. NGOs (local and international) can support the implementation of these services through ongoing training (formal and on the job) and active implementation at health post level. It is advised to start a pilot project to test the model.

The job of a community-based mental health worker requires thorough counselling skills and knowledge of various topics (dealing with sexual abused, amputees, problems of returnees, substance abuse, domestic violence, children in distress, former child soldiers etc.). It should not become a highly specialised profession since this is not appropriate on this level of the health care system. A standard curriculum should be developed and institutionalised through a training centre. Trainers should be trained as trainers to secure the sustainability of community-based services and to guarantee a quality standard.

A number of NGOs offer specialist services to very vulnerable groups (most notably: children of armed forces, amputees and victims of sexual violence). Co-operation, sharing of knowledge and experiences between the specialist counsellors and the community-based mental workers will increase the professional level and facilitate cross referral.

In this assessment the role of traditional healers has not been taken into account. In some regions they play a meaningful role on community level. The contribution of traditional healers should be further researched and will vary from region to region. When appropriate, their services should be valued as a vital resource and acknowledged as a referral system. For most parts of the country community structures have been severely disrupted. On an individual and group level these structures provide strong protective mechanisms against mental health problems. A healthy community can support its members and is able to (re)integrate those that are vulnerable. In a model for mental health care the healing capacity of the community has to be acknowledged and valued. Community workers need further training on community (psycho) education, giving advice, community sensitisation, organising community support and activities, monitoring and advocating rights of vulnerable individuals, referring cases to the health posts, and organising the outreach from the health posts. The Ministry of Social Affairs has already a training centre for community services in Bo. It should be further supported through training of trainers courses. The NGOs involved in providing community-based mental health care should actively involve the local grass root organisations and consider to train community workers through the centre in Bo. An active connection between the community-based mental health workers and the community workers is important for prevention, monitoring and case identification.
MSF program proposal: capacity building and emergency support

The proposal is based on various principles:

1. Almost every Sierra Leonian is affected by the violence. The assistance will not be limited to specific groups alone but rather focus on the mental health in general. A community based mental health approach is required to meet the needs of the people. Moreover a community based approach reduces suffering in an early stage, is tailor made to the local culture and is cost effective.

2. Not all mental health consequences of violence are disorders nor do they qualify as pathology. This message will be brought across to avoid stigmatisation.

3. The principle 'local people support local people' is prevailing. Expatriate staff should refrain from counselling. The role of foreigners is supportive (training, training on the job), supervisory (guaranteeing quality of services) and facilitating (on organisational level).

4. Capacity building of national staff is combined with the provision of immediate services for those affected by violence.

5. Training and services are developed through an interactive process in which the mix of Western mental health principles and Sierra Leonian healing systems eventually result in a specific Sierra Leonian support method and mechanism.

6. A minimum quality standard of counselling service will be developed. The level will increase over time from basic into more professional.

7. To reduce the mental health effects of violence more effectively both the social and (traditional) health system needs to be further assessed and when appropriately integrated into mental health care program.

8. Parallel to the community based care for all people, specialist services with specialist knowledge (children of fighting forces, support for amputees, victims of sexual violence) are essential to address the specific needs for the groups dealing with specific experiences.

9. Helping the helpers support is mandatory for every mental health program.

10. Close co-operation among the NGOs, WHO, UNICEF, the Health and Social authorities is essential to achieve the objective of creating sustainable support for mental health problems.

11. MSF will involve the MoH from the beginning. A Memorandum of Understanding to arrange the hand over of major components of the program after one year.
Objectives

The MSF mental health program has the overall objective of creating community based mental health services able to provide mental health support to those suffering from mental health problems caused by the violence in Sierra Leone. The overall objective is realised through the two project purposes:

1. To implement a community mental health centre in Freetown, providing counselling services to those in need and training services to educate new community based mental health workers.

2. To start a pilot project in which mental health services are implemented on community and primary mental health care level (location to be defined later).

Freetown Community Mental Health Training Centre

The Freetown counselling centre is implemented by MSF. Collaboration with the MoH (Ministry of Health) is preferred and the collaboration is defined through a mutual memorandum of understanding defining the services, mutual responsibilities and a plan of action for handing over.

