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National Disaster Management Guidelines

Mental Health and Psychosocial Support Services in Disasters

2023

National Disaster Management Authority
Government of India

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Developed in collaboration with

Rahbar
A field action project of
Tata Institute of Social Sciences

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A publication of:
National Disaster Management Authority
Government of India
NDMA Bhawan
A-1, Safdarjung Enclave
New Delhi - 110 029

September 2023

When citing this guidelines, the following citation should be used:
National Disaster Management Authority and Rahbar(2023). National Disaster Management Guidelines Mental Health and Psychosocial Support Services in Disasters.

A publication of the National Disaster Management Authority, Government of India.
Developed in collaboration with Rahbar, a field action project of Tata Institute of Social Sciences
September 2023, New Delhi.

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भारत सरकार
Government of India

Foreword

India experiences numerous disasters at a small and large scale: all of which affect not only in terms of physical and economical damage but also the mental heath and psychological well-being of the population. In a country like India, where mental health professionals are in smaller proportion, training community level workers to reach the unreached sections of the population is essential to provide psychosocial first aid immediately after the event of emergencies and disasters.

There has been growing acknowledgement towards linking mental health and psychosocial support (MHPSS) with disaster risk reduction; though adoption of a proactive approach towards planning and conducting MHPSS activities in disasters. In this context, NDMA partnered with the Rahbar (a field action project of Tata Institute of Social Sciences) to revise and update the National Disaster Management Guidelines: Psychosocial Support and Mental Health Services in Disasters from 2009.

The purpose of updating the existing guidelines is to provide concrete actions and activities to be carried out through all phases of a disaster including preparedness, mitigation, response, recovery, rehabilitation, and reconstruction. It presents updated information to carry out targeted meaningful MHPSS activities which follow the latest national and international best practices. The guidelines view MHPSS beyond traditional clinical services; and involve the whole community in supporting and improving the mental health and well-being of those in disaster-affected areas.

The guidelines emphasize the importance of pre-disaster activities and provide a framework for activities and actions to be carried out within the domains of institutional, legal, and policy frameworks; assessment of MHPSS vulnerabilities and capacities; training and capacity building, and research. Coordinated, consolidated actions at the local, state and national level, with support from appropriate institutional mechanisms and technological infrastructure, are important thrusts provided in the guidelines. Further, the guidelines detail post-disaster activities to be carried out with a focus on assessment of vulnerabilities and capacities; service delivery; and support for service providers.

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Foreword

We take this opportunity to express our heartfelt appreciation to the Rahbar team, led by Dr. Chetna Duggal and various stakeholders who extended their willing support, cooperation, and commitment by devoting their expertise to make valuable contributions to revise and update the guidelines. We are optimistic that this effort will go a long way in enhancing the activities to be carried out through all phases of a disaster including preparedness, mitigation, to response, recovery, rehabilitation, and reconstruction by involving the whole community in supporting and improving the mental health and well-being of the people in disaster affected areas.

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Acknowledgements

Disasters have a profound impact on the mental health and wellbeing of individuals, families, and communities; often having an especially devastating impact on the most vulnerable groups in the population. Provision of MHPSS support is an essential part of disaster management. This guideline is a crucial step in providing concrete, clear actions for all relevant stakeholders to ensure accessible, tailored, quality mental health and psychosocial support for all. The guidelines build on the activities and structures laid out in the National Disaster Management Guidelines: Psychosocial Support and Mental Health Services in disasters from 2009, draws on all available resources in the community, and provides a vision for planning and conducting MHPSS activities in the future.

The continued support of Shri Kamal Kishore, Member & HoD, NDMA, Lt Gen Syed Ata Hasnain (Retd), Member, Shri Rajendra Singh, Member, Shri Krishna S. Vatsa, Member and Shri Alok, Additional Secretary, NDMA were crucial in revision and updation of the Guidelines.

Shri Safi Ahsan Rizvi, Advisor, Col. K.P. Singh, Advisor, Shri Biswarup Das, Joint Advisor (Mitigation), Shri Chandan Singh, Under Secretary (Mitigation) and Shri Neel Kamal Choudhary, Project Assistant, NDMA were instrumental in guiding and providing technical and administrative support in revising the guidelines.

NDMA acknowledges the contribution of the Rahbar Team - Dr. Chetna Duggal, Ms. Ritika Chokani, Ms. Tejaswi Shetty, Ms. Tooba Iftikhar, Ms. Prachi Pal for their extensive efforts in developing the guidelines. NDMA also acknowledges the valuable comments/suggestions of the Members of the Expert Committee comprises with M/o Health and Family Welfare, IHBAS, WHO, NIMHANS, Kerala SDMA and Odisha SDMA.

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RE-IMAGINING FUTURES
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PREFACE

Through the last century, India has faced the challenges of an array of high-impact natural calamities and disasters. Notably, in the recent three decades spanning from 1995 to 2020, nearly 400 flood and cyclone events have been recorded in various parts of India, affecting physical, mental, and socioeconomic well-being of millions. And in 2020 came the global COVID-19 pandemic that once again impacted all aspects of our lives. As India grapples with the heightened impacts of disasters, encompassing intense heatwaves, severe floods, prolonged droughts, and global pandemics, extensive disruptions within communities are becoming more pronounced, further exacerbating pre-existing vulnerabilities.

The persistent and severe occurrences of disasters, coupled with the loss of livelihoods and forced migrations, intensify the levels of distress and trauma communities experience. The mental health repercussions stemming from the aftermath of disasters are intricately linked to the local, cultural, and social dynamics of communities.

Recognizing the significance of bolstering well-being of individuals and communities in the face of disasters, governments worldwide are emphasizing psychosocial care as an integral component of disaster response strategies. During the COVID-19 pandemic, several crisis helplines and counselors emerged as pivotal lifelines for accessible mental health assistance in India. The National Disaster Management Authority (NDMA) of India and Rahbar, a field action project of the Tata Institute of Social Sciences, collaborated during Covid-19, to offer supportive supervision for counselors providing psychosocial care. The 'Psychosocial Support during the COVID-19 pandemic: A training manual for counsellors' was an important resource that was jointly created.

Rahbar then received an invitation from NDMA to revise the National Guidelines on Mental Health and Psychosocial Support during Disasters. This undertaking holds significant importance in the NDMA's mandate. The guidelines acknowledge the complexities of delivering Mental Health and Psychosocial Support (MHPSS) to India's vast and diverse population while also endeavoring to harness the available institutional and infrastructural capacities. Drafted with utmost care, these guidelines align with both international and national frameworks, contributing to India's dual ambitions of fortifying disaster resilience and nurturing mental well-being before, during and post disasters.

I extend my gratitude to the NDMA for proactively revisiting the 2009 guidelines in contemporary context and trusting Tata Institute of Social Sciences with the responsibility to update the previous guidelines. I commend the Rahbar team, led by Dr. Chetna Duggal, Associate Professor at the School of Human Ecology, for drafting this invaluable resource. I fervently hope the updated guidelines will greatly assist all relevant stakeholders nationwide as they navigate the enduring mental health repercussions of disasters.

Shalini Bharat
September 22, 2023

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Executive Summary

India is one of the most disaster-prone countries in the world. Disasters, whether natural disasters or human-induced disasters, can be devastating and usually leave a trail of agony including loss of family members and friends, damage to homes and community, loss of livelihoods and livestock and loss of dignity that can have a significant impact on the well-being and mental health of people. Hence, along with essential services and security, people affected by disasters also require mental health and psychosocial support (MHPSS). MHPSS services aim to promote wellbeing, reduce emotional distress and trauma as well as prevent, reduce, or treat mental disorders that are exacerbated by or occur due to a disaster or its management.

The guidelines are divided into four sections.

Section 1 provides an introduction to the guidelines, provides a rationale for mental health and psychosocial support services in the context of disasters in India and presents the landscape of policy, institutional and infrastructural capacities in India for MHPSS during disasters. It is divided into three chapters.

Chapter 1 presents the vision, scope, objectives, guiding principles and the intended audience of the guidelines.

Chapter 2 introduces the types of disasters experienced in India, how disasters are understood and defined, the concept of disaster risk reduction and the disaster management cycle. It further details the mental health and psychosocial impact of disasters. Key ideas such as mental health, well-being, emotional distress, individual and collective trauma reactions and mental disorder are defined. The idea of risk and protective factors or vulnerabilities and capacities is then examined, with a special reference to vulnerable groups in the Indian context. The section ends with defining mental health and psychosocial support (MHPSS) and highlighting the need for tailored MHPSS interventions. The proposed central framework of MHPSS is introduced in the form of a visual pyramid and the levels are described.

Chapter 3 aims to present the current landscape of disaster management and MHPSS services in India, and record how their context has changed since the publishing of the original guidelines in 2009. It summarises international regulatory frameworks that have implications for disaster management and mental health. It also describes national legislations relevant to disaster

governance and MHPSS, including Disaster Management Act 2005, National Policy on Disaster Management 2009, National Disaster Management Plan 2019, PM's Ten Point Agenda for DM, National Health Policy 2017, Mental Healthcare Act 2017, National Mental Health Policy 2014, and Persons with Disabilities Act 2016. The roles and responsibilities of various bodies are presented. Finally, an overview of functional MHPSS infrastructures in terms of human resource, technological, institutional, organisational and material infrastructure are presented.

Section 2 presents the guidelines for MHPSS in the prevention, mitigation and preparedness phases of the DM cycle. It is divided into four chapters.

Chapter 4 introduces the various national and state level institutional, legal, and policy frameworks that can be established to build MHPSS preparedness capacities. The establishment of a National MHPSS Working Committee and State MHPSS Working Committee is proposed for the key purpose of implementing the guidelines, formulating action plans, and coordinating among stakeholders. The scope, organisation, members, and functioning of the committees are also defined. The funding framework for MHPSS activities is described. Legal and policy directives related to MHPSS actions and their integration into national, state, and district policies, plans, programmes, and strategies, etc. are outlined.

Chapter 5 outlines a framework for conducting pre-disaster assessments of MHPSS vulnerabilities and capacities to better inform actions related to capacity-building and preparedness. A detailed template is provided for how to conduct a pre-disaster assessment, along with suitable tools, steps, and guidelines to assess the likely MHPSS impacts of disasters in a particular geographical region and to make recommendations for actions. Guidance on the timing, coordination, reporting, and dissemination of assessment data is also offered.

Chapter 6 details MHPSS capacity-building initiatives in three main focus areas: human resources, technological resources, and institutional, organisational, and material resources. The MHPSS training and community capacity-building pyramid forms the central aspect of this chapter, detailing training actions, available training content, and targets of training for all four levels of the pyramid. MHPSS service providers have been envisioned as belonging to eight possible cadres, ranging from community workers to volunteers and healthcare professionals to MHPs. A centralised MHPSS portal and MHPSS helplines have been proposed under technological capacity-

building. Within institutional, organisational, and material resources, various institutions including NDMA, SDMA, DMHP, healthcare facilities, nodal institutes, multi-stakeholder partnerships have been mentioned and their role in building MHPSS readiness and capacity is described.

Chapter 7 deals with disaster mental health research and its role in promoting disaster mental health risk reduction. DMH research is encouraged through defining roles of various stakeholders in identifying priority research areas, conducting ethical, participatory research, as well as building research skills. The necessity of grants and funding for this research is also highlighted. Key ethical guidelines and considerations for teams conducting DMH research are then detailed, followed by guidelines on the dissemination of findings.

Section 3 presents the guidelines for MHPSS in the response, recovery, and reconstruction phases of the DM cycle. It is divided into four chapters.

Chapter 8 extends the MHPSS assessment model introduced in Chapter 5 and elaborates on post-disaster MHPSS assessment to help guide programming and service delivery. The community-wide assessment is spread over two phases: a rapid assessment and an extended assessment. The purpose, assessment categories, assessment tools and methods, step-by-step procedure, and coordination principles for both phases are presented. A detailed framework for conducting early identification and referrals is also given.

Chapter 9 details the principles, components, and operational mechanisms of the proposed MHPSS services framework. Key MHPSS actors, target populations, services, and service locations across the four levels of the MHPSS pyramid are identified. This is followed by specific considerations for the setting up of MHPSS service delivery sites in three key locations- on-site, in healthcare institutions, and helplines, with further discussions on steps to increase the safety, participation, access, and effectiveness of services at these sites. Key MHPSS messages to be disseminated to the affected community are also provided. The chapter ends with guidelines on how systemic and supervisory support can be offered to service providers through different stages and challenges of service delivery.

Chapter 10 offers guidance to service providers from all levels of the MHPSS services model in navigating the three phases of delivering services to disaster-affected people- preparing for

service delivery, during service delivery, and after service delivery. General guidelines are given for all vulnerable groups, and specific guidelines are also given for these groups- women and people identifying as a gender minority group; children and adolescents; older adults; and people with disabilities.

