psychopathology, and reduces the effect of adversity on brain circuits involved in threat processing.[9]

The second part of the Commission[3] calls for the implementation of practices to support families and prevent unnecessary family–child separations, strengthen child-welfare and child-protection systems and services, and promote appropriate alternative family-based care when necessary. Detailed guidelines and resources to achieve these goals are also provided, and it is recommended that international agencies use their resources to develop and strengthen models of practice across the continuum of care, and pilot proof of concept examples to convince national stakeholders that change is achievable, economically sustainable, and will deliver better outcomes for children.[3]

van IJzendoorn and colleagues[2] and Goldman and colleagues[3] call for the progressive elimination of all forms of institutional care for children, but no timeframe for achieving this goal was set. As in 4 years (2012–2016), Rwanda successfully placed 2338 (70%) of 3323 children living in institutions with their biological families or into foster care,[2] 10 years should be sufficient to achieve the goal of eliminating institutional care for children worldwide. Under international law, there is an obligation to take immediate action to enforce specific rights, such as the child's right to family established by the CRPD, even if progressive implementation is required over time.[4]

With will and commitment, proper resourcing, crucial international and national partnerships, and proper data to monitor progress, the practice of institutionalisation of children could be eradicated by the end of 2030. Existing residential and group care settings can be transformed into community centres offering assessment, case management, physical therapy, mental health treatment, and other needed services; or transformed into family treatment centres where parents can receive substance abuse treatment or other necessary services and supports while staying with their children. Institutional care is not just bad for children's development; group care is substantially more expensive than foster care.[2,10] It is time to make children's right to a family a reality.

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Venezuelan migrants in Colombia: COVID-19 and mental health

Venezuelan migrants in Colombia are experiencing psychological stressors stemming from political turmoil, poverty, displacement, exploitation, and the COVID-19 pandemic.[1] More than 5 million people have departed Venezuela since 2015.[2] The largest subgroup, more than 1·8 million individuals, continues to move

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into Colombia, often trekking on foot and dispersing nationwide. Two million pendular migrants cross into Colombia cyclically, seeking food, clothing, medicines, health care, and education.

The mental health of Venezuelan migrants is compounded by the extreme hardships inside Venezuela, the resulting exodus, and the uncertainty surrounding the COVID-19 pandemic. Exposure to trauma, loss, and life changing events throughout all phases of migration increases the risk of developing psychiatric disorders.[3-5] We discuss these risks while describing the migration journey (appendix 2).

See Online for appendix 2

First, the impetus for mass Venezuelan emigration is the collapse of democratic institutions and the ensuing deterioration of Venezuela's public services. Faced with destabilising hyperinflation, 94% of Venezuelans live in poverty and approximately 30% cannot put enough food on the table to meet minimum nutritional requirements.[6] The Venezuelan health-care system has lost half of its physicians to migration, has an 85% shortage of medications, and has hospitals that have unstable access to power and running water.[6] People with chronic and persistent mental illness often need to be cared for at home. Antipsychotic medications are in short supply in Venezuela. Self-medication with antidepressants and anxiolytics sourced in other countries is common. Venezuela's rising suicide rate ranks second only to Guyana in the western hemisphere.[7]

Second, the departure from an individual's country of origin involves profound loss.[3,4] Many migrants will never return. Loss of home and all tangible resources is compounded by devastating social losses. Migrants leave family members, friends, and pets behind. They also lose their national identity, their livelihood, and their status in the community.

Third, the migration journey is fraught with danger. The UN High Commissioner for Refugees did 8000 protection monitoring interviews with Venezuelan migrants at sites throughout South America and found that half (50·2%) of families were at risk of harm (either by others or while in transit) or resorted to survival behaviours.[8] Victimisation and exploitation is rampant in border regions. Roving bandits and paramilitary groups recruit Venezuelan youth and young adults (age 13–25 years) into gangs. Armed actors coerce undocumented migrants into working the coca fields or illegal gold mines, and Venezuelan women have been forced into sex work.

