INTERIM GUIDANCE ON CONTINUITY OF MENTAL HEALTH SERVICES DURING THE COVID-19 PANDEMIC
INTERIM GUIDANCE ON CONTINUITY OF

MENTAL HEALTH SERVICES

DURING THE COVID-19 PANDEMIC
These guidelines on provision of mental health services to persons with mental illness and healthcare workers during the COVID-19 pandemic have been developed as a response to the ongoing COVID-19 pandemic. The pandemic has spread to 210 countries, with over 2.5 million confirmed cases and 171,249 deaths.

As the disease continues to spread, the main psychological impact is elevated rates of stress or anxiety. As new measures and impacts are introduced especially quarantine, its effects on many people's usual activities, levels of loneliness, depression, harmful alcohol and drug use, and self-harm or suicidal behavior may rise.

Mentally ill persons form a population of vulnerable groups and their care during this pandemic shall require special consideration. In addition, the mental health and well-being of frontline workers is now a major concern. The protocol offers guidelines on continued management of stable patients, admission of patients, management of mentally ill persons who test positive for COVID-19 and the mental well-being of health care workers.

As experience and knowledge on COVID-19 is currently evolving rapidly, these interim guidelines could be updated periodically.

Dr. Patrick Amoth
Ag. Director General for Health
# TABLE OF CONTENTS

I. Foreword ...................................................................................................... iv

iii. List of Abbreviations .......................................................................................... vi

A. Introduction and Guiding Principles ........................................................................ 7
B. Purpose of Guidelines .............................................................................................. 9
C. Preparedness and Readiness .................................................................................. 11
D. Universal Infection Prevention Measures .............................................................. 12
E. Tele-health/ Tele-psychiatry ................................................................................... 13
F. Outpatient Care ...................................................................................................... 14
G. Inpatient Care ......................................................................................................... 16
H. Management of Substance Use Disorders ............................................................. 18
I. Integration of Psychiatric Care into Isolation / Treatment Centres ...................... 19
J. Staff Safety and Wellbeing .................................................................................... 20

Appendix I - List of Contributors ............................................................................. 23

Appendix II - Contacts for Mental Health Referral Facilities ................................. 24
   i. Mathari National Teaching and Referral Hospital (MNTRH)
   ii. Moi Teaching and Referral Hospital (MTRH), Eldoret

Appendix III - Case Definition by the Ministry of Health ....................................... 25

Appendix IV - COVID-19 Triage Checklist ............................................................. 26

Appendix V - Management of Acute Withdrawal Symptoms .................................... 27

References ................................................................................................................. 29
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19</td>
<td>Corona Virus Disease 2019</td>
</tr>
<tr>
<td>KNH</td>
<td>Kenyatta National Hospital</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>MAT</td>
<td>Medically Assisted Therapy</td>
</tr>
<tr>
<td>MHPSS</td>
<td>Mental Health and Psychosocial Support</td>
</tr>
<tr>
<td>MNTRH</td>
<td>Mathari National Teaching and Referral Hospital</td>
</tr>
<tr>
<td>MTRH</td>
<td>Moi Teaching and Referral Hospital</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
</tbody>
</table>
A. INTRODUCTION AND GUIDING PRINCIPLES

The ongoing pandemic of Corona Virus Disease 2019 (COVID-19) caused by the severe acute respiratory syndrome corona virus 2 (SARS-CoV-2). The outbreak was identified in Wuhan City, China, in December 2019. It was declared a Public Health Emergency of international concern on 30th January 2020, and recognized as a Pandemic by the World Health Organization on 11th March 2020.

The COVID-19 outbreak and the national measures being announced to delay the spread of the pandemic, will inevitably have significant impact on both the demand for and the capacity to deliver support for people with mental health needs. It is also important to note that the impact on people's mental health will endure beyond the pandemic.

Given the movement restrictions imposed within the country, it is important that the Mental Health Units within the County Referral Hospitals be optimized to provide the necessary services within their capability.

The following principles should be considered while addressing the mental health needs of Kenyans during the ongoing COVID-19 pandemic:

1. People with mental health and psychosocial needs should receive the same degree of protection and support with managing COVID-19 as other members of the population. This may mean providing additional support including by making reasonable adjustments.

