

ESTSS

Recommendations
on Mental Health
and
Psychosocial Care
During Pandemics



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ESTSS Recommendations on Mental Health and Psychosocial Care During Pandemics

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The following recommendations were developed by the members of the *ESTSS Responding to COVID-19 Task Force*:

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PREMISE

The present document was derived from the framework of The European Network of Traumatic Stress Guidelines for Psychosocial Care Following Disasters and Major Incidents - TENTS Guidelines (Bisson et al, 2010). The TENTS Guidelines were developed based on a systematic review of research evidence on psychosocial care following disasters as well as a Delphi process with participation of 106 experts and professionals from 25 countries. These guidelines provide recommendations on planning, preparation, and management of care at the different phases of a major emergency.

The recommendations given here were developed in response to the COVID-19 crisis, though they may also be applicable to similar situations caused by other epidemics or pandemics.

The COVID-19 crisis differs from many other natural or man-made catastrophes by its scale, its multi-layered system of stressors affecting the well-being of individuals and societies, and by the uncertainty regarding its resolution. As there is no specific treatment or vaccine currently available for COVID-19, and such measures might take years to develop, no 'post-emergency' phase can be foreseen in the near future. At the same time, the general trajectory of COVID-19-related measures worldwide can be identified. The initial phase in most countries entailed the introduction of more or less strict lockdown and physical distancing measures. Subsequently, these measures were relaxed as countries sought to restore economic and social activity by adapting a 'living with COVID-19' approach. A possible future development is that COVID-19 will become a seasonal infection, creating a cyclic character of the crisis.

The recommendations presented here take into consideration the characteristics of the current outbreak and comprise comprehensive responses at the following three levels: macro (policies), mezzo (strategies), and micro (services). Micro-level interventions are further divided into two phases: responses to the initial crisis, and longer-term responses to ongoing consequences of the crisis.

The recommendations are based on a holistic vision according to which trauma is a public health issue (Magruder et al., 2017; Olf et al., 2019) and on the well-evidenced assumption that there is no health without mental health (Prince et al., 2007). Accordingly, this document promotes the principle that any intervention aimed at crisis management should be trauma-informed. Two major types of responses are described in the recommendations: trauma-informed and trauma-specific, and these are applied to each of the three levels – macro, mezzo, and micro (Javakhishvili et al., 2020).

The rationale behind the ESTSS recommendations is based on the interplay between two sets of factors relevant to the mental health and psychosocial dimensions of the COVID-19 crisis: (1) the complex of COVID-19-related stressors, and (2) the mental health and psychosocial problems developing in response to these stressors. Both sets of factors are described below.

COVID-19 PANDEMIC-RELATED SYSTEM OF STRESSORS

The following table summarises the multi-layered system of COVID-19 stressors affecting both the general population and particular groups at risk of developing mental health and psychosocial problems. This summary could also be relevant for other similar pandemics.

