



Operational considerations for
multisectoral mental health and
psychosocial support programmes
during the COVID-19 pandemic

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This document was released in May 2020. It will be updated regularly during the COVID-19 outbreak. Contact the IASC MHPSS Reference Group (mhpss.refgroup@gmail.com) for a copy of the latest version.

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Abbreviations and acronyms

| | |
|-----------------------------|--|
| 4Ws | Who does What, Where and When |
| ACF | Action Contre la Faim |
| COOPI | Cooperazione Internazionale |
| COVID- 19/ 2019-nCoV | Corona Virus disease |
| CVT | Center for Victims of Torture |
| GBV | Gender Based Violence |
| HI | Humanity and Inclusion |
| HIAS | Hebrew Immigrant Aid Society |
| IASC | Inter-Agency Standing Committee |
| IDP | Internally Displaced People |
| IEC | Information, Education and Communication |
| IFRC | International Federation of Red Cross and Red Crescent Societies |
| IMC | International Medical Corps |
| IOM | International Organization for Migration |
| IRC | International Rescue Committee |
| LGBTI | Lesbian, Gay, Bisexual, Transgender and Intersex |
| MDM-Es | Medicos del Mundo-Espana |
| MDM-France | Medecins du Monde- France |
| M&E | Monitoring and Evaluation |
| MHPSS | Mental Health and Psychosocial Support |
| MSF | Medecins Sans Frontieres |
| OPD | Out Patient Department |
| PIH | Partners in Health |
| PSTIC | Psycho-Social Services and Training Institute in Cairo |
| PFA | Psychological First Aid |
| PPE | Personal Protective Equipment |
| SIM Card | Subscriber Identity Module Card |
| SOPs | Standard Operating Procedures |
| TPO-Nepal | Transcultural Psychosocial Organization in Nepal |
| TPO-Uganda | Transcultural Psychosocial Organization in Uganda |
| TV | Television |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Children's Fund |
| WHO | World Health Organization |

Introduction

People all over the world are facing severe impacts on their mental health and psychosocial wellbeing due to the COVID-19 pandemic. Psychological distress is widespread among large segments of the populations, due to the immediate effects of the virus on health, due to the consequences of measures to contain the spread, such as physical isolation and suspension of services, and due to the worries about loss of livelihoods and education.¹ The direct effects of the pandemic are compounded by the effects of ongoing humanitarian emergencies and sociopolitical and economic fragility in countries hosting vulnerable populations. The humanitarian community through the Inter-Agency Standing Committee has therefore asked for dedicated attentions and resource mobilization for mental health and psychosocial support (MHPSS) within the Global Humanitarian Appeal for the COVID-19 response.²

In March 2020 the IASC Reference Group on Mental Health and Psychosocial Support uniting 57 humanitarian organizations as member issued the Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak.³ This document has proven to be very useful in the response and has till now been translated in 24 languages. It covers a set of recommended activities as well as messages for different target groups.

The current document is an annex to the Interim Briefing Note and is meant to support the MHPSS operational response within the various sectors of humanitarian work. Approaches and interventions to MHPSS are not confined to one sector, but need to be integrated within many existing sectors and clusters.⁴ This document contains a wealth of operational information and practical approaches that can be used for humanitarian programming in health, SGBV, community-based protection, nutrition, camp management and camp coordination.

It contains five sections:

1. Adapting psychological first aid for the COVID-19 context
2. Continuation of comprehensive and clinical MHPSS care in humanitarian settings during the COVID-19 pandemic
3. Mental health and psychosocial support considerations for children, adolescents and families during the COVID-19 response
4. Considerations for developing MHPSS responses to the COVID-19 pandemic for older adults
5. Addressing substance use and addictive behaviours during the COVID-19 outbreak

The document contains many references to other documents that can be accessed through hyperlinks. Make sure that you consult the latest version of those documents, since knowledge around COVID-19 is developing rapidly. For guidance on health aspects of the pandemic, see the Country and Technical Guidance on Coronavirus disease (COVID-19) on the website of the World Health Organization.⁵

We hope the document will boost the inclusion of mental health and psychosocial support within the whole humanitarian response. This is not a luxury or an add-on but is essential to make the global response to COVID-19 a success.

¹ United Nations Policy Brief: COVID-19 and the Need for Action on Mental health (2020). https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf

² United Nations: COVID-19 Global Humanitarian Response Plan – May 2020 Update (2020). <https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf>

³ Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak, IASC: Geneva, 2020. <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing>

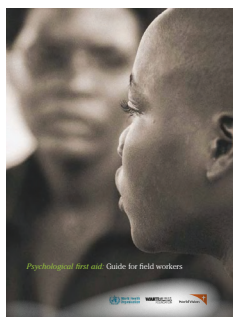
⁴ IASC MHPSS Guidelines: <https://interagencystandingcommittee.org/iasc-reference-group-on-mental-health-and-psychosocial-support-in-emergency-settings>

⁵ WHO website: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>

1. Adapting psychological first aid for the COVID-19 context

The *Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak* (developed by the IASC's Reference Group on Mental Health and Psychosocial Support) recommends training in psychological first aid (PFA) for frontline workers in the COVID-19 context:

“Train all frontline workers (including doctors, nurses, ambulance drivers, volunteers, case identifiers, teachers and other community leaders), including non-health workers in quarantine sites, on essential psychosocial care principles, **psychological first aid** and how to make referrals when needed. COVID-19 treatment and isolation/quarantine sites should include trained MHPSS staff. Online training might be used if it is not possible to bring staff together due to infection risks.”



During the COVID-19 response, PFA guidance and training materials (developed by WHO and partners) need to be adapted for special considerations of safety, preventing the spread of disease and understanding the place of PFA within the range of mental health and psychosocial support (MHPSS) interventions. Please consider the following recommendations to use PFA guidance in situations of COVID-19, in conjunction with the original guidance contained in *Psychological first aid: Guide for field workers*¹ and training materials.²

In addition, *IASC Basic Psychosocial Skills: A Guide for COVID-19 Responders*³ is a good source of information for orienting workers in basic psychosocial considerations, as recommended in this briefing note.

1.1 WHAT IS PFA?

PFA involves humane, supportive and practical help to fellow human beings who are suffering serious crisis events, within a framework that respects people's dignity, culture and abilities. It is a set of skills that can be used by all types of frontline and essential service workers to help children and adults who are in acute distress.

PFA skills are useful in order to know what to say and do, to be supportive and helpful and not cause further harm.

PFA is part of a range of MHPSS approaches. For an effective response to support people's mental health and well-being, it is important to consider various MHPSS interventions for implementation. PFA is one type of basic psychosocial care that can be implemented by anyone. You do not have to be a mental health specialist to provide PFA. Skill development in PFA is particularly useful during the COVID-19 response for:

- frontline workers (including all health workers, social workers, ambulance drivers, pharmacists);
- essential service workers (shop workers, food distribution and other delivery workers, garbage collectors);
- law enforcement and other civil servants (police, firefighters, military personnel, airport security staff, immigration officers, faith-based workers);
- individuals with managerial responsibilities (managers and supervisors, community leaders) and those with caregiving responsibilities for children or other adults (teachers, parents, other caregivers);
- children and adolescents who, with adult supervision, can provide support to their peers.

PFA involves helping people to:

- feel safe, connected to others, calm and hopeful;
- have access to social, physical and emotional support; and
- feel able to help themselves, as individuals and as communities.

¹ World Health Organization, War Trauma Foundation and World Vision International (2011). *Psychological first aid: Guide for field workers*. WHO: Geneva. https://www.who.int/mental_health/publications/guide_field_workers/en/

² World Health Organization, War Trauma Foundation and World Vision International (2013). *Psychological first aid: Facilitator's manual for orienting field workers*. WHO: Geneva. https://www.who.int/mental_health/emergencies/facilitator_manual_2014/en/

³ <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/basic-psychosocial>

During an outbreak of disease, such as COVID-19, it is of primary importance to utilize PFA skills in ways that are **safe for both the helper and the person who is distressed**. It is important as well to acknowledge that this changes how we provide support to each other (e.g. not being able to touch people or get close to them) and how we cope with the illness or death of loved ones (e.g. needing to respect quarantine and isolation instructions, and being unable to attend burials or commemorations in person).

1.2 CARING FOR YOURSELF, YOUR COLLEAGUES AND STAFF

In this time of pandemic, everyone is affected in a different way – for example, anxiety and stress due to sudden job loss, isolation, uncertainty, fear of illness or death, and sadness and grief for those who have died. Isolation measures may cause various stressors for families and caregivers (of children, older adults and those who are sick), who need to adapt their daily life and school and work routines. Frontline and essential service workers are especially vulnerable to particular stressors when caring for people who are ill, being at risk of infection (and being afraid of infecting loved ones), delivering difficult news of illness or death, working long shifts while needing to follow special safety measures, sometimes even lacking safety equipment. In addition, these groups also potentially face stigmatization, and particular consideration needs to be taken of their protection and well-being.

Managers or supervisors may also be supporting staff or volunteers who are experiencing distress. The way that managers support staff and volunteers during stressful times and how they communicate can make a big difference to the way that their workers cope.¹

Everyone must pay extra attention to their own well-being, and to the well-being of staff and volunteers. Ensuring well-being is not a luxury in the COVID-19 response, it is a responsibility. Protecting the physical and mental health of all frontline and essential service workers is essential in order to be able to serve others in the best way. Resources for managing stress and positive coping strategies include: *Doing What Matters in Times of Stress: An Illustrated Guide* WHO: Geneva, 2020: <https://www.who.int/publications-detail/9789240003927>

1.3 WHO CAN BENEFIT FROM PFA, WHEN AND WHERE

- **Who:** Children, adolescents and adults (especially older adults) who are acutely distressed can benefit from PFA, including those who are unwell with COVID-19, relatives of those who are ill, people in quarantine, those who have recently lost a loved one or those who are extremely worried, anxious or upset. In addition, people who are experiencing non-COVID-19 conditions or risks (such as chronic/severe illnesses, cancer, mental health conditions, protection risks and gender-based violence (GBV) who have had their care cancelled or delayed, and their relatives, can all benefit from PFA.
- **When:** PFA is a first response to help a distressed person feel calmer and regain their capacity to cope and make decisions. Then, other MHPSS interventions or referrals may be more appropriate if the person needs additional support.
- **Where:** PFA may be provided through hotlines or by other remote means,² or may be provided in person, as long as safeguarding measures (including personal protective equipment (PPE)) are put in place to keep the helper and the affected person safe.

1.4 RESPECT SAFETY, DIGNITY AND RIGHTS

The basic principles of any type of essential psychosocial care, including PFA, are to respect the **safety, dignity and rights** of anyone you are helping. The specific nature of COVID-19 is that people can be carriers without having symptoms, and the virus is spread rapidly among communities and globally. People who (are thought to) have COVID-19 or who are ill with COVID-19 may suffer distrust, stigma and discrimination. Consider how you would like to be treated in that situation, and treat people in the same way.

Points to remember

- **Avoid putting yourself or others at risk of infection**, by ensuring that you communicate remotely or wear protective equipment during direct contact.
- **Do not expose anyone to further stigma or discrimination**, by ensuring informed consent and confidentiality.
- **Treat all people with respect** and ensure that they can access help fairly and without discrimination, regardless of age, gender or ethnic background and regardless of infection status, illness or work in the COVID-19 response. In some cases, this involves proactively addressing barriers to access.

¹ For more advice specific to COVID-19, see intervention 5 in this briefing note: "Messages for team leaders or managers".

² See guidance from the IFRC Reference Centre for Psychosocial Support on Remote PFA during COVID-19: <https://pscentre.org/archives/9119> and 'An online training package for PFA in the COVID-19 outbreak response from the IFRC Reference Centre for Psychosocial Support': <https://pscentre.org/archives/9261>

1.5 PROVIDING PFA DURING THE COVID-19 PANDEMIC

First, **Prepare** to help by learning about COVID-19, available services and supports, and safety protocols:




| | |
|--|---|
| Learn about COVID-19 | <ul style="list-style-type: none"> • Use reliable sources of information, such as WHO or your national health authority. • Learn how COVID-19 is transmitted, and how to stay healthy and avoid spreading the disease. • Learn the risks, signs and symptoms of infection, as well as how to proceed if you have been in contact with someone who has symptoms or who tests positive for COVID-19, or if you become ill. • Learn about the ways that people might respond to the crisis in terms of mental health in their context. |
| Learn about available services and supports | <ul style="list-style-type: none"> • For people who need extra help in coping emotionally, socially or practically with the situation, find out about the contact information for relevant resources in your area, including mental health care, social services, food delivery, how to access health care when needed and government support packages. • Learn about communication tools to support people remotely, including those with different levels of access (e.g. language, literacy, disability). • In humanitarian settings, review interagency service mapping (ideally updated with access considerations relating to COVID-19). |
| Learn about safety protocols | <ul style="list-style-type: none"> • Learn and follow the protocols recommended to prevent the spread of infection in your country, including hand washing, physical distancing and quarantine, as needed. • Remember that you, or the person you are seeing, may not necessarily have symptoms in order to be carrying and potentially spreading COVID-19 to others. • Find out about the availability of PPE and when and how to use it. |

Chad: refugee students teach COVID-19 awareness in city communities.