2. In preparing for and responding to COVID-19, mental health workers may need to make difficult decisions in the context of reduced capacity and increasing demand. These decisions will need to balance clinical need (both mental and physical), patient safety and risk. Due to the need for rapid decision-making, providers may choose to use an existing patient panel or an ethics committee to advice on decisions.
3. When considering plans, providers should consider not just patients' vulnerability to the physical infection but also their vulnerability stemming from mental health needs. People will be at risk of mortality through suicide, injury through self-harm and of self-neglect, and therefore concern for patient safety needs to be paramount in any changes to services.

4. Providers will need to maximize mental health care delivery through digital technologies to ensure continuity of care for patients who are asked to isolate and in response to reduced staff numbers or mobility. Digital technology can also be used to support continuity of social contact for patients, families and caregivers.

5. Teamwork and Partnerships with stakeholders in the general healthcare field are crucial. It is important to maximize the use of community assets and to draw on the insight and expertise of partners. Response plans will need to be developed alongside patients, families, caregivers, volunteer organizations as well as local mental health workers. This will need involvement of stakeholders in the Education, Criminal Justice System, Rehabilitation and Social Work, Civil Service and Community Based Organizations amongst others.

6. Providers should bear in mind the longer term impact of the pandemic and the associated impact on the mental health needs of the larger population, and seek to minimize changes that impact on the capacity and capability of the system in the longer term.
B. PURPOSE OF THE GUIDELINES

To provide guidance for all mental health care workers both in National and County Government institutions on management of people with existing mental disorders and those newly diagnosed with mental disorders and psychological distress during the period of the COVID-19 pandemic.

Specifically the guidelines will address the following key areas:

1. Continued management of stable patients on follow-up as outpatients
2. Continued management of patients already admitted in the psychiatric wards
3. Admission of patients with existing mental disorders who have relapsed
4. Admission of patients with newly diagnosed mental disorders
5. Management of patients who test positive for COVID-19 with mild to moderate psychological distress but not meeting criteria for a major mental disorder diagnosis.
6. Provision of clear path to care and/or referral for patients with co-morbid mental disorders and COVID-19.
7. Guidance on tele-psychiatry; maximizing on use of digital and online channels.
8. Provision of psychosocial support to people in quarantine, isolation and on treatment for COVID-19, including their family members.
9. To provide mental health and psychosocial support to health care workers and other frontline workers involved in the COVID-19 Pandemic response.
10. Recommendations on the setting up of facility mental health teams to support both the Covid-19 response but also to strengthen overall mental health care provision at facility level that is expected to rise during this pandemic and beyond.

This guidance will also guide healthcare managers through the COVID-19 pandemic to ensure that they are able to:

- Support healthcare facilities to maintain essential services during the COVID-19 outbreak.
• Give practical solutions to challenges facing provision of healthcare services during the COVID-19 outbreak
• Monitor essential health service provision throughout the COVID outbreak
• Communicate appropriately to health care workers and the public regarding access to standard health services
C. PREPAREDNESS AND READINESS

Health facilities should ensure that the following measures are in place for effective Continuity of health services through the COVID-19 Pandemic

- Sensitization and training of all staff on COVID-19 preparedness
- Adequate supplies and commodities
- Reorganization of patient flow
- Referral and linkage systems.
- Coordination mechanisms and efficient communication.
- Resources planning and healthcare financing.
- Quality assurance, monitoring and evaluation.
D. UNIVERSAL INFECTION PREVENTION MEASURES

The following precautionary measures should be taken by everyone within the health facilities.

1. **Hand hygiene**: frequent cleaning of hands using soap and water or alcohol-based hand sanitizers.

2. **Respiratory hygiene**: covering the nose and mouth with a flexed elbow or disposable tissue when coughing and sneezing.

3. **Wearing a mask**: in all public places.

4. **Avoid touching the face**: especially the mouth, nose and eyes.

5. **Stay at home**: contact the hospital on phone and only visit the hospital if absolutely necessary.