Chapter 11 discusses another important element of MHPSS programming besides assessment, planning, and delivery, i.e. the MEAL framework (monitoring, evaluation, accountability, learning). The indicators, steps, and sample plan for conducting the MEAL process are outlined.

Section 4 includes the implementation guidelines.

Chapter 12 has a checklist for the implementation of these guidelines, designed for use by national and state disaster management authorities, and specifically the National and State MHPSS Working Committees. In both pre-disaster and post-disaster implementation checklists, indicators and timeframe for all actions are clearly outlined across the domains detailed in previous chapters - institutional framework, legal and policy framework, capacity building, assessment, research, and service delivery, early identification and referral, as well as support for providers.

List of Abbreviations

AB-PMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
AICTE	All India Council for Technical Education
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
CBO	Community-Based organisation
CBT	Cognitive Behavioural Therapy
CHC	Community Health Centre
CLW	Community-Level worker
DEOC	District Emergency Operation Center
DM	Disaster Management
DMH	Disaster Mental Health
DMHP	District Mental Health Programme
DDMA	District Disaster Management Authority
DPSSDM	Department of Psychosocial Support in Disaster Management
DRR	Disaster Risk Reduction
GBV	Gender-Based violence
GOI-UNDP	Government of India-United Nations Development Programme
HRV	Hazard, Risk and Vulnerability
HWC	Health and Wellness Centre
IASC	Inter-Agency Standing Committee
ICD	International Classification of Disease
IEC	Information Education Communication
INGO	International Non-Novernmental Organisation
IP	In-Patient
IPSH	Indian Public Health Standards
IPT	Interpersonal Psychotherapy
IRB	Institutional Review Board
IT	Information Technology
LMIC	Low- or Middle-Income Country
M&E	Monitoring and Evaluation
MH	Mental Health
MHPSS	Mental Health and Psychosocial Support
MNS	Mental, Neurological and Substance Use Disorders
MoHFW	Ministry of Health and Family Welfare
NCERT	National Council of Educational Research and Training
NDMA	National Disaster Management Authority

List of Abbreviations

NDMF	National Disaster Mitigation Fund
NDRF	National Disaster Response Force
NDRF	National Disaster Response Fund
NDRMF	National Disaster Risk Management Fund
NGO	Non-Governmental Organisation
NIDM	National Institute of Disaster Management
NIMHANS	National Institute of Mental Health and Neuro Sciences
NPDM	National Policy on Disaster Management
OP	Outpatient
PDNA	Post Disaster Needs Assessment
PFA	Psychological First Aid
PHC	Public Health Centre
PPP	Public Private Partnership
PRI	Panchayati Raj Institutions
PTSD	Post-Traumatic Stress Disorder
POCSO	Protection of Children from Sexual Offences
RKSK	Rashtriya Kishor Swasthya Karyakram
SDMA	State Disaster Management Authority
SDMF	State Disaster Mitigation Fund
SDRF	State Disaster Response Force
SDRF	State Disaster Response Fund
SDRMF	State Disaster Risk Management Fund
SEOC	State Emergency Operation Center
SMHA	State Mental Health Authority
SMS	Short Messaging Service
TISS	Tata Institute of Social Sciences
UGC	University Grants Commission
WHO	World Health Organisation
WASH	Water, Sanitation and Hygiene
UNICEF	United Nations Children's Fund

SECTION ONE

Introduction

SECTION ONE

The National Disaster Management Guidelines on Psychosocial Support and Mental Health Services in Disasters were first published in 2009. The current guidelines update the previous guidelines by specifying clear frameworks for assessment, capacity-building and service delivery. The guidelines also suggest paradigm shifts such as an increased focus on preparedness, an integrated and coordinated response with the various stakeholders involved, and a focus on trauma-informed and social-justice informed care for MHPSS during disasters.

Section 1 provides the background to the guidelines, with Chapter 1 presenting the vision, scope, objectives, guiding principles and intended audience of the guidelines. Chapter 2 introduces the disaster context of India as well as presents the mental health and psychosocial support framework used in the guidelines. Chapter 3 summarises the current policy, institutional and infrastructural capacities for MHPSS in India.

01 Introduction to the Guidelines

1.1 Vision

To foster a mentally healthy and resilient India by cultivating a comprehensive, coordinated, proactive, trauma-informed and whole-society approach to addressing mental health and psychosocial needs in disasters through carrying out prevention, preparedness, response and recovery actions in an accessible and equitable manner.

1.2 Scope

Planning for and responding to disasters is a complex process involving numerous stakeholders. There is a need for well-coordinated, clearly defined actions to be taken.

These guidelines provide an overarching framework for mental health and psychosocial support (MHPSS) actions and activities in any disaster that occurs within India, at a small or large scale. The guidelines shall be adapted by States and Union Territories to their context to develop MHPSS action plans for disasters.

The guidelines incorporate the latest national and international directions on MHPSS in disasters to provide a comprehensive outlook to stakeholders, and strengthen MHPSS planning and implementation across all disaster phases at a district, state, and national level.
These guidelines include:

- Actions to be taken pre-disaster (prevention, mitigation, and preparedness)
- Actions to be taken post-disaster (response, recovery, rehabilitation, and reconstruction)
- Framework of how pre and post-disaster actions can be operationalised
- Roles and responsibilities of all relevant stakeholders (including government ministries and bodies, organisations, service providers, and citizens)

These guidelines have been planned for a period of 5 years, and will undergo a review and update at the end of this timeline to build on the progress made in implementing the vision of this document. Furthermore, the guidelines can be then revised to incorporate any changes that have occurred in the field of disaster MHPSS.

1.3 Objectives

The main objectives of the guidelines are:

- To provide guidance to government and other stakeholders on the prevention, mitigation,

preparedness, response, relief, recovery, and rehabilitation aspects of MHPSS actions before, during, and after disasters, thereby facilitating increased clarity and coordination of MHPSS measures in disaster situations.

- To shift from a reactive to proactive approach, and mainstream MHPSS not only in response, but also in the pre-disaster phases (prevention, mitigation, preparedness) and long-term post disaster phases (reconstruction and rehabilitation).
- To seamlessly integrate mental health and psychosocial support within wider pre-disaster (prevention, mitigation, preparedness), and post-disaster (response, rehabilitation, reconstruction) activities.
- To identify/ establish, operationalise, and promote utilisation of MHPSS services in disasters beyond clinical services, thus integrating intersectoral social and community supports, and encouraging community ownership and participation towards resilience and sustainability.
- To promote mental health and well-being of communities who experience disasters, not merely prevent or reduce mental disorders.
- To ensure availability, accessibility, and quality of MHPSS services in disasters in an equitable manner, especially tailoring support for vulnerable, marginalised, and at-risk groups.
- To restore and maintain provision of essential MHPSS services in the aftermath of disasters.

1.4 Guiding Principles

The guidelines are anchored around the following guiding principles:

All-hazards approach: The guidelines espouse a commitment to being prepared for and responding to the entire spectrum of disasters, regardless of the nature or scale of the hazard. This includes natural, technological and human-induced disasters. Secondly, the all-hazards approach suggests that while the cause of hazards may differ, they have a similar effect on health systems and communities, and a similar model, with appropriate adaptations, can be used to plan and implement MHPSS actions across various hazards[1].

Social justice-informed approach: The guidelines acknowledge and recognize that disasters affect people disparately and that some individuals and groups are more vulnerable to disasters and their impact. Social justice is based on the principles of equity and inclusivity and is the view that everyone deserves equal economic, political, and social rights and opportunities[2].

Trauma-informed approach[3]: The guidelines propose that the organisational and community context must be trauma-informed, that is, rooted in the scientific and experiential knowledge and understanding of trauma and its far-reaching implications on the lives of individuals. A trauma-informed approach involves *realising* the widespread prevalence and impact of trauma, *recognizing* the signs and symptoms of trauma in service users, families and organisations, including its own workforce, *responding* by integrating this knowledge into procedures and practice, and actively *resisting* retraumatization.

Proactive and risk-focused: The guidelines encourage and outline efficient, planned responses to disasters emphasising proactive measures rather than solely responding after a disaster occurs. The guidelines emphasise a risk-focused approach, thereby taking into account the impact of the hazard based on the vulnerabilities and capacities of the community.

Whole-of-society approach: MHPSS activities require the involvement of the entire community to prepare and respond to disasters. This involves empowering communities and engaging all sections of society in disaster MHPSS activities.

Culturally-sensitive and culturally-appropriate support: The guidelines recognise and respect the cultural diversity that exists across India. Hence, while they aim to standardise and bring clarity to the operational framework of MHPSS actions, they also encourage the adaptation of MHPSS to the local context.

1.5 Intended Audience

The guidelines are intended for all individuals and organisations involved in planning, coordinating, or implementing disaster management activities or MHPSS activities in India. This includes:

- Government officials and personnel at the national, state, and district level, both from disaster management and non-disaster management related ministries
- Academic, research, technical, and healthcare institutions
- NGO personnel (including and not limited to those working in the domains of health, education, protection, child protection, gender-based violence, nutrition, shelter, WASH, food security, camp coordination and management) and personnel from other global organisations and international agencies
- Professional bodies and government-associated organisations
- Donors and funders
- Community level workers (including and not limited to health, social welfare, education, employment, social support etc.)
- Disaster responders and frontline workers
- Health and allied health professionals
- Mental health practitioners
- Mental health professionals
- Community leaders
- Media personnel
- Individual citizens and citizen groups

References

[1] World Health Organization. Key approaches to strengthening emergency preparedness and response [Internet]. WHO. [cited 2023 Aug 16] Available from: https://www.who.int/europe/emergencies/our-work-in-emergencies/key-approaches

[2] Morgaine, Karen. "Conceptualizing social justice in social work: Are social workers “too bogged down in the trees?”." Journal of Social Justice 4, no. 1 (2014): 1-18.

[3] US Department of Health and Human Services. SAMHSA's concept of trauma and guidance for a trauma-informed approach.

02 Mental Health and Psychosocial Support in Disasters

India experiences numerous disasters which occur on a local, state, or national level. Due to its unique geo-climatic conditions, it is one of the most disaster-prone countries in the world. Even within the country, of the 36 States and Union Territories, 27 have been identified as being disaster-prone[1]. Overall, the disaster context in India is complex. Responding to these disasters is further complicated by a large population, the social, economic, and cultural diversity in communities, low literacy levels, high poverty, and inequitable availability and distribution of resources.

2.1 Disasters, Disaster Risk, and Disaster Management

This section provides an overview of the types of disasters experienced in India, how disasters can be understood and defined, the concept of disaster risk reduction and the disaster management cycle. This forms the basis of the guidelines and is referenced throughout the guidelines.

2.1.1 Types of Disasters

The Disaster Management Act (2005)[2] defines a disaster as a catastrophe, mishap, calamity, or grave occurrence in any area, arising from natural or manmade causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of, property, or damage to, or degradation of, environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area.

Disasters can broadly be understood within two categories: natural and human-induced disasters[3].

Natural disasters can be geophysical, meteorological, hydrological, climatological, or biological in nature. Some recent natural disasters include the Gujarat cyclone in 1998, Orissa super cyclone in 1999, Indian ocean tsunami in 2004, Kashmir and Uttarakhand floods in 2013, and the Kerala floods in 2018. In the period between 1995-2020, India experienced 1058 natural disasters[4]. There is a history of frequent flooding in various parts of India due to the strong monsoons that occur. Droughts are also common in many states like Rajasthan, Gujarat, Andhra Pradesh, and Maharashtra, causing major disruptions in agricultural activities, food supplies, and drinking water sources. Disasters like earthquakes, landslides, cyclones, heatwaves have all caused damage. The COVID-19 pandemic is an example of a biological hazard causing a disaster, with devastating social, psychological and economic effects in India and globally. Globally, the World Health Organisation estimates that COVID-19 caused a 25% increase in anxiety and depression in 2020 with higher prevalence rates in communities with higher rates of COVID-19[5].

Human-induced disasters are those that occur due to intentional or unintentional human actions. There are various classifications of human-induced disasters, but they largely encompass technological and societal disasters. Technological disasters include industrial accidents (e.g. chemical spills, poisoning, gas leaks, or radiation accidents), transportation accidents (e.g. car, railway, aeroplane, water accidents) and other kinds of accidents (e.g. fires). Societal disasters include armed conflict, acts of terrorism and violence, and other intentionally-caused disasters. One significant example is the Bhopal gas tragedy, one of the worst chemical disasters in India, which took over 5 lakh lives, and had debilitating health and economic repercussions in the affected community that continue even to this day. Significant psychosocial and mental health impacts such as interpersonal difficulties, grief, anxiety, depression and psychosis are also present amongst the survivors[6].