© UNHCR/Simplice Kpandji



Keep the following specific COVID-19 tips in mind when you **Look, Listen and Link** – the action principles of PFA:

| Action principle | COVID-19 considerations |
|--|--|
| <p>Look</p>  | <ul style="list-style-type: none"> • Safety first! Take all necessary safety precautions to protect yourself and others from infection. For example, communicate remotely (via phone or from a safe distance) or use PPE when interacting directly with people. • Understand how the specific context will change the way that you approach PFA (e.g. what is possible in confined or crowded living conditions, availability of basic services and referral), and adjust to the local language and culture. <ul style="list-style-type: none"> ◦ If having only remote contact with people, consider how you can know if someone is distressed without face-to-face contact. For example, pay extra attention to signs such as changes in tone of voice, negative thinking, being unusually quiet, keeping irregular routines, etc. • Identify people likely to need special attention, such as: <ul style="list-style-type: none"> ◦ people with signs of respiratory infections or conditions where recommended public health measures are either not being implemented (e.g. social distancing in crowded living conditions) or are not possible to implement (e.g. lack of water/soap); ◦ groups who may be vulnerable or marginalized (see below). |
| <p>Listen</p>  | <ul style="list-style-type: none"> • Be safe, but DO communicate. Social support is essential during this time, as many people will feel isolated. Take opportunities to stay in touch with loved ones, friends and those who are isolated, such as older adult neighbours. • Explain to people that while you cannot come close or touch them, you can listen and care about how they are feeling. Remember that you can still be calm and supportive with your body language and tone of voice and by giving your undivided attention to the person. Validate and help people to normalize their emotional responses. • Do not force anyone to discuss distressing events if they do not wish to do so, but be available to listen empathetically if they wish to raise the subject. • When checking on loved ones and those in quarantine, or delivering food and supplies, use the opportunity to offer support by communicating from a safe distance. • Use the phone to communicate across any physical barriers (e.g. you can see each other through a window while talking and still use a calm and supportive tone of voice). See <i>Basic Psychosocial Skills: A Guide for COVID-19 Responders</i> for further tips on communicating by phone. • Provide opportunities for people in isolation, in quarantine or in hospital to be in touch with loved ones via phone, audio or video online chat or other safe available means. |
| <p>Link</p>  | <ul style="list-style-type: none"> • Know your role and what you can and cannot do. If you can, try to get help for people who need special assistance (e.g. those with obvious urgent basic needs). • Link people in your area to social services, food delivery, health care when needed and outlets for government support packages. • Support people to identify their positive coping mechanisms and supportive people in their lives. • Link someone who is ill to a health worker for testing, contact tracing and referral. • Link to reliable sources of information. Remember that rumours are common in situations of disease outbreak. Trusted people sharing accurate information in ways that people can understand is the best way to stop rumours. • Try to link people with their spiritual community or other trusted advisors in safe ways, if requested. |

1.6 PEOPLE WHO ARE LIKELY TO NEED SPECIAL ATTENTION

Some people are likely to need special attention during disease outbreaks such as COVID-19. Consider those who are most vulnerable and note additional information in this guidance note to assist these groups:¹

- older adults, especially those with cognitive decline or dementia;
- people living with disabilities with pre-existing health conditions;
- people living with disabilities, including psychosocial disabilities;
- people living with disabilities in crowded living conditions (e.g. prisoners, people in detention, refugees in camps and informal settlements, older adults in nursing homes, people in psychiatric hospitals, inpatient units or other institutions) or those who are homeless;
- people living with disabilities at particular risk of discrimination or violence, such as those at risk due to COVID-19-related stigma (e.g. specific ethnic groups, health workers) and people exposed to GBV, including sexual violence;
- pregnant, postpartum or in post-abortion, and lactating women;
- children, adolescents and their caregivers;
- people with difficulties in accessing services (e.g. migrants).

¹ For information on COVID-19 for specific groups, such as older adults, people with disabilities, children and adolescents and their caregivers, please see the relevant sections in this document.

Supporting people grieving the loss of loved ones

During the COVID-19 outbreak, normal rituals that help people to grieve and say goodbye to loved ones who have died may not take place because of the risk of spreading infection. Help people to find safe ways to grieve and to honour and remember their lost loved ones:

- Help them to discuss what alternative commemorations are possible when a body is not available, and/or delay commemorations or funerals until it is safe to gather.
- Provide people with ways to be in touch with sick or dying loved ones to say goodbye, if possible.
- Identify religious leaders who can provide phone and online support to those who are grieving.
- Support people in identifying other ways to safely say goodbye using their own adapted cultural practices.



training session for staff and volunteers in Cox's Bazar, Bangladesh.

© Bangladesh Red Crescent Society

2. Continuation of comprehensive and clinical MHPSS in humanitarian settings during the COVID-19 pandemic

The COVID-19 pandemic and associated activities for prevention, mitigation and treatment of the disease have major consequences for the provision of services for mental health and psychosocial support (MHPSS) in humanitarian settings, such as an increase in conditions related to stress, mood, anxiety, risk of suicide and substance abuse, an increase in gender-based violence (GBV) and abuse, and also limited access to services due to safety measures being taken by governments.¹ During the pandemic, people with MHPSS needs should be able to receive support, even if it is delivered in new ways, and people with moderate to severe mental health conditions should be able to access essential clinical services. As a lack of oversight is anticipated, creating awareness of and advocacy for the human rights of people with mental health conditions is even more pertinent during the pandemic. This document focuses on what needs to be done to continue comprehensive programmes for MHPSS, including clinical services. Efforts should be made to ensure access to MHPSS services for all women, girls, men and boys, with specific considerations for persons with disabilities or chronic health conditions, older persons, LGBTI persons, racial, ethnic or linguistic minorities and other persons who may have issues with access.

2.1 WHO CAN BENEFIT FROM THIS DOCUMENT?

This document aims to support managers and coordinators of existing programmes for MHPSS in humanitarian settings to make informed decisions about how to adapt their services to the evolving situation around the COVID-19 pandemic. It will **inform but not replace** the decision-making process. Each organization, based on its own organizational policies, available resources and the operational context, will have to make its own choices. Moreover, knowledge about COVID-19 and the optimal ways to prevent its spread and manage its consequences is rapidly expanding, which may have consequences for how MHPSS programmes need to be adapted. It is therefore important to regularly check updates on WHO's COVID-19 sites² and information and instructions disseminated by governments in countries where MHPSS programmes are being implemented. In order to facilitate local decision-making, this document includes a number of scenarios with clear descriptions and actions to be considered when adapting MHPSS programmes.

2.2 SCENARIOS

WHO defines four transmission scenarios for COVID-19 (see Table 1):

- 1) countries with no cases (“No cases”);
- 2) countries with one or more cases, imported or locally detected (“Sporadic cases”);
- 3) countries experiencing cases clustered in time, geographic location and/or common exposure (“Clusters of cases”); and
- 4) countries experiencing larger outbreaks of local transmission (“Community transmission”).³

In each of these scenarios, the actions for preparedness and response to the COVID-19 pandemic are different, and this has consequences for the way that MHPSS programmes can operate. Additionally, there are major contextual variations related to:

- the possibilities of implementing prevention and response strategies such as physical distancing and hand hygiene;
- the quality and capacity of the health care system;⁴
- the accessibility and organization of health care (accessible to all, or only to those who can pay or have private health insurance);
- the level of inclusion in health and social systems of people affected by humanitarian crises (such as refugees, asylum seekers, migrants, internally displaced persons (IDPs) and stateless people);

¹ World Federation for Mental Health: Appeal for National Plans for Mental Health during the Coronavirus Global Emergency (22 April 2020).

² WHO: Coronavirus disease (COVID-19) Pandemic. <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

³ WHO: Critical preparedness, readiness and response actions for COVID-19 (19 March 2020).

⁴ IASC: Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings (jointly developed by IFRC, IOM, UNHCR and WHO) (17 March 2020).

- the response of national and local authorities to the global pandemic and how movement restrictions are implemented and enforced. For example, the government of a country with isolated cases (scenario 2) may implement far-reaching measures that would necessitate the adaptation of MHPSS activities as described in scenarios 3 and 4.

Of critical importance is whether MHPSS workers can do their work safely – with minimal personal risk, and with minimal risk that their activities might inadvertently contribute to the spread of COVID-19.

In humanitarian settings, the effects of the COVID-19 pandemic are often compounded by other crises (e.g. natural disasters, armed conflict, drought, etc.). In such situations, COVID-19 outbreaks can lead to catastrophic situations in which health and social welfare systems collapse, the basic needs of people for food, water and shelter cannot be met and people are deprived of their livelihoods, which may prompt major social unrest.

2.3 CONSIDERATIONS WHEN PREPARING SERVICE ADAPTATION FOR COVID-19 SCENARIOS

- Review internal and external documents, guidance notes or recommendations related to the COVID-19 response and concerning health, protection, risk communication and community engagement.
- Gather information, preferably as part of a multi-sector assessment, from service users and other community members about their knowledge, fears, concerns, coping and needs regarding COVID-19.¹ If it is safe (e.g. scenarios 1 and 2) this may be done in person, otherwise consider online or phone-based consultations.

¹ WHO and UNHCR: Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings (2012).

Sudan: International Medical Corps (IMC) medical worker receives psychosocial support (deep breathing relaxation technique) to help cope with unique stressors faced by health care staff responding to COVID-19.

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Table 1: Description of COVID-19 scenarios and the consequences for MHPSS programming

| Scenarios ¹ | Effects on MHPSS programming | Adaptations for MHPSS programming (summary). For detailed information, consult the specific sections in this document |
|---|--|---|
| <p>1. No cases in country</p> <p>Transmission scenario: no reported cases</p> | <ul style="list-style-type: none"> Health authorities may implement measures to stop transmission and prevent spread, which can include promoting hand hygiene, respiratory etiquette and practising physical distancing. MHPSS activities can take place, but with some adaptations and preparation for further scenarios. | <ul style="list-style-type: none"> Discuss the consequences of a deterioration in the situation with individual service users and their families and communities. Adapt programming to prevent transmission, through physical distancing and COVID-19 prevention measures. Prepare and train facility-based MHPSS staff for new ways of service delivery. Prepare and train community-based MHPSS staff for work in COVID-19 situations, including online work. Make a contingency plan for MHPSS services, aligning with organizational policies and country-specific preparedness and response plans. |
| <p>2. Sporadic cases in country</p> <p>Transmission scenario: one or more cases, imported or locally acquired</p> | <ul style="list-style-type: none"> The focus of COVID-19 measures is to reduce the risk of transmission through active case finding, contact tracing, monitoring and quarantine of contacts, and isolation of cases. Depending on government measures to halt the spread of infections, it may be possible to continue most MHPSS services, but with adaptation and reduced coverage. | <ul style="list-style-type: none"> Review activities and define how essential they are to reduce symptoms/suffering and to maintain functionality of service users. Scale down or stop what is less essential. Reduce activities involving face-to-face contact and consider stopping group activities or reducing the size of groups. Train facility-based staff for remote working. Train community-based staff for potentially new or expanded roles. Set up systems for remote supervision, technical support and risk management. Make individual safety plans with service users who have increased risks for COVID-19 relating to health complications and/or protection risks. |
| <p>3. Local transmission</p> <p>Transmission scenario: most cases of local transmission are linked to identifiable chains of transmission</p> | <ul style="list-style-type: none"> In areas with high numbers of infected people and/or poor health systems, the effects of measures to prevent and mitigate COVID-19 transmission may have a significant impact on MHPSS programming. | <ul style="list-style-type: none"> Adapt services, with prioritization of care for people with moderate to severe mental health conditions. Strengthen links with protection services: increased COVID-19-related hospital admissions may lead to an increase in psychosocial problems due to family separations. Use tele-MHPSS services where possible. Enable community-based staff to adjust to new ways of working. Set up online or phone supervision systems to support staff. Prepare all staff for working in situations of severe movement restrictions. Train staff who continue to have direct contact with service users on the specific processes for personal protection that will be implemented if transmission reaches scenario 4 levels. |
| <p>4. Community transmission</p> <p>Transmission scenario: outbreaks with the inability to relate confirmed cases through chains of transmission for a large number of cases, or by increasing positive tests through sentinel samples</p> | <ul style="list-style-type: none"> Measures to mitigate and halt the COVID-19 outbreak can have severe consequences for all service delivery, including MHPSS services. These measures may vary from movement restrictions to partial or complete lockdown (access only to emergency medical services and to food during certain hours of the day). This may result in an increase of MHPSS problems. COVID-19 infections within humanitarian or humanitarian-like settings, such as crowded camps/settlements or urban areas, can rapidly have strong negative impacts on livelihoods, food security, protection and social systems. Medical care for people with COVID-19 constitutes a severe burden for health and social welfare systems. In places with weak health systems this can quickly lead to overburdened and dysfunctional health facilities. Inpatient mental health units may be repurposed for COVID-19 response, reducing the capacity for clinical mental health services. | <ul style="list-style-type: none"> Provide direct clinical services in adapted forms (with appropriate protection against COVID-19 infection) and only when they are essential for survival and/or for the reduction of severe symptoms and suffering. Develop contingency plans with hospitals offering psychiatric services to determine decision-making processes and alternative continuity of care for people with mental health conditions. Provide community-based care in remote ways (using the phone or other means of communication) and provide direct support only for mental health crisis response. Implement plans for personal protection of staff who continue to have direct contact with service users. Use remote methods of management, training and supervision. If this scenario continues for a long period, emergency measures will need to be replaced by long-term service adaptations. |

¹ WHO: Interim guidance Critical preparedness, readiness and response actions for COVID-19 (22 March 2020).

- Engage in open discussion with MHPSS staff about their willingness and ability to continue their work. Create an atmosphere in which staff can openly discuss their fears and worries. Strive to create an agreed plan of action, with ongoing dialogue. Ensure that each individual staff member understands and agrees to their role in adapted service delivery, knows the limitations of what they can do and understands the risks they accept to take for themselves and their families.
- Brainstorm with the MHPSS team on how activities could evolve in different potential scenarios:
 - Define the activities that should be **continued** or **stopped**:
 - Discuss when and how to downscale face-to-face activities, based on how essential the activities are.
 - Develop clear standard operating procedures (SOPs) for face-to-face services, considering staff safety and ensuring non-transmission of COVID-19.
 - Prioritize urgent vs. non-urgent service users, based on assessment of individual risks and needs (see section 2.8).
 - Discuss whether new service users can be accepted and under what conditions (see Table 2 at the end of this section).
 - Discuss how to **adapt** existing MHPSS activities:
 - Adapt the delivery mode of existing services. Consider which practices you can and will prioritize to deliver services remotely (see section 2.6). Face-to-face provision may still be necessary and feasible (depending on country guidance and local context).
 - Think of **creating new** supports and services:
 - Should a helpline/emergency number be established? Is this feasible in the operational context?^{1,2}
 - How can people with high levels of emotional distress and/or mental health problems who need care be identified? (Consider outreach and mental health screening tools.)
 - Should MHPSS staff be used differently, including contributing to the general non-MHPSS COVID-19 response (e.g. in risk communication, distribution of food/nonfood items or facilitation of cash transfers)?
 - Should non-MHPSS staff (particularly those based in the community) be utilized in the provision of MHPSS care in the community for those who cannot access facility-based or online care? What training and support are required to ensure sufficient quality of care?
- Prepare alternatives for people who are in group treatment:
 - Consider alternatives for existing group activities, e.g. reducing group size (based on in-country guidance on prevention and physical distancing), online groups or tele-conferencing.
 - Make provisions for participants who develop symptoms of COVID-19.

¹ WHO: Preventing suicide: A resource for establishing a crisis line (2018).

² Child Helpline International: Counselling Practice Guide (2009).



Visiting a patient with suspected symptoms of COVID-19.

