Mental Health and Health Crises: what the Ebola epidemic can teach us about mental health during pandemics?

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As countries rapidly formulate appropriate responses to the global coronavirus disease 2019 (COVID-19) pandemic, the World Health Organisation (WHO) has issued an urgent statement noting, "Unless governments and communities take action discrimination against people with disabilities could increase during the COVID-19 pandemic".[1] It is the intention of this brief to first examine the challenges people living with disabilities – specifically mental illness – in low-income countries face and, secondly to advance some suggestions in order to best formulate a response that is mental health inclusive, and how CBM can offer support to ensure that vulnerable people do not fall down the cracks.

While much remains unknown about the virus, and these gaps present challenges to government responses to the unfolding crisis. Questions persist about rapid transmissibility and symptom severity and these gaps in our knowledge create challenges in building a robust framework to respond to the crisis. In this endeavour it is necessary to recognise that both 'disability' and 'mental illness' are umbrella terms that cover a varied and extensive range of symptoms, and an inclusive response will be receptive to this factor. By drawing on the lessons learned from the recent Ebola crisis in West Africa in 2013-2016, this brief contends that it is possible to identify some of the challenges people living with mental illness face during epidemics. From these lessons, we can respond to the current COVID-19 crisis in the absence of complete knowledge of the virus.

Epidemics, low-income countries and mental illness: The Ebola crisis

The beginnings of the Ebola Virus Disease (hereafter Ebola) was reported in March 2014, after a case of haemorrhagic fever was diagnosed in the south eastern region of rural Guinea. In the months that followed the cases and rates of infections escalated, spreading to neighbouring states of Sierra Leone and Liberia and then further into West Africa. The combination of ill-equipped monitoring systems and overburdened healthcare systems aided the transmission of the virus to surrounding countries.[2] Estimates from the WHO note 28,616 cases were reported and claiming 11,310 lives, most in Guinea, Liberia, and Sierra Leone.

[1] UN Preventing discrimination against people with disabilities in COVID-19 response, 19 March 2020, Accessed 5 April 2020 from https://news.un.org/en/story/2020/03/1059762
[2] 2014-2016 Ebola Outbreak in West Africa, Centers for Disease Control and Prevention, N.D., Accessed 10 June 2020 from https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/index.html

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The repercussions of this crisis introduced new challenges for the health system including extensive mental health concerns. In light of the recent COVID-19 outbreak, it is worth returning to the Ebola crisis to assess what lessons were learned and how these might be applicable to the current situation.

Apply the lessons from Ebola to the COVID-19 crisis

Recognising the impact of isolation on mental health

Challenges associated with periods of prolonged isolation and the breakdown of regular routines and support systems present a series of unexpected adaptation. Many patients who survived Ebola and care-givers reported a change in their mental health, noting feelings of grief, guilt, shame and depression linked to the loss of loved ones. People who had been separated from loved ones as they battle the Ebola disease, or succumbed to the illness also noted feelings of distress, guilt and shame.[3] According to CBM International mental health advisor, Julian Eaton, most people will experience some mental distress during periods of isolation, but this effect can be amplified for some people living with mental illnesses.

> *"Isolation breaks down support when people need support more than ever" Julian Eaton*

Periods of isolation relating to Ebola saw a disruption to normal routines and lifestyles. Where this became deeply problematic was in relation to accessing medication for mental illness or chronic pain medication. Many people rely on family and support workers to provide medication and without this service, this may lead to profound health concerns relating to their own and others health and well-being.[4]

Isolation can have adverse impacts on people living in institutions. Where people living with mental illness receive institutionalised care, they are at increased risk of neglect and abuse. In many cases, Eaton notes, people within these institutions are vulnerable and are often wards of the state or have limited family support or contacts, leaving them reliant on the support and care staff within these establishments for their daily needs. In times of reduced contact such as epidemics, Eaton cautions that these people are amongst the most at risk groups.[5]

Recognising the financial strain of epidemics.

According Julian Eaton, at the heart of a response to an epidemic is the need to prioritise the necessities of human life: ensuring safe access to food, water, shelter and sanitation. In addition to safeguarding basic needs, an inclusive response to COVID-19 need to take into account the need for economic assistance to be accessible to people with mental illness.

Research in the aftermath of the Ebola crisis also noted ongoing economic challenges in the provision of services such as closures of local business and industries, as well as challenges to social structures including overstretching community health and support services.[6] These challenges have ongoing implications particularly for people living with disabilities since accessing many of these services are critical to their independence and ongoing engagement. COVID-19 lockdowns have similarly closed many markets and informal avenues of earning income, leaving many people without access to financial support.

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[3] T. Van Bortel, A. Basnayake, F. Wurie, M. Jambai, A. Sultan Koroma, A.T. Muana, K. Hann, J. Eaton, S. Martin & L.B. Nellums (2016), 'Psychosocial effects of an Ebola outbreak at individual, community and international levels', *Bull World Health Organ* , 94, pp. 210–214.
[4] Personal communications with Julian Eaton
[5] Ibid.
[6] Ibid.