The distinction between natural and human-induced disasters has been blurred with rapid and unplanned urbanisation, encroachment, indiscriminate use of resources and poor construction contributing to some natural disasters. For example, floods may be exacerbated by poor planning and rampant development in a particular region.

A third category that has been added to recent classification of hazards is **environmental degradation-related disasters[7].** It would be remiss to not acknowledge the growing concern around climate change and its impact[8]. Climate change has heavily contributed to a heightened increase in the number and intensity of disasters such as cyclones, floods, droughts, wildfires, and heatwaves. Forced displacement, loss of livelihood and property, increased conflicts, poverty, disrupted social ties, and effects on culture are some of the psychosocial impacts that may occur. Vulnerable groups like coastal communities, indigenous communities, and low income groups are more susceptible to these disasters, and are at risk to be disproportionately affected further widening inequitable distribution. With an increase in disaster occurrences, individuals may express a wide array of stress reactions, helplessness, fear, grief, develop mental disorders, or stress related physical conditions, and even may engage in harmful behaviours and/or alcohol or substance use. Terms like ecological grief and climate change anxiety are now being used to describe the experience of intense emotions, showing a growing concern about the mental health impact of climate change.

While the current guidelines advocate an all-hazards approach to planning for disasters, understanding the different characteristics of different disasters can help to adapt the plan to specific hazards. For example, some disasters like earthquakes, chemical explosions, or tsunamis have a sudden onset and unfold in a very short span giving little time to prepare. Others like heat waves or droughts have a slow onset and span across days or even months. Additionally, some disasters can be predicted beforehand giving time for preparedness activities, mobilisation of resources, and evacuation or support for people.

2.1.2 Disaster Risk, Disaster Risk Reduction (DRR), and Disaster Management

Disasters can have varying levels of impact on the community and are mediated by a complex interaction between the following factors: hazard, exposure, vulnerability, and capacity[9]. The UNISDR defines a disaster as a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts.

Hazard: A hazard is the potential occurrence of a natural or human-induced physical event 'that may cause loss of life, injury or other health impacts, property damage, social and economic disruption or environmental degradation'[10]. In other words, any process or event having the potential to cause harm is a hazard. However, hazards don't always result in disasters; it is when they interact with vulnerabilities that they produce disasters.

Exposure: This refers to the presence of individuals, resources, and infrastructure in areas that are susceptible to hazards. Exposure includes factors such as physical closeness of the individual or community to the hazard and expressive closeness (e.g. degree of close relationship to those injured or dead due to the hazard).

Vulnerability: Vulnerabilities are the characteristics of a person, community or their environment that negatively influence their ability to anticipate, cope with, resist, and recover from the impact of a hazard. Vulnerabilities can include physical vulnerabilities (e.g. unsafe housing), environmental vulnerabilities (e.g. deforestation leading to increased flooding), socio-economic-cultural vulnerabilities (e.g. marginalisation, low income levels, stigma towards mental distress), mental health and psychosocial vulnerabilities (e.g. pre-existing mental health problems), and systemic vulnerabilities (e.g. poor formal mental health systems).

Capacity: Capacities are all the strengths, attributes, and resources available within a community, society, or organisation that can be used to protect the individual or community, and/or facilitate recovery from the hazard. Capacities include physical, environmental, socio-economic-cultural, mental health, psychosocial, and systemic capacities.

Thus, the likelihood of hazards having consequences on people and communities is mediated by an interaction between the severity or intensity of the hazard itself, the extent of exposure to it, the vulnerability to the hazards, and the capacity of the community to protect itself and recover from the hazard. This is known as disaster risk. Hence, by preventing or reducing intensity of hazards, reducing the exposure and vulnerability of communities to hazards, and building society's capacity to respond to hazards, it is possible to minimise the impact of disasters. In fact, in recent years, there has been growing acknowledgement of the importance of prevention and mitigation activities along with response and recovery in the aftermath of a disaster. This is known as disaster risk reduction[11] which aims to assess, reduce, and manage risks to minimise the impact of disasters on individuals, communities, assets, and ecosystems. It also prioritises building resilience of people and communities, enhancing preparedness, and 'building back better'[12]. This is a shift from a reactive approach to a proactive approach to disasters.

Disaster management is a non-linear, cyclical process, consisting of pre-disaster and post-disaster phases. The pre-disaster phase includes prevention, mitigation and preparedness, and the post-disaster phase includes response, recovery, reconstruction, and rehabilitation[13]:

Prevention and Mitigation focuses on preventing the disaster from occurring or minimising the effects or consequences of the disasters.

Preparedness is ensuring readiness by setting up processes and actions to boost the effectiveness of post-disaster measures.

Response occurs immediately after the disaster takes place, and focuses on reducing the effects

of the disaster and meeting the needs of the community by providing immediate assistance.

Recovery, Rehabilitation and Reconstruction phases focus on taking consolidated action to support the community in dealing with the disaster and its effects; and building back communities and infrastructure in a more sustainable manner than pre-disaster conditions.

2.2 The Mental Health and Psychosocial Impact of Disasters

Disasters have a devastating impact on individuals, families, communities, and society as a whole. They lead to loss of life, injury, disability as well as have repercussions on livelihood, property, purchasing capacity, and financial security. They can disrupt routines, isolate from support systems, force displacements, and put a strain on meeting basic needs by contaminating or restricting access to water supplies, obstructing food supply chains, and damaging services, infrastructure and systems. Health services, too, can be severely disrupted. All of this can cumulatively have far-reaching impacts on the psychosocial and mental health of people.

This section elaborates on the mental health and psychosocial impact of disasters, highlighting the strong need for mental health and psychosocial support services in India to support people and communities when a disaster occurs.

2.2.1 Mental Health, Well-being, Emotional Distress, Trauma Responses, and Mental Disorders in Disasters

Planning for and inclusion of mental health and psychosocial support (MHPSS) along with other essential services provides holistic support that responds to the problems listed above and promotes individual and community recovery when a disaster occurs. Thus mental health and psychosocial health form the crux of these guidelines, and an understanding of both these terms as well as other related terms is essential to reading and implementing these guidelines.

Mental health[14] is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. **Psychosocial health**[15] refers to the dynamic relationship between psychological aspects of experience (thoughts, emotions, feelings and behaviour), wider social experience (relationships, traditions) and values and culture.

Mental health and psychosocial health are strongly linked and mediated by social, cultural, biological, and psychological factors. These guidelines too recognise this interconnectedness, and uses the two continua model of mental health[16] and illness to frame the discussion of mental health and psychosocial health to capture these complexities.

The two intersecting continua that this model refers to are: well being and mental health. On the first continuum is **wellbeing,** with high wellbeing on one end and low wellbeing on the other.

Attempts to define wellbeing have been made by many authors, yet there is no universally accepted definition of wellbeing. One conceptualization is Sarah White's (2009)[17] conceptualization of wellbeing for development practice. White describes three key dimensions of wellbeing.

The material dimension consists of physical, and economic assets; welfare, and standards of living. The relational dimension is categorised into two spheres: the social domain which includes interpersonal, and social relations; and access to public resources; and the human capabilities, attitudes to life and personal relationships. Lastly, the subjective dimension also has two components: people's perceptions of their (material, social and human) positions; and the larger cultural values, systems, ideologies, and beliefs. Disasters can have an impact on all these dimensions of wellbeing as well as the interrelationships between them. Further, the impact of disasters on wellbeing is not static and changes over time.

The second continuum of mental health has no or minimal mental illness at one end and mental disorders at the other.

Emotional distress can be thought of as being on this continuum. In disasters, almost all individuals demonstrate emotional distress, which may be transient or may sustain over time. **Emotional distress** (alternatively referred to as mental or psychological distress) refers to a range of negative and/or painful emotions and experiences, both physiological and psychological.[18] For example, immediately after a disaster occurs, people may experience stress, disbelief, shock, helplessness, or anger. Feelings of agitation, anxiousness, depression, and grief are also common. People can also feel angry over the perceived cause and consequences of the disaster; be fearful of a recurrence, or for their own safety, and that of their loved ones. Individuals may find it difficult to think or concentrate, and may find themselves making more mistakes, or taking longer than they expect to make decisions. Another common experience is sleep disturbances with fatigue, fitful sleep, or difficulty falling asleep being predominant. People may find themselves feeling detached, or avoiding people or alternatively; feeling fearful of being separated from loved ones, irritated at others, or losing interest in activities. Individuals may also engage in health risk behaviours to manage the distress. These behaviours can include increased alcohol[19] or tobacco use[20], excessive time at work, changes in travel habits, and even isolating self from social and health support systems[21].

Such emotional distress can impact the actions and behaviours of the individual as well as affect their relationships with the people around them, thereby affecting their daily functioning. Hence, emotional distress is not restricted to the emotional, physiological and cognitive realm, but also has an impact on the behavioural realm. Emotional distress can form a part of normal experiences that subside over time. However, when emotional distress is significant and associated with significant impairment of functioning over a period of time, it may result in a diagnosis of mental disorder *(see below)*.

Trauma responses such as shock, numbness, hyper-arousal, hypo-arousal, agitation, flashbacks, and disorientation can also be thought of as being on this second continuum. Individual trauma rises from an event, or a series of events or set of circumstances that are experienced by an individual as physically or emotionally harmful or life threatening; and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being[22].

The three important elements[23] of trauma are:

- **Events:** This includes being in situations and circumstances that pose an actual or extreme threat of physical or psychological harm. This can be a single event or multiple or extended ones.

- **Experience:** This is the subjective experience of events that helps an individual determine if

an event is traumatic. Feelings of humiliation, guilt, shame, betrayal, or silencing shape the experience of the event. An individual's developmental stage, cultural beliefs, and access to social support also influence how an event is experienced.

- **Effects:** Effects of an event can be immediate, or delayed; short term, or long term.

Disasters may also result in experiences of **collective trauma** in the community. Collective trauma is "the psychological reactions to a traumatic event that affect an entire society; it does not merely reflect a historical fact, the recollection of a terrible event that happened to a group of people. It suggests that the tragedy is represented in the collective memory of the group, and like all forms of memory it comprises not only a reproduction of the events, but also an ongoing reconstruction of the trauma in an attempt to make sense of it"[24]. Families and communities who are experiencing collective trauma tend to be more passive, mistrustful, silent, dependent and leaderless[25]. Additionally, there may be a breakdown in traditional family, and social structures; changes in relationships, and child rearing patterns; or widespread displacement, and disenfranchisement.

On the other end of the second continuum lies **mental disorders.** The International Classification of Diseases-11 defines mental, behavioural and neurodevelopmental disorders as syndromes characterised by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning[26]. Mental disorders are usually diagnosed on the basis of a constellation of symptoms that cause significant emotional distress and impairment of functioning over a period of time. For example, the trauma responses described above may be diagnosed as Post Traumatic Stress Disorder (PTSD) and other traumatic disorders for some individuals.

Another way of understanding the psychosocial and mental health consequences of a disaster is through IASC's framework, which specifies that disasters can influence both social and psychological problems[27]. Significant problems of a predominantly social nature that can occur due to a disaster include:

- Exacerbation of pre-disaster problems: Pre-existing social problems can get exacerbated such as extreme poverty, belonging to a group that is discriminated against or marginalised, or political oppression.

- Disaster-induced problems: The disaster can cause social problems such as family separation; disruption of social networks; destruction of community structures, resources and trust; increased gender-based violence.

- Disaster management/response-induced problems: The response to the disaster or the management of a disaster can influence social problems such as the undermining of community structures or traditional support mechanisms.

Significant problems of a predominantly psychological nature that can occur due to a disaster include:

- Pre-disaster problems: Pre-existing psychological problems can get exacerbated due to the disaster, such as severe mental disorders or alcohol abuse.

- Disaster-induced problems: The disaster can cause psychological problems such as emotional distress, grief, depression and anxiety disorders, post-traumatic stress disorder (PTSD).

- Disaster management/response-induced problems: The response to the disaster or the management of the disaster can influence psychological problems such as anxiety due to a lack of information about food distribution.