© Partners in Health, Peru

- Prior to moving to remote service provision, staff should review their own caseloads:
 - Collect contact details of service users, particularly those with appointments already scheduled (ensure that proper consent procedures are followed);
 - Document by what means service users can be reached (phone, video chat, email, visit to home/tent/ shelter);
 - Prepare or revise safety plans with high-risk service users.
- Plan in consultation with all team members and decide about procedural issues such as:
 - Availability
 - Will all staff be available on all days for their service users, or will there be a daily contact person who is on duty?
 - How many hours a day should a staff member be available?
 - How long should online sessions take (frequent but brief calls are important)?
 - Are staff reachable by remote means (phone, video chat, email) for supervision or coordination?
 - Quality of services
 - What content is appropriate for remote sessions given the limitations on privacy and confidentiality (see section 2.6)?
 - Is there a mental health professional on call who could be contacted by more junior/non-specialized staff and volunteers in the event of emergencies or situations they cannot manage?
 - How will supervision be arranged?
- Plan how to work with volunteers and helpers in the community:
 - What working arrangements or protocols are in place to work with volunteers/community helpers (see section 2.9)?
 - Communicate different potential scenarios with key stakeholders (e.g. service users, caregivers, service providers, government). Provide clear information and outline the potential risks of each scenario.
- Make plans to inform all (potential) service users of the new organization of services, and consider informing:
 - existing service users through their service providers or community-based MHPSS staff;
 - the coordination structures for health, protection and education;
 - partners through email and calls;
 - the general population by using radio messages, social media, information leaflets or banners with key messages.
- Engage with community stakeholders (community leaders, religious leaders) to inform them of cultural and contextual adaptations of MHPSS activities.

2.4 CONSIDERATIONS AROUND IDENTIFICATION AND MANAGEMENT OF HIGH-RISK SERVICE USERS

There are two types of risks during the COVID-19 pandemic:

Risks that are directly related to COVID-19

Everyone is at risk of contracting COVID-19, and the general rule is to ensure that people with MHPSS issues are included in the COVID-19 response on an equitable basis. Some people with MHPSS conditions are at higher risk than others because of:

- increased risk of contracting COVID-19 (e.g. people with mental health conditions who are admitted to hospital);
- increased risk of transmitting COVID-19 to others (e.g. due to an inability to understand transmission risks or to follow instructions for physical distancing);
- increased likelihood that infection with COVID-19 will have a serious course due to additional health concerns or vulnerabilities.

Risks that are indirectly related to COVID-19 due to contextual changes

The COVID-19 pandemic may profoundly change the socio-ecological environment for adult and child MHPSS service users due to:

- social support systems becoming dysfunctional or overburdened and caregivers becoming sick or dying;
- increased stress levels due to movement restrictions and crowded living conditions;
- deteriorating financial situations/livelihood opportunities;
- child protection risks due to disruption of the environment in which children grow up and develop;¹
- increased exposure to GBV (particularly intimate partner violence and sexual abuse and exploitation);^{2,3,4}
- limited access to services, including MHPSS services.

¹ Alliance for Child Protection in Humanitarian Action: Technical Note: Protection of Children during the Coronavirus Pandemic (March 2019).

² IASC: Interim Guidance: Gender alert for COVID-19 outbreak (March 2020).

³ IASC: Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response (6 April 2020).

⁴ WHO: COVID-19 and violence against women: What the health sector/system can do (2020).

These two broad types of risk can reinforce each other. Examples of MHPSS service users with increased risks in COVID-19 situations include those who:

- have current suicidal ideations;
- have a current risk of harming others;
- present with agitation due to active symptoms of severe mental disorder such as delusions or behavioural disturbances (e.g. people with acute psychotic or manic episodes);
- present with symptoms affecting memory, orientation and self-care (e.g. dementia);
- are prone to relapse of mental health symptoms (which may be related to non-adherence to treatment, or triggering of previous stressful or life-threatening experiences);
- have (a recent history of) uncontrolled substance/alcohol abuse;
- have developed significant COVID-19 symptoms and have severe pre-existing mental health conditions;
- have inadequate or risk-aggravating social support systems;
- have intellectual and developmental disabilities;
- are quarantined in institutions or are in medical isolation units;
- are older service users;¹
- have medical comorbidities that increase the risks for COVID-19-related complications;
- experience severe anxiety/psychosomatic symptoms due to COVID-19-related fears and concerns;
- face complicated or prolonged bereavement due to COVID-19 deaths and/or inability to conduct proper burials or say farewell properly.

It is important for team members to review the files of all service users and to arrange individual treatment and care plans aimed at minimizing visits to health care services. Ask team members to prioritize the review of people with severe/acute symptoms and/or at risk of harming themselves or others.

- Do risk assessments.
- Proactively contact current clients to update care plans.
- Review and update safety plans.

¹ HelpAge: COVID-19 Everyone matters (2020).

Providing remote support.

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- Review medications.
- Identify potential protection concerns (e.g. does the person have access to food and water? are they safe in their homes?).
- Ensure that emergency contacts are up to date and available to service providers in charge of carrying out (remote) follow-up.
- Consider identifying a family member to engage more actively in the care plan.

High-risk service users should be prioritized for frequent contact in order to manage emerging concerns. Service providers should strive to create proactive, periodically updated care plans for each of these users.

2.5 CONSIDERATIONS AROUND ADAPTATION OF FACILITY-BASED SERVICES

Decisions to continue or initiate face-to-face treatment for moderate mental health conditions (e.g. moderate depression) should be taken on a case-by-case basis (e.g. prenatal and postnatal depression is a priority even when the symptoms are not severe). Services and care for people with acute symptoms of severe mental, neurological and substance use disorders (e.g. acute mania, psychosis, severe depression, delirium, overdose, substance withdrawal) should continue.

MHPSS consultations

Take measures to prevent transmission during consultations (for mental health outpatient services in health facilities or services in MHPSS centres or community centres).¹ Consider:

- physical distancing in waiting areas;
- restricting the number of service users in waiting areas (and the number of accompanying family members);
- outreach workers collecting service users from shelters/tents/houses to bring to the clinic for their appointment;
- providing people with ticket numbers and specific appointment times rather than running an open outpatient department (OPD);
- how to promote hygiene measures:
 - create handwashing stations outside waiting areas;
 - ensure that supplies are available (e.g. hand soap, waste receptacles and alcohol-based hand sanitizer);
 - clean surfaces, including door handles, regularly;
- providing personal protective equipment (PPE) if necessary and as per national government guidelines for clinicians;²
- if service providers do not speak the language of the service users, arranging for remote translation (by translators who are “on call”);
- posting information, education and communication (IEC) materials in appropriate languages and formats in waiting areas on:
 - protecting oneself from COVID-19;
 - stress and coping;
 - how to get emergency support (hotline numbers).

Psychiatric wards and other inpatient services

Treatment facilities for people with mental disorders need to adhere to the prevailing procedures for other inpatient units in hospitals, following national and international guidelines.³ Consider the following:

- Conduct advocacy for inpatient units for mental health conditions to be fully included in hospital plans for COVID-19 prevention and mitigation, and for the rights of people with mental health conditions, including their right to health and their right to make decisions about their care, to be protected.
- Take measures to prevent infection in hospital wards (e.g. education on infection prevention and control, access to water and soap, possibilities for physical distancing, restricting visitors).
- Prepare plans for what to do when COVID-19 infections occur in service users on mental health wards.
- When people with mental health conditions require hospital admission due to COVID-19 symptoms they should get the same or similar medical care as any other person with the disease:
 - COVID-19 patients with moderate/stable mental health conditions can usually be placed on general medical units with other patients.
 - If this is not possible, consider alternative arrangements for COVID-19 patients with acute mental health conditions (e.g. isolation within a psychiatric facility or psychiatric ward), ensuring that they can still access good physical health care on an equal basis with any other.

¹ WHO: COVID-19: Operational guidance for maintaining essential health services during an outbreak (25 March 2020).

² WHO Interim guidance: Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages (6 April 2020).

³ WHO Interim guidance: Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected (19 March 2020).

2.6 CONSIDERATIONS AROUND REMOTE WORKING IN MHPSS

For detailed information, consult more specialized resources.^{1,2,3,4} After appropriate adaptation, some MHPSS interventions can be effectively provided remotely, by phone or via online tools (e.g. messaging, video). To provide remote support, existing MHPSS practices will have to be organized and approached differently.⁵ Remote service provision may not be suitable for all service users, for example when people have difficulties in accessing services (e.g. people with disabilities may require specific adaptations) or when people are not able to have private conversations due to crowded housing conditions.

General considerations for remote working

- Ensure that required equipment (e.g. telephone, smartphone) is available, and consider network stability and costs for users.
- When providing support remotely (e.g. via video or telephone), train and supervise service providers on remote working.
- Identify the most suitable platforms for remote service provision in your context (applications need to be accessible and able to operate on variable network quality).⁶

¹ WHO Equip project: Providing psychological care remotely.

² International Federation of the Red Cross and Red Crescent Societies Psychosocial Centre: Remote Psychological First Aid during a COVID-19 outbreak, final guidance note (March 2020).

³ American Psychiatric Association: Telepsychiatric Toolkit.

⁴ International Medical Corps: Guidelines for MHPSS Staff Providing Tele-MHPSS to Clients during the COVID-19 Pandemic (Field Test Version – 24.04.2020 and online training package for PFA for COVID-19 Outbreak response, May 2020).

⁵ WHO: WHO guideline: recommendations on digital interventions for health system strengthening (2019).

⁶ Check locally (e.g. with other organizations, government guidelines) which platforms are most appropriate. Communication through end-to-end encrypted applications preserves confidentiality better than non-secure platforms.

Kenya: a Somali refugee teacher gives an English lesson to grade five pupils over the radio system.

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COVID-19 awareness raising campaign in Ombeda locality, Omdurman-Khartoum State targeting homeless people in the community.

© International Organisation for Migration

- Consider providing compensation or reimbursement to service users who cannot afford the associated costs (e.g. Internet consumption). Consider providing extremely vulnerable service users or their families with phones, SIM cards or airtime, or funds to purchase these.
- Make clear arrangements about who will pay for the costs incurred in using remote support (e.g. telephone bills).
- Establish SOPs to ensure the safety and privacy of people using the support, and ensure that the support provided is accountable and traceable (e.g. documented). SOPs and policies for MHPSS may include: a) specific issues such as responding to people at risk or in crisis and when a physical meeting is required; b) remotely performing key functions such as case allocation, case management and referral; and c) delivery aspects, such as contact outside of session times, working hours and caseloads.
- Service providers should be supplied with a professional phone number to contact service users, rather than using their own personal number.
- Usually, sessions are provided verbally (by phone or Internet call) and not by text message or voice message in order to improve confidentiality and safety of service users, as well as to protect professional boundaries. Stored voice messages or texts on phones may lead to breaches of confidentiality.
- Provide clear instructions for when services will be operational (e.g. regular phone only during working hours with an option to leave a message to be called back if the issue is not urgent, and a separate phone number for crisis situations which is staffed 24 hours a day).
- Guide staff on how to conduct work-related calls from their home (e.g. in a quiet, separate room) so that confidentiality and professional boundaries are maintained.
- Ensure compliance with relevant laws (e.g. privacy, secure transfer of data) and policies concerning the provision of support remotely.
- Ensure that there are clear key indicators for monitoring and evaluation (M&E).

Service user-related information

- Ensure that service users are fully aware of how to protect their privacy on devices (e.g. deleting messages, password protection); this is particularly critical where a phone is shared or the service user may be at risk (e.g. from intimate partner violence).
- Adhere to the principles of data protection and confidentiality:
 - Store secure data from service users in a protected folder with a password on a computer.
 - Store sensitive documents with additional password protection.
 - Handwritten clinical notes or files are not recommended. If they are used, they must be stored in a safe place with a secure lock and limited access to ensure the confidentiality and protection of information.
- Staff in clinics or offices should have access to the documents, with one person per service user assigned as “case manager”.
- Assign a manager to compile the information and allocate the workload to staff on a daily or weekly basis.

Training and clinical supervision and clinical consultation for remote services^{1,2}

- Ensure adequate training of MHPSS staff on how to adapt helping skills and provide or mobilize remote interventions. The training itself can be conducted remotely using telephone or video, including practising role-plays.
- Schedule a fixed time for clinical supervision for the team (both individual and group).
- Provide more frequent clinical supervision when staff have limited prior experience in providing remote services.
- Consider establishing a mechanism for remote clinical (interdisciplinary) consultation, especially for high-risk service users.

Clinical management over the phone

- Create an environment that facilitates open communication over the phone, and explain how confidentiality and privacy will be protected and how to seek consent. Offer reasons for providing continuity of care at a distance. Prepare staff to be aware that rapport is more difficult to achieve remotely and that they may need to spend more time than for in-person sessions.
- Assess risks and take action if there are grave or imminent risks. If there are risks of self-harm or of harm to others, it may be necessary to inform others in order to save lives.
- Provide information in a clear and concise manner, and be mindful of language (avoid using technical terms). Stress can impair service users' ability to process information; this is especially true with communication over the phone. Cover one point at a time to help the service user understand what is being said, before moving on to the next point.
- Consider alternatives to care, and respect service users' right to refuse care. If the person does not feel comfortable with the process of communication and/or does not give consent, make sure that they are aware of how to contact the team if the need arises later. Service users should be given the work phone number of their therapist, counsellor or psychosocial worker, along with contacts for other useful services.
- Ensure that users are aware of limitations to support when it is provided remotely, and that they consent to remote MHPSS.
- Provide advice on confidentiality and privacy (e.g. if using a shared device). Confidentiality can be a challenge due to crowded living conditions for service users in situations where "stay at home" orders are in place.

Remote psychological treatment for children

- Providing remote psychological interventions for children and adolescents requires specific skills. Consult specialized resources on this topic for practical tips, guidance on working with treatment-specific challenges in phone delivery to children (such as children who are very anxious, withdrawn, angry and/or sad) and using games or play to facilitate remote psychological interventions.^{3,4}
- Children may face specific barriers in accessing remote care (lack of access, lack of permission to use devices).
- Have clear child safeguarding measures in place if staff members are contacting children remotely, outside of a usual clinic setting and with no other adults witnessing interactions.

Team communication

- Establish mechanisms for the exchange of non-sensitive information, e.g. through a platform that is end-to-end encrypted.
- Schedule regular team meetings through relevant means of communication (e.g. communication app or telephone) and ensure regular communication with a team leader for updates or follow-up.

2.7 CONSIDERATIONS AROUND MEDICATION

- Service users with stable conditions might be given additional medication supplies, with close remote monitoring. If possible, consider giving 2–3 months' supply based on factors such as:
 - national guidelines
 - pharmacy stock
 - storage capacity at home
 - clinical risk
 - service user capacity and
 - caregiver support.
- If there is a history of substance use disorders or recent/active suicidal ideation, negotiate a safe scenario (e.g. involving a household member in storing the medication in a safe place).
- Create designated medication pick-up points for populations during stay at home orders or create a safe delivery mechanism that involves community volunteers or health care staff. For a health organization, the delivery of psychotropic medications should be integrated into protocols for the management of service delivery for people with noncommunicable or chronic conditions.

