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Impact of global and national crises on people with severe mental illness

CLINICAL REFLECTION

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SUMMARY

As experts in disaster mental health push to reframe disaster response as a preventive medicine rather than its actual state of acute management, various factors should be considered. Although a whole population may be victim to the effects of disasters, particularly vulnerable are those with severe mental illness. Therefore, efforts geared to bolster trauma response should centre on these individuals, starting at a community level and reaching organisational and governmental endeavours and funding.

KEYWORDS

Trauma; pandemic; in-patient treatment; out-patient treatment; severe mental illness.

Large-scale crises have an impact on all strata of society and affect entire communities and their organisations. However, some individuals and services are especially vulnerable to acute and chronic insults, whether natural or inflicted by humans. Mental health services and people who depend on them are among the most vulnerable and, regretfully, out-of-spotlight groups during general disasters. Here, we will underscore some key issues to address the well-being of people with severe mental illness (SMI).

The following are multilevel factors that deserve attention in preparing disaster responses:

- organisational and institutional capabilities and procedures
- preparedness and immediate response to crisis
- personnel resilience and professionalism under stress
- patients' management in various treatment settings: psychiatric or general hospitals, in-patients or out-patients.

Future-oriented solutions to the above issues would potentially place mental health services in better shape for the next anticipated epidemics, climate-related problems and other disasters.

Professional organisations and mental health services

Mental health services are often underfunded and least prioritised in building disaster prevention and response strategies. This can potentially incapacitate an already stretched mental healthcare system when resources are depleted and delivery systems overwhelmed. As the COVID-19 pandemic has shown us so far, the incidence of mental disorders in the general population increases with major disasters, especially depression, anxiety and post-traumatic stress disorder (PTSD). Furthermore, people with a history of PTSD may be more likely to have reactivation of symptoms than those with psychotic disorders (Kinzie 2002) and this may depend on cultural aspects that should be closely considered. Although anecdotal reports indicate that some groups may be more resilient than others, these were mostly on local disasters, and cross-cultural comparisons of responses to the same events are still needed. The COVID-19 pandemic will probably provide some answers. People with depression or anxiety may also experience worsening of symptoms. In either case, most patients who seek care are first seen in emergency rooms and by internists and family practitioners before being referred to psychiatrists.

Therefore, professional organisations such as the American Psychiatric Association and the Royal College of Psychiatrists might consider approaching sister organisations, such as the American Medical Association, American Psychological Association or the Royal College of Physicians, to form collaborative interdisciplinary partnerships (Halbreich 2019). These might serve to train practitioners and form operational interdisciplinary treatment teams that could also collaborate to better understand level of need and titrate the allocation of resources. Our current experience and predictions of future crises provide for incentives for organisational partnerships, lobbying of policy makers for funding as well as upgrading of current services and their restructuring if needed to better serve the surge in demand during these times.

Preparedness for future disasters for a more immediate response

Some events are predictable and potentially preventable, but others cause massive damage with little room for planned responses. Therefore, interventions such as providing early reassurance, clear

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plans for safety management and guidance on best action during a disaster are likely to help and decrease the anxiety patients may face. When disasters such as hurricanes or floods are anticipated, shelter and evacuation plans should also be in place and proactive group education should be conducted. In disasters, individuals with SMI may require more assistance than usual, although resources and provider availability are stretched thin or non-existent. Although local and state governments have the most breadth of outreach and resources to serve entire communities, efforts can and should start at a lower level, with clinics and out-patient community programmes to proactively outline individual patient needs for times of crises.

Personnel resilience and professionalism

Experts prefer disaster mental health responses be reframed as 'preventive medicine' rather than the previous 'post-disaster management' (Bada Math 2015). Training professionals in responding to mental health emergencies affords communities more preparedness and supports in unpredictable disasters. During viral epidemics and strict public health restrictions, medical personnel suffer from similar emotional and mental symptoms as their patients (Halbreich 2020), further highlighting the importance of training them to deal with trauma responses ahead of time.

That huge need creates a niche for educational and resilience enhancement programmes to be further developed and implemented. Additionally, those in psychiatric clinic and hospital leadership positions might consider having an 'on-call task force' to rapidly mobilise resources and accommodate the need for emergency, trauma-based responses. Providing staff and front-line workers with education, clear and concrete responses, and a safe space to process reactions would be highly beneficial in the downstream effect on staff's ability to be therapeutically available for patients.