Fourth, arriving at a destination point in Colombia, many migrating Venezuelans do not have official status in the country. Although Colombia has generously provided special permits to more than 60% of Venezuelan migrants, these individuals struggle to find employment, often competing against and underbidding locals—including Colombian internally displaced persons (IDPs)—to eke out a meagre living in the informal economy.[5] In common with Colombia's own 5·5 million IDPs, Venezuelans living in Colombia are at risk for major depression, generalised anxiety, post-traumatic stress disorder (PTSD), and substance use disorders.[3-5] A study that assessed depression, generalised anxiety, and PTSD in Colombian women IDPs in Bogotá found that 63·4% of the women had symptomatology suggestive of at least one of these conditions.[4] A study of Venezuelan migrants in Bogotá, found that 21% had probable PTSD.[9]

Fifth, the unprecedented COVID-19 pandemic is the latest in a succession of life-changing events that predispose Venezuelan migrants to psychopathology.[1,3,4] Migrants are at increased of having COVID-19 because they are exposed to high population densities, poor sanitation, and cannot effectively socially distance or wash hands. Preventative isolation measures impose disproportionate hardships for migrants. According to a rapid assessment, 84% of Venezuelan migrant households do not have enough food for three meals per day and paid work as the primary source of financial support has plummeted from 91% to 20% of households during the lockdown.[10]

Sixth, thousands of Venezuelan refugees who unsuccessfully sought work in other South American nations—that now have high rates of COVID-19—are reverse migrating back through Colombia. It is plausible that some returnees are bringing the causative virus with them. They are surely feeding into the rising, COVID-19-fueled xenophobia.[1]

How can the mental health needs of Venezuelan migrants in Colombia be addressed?

Already, field-tested strategies for mental health and psychosocial support (MHPSS) are being revised for the current situation. Migrants must be prioritised in public health measures to mitigate the spread of COVID-19. Priorities include provision of food, support for rent payments, and income opportunities when mitigation

measures are eased. Colombian municipalities have established crisis hotlines to provide mental health support and connect individuals to services. About 10% (180 000) of the Venezuelan migrants have Colombian health insurance, which allows up to ten sessions with a psychologist and the possibility of a referral to a psychiatrist. Expediting the care pathway to allow more refugees to be regularised and enrolled in the national health insurance program would be the most direct route for ensuring access to quality mental health services. There are also multiple intergovernmental and non-governmental organisations active in Colombia that provide MHPSS services. The Inter-Agency Standing Committee (IASC) uses a four-tiered intervention pyramid for organising and coordinating diverse services, ranging from population level provision of security and basic needs up to psychiatrist-delivered group or individual psychotherapy. IASC has adapted its model to COVID-19.

Coordination among responding organizations is needed to achieve comprehensive coverage. Proven approaches include: community outreach; screening for stressors and common mental disorders using validated instruments; and applying a stepped-care model to route migrants with symptom elevations into WHO-approved, evidence-based interventions provided by trained and supervised counsellors.[4] Given the dearth of mental health professionals in low-income and middle-income countries, staffing can be extended by training para-professionals to deliver interventions (so-called task shifting or task sharing). Provisions should be made for referral and transport of migrants with severe symptoms or suicidal thoughts to emergency psychiatric evaluation. Intervention sessions should continue until symptoms decline to sub-syndromal levels.

For Venezuelans who remember their country before the 2000s, the complete metamorphosis from proud, functional, solvent democracy to disgraced, dysfunctional, bankrupt autocracy has been psychologically disorienting and disturbing. Millions who made the consequential decision to migrate are experiencing severe psychological stressors, while the fearsome overlay of COVID-19 exacerbates risks for distress and disorder. Providing MHPSS for Venezuelan migrants in Colombia is a compelling need and a daunting challenge.

We declare no competing interests.