¹ WHO Equip Project: Supervision of Helpers for Remote MHPSS.

² IFRC: Interim Guidance, Supportive Supervision for volunteers providing Mental Health and Psychosocial Support during COVID-19 (2020).

³ Queen Mary University of London, American University of Beirut, Médecins du Monde, Johns Hopkins University: Delivering Psychological Treatment to Children Via Phone: A Set of Guiding Principles Based on Recent Research with Syrian Refugee Children (2020).

⁴ UNICEF: UNICEF COVID-19 Operational Guidance for Implementation and Adaptation of MHPSS Activities for Children, Adolescents, and Families (2020).



Ethiopia: staff providing mental health and psychosocial support while maintaining COVID-19-sensitive arrangements.

© Eden Doctor

- Develop a clear strategy for the administration of long-acting antipsychotic medication. This may involve changing the interval of administration to avoid travel during periods of high contagion risk, or administering the medication during home visits instead of at the health facility.
- For service users with a high risk of non-compliance, make regular telephone calls or arrange for home visits by community workers, where this can be done safely.
- In the event of a sudden lockdown, service users who require medication may face problems with follow-up if they cannot reach their service provider. In such cases, make attempts to contact service users to discuss alternative arrangements (e.g. contacting pharmacies and sending prescriptions by email or other remote mechanism when this is legally allowed).
- Consider developing contingency planning to prepare for any disruptions to procurement or to the supply chain.
- If implementing new task-shifting approaches, consult with the health authorities on rules and regulations (e.g. who is allowed to prescribe or dispense medication).

2.8 CONSIDERATIONS AROUND PSYCHOTHERAPY AND COUNSELLING

- In COVID-19 scenarios 3 and 4, in-person group sessions should be suspended and/or replaced by individual sessions or phone contacts. Teams may explore options for remote group sessions through end-to-end encrypted applications.
- Plan under what conditions new psychotherapy treatments can be started. In many settings this may mean not initiating new psychotherapy treatments unless there is a clear and urgent reason to do so, e.g. when psychotherapy is essential to prevent harm to the service user or to others. A condition is that service user and service provider must have appropriate means for remote communication.
- Consider reducing the frequency of sessions or temporary suspension of treatment for people in psychotherapy with stable symptoms and sufficiently healthy coping mechanisms. Identify coping strategies with the service user and provide them with an emergency contact number should their situation or symptoms worsen. Details should be outlined in individual treatment plans. A sudden interruption of the intervention should be avoided as this could have a negative impact on the well-being of the service user, and therefore it is important to contact them to jointly plan how to move forward in the new situation.
- Focus on short interventions targeting stress management and positive coping strategies, if possible, with home assignments between sessions. Many people will need MHPSS at key moments to help them adapt to the main changes in the situation.¹
- Consider adapting psychological interventions, and strengthen focus on grief, anxiety/worry and tolerance of distress.

¹ WHO: Doing What Matters in Times of Stress: An Illustrated Guide (2020).

2.9 CONSIDERATIONS AROUND WORKING WITH COMMUNITY VOLUNTEERS/OUTREACH WORKERS

- Educate all community volunteers and outreach workers about how to work safely, including the principles of physical distancing and prevention of infection. Organizations have a duty of care towards all their staff and volunteers.
- If community volunteers/outreach workers remain active, provide them with means of safe communication (phone credit, phone/tablet, radios, as well as recommended hygiene supplies and PPE, depending on government guidelines).
- Discuss if and how home/tent visits can be done in a safe and acceptable way:
 - Balance risks for mental health and well-being of service users with risks of COVID-19 infection in staff or service users.
 - Define home visit criteria (prioritizing people with specific risks for health and well-being).
 - Discuss how to handle discussions about emotional subjects in situations where there is little privacy.
- Ensure ongoing (remote) support, supervision and education for community volunteers/outreach workers.
- Discuss with community volunteers what they can do to dispel myths and stigma around COVID-19 and ensure that they can deliver appropriate and correct messages around mental health and COVID-19 to communities.¹
- Coordinate the work of community volunteers/outreach workers across key sectors (health, protection, nutrition).

2.10 CONSIDERATIONS AROUND PEOPLE WITH MENTAL HEALTH CONDITIONS IN SPECIFIC LIVING CIRCUMSTANCES

People with mental health conditions living in institutions

During the COVID-19 outbreak, people with mental health conditions who live in long-stay units, institutions or facilities for assisted living are even more vulnerable than in other circumstances. When supply chains are interrupted and/or many staff cannot come to work, they may be at risk of contracting COVID-19, and of neglect and abuse. Humanitarian MHPSS organizations should:

- discuss the situation of people with mental health conditions living in institutions and jointly decide on action;
- make regular visits or follow-up calls;
- insist on access to appropriate medical care and infection prevention;²
- discuss possible self-protection measures with people living in institutions;
- advocate that their human rights are respected. The COVID-19 pandemic should not be misused to deprive people with mental health conditions of their rights, or to limit person-centred and recovery-based practices. Service users should be included in the decision-making process throughout.

People with mental health conditions who are homeless

During the COVID-19 outbreak and related measures to control it, the situation of people with mental health and substance use conditions who live on the streets can deteriorate rapidly. They may not be able to get money or obtain food. They may not be able to adhere to rules on physical distancing or take recommended protective actions and may be more susceptible to infection. Humanitarian MHPSS organizations should:

- discuss the situation of homeless people with mental health conditions in their context and jointly decide on action;
- liaise with social services and protection agencies for shelter, protection and other basic needs;
- advocate for appropriate medical care;
- advocate that their human rights are respected. The COVID-19 pandemic should not be misused to deprive people with mental health conditions of their rights.

People with mental health conditions who are deprived of their liberty

Special consideration should be given to people with mental health conditions who are imprisoned or otherwise deprived of their liberty (e.g. in immigration detention centres).³

Consider the following actions:

- Discuss among MHPSS actors if and how to obtain access (directly or through mandated organizations, e.g. the International Committee of the Red Cross) and appoint focal points to follow up regularly.
- Insist on access to appropriate medical care.
- Advocate for their rights: people with mental health conditions should not be in detention centres.

¹ WHO: Coronavirus disease (COVID-19 advice for the public: Myth busters (2020).

² WHO Interim guidance: Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 (21 March 2020).

³ IASC Interim Guidance: COVID-19: Focus on Persons Deprived of their Liberty (March 2020).



Handwashing facility in Bagong Evacuation Centre, Kidapawan, Cotabato Province, southern Philippines.

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2.11 CONSIDERATIONS AROUND SELF-CARE/STAFF CARE OF THE MHPSS TEAM

The COVID-19 situation is likely to cause an increase in workload and more stress on MHPSS staff in their professional roles and in their personal spheres (many are also caregivers and many will be worried about their loved ones). It is important to help them to cope in these circumstances, maintain boundaries and manage the demands being made on them. Providing psychosocial support to all staff is part of the organization's duty of care and should not be "dumped" on the MHPSS team alone.

- Establish a staff support system for MHPSS providers, particularly for staff members working remotely without regular contact with other team members or supervisors.
- If there is a formal staff care system in the organization, make sure that MHPSS staff know how to access it and encourage them to use staff support. Ensure that any formal staff care system has the capacity to serve a potentially increased number of staff.
- If there is no adequate staff care system, advocate for one within the organization.
- Discuss with staff who work from home, particularly those with caregiving responsibilities for children or other family members, arrangements to enable them to combine their professional role with their caregiving role.
- Continue regular clinical supervision and encourage supervisors to ask about the well-being of the supervisee and, where needed, to address any issues that arise.
- Arrange for team leaders to contact their team members regularly to ask about their well-being.
- Organize or facilitate a system for peer support by MHPSS staff using remote messaging or voice/video conferencing tools.
- Consider a "buddy system" in which staff pairs (including supervisors) keep in informal contact about their well-being.

2.12 CONSIDERATIONS AROUND THE COORDINATION OF MHPSS SERVICES

When adapting services to the new context, referral pathways need to be repeatedly adapted and updated. This requires coordination between the various organizations involved in MHPSS service provision, and actions such as:

- adding COVID-19-related considerations to existing 4W (Who does What Where and When) mappings;
- reconfiguring coordination mechanisms (increase frequency and keep discussions brief and solution-focused). Consider establishing a technical working group for MHPSS if one does not already exist.

2.13 CONSIDERATIONS FOR SERVICE PROVIDERS WITHIN THE ORGANIZATION WHO BECOME INFECTED WITH COVID-19

If an MHPSS staff member becomes sick and is likely to have COVID-19, immediate action must be taken. This usually includes:

- ensuring that the sick staff member gets appropriate medical care and advice;
- conducting contact tracing within the organization and providing clear instructions to all staff who may possibly be infected to follow instructions from the public health authorities in your area;
- informing service users who have been in contact with the sick staff member and taking measures to prevent service users being exposed to COVID-19 through contact with MHPSS staff members;
- providing emotional support to staff and/or service users as appropriate;
- deep cleaning and disinfecting the facilities where the staff member was seeing service users, before they reopen. Facilities may include consulting rooms, shelters/tents and associated toilet facilities.

2.14 CONSIDERATIONS AROUND A “RETURN TO NORMAL”

The COVID-19 pandemic may have long-lasting consequences for the provision of care, e.g. when local or community transmission continues to occur for a prolonged period. In such situations, and when PPE is available in sufficient quantity and quality, MHPSS organizations need to plan for increasing coverage of their services in safe ways.

After health authorities have declared that the outbreak in their country is “over” and special provisions and restrictions have been lifted, plans need to be made for a return to normality. There will likely be an increased demand for MHPSS support and services because of the direct consequences of the pandemic and its secondary effects on people’s communities, livelihoods and family lives. We may expect an increase in particular in conditions related to grief, loss, stress, alcohol and substance use, mood disorders and risk of suicide, as well as more severe mental disorders where people have been unable to access care. Planning needs to take this increased demand into account.

As the pandemic subsides in an area of operation, those leading MHPSS programmes will need to make difficult decisions about when to return to previous levels and types of service provision, what protective measures may be necessary and how to adapt services to address the post-pandemic needs of service users. However, guidance for navigating this situation is not within the scope of the current document.

Table 2 presents an adaptation of the MHPSS activities described in the 4W document by the IASC Reference Group.¹ The aim is to assist MHPSS managers to develop their own context-specific adaptation plan, which will depend on many factors including government regulations, organizational policies and priorities, financial and human resources and the overall context of service delivery. The adaptations described in the table are suggestions and should not be taken as formal advice.

¹ IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings: Who is Where, When, doing What in Mental Health and Psychosocial Support (4W Tool) (2014).

Table 2: Adaptation of specific MHPSS interventions in different COVID-19 scenarios

| | Scenarios 1 and 2 (No cases/sporadic cases) | Scenario 3 (Local transmission) | Scenario 4 (Community transmission) |
|---|--|---|--|
| 1. Disseminating information to the community at large | | | |
| Information on the current situation, relief efforts and available services in general | <ul style="list-style-type: none"> Determine contextually and linguistically appropriate methods for sharing messages. Choose some face-to-face methods of sharing information that respect physical distancing. Coordinate with agencies in all sectors for consistency of messaging and to minimize duplication. Disseminate information about referral pathways, with adjusted activities. | <ul style="list-style-type: none"> Stronger focus on remote messaging (e.g. radio or social media) to reduce face-to-face contact. | <ul style="list-style-type: none"> No face-to-face activities – only remote messaging. In “catastrophic” situations: information dissemination is still essential. Focus on information on how to access services and basic needs. |
| Raising awareness on MHPSS (e.g. messages on positive coping) | <ul style="list-style-type: none"> Develop materials with COVID-19-related MHPSS messages in appropriate languages on: <ul style="list-style-type: none"> strategies for maintaining well-being managing anxiety activities at home parenting. Develop age-appropriate messages for children. Use context-appropriate dissemination methods for mass communication methodologies that respect physical distancing rules (e.g. radio, social media, posters in prominent places). | <ul style="list-style-type: none"> Similar to scenarios 1 and 2. AND Include information about crisis services. Add messages of hope/caring/ managing distress for people in prolonged “stay at home” situations or lockdowns. | <ul style="list-style-type: none"> Similar to scenarios 1, 2 and 3. In the event of “catastrophic” situations, emphasize information on how to access services and basic needs. |
| 2. Facilitating conditions for community mobilization/organization/ownership | | | |
| Support for emergency relief that is initiated by the community | <ul style="list-style-type: none"> Engage community leadership (including those representing minority or vulnerable groups) to create effective modes of communication with the community and use them to inform communities about adjustments to services. | <ul style="list-style-type: none"> Engage communities to give feedback and use this to inform emergency relief. Engage, train and supervise MHPSS volunteers as hotline operators. Contact (e.g. by phone) key persons in the community (such as teachers, local child protection committees, religious leaders, local healers) to disseminate positive messages on adaptive responses. Ensure that all vulnerable groups are included equitably in services. | <ul style="list-style-type: none"> Similar to scenario 3. |
| Support for communal spaces/ meetings | <ul style="list-style-type: none"> Assist the community to determine alternative ways of meeting/sharing information that minimize the risk of transmission (e.g. avoid large groups). | <ul style="list-style-type: none"> Similar to scenarios 1 and 2. Arrange essential meetings in small groups, respecting social distancing. | <ul style="list-style-type: none"> Organize virtual meetings through Internet or telephone. |