The staff of the centre is preferably recruited from a group experienced counsellors trained by Dr Nahim. The staff is employed full time and do not necessarily have a medical background. The staff receive a Training of Trainers (ToT) by MSF. Part of the training is the development of a four week (full time) Sierra Leonian curriculum for community based mental health workers. The curriculum is certified and will be submitted to the MoH (Ministry of Health) for official approval. When approved by the MoH the certificate can be a future selection criteria for primary mental health care workers.

The curriculum should contain some theory on the psychological consequences of violence (the normal reaction to abnormal circumstances, traumatic stress, mood disorders, acute/chronic PTSD (post-traumatic stress disorder)), psycho-social problems (substance abuse, marriage problems, children in distress etc.) and psychiatric consequences of violence (most notably, psychosis, depression, anxiety disorders). The predominant methodology of the curriculum is ‘learning by doing’. Skills like interviewing, counselling, active listening and communication should be formulated for the Sierra Leonian context. Especially the intervention skills are defined during the ToT (Training of Trainers) course through interaction between the (Western) trainer and Sierra Leonian participants. The frame work intervention techniques have to focus on short (group and individual) interventions containing elements of psycho-education, self help techniques, promoting self control and giving advice. In both the ToT (Training of Trainers) and the curriculum attention has to be given to the topic of 'Helping the Helpers'.

Over time the knowledge of the staff can and should be improved. NGOs focusing on special topics and trainers/consultants visiting Sierra Leone can support this activity by sharing their knowledge with our staff. To support this quality improvement of MSF staff UNICEF Freetown has been asked for active support. The increase of the professional level of the MSF staff is beneficial for all the NGOs because MSF staff can train the staff of other NGOs and new community based mental health workers. Special training attention has to be given to the health staff working in the health system (case identification and referral).

A second activity of the staff of the community based mental health centre is to provide support to those suffering from mental health complaints. The link between practice and training is vital to keep the training practical. The improvement of knowledge and experience of the staff may eventually result in a potential referral place for those in need of longer treatment. From the centre visitors can also be referred to specialist services offered by NGOs. The quality of services and treatment within the centre are supervised by an expat
mental health professional with a national mental health counterpart.

The centre has to maintain an active link to the community. In collaboration with the Ministry of Social Affairs the training of community workers has to restart. The community workers that maintain active links with the centre are preferably selected from the national NGO FAWE. FAWE’s mandate is rooted in the education of women and its community network is extremely well organised and active.

The community workers should be regularly trained by the staff of the community based mental health centre. The curriculum of the initial training organised in active collaboration with the Ministry of Social Affairs and UNICEF should entail: knowledge on psycho-education, identification/referral of vulnerable groups, child protection, special topics like reintegration of children of armed force and sexual violence. The organisation of the activities has to be discussed in detail with the Ministries of Social Affairs and Health.

The estimated time to realise the community based mental health centre is one year. After one year the gradually increasing involvement (including financial) by the MoH will be essential to secure a final hand over in two years. The upgrading of the professional skills of the staff is an ongoing process.

**Pilot program on community based mental health services**

To support the establishment of primary mental health care services in Sierra Leone, MSF intends to implement a pilot project that can serve as a model. To realise this project purpose and the sustainability of the implemented services the active collaboration and commitment of the MoH is essential. The best time to implement the pilot project is after the ToT of the staff in the Freetown community based mental health centre. The up-country location of the pilot is still under discussion and depending on the security situation.

The existing primary health care services will be enriched by community mental health workers (added to the existing health staff). The workers are trained by MSF on the curriculum developed in the centre in Freetown. Ongoing training is guaranteed through the same institution.

Services offered by the community based mental health workers include: counselling support, outreach to the community, training of health workers (identification, referral) and education of community workers. On this primary level of health care support is only provided for mild mental health problems. The services offered are short term and do not involve the prescription of drugs. Severe pathology, psychiatric cases, people in need for drugs or longer treatment have to be referred to the secondary level of the health care system (district hospital). During the implementation phase, training on the job and supervision is provided through expat mental health professionals.

The link between the primary mental health care system and the community is essential. Community workers need training on psycho-education, sensitisation, identification/referral of vulnerable groups, child protection, special topics like reintegration of children of armed forces and sexual violence. The training of community workers is the responsibility of the Ministry of Social Affairs. The community mental health workers can participate in the training of community workers through their knowledge of mental health problems. Since the local NGO FAWE is wide spread over the country likely candidates for this job of community workers are people from this organisation. The organisation of the additional training and the active collaboration with the health system has to be discussed in detail with the Ministries of Social Affairs and Health.