6. **If possible**, patients to go to hospital unaccompanied; one relative may be allowed to accompany, if absolutely necessary.

7. **Inpatient visits**: to be reduced to only when absolutely necessary, and should be restricted to 1 or 2 relatives at a time; children should not accompany adults unless they are the patients.

8. **Keep a safe distance**: at least 2 meters/6 feet from other people.

*Triage of all patients and staff at the health facilities for COVID-19* (see Appendix II, *COVID-19 Triage Checklist*)
E. TELE-HEALTH/ TELE-PSYCHIATRY

In this new urgent and emerging social and physical environment whose ideas have been developed with the future in mind but has now been thrust upon us by the COVID-19 pandemic, Tele-health and Tele-Psychiatry will now be urgently adapted for follow up of patients and anyone with mental health needs or concerns. This involves maximizing on the use of digital and online channels, where applicable, depending on the accessibility by the various needs of patients/clients, family, professional colleagues and will include patient management and care, consultation and referral among other uses.

1. Telephone calls to the service provider are preferred and encouraged. Detailed documentation including medical evaluations, diagnoses, with appropriate provision for filing in consultation with the facility health information departments for official records. These should be practiced as would occur in face to face consultations. In case of referrals, these should be well linked preferably to specific services or providers where possible.

2. Where applicable, the healthcare provider shall write a prescription and send the client a picture or scanned image through WhatsApp (or other available modality), for purchase of medication near them. Where WhatsApp does not apply, a text message with the name of the doctor and practice license number (e.g KMPDC Number) can be sent to the client.

3. Video – providers may utilize any methods of face-to-face technology to facilitate tele-health service, such as Skype, Face, time, Zoom, Duo, as is appropriate.

4. Email – providers may use email or exchanges via secure patient portal when available.

NOTE: Contact center numbers for facilities should be widely circulated through various media platform
F. OUTPATIENT MANAGEMENT

I. Outpatient Management of patients who are negative for COVID-19

This includes but is not limited to management provided in the following medical set-ups and programs:

- Out-Patient Department (OPD)
- Weekly Psychiatric and Drug Addiction/Substance Abuse Clinics
- Specialized Clinics – Forensic, Child & Adolescent Psychiatry, Psychiatric Disability Assessment, Psychotherapy, Occupational Therapy.
- Medically Assisted Therapy (MAT) Clinic

In particular facilities and at specific times of this COVID-19 pandemic, some of specialized clinics may have been put on hold until normal services resume. Follow up clinics have been rescheduled to long term appointments with provision of long term prescriptions refillable in the nearest health facilities. This resumption will be based on further knowledge and direction by National Medical Covid-19 response teams, the National and County Governments and individual facilities as they assess their abilities to resume these critical services as soon as possible.

The Out-Patient Department (OPD)

- Daily outpatient clinic with different Doctors on call each day
- Attends mainly to patients who are acutely ill (either with pre-existing mental disorders and have relapsed or newly diagnosed with mental illness)
- May receive stable patients seeking review and refill of prescriptions

In light of the COVID-19 pandemic and restrictions imposed by the Government,

1. Out-patient services for stable patients should be minimized and widely spaced by providing long term prescriptions of 3 to 6 months, to reduce exposure. These medications should be issued by pharmacies as per the clients' order within the
prescription valid duration.
2. A call to the health care provider/ health facility is preferable. In case this is not possible, the client should go to the hospital alone, or with a preferred supporter, relative or care-giver well versed with the patient's condition, all of whom should wear masks.
3. Referrals can also be done by telephone, video or electronically.
4. All records of visits/consultations of the patient should be well kept, whether face to face or electronic.
5. People with probable or confirmed COVID-19, will be managed as per the Interim Guidelines on Management of COVID-19 in Kenya.
6. The MAT Clinics which are stationed in selected health facilities within the country, are run daily and have specific guidelines tailored to each facility.

**NOTE:** Proper triage and history taking should be done at the outpatient level. Any patients with upper respiratory tract symptoms, history of travel, history of contact with a known COVID-19 positive patient should be scored as high risk patients. They should not be allowed to leave the hospital premise. They should be transferred to the holding area as they await testing or transfer to an isolation center.