Most people experience some level of emotional distress in relation to a disaster. These reactions are appropriate, typical and usually transitory in nature. Many individuals demonstrate resilience and are able to bounce back post disasters. They don't experience severe or long-lasting emotional distress, trauma reactions, or mental disorders. Protective factors (explained in Section 2.2.2 below) contribute to resilience in individuals and communities. However a percentage of those experiencing distress in disaster situations go on to develop mental disorders. Mental disorders such as depression, post-traumatic stress disorder, anxiety, schizophrenia, prolonged grief disorder, and bipolar disorder are prevalent in the population post disasters. The World Health Organisation identifies that 1 in 11 people (9%) will have a moderate or severe mental disorder, and 1 in 5 (22%) in humanitarian disasters will have any mental disorder. A review conducted in India also found that the prevalence of mental disorders identified in the population post disasters is highly variable, with different studies capturing figures between 5% to as high as 80%[28]. In addition, these problems may co-occur, further complicating the individual's experience and the care required. Children and adolescents, too, demonstrate symptoms of mental disorders such as post-traumatic, anxiety, or depressive symptoms. In fact, children have been found to show higher prevalence rates for anxiety and depression compared to adults. This magnifies the need for mental health services for this vulnerable group too. However, there is no linear relationship between disaster occurrence and mental disorder. A variety of biological, psychological, social and environmental factors can influence whether a mental disorder develops. These factors are further expanded on in Section 2.2.2 below.

Thus, many individuals and communities have differing experiences on the dual continuum of mental health such as distress, trauma symptoms, or even mental disorders in disaster situations. There is a strong need for mental health and psychosocial support services in India to support people and communities who have varying needs when a disaster occurs.

2.2.2 Vulnerabilities and Capacities

Disasters impact people or communities unequally, in terms of their mental and psychosocial well-being. For example, some individuals may be able to cope with the distress and recover fairly quickly, while others may experience long term or severe mental disorders. The differences in how people respond to, and are affected by disasters are mediated by many different biological, psychological, social, and environmental factors. These factors interact in complex ways and influence whether individuals are likely to develop psychological problems.

These have traditionally been referred to as risk and protective factors in the mental health literature, and can also be referred to as vulnerabilities and capacities. Risk factors or vulnerabilities increase the risk of emotional distress, trauma responses, and mental disorders during or after a disaster. Protective factors or capacities are those factors that are likely to build resilience and protect individuals from the likelihood of experiencing emotional distress, trauma responses, and mental disorders during or after a disaster.

Risk and protective factors can be inherent to the individual (e.g. sex, age, biological characteristics) or can be linked to the environment. In fact, the characteristics of the disaster itself, and experiences during and after the disaster, too, can impact mental health outcomes. Bronfenbrenner's socio-ecological model[29] identifies various levels of the environment at which risk and protective factors may exist such as the mesosystem consisting of family, school, peers, religious affiliation, workplace, etc.; mesosystem including interrelationships between the various microsystems; exosystem consisting of economic, political, education, health, and other systems; macrosystem including overarching beliefs and value systems in the individual's environment; and the chronosystem consisting of environmental events and transitions across the lifespan of the individual.

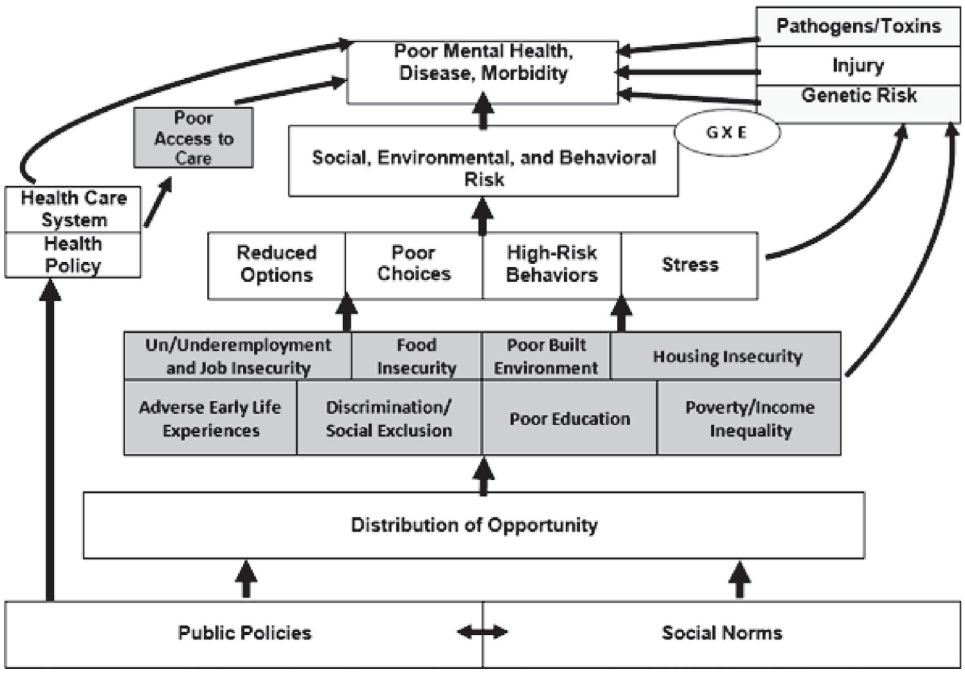

Figure 2.1: Social determinants of mental health. Reproduced with permission from Compton MT, Shim RS. The social determinants of mental health. Focus. 2015 Oct;13(4):419-25

The framework of social determinants of mental health highlights how the contexts that people live and work in influences their mental health. These circumstances are rooted in larger social structures that place people on a social gradient, privileging some while marginalising others. Researchers have identified nine core factors or social determinants of mental health: discrimination and social exclusion; adverse early life experiences; poor education; unemployment, underemployment, and job insecurity; poverty, income inequality, and neighbourhood deprivation; poor access to sufficient healthy food; poor housing quality and housing instability; adverse features of the built environment; and poor access to health care[30]. They further elaborate on other factors including family related variables, workplace discrimination, exposure to war, conflict, disasters and violence, pollution and climate change as also influencing outcomes for individuals. One key element of the social determinants of mental health model is the emphasis on public policies and social norms that have an overt and covert influence on the mental health of individuals and communities. Within the disaster context, this is particularly important as it puts the onus on governmental, non-governmental, and institutional bodies to create and implement a well rounded mental health response.

Vulnerable Groups: While vulnerability can be uniquely conceptualised for each individual, some groups and communities can be clearly identified as being more vulnerable to the psychosocial and mental health impact of disasters. For these groups, disasters may exacerbate already existing structural inequalities. The degree of exposure to the disaster may itself be greatly variable within groups. For example, those with higher access to economic resources can access better care post disasters or even evacuate before a disaster strikes. The table below describes some vulnerable groups in the Indian context[31]. Note that this is not an exhaustive list of vulnerable groups and local power structures and contexts can interact to produce vulnerability in various ways.

Table 2.1: Vulnerable Groups in India

Factor	Vulnerable Groups
Age	Children (unaccompanied children, orphans, child labourers, children in conflict with law) Older adults (those not cared for in families, living alone and in elderly homes)
Gender and Sexuality	Women (pregnant women, divorced women, widows) Gender minorities (transgender and intersex people) People identifying as lesbian, gay, bisexual, or other sexualities
Occupation	People in vulnerable occupations, informal sector, and those who are unemployed or undocumented (like daily wage workers, bonded labourers, sex workers, mine workers) Disaster responders including first responders, government officials, media personnel, and health care providers
Socio-economic status	People who are socio-economically disadvantaged (families below the poverty line, homeless persons, slum dwellers)
Caste and Tribal communities	Individuals from Scheduled Castes, Scheduled Tribes
Disability	People who have visual impairment, hearing impairment, locomotor disabilities, developmental disabilities (including autism, intellectual disability, speech and language impairments), muscular and neurological disabilities and mental illness
Health	People with chronic medical conditions, immunocompromised status, persons with limited life span, and those in palliative care ; individuals with pre-existing mental health concerns
Trauma	People experiencing or having experienced intimate partner violence, other community or domestic violence, traumatic bereavement, survivors of sexual violence, and other traumatic experiences
Family	Single parent families, families with multiple dependent individuals and caregiving responsibilities

Ethnicity	Indigenous people and people belonging to cultural and linguistic minorities
Displacement	Immigrants, migrants, people who are internally displaced and climate change refugees
Others	Tourists, prisoners

2.3 Mental Health and Psychosocial Support (MHPSS)

One of the most internationally influential documents defining MHPSS has been the Inter-Agency Standing Committee's (IASC) guidelines on Mental Health and Psychosocial Support in Emergency Settings released in 2007[32]. These guidelines proposed an understanding of mental health and psychosocial services to unify all activities undertaken by different actors in disaster settings. Mental health and psychosocial support (MHPSS) was defined as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders. This expanded psychosocial and mental health problems beyond the narrow scope of mental disorders and included an understanding of varying experiences of distress, and the intersection of mental well-being with other needs like safety and essential services.

The current guidelines also discuss both mental health and psychosocial support services. As reviewed in the above literature, timely mental health and psychosocial support services, directed towards individuals, families and communities, are crucial to promote mental health and wellbeing, reduce emotional distress and trauma responses, as well as to prevent the development of mental disorders when a disaster occurs. Using ideas from the IASC guidelines and other references, the current guidelines define mental health and psychosocial support as the following:

Both mental health and psychosocial support aim to promote wellbeing; reduce emotional distress and trauma; as well as prevent, reduce, or treat mental disorders. **Mental health** treatments or interventions are specialised interventions that are usually focused on preventing and treating distress, trauma and mental disorders directly. **Psychosocial support** includes those services and initiatives, that are offered before, during and after disaster, that aim to enhance well-being and reduce distress and trauma, by influencing the psychosocial context of individuals and communities. This involves meeting essential needs, supporting and promoting individual and community capacities; improving social ecology (social networks and existing support systems of people in their communities); and understanding the influence of cultures, value systems, and social determinants of mental health. Mental health and psychosocial support are comprehensive and cannot be clearly separated from each other. They shall be integrated within general health services offered in disaster situations

2.3.1 Mental Health and Psychosocial Support Service Pyramid

In the aftermath of a disaster, it may be difficult to differentiate between those experiencing transient emotional distress from those developing mental disorders requiring more specialised support. However, over time it is important to set up processes to identify and direct people to appropriate care based on their current mental health situation. This care should be extended

not only to those requiring more long-term or intensive mental health care, but also to those experiencing short-term emotional distress and trauma responses as well as those who are vulnerable due to exposure to the disaster or social circumstances but not necessarily showing signs of distress or trauma.

Hence, well-organised and multi-tiered MHPSS services that can be scaled up or down based on the requirements of the community are essential. The IASC Guidelines propose an integrated, multi-layered intervention model that can provide support to different groups[33]. This model has been adapted to the Indian context for the current guidelines. India is a composite of diverse people with vastly differing beliefs, practices, ways of living, challenges, and resources. These guidelines, too, respond to the dynamic needs of the Indian population and propose a flexible, innovative organisation of MHPSS which accounts for the unique situation, barriers, and needs. It acknowledges that people may not express distress in recognizable or similar ways, and vulnerability needs to be taken into account for targeting interventions. Further, it also recognizes the preference people may have for family and community based supports as compared to formal mental health interventions. Overall, the pyramid organises MHPSS activities across four levels, which are operationalized to training and service delivery of MHPSS in Chapter 6 and Chapter 9 respectively.

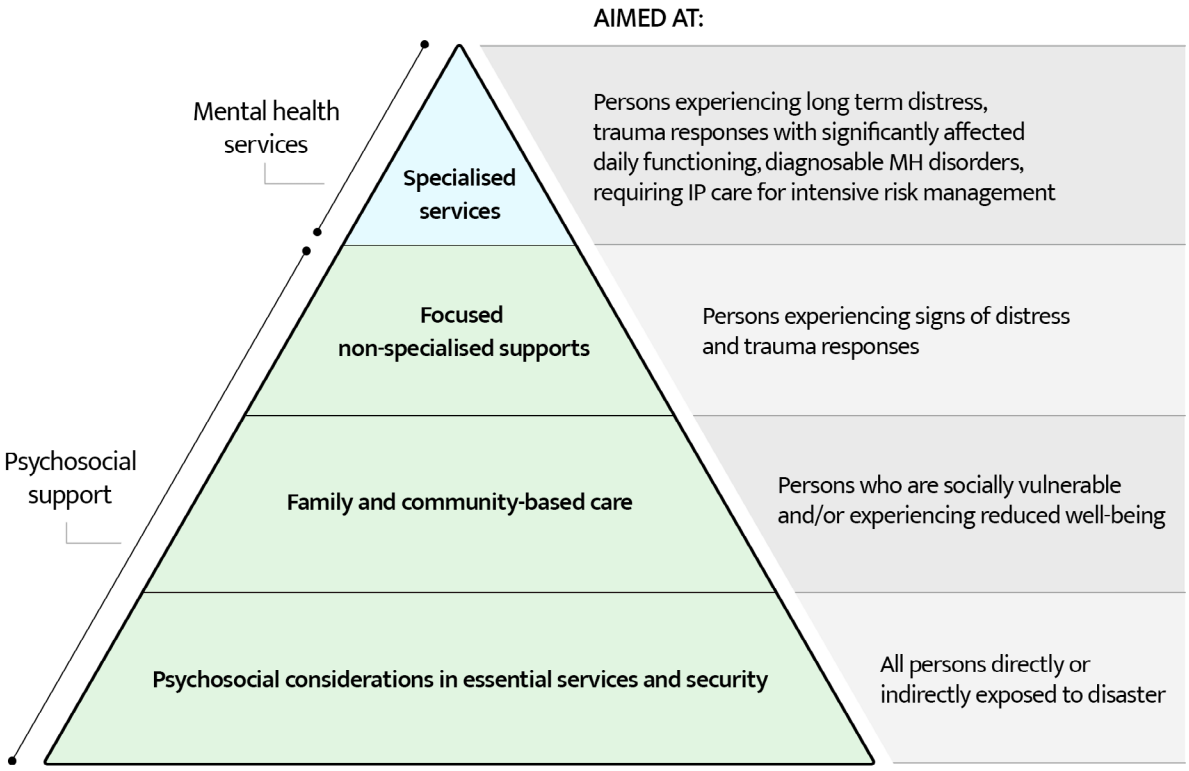

Figure 2.2: MHPSS Pyramid for disasters

Level 1 (Psychosocial considerations in essential services and security). Level 1 forms the base of the pyramid. It advocates for and documents provision of basic services and establishing safety, in a manner that is psychosocially sensitive, trauma-informed, culturally appropriate, and designed to protect the rights and dignity of people. This level is aimed at all persons who are directly or indirectly exposed to the disaster.