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Global mental health and COVID-19

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The COVID-19 pandemic has disrupted the delivery of mental health services globally, particularly in many lower-income and middle-income countries (LMICs), where the substantial demands on mental health care imposed by the pandemic are intersecting the already fragile and fragmented care systems. The global concern regarding the psychosocial consequences of COVID-19 has led major funding bodies and governments to

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Supplementary appendix 1

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Supplement to: Espinel Z, Chaskel R, Berg RC, et al. Venezuelan migrants in Colombia: COVID-19 and mental health. *Lancet Psychiatry* 2020; **7:** 653–55.

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Migrantes venezolanos en Colombia: COVID-19 y salud mental

Los migrantes venezolanos en Colombia están enfrentándose a un gran número de estresores psicológicos derivados de la situación política, la pobreza, el desplazamiento, la explotación y la pandemia del COVID-19. Más de 5 millones de personas han abandonado Venezuela desde el año 2015. El subgrupo más grande, más de 1·8 millones de personas, continúan desplazándose hacia Colombia, a menudo caminando a pie y dispersándose por todo el país. Dos millones de venezolanos migran pendularmente hacia Colombia en busca de comida, ropa, medicamentos, atención médica y educación.

La salud mental de los migrantes venezolanos se afecta por las adversidades que sufrieron en Venezuela, el éxodo resultante y la incertidumbre que rodea la pandemia del COVID-19. La exposición a trauma, los eventos que transforman la vida y las pérdidas en todas las fases de la migración son factores de riesgo que contribuyen a que los migrantes sean más susceptibles a desarrollar trastornos psiquiátricos.[3-5] Presentaremos los factores de riesgo a los que se enfrentan en el proceso de migración.[7]

Primero, el ímpetu para la migración masiva de venezolanos es el colapso de las instituciones democráticas y el consiguiente deterioro de los servicios públicos en Venezuela. Ante una hiperinflación desestabilizadora, el 94% de los venezolanos vive en la pobreza y aproximadamente el 30% no puede poner suficientes alimentos sobre la mesa para cumplir con los requisitos mínimos de nutrición.[6] El sistema de salud venezolano ha perdido la mitad de sus médicos debido a la migración, hay un 85% de escasez de medicamentos, y hay hospitales que carecen de servicios de agua y electricidad. A menudo, a las personas que padecen de trastornos mentales graves y crónicos solo se les puede brindar atención en el hogar. Los medicamentos antipsicóticos son escasos en Venezuela. La automedicación con antidepresivos y ansiolíticos que son traídos de otros países es frecuente. La tasa de suicidios en Venezuela ocupa el segundo lugar en el hemisferio occidental después de Guyana.[7]

En segundo lugar, la partida de un individuo de su país de origen implica una pérdida profunda.[3,4] Muchos migrantes nunca regresarán. La pérdida del hogar y de todos los recursos tangibles se intensifica por las enormes pérdidas sociales. Los migrantes dejan atrás a familiares, amigos y mascotas. También pierden su identidad nacional, su sustento y su estatus en la comunidad.

Tercero, el desplazamiento de los migrantes está lleno de peligros. El Alto Comisionado de las Naciones Unidas para los Refugiados llevo a cabo 8000 entrevistas de monitoreo de protección con migrantes venezolanos en diversos lugares de Suramérica y encontró que la mitad (50·2%) de las familias corrían el riesgo de sufrir lesiones (ya sea por otras personas o mientras estaban en tránsito) o recurrían a comportamientos riesgosos de supervivencia.[8] La victimización y la explotación son comunes en las regiones fronterizas. Grupos al márgen de la ley y grupos de atracadores reclutan jóvenes y adultos jóvenes venezolanos (de 13 a 25 años) . Los actores armados obligan a los migrantes indocumentados a trabajar en los campos de coca o en las minas ilegales de oro, y las mujeres venezolanas se han visto obligadas a realizar trabajo sexual.