**II. Outpatient Management of patients who test positive for COVID-19 with mild to moderate psychological distress but not meeting criteria for a major mental disorder diagnosis**

1. This care can be provided within the Isolation or Treatment Centres.
2. The Counselors/ Psychologists assigned to the respective facilities assess the patients during their routine care, as per the SOPs for MHPSS provided. If there is need for further management, the Doctor/Psychiatrist on call is consulted.
3. The Doctor/ Psychiatrist on call can provide care using the tele-psychiatry options available.
4. If absolutely necessary, face to face assessment can be arranged, with the Doctor wearing the full PPE.
G. INPATIENT MANAGEMENT

I. Patients who test negative for COVID-19, with existing mental disorders and have relapsed or patients with newly diagnosed mental disorders.

1. The hospitals should identify separate wards/rooms where newly admitted patients can be managed away from other existing in-patients
2. All universal protection measures against COVID-19 should be applied in the wards to enhance the safety of healthcare workers.
3. New admissions should be minimized, to those that are absolutely necessary
4. All admissions into a psychiatric ward should have been screened for COVID-19 using MOH case definition and Triage Checklist. (See Appendix I and II).
5. There should be continuous monitoring of inpatients for any development of COVID-19 symptoms.
6. Staff attending to the inpatients should wear masks and gloves at all times and continue to practice protective measures at all times as per the guidelines. Visors and aprons if available would also be advised.
7. Staff should reduce patient contact to an essential minimum
8. As far as is possible, avoid visitors. Should the need arise any visitor allowed must wear a mask and observe the 2 metre rule physical distancing.

NOTE: Patients who meet case definition for Suspect Case for COVID-19 should be isolated immediately (in an identified holding area) away from other patients and tests done immediately. The patient should be cared for while taking all appropriate precautions.
As soon as the Government is able to provide rapid testing, all new admissions should be tested for COVID-19.

II. Patients who test positive for COVID-19, with existing mental disorders and have relapsed
1. Patients who test positive for COVID-19 should be managed in COVID-19 Isolation/Treatment centers identified by the government because of the need for other medical support, which may include use of ventilators.

2. A Psychiatrist on call shall review the patient using the platforms available for tele-psychiatry or face to face in severe case, and institute the appropriate management.

III. Patients who test positive for COVID-19, with newly diagnosed mental disorders.

1. For patients with mild to moderate symptoms, the Psychologist and Psychiatrist on call shall review the patient using the platforms available for tele-psychiatry facilitated by the team leader of the Isolation/Treatment Centre. Appropriate management shall be instituted and continued follow up should be made, even after discharge.

2. For severe cases, a face to face psychiatric review may be warranted. The health care worker must observe all infection prevention measures and don full PPE.
H. MANAGEMENT OF SUBSTANCE USE DISORDERS

The goal of these guidelines is to reduce the risk of COVID-19 infection to patients and staff while providing the appropriate care to those in critical need. However, it is also important to note that during the period of lockdown and restricted movement, there is likely to be an increase in patients presenting with acute withdrawal syndrome, especially alcohol and opioids.

1. Uncomplicated cases can be managed as out-patients (see Appendix III-Treatment for Opioid and Alcohol Withdrawal during the COVID-19 period).
2. Depending on the set up of the respective facility, emergencies can be admitted in the Medical Wards, and liaise with the Psychiatrist on Call to review the patient.
3. If the emergency is more Psychiatric in nature, the patient may be admitted in the Psychiatric Ward/Unit following the same precautions as outlined for other patients with mental illness as in section F above.
4. The newly admitted patients must be screened at point of first contact, and tested for COVID-19 if possible. Visitors should be restricted during this period.
5. The number of beds in the unit should be reduced to a bare minimum to allow for physical distancing.
6. The patient can be discharged as soon as they have stabilized, with advice on home quarantine for at least 14 days.
7. Psycho-education and Family Therapy can be done using digital or online platforms where possible.
8. Group Therapy may be attempted using digital or online platforms or postponed until the COVID-19 risk has reduced and normal services resume.
9. Regarding long term treatment and rehabilitation, it is advisable to limit to short term acute withdrawal management and the continuum of care provided as an outpatient or community based care and rehabilitation using digital or online platforms or community outreach teams.
I. INTEGRATION OF PSYCHIATRIC CARE INTO ISOLATION / TREATMENT CENTRES

Due to the unpredictable nature of the course of the COVID-19 symptoms, it is highly recommended that psychiatric care be integrated into the designated Government Isolation/Treatment Centres to manage any sudden change of condition which may need further emergency medical support, including the use of ventilators.