Management of patients in psychiatric hospitals

Although individuals with SMI may be more prone than people with other mental illnesses to experience symptom deterioration during disasters, it is not always the case. Studies have reported that in-patients with SMI did not decompensate as expected and the rates of in-patient admissions did not increase following major disasters (Beaglehole 2015). These patients are likely not as fragile as we may expect. Nevertheless, this does not mean that we should neglect the following.

Although physically sheltered in psychiatric hospitals, in-patients remain vulnerable to external disasters and are further isolated from loved ones in the community in times of crisis. Confinement in hospital – when no less restrictive, more integrated alternative is available – may amplify the lack of agency and patients' inability to escape to safer places when their sense of security is shaken by external forces.

Patients often obtain news from television, other patients or staff but seldom have the opportunity to clarify and process. Frequently, their interpretation and reactions to events are coloured by their symptoms (Geller 2020), and these symptoms may cloud judgement, minimise retention of information and put their coping skills to the test. For example, in a COVID-19 scenario, a patient with obsessive–compulsive disorder (OCD) could feel reassured that her behaviours are now normalised and shared by the majority, and hence show improvement in some symptoms while resuming intense cleaning habits to avoid contamination. This is where clinical teams can intervene by validating the fears and normalising some of the behaviours in the context of the pandemic. Educating patients and staff alike and providing clear and concise information about the situation is another way to address anxieties, decrease misinformation and create a sense of community on the unit. Staff and patients are living through shared experiences.

From our own observations during the COVID-19 pandemic, some in-patients experienced more isolation, stress, anxiety, nightmares, irritability and helplessness. Others fared better overall with the pandemic-induced social changes, the sense of community created by the common experience and the reassurance received from being cared for and protected. The day structure – although changed, but not fully dismantled – and regular check-ins with their clinical teams also provided reassurance and prevented feared outbursts and decompensation. Medication adjustments were rarely needed to manage disaster-specific symptom resurgence, although some patients may require special attention depending on individual cases.

Management of psychiatric patients in general hospitals

U.H.'s personal observations of the period prior to the 1967 Arab–Israeli war and the time immediately thereafter may shed some light on the emotional state and behaviour of patients with schizophrenia under stress. The weeks leading to the war were very grim and stressful for the entire Israeli civilian population. Personnel on the psychiatric ward in the Hadassah University Hospital in Jerusalem were as anxious as most other civilians and the doomsday atmosphere was contagious. Patients

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absorbed the prevailing atmosphere and mood. During the days before the war, most patients were sent home to vacate beds for the anticipated casualties. Only the most severely ill individuals, deemed too dangerous to be discharged, stayed as inpatients. Shortage of personnel in the surgery and orthopaedic wards, where most of the wounded soldiers were admitted, led to recruitment of volunteers. These included the able-bodied patients in situ, who helped with routine functions alongside volunteers from the community. Like the other lay volunteers, they received hospital-staff gowns and some brief instructions. Under pressure and while given responsibilities and dignity, these patients with schizophrenia – otherwise deemed unfit to be discharged from the hospital – functioned adequately and performed very well. At the end of their shifts, they returned to the psychiatric ward, where they occasionally participated in group therapy. They were discharged to their homes and the community shortly thereafter. It might be worthwhile systematically replicating this non-intentional experiment.

Conclusions and recommendations

In acute crises, despite the panic that may amplify a disastrous event, a glimpse of hope exists: people undergoing the same experience tend to be more supportive of each other. This 'pulling-together' effect may be positive for patients with SMI, and can increase the sense of belonging and bolster resilience in the face of adversity.

However, the reality is that mental health services remain underfunded and underdeveloped to meet population needs during disasters, and especially in their aftermath. Rather than the typical acute management response, our efforts should be focused on shifting to long-term predictions and planning for care and prevention.

Author contributions

All authors have contributed to the writing of this article. M.A.Z.D. led the review, editing and the collaboration with U.H., J.G. and the journal for finalization of the paper.

Declaration of interest

J.G. is the current president of the American Psychiatric Association.

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