Cuarto, al llegar a su destino final en Colombia, muchos migrantes venezolanos no tienen un estatus oficial en el país. Si bien Colombia ha otorgado de manera generosa permisos especiales a más del 60% de los migrantes venezolanos, estas personas luchan por conseguir empleo, a menudo compitiendo con los colombianos, entre ellos, con los desplazados internos (PDI), para ganarse la vida en la economía informal.[5] Al igual que los 5·5 millones de desplazados internos de Colombia, los venezolanos que viven en Colombia corren el riesgo de sufrir depresión mayor, ansiedad generalizada, trastorno de estrés postraumático (TEPT), y trastornos por consumo de sustancias.[3-5] Un estudio que evaluó la depresión, la ansiedad generalizada, y el trastorno de estrés postraumático en mujeres colombianas desplazadas en Bogotá encontró que 63·4% de estas mujeres tenían sintomatología que sugería la presencia de al menos una de estas condiciones.4 Un estudio de migrantes venezolanos en Bogotá mostró que el 21% tenía un posible TEPT.9

Quinto, la pandemia del COVID-19, que no tiene precedente, es el último hecho en una serie de eventos que le ha cambiado la vida a los migrantes venezolanos y que los predisponen a psicopatología.[1,3,4] Los migrantes tienen un mayor riesgo de contagiarse con el COVID-19 porque están expuestos a mayores densidades de población, deficiencias en saneamiento, y a la dificultad de no poder distanciarse socialmente o lavarse las manos de manera efectiva. Las medidas preventivas de aislamiento generan dificultades desproporcionadas para los migrantes. De acuerdo con una evaluación rápida, el 84% de los hogares con migrantes venezolanos carece de alimentos suficientes para las tres comidas del día y el trabajo remunerado como fuente principal de ingresos se ha desplomado del 91% al 20% durante el aislamiento en los hogares.[10]

Sexto, miles de refugiados venezolanos que sin éxito buscaron trabajo en otras naciones sudamericanas, que ahora tienen altas tasas de COVID-19, están migrando a su país nuevamente a través de Colombia. Es posible que algunos de estos migrantes traigan consigo el virus. Seguramente están alimentando la creciente xenofobia alimentada por COVID-19.1

¿Cómo pueden abordarse las necesidades de salud mental de los migrantes venezolanos en Colombia?

Las estrategias de campo para la salud mental y el apoyo psicosocial (MHPSS) que han sido revisadas se están evaluando para la situación actual. Las medidas de salud pública para mitigar la propagación del COVID-19 deben priorizarse para los migrantes. Las prioridades incluyen el suministro de alimentos, el apoyo para el pago del alquiler y las oportunidades de empleo cuando se relajen las medidas de mitigación. Los municipios colombianos han establecido una línea directa para brindar apoyo en salud mental y conectar a las personas con los servicios.

Alrededor del 10% (180 000) de los migrantes venezolanos tienen seguro de salud colombiano, lo cual permite hasta diez sesiones con psicología y la posibilidad de remisión a psiquiatría. La forma más directa para garantizar el acceso a servicios de salud mental de calidad es acelerar la inscripción de migrantes en el sistema nacional de salud. También hay múltiples organizaciones intergubernamentales y no gubernamentales activas en Colombia que brindan apoyo psicosocial. El Comité Permanente entre Organismos (IASC) utiliza una pirámide de intervenciones en cuatro niveles para organizar y coordinar diversos servicios para la población, que van desde el establecimiento de medidas de seguridad y necesidades básicas hasta los servicios más especializados como la psicoterapia individual o la de grupo administrada por psiquiatras. IASC ha adaptado su modelo para el COVID-19.