Table 1: System of stressors related to the COVID-19 pandemic

Stressors Target groups	Physical	Psychological	Social
General Population	<ul style="list-style-type: none"> Threat of contracting COVID-19 with the potential of severe consequences (including death); Tested Coronavirus positive; Having COVID-19 and related somatic symptoms; Health conditions increasing risk for complications and death. 	<ul style="list-style-type: none"> Fear of contracting COVID-19; Lack of (perceived) social support due to physical distancing measures; Feeling of loneliness; Deprivation of fundamental human rights (e.g. freedom of movement); Dissatisfaction with policies and strategies implemented by governments; Not being able to mourn out grief related to loss of loved ones; Survivor's guilt. 	<ul style="list-style-type: none"> Abrupt change of life circumstances; Possible quarantine; Loss of loved ones; Stigma and discrimination; Job loss due to lockdown and related economic difficulties; Decreased opportunities to practice spiritual rituals as usual; No opportunities to implement culturally appropriate mourning rituals after loss of loved ones.
Medical staff and other frontline personnel	<ul style="list-style-type: none"> Lack of personal safety equipment; High exposure to the virus threat; Tested Coronavirus positive; Having COVID-19 and related symptoms; Exhausting work schedule. 	<ul style="list-style-type: none"> Facing moral dilemmas and moral stress; Exposure to death of COVID-19 patients; Perceived lack of social support; Perceived lack of acknowledgement by employers, and/or patients and/or the general public. 	<ul style="list-style-type: none"> Deprivation of contact with family members (while staying apart to protect health); Stigma and discrimination by community members; Low acknowledgement and/or appreciation and/or incentives from employers.
Children & Adolescents	<ul style="list-style-type: none"> Decreased opportunities for outdoor activities and spending physical energy due to 'stay at home' policies; Tested Coronavirus positive; Having COVID-19 and related symptoms. 	<ul style="list-style-type: none"> Difficulties related to virtual classrooms; Dysfunctional coping strategies (e.g. enormous increase in online activities); Distress from medical manipulations related to COVID-19. 	<ul style="list-style-type: none"> Deprivation of social contacts and, in some cases, isolation from caregivers; Lack of social interaction with peers; Lack of access to the developmental infrastructure, i.e. playgrounds.
Elderly	<ul style="list-style-type: none"> Increased risk due to multiple health conditions and chronic disease; Tested Coronavirus positive; Having COVID-19 and related symptoms; Lack of personal safety equipment in elder-care institutions. 	<ul style="list-style-type: none"> Feeling disconnected due to social distancing policies and restrictions on movement; Feeling lonely; Worsening of possible mental health conditions due to stress and anxiety related to COVID-19. 	<ul style="list-style-type: none"> Social Isolation and marginalization; Lack of social and emotional support; Age-related stigma (i.e. statements like, 'COVID-19 is not dangerous, only the elderly are in danger', etc.).
Forced migrants and other survivors of man-made violence	<ul style="list-style-type: none"> Possible physical health problems due to previous adverse experiences; Tested Coronavirus positive; Having COVID-19 and related symptoms. 	<ul style="list-style-type: none"> Distress and anxiety related to COVID-19; Worsening of possible mental health conditions (developed in response to previous adverse experiences). 	<ul style="list-style-type: none"> Job loss and economic deprivation; Further social marginalization; Re-traumatization in case of imposed quarantine.

IMPACT OF PANDEMICS ON MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING

In the early aftermath of traumatic stressors, it is normal to experience short-term adverse reactions. These reactions can be seen as part of the adaptive process of moving from survival mode to adjustment and adaptation, and they have historically been conceptualized as transient reactions (Shalev, 2002). The majority of the exposed are expected to be resilient and have effective coping strategies and not develop long-term mental health or psychosocial problems (McFarlane & Williams, 2012; Kitson, 2020; Smith et al., 2020). At the same time, a certain part of the population (individuals, families, groups, or communities), are more vulnerable after an exposure to a traumatic event. A number of factors may contribute to this vulnerability, including pre-existing mental health conditions and psychosocial problems, the system of stressors affecting different life domains before, during and after a disaster, and the availability of mental health and psychosocial services (McFarlane & Williams, 2012).

Prognoses regarding possible consequences of COVID-19 on mental health and psychosocial wellbeing are alarming (WHO, 2020). Indeed, emerging data show that if timely measures are not implemented, the COVID-19 pandemic may result in a major mental health crisis (Ahmed et al., 2020; Kang et al., 2020; Leim et al., 2020; Lima et al., 2020; Rossi et al., 2020; UN, 2020; Xiang et al., 2020). This picture is supported by findings from studies of previous epidemics – SARS, MERS and Ebola (Shah et al., 2020). From these studies, we can distinguish several key findings:

- National surveys report a high level of distress among the populations of affected countries. For instance, in China, Iran, and the United States, the prevalence rates of distress among the general population are 35%, 40% and 55%, respectively (UN, 2020);
- The group most vulnerable to developing mental health and psychosocial symptoms are health care workers, especially those in high-risk zones, subjected to quarantine, or facing moral dilemmas, stigma and discrimination. The spectrum of mental health problems they suffer includes depression, anxiety, post-traumatic stress disorder (PTSD), moral injury and burn out (Phua et al., 2008; Wu et al., 2009; Lee et al., 2018; Kang et al., 2020; Maunder et al., 2003; Williamson et al., 2020, etc.);
- People who have contracted an epidemic disease are another at-risk group. At the earlier stage of manifestation of diseases (MERS, SARS, Ebola), they suffered from such problems as depression, anxiety, panic attacks, suicidality, delirium, and psychotic symptoms (Maunder et al., 2003; Xiang et al., 2014; Lee et al., 2018; Shah et al., 2020);
- Mental health problems were also tracked among survivors of these diseases. For instance, 25% of SARS survivors suffered from PTSD symptoms, and 15.6% from worsened depression (Mak et al., 2008); MERS survivors reported lower quality of life in comparison to those who were indirectly affected (Batawi et al., 2019);
- Increased rates of suicidality were reported among older adults, which makes this group especially vulnerable (Cheung et al., 2008);
- People who experienced quarantine and social isolation are also seen as at risk of developing mental health problems (Brooks et al., 2020; Rubin & Wessely, 2020; Shah et al., 2020; Spran & Silman, 2013);
- International Migrant Workers (IMWs) are considered a group at risk because of a high prevalence of pre-existing mental health problems and economic hardship (Mohamed et al., 2015; Hargreaves et al., 2019; Liem et al., 2020);
- Stigmatization and discrimination towards people who contracted the virus, their family members, and bereaved families who lost family members, are reported as a cause of mental health problems as well (Sim, 2016; Park et al., 2018; Shah et al., 2020).

These recommendations are informed by the findings listed above, relevant international guidelines and the latest systemic review and meta-analysis of the early psychological interventions following recent trauma (Roberts et al., 2019) and post-disaster care (Jacobs et al., 2019).

A number of studies on mental health aspects of the COVID-19 situation have already been undertaken, and more will follow in the coming months. Therefore, the ESTSS recommendations, once issued, will be updated in the future, based on the newest evidence.

AIMS AND PRINCIPLES OF THE ESTSS RECOMMENDATIONS

The ESTSS recommendations aim to support decision makers and professionals in managing the COVID-19 pandemic, or other pandemics, with strategies that foster resilience in affected populations (individuals, families, communities, and societies). Likewise, the recommendations are meant to support best practices for people in need of care for their mental health and psychosocial vulnerabilities.

The recommendations are based on the following principles:

- Evidence-based
- Trauma-informed
- Respecting human rights and dignity
- Respecting culture
- Supporting resilience of individuals, families, communities and societies
- Creating opportunities for the best possible care for people in need
- Equity of care
- Holistic and balanced approach
- Encouragingd multi-sectorial and multi-actor cooperation

THE RECOMMENDATIONS

I. Macro Level Recommendations – Policies

1.1. Trauma-informed General Crisis Management Policies

1.1.1. Every country and affected area should have a pandemic management plan and a corresponding crisis management task force responsible for its implementation. The crisis management task force should include public mental health professionals with expertise in traumatic stress who have a designated responsibility for mental health and psychosocial care following the outbreak of the pandemic.

1.1.2. Public service messages on the pandemic should take into consideration public mental health and the risk of traumatization/re-traumatization for the general population and at-risk groups.

1.1.3. Wording matters, therefore it is important to avoid expressions containing a risk of social isolation or stigmatization (e.g. the term ‘social distancing’), and choose wording according to the ‘first, do no harm’ principle, taking into consideration risk factors of mental health including traumatic stress.

1.1.4. While introducing measures aimed at slowing the spread of the infection (e.g. physical distancing and quarantine) it is important to consider the special mental health needs of at-risk groups (e.g. forced migrants or other survivors of man-made violence who are susceptible to re-traumatization) and find a good balance to assure public and individual safety.

1.1.5. The overall response should promote a sense of safety, self and community efficacy/empowerment, connectedness, calm, hope, and regaining control.

1.1.6. A transparent policy regarding information given to the public should be in place, and the rationale behind key decisions adequately explained.