Level 2 (Family and community-based care). Level 2 describes the foundational support provided to people by re-establishing family and community support that may have been disrupted due to the disaster. This level is aimed at all persons who are at risk for developing psychosocial and mental health concerns, due to various forms of exposure to the disaster (e.g. facing bereavement due to the disaster) as well as being socially vulnerable. Services at this level include establishing support through access to assisted mourning and community healing practices, activation of social networks and social supports, and establishing appropriate access to information and resources to cope with distress.

Level 3 (Focused, non-specialized services). Level 3 involves provision of focused psychosocial care and support interventions, including psychosocial first aid. This is aimed at those experiencing mild distress and trauma responses and is provided by trained non-specialists.

Level 4 (Specialised services). Some individuals may experience moderate/severe distress, risk of harm to self or others and/or significant impact on daily functioning or long-sustaining mental health distress and/or trauma leading to mental disorders. They may require more intensive and frequent intervention than that available at previous levels. Services at this level include a wide array of counselling, psychotherapy, and pharmacological interventions, such as cognitive-behavioural therapy, rational-emotive behavioural therapy, interpersonal therapy, narrative therapy, psychotropic medication etc. They also include in-patient services.

Table 2.2: Important Points About The MHPSS Service Pyramid

All mental health and psychosocial activities are equally important, and should be planned and provided in parallel.
The aim of MHPSS services during a disaster is not to diagnose or label a person, but rather to support them with appropriate help. Hence, the focus is not on correctly identifying or classifying into diagnostic categories.
The pyramid should be used as a dynamic, rather than rigid, framework; and individuals can be stepped up or stepped down based on their needs (using clear referral pathways).
A special focus should be given to the provision of services for vulnerable groups as mentioned in Chapter 2, Section 2.2.2
People's expression of distress and trauma will differ. MHPSS service providers should be aware of a communities' unique ways of expression, and accordingly tailor early identification and support.
Mental health and psychosocial activities are not just provided by mental health professionals, but require active collaboration between actors from different sectors and departments, including civil society.

References

[1]National Disaster Management Authority. Annual Report 2020-2021. [Internet]. [cited 2023 March 9]. Available

from https://ndma.gov.in/sites/default/files/PDF/Reports/NDMA-Annual-Report_20-21.pdf

[2]Parliament of India. "Disaster Management Act, 2005 [23rd December, 2005.] No. 53 OF 2005" [Internet]. [cited 2023 August 30]. Ministry of Home Affairs. Available from https://web.archive.org/web/20160129071454/http://mha.nic.in/sites/upload_files/mha/files/pdf/DM_Act2005.pdf

[3] National Disaster Management Authority. National Disaster Management Plan [internet]. November 2019 [cited 2023 March 9]. Available from https://ndma.gov.in/sites/default/files/PDF/ndmp-2019.pdf

[4] Gupta AK, Chopde S, Nair SS, Singh S, Bindal S. Mapping climatic and biological disasters in India: study of spatial & temporal patterns and lessons for strengthening resilience. deutsche gesellschaft für internationale zusammenarbeit (GIZ) GmbH India.

[5] World Health Organisation. [Internet]. WHO 2022 Mar 2. COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide [cited on 2023 Sept 23]. Available from https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

[6] Basu AR, Murthy RS. Disaster and mental health: Revisiting Bhopal. Economic and Political Weekly. 2003 Mar 15:1074-82.

[7]World Health Organization. WHO guidance on research methods for health emergency and disaster risk management.

[8]Corvalan C, Gray B, Prats EV, Sena A, Hanna F, Campbell-Lendrum D. Mental health and the global climate crisis. Epidemiology and Psychiatric Sciences. 2022;31:e86.

[9]Gupta AK, Mani N, Sarkar BB, Singh S, Katyal S. Developing Disaster Risk Resilient Cities. Gorakhpur Environmental Action Group (GEAG), Gorakhpur (UP), National Institute of Disaster Management, New Delhi, India and United Nations Children's Fund (UNICEF), India. 2019 Sep;72.

[10]United Nations Office for Disaster Risk Reduction (UNISDR). Hazard [Internet]. UNISDR. [cited 2023 Aug 16]. Available from https://www.undrr.org/terminology/hazard

[11]UNDRR. Disaster Risk Reduction & Disaster Risk Management [Internet]. www.preventionweb.net. 2015. Available from: https://www.preventionweb.net/understanding-disaster-risk/key-concepts/disaster-risk-reduction-disaster-risk-management

[12]UNISDR (United Nations International Strategy for Disaster Reduction). 2015. Sendai framework for disaster risk reduction 2015–2030. https://www.undrr.org/publication/sendai-framework-disaster-risk-reduction-2015-2030. Accessed 16 Jun 2023.

[13]National Disaster Management Authority. National Disaster Management Plan [internet]. November 2019 [cited 2023 March 9]. Available from https://ndma.gov.in/sites/default/files/PDF/ndmp-2019.pdf

[14]World health organisation. Key approaches to strengthening emergency preparedness and response [Internet]. Who.int. [cited 2023 May 07]. Available from: https://www.who.int/europe/emergencies/our-work-in-emergencies/key-approaches

[15]United Nations Development Programme. Integrating mental health and psychosocial support into peacebuilding. New York, USA: UNDP 2022, p. 11

[16]Keyes CLM. Mental illness and/or mental health? Investigating axioms of the complete state model of health. Journal of Consulting and Clinical Psychology. 2005;73:539–548.

[17]White SC. Analysing wellbeing: a framework for development practice. Development in practice. 2010 Apr 1;20(2):158-72.

[18]American Psychological Association. Psychological distress [internet]. [cited 2023 Apr 19]. Available from https://dictionary.apa.org/distress and https://dictionary.apa.org/psychological-distress

[19]Beaudoin CE. Hurricane Katrina: addictive behavior trends and predictors. Public Health Reports. 2011 May;126(3):400-9.

[20]Fullerton CS, McKibben JB, Reissman DB, Scharf T, Kowalski-Trakofler KM, Shultz JM, Ursano RJ. Posttraumatic stress disorder, depression, and alcohol and tobacco use in public health workers after the 2004 Florida

hurricanes. Disaster medicine and public health preparedness. 2013 Feb;7(1):89-95.

[21]West C, Bernard B, Mueller C, Kitt M, Driscoll R, Tak S. Mental health outcomes in police personnel after Hurricane Katrina. Journal of Occupational and Environmental Medicine. 2008 Jun 1:689-95.

[22]US Department of Health and Human Services. SAMHSA's concept of trauma and guidance for a trauma-informed approach.

[23]US Department of Health and Human Services. SAMHSA's concept of trauma and guidance for a trauma-informed approach.

[24]Hirschberger G. Collective trauma and the social construction of meaning. Frontiers in psychology. 2018 Aug 10;9:1441.1

[25]Somasundaram D. Addressing collective trauma: Conceptualisations and interventions. Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas. 2014 Dec.

[26]World Health Organization (WHO). International Classification of Diseases, Eleventh Revision (ICD-11). 2019/2021. https://icd.who.int/browse11. Licensed under Creative Commons Attribution-NoDerivatives 3.0 IGO licence (CC BY-ND 3.0 IGO).

[27]Inter-Agency Standing Committee. IASC guidelines on mental health and psychosocial support in emergency settings. Geneva, Switzerland: IASC 2006.

[28]Kar N. Indian research on disaster and mental health. Indian journal of psychiatry. 2010 Jan;52(Suppl1):S286.

[29]Bronfenbrenner U. The ecology of human development: Experiments by nature and design. Harvard university press; 1979.

[30]Compton MT, Shim RS. The social determinants of mental health. Focus. 2015 Oct;13(4):419-25.

[31]Adapted with permission: National Disaster Management Training Modules (2023), jointly developed by NDMA and NIMHANS (p. 34).

[32]Inter-Agency Standing Committee. IASC guidelines on mental health and psychosocial support in emergency settings. Geneva, Switzerland: IASC 2006.

[33]Inter-Agency Standing Committee. IASC guidelines on mental health and psychosocial support in emergency settings. Geneva, Switzerland: IASC 2006. 2006 (Used and adapted under the CC By 4.0 licence https://creativecommons.org/licenses/by/4.0/)

03 Policy, Institutional, and Infrastructural Capacities for MHPSS in Disasters

In the past decade, the landscape of mental health services in India has undergone numerous and significant changes, reflecting a paradigm shift in the country's approach. Amidst this evolving landscape, MHPSS operates within a larger framework that encompasses legal and policy frameworks, resources and infrastructural capacities within systems and personnel. This chapter provides an overview of the current landscape of MHPSS during disasters, focusing on policy, institutional and infrastructural capacities, and human resources for MHPSS during disasters.

3.1 International Regulatory Frameworks

In 2015, India became a signatory to the following three landmark international agreements that have implications on disaster management, including mental health and psychosocial support. They signal the need for increased attention to preparedness and resilience during disasters, promoting mental health and well-being for sustainable development and considerations of climate change in MHPSS activities.

The Sendai Framework for Disaster Risk Reduction 2015-2030 advocates for "the substantial reduction of disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries"[1]. The Sendai Framework elucidates four major priorities, of which Priority 4 (Enhancing disaster preparedness for effective response and to "Build Back Better" in recovery, rehabilitation and reconstruction) mentions MHPSS. Specifically, it mentions "providing recovery schemes addressing MHPSS at national and local levels for all individuals in need" as a priority.

The 2030 Agenda for Sustainable Development[2], lists 17 Sustainable Development Goals (SDGs) of which the significance of mental health and well-being is recognised through Goal 3, which aims to ensure healthy lives and promote well-being for all individuals across all age groups. In particular, Clause 3.4 mentions the following goal: 'By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being'. Although there is no explicit mention of MHPSS in disasters, the idea of promoting mental health and well-being would apply to disaster settings as well.

The Paris Agreement on Climate Change at the 21st Conference of Parties (COP 21), acknowledged climate change as a global emergency and aimed to significantly reduce global warming and its impact. It recognizes the tremendous adverse effects of global climate change

on populations, infrastructure, economies, and livelihoods, and also that these effects are not experienced uniformly by all countries and geographical areas. A relevant document is the World Health Organization's Policy Brief on Mental Health and Climate Change[3]. This policy brief highlights the direct and indirect effects of climate on the mental health of people, especially vulnerable groups and recommends that climate change considerations should be integrated into policies and programmes for MHPSS and climate change, funding should be encouraged for mental health and health impacts of climate change and multisectoral and community-based approaches to reduce vulnerabilities should be implemented.

3.2 National Legislative and Policy Frameworks

The Disaster Management Act 2005[4] is the main legislation that outlines the institutional, legal, financial, and coordination mechanisms of disaster management at the national, state, and district levels. It constituted the National Disaster Management Authority as the apex body for disaster management in India. State and district-level responsibilities are assigned to the State Disaster Management Authorities and the District Disaster Management Authorities. It includes provisions for actions aimed at prevention, mitigation, preparedness and capacity-building and also identifies healthcare as a service during disasters. The National Disaster Response Fund and the State Disaster Response Funds were also established to meet the expenses for emergency response, relief, and rehabilitation, while the National Disaster Mitigation Fund and State Disaster Mitigation Funds provided exclusively for mitigation measures.