Se necesita coordinación entre los organismos de respuesta para lograr una cobertura integral. Los enfoques probados incluyen: búsqueda activa, tamizaje de los trastornos de la salud más comunes utilizando instrumentos de evaluación validados y la aplicación de un modelo de atención escalonada para remitir a las personas que presenten con síntomas serios a intervenciones basadas en la evidencia, aprobadas por la OMS y proporcionadas por consejeros que han sido capacitados y son supervisados. Dada la escasez de profesionales de la salud mental en países de medianos y bajos ingresos, la cobertura de salud mental puede ampliarse mediante la capacitación de trabajadores comunitarios para que lleven a cabo las intervenciones (el llamado task shifting o intercambio de tareas). Deben tomarse medidas para que se puedan remitir migrantes que presenten ideación suicida o síntomas severos a una evaluación psiquiátrica de emergencia. Las sesiones de intervención deben continuar hasta que los síntomas disminuyan a niveles sub-sindrómicos.

Para los venezolanos que recuerdan a su país antes de la década del 2000, la transformación de una democracia funcional y solvente a una autocracia, disfuncional y en bancarrota ha sido psicológicamente desconcertante y agobiante. Los millones de venezolanos que tomaron la decisión de migrar se enfrentan a un sinnúmero de estresores y ahora, sumado a la pandemia de COVID-19, se aumenta el riesgo de mayores problemas de salud mental. Proporcionar ayuda psicosocial (MHPSS) para los migrantes venezolanos en Colombia constituye un enorme desafío y una necesidad imperiosa.

No tenemos conflictos de interés.

Zelde Espinel, Roberto Chaskel, Ryan C Berg, Hermes Jose Florez, Silvia L Gaviria, Oscar Bernal, Kim Berg, Carlos Muñoz, Marisa G Larkin, James M Shultz

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Venezuelan migrants in Colombia: Exposure to hazards, losses, and life changes throughout phases of migration	Mental health and psychosocial support interventions following IASC guidelines and using WHO-sanctioned interventions
Migration stressors **1) Pre-migration:** Collapse of democratic institutions Poverty Hunger and malnutrition Deterioration of health care systems Lack of mental health care/medications **2) Departure:** Loss of home and tangible resources Loss of family/community/social ties Loss of status, identity, occupational roles **3) Migration journey:** Physical exhaustion, hunger, and fatigue Danger of victimization and exploitation **4) Settlement in Colombia:** Poverty Homelessness Lack of official status Lack of access to healthcare Danger of victimization and exploitation Employment in informal sector Possible need to engage in survival behaviors Stigma, stigmatization, xenophobia **Overlay of COVID-19 risks** **5) COVID-19 infection risks** Severe disease risks for older persons Risks for those with underlying medical conditions Malnutrition from living in Venezuela Immune suppression from living in Venezuela High population density in informal settlements Inability to socially distance Lack of access to water, sinks, soaps, cleansers Livelihood imperative to work in public settings Reliance on public transportation **6) COVID-19 mitigation hardships** Lack of food Lack of paid work during lockdown Lack of rent monies Lack of health care access **Elevated rates of common mental disorders** (major depression, generalized anxiety, PTSD, substance use disorders) Elevated rates predating COVID-19 Potentially higher rates during/after COVID-19	**1) Prioritize migrants for public health measures to mitigate the spread of COVID-19** Food Rent support Access to testing, health care if symptomatic **2) Connect migrants to available crisis hotlines and networks of mental health services** **3) Regularize migrants / enroll them in national health insurance programs to allow access to mental health consults** **4) Involvement of intergovernmental and non-governmental organizations** Apply Inter Agency Standing Committee (IASC) guidelines Adapt IASC principles to COVID-19 Coordinate services using Mental Health and Psychosocial Support (MHPSS) intervention pyramid Adapt MHPSS to complex emergencies: forced migration and COVID-19 pandemic Use "whole of society" approach **5) Develop and refine the MHPSS interventions** Develop stepped-care models Outreach to venues where migrants live Screen for common mental disorders using validated tools Train para-professionals to deliver interventions Deliver WHO-vetted, evidence-based interventions Optimize task shifting/task sharing Continue intervention sessions until symptom resolution Adjust intervention to the cultural context Follow-up, evaluate, refine the intervention Scale/disseminate promising interventions Bring MHPSS interventions to scale