Table 2: Adaptation of specific MHPSS interventions in different COVID-19 scenarios (continued)

| | Scenarios 1 and 2 (No cases/sporadic cases) | Scenario 3 (Local transmission) | Scenario 4 (Community transmission) |
|--|---|--|---|
| 3. Strengthening community and family support | | | |
| Support for social activities that are initiated by the community | <ul style="list-style-type: none"> Assist the community to arrange alternative ways of providing social support that minimize the risk of transmission. Encourage families to use their added time together at home in positive and supportive ways. | <ul style="list-style-type: none"> Provide follow-up to encourage use of alternative modalities for support. | <ul style="list-style-type: none"> Similar to scenario 3. Emphasize the importance of family support. |
| Strengthening parenting and family supports | <ul style="list-style-type: none"> Give simple guidance to parents and caregivers on how to help keep children, including adolescents, safe and engaged at home. Give simple guidance on healthy coping skills to help children and adults manage their anxiety. Identify families at risk of MHPSS or protection issues and establish a follow-up plan. Inform families about ways to use their time together to bond, build closer relations and enjoy spending time with each other. | <ul style="list-style-type: none"> Provide remote support to families at risk. Identify referral pathways for serious protection concerns, including alternative shelter. Support parents and caregivers to develop well-being plans for their out-of-school children and alternative care plans for children in the event of the confinement or illness of caregivers. Ensure the availability of face-to-face or remote emergency response for families at risk. | <ul style="list-style-type: none"> Provide remote support to families at risk. Ensure the availability of remote emergency response for families at risk. |
| Facilitation of community supports for vulnerable people | <ul style="list-style-type: none"> Assist the community on how to identify and protect people with increased MHPSS or protection risks during the pandemic. | <ul style="list-style-type: none"> Provide follow-up to ensure that alternative care pathways are functioning; if not, advocate for adjustment. Facilitate community outreach efforts (home visits) carried out by community-based contacts in remote locations with adequate protections. Ensure that emergency response is available either face-to-face or remotely. | <ul style="list-style-type: none"> Similar to scenario 3. Focus on household units instead of larger units. Ensure that staff and volunteers have PPE and are aware of risks. Ensure that remote emergency response is available. |
| Structured social activities (group activities) | <ul style="list-style-type: none"> Assist the community to determine alternative ways of providing social support that minimizes the risk of transmission. | <ul style="list-style-type: none"> Provide follow-up to encourage use of alternative modalities and/or stop activity. | <ul style="list-style-type: none"> Stop activity. |
| Structured recreational activities | <ul style="list-style-type: none"> Stop any activities being offered by the organization. Assist service users in identifying safe ways to participate in recreational activities at their home, independently or using remote devices. | <ul style="list-style-type: none"> Stop activity. Consider involving staff in remote activities with participants e.g. work with youth groups remotely using video or audio tools. Provide psycho-education to caregivers about recreational activities for children at home. | <ul style="list-style-type: none"> Stop activity. Continue remote activities. |
| Early childhood development activities | <ul style="list-style-type: none"> Identify children and caregivers at risk and develop safety plans/ alternative sheltering options. | <ul style="list-style-type: none"> Stop group activities. Implement individual follow-up and safety plans as needed. | <ul style="list-style-type: none"> Implement remote follow-up and safety plans as needed. |
| Facilitation of conditions for indigenous traditional, spiritual or religious support | <ul style="list-style-type: none"> Engage traditional, spiritual and/or religious leadership in helping communities find alternative ways to practise important traditions and rituals, and find ways to help people use their faith to manage their distress. | <ul style="list-style-type: none"> Provide follow-up to encourage the use of spiritual/religious practices adapted to the situation. | <ul style="list-style-type: none"> Encourage the use of spiritual/religious practices adapted to the situation. Promote adapted funeral and burial rituals. |

Table 2: Adaptation of specific MHPSS interventions in different COVID-19 scenarios (continued)

| | Scenarios 1 and 2 (No cases/sporadic cases) | Scenario 3 (Local transmission) | Scenario 4 (Community transmission) |
|--|---|--|--|
| 4. Safe spaces | | | |
| Baby-friendly spaces Child-friendly spaces Women-friendly spaces, etc. | <ul style="list-style-type: none"> Use these spaces to provide important information on COVID-19 prevention, health practices and healthy coping. Ensure that hygienic standards are respected in the safe space (e.g. hand washing when entering). Identify people at risk and develop safety plans/alternative sheltering options. Consider limiting group size. Ensure that everyone washes their hands very regularly during activities. Build parents' awareness about how to manage their babies if isolated at home. | <ul style="list-style-type: none"> Close spaces or consider repurposing them. Implement individual follow-up and safety plans as needed. Maintain telephone contact with vulnerable service users, providing advice and awareness. | <ul style="list-style-type: none"> Similar to scenario 3. |
| 5. MHPSS support in education | | | |
| Psychosocial support to teachers/other personnel at schools/learning places | <ul style="list-style-type: none"> Train teachers/other school personnel to provide important information on health practices and healthy coping. Train teachers who live in communities with affected populations on providing psychological first aid (PFA). Facilitate teachers to be able to provide remote support by providing finance for telephone calls. | <ul style="list-style-type: none"> Assist teachers to provide PFA and advice to their students and their families remotely. Provide teachers with support for their own well-being and coping. If delivering education materials to homes, add parent well-being materials and parenting tips, alongside information on how to support children's learning at home. | <ul style="list-style-type: none"> Similar to scenario 3. |
| Psychosocial support to classes/groups of children at schools/learning places | <ul style="list-style-type: none"> Use these spaces to provide important information on healthy practices and healthy coping. Identify children at risk and develop safety plans. | <ul style="list-style-type: none"> Maintain contact with children at risk and their families by remote means. | <ul style="list-style-type: none"> Similar to scenario 3. |
| 6. Support including (psycho)social considerations in protection, health, nutrition, food aid, shelter, site planning, WASH | | | |
| Social and psychosocial considerations in non-MHPSS programming | <ul style="list-style-type: none"> Provide training on PFA, well-being and supportive communication to frontline workers. Provide burn-out awareness/self-care training sessions to frontline workers and management. | <ul style="list-style-type: none"> Provide additional remote training, with supervision and staff support as needed. | <ul style="list-style-type: none"> Promote the message that basic needs continue to be available to all e.g. rent payments, food delivery, particularly for persons with severe mental health conditions or protection risks. |
| 7. Person-focused psychosocial support | | | |
| Psychological first aid | <ul style="list-style-type: none"> Train frontline workers in PFA, well-being and supportive communication. Adapt remote modalities for PFA.¹ | <ul style="list-style-type: none"> Implement remote PFA. | <ul style="list-style-type: none"> Similar to scenario 3. |

Table 2: Adaptation of specific MHPSS interventions in different COVID-19 scenarios (continued)

| | Scenarios 1 and 2 (No cases/sporadic cases) | Scenario 3 (Local transmission) | Scenario 4 (Community transmission) |
|--|---|--|---|
| 8. Psychological interventions | | | |
| Individual psychological interventions (psychotherapy/counselling) | <ul style="list-style-type: none"> • Develop prioritized list of service users and types of support needed when face-to-face sessions end. • Determine appropriate remote modalities for services. • Ensure that both clinicians and service users have access to the means of remote connection. • Hold a closing session to explain to service users and transition to remote modality. • Conduct in-person safety planning as necessary to ensure that service users have access to crisis care. • Ensure that clinicians are trained in remote counselling skills. • Set up systems for remote supervision as necessary. | <ul style="list-style-type: none"> • Transition to remote counselling or guided self-help. • Ensure the availability of emergency MHPSS services. | <ul style="list-style-type: none"> • Similar to scenario 3. • Organize psychological support for people who are hospitalized with COVID-19. |
| Basic counselling for groups | <ul style="list-style-type: none"> • Discuss the new situation with groups and discuss what to do if they cannot meet in person. • Consider reducing group size and/or suspending groups (if possible, organize a closing session). • Identify people who require ongoing individual follow-up if the group is suspended. | <ul style="list-style-type: none"> • Suspend group sessions. • Continue groups remotely when possible. • Provide remote individual follow-up with identified service users. | <ul style="list-style-type: none"> • Similar to scenario 3. |
| 9. Management of mental health conditions in outpatient health care | | | |
| General management of mental health conditions in primary health care | <ul style="list-style-type: none"> • Discuss longer follow-up with service users. • Discuss how service users can stay in touch. • Prepare plans for emergency response. | <ul style="list-style-type: none"> • Minimize visits to health facilities. • Prioritize follow-up for people with severe or acute mental, neurological and substance use conditions and related emergency situations. • Where possible, replace facility-based consultation with remote consultation. • When feasible and safe, home visits can be considered. • Take appropriate safety measures when doing facility-based consultation (see section 2.5). | <ul style="list-style-type: none"> • For service users with mild symptoms, maintain contact remotely. • For service users with acute or severe symptoms, take measures to ensure that services can be continued: <ul style="list-style-type: none"> ◦ Where possible, replace facility-based consultation with remote consultation. ◦ When feasible and safe, home visits can be considered. ◦ Take appropriate safety measures when doing facility-based consultation (see section 5). |
| Pharmacological management of mental health conditions | <ul style="list-style-type: none"> • Provide 2–3 months' medication if feasible, with a clear plan for safe storage and compliance. • Initiate telephone consultations for future visits. • Prepare emergency plans for medication issues. | <ul style="list-style-type: none"> • Consider discreet medication distribution in remote or community delivery consultation points. • Conduct face-to-face consultation when needed (for side-effects, uncontrolled symptoms) or remote consultation. | <ul style="list-style-type: none"> • Prioritize consultations for people with problems that are both acute and severe. • Continue maintenance treatment for chronic mental, neurological and substance use conditions. |

Table 2: Adaptation of specific MHPSS interventions in different COVID-19 scenarios (continued)

| | Scenarios 1 and 2 (No cases/sporadic cases) | Scenario 3 (Local transmission) | Scenario 4 (Community transmission) |
|---|--|--|--|
| 10. Management of mental health conditions in hospitals and institutions | | | |
| Inpatient mental health units | <ul style="list-style-type: none"> Contact service users and their families to assess possibilities and safety of discharge. Review safety and hygiene on unit. Assess how basic needs are met (for food, non-food items). Advocate to authorities to shield the unit from COVID-19. Educate staff and patients on safe behaviour. | <p>If no COVID-19 cases in unit:</p> <ul style="list-style-type: none"> Continue essential services with proper safety measures (see section 2.5). Facilitate that hospitalized service users can remain connected with their social networks (if in-person visits with proper safety measures are not possible, find other ways for contact). <p>If COVID-19 cases in unit:</p> <ul style="list-style-type: none"> Follow medical advice from health authorities, which may include placing the whole unit in quarantine with a separate isolation area and staff for infected patients. | <ul style="list-style-type: none"> Similar to scenarios 1, 2 and 3. |
| Inpatient mental health care on general (non-psychiatric) wards | <ul style="list-style-type: none"> Minimize hospitalizations due to mental health conditions on general (non-psychiatric) wards. | <ul style="list-style-type: none"> When hospitalizations are required due to acute or severe symptoms, take proper safety measures (see section 2.5). | <ul style="list-style-type: none"> Similar to scenario 3. Hospitalize people with COVID-19 and mild or moderate mental health conditions in principle in regular COVID-19 wards. Hospitalization of people with COVID-19 and severe or acute mental health symptoms in a general ward should occur only after consultation with a mental health professional. |
| 11. General activities to support MHPSS work | | | |
| Situation analysis | <ul style="list-style-type: none"> Only related to COVID-19. | <ul style="list-style-type: none"> Similar to scenarios 1 and 2. | <ul style="list-style-type: none"> Similar to scenarios 1, 2, and 3. |
| Monitoring and evaluation | <ul style="list-style-type: none"> Simplify as much as possible. | <ul style="list-style-type: none"> Similar to scenarios 1 and 2. | <ul style="list-style-type: none"> Similar to scenarios 1, 2, and 3. |
| Training | <ul style="list-style-type: none"> Train MHPSS staff on providing remote MHPSS care. Train first responders on PFA and therapeutic communication with vulnerable persons. Limit trainings to those relevant to COVID-19 situations and postpone other trainings. | <ul style="list-style-type: none"> Ongoing training as needed by staff to ensure the capacity to manage new COVID-19-related issues and issues related to remote work. | <ul style="list-style-type: none"> Similar to scenario 3. |
| Technical or clinical supervision | <ul style="list-style-type: none"> Prepare to move supervision to context-appropriate remote modalities. Ensure that supervisors and clinicians have the technology necessary to access remote supervision. Train supervisors in providing remote supervision. | <ul style="list-style-type: none"> Remote supervision. Focus on: <ul style="list-style-type: none"> acute or severe MHPSS issues; and mental health aspects of COVID-19, including normalizing stress and managing anxiety, emotional reactions, managing family tensions, grief support. | <ul style="list-style-type: none"> Similar to scenario 3. |
| Psychosocial support to aid workers | <ul style="list-style-type: none"> Provide awareness-raising sessions on self-care and prevention of burn-out and how to access remote staff support. Advocate for staff care to be included in response plans and budgets. | <ul style="list-style-type: none"> Promote remote staff support. | <ul style="list-style-type: none"> Intensify remote staff support and ensure that all staff receive support. |

Table 2: Adaptation of specific MHPSS interventions in different COVID-19 scenarios (continued)

| | Scenarios 1 and 2 (No cases/sporadic cases) | Scenario 3 (Local transmission) | Scenario 4 (Community transmission) |
|-----------------|--|---|--|
| Research | <ul style="list-style-type: none"> Design a risk mitigation plan. | <ul style="list-style-type: none"> Consider whether non-COVID-19-related research can continue with appropriate safety measures. Consider remote data collection. Research in humanitarian settings that is related to MHPSS and COVID-19 can be considered if it: <ul style="list-style-type: none"> has operational relevance (results are likely to influence clinical or humanitarian practice) AND it is feasible in the context without posing a significant burden or risk to staff and service users. | <ul style="list-style-type: none"> Similar to scenario 3. |

Acknowledgements

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¹ International Medical Corps: Guidelines for MHPSS Staff Providing Tele-MHPSS to Clients during the COVID-19 Pandemic (Field Test Version – 24.04.2020).

² International Rescue Committee: COVID-19 Operational Guidance Note Mental Health and Psychosocial Support (MHPSS) within Health Programs (April 6 2020).

³ Partners in Health: COVID-19, Part II: Clinical Management of COVID-19 (April 21 2020).

3. Mental health and psychosocial support considerations for children, adolescents and families during the COVID-19 response

(Adapted from the UNICEF COVID-19 operational guidance for implementation and adaptation of MHPSS activities for children, adolescents and families)¹

While the full impact and long-term fallout of COVID-19 are still unclear, there is one thing we do know: that the mental health and psychosocial impact of the coronavirus on the lives of children and adolescents and their caregivers is already significant. Almost all the world's children – 2.33 billion – live in countries that have imposed some form of movement restrictions as a result of COVID-19. For most, these restrictions mean no school, no meet-ups or playing with friends and limited recreational activities, and in humanitarian settings the inability to access safe spaces for essential support to their well-being. UNESCO estimates that 1.58 billion learners (over 90% of the world's student population) are affected by national closures of educational institutions due to the COVID-19 pandemic,² and research has shown that the interruption of formal education is one of the most significant stressors on children and families.³

Parents and caregivers will also be affected and will need support as they provide the necessary environment and in turn support their children to cope during this crisis; therefore, looking after the mental health and psychosocial needs of children of all ages and at all developmental stages and of the entire family unit is essential. Even without a pandemic, 10–20% of children and adolescents worldwide experience mental health conditions, with half beginning by the age of 14; and one in four children lives with a parent who has a mental health condition, highlighting the imperative nature of mental health and psychosocial support (MHPSS) considerations during the COVID-19 pandemic.