The National Policy on Disaster Management (NPDM) 2009[5] envisions "building a safe and disaster-resilient India by developing a holistic, proactive, multi-disaster oriented and technology driven strategy through a culture of prevention, mitigation, preparedness and response". With regards to MHPSS, the NPDM recognizes the importance of psycho-social care, and trauma in addressing the impacts of natural and man-made disasters. It emphasises the need for capacity building, including the training of medical teams and paramedics, to effectively provide trauma and psycho-social care during emergencies. Additionally, the policy highlights the significance of developing systems for psychosocial support and trauma counselling during the reconstruction and recovery phase of disasters.

National Disaster Management Plan (NDMP) 2019[6] serves as a comprehensive framework for disaster management actions in India, including elucidating clear roles and responsibilities for various governmental actors. The plan recommends "monitoring and managing the long-term impact of disasters on mental health and psychosocial care", along with mobilising professionals and community members to provide psycho-social support. Regular counselling sessions are proposed to strengthen the mental well-being of vulnerable groups like the elderly, women, children, and persons with disabilities, ensuring their comprehensive rehabilitation after a major disaster.

Prime Minister's Ten-Point Agenda for Disaster Risk Reduction was shared in the inaugural speech at the Asian Ministerial Conference on Disaster Risk Reduction in 2016. Prime Minister Narendra Modi outlined a Ten-Point Agenda that is incorporated in the National Disaster Management Plan (NDMP). Of particular relevance to MHPSS is Point 5, which calls for efforts to leverage technology in disaster management efforts and Point 8, which advocates that disaster

management must build on local and community capacities and initiatives.

The Mental Healthcare Act 2017[7] revised the previous Mental Health Act 1987, in compliance with the United Nations Convention on the Rights of Persons with Disabilities. It advocated for the right to good quality, affordable, and accessible mental healthcare services for all, and the right to improvement in services found to be deficient. Special emphasis was laid on the rights and treatment of persons with mental illness, and provisions were made to grant them protection from inhuman treatment, access to their medical records, access to free legal aid, and the creation of an "advanced directive" to express treatment preferences. As for institutional mechanisms, the Act requires the setting up of a Central Mental Health Authority at the national level and State Mental Health Authorities in every state. It calls for the systematic registration of all mental health professionals and establishments in order to maintain records, monitor services, and ensure quality. The Mental Healthcare Act also mandates the provision of rehabilitative services to persons with mental illness and their families, including services like medical treatment, psychotherapy, family counselling, community inclusion, vocational support, self-help groups, and mental health promotion. The state government is also required to initiate a number of measures towards rehabilitative services, such as training of personnel, promoting awareness of mental health and illness and making services respectful, accessible, affordable, and community-based. While the Mental Healthcare Act does not specify unique provisions for mental health care during disasters, the general provisions and rights accorded by the act must also be adhered to in disaster settings.

The National Mental Health Policy 2014[8] is based on values and principles such as equity, justice, quality, integrated care, effective governance, a holistic approach to mental health, and the inclusion of values in all forms of training and teaching. Its overall vision is to promote mental health, prevent mental illness, and enable recovery from it. There is special emphasis on ensuring that service development, delivery, and implementation are participatory, evidence-based, and rights-based. Additionally, it highlights the need to provide adequate training and good working conditions to service providers. The policy also states that mental health consequences of disasters should be acknowledged and appropriate medical and social welfare responses should be provided.

The National Health Policy 2017[9] aligns with the provisions of the National Mental Health Policy (2014) and aims to take simultaneous action on additional focus areas such as the creation of specialists, creation of a network of community members trained in providing psychosocial support, as well as leveraging digital technology to improve access to qualified psychiatrists. Regarding emergency preparedness and disaster management, the policy highlights the need for collaboration with the private sector to expand available infrastructure, human resources, and capacity-building efforts. The development of emergency response protocols for facilities providing care is another objective. A comprehensive information system with information on available services and resources that can be readily deployed in the aftermath of a disaster is also envisioned.

The Rights of Persons with Disabilities Act 2016[10] clearly provides that 'persons with disabilities shall have equal protection and safety in situations of risk, armed conflict, humanitarian emergencies and natural disasters'. Further, it mentions that NDMA and the SDMAs shall include persons with disabilities in their disaster management activities and DDMAs shall maintain records of persons with disabilities in the district. It also emphasises the need to carry out reconstruction

activities post a disaster in accordance with accessibility requirements of persons with disabilities. Finally, the act mentions that persons with disabilities must be provided healthcare during natural disasters and other situations of risk.

In summary, national legislative and policy frameworks signal the need for a socially-inclusive, rights-based, community-centric and technologically-informed approach to services during disasters.

3.3 Institutional Framework

The National Disaster Management Plan 2019[11] provides details of the institutional framework related to disasters available in the country.

The National Disaster Management Authority (NDMA), headed by the Prime Minister, is the apex body for disaster management. As mandated by the Disaster Management Act 2005, it is chiefly responsible for laying down disaster management policies, plans, and guidelines and overseeing their coordination, enforcement, and implementation. These guidelines are used by Central Ministries, Departments, and States to formulate their respective DM plans, which are then approved by the NDMA. The NDMA:

- Takes any necessary measures for the prevention and mitigation of disasters, as well as for capacity building, preparedness and response to disaster situations
- Oversees the provision and application of funds and resources for these objectives
- Exercises general superintendence, direction and control of the National Disaster Response Force (NDRF)
- Outlines broad policies and guidelines for the functioning of the National Institute of Disaster Management (NIDM)
- Constitutes advisory committees consisting of experts in the field of disaster management to make recommendations on different aspects of disaster management.

NDMA has also developed Guidelines on the Incident Response System (IRS), 2010 which provides comprehensive guidance on all tasks and activities that are to be conducted within disaster management with a streamlined team structure to carry out these actions.

The National Executive Committee (NEC), the coordinating and monitoring body for disaster management, is mandated to assist the NDMA in the discharge of its functions, implement its policies and plans, and ensure the compliance of directions issued by the Central government for the purpose of disaster management in the country.

The National Institute of Disaster Management (NIDM) is primarily responsible for planning and promoting capacity-building and research in the area of disaster management. It is tasked with developing and documenting training modules, academic programs and professional courses on disaster management as well as organising training programmes. It maintains a national level information base of disaster management policies and measures of prevention and mitigation. Other roles include formulating and implementing a comprehensive human resource development plan covering all aspects of disaster management, providing assistance in policy formulations and trainings at national and state levels, and promoting awareness among stakeholders like college

and school teachers, students, technical personnel, etc.

The National Disaster Response Force (NDRF) was constituted as a specialist response force to disaster situations and emergencies. As of August 2023, it comprises 16 battalions, with 1149 personnel in each battalion. These battalions are positioned in different locations as required and work in close liaison with state governments.

Further, State Governments are directed to establish their own **State Disaster Response Force (SDRF)** to ensure prompt disaster response. As of August 2023, 24 State/UTs have successfully established their SDRFs, strategically locating them in accessible areas near airports, railways, and roads for swift deployment during disasters. In addition to their response capabilities, the SDRFs are utilised for conducting community capacity building and awareness generation programs within the State. NDRF and SDRF are being oriented to MHPSS currently.

The State Disaster Management Authority (SDMA), headed by the Chief Minister, lays down the state disaster management policy, the guidelines to be followed by state government departments, and coordinates implementation of the State Plan. It is also mandated to recommend the provision of funds for mitigation and preparedness measures, and to review measures taken by state government departments for mitigation, capacity building, and preparedness.

The State Executive Committee, as the coordinating and monitoring body for the state, is responsible for implementing the National Policy, National Plan and State Plan, and guidelines laid down by the state authority. It provides technical assistance and advice to district and local authorities

The District Disaster Management Authority (DDMA) is headed by the District Collector, Deputy Commissioner or District Magistrate as the case may be, along with the elected representative of the local authority as the co-chairperson. It acts as the district planning, coordinating, and implementing body and takes all measures for the purposes of disaster management in accordance with guidelines laid down by national and state authority. It prepares the district response plan, and lays down guidelines to be followed by state government departments at the district level. It identifies vulnerable areas, reviews the district's capabilities of response and preparedness, and gives directions to concerned departments and authorities to enhance the same. DDMAs are also required to organise community trainings, awareness programs, and specialised training programmes for officers, employees, and voluntary rescue workers in the district. Lastly, upgrading mechanisms for the proper dissemination of information to the public also lies with district authorities.

In addition, **Central Ministries and State Departments from various sectors** also share the goals of MHPSS in disaster management. These ministries also play a crucial role in coordinating and implementing intersectoral initiatives for MHPSS at the national and state levels.

Local Authorities, including Panchayati Raj Institutions (PRIs), Municipalities, District and Cantonment Boards, and Town Planning Authorities which control and manage civic services, are also crucial in the institutional framework. These bodies are responsible for ensuring that their officers and employees are adequately trained for the purposes of disaster management. They carry out relief, reconstruction, and rehabilitation activities in affected areas in accordance with

the state and district plan, and ensure that resources are maintained and available for ready use.

Hence, clear institutional frameworks for disaster management have been established through the setting up of disaster management authorities at national, state and district levels. Other central ministries and state departments, district authorities and local authorities also play a role in disaster management and thereby, in disaster mental health services.

3.4 Infrastructural Capacities

This section delves into the current infrastructure for MHPSS in India, including human, technological and institutional, organisational and material resources.

3.4.1 Human Resources

Given the scarcity of mental health professionals in India[12], it becomes imperative to explore alternative approaches to address the MHPSS needs of the population. Task shifting models have been successfully used in LMICs to improve delivery of MHPSS, by shifting tasks from specialised personnel to individuals who are less specialised, but appropriately trained. Along with the emphasis placed on community-based services in the National Disaster Management Policy 2009, the PM's 10 Point Agenda as well as international recommendations about community-based work, it is important to leverage community-based infrastructure and personnel to deliver MHPSS services.

Within the public sector, healthcare providers such as doctors within PHCs, Anganwadi workers, ANMs, RKSK counsellors, and Aapda Mitras and mental healthcare providers including DMHP doctors and psychologists, can play crucial roles in delivering MHPSS services. In the private sector, private practitioners including psychiatrists, counsellors, and psychologists, as well as tertiary care hospitals and school counsellors, can volunteer for MHPSS activities. Additionally, community-based support can be harnessed from local NGO workers, international NGO workers, volunteers, community-based organisations, self-help/support groups, women's groups, community leaders, and religious leaders. More details have been provided in Chapter 6.

By collaborating with these stakeholders and tapping into their potential, the formal mental health systems can enhance their capacity to provide comprehensive and accessible mental healthcare during disasters in India.

3.4.2 Technological, Institutional, Organisational and Material Resources

This section provides a broad overview of India's current infrastructure for mental health as well as other infrastructure that can be used for mental health purposes.

In terms of mental health-specific infrastructure, India has 47 psychiatric hospitals, including 3 Central Mental Health Institutions, and provision for mental health services is also available in 22 AIIMS[13]. Notably, the National Institute of Mental Health and NeuroSciences (NIMHANS) is a premier mental health institute that was accorded the status of an 'Institute of National Importance' in 2012 by the Government of India. NIMHANS is also the national nodal centre

and centre of excellence for MHPSS in disasters. Since its inception, NIMHANS has produced over 1,000 Psychiatrists, approximately 600 Clinical Psychologists, and other mental health professionals who are actively working in national and international contexts[14]. NIMHANS has also recently established a specialist department, 'Department of Psychosocial Support in Disaster Management', for MHPSS in disasters.

As part of Scheme A under the 12th five year plan, 25 centres of excellence for mental health were identified by the Ministry of Health and Family Welfare[15]. They have been sanctioned to increase student intake in mental health specialities-related departments, as well as to provide tertiary level treatment facilities. These institutes include IMHANS in Kozhikode, Kerala; the Hospital for Mental Health in Ahmedabad, Gujarat; SCB Medical College Hospital in Cuttack, Odisha; the Institute of Psychiatry in Kolkata; the Psychiatric Diseases Hospital at the Government Medical College in Srinagar, Jammu and Kashmir; Maharashtra Institute of Mental Health in Pune, State Mental Health Institute in Rohtak, Haryana, and Government Medical College & Hospital in Chandigarh are also recognized as leading institutions. Other notable centres include the Institute of Mental Health in Hyderabad, Telangana; IHBAS in Delhi; and the Institute of Mental Health and Hospital in Agra, Uttar Pradesh. Further, under Scheme B, several government medical colleges and hospitals were supported to establish and/or improve their mental health departments (psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing). These institutions can be drawn upon as state partner institutes for coordinating MHPSS capacity-building and service delivery for disasters.