1. It is recommended that each COVID-19 Isolation/Treatment Centre sets aside a section where patients with mental illness can be treated. This will ensure that should any of the admitted COVID-19 patients develop psychiatric symptoms; the mental health team can treat them at the facility rather than transferring them to a Psychiatric Hospital/Unit with the attendant risks along the way.

2. Should a patient in the psychiatric facility develop COVID-19 symptoms or test positive, they may be transferred to the nearest COVID-19 Treatment Centre for care.

3. Psychiatric facilities may be required to establish quarantine rooms/wards for patients suspected of having COVID-19 before this is confirmed, after which appropriate transfers may be made.
J. STAFF SAFETY AND WELL BEING

I. The Mental Health Team

It is recommended that all facilities set up mental health teams that will be able to coordinate all the mental health activities at the facilities during this COVID-19 pandemic and beyond. The recommended composition of the teams shall include but not limited to the following:

1. A team leader- A Preferably a Psychiatrist or the senior most experienced mental health care worker (Psychiatric Nurse or Clinical Officer)
2. Medical Officers with training or experience in mental health
3. Psychiatric Nurses
4. Clinical officer in Mental health and Psychiatry
5. Clinical Psychologists
6. Medical (psychiatric trained) Social Workers
7. Counselors

II. Personal Protective Equipment (PPE)

1. All hospital administration must provide the appropriate PPE for each cadre of staff within the health facility
2. All mental health workers should follow PPE guidelines, including the appropriate steps of donning and doffing.

NOTE: Given the risks that may be posed while attempting to restrain some patients, it is important that an individual risk assessment is made and reviewed on a daily basis to ensure that all risks are managed in an appropriate and timely manner. Alternative methods of calming a patient may need to be used.
III. Staff Capacity Building

Given the new nature of the COVID-19 Pandemic, it is highly recommended that all the cadres of staff in the healthcare facilities are appropriately sensitized and trained. This ensures that the appropriate information is relayed; hence reducing fear and stigma, while increasing confidence in the staff.

1. This can be done using digital or online platforms, and where it is necessary to have practical demonstrations, physical meetings can be done, while observing all the universal infection prevention precautions.
2. The information disseminated should be appropriate for each cadre of staff within the health facility.
3. Staff are encouraged to continue with self-learning through the various portals, and webinars available.

IV. Staff Wellbeing

1. All healthcare workers will feel the impact of COVID-19 and it is likely to be distressing and potentially traumatizing for many. Staff wellbeing is vital. This is crucial both for responsibilities as employers and as providers of compassionate, safe and high quality healthcare.

2. It is strongly recommended that each facility organize a team of mental health workers to offer regular debrief sessions for Staff, and psychological support for their family members. Confidentiality as ethically required must be adhered to.

3. Risk assessments are required for health and social care staff who are more vulnerable to COVID-19. Employees who are assessed as being more vulnerable will need to be deployed away from COVID-19 high risk areas to low risk areas.

4. It is also recommended that the staff members are organized in teams that work in shifts, to reduce chances of all health care workers being exposed at the same time, in the unfortunate event that a patient or staff member tests positive for
COVID-19.

5. Despite reduced workforce, staff should work in pairs to provide a buddy system. The buddy system helps to provide support, monitor stress and reinforce safety procedures.

6. Matters regarding Staff Medical Insurance, Personal Indemnity Cover, motivation and compensation can be addressed by the appropriate authorities and communicated clearly to the staff, especially those working in high risk departments/units.