1.1.7. The human rights of individuals should be explicitly considered, especially in introducing lockdown and quarantine measures. Possible human-rights violations amid the upheaval of the crisis (such as separating children from parents during prolonged isolation or hospitalization, or mistreatment of forced migrants) should be taken into consideration.

1.1.8. Conditions for appropriate spiritual and religious healing practices should be facilitated; it is especially important to define allowable mourning rituals for people who have lost loved ones.

1.2. Trauma-informed Mental Health & Psychosocial Care Policies

1.2.1. Every country/affected area should have a multi-agency mental health and psychosocial care planning group that includes mental health professionals with expertise in traumatic stress who have a designated responsibility for psychosocial care following disasters and major incidents, including pandemics. Individuals affected by the pandemic should also be represented (for example, those in quarantine could communicate online).

1.2.2. Individuals knowledgeable in local cultures and communities (including awareness of healing and mourning practices) should be involved if they are not already members of the psychosocial care planning group.

1.2.3. Inter-agency planning and coordination should occur to ensure that the strategy for psychosocial care is effective; addressing psychological trauma should be part of this planning.

1.2.4. Existing mental health and psychosocial services should be fully mapped and incorporated into a formal Mental Health and Psychosocial Care Plan (MHPCP), including crisis intervention and stress- and trauma-specific services. In this plan, existing referral pathways should be reflected and possible new ones defined, taking into account the likelihood of an increased need for online- and tele-health services.

1.2.5. Governments/authorities should provide adequate funding to implement a trauma-informed MHPCP that can be effectively delivered in time of need.

1.2.6. Response plans should provide general support, social support, physical support, and psychological support, including measures focused on prevention of psychological trauma.

1.2.7. Response plans should include access (preferably online) to specialist psychological and pharmacological assessment and management when required; assessment and management should be trauma-informed.

1.2.8. Where resources are limited, priorities should be based on the needs of those most seriously affected by the pandemic (e.g. frontline workers, infected individuals) and other vulnerable groups.

1.2.9. Efforts should be made to identify the correct supportive resources (e.g. family, community, school, friends, etc.) to promote resilience.

1.2.10. The most vulnerable groups should be identified and their needs assessed and addressed via multi-disciplinary and multi-layered support. Responses should provide support both for the vulnerable individuals and their families.

1.2.11. Detailed planning should occur with local authorities/governments and existing services to fund and support local services for several years following the pandemic, with a special focus on development of online and tele-health services, including psychotrauma-care services.

1.2.12. Support and information services, other than physical and psychological care, should also be made available, such as financial assistance and employment opportunities.

1.2.13. Attention should be given to promoting greater understanding and compassion in the broader community towards people who contracted the virus and their families, people in quarantine, and people exposed to the virus at their work place. Social psychoeducation around this should be implemented to encourage a supportive communal response. This education effort should include the dissemination of reliable information about infection pathways and safety precautions.

1.2.14. Governments should allocate funding for research on the effects of the pandemic on psychosocial and mental health functioning. This research will help improve existing services and maintain up-to-date guidelines.

1.3. Trauma-specific Mental Health and Psychosocial Support Policies

1.3.1. Trauma-specific services should be incorporated in the general system of mental health care, and the government should provide adequate funding for their functioning.

1.3.2. In case of increased demands in trauma-specific services, government/authorities should consider financial and organizational support in developing such services.

II. Mezzo Level Recommendations – Strategies

II.1. Trauma-informed strategies

Research

II.1.1. Needs assessment should be implemented among affected populations to assess their needs for pandemic-related mental health and psychosocial care, including psychotrauma-related needs.

II.1.2. The needs assessment should be participatory and involve all stakeholders. It should use online and other telecommunication resources and include people in need of mental health and psychosocial care.

Professional Guidance (guidelines)

II.1.3. Every country/affected area should have trauma-informed guidelines for providing mental health and psychosocial care in case of major disasters, including pandemics.

II.1.4. Such guidelines should be integrated into overall plans to cope with pandemics, and should be regularly updated.