3.1 CHILDREN

Physical distancing, isolation from friends and other loved ones (e.g. grandparents), loss of school structure, disruption to education, missing education or needing to adjust to education at home, and concerns about the virus and its various impacts on their families may create feelings of worry, anger, frustration, sadness, uncertainty and loss for children. It is especially important to monitor the mental health and psychosocial well-being of children (and caregivers) who have pre-existing mental health conditions and of children with disabilities, as well as those living in vulnerable or high-risk circumstances. Children may also have to face the death of caregivers, other family members or family friends.

Key considerations

- Ensure that all materials, including radio, leaflets and services delivered directly, are child-friendly, translated into local languages, adapted to intellectual, hearing and visual impairments, and relevant to the context and culture.
- It is essential that any online resources and contacts from service providers working remotely are assessed from a safeguarding and child protection perspective.
- Ensure that materials and activities are developmentally appropriate (e.g. toys, games) to help young children understand and develop coping mechanisms and strategies, as well as to create feelings of engagement.
- MHPSS activities will need to be adapted based on the type of delivery that is available, depending on national containment strategies.



Resources

- **How to Speak with Children About Coronavirus?**
- **Helping children cope with stress during the 2019-nCoV outbreak**
- **My Hero is You storybook**
- **The Flying Scientist storybook**
- **Guidance for COVID-19 prevention and control in schools**

¹ https://app.mhpss.net/?get=354/unicef-april-2020-covid-19-operational-guidance-for-mhpss-implementation-and-adaptation_field-test-version-1.pdf

² <https://en.unesco.org/covid19/educationresponse>

³ https://assets.publishing.service.gov.uk/media/57a0897ee5274a31e0000e0/61127-Education-in-Emergencies-Rigorous-Review_FINAL_2015_10_26.pdf

3.2 ADOLESCENTS

Adolescents will have unique needs during the COVID-19 pandemic due to them missing out on events, schools being closed, stress at home, loss of autonomy and missing direct interaction with their peer groups. This may increase feelings of anxiety, frustration, anger, depression and isolation, and lead to a lack of concentration during home schooling. The public health crisis may also increase existing vulnerabilities and inequalities for adolescents, particularly for girls and young women. Adolescent girls may be at increased risk of early pregnancy and gender-based violence (GBV), and adolescents are impacted in various ways by financial insecurity of the family and/or the loss of livelihoods. Adolescents already living in settings such as conflicts, natural disasters and other humanitarian emergencies, those living alone without any parental care or adolescents with disabilities, or living with parents with disabilities, may face significant risks with the onset of COVID-19.

Key considerations

- As media and social conversations are at present entirely dominated by the outbreak, adolescents and young people are exposed to large amounts of information and to high levels of stress and anxiety in the adults around them. Simultaneously, they are experiencing substantial changes to their daily routines and social infrastructure, which ordinarily foster resilience to challenging events.
- While the COVID-19 response will need to address the priorities and needs of adolescents and youth, they should not be considered simply as affected populations but also as highly effective partners in COVID-19 efforts. They can meaningfully engage to be educators and change agents among their peers and in their communities.
- In contexts where adolescents are already more engaged in social media than in physical gatherings, or there is a high level of use of mobile phones, there may be difficulties in encouraging physical activities and the overuse of technology may lead to increased isolation.
- Provide resources that are specific to the needs of adolescents, taking into account that the needs of very young adolescents (10–14) may be different from those of older adolescents (such as strategies for self-care), and that the needs of adolescent girls may be different from those of adolescent boys.
- Find ways to share information about referrals and services that adolescents may need, such as where to seek care and services for GBV, where to seek psychosocial support, etc., and consider how to disseminate information to adolescents without access to phones and the Internet.
- Ensure that measures are in place to prevent, protect and mitigate the consequences of all forms of violence, stigma and discrimination against adolescents, especially adolescent girls and youth, during quarantine and self-isolation.



Resources

- **Practical Tips on Engaging Adolescents and Youth in the Coronavirus Disease (COVID-19) Response**
- **Toolkit to Spread Awareness and Take Action on COVID-19**

3.3 PARENTS AND CAREGIVERS

Caregivers may be under increased levels of stress due to worries about the virus, lack of access to their relatives, needing to care for sick or older family members, meeting the needs of children living with disabilities, children being at home all the time and out of school, the increased pressure of balancing work and home schooling, the illness or death of family members, loss of livelihoods and financial insecurity. Tensions within the household may also result in verbal or physical aggression between family members. For families living in locations where they are not able to practise physical distancing, such as camps and crowded urban areas, there may be additional worries about coping and survival.

It is important to note that even though children, families and communities may be under increased stress, there are also opportunities for strengthening family dynamics that can be explored through programmes that build capacity to restore protective relationships.

Key considerations

- Many caregivers may be feeling stress, worry and uncertainty about how to support both their children's well-being and the continuation of learning during COVID-19 school closures, in addition to ensuring that their families' basic needs are met. Normalize caregivers' feelings of worry, uncertainty and stress during this time as they take on additional responsibilities and tasks.
- Provide remote family and peer support by phone, online or via social media channels (e.g. WhatsApp), as available and accessible.



Kyrgyzstan: Mother playing with her child at home.

Sarah Harrison/ IFRC

- Consider audio or video options for caregivers with limited literacy and offline options for those without access to the Internet, such as the use of radio, TV or paper leaflets.
- Identify referral sources for non-MHPSS supports such as livelihood opportunities, unemployment benefits, cash transfer opportunities, etc.
- Integrate ways to deliver key stress management and parenting messages via other sectors and essential services that may have greater access to families.
- Identify referrals for caregivers and families in need of additional support for general health issues, GBV, COVID-19 illness or exposure, case management, etc.
- Provide information on common reactions for caregivers under stress and positive coping strategies. This may include information on the impacts of losing livelihoods, social isolation, relationship challenges, domestic violence and managing challenging behaviours in children.



Resources

- **Tips for parenting during the coronavirus (COVID-19) outbreak**
- **Tips for parents and caregivers during COVID-19 school closures: Supporting children's wellbeing and learning**
- **COVID-19: Wellbeing of you and your children and animated video**
- **Coronavirus and Kids: weekly learning activities by age group**
- **COVID-19 grief and loss guidance for parents**

4. Considerations for developing MHPSS responses to the COVID-19 pandemic for older adults

4.1 WHY FOCUS ON OLDER ADULTS?

- The **older population is incredibly diverse**. Most older adults are capable of coping and adapting, despite the increased likelihood of declining capacity as they age. Older adults contribute immeasurably to their families and communities in various roles, and often play key roles in the context of emergencies. Given their strong community ties, older adults are well placed to communicate messages and provide mental health and psychosocial support (MHPSS) to their peers and families. Older adults, particularly community, religious or spiritual leaders, should be provided with access to factually accurate information in order to ensure that safe behaviours are modelled and to avoid reinforcing pre-existing biases (e.g. ethnic or gender-based).
- Older adults are at **higher risk of developing more severe symptoms of COVID-19, and of dying as a result**. This may be due to age-related changes to the immune system, which make it harder to fight off diseases and infection. Older adults are more likely to have underlying health conditions, such as lung, kidney, cardiovascular or cerebrovascular disease or cancer, and to take multiple concurrent medicines that make it harder to cope with, and recover from, illness, including COVID-19.
- Furthermore, the gender, age, ethnicity, language, literacy, legal status and other aspects of each individual older person will have an effect on their potential vulnerability and capacity in relation to the health and social impacts of COVID-19. Older adults may have limited **access to accurate information** and are more likely to fall victim to misinformation about the COVID-19 pandemic.

- The **stress and social isolation** associated with measures put in place to contain COVID-19 may exacerbate underlying mental health or neurological conditions, which may have impacts on psychological well-being or the risk of suicide and/or worsen cognitive decline. Older adults in vulnerable situations may also be at higher risk of experiencing symptoms of new mental health and neurological conditions. These may include people who are homeless; displaced; who live in urban slums, camps or camp-like settings, or detention or transit centres; who are neglected or abused; who live in poverty, or in rural and remote areas.

! *It is important to identify who are the **vulnerable sub-groups in your context**.*

- Some older adults, including those with **disabilities and/or cognitive impairment and dementia**, who rely on others to carry out basic activities of daily living may not be able to access this needed support during lockdown or in situations where their caregiver becomes ill. At the same time, older adults who are care-dependent may be at increased risk of infection from caregivers and may have difficulty following the guidelines for infection prevention and control, particularly those who have disabilities and/or cognitive impairment and dementia.
- Due to their health risk profile, older adults may be one of the **last population groups for whom lockdown measures are lifted**, resulting in more time spent in potential social isolation. If COVID-19 transmission rates remain high, older adults may also remain at higher risk of infection once disease-related measures are lifted.

! *Long-term, targeted MHPSS strategies will need to be implemented to **prevent cognitive and functional decline**, taking into account the fact that the mental and physical health impacts of lockdown and social isolation may only surface once COVID-19-related restrictions are lifted.*

- During the entire period of lockdown and beyond, older adults with underlying physical and/or mental health conditions require **continued access to care**. Ensuring continuation of care may be particularly challenging if families choose to relocate their loved ones from long-term care and nursing homes to community-based settings.
- Some older adults may not have **access to key essential services and protections** during lockdown, such as food, medicine, shelter and other resources, due to fear of becoming infected, reduced mobility or COVID-19-related measures.

! *Ensuring that older adults' basic nutritional, safety and care/medical needs are met is essential in protecting their mental and physical health during and beyond the pandemic.*



Ukraine: UNHCR staff explain to a community member how they can protect themselves from the COVID-19 virus.

© NGO Proliska

- As should MHPSS responses in general, associated **monitoring and evaluation (M&E) efforts** need to take into account the diversity of different populations.

! *Collecting and tracking **disaggregated information on target populations** (e.g. by age, gender, ethnicity, disability, education/literacy level, socio-economic status) is critical for improving and ensuring equitable access to MHPSS and future planning.*

4.2 EQUITY AND HUMAN RIGHTS

- **Ageism** is stereotyping, prejudice and discrimination towards people because of their age. The current COVID-19 pandemic has provoked ageist attitudes and behaviours towards older adults across the world,¹ including in access to services and information. COVID-19-related ageism may exacerbate pre-existing age-, gender-, ethnic- or disability-based prejudice and discrimination.

- The measures taken in the context of the pandemic should respond to the diversity representative of older age. Policies and protocols that are put in place as part of the COVID-19 response should **not neglect older people's needs or discriminate on the basis of age** (e.g. denying or limiting older adults' access to screening or care on the basis of their chronological age), **gender, disability or ethnicity**. The following are important points to remember:

! ***Avoid labelling older adults as uniformly frail and vulnerable**, given that they represent a very diverse population group. Terms used to describe older adults should not reinforce stereotypes or stigmatize them. Consult with older people in the community to identify the best terms to use. In the absence of such guidance, terms such as "older people", "older persons" or "older adults" may be used, while referring to "the elderly" or "seniors" should be avoided due to the negative connotations these terms carry. It is crucial to engage with stigmatized groups of older adults and to speak out against discriminating behaviours.*

¹ McClean D. COVID-19: Battling stigma and discrimination against older persons. United Nations Office for Disaster Risk Reduction. 3 April 2020. <https://www.undrp.org/news/covid-19-battling-stigma-and-discrimination-against-older-persons>

❗ **Foster a positive attitude towards older adults** and empower them to maintain their autonomy and dignity¹ during the COVID-19 pandemic by raising awareness regarding their human rights, including their right to make decisions for themselves (i.e. legal capacity) and to receive support in decision-making from trusted persons, should they need it (i.e. supported decision-making).

❗ **Promote activities between people of different generations**, such as talking on the phone or online, reading and storytelling or transferring skills, all of which can help combat ageism. These activities should provide an opportunity for older adults to learn about signs and symptoms of COVID-19 and related complications from the younger generation, while transferring their own skills, knowledge and wisdom to young adults and grandchildren. This could be achieved through digital platforms and technology, more traditional communication channels such as the telephone or simple day-to-day interactions within the household.

❗ **Make visible the resilience and recovery and positive contributions of older adults** during the COVID-19 response; this represents another important way of providing older adults with a sense of dignity and responsibility. Older adults' life skills and experience of overcoming difficult life events represent acquired wisdom that can be used to support friends, family and community members.

4.3 MHPSS CONSIDERATIONS FOR OLDER ADULTS

- Some older adults may experience increased **anxiety, worry, distress, loneliness** or suicidal thoughts in response to the current pandemic and associated COVID-19-related measures such as lockdown and physical distancing, in both the short and the long terms. This may be particularly the case for older adults with underlying mental or physical health conditions, who live alone, who have limited social contact in normal situations, who suffer from domestic violence or who live in societies with highly defined gender roles leading to unequal caregiving burdens. Together, these factors exacerbate the risk of social isolation when lockdown measures are put in place.

- **Physical distancing should not be the same as social isolation and does not have to lead to loneliness.** It is very important that older adults stay socially connected in order to maintain their emotional, cognitive and physical health.

❗ *Social connections (e.g. through phone or video calls, crisis lines or informal support groups) can create a sense of safety and responsibility for older people, knowing that there is someone who cares about and can support them, and who they care for in return.*

- Some older adults may react more strongly to **stressful events** and take more time to recover from stress, which **can affect both their mental and physical health.**

❗ *It is important that older adults remain physically active² and socially involved with others and that they feel productive both during the lockdown period and as COVID-19-related measures are gradually lifted. This can lessen the impact of stress on their mental and physical health,³ preserve flexibility/mobility and prevent functional/cognitive decline. Negative coping strategies such as harmful use of alcohol, tobacco or other drugs are to be avoided.*

- Older adults may be particularly afraid of becoming infected with COVID-19 or infecting family and friends. Stress related to COVID-19 may also exacerbate pre-existing **fears and anxieties related to dying or dying alone.** Likewise, the **death of family members or close friends due to COVID-19** may lead to a wide range of emotions and symptoms for older adults, including sadness, anger, guilt, difficulty sleeping, fatigue and lower levels of energy. It is important to note that all these feelings are normal and that there is no right or wrong way to grieve. Depending on national or local measures, it may not be possible to visit the deceased person; funeral services may also not be permitted.