V. Remote Working

1. If it is decided that a staff member should work from home they should still expect to receive support and guidance from their line manager.

2. Attempts should be made to increase online/telephone contact with colleagues working from home.

3. Staff who are well but need to self-isolate may be able to undertake certain clinical activities remotely, including providing clinical advice by telephone/online or undertaking telephone/video consultations.

Such activities should be discussed and agreed with the service manager.
APPENDIX I: LIST OF CONTRIBUTORS

1. Dr. Simon Njuguna - Director of Mental Health, Ministry of Health
2. Dr. Victoria Wamukhoma - Mathari National Teaching and Referral Hospital
3. Prof. Lukoye Atwoli - Moi University School of Medicine and CitiesRISE
4. Dr. David Bukusi - Kenyatta National Hospital
5. Dr. Monique Mucheru - Mathari National Teaching and Referral Hospital
6. Dr. Edith Kwobah - Moi Teaching and Referral Hospital, Eldoret
7. Dr. Florence Jaguga - Moi Teaching and Referral Hospital, Eldoret
8. Dr. Silvia Kemunto - Mathari National Teaching and Referral Hospital
9. Dr. Jackline Ochieng' - Mathari National Teaching and Referral Hospital
APPENDIX II. CONTACTS FOR MENTAL HEALTH REFERRAL FACILITIES

1. Mathari National Teaching and Referral Hospital (MNTRH)
   - Inquiries on continuity of care and Psychiatric emergency crisis: 0721336017
     This call shall be connected to Consultant on call if there is need.
   - In-charge of Nursing: 0715 657 278

2. Moi Teaching and Referral Hospital (MTRH), Eldoret
   Hotline: 0110052150 – This shall connect to the Mental Health Unit

Feeling distressed and need counseling & psychological support? Call: 1199 or 719
APPENDIX III  CASE DEFINITION BY MINISTRY OF HEALTH

CASE Definition for Novel Coronavirus Disease (COVID-19)

The case definition is based on the current information available and may be revised as new information accumulates.

Suspect case

A. A patient with acute respiratory illness (fever or cough or shortness of breath) AND
   • A history of travel to a foreign country during the 14 days prior to symptom onset OR
   • Having been in contact* with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset
B. A patient with severe acute respiratory illness (fever or cough or shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

A. A suspect case for whom testing could not be performed for any reason OR
B. A suspect case for whom testing for the COVID-19 virus is inconclusive.

Confirmed case

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

*Definition of a Contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:

Close contact is defined as:
   • Working together in close proximity or sharing the same environment with a COVID-19 patient
   • Face-to-face contact within 1 meter and for more than 15 minutes
   • Traveling together with a COVID-19 patient in any kind of conveyance
   • Living in the same household as a COVID-19 patient
   • Health care associated exposure, including providing direct care for COVID-19 patients, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment as a COVID-19 patient.

Note: for confirmed asymptomatic cases, the period of contact is measured from the 2 days before through the 14 days after the date on which the sample was taken which led to confirmation.

Lay/Community Case Definition

Any person presenting with hotness of the body or cough or difficulty in breathing having history of travel from outside the country OR lived with or visited somebody known to have Coronavirus disease.

Dr. PATRICK AMOTH
Ag. DIRECTOR GENERAL FOR HEALTH
25th March, 2020
**APPENDIX IV COVID-19 TRIAGE CHECKLIST (CAN BE MODIFIED TO SUIT EACH INSTITUTION)**