Especially in rural areas traditional healers are important in the provision of mental health support. When appropriate, their services should be valued as a vital resource and the community mental health workers need to collaborate closely in the referral of cases (vice versa). Competition with this established and widely respected group of people should be avoided. However, the services of traditional healers should meet the ethics of the health system.

The implementation of the pilot program on community based mental health services is estimated to take one
year. After this stage the services are gradually handed over to the MoH (financial, co-ordination and quality).

**Input of Ministry of Health and WHO**

MSF strongly requests the involvement of the Ministry of Health and WHO. To make the community based mental health services sustainable on the long term, the MoH of Sierra Leone has to commit itself to add staff who are capable of providing primary mental health care services to the primary health care units. These commitments should be formalised by a memoranda of understanding.

In addition to this the MoH has to organise, in collaboration with WHO, the mental services on secondary and tertiary level in order to secure a proper referral system. Without this involvement on all levels the program objectives of this proposal are seriously jeopardised. An immediate step to take is to execute the recommendations of the document: Mental health in Sierra Leone the way forward by Dr T.O. Matturi.

During a meeting on the 23 of July with the Honourable Minister of Health of Sierra Leone Dr Jalloh, full co-operation and support for our initiatives was granted. The role and responsibility of the government to improve the primary, secondary and tertiary mental health care was fully acknowledged. His Excellency the President of Sierra Leone Dr Kabbah and the Honourable Minister of Health Dr Jalloh have committed themselves to the improvement of the mental health care system in Sierra Leone.
Notes

1. FAWE is a local NGO, associated with the African movement for education of women. After the January 1999 events FAWE temporarily extended its mandate and provided (counselling) support to victims of sexual violence.

2. Children of armed forces is used in this context for those children that were actively participating in combat, those in possession of a weapon and those that carried loads.
**Appendix 1: Overview of mental health NGOs, activities and requests**

<table>
<thead>
<tr>
<th>NGOs</th>
<th>Programme</th>
<th>Purpose of training</th>
<th>Nos. trained</th>
<th>Type of training</th>
<th>Length of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodist Med</td>
<td>Preventive and Curative Counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNICEF</td>
<td>Children &lt;18 yrs Sexually abused Child soldiers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLRX</td>
<td>HIV/STDs, Psycho-education, Home Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOAL</td>
<td>Street children</td>
<td>Social work, General counselling</td>
<td></td>
<td>Professional studies</td>
<td></td>
</tr>
<tr>
<td>MARIE STOPES</td>
<td>Family planning</td>
<td>Family Planning, HIV/AIDS</td>
<td></td>
<td>on the job, abroad</td>
<td></td>
</tr>
<tr>
<td>FAWE</td>
<td>Victims of sexual abuse</td>
<td>Professional</td>
<td>1</td>
<td>education &amp; religious</td>
<td></td>
</tr>
<tr>
<td>SAVE THE WOMAN</td>
<td>Commercial sex workers</td>
<td>Informal</td>
<td></td>
<td>on the job</td>
<td></td>
</tr>
<tr>
<td>City Council</td>
<td>Reunification/tracing</td>
<td>Psycho-social, Trauma healing</td>
<td>8</td>
<td>workshop</td>
<td>10 days</td>
</tr>
<tr>
<td>CADO</td>
<td>Children 12-15 yrs, Reproductive health, Youth animation, STD/AIDS, Drug abuse, Productive skills</td>
<td>Peace building, reconciliation</td>
<td>2</td>
<td>Orientation training</td>
<td>1 day</td>
</tr>
<tr>
<td>PPASL</td>
<td>Peer counselling of youths. Men, women, displaced, traumatised</td>
<td>Family planning</td>
<td>30</td>
<td>refresher</td>
<td>10 days</td>
</tr>
<tr>
<td>COOPI</td>
<td>Psycho-social follow up of returned abductees (children)</td>
<td>Field practice w/ supervision by psycho- therapist</td>
<td>7</td>
<td>Supervision, Case studies</td>
<td>3 mths</td>
</tr>
<tr>
<td>HANDI-CAP INT</td>
<td>Counselling of all traumatised Amputees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSWGCA</td>
<td>Families of children in conflict/war,</td>
<td></td>
<td></td>
<td></td>
<td>college</td>
</tr>
<tr>
<td>Domestic, Sexually abused</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>