Training of local healthcare worker to recognise mental illness symptoms

When reintegrating recovered survivors of the Ebola crisis into the community they were often met with stigma and faced an extensive uphill battle. Many had lost friends and family members to the disease and were struggling with feelings of loss, grief and hopelessness. Reports have noted that on top of dealing with the loss of family and friends to the Ebola virus, many lost income and livelihoods through looting and property damage. One anecdote from the WHO recounts a story in which an Ebola patient was finally discharged from the Ebola Treatment Unit only to return home and find his property burnt and destroyed.[7]

Recognising the toll of this loss and grief on mental health is vital to ensure the community can recover and rebuild collectively. In responding to Ebola, this included sending healthcare educational teams into regions affected by the disease to better equip the community with the knowledge of where to access help. Research has also noted during Ebola that there was a preference for traditional healers in many remote regions, perhaps informing and assisting traditional healers to better equip key members in the community with resources to refer people for assistance.[8]

Reinforcing social networks during crisis

In times of epidemics and crises, these family networks of support are vulnerable. In low-income countries were government capacity is low, the burden of care and support is not facilitated through extensive welfare system and safety nets but rather carried by family members and communities. During the Ebola epidemic existing healthcare and designated Ebola units struggled to respond to the numbers of patients requiring care.[9] This left much of the burden of patient care on family and support networks. Often family members were ill equipped or lacked protective wear to prevent further contamination. Other cases noted occasions were family members had refused to transport their relatives to treatment facilities, preferring rather to treat them at home and spreading the virus in doing so.[10]

Responding to the Ebola crisis required reinforcing the exiting social and formal healthcare networks. Strengthening these networks through greater support structures and access to healthcare providers and services will enable people to retain access to medication and support structures to maintain their quality of life. This may require greater training services for community mental health providers to ensure they are equipped with the knowledge and resources necessary. In tackling the Ebola crisis, this support service came in the form of training programs and use of additional mental health support workers and professionals provide assistance to Ebola-affected regions. Ultimately, Eaton stresses what is needed is a referral mechanism, that enables community workers to identify, recognise and refer people suffering with mental health concerns to further treatment services.

> *"We need to reinforce existing networks of support such as family or self-help group to ensure people have access to help" Julian Eaton*

Prioritising clear communication and messaging during epidemics and in crises responses

Ensuring clear communication was a challenge during the peak of the Ebola crisis. In this instance, the lack of clear messaging led to the spread of mistrust and stigma within communities, which can exacerbate mental health concerns and may even prevent people from seeking help when ill. Finding from Ebola research indicated that misunderstanding led to people concealing ill family members and nursing family members without the protection to prevent further transmission within the family unit.[11]

[7] 'Tackling mental illness after Ebola' The World Health Organisation, 11 April 2017, Accessed 10 June 2020 from https://www.afro.who.int/news/tackling-mental-illness-after-ebola
[8] Ibid.
[9] J. Shultz, F. Baingana, Y. Neria, (2015), 'The 2014 Ebola Outbreak and Mental Health: Current Status and Recommended Response', JAMA February (313): 567
[10] Ibid.
[11] Ibid.

The lack of clear information relating to clearly identifying how the virus is transmitted, preventative measure and where to access further information. Ensuring people with mental illness receive appropriate messaging is vital in preventing additional stress and anxiety. Poor communication and a lack of information increases risks of contracting the virus. Where healthcare systems are already poorly resourced or overstretched as is often the case in low-income countries, misinformation can lead to increased risks of transmission and greater strain on the healthcare system.

> *"Getting messaging right in times of uncertainty is crucial, because the lack of clear messaging can mean people are at risk" Julian Eaton*

An immediate response to the COVID-19 crisis can build on this lesson. Responses needs to ensure that people with mental illness can remain informed and connected in times of uncertainty. Social networks might be strengthened through the provision of phone or internet credit or access, which might enable self-help groups to remain connected to the members of the community with mental health concerns, but also as a means of disseminating appropriate messaging around information and preventative measures and ensure that this information reaches the necessary people. Dissemination of information would be multifaceted, to address information around the epidemic to counter the spread of myths and misconceptions, but also to provide clarity around where and how to access healthcare services.

Amplifying the voice and visibility of people living with mental illness

In responding to the COVID-19 crisis, the lessons from Ebola underscore how necessary the role of advocacy is in amplifying the voice and visibility of people living with mental illness during epidemics. This response will demonstrate the need to safeguarding practices that prioritize the personal welfare of people living with mental illness against physical and sexual harm and neglect. Here, CBM Australia can support this work, collaborating with disabled people's organisations (DPO) and self-help groups to lobby governments and raise awareness. CBM Australia is uniquely positioned at the forefront of advocating for disability-inclusive development and this position can be maximised by DPOs and self-help groups looking to capitalise on a platform with both community and national reach.

> *"CBM is already in a position to advocate for vulnerable people at community and national level." Julian Eaton*

In closing, the lessons from the Ebola crisis provide valuable insight into responding to other epidemics or even pandemics such as the current COVID-19 crisis. Futureproofing will also involve further documenting and prioritizing monitoring and evaluative measures and the production of learning strategies around what has been successful. The value in such lesson enable us to produce resources that can map and plan where vulnerable people exist at both a community and national level. These lessons – such as the lessons from the Ebola crisis – will provide a resource bank that can expedite responses in the future, should the need arise.