The District Mental Health Program (DMHP)[16] is a visionary program established under the National Mental Health Programme (1982), which aims to provide basic mental health care services at the community level. The proposed program components include:

- The provision of outpatient and inpatient mental health services, with a 10-bedded inpatient facility
- An outreach component with regular satellite clinics held at Community Health Centres (CHCs) and Primary Health Centres (PHCs) by the DMHP team.
- Targeted interventions such as life skills education and counseling in schools, college counseling services, workplace stress management, and suicide prevention services.
- Sensitization and training of health personnel at the district and sub-district levels
- Community participation through linkages with self-help groups, family and caregiver groups, and NGOs working in the field of mental health.
- Awareness camps to disseminate information about mental illnesses and combat associated stigma, involving local PRIs (Panchayati Raj Institutions), faith healers, teachers, and community leaders.
- Sensitization of enforcement officials to the legal provisions of the Mental Healthcare Act to support its effective implementation.

Currently, as of August 2023, the program has been sanctioned for implementation in 738 districts[17]. The program relies on a dedicated team of professionals, including psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers, community nurses, monitoring and evaluation officers, case registry assistants, and ward assistants. However, there are some challenges faced in implementing the DMHP such as shortage of human resources. Due to the large number of districts in India and the ratio of mental health professionals to the population being low, it is often difficult to staff DMHPs with appropriately qualified mental

health professionals. Nevertheless, DMHPs are an important resource to draw upon in MHPSS during disasters.

Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana has been implemented across 33 States/ Union territories. It provides health coverage of 5 lakhs per beneficiary per annum to over 60 crore beneficiaries, making it the world's largest health protection scheme[18]. Out of its 1682 procedures, 10 packages pertain to the field of mental healthcare, and include services aimed towards disorders like mental retardation, mood (affective) disorders, neurotic, stress-related and somatoform disorders, mental and behavioural disorders due to psychoactive substance use among others.

Under the Ayushman Bharat - Health and Wellness Centres, 1.5 lakh Health sub centres and primary health centres are converted into Health and Wellness Centres (HWCs) which provide comprehensive primary care within the community[19]. Mental health services i.e. screening and basic management of mental health problems are also part of the expanded package of service provided at HWCs. Operational guidelines for care of mental, neurological and substance use (MNS) disorders in these AB-HWCs exist, and training is being provided to frontline community workers (ASHA & MPW) as well as specialists at national and state levels.

Apart from the public mental healthcare system, mental health services are also provided in private healthcare settings (e.g. hospitals, clinics, private web-based services), educational settings (e.g. schools, colleges) and the social and development sector (e.g. NGOs). However, a comprehensive documentation and mapping of these services is not available. A number of these establishments also conduct regular mental health outreach programs for the general public as well as for targeted population groups such as adolescents, women, police personnel, frontline healthcare professionals, persons with mental illness, etc.

India has also embraced technology-assisted initiatives to enhance mental healthcare services. These efforts, led by various ministries and institutions, utilise a range of digital tools including helplines, portals, websites, and apps. Some examples include:

Kiran: The Department of Empowerment of Persons with Disabilities (DEPwD) of the Ministry of Social Justice & Empowerment launched a national 24x7 mental health rehabilitation helpline named Kiran in September 2020. It offers services such as early identification, psychological support, distress management, crisis support, and referrals for further care.

eSanjeevani: In April 2020, the Ministry of Health and Family Welfare (MoHFW) initiated eSanjeevani, a telemedicine service that connects users to healthcare professionals virtually from HWCs or even from their homes.

Tele MANAS: Another initiative launched by MoHFW in 2020 is Tele MANAS (Tele Mental Health Assistance and Networking Across States) which is envisioned as a "comprehensive mental healthcare service", and is the digital component of the National Mental Health Programme (NMHP). It aims to provide 24x7 tele mental health services to ensure universal access to affordable, equitable, and quality care. As of March 2023, 36 Tele MANAS cells have been set up in 25 States/ UTs and have handled 63,806 calls on the helpline number[20]. As of July 2023, 42 Tele MANAS cells have been set up in 31 States/UTs and have handled more than 1,94,000 calls on the helpline number[21].

The MANAS (Mental Health and Normalcy Augmentation System) app: The app was initiated by the Prime Minister's Science, Technology, and Innovation Advisory Council (PM-STIAC) in 2021. It is designed as a comprehensive, scalable, and national digital wellbeing platform to cater to users across age groups.

NIDM Resources: NIDM maintains and monitors the India Disaster Resource Network (IDRN), a web-based platform established in 2004 by the Ministry of Home Affairs (MHA) under the GOI-UNDP Disaster Risk Management Programme which aims to build a systematic inventory of equipment and skilled human resources, allowing decision-makers to access and locate available resources for immediate emergency response. NIDM also has a training portal for individuals and organisations seeking to enhance their knowledge and skills in disaster management. The portal offers a wide range of training courses and resources to support capacity building in disaster risk reduction and preparedness. Through the training portal, participants can access face-to-face, online, and self-learning modules developed by NIDM experts. The portal has been instrumental in conducting 1,208 trainings, with 78,636 participants benefiting from these programs. To recognize the successful completion of the courses, NIDM has issued 53,712 e-certificates, validating the acquired knowledge and skills[21]. The NIDM training portal serves as a significant tool in promoting disaster resilience and building the capacity of individuals and organisations in India.

NIMHANS Digital Academy: NIMHANS has a Digital Academy and e-learning hub which offers diplomas and certificate courses across mental health, neurosciences, and disaster management, empowering both internal students and external trainees to gain specialised skills and contribute to the fields of research, patient care, and community resilience. A total of 25,149 professionals[22] have been trained, including doctors, psychologists, social workers, nurses and others.

In summary, despite significant development in the past two decades, the infrastructural capacities available present a mixed picture. While a number of centres of excellence for mental health have been established, the number of specialist mental health professionals is still low, considering the large population they serve. Hence, task-shifting models, which aim to train personnel from other sectors in MHPSS are important in building capacity for disaster mental health. Existing infrastructure such as DMHPs as well as PHCs and CHCs can be used to provide MHPSS services as well. Several technological initiatives for mental health services have also been initiated in the past two decades, especially in the wake of the COVID-19 pandemic which signalled a major shift in telemedicine in the country. This infrastructure can be drawn upon to provide MHPSS, especially in areas and communities that are more difficult to reach using traditional in-person services.

Hence, the current guidelines carefully consider the challenges of delivering MHPSS to a large and diverse Indian population, while also aiming to draw upon the multiple institutional and infrastructural capacities that are present. They aim to align with the vision of international and national frameworks in making India disaster-resilient and mentally healthy.

References

[1] UNISDR (United Nations International Strategy for Disaster Reduction). 2015. Sendai Framework for Disaster Risk Reduction 2015–2030. https://www.undrr.org/publication/sendai-framework-disaster-risk-reduction-2015-2030

[2] United Nations. 2015. Transforming our World: The 2030 Agenda for Sustainable Development. https://sdgs.un.org/goals

[3] Mental Health and Climate Change 2015 (Policy Brief). Geneva: World Health Organization; 2015.

[4] Disaster Management Act 2005. New Delhi: Government of India; 2005.

[5] National Policy on Disaster Management 2009. New Delhi: Government of India; 2009.

[6] National Disaster Management Plan 2019. New Delhi: Government of India; 2019.

[7] Mental Healthcare Act 2017. New Delhi: Government of India; 2017.

[8] National Mental Health Policy 2014. New Delhi: Government of India; 2014.

[9] National Health Policy 2017. Ministry of Health and Family Welfare, Government of India; 2017.

[10] The Rights of Persons with Disabilities Act 2016. New Delhi: Government of India; 2016.

[11] All information for 'Institutional Framework' is accessed from National Disaster Management Plan 2019. New Delhi: Government of India; 2019.

[12] Data from the Mental Health Atlas 2017. Geneva: World Health Organization; 2018 shows that there are 0.29 psychiatrists, no child psychiatrists available per 100,000, 0.07 psychologists, 0.06 social workers population, 0.80 mental health nurses, and 0.36 other paid mental health workers per 100,000 population in India.

[13] Ministry of Health and Family Welfare, Government of India. Update on mentally ill patients [Press Release]. [Posted on 2023 March 28]. Available from: https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1911470

[14] Cited on 7th July 2023 from NIMHANS website: https://nimhans.ac.in/about-us/

[15] Ministry of Health and Family Welfare, Government of India. SCHEME – A : CENTRES OF EXCELLENCE: Institutions supported under NMHP. [Internet]. (Cited 2023 August 30). https://main.mohfw.gov.in/sites/default/files/Institutions%20supported%20under%20NMHP_0.pdf

[16] Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. National Mental Health Programme [Internet]. (Cited 2023 August 30). https://dghs.gov.in/content/1350_3_NationalMentalHealthProgrammeme.aspx?format=Print

[17] Ministry of Health and Family Welfare, Government of India. Update on Affordable Mental Health Services. [Press Release]. [Posted on 2023 Aug 04]. Available from https://pib.gov.in/PressReleasePage.aspx?PRID=1945743

[18] Press Information Bureau Delhi [Internet]. Delhi: Ministry of Health and Family Welfare. 2023 Mar 17. Update on AB-PMJAY [cited on 2023 Sept 23]. Available from https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1908050

[19] Press Information Bureau Delhi [Internet]. Delhi: Ministry of Health and Family Welfare. 2021 Mar 23. Health and Wellness Centres Providing Mental Health Services [cited on 2023 Sept 23]. Available from https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1706945

[20] Ministry of Health and Family Welfare, Government of India. Update on Affordable Mental Health Services. [Press Release]. [Posted on 2023 Aug 04]. Available from https://pib.gov.in/PressReleasePage.aspx?PRID=1945743

[21] Cited on 7th July 2023 from NIDM Training Portal: https://training.nidm.gov.in/

[22] Cited on 4th July 2023 from NIMHANS website: https://nda.nimhans.ac.in/

SECTION TWO

Mental Health and Psychosocial Support during the Prevention, Mitigation and Preparedness (Pre-Disaster) Phases of Disasters

SECTION TWO

There has been a global shift in disaster management from response to disaster risk reduction, with calls to align Mental Health and Psychosocial Support (MHPSS) steps and actions in disaster settings with this paradigm too. A focus on actions taken in the pre-disaster phases is seen as essential to disaster management. MHPSS activities in these phases include:

Prevention: This refers to actions and efforts taken to promote positive mental health and wellbeing.

Mitigation: This refers to actions directed towards reducing or eliminating the mental health and psychosocial impact of disasters on people. Further, it is focussed on preventing the development of mental health concerns in the event of a disaster by reducing or eliminating the risks associated with it.

Preparedness: This refers to efforts made to increase planning and improve the state of readiness to cope with the psychosocial impact of disasters. It includes actions and activities aimed at equipping individuals, communities, and systems to be appropriately prepared to deliver MHPSS response in the immediate, short-term and long-term aftermath of a disaster.

This section provides directions for necessary actions to be taken before a disaster occurs. This enables swift and coordinated efforts to prevent, minimise, and respond to the impact of disasters on the mental health of people. Planning and implementing MHPSS activities that prevent new risks from developing, and responding to existing risks are essential.

It is important to note that MHPSS actions are broad in nature and will often cut across the various phases of disaster management. For example, research in disaster mental health can contribute to building resilience, preventing mental health problems from occurring, mitigating or minimising effects on mental health, and even outlining evidence-based preparedness actions to respond to mental health problems that arise as a consequence of disasters. Thus, the actions covered under the guidelines here have been organised into 4 cross-cutting domains which are to be generalised across all pre-disaster phases. While they may continue well into the post-disaster phase, planning and organisation of these activities should take place before the threat of a disaster. This section is organised into 4 chapters as listed below:

Chapter 4: Institutional, legal, and policy frameworks
Chapter 5: Pre-disaster assessment of MHPSS vulnerabilities and capacities
Chapter 6: Capacity Building
Chapter 7: Research

04 Institutional, Legal and Policy Frameworks

Establishing institutional, legal, and policy frameworks involving both public and private entities can significantly contribute to all aspects of preparedness. It effectively minimises the duplication of efforts, complements resources, and fills any gaps, thereby strengthening organised, synergistic, and targeted activities that align with the community's needs. It provides robust systems within which assessments, training and capacity-building, service delivery, research and monitoring and evaluation can be planned and carried out in a systematic manner.