Training and Supervision

II.1.5. The mental health and psychosocial care plan should be tested through exercises with participating agencies, taking into consideration trauma-related aspects of the crisis.

II.1.6. Politicians/government officials should be involved in the trauma-informed management of training and exercises.

II.1.7. Governments should implement a training programme for managers dealing with the crisis. This training should incorporate the expertise of specialists in the prevention of psychological trauma, moral injury, and burn out.

II.1.8. All professional services offering help during the pandemic should have undergone training in crisis intervention.

II.1.9. All care providers should have undergone formal training that includes trauma-related topics, and receive ongoing online training, support and supervision.

II.1.10. The content of training should be tailored to correspond to the roles and responsibilities of the providers of mental health and psychosocial care.

II.1.11. Journalists should undergo training on coverage of mental health issues, including crisis and trauma.

II.1.12. Frontline workers (e.g. uniformed services personnel, journalists, and local governance-structure representatives) should undergo pre-deployment training to decrease risks of secondary traumatization.

II.1.13. Doctors and other medical staff should be made aware of possible psychopathological sequelae, including psychotrauma.

Staff Care

II.1.14. The planning group should monitor for possible secondary traumatisation and burn out symptoms among care providers, including volunteers.

II.1.15. A trauma-informed organisational culture should be in place in the organizations and agencies involved in management of the crisis.

II.1.16. Trauma-informed staff care and regular supervision should be provided for medical personnel and other frontline responders.

II.2. Trauma-specific Strategies

Research

II.2.1. Research should be done on the impact of the pandemic on the general population and at-risk groups, and on the effectiveness of trauma-specific interventions.

II.2.3. This research should be based on rigorous academic methodology. It should be adequately funded by governments and international donors and considered an essential element in response to the pandemic.

Professional Guidance (guidelines)

II.2.4. Trauma-specific professional guidance should be provided via mental health and psychosocial support guidelines regarding pandemics.

II.2.4. The guidelines should be regularly updated based on the newest evidence to keep up with evolving care requirements.

II.2.5. Psychotrauma prevention and treatment guidelines should be in place to assure evidence-based responses.

Training and Supervision

II.2.6. Online training should be provided for trauma-care professionals to facilitate the use in counselling and therapy of the internet and other telecommunication technologies.

II.2.7. Online supervision should be provided on a regular basis to people involved in crisis counselling and trauma care.

Staff Care

II.2.8. Adequate staff care and regular supervision should be provided for professionals engaged in crisis counselling and trauma care.

III. Micro Level Recommendations - Services

Initial Phase

III.1. Trauma-informed responses in the initial phase

III.1.1. The initial response requires practical help and pragmatic support provided in an empathic manner, immediate and efficient reorganization of daily routines and structures, and the promotion of physical safety and financial security. Clear and calm guidance and rules around reorganized structures should promote a sense of stability and ease adjustment to new circumstances.

III.1.2. Information regarding the outbreak and addressing concerns of affected individuals should be provided in an honest, open and trauma-informed manner:

- All educational and healthcare organizations, government institutions, and corporate entities should include pandemic-specific information for visitors and staff members on their official websites.
- Social media should be used for dissemination of evidence-based information by official organizations and healthcare institutions.
- It is important to include information describing the distinct features of the crisis, such as the unpredictability of its duration and the effects this may have on the economic wellbeing and mental health of individuals, families and communities.
- Informational material helping the public understand the pandemic and take preventative measures should be made available. This can include e-leaflets, audio- and audio-visual documents, and tangible materials to reach those without access to the internet.

III.1.3. The most vulnerable groups should be identified and their needs assessed and addressed via multi-disciplinary and multi-layered support. This support should be given to affected individuals as well as their families. Namely:

- Mental health professionals should work closely with other services to provide support to families and individuals at risk of domestic violence and abuse. Social isolation for prolonged periods during the crisis may heighten the risk of domestic violence.
- Ongoing psychological support should address the needs of frontline service providers. Online supervision and staff-care measures, as well as interventions to prevent moral injury and burn out, should be offered to help them cope with difficult work conditions and reduce trauma risks.
- Psychological support should be given to the vulnerable population with underlying health issues and comorbid conditions.
- Support should be given to people with limited access to psychoeducational information or who may be living in conditions that do not easily facilitate the recommended level of physical distancing, such as the elderly, prisoners, asylum seekers, refugees and ethnic minorities.
- It is important that during the formal mental health screening or intervention, helpers are aware there may be an increased number of individuals with difficulties in their coping behaviour.