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Points System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a cough?</td>
<td>1 pt</td>
</tr>
<tr>
<td>Do you have colds?</td>
<td>1 pt</td>
</tr>
<tr>
<td>Are you having Diarrhea?</td>
<td>1 pt</td>
</tr>
<tr>
<td>Do you have sore throat?</td>
<td>1 pt</td>
</tr>
<tr>
<td>Are you experiencing MYALGIA or Body Aches?</td>
<td>1 pt</td>
</tr>
<tr>
<td>Do you have a headache?</td>
<td>1 pt</td>
</tr>
<tr>
<td>Do you have fever (Temperature 37.8°C and above)</td>
<td>1 pt</td>
</tr>
<tr>
<td>Are you having difficulty breathing?</td>
<td>2 pts</td>
</tr>
<tr>
<td>Are you experiencing Fatigue?</td>
<td>2 pts</td>
</tr>
<tr>
<td>Have you travelled recently during the past 14 days?</td>
<td>3 pts</td>
</tr>
<tr>
<td>Do you have a travel history to a COVID-19 INFECTED AREA?</td>
<td>3 pts</td>
</tr>
<tr>
<td>Do you have a direct contact or is taking care of a positive COVID-19 PATIENT?</td>
<td>3 pts</td>
</tr>
</tbody>
</table>

**Score Results:**

0-2 May be stress related and observe.

3-5 Hydrate properly and proper personal hygiene.

Observe and Re-evaluate after 2 days.

6-12 Seek consultation with a Doctor.

12-24 Call the MOH Hotline - 800721318.

For more information about Corona Virus Dial 719 or *719*
You also can reach the Ministry's @MOH_Kenya hotline on 800 721 316

#MulikaCorona #KomeshaCorona
TREATMENT FOR OPIOID AND ALCOHOL WITHDRAWAL DURING THE COVID-19 PERIOD

MINISTRY OF HEALTH
MATHARI NATIONAL TEACHING & REFERRAL HOSPITAL

TREATMENT FOR OPIOID AND ALCOHOL WITHDRAWAL DURING THE COVID-19 PERIOD

During this period of Lockdowns and restricted movement we are likely to witness a higher number of patients suffering from substance withdrawal.

**Opioid withdrawal**
Mild opioid withdrawal may be managed on an outpatient basis. Symptomatic treatment includes:

- **Diazepam, oral 5-20mg/day in divided doses**
  - Taper off over 5-7 days

For stomach cramps:

- **Hyoscine butylbromide, oral, 20 mg 8 hourly as required.**

For Headaches:

- **Paracetamol, oral, 1g 4-6 hourly when required to a maximum of 4 doses per 24 hours**
  - Maximum dose 15mg/kg/dose
  - Maximum does 4 g in 24 hours

For muscle pains

- **Ibuprofen, oral 400mg 8 hourly, with meals, as required**

For diarrhea

- **Loperamide, oral 4 mg immediately**
  - Then 2 mg after each loose stools
  - Maximum dose: 16 mg in 24 hours

**Moderate to severe withdrawal**
Where methadone is unavailable or if there is insufficient capacity within the county to manage the prescribing and dispensing legailities applicable to methadone (a schedule 6 medication) and where there are constraints with the administration of the methadone as directly observed treatment (DOT), then Tramadol can be considered.

- **Tramadol, oral 200mg 12 hourly for 14 days may attenuate withdrawal symptoms**
Alcohol withdrawal uncomplicated

The treatment regimen recommended for uncomplicated alcohol withdrawal includes:

- Thiamine oral, 300 mg daily for 14 days and
- Diazepam oral, 10 mg immediately
  - Then 10 mg 8 hourly for 3 days
  - Then 10 mg 12 hourly for 2 days
  - Then 5 mg daily for 2 days
  - Then stop

NB

1. Consider available anticonvulsants as prophylaxis to alcohol withdrawal seizures.
2. Consider low dose antipsychotics for a limited period of time if the client has psychotic symptoms.

Refer to appropriate level of care for alcohol withdrawal delirium.

Adapted from the Ministry of Health Kenya, National protocol for Treatment of Substance Use Disorders

Dr. Victoria Wamukhoma
Consultant Psychiatrist/ Deputy Medical Superintendent
REFERENCES

2. Workforce guidance for mental health, learning disabilities and autism, and specialized commissioning services during the coronavirus pandemic, NHS England

OTHER DOCUMENTS TO BE USED ALONGSIDE THESE GUIDELINES

1. SOPs for Counselors and Psychologists in the MHPSS for the COVID-19 response in Kenya
2. Psychological First Aid (PFA) – Adapted for COVID-19, Kenya.
CORONAVIRUS DISEASE
COVID-19

MINISTRY OF HEALTH