❗ *Facilitating, as much as possible, appropriate cultural, spiritual and religious practices and rituals can ease distress and enable mourning and grief at a population level.^{4,5}*

¹ Inter-American Convention on Protecting the Human Rights of Older Persons (A-70). http://www.oas.org/en/sla/dii/inter_american_treaties_a-70_human_rights_older_persons.asp

² WHO (2019). Risk reduction of cognitive decline and dementia: WHO guidelines. Geneva: World Health Organization. <https://www.who.int/publications-detail/risk-reduction-of-cognitive-decline-and-dementia>

³ IFRC (2016). Healthy ageing toolkit for facilitators, volunteers and community. https://www.ifrc.org/Global/Documents/Secretariat/Health/Toolkit_MRC_092216.pdf

⁴ WHO (2015). mhGAP Humanitarian Intervention Guide (mhGAP-HIG). https://apps.who.int/iris/bitstream/handle/10665/162960/9789241548922_eng.pdf;jsessionid=C59290F0F882248BE1FC7CEAD638D0BB?sequence=1

⁵ IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action Sheet 5.3: Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices and Action Sheet 8.2: Provide access to information about positive coping methods. https://interagencystandingcommittee.org/system/files/iasc_guidelines_on_mental_health_and_psychosocial_support_in_emergency_settings.pdf



Iran: Two older adults.
© Sarah Harrison/IFRC

4.4 VIOLENCE AGAINST OLDER PEOPLE AND NEGLECT

- Older adults, particularly older women, may be at higher risk of **violence, abuse, neglect or overprotection**¹ during the COVID-19 pandemic, when families are in lockdown for extended periods of time.²

❗ *It is important to ensure that the **increased risk of violence, abuse and neglect is reflected in Risk Communication and Community Engagement Action Plans**³ as well as service provision, MHPSS, and health support plans.*

❗ ***Raising public awareness** of the increased risk of violence against older people in a culturally and context-specific manner is essential. This can be achieved by providing information (e.g. via radio, television, print media or Internet-based campaigns) on how to seek help as a victim of violence or neglect, and how to safely provide support to victims. This information can also be displayed at health care and testing facilities.*

❗ ***Health and social care workers**, as well as emergency first responders (including volunteers), should be trained to identify signs of violence and neglect, provide medical and psychological support, safely report concerns⁴ and share information about available community resources, grounded in age-, gender- and diversity-specific needs.⁵ If not immediately feasible due to capacity issues, this should be integrated into longer-term MHPSS strategies and capacity building programmes.*

❗ ***National helplines for violence against older people** should be implemented and maintained. Consideration should be given to how shelters and centres for victims of violence or neglect can remain operational during the pandemic, provided safety and hygiene measures can be implemented. In settings where these services exist only for children and women exposed to violence, staff may require training on violence against older people.*

¹ “Overprotection” refers to situations where caregivers or family members insist on doing everything for the older adult, even activities that they could do for themselves. Overprotection may occur when a family member or caregiver perceives that it is “easier” for them, rather than for the older person, to carry out the activity. Overprotection is disempowering and can lead to increased disability, as well as feelings of loss of control and helplessness.

² CARE. Gender implications of COVID-19 outbreaks in development and humanitarian settings. https://www.care.org/sites/default/files/gendered_implications_of_covid-19_-_full_paper.pdf

³ IFRC, WHO (2020). Risk Communication and Community Engagement (RCCE) Action Plan Guidance COVID-19 Preparedness and Response. [https://www.who.int/publications-detail/risk-communication-and-community-engagement-\(rcce\)-action-plan-guidance](https://www.who.int/publications-detail/risk-communication-and-community-engagement-(rcce)-action-plan-guidance)

⁴ WHO (2019). Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care. <https://www.who.int/ageing/publications/icope-handbook/en/>

⁵ (LINK TO IASC Orientation Manual for Frontline Workers – same Annex)

❗ **Support for victims of violence should be included in the bundle of accessible “essential services”.**¹ In settings with movement restrictions, exceptions may be granted for people to leave their place of residence or village in cases of violence, abuse or neglect. Close collaboration with other sectors, such as criminal justice, health and social services, is key.

4.5 CONSIDERATIONS FOR FAMILY MEMBERS AND CAREGIVERS OF OLDER ADULTS

- Restrictions adopted in response to COVID-19 such as **lockdown and self-isolation mean that family members or caregivers of older persons may not be able to physically visit them**. Older adults may also not be able to visit their friends or draw on their social or community networks as they are accustomed to doing. As a result, they may feel increasingly socially isolated and lonely. It is important to **encourage family members and/or caregivers to regularly speak** with the older person, e.g. through daily phone or video calls, text messages, letters and/or emails.

❗ *Where possible, family members and grandchildren can **visit older adults at a distance**, e.g. by speaking over a balcony or in a large outdoor space.*

- Older adults may have limited **access to accurate information** and are more likely to fall victim to misinformation about the COVID-19 pandemic. Some older adults may have difficulties understanding the public health information issued to them or remembering safety procedures, such as hand hygiene and wearing masks, particularly people with dementia.

❗ *Family members and/or caregivers can **communicate accurate information using simple words and language** that the older person can understand.*

- Family members and/or caregivers can support the older person in **managing their physical and mental health needs**. This includes:

❗ *ensuring that the person continues to receive care if they develop symptoms of COVID-19;*

❗ *responding to stress, anxiety, loneliness or suicidal thoughts^{2,3} that the older person may experience as a result of the changing circumstances or social isolation; and*

❗ *continuing to provide everyday care.*

- The **mental and physical health impacts of the pandemic may only surface once COVID-19-related measures such as lockdown are lifted**. Older adults may experience feelings that “nothing is as before”, while family members and/or caregivers may feel that “the person does not seem the same”. This may foster a challenging process of acceptance and it may require comprehensive MHPSS strategies.

- The COVID-19 pandemic may cause **additional stress to family members and/or caregivers**, in part due to the discontinuation of home care and caregiver support services. They may feel more anxious, worried, agitated, irritated or angry than usual. They may also be more concerned about the health of the older person, and/or experience more conflicts with them than normal.

❗ *Family members and/or caregivers should be encouraged to ask for help if and when needed, and to care for themselves, e.g. through relaxation exercises, meditation, engaging in physical activity and doing pleasant activities. Given the disproportionate caregiving burden carried by women, gender-specific needs should be considered when providing MHPSS and caregiver support.*

❗ *Where feasible, alternatives to home care and caregiver support services should be offered, e.g. through helplines, online community support groups or volunteers.*

4.6 DISSEMINATION AND COMMUNICATION CONSIDERATIONS

- **MHPSS messaging will need to evolve and adapt as the pandemic unfolds**. Topics of particular relevance to older adults include fear (e.g. fear of becoming infected, especially for those with underlying physical or mental health conditions, fear of infecting family and friends, fear of dying or dying alone), prolonged lockdown measures for older adults leading to extended movement restrictions, social isolation and loneliness, grief and mourning, stigma, spiritual and religious needs, negative coping strategies and the risk of taking one’s life.

¹ High-priority categories of essential services may include essential prevention for communicable diseases; reproductive health services; care of vulnerable populations, such as young infants and older adults; provision of medications and supplies for the ongoing management of chronic diseases, including mental health conditions; continuity of critical inpatient therapies; management of emergency health conditions and common acute presentations that require time-sensitive intervention; and auxiliary services, such as basic diagnostic imaging, laboratory services and blood bank services. WHO. COVID-19: Operational guidance for maintaining essential services during an outbreak. <https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak>

² WHO. Do you feel like life is not worth living? <https://www.who.int/campaigns/world-health-day/2017/handouts-depression/life-worth-living-03.pdf?ua=1>

³ WHO. Do you know someone who may be considering suicide? <https://www.who.int/campaigns/world-health-day/2017/handouts-depression/suicide-04.pdf?ua=1>

- All messages need to be disseminated in **accessible formats** through communication channels that are familiar to, and used by, older adults, **taking into account older adults with sensory and/or cognitive impairment and dementia and/or who may be illiterate.**

❗ *For this reason, different modes of communication (written, audio, visual, Braille, sign language) will need to be used.¹ Messages should be developed in partnership with older adults and should include pictures, sketches or audio recordings of, and by, them.*

❗ *Sharing **simple facts** about the pandemic and associated measures, and giving clear information about how to reduce the risk of infection in words that older people with or without cognitive impairment can understand, is important. **Information may need to be repeated whenever necessary.** Older persons with dementia may require frequent reminders of all relevant information.*

- Remote connectivity may be more difficult for older adults, since many of them have less access and/or lack the knowledge to use technology and social media.

❗ *Alternative communication channels may need to be used to reach older people (see Table 3). Mapping actors and organizations involved in providing services and support to older adults represents an important first step in identifying appropriate dissemination mechanisms.*

- Older adults may be more vulnerable to misinformation related to COVID-19 and fraud and/or intrusion attempts more generally (e.g. intruders soliciting false donations or requesting home visits under the false disguise of authorities).

❗ *It is important to ensure that older adults have access to reliable information from trusted sources. Older adults should be provided with information related to the risk of misinformation, how to report fraud and intrusion attempts and where to find accurate and reliable facts.*

¹ CBM. Digital Accessibility Toolkit. https://www.cbm.org/fileadmin/user_upload/Publications/CBM-Digital-Accessibility-Toolkit.pdf

Table 3: Dissemination mechanisms that may work particularly well for older adults

| WHAT | HOW and WHO |
|--|--|
| Audio messages and community broadcasts | <ul style="list-style-type: none"> • National radio broadcasting • Community announcements (e.g. over loudspeakers), or announcements in camps for refugees and internally displaced persons, camp-like settings, transit and detention centres |
| Video messages | <ul style="list-style-type: none"> • National television broadcasting • Social media (e.g. YouTube, Twitter, WhatsApp, Viber, Facebook, LinkedIn, Instagram) • Public billboards and projections |
| Signs and posters | <ul style="list-style-type: none"> • In pharmacies, doctors' offices, community clinics or mobile clinics • In grocery stores or food stations • At community sanitation posts • Through community and neighbourhood notice boards • At shelters for homeless people and victims of abuse |
| Leaflets and information brochures¹ | <ul style="list-style-type: none"> • National government and/or public health and social care authority websites • Mailbox delivery/post at private dwellings, long-term care and nursing homes and hospitals • Mailbox delivery/post via municipalities and/or social welfare agencies with lists of older adults residing at home and/or who receive home-based care • In pharmacies, doctors' offices, community clinics, mobile clinics and/or home care services • Through social workers, caregivers, volunteers or neighbours • Through community, religious and/or spiritual leaders • Through pension funds, e.g. via email, written or phone call communication |
| Newspaper ads and newsletter articles | <ul style="list-style-type: none"> • In local newspapers and other publications • In newsletters sent by community organizations and social activity clubs |
| Helplines and psychological support crisis lines | <ul style="list-style-type: none"> • Through organizations and individuals operating these helplines |
| Community initiatives, support and volunteer groups | <ul style="list-style-type: none"> • Through individual or collective calls to older adults • Through established support and volunteer groups |

¹ For examples, see Pan-American Health Organization (PAHO) infographics: Infographic: COVID-19 Ways you can help the elderly and people with underlying conditions living with you. Infographic: COVID-19 Ways to help the elderly and/or people with underlying conditions living alone. Infographic: COVID-19. Ways to prepare and protect yourself if you're 60+ and/or living with underlying conditions.

5. Addressing substance use and addictive behaviours during the COVID-19 pandemic

This section was developed by the IASC MHPSS Reference Group and provides several recommendations related to substance use within the context of the COVID-19 outbreak, in particular:

- Avoid using unhelpful coping strategies such as tobacco, alcohol or other drugs. In the long term, these can worsen your mental and physical well-being.
- Don't use tobacco, alcohol or other drugs to cope with your emotions.

Individual and public health responses to the COVID-19 outbreak (including physical distancing and social isolation) may change levels and patterns of alcohol and drug use, increase intensity of engagement in video gaming or gambling and have impacts on existing regulations, their implementation and public support for such regulations. Maintaining continuity in the treatment and care of people affected by disorders due to alcohol, drugs and addictive behaviours may be challenging during a pandemic, but health systems should ensure the provision of essential services particularly to urgent and severe conditions.

Against this background, additional information and recommendations to address alcohol, drugs and addictive behaviours in the content of the COVID-19 outbreak are urgently needed. This section addresses this need and can be recommended for use in addition to the original IASC briefing note.

5.1 BACKGROUND INFORMATION

- The use of psychoactive substances such as alcohol, nicotine or psychoactive drugs is associated with significant health risks, and can lead to the development of substance use disorders and other health conditions due to intoxication, toxicity or other long-lasting effects.
- The use of psychoactive substances can impair judgment, self-regulation, motor coordination and reaction time. This, in turn, increases the risk of injuries, violence and social problems. Robust links have been found between alcohol use and the occurrence and severity of domestic violence, including intimate partner violence.
- Substance use can interfere with the ability to take precautions to protect oneself against infection, such as compliance with hand hygiene, and can decrease the effectiveness of COVID-19 protective measures by interfering with compliance with regulatory and treatment regimens.
- Video gaming is a popular and very common hobby for youths and adults of different ages. It can be one option to pass the time and have fun, and online games can be used as a channel for social interaction amid the COVID-19 outbreak. However, it is important to acknowledge that excessive gaming is associated with a range of physical, mental and interpersonal problems and can lead to the development of gaming disorder.
- In challenging times such as during the COVID-19 outbreak, it can be easy to fall into unhealthy patterns of behaviour, including psychoactive substance use and excessive gaming or gambling, as coping strategies to relieve stress or anxiety caused by the situation or to pass time if self-isolating, in quarantine or in lockdown.
- People with substance use disorders may be at higher risk of acquiring a range of infections due to risk factors associated with substance use, such as sharing objects for substance use (bottles and other containers, tableware, pipes, syringes), gathering in groups, poverty, unemployment and a greater likelihood of arrest and incarceration.
- Risks of a fatal substance overdose can increase during the COVID-19 outbreak for a number of reasons, such as use of drugs in solitude because of social isolation and quarantine, affected lung function because of COVID-19 infection, changes in strength and quality of drugs or alcohol due to changes in supply chains, and limited access to treatment and care.

- Withdrawal syndromes due to the use of alcohol or other psychoactive substances may develop after abrupt discontinuation or significant reduction in heavy use. Severe withdrawal syndromes can be dangerous, even life-threatening, when they are complicated by delirium, seizures or dysregulation of vital functions. Withdrawal management services should be available for these cases. In global humanitarian settings, persons with substance use disorders are often already marginalized, and in many settings do not have appropriate treatment options. During a pandemic, this population may be particularly vulnerable and neglected, and should therefore be considered in mental health and psychosocial support responses.