III.1.4. Self-help intervention tools and guidelines are required to address the needs of populations affected on a large scale. Digital health and support packages and psychoeducational materials should be developed and made widely and easily accessible.

III.1.5. Telephone helplines should be considered, as well as internet-based chats and tele-health services. These should be staffed by trained personnel who can provide psychological first aid and emotional and psychological support.

III.1.6. Additional telephone and online helplines with professionally trained personnel should be considered in the event of increased domestic violence.

III.1.7. A humanitarian-assistance virtual call centre/one-stop shop should be considered where referral to the range of services can be implemented.

III.1.8. Those overseeing the initial mental health and psychosocial response should conduct regular media briefings.

III.1.9. Formal screening of everyone affected is not recommended, but helpers should be aware of the importance of identifying individuals with significant difficulties and this process should be trauma-informed.

III.1.10. Other psychological help services should be made available, for example financial assistance and legal advice.

III.1.11. Memorial services and funerals should be planned in conjunction with those affected, and opportunities should be created for grieving individuals to mourn without violating health regulations.

III.2. Trauma-specific responses in the initial phase

III.2.1. Individuals should be provided with information about reactions to trauma if they are interested in receiving it.

III.2.2. Informational materials, such as e-leaflets, and audio- and audio-visual documents, should be available online and similar information should be produced in hard copy to be distributed via pharmacies or other appropriate venues. This material should provide psychoeducation specific to the nature of the crisis on topics such as possible short- and long-term responses to psychological stress, guidance on coping skills, and how to access social, mental health, and physical health services.

III.2.3. Psychological reactions should be normalised during the initial response and the duration of the crisis. Supports fostering a sense of safety, control, mental flexibility and successful adjustment should be encouraged.

III.2.4. Crisis counselling should be available online and by phone. Individuals should be neither encouraged nor discouraged from giving detailed accounts of their situations. Those giving counselling should provide information on reactions to trauma and how to manage them.

III.2.5. Provision of specific formal interventions such as single-session individual psychological debriefing for everyone affected should not occur.

III.2.6. Early preventive interventions and psychological treatments as recommended by the relevant international guidelines should be available for children, adolescents and adults in need.

Long-term support

III.3. Trauma-informed long-term responses

III.3.1. As the crisis extends beyond the initial phase, mental health providers as well other services should be prepared to see an increasing number of individuals with coping difficulties related to prolonged, continued exposure to stress and uncertainty. Screening, triage, and referrals to specialist services should be readily available.

III.3.2. Individuals with diminishing coping skills and mental health and psychosocial difficulties should be identified and formally assessed by a trained professional with consideration for their physical, psychological and social needs before receiving any specific intervention.

III.3.3. Evidence-based interventions for long-term mental health consequences should be made available.

III.3.4. Adults and children exposed to domestic violence should be identified and supported, and an increase in domestic violence should be expected. Mental health professionals should work closely with support services such as police, social services and other relevant organizations. On-line services and apps for victims of domestic violence should be available.

III.3.5. Online psychoeducational resources promoting self-help activities should be introduced and regularly updated at the government, organization and community levels.

III.4. Trauma-specific long-term responses

III.4.1. Psychological treatments and other evidence based therapies as recommended by the relevant international guidelines should be available for children, adolescents and adults in need.

The following recommendations were developed by the European Society for Traumatic Stress Studies (ESTSS) for mental health professionals, organizations, and policy makers to facilitate the understanding of mental health and psychosocial responses to the COVID-19 crisis and to provide trauma-informed, evidence-based knowledge for action. The recommendations are tailored to the COVID-19 pandemic, but are applicable and to other pandemics caused by infectious diseases.

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