Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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

For the Spanish translation see Online for appendix 1

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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