5.2 MESSAGES TO SERVICE PROVIDERS, POLICY MAKERS AND REGULATORS

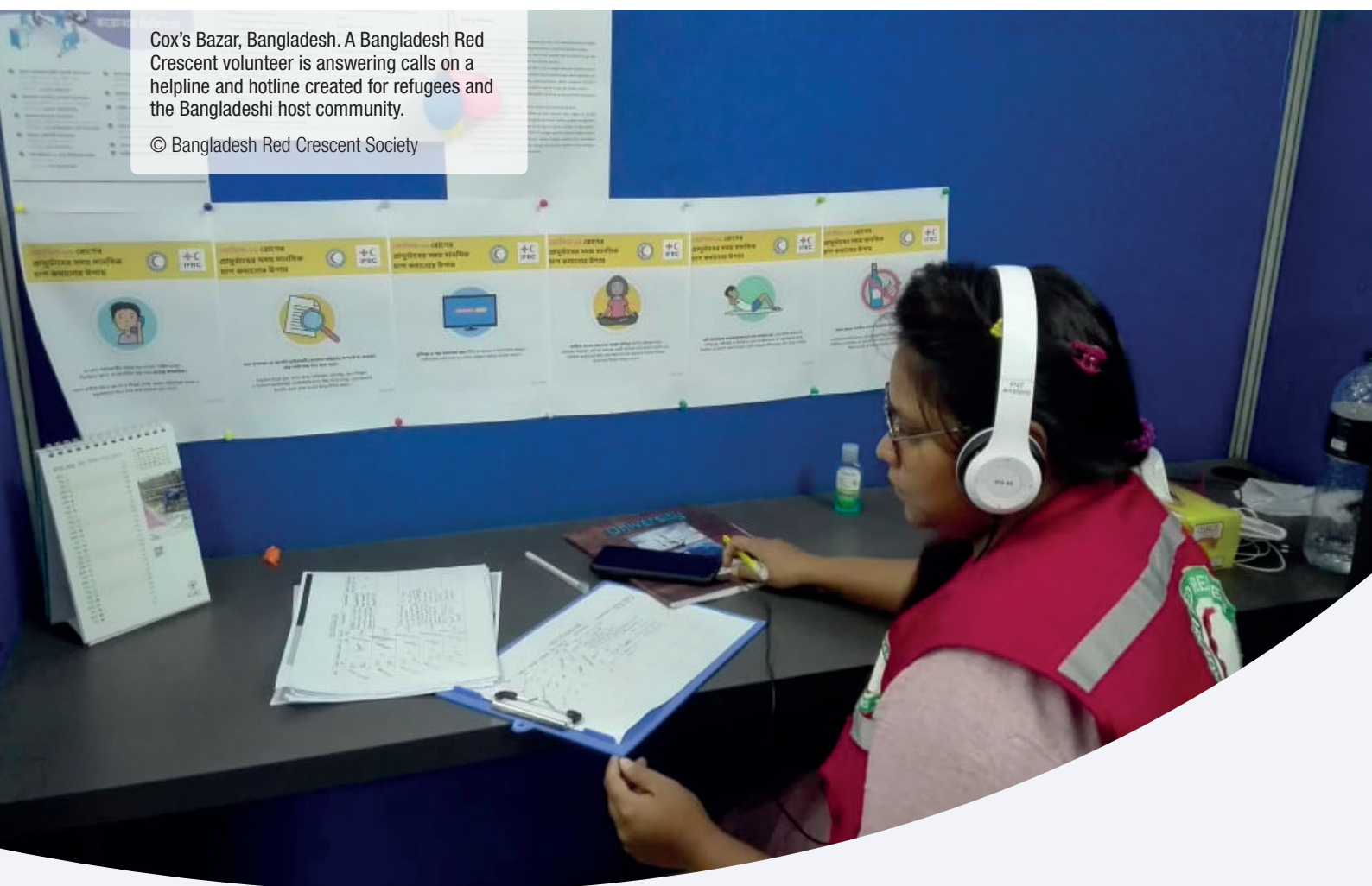
- Rules and regulations put in place to protect public health and reduce harm caused by alcohol¹ and other psychoactive substance use and addictive behaviours should be upheld, and may need to be strengthened during the COVID-19 outbreak or in similar emergency situations. Any relaxation of regulations should be avoided, and enforcement of regulatory measures secured. If regulations are relaxed, they should be reinstated as quickly as possible.
- It is necessary to ensure continued access to critical interventions for people with substance use disorders (e.g. outreach services, harm reduction with needle and syringe programmes) and management of acute health conditions (e.g. overdose, withdrawal syndromes), as well as the treatment of substance use disorders and support for those in recovery.² Treatment services for substance use disorders, especially to urgent and severe conditions, are essential health services. Further guidance on adapting and tailoring services to different contexts and settings is available from WHO and other organizations (see the ‘Additional resources’ section below).

¹ WHO (2010). Global Strategy to Reduce the Harmful Use of Alcohol. <https://apps.who.int/iris/handle/10665/44395>

² WHO and UNODC (2020). International Standards for the Treatment of Drug Use Disorders: Revised edition incorporating results of field-testing. <https://apps.who.int/iris/handle/10665/331635>; and WHO (2016) mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings: mental health Gap Action Programme (mhGAP) version 2.0. <https://apps.who.int/iris/handle/10665/250239>

Cox's Bazar, Bangladesh. A Bangladesh Red Crescent volunteer is answering calls on a helpline and hotline created for refugees and the Bangladeshi host community.

© Bangladesh Red Crescent Society



- Ensuring continuity of medical and health commodities is essential, including methadone and other medications for the management of opioid dependence,¹ naloxone for the management of opioid overdose,² sterile needles and syringes, alcohol swabs and diagnostics and medicines for the testing and management of major coinfections (such as HIV and viral hepatitis) and other comorbidities.³
- Take-home doses of medications can be provided for longer periods of time in situations of quarantine, self-isolation or lockdown and health service disruptions. The maximum periods of time possible for take-home doses of medications are recommended when the dose and social situation are stable. Clients should be properly informed about changes in practice and should receive appropriate support in case of uncertainty or concerns.
- Access to medications should be arranged for those patients who are not eligible for take-home medication (e.g. providing medications in supervised settings such as nursing homes or other officially recognized health facilities), those who live in long-term institutions, those in prisons and those hospitalized for inpatient treatment or rehabilitation. Relevant health, social care and custodial facilities should provide uninterrupted access to opioid agonist medicines and to medicines for the management of comorbid conditions for patients in treatment with the involvement of trained personnel.
- Whenever necessary and feasible, consideration should be given to the prescription of extended-release formulations of opioid agonists for treatment of opioid dependence. Additional psychosocial support should be provided to those in isolation via web-based services or by phone.
- Increased dispensing of take-home medications within relatively short periods of time may result in increasing demand on the supply of medicines, which should be considered at different stages of supply planning and management.
- People with substance use disorders have a higher prevalence of comorbid physical and mental health conditions and, accordingly, should be provided with appropriate care.
- People with substance use disorders in contact with the criminal justice system need to be considered as a vulnerable group during the COVID-19 pandemic and be included in schemes to enhance alternatives to conviction or punishment, such as compassionate prison release schemes.⁴

5.3 MESSAGES TO THE GENERAL PUBLIC

- There is no evidence that drinking alcohol, smoking tobacco or using opium, cannabis or other psychoactive substances protects from viral or other infections. In fact, the opposite is true, as the harmful use of alcohol and other psychoactive substances is associated with an increased risk of infectious diseases and/or worse treatment outcomes, as well as other negative health consequences.
- Avoid drinking alcohol or keep it to the minimum if you drink. Don't start drinking if you have not consumed alcohol before. Avoid using alcohol and drugs as a way of dealing with fear, anxiety, boredom and social isolation.
- Avoid using alcohol or other psychoactive substances if you are a family member or caregiver responsible for children, people with disabilities or elderly people.
- Avoid using alcohol or other psychoactive substances as a way of dealing with fear, anxiety, boredom or social isolation. Seek alternative, more effective strategies to cope with stressors.
- Be aware of potential increases in the marketing of alcoholic beverages, video games and online gambling, and protect minors and vulnerable members of the family from these marketing activities.
- Be aware of how much time you spend in front of a screen every day. Make sure that you take regular breaks from on-screen activities. Make sure that children do not spend significantly more time than usual playing video games.

¹ WHO (2009). Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. <https://apps.who.int/iris/handle/10665/43948>

² WHO (2014). Community Management of Opioid Overdose. <https://apps.who.int/iris/handle/10665/137462>

³ WHO (2016). Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, 2016 update. <https://apps.who.int/iris/handle/10665/246200>

⁴ WHO and UNODC (2018). Treatment and Care for People with Drug Use Disorders in Contact with the Criminal Justice System: Alternatives to Conviction or Punishment. https://www.unodc.org/documents/UNODC_WHO_Alternatives_to_Conviction_or_Punishment_2018.pdf

5.4 MESSAGES TO PEOPLE WITH HEALTH CONDITIONS CAUSED BY SUBSTANCE USE OR ADDICTIVE BEHAVIOURS (GAMING AND GAMBLING)

- Like many people, you may feel more scared or stressed due to the COVID-19 pandemic. In these difficult times, it is especially important to look after yourself, as the chances of relapse and negative health and social consequences are higher.
- If you are being treated for disorders due to substance use or addictive behaviour, continue with your treatment if possible. You are encouraged to keep in touch with your therapist, psychologist, other caregiver or a support group by email, phone or other remote communication methods. Find out how to continue support during the outbreak.
- Continue with prescribed medication (e.g. methadone or buprenorphine). Talk to your health care provider to plan how you will access these medications.
- Be aware of the risk of a substance overdose (especially opioid overdose) if you use drugs, have a substance use disorder or live with someone who uses psychoactive substances. Risk of a fatal substance overdose can increase during the COVID-19 outbreak or other emergencies.
- Know how to identify the signs of an overdose, agree with your peers on a response plan and provide immediate help when witnessing a suspected overdose, including the use of opioid antagonist naloxone in case of an opioid overdose.
- Be aware of potentially harmful interactions between prescribed medications, including psychotropic medicines, and psychoactive substances such as alcohol, amphetamine-type stimulants or cannabis.
- If you have previously experienced serious withdrawal symptoms and continue to use alcohol or other psychoactive substances, it is advisable to gradually reduce the use of alcohol or other substances, rather than stop their use abruptly. If you start to experience serious withdrawal symptoms, find out what services are available where you can receive help in a safe environment.
- Contact your health care provider if you have signs of COVID-19 infection and follow standard recommendations to prevent the spread of infection.

An awareness session on COVID-19 was organized on the IOM premises in Beirut, Lebanon.

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Additional resources

WHO resources on the COVID-19 pandemic

Latest information, advice and guidance from WHO on COVID-19:

Coronavirus disease (COVID-2019) situation reports: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/>

Coronavirus disease (COVID-19) Pandemic: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

EPI-WIN: WHO information network for epidemics: <https://www.epi-win.com/>

Preventing COVID-19 outbreak in prisons: a challenging but essential task for authorities: <http://www.euro.who.int/en/health-topics/health-emergencies/pages/news/news/2020/03/preventing-covid-19-outbreak-in-prisons-a-challenging-but-essential-task-for-authorities>

Resources on the COVID-19 pandemic for people who use psychoactive substances and services for people with substance use disorders

WHO EURO Factsheet: Alcohol and COVID-19: what you need to know: <http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov-technical-guidance/coronavirus-disease-covid-19-outbreak-technical-guidance-europe/alcohol-and-covid-19-what-you-need-to-know>

Infographic: <http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/data-and-statistics/infographic-alcohol-and-covid-19-what-you-need-to-know>

UNODC Suggestions about treatment, care and rehabilitation of people with drug use disorder in the context of the COVID-19 pandemic. Available in 12 languages: Arabic, Bahasa, Dari, English, French, Khmer, Laotian, Pashto, Russian, Serbian, Spanish, Uzbek

COVID-19: HIV Prevention, Treatment, Care and Support for People who Use Drugs and People in Prison: <https://www.unodc.org/unodc/en/hiv-aids/new/covid-19-and-hiv.html>

Resources on mental health and substance use

UNODC, World Drug Report 2019: <https://wdr.unodc.org/wdr2019/>

UNODC/WHO International Standards on Drug Use Prevention: <https://www.unodc.org/unodc/en/prevention/prevention-standards.html>

WHO, Management of substance abuse homepage: https://www.who.int/substance_abuse/en/

WHO (2016). mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings: mental health Gap Action Programme (mhGAP), version 2.0: <https://apps.who.int/iris/handle/10665/250239>

WHO (2010). Global Strategy to Reduce the Harmful Use of Alcohol: <https://apps.who.int/iris/handle/10665/44395>

WHO (2009) Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence: <https://apps.who.int/iris/handle/10665/43948>

WHO (2014). Community Management of Opioid Overdose: <https://apps.who.int/iris/handle/10665/137462>

WHO and UNODC (2020). International Standards for the Treatment of Drug Use Disorders: Revised edition incorporating results of field-testing: <https://apps.who.int/iris/handle/10665/331635>

WHO (2016) Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, 2016 update: <https://apps.who.int/iris/handle/10665/246200>

Humeniuk R. et al. (2010). The Alcohol, Smoking and Substance involvement Screening Test (ASSIST): manual for use in primary care: <https://apps.who.int/iris/handle/10665/44320>

WHO (2001). AUDIT: the Alcohol Use Disorders Identification Test guidelines for use in primary health care: <https://apps.who.int/iris/handle/10665/67205>

UNODC Treatnet training materials: <https://www.unodc.org/unodc/en/treatment-and-care/treatnet-training-package.html>

Resources on psychosocial support in emergency settings

IASC (2007). Guidelines on Mental Health and Psychosocial Support in Emergency Settings: https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

WHO (2012). Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for humanitarian settings: <https://cms.emergency.unhcr.org/documents/11982/49286/WHO+and+UNHCR%2C+Assessing+mental+health+and+psychosocial+needs+and+resources/0ab28c11-fc35-4996-8ea4-0575e88ee299>

UNHCR (2013). Operational Guidance: Mental Health & Psychosocial Support Programming for Refugee Operations: <https://www.refworld.org/docid/53a3ebfb4.html>

Mental health and psychosocial support. UNHCR Emergency Handbook: <https://emergency.unhcr.org/entry/251117/mental-health-and-psychosocial-support>

WHO (2015). mhGAP Humanitarian Intervention Guide (mhGAP-HIG): https://apps.who.int/iris/bitstream/handle/10665/162960/9789241548922_eng.pdf?sequence=1

WHO (2011). Psychological first aid: Guide for field workers: https://apps.who.int/iris/bitstream/handle/10665/44615/9789241548205_eng.pdf?sequence=1

UNODC. Family skills training materials: https://www.unodc.org/documents/drug-prevention-and-treatment/Strong_families_Brochure.pdf

