Adaptation of MHPSS in camps in the context of COVID-19

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The pandemic has placed significant additional mental and emotional burdens on forced migrants. MHPSS interventions must be adapted to meet this challenge and not be overlooked in the wake of containment and mitigation efforts.

The IASC intervention 'pyramid' for mental health and psychosocial support (MHPSS) in emergencies promotes the need for a layered system of complementary support that meets the needs of different groups during emergencies.[1] The recommendations here reflect these layers of intervention, and focus on the importance of establishing collective care and mutual aid networks that integrate the cognitive, affective, spiritual and social realities of displaced persons living in camp settings in the context of COVID-19.

Basic services and security

Decisions made by host countries during the pandemic response, including lockdown measures and travel restrictions, have disproportionately affected forced migrants, who are experiencing increased barriers to meeting their basic needs when they may already be traumatised and emotionally strained. Advocacy must continue for their **inclusion in national responses** and to maintain access to aid delivery and physical access for aid workers, as well as to ensure that migrants' movements are not unnecessarily restricted in ways that discourage them from seeking routine health care and mental health support.

Outside groups and minorities have become targets for blame as failed containment responses exacerbate ethnic and religious divides, with refugees, IDPS and asylum seekers in particular often portrayed as competing for access to diminishing resources. The risk of disease outbreaks in camps creates further feelings of justification among host governments and populations for inhumane treatment and lockdown measures. **Anti-stigma campaigns** will be essential for creating an accepting environment where forced migrants feel confident enough to seek treatment, self-isolate and identify as having COVID-19 without fear of social or legal repercussions.

Religious and cultural leaders within both the host community and the camp populations can be effective in spreading the message that religion, ethnicity or any other identifying factor does not determine

whether or not someone is more likely to contract and carry the virus.[2] Sharing the importance of seeking health care when individuals fall ill and advocating for systems where those affected can be cared for without social or legal repercussions will also be essential to the MHPSS response.

Displaced populations living in camp settings have expressed the fear of starvation, of common illnesses caused by deteriorating living conditions, and of interruptions to standard aid delivery is taking precedence over fear of contracting the virus. Focused MHPSS interventions are unlikely to achieve full potential for success unless people have consistent **provision of basic needs and essential health services**, in order to feed their children, receive pre-natal care, manage chronic health conditions, and receive preventive services and treatment for common illnesses in camp settings. In addition, incorporating psychosocial stabilisation techniques and spiritual care practices may help strengthen emotional and spiritual well-being during the stressful experiences that refugees are coping with on a daily basis.

Community and family support

Being able to turn to immediate and distant social networks is often more vital to healing and survival than any humanitarian programming – and this is directly threatened by the nature of the COVID-19 pandemic.[3] Transferring **support networks** to phone messaging apps for the duration of the pandemic may be one option for safely maintaining social ties both within and outside camp boundaries. Rearranging in-person networks for groups who are more prone to isolation and have less access to technology (such as women, girls and young children) to take place in safe physically distanced spaces may also be an effective solution.

By **involving forced migrants in the COVID-19 response**, aid agencies can offer people who have been cut off from their previous occupations the opportunity to be active and engaged again. This may require supporting training of community health workers, of contact tracing and surveillance teams, or of teachers in providing COVID-adapted education. People can also be involved in sewing groups for cloth mask production, sanitising teams for public spaces, and helping with home distribution of food and medicine for people in isolation.

For people in isolation, maintaining social contact outside the home and camp through telephone calls and messaging can reduce feelings of isolation and thereby **support their mental health**. Distribution of inexpensive entertainment items for children that can be used in isolation – such as books, games, colouring supplies, music, and meditation apps – can provide calming activities that support well-being. In contrast, much exposure to negative information and frightening imagery regarding the virus can stoke fears and be detrimental to positive coping and mental health. Reducing exposure to TV news and reducing the amount of time spent seeking information on the virus can help reduce feelings of isolation-induced anxiety, fear and depression.[4] Spiritual care practices and interventions may be useful complements to MHPSS programming.

Focused non-specialised supports

All humanitarian workers and community health workers (CHWs) from the local camp population can play a role in reducing stress associated with the virus by delivering evidence-based information in plain language through universally accessible channels. This can also help prevent anxiety by reducing the spread of rumours and misinformation. **Delivering specific advice** in a way that is empathetic and clear, without the use of potentially threatening or ambiguous language (for example, giving clear instructions to avoid physical contact with others rather than talking of 'social distancing'), is something that can be done by most non-specialised workers with very little training and supervision.[5]

There are **mental health considerations for people in quarantine** who may be feeling social and psychological stress after a COVID-19 diagnosis, including shame, fear, anxiety and depression. Care should be taken to ensure that people in quarantine

are not exposed to excessive amounts of reporting of negative or frightening aspects of the pandemic. Having MHPSS staff and non-specialised teams of CHWs present and accessible for people in quarantine, either in-person or through remote services, will be essential to support the fluctuating needs of patients and their families.[4]

CHWs from the camp population need to be prepared to deal with heightened levels of distress and anxiety. While **Psychological First Aid (PFA)** does not constitute professional psychiatric treatment or counselling, PFA training is designed so that any worker can feel equipped to provide a humane, supportive response to a person who is showing signs of distress and suffering. Since World Health Organization guidelines indicate that successful PFA training can be completed in one day, widespread implementation seems feasible, especially if trainings can be adapted to remote online learning.[6] Current evidence of the effect of PFA on psychosocial outcomes indicates that it improves retention of knowledge and strengthens capacity for providing psychosocial support in humanitarian crises.[7]

Specialised mental health services

Clinical psychiatric care is overwhelmingly unavailable to displaced populations who are in desperate need of such services.[8] The COVID-19 pandemic has further reduced access to the already far from sufficient provision of high-level mental health care to displaced populations due to movement restrictions, elimination of group programming to reduce transmission risk, and understaffing as humanitarian agencies are forced to pare down operations. **Expansion of telepsychiatry** can mitigate this issue by providing health care remotely. It is also possible that telepsychiatry programmes will expand the available pool of psychiatrists, as trained clinicians from locations all over the globe could opt to accept remote patients in camp settings.

Task-sharing of psychological support between clinicians (whether on-site or remote) and CHWs can be effective in improving social function, reducing depression and disability, and improving access to mental health care. Task-sharing can increase the availability of mental health care and help achieve the most efficient allocation of mental health specialists' time.[9]

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