4.1 Institutional Framework

Clear and standardised national and state institutional frameworks are crucial for effective MHPSS disaster response at the state and national level. These frameworks should be integrated with overall disaster response efforts to effectively coordinate and maximise available resources across all sectors. The guidelines outline a coordinating structure within which government and private entities can operate. It includes ministries, organisations, individuals, and institutes from all sectors, especially education, health, employment, protection, social services, nutrition, water, and shelter. It provides an inter-sectoral, inter-ministerial lens to MHPSS coordination and reduces fragmentation to ensure all levels of the MHPSS Service Pyramid are prioritised and provided.

Prior to establishing an institutional framework, NDMA shall ensure widespread dissemination of the guidelines to all stakeholders, including ministries, NGOs, international agencies, and academic institutions. Priority shall be given to hold orientations for all relevant national level government ministries and bodies (as listed in Chapter 6, Table 6.1), and SDMAs along with State Health Departments. In turn, SDMAs shall disseminate the guidelines to all relevant stakeholders at the state level including DDMAs, ministries, NGOs, international agencies, and academic institutions.

The following institutional framework shall be established as part of preparedness activities.

National Level: The National Disaster Management Authority (NDMA), in coordination with the Ministry of Health and Family Welfare (MOHFW), shall establish a National MHPSS Working Committee for disasters.

State level: SDMAs in every State, in coordination with NDMA and their respective State Health Departments, shall establish a State MHPSS Working Committee for disasters.

The function of these committees is to coordinate and carry out the planning and management of the MHPSS activities before, during, and after a disaster. These guidelines establish the functioning

of the National and State MHPSS Working Committees at three levels of coordination:

1. Vertical Coordination: At this level, coordination activities flow from national-level administrative bodies to state-level bodies, or from state-level to district-level or local-level bodies,

2. Horizontal Coordination: This includes activities and actions between administrative bodies that are at the same level. This includes coordination between different ministries that share MHPSS goals in disasters, across sectors such as: Disaster Management (NDMA; Ministry of Home Affairs)
   a. Health (Ministry of Health and Family Welfare)
   b. Education (Ministry of Education)
   c. Protection and Social Welfare (Ministry of Women and Child Development; Ministry of Social Justice and Empowerment),

3. Horizontal Intersectoral Coordination: This includes coordination and collaboration activities that occur between governmental bodies and non-governmental bodies (like local and national NGOs; private healthcare centres and educational institutes; and other international agencies)

These guidelines also specify a funding framework that the National and State MHPSS Working Committees can follow in order to allot funding for MHPSS activities.

4.1.1 National MHPSS Working Committee

Who forms the committee?

The National MHPSS Working Committee will be established by the National Disaster Management Authority of India (NDMA), in coordination with the Ministry of Health and Family Welfare (MOHFW). NDMA shall conduct a systematic mapping of key stakeholders (and key personnel within the different departments and organisations), and invite members of the various departments, institutes and organisations to form the committee. Further, NDMA shall orient all members to the National Disaster Management Guidelines for MHPSS in Disasters, and the purpose and functioning of the committee.

Who is part of the committee?

The committee shall be composed of permanent members and those who participate in committee meetings and activities on the basis of the agenda at hand.

1. **Members:**
   a. **Chairperson:** The NDMA shall appoint an NDMA official as the Chairperson to serve as a liaison between NDMA and the committee as well as between the National MHPSS Working Committee and the State MHPSS Working Committees. They will coordinate and lead the National MHPSS Working Committee activities.
   b. **Members of Key Government Ministries:** The National MHPSS Working Committee will consist of appointed representative members from NDMA, and the MOHFW (especially the mental health division). It shall include designated representatives from the Ministry of Home Affairs, Ministry of Education, Ministry of Social Justice and Empowerment, and Ministry of Women and Child Development.

2. **Advisory Members**
    a. **Members of relevant government ministries:** Relevant personnel from ministries and government bodies like Ministry of Minority Affairs, Ministry of Human Resource Development, and Ministry of Information and Broadcasting shall also be invited for relevant meetings. Additionally, members can coordinate with and assign activities to these departments.

3. **Invited Experts**
    a. **Educational, Research, and Healthcare Institutes:** Individuals from the centre of excellence, partner educational institutes, and other research and healthcare institutions shall be invited to advise the committee on key priorities and planning.Additionally, the committee shall assign specific institutes the responsibility of planning and carrying out specific actions. The National Institute of Disaster Management (NIDM) and the national nodal institute for MHPSS in disasters are key institutes that shall be involved in the committee functioning.
    b. **NGOs and other international agencies:** The committee shall also invite individuals from local and national NGOs and other international agencies with specialised domain knowledge to advise and contribute to MHPSS planning and response activities.
    c. **Professional societies:** Professional societies shall be invited for specific meetings based on the agenda.

4. **State Members**
    a. **State MHPSS Working Committee Members:** The National MHPSS Working Committee will conduct meetings with members of the State MHPSS Working Committee.
        i. For national-level disasters, representatives from all the State MHPSS Working Committees will be invited.
        ii. For disasters occuring in a particular state or covering multiple states, relevant members of the State MHPSS Working Committee will be invited.

Scope of the committee

The National MHPSS Working Committee is responsible for the pre-disaster and post-disaster activities that occur at the national level, as well as those that affect more than one state. Further it shall support the State MHPSS Working Committee with MHPSS disaster activities at the state level.

Functioning of the committee

- NDMA shall clearly outline and communicate directives about the committee's functioning, including scope, composition, roles and responsibilities, frequency of meetings, key priorities and timeline.
- The committee shall convene every quarter. More frequent meetings shall be organised on an as-needed basis.
- The committee will organise regular meetings with the State MHPSS Working Committees to apprise them of decisions and plans of the National MHPSS Working Committee.
- The Committee will involve other advisory members and experts as needed to ensure MHPSS activities are carried out in a coordinated manner.

Responsibilities of the committee

The committee is responsible for the activities listed below. Details of these responsibilities are

further elaborated in the guidelines in the relevant sections.

1. **Institutional framework**
   a. The committee shall orient State MHPSS Working Committee members to the National MHPSS Guidelines for disasters.
   b. The committee shall build on the implementation checklist provided in these guidelines (Section 4, Chapter 12) to develop a National MHPSS Action Plan and carry out MHPSS activities for a period of 3 years. The plan should include concrete timelines for actions, cover all domains mentioned in these guidelines and cover the activities to be taken across all phases of the disaster. The template for the plan is provided below in Table 4.1. The committee will establish mechanisms to monitor and review its progress every six months.
   c. The committee shall provide support for States to develop State MHPSS Action plans by adapting the guidelines to their particular context.
   d. The committee shall establish linkages between major stakeholders (between two or more states, between national and state bodies, between private and public actors) to avoid duplication of work, and to ensure multisectoral coordination of MHPSS response at a national level.
   e. The committee shall, in coordination with the State MHPSS Working Committees, set timelines for planning and executing of pre and post-disaster activities in all States.
   f. The committee shall provide administrative and financial support for States to implement MHPSS disaster activities, identify key experts to support or carry out activities, monitor progress, and coordinate all national preparedness and response activities.

2. **Legal and Policy Framework**: The committee will create a task force responsible for identifying and executing the process of updating existing national policies, acts, rules and regulations to align them with the mandates outlined in this guideline.

3. **Funding Framework:** The National MHPSS Working Committee is responsible for planning and accessing the funding available in the National Disaster Mitigation Fund and the National Disaster Response Fund for MHPSS activities at a national level. Further it shall outline a protocol for, and share clear information with SDMAs and State MHPSS Working Committees about the process to access relevant funding from national and state funds. Further details are provided in Section 4.1.3 of this chapter.

4. **Assessment:** The committee shall provide support to the State MHPSS Working Committees with conducting pre and post-disaster assessments. Further it shall build on the keys provided in Chapter 5, Section 5.2.1 (Steps 9-11) and provide a standardised operationalisation of levels of vulnerability, capacity, and impact that will be used by States in assessment, interpretation and reports to estimate levels of vulnerability, MHPSS capacity, and impact of disasters.

5. **Capacity-building**
   a. **Human Resources:** The committee shall, in coordination with NDMA, mandate the development and conduction of training programs for actions at all levels of the MHPSS Training and Capacity Building Pyramid. This shall be done in partnership with MOHFW, NIDM, and other partner organisations. Further, it shall ensure dissemination of the training curriculum amongst States and provide them with support in translation, adaptation, and conduction of the training.

b. **Technological Infrastructure:** The Committee shall set up, collate, and manage the National Centralised MHPSS Portal for disasters.
c. **Institutional, Organisational, and Material Infrastructure:** The committee shall coordinate with NDMA and the Ministry of Health and Family Welfare to involve the nodal centre and other partner organisations in disaster MHPSS activities. The committee shall, in coordination with relevant educational bodies, ensure the inclusion of topics like mental health in disaster situations in educational courses.

6. **Service Delivery:** In disasters at a national level, the committee will coordinate the development and dissemination of key messages and IECs (Information, Education, Communication) about MHPSS.

7. **Research:** The National MHPSS Working Committee will take efforts to encourage disaster mental health research in an ethical manner. The Committee shall plan and allocate funding for systematic reviews and meta-synthesis (quantitative and qualitative) of progress and work in various areas of disaster mental health research since the publishing of the previous guidelines (2009 onwards).

8. **Monitoring, Evaluation, Accountability and Learning:** The Committee shall set up mechanisms to ensure monitoring and evaluation of all capacity-building and service-delivery actions at a national level. The Committee shall also ensure that State MHPSS Working Committees set up mechanisms for ensuring monitoring and evaluation of all MHPSS activities conducted at the state level. Further, the committee shall set up a protocol for independent and fair handling of any reports about ethical malpractice in MHPSS activities. An accessible mechanism by which all citizens and organisations in India, regardless of their status, can report such malpractice to the Committee.

4.1.2 State MHPSS Working Committee

Who forms the committee?

All State Disaster Management Authorities (SDMAs) shall establish a State MHPSS Working Committee in their respective States. This shall be done in coordination with NDMA and the National MHPSS Working Committee.

Who is part of the committee?

The State MHPSS Working Committee will have a similar constitution as the National MHPSS Working Committee. It will include:

1. **Members:**
   a. **Chairperson:** The SDMA shall appoint an SDMA official as the Chairperson to lead activities within the committee. This member shall also serve as the liaison between the SDMA, the National MHPSS Working Committee, and the State MHPSS Working Committee.
   b. **Members of Key State Government Ministries:** The committee will consist of appointed representative officials from the SDMA along with support from the Mental health division at the State Health Departments. Key officials from the State Home Department, State Health Department, State Department of Medical Education, , State Department of Education, State Social Justice Departments, and State Women and Child Development Department will also be part of the committee. SDMAs shall coordinate with NDMA and

identify key departments to be included.

c. **DDMA Officials:** The SDMA shall identify and appoint MHPSS representatives at the district level. These officials will be the focal point to coordinate MHPSS activities at the district level.

2. **Advisory Members**
   a. **Members of relevant government ministries:** Relevant personnel from State departments and government bodies will be included. These will be similar to those at the National level

3. **Invited Experts:**
   a. **Educational, Research, and Healthcare Institutes:** Identified state educational (and specially mental health) institutes, research, and healthcare institutes shall be invited to contribute to committee activities, provide expertise in planning and carrying out activities on invitation.
   b. **NGOs and other international agencies:** NGOs and other global organisations and international agencies working within the State will also be invited based on expertise to participate in committee activities.
   c. **Professional societies:** State professional societies can also be invited by the committee to contribute their expertise.

Scope of the committee

The State MHPSS Working Committee is responsible for the planning and coordination of MHPSS activities relevant to all disasters that occur within the State. It is also responsible for the planning and coordination of MHPSS activities within that particular State for all disasters that occur at a national level.

Functioning of the committee

The State MHPSS Working Committee will function similarly to the National MHPSS Working committee:

- SDMAs, with support from NDMA, shall clearly outline and communicate directives about the committee's functioning, including scope, composition, roles and responsibilities, frequency of meetings, key priorities, and timeline.
- Meetings shall be held at least once every quarter. More frequent meetings shall be organised based on identified needs and phase of disaster.
- The committee will organise regular meetings involving DDMA officials to convey decisions and updates, as well as to take updates and provide support for district activities.
- Advisory members and experts will be involved in committee activities as needed.

Responsibilities of the committee

The State MHPSS Working Committee shall carry out the following functions:

1. **Institutional Framework**
   a. The committee will clearly outline its priorities and agenda every year. It will establish mechanisms to monitor and review progress every 6 months.
   b. The committee shall adapt the National MHPSS Guidelines to make it relevant to their State, by developing a State MHPSS Action Plan for disasters. This shall involve tailoring the frameworks outlined within these guidelines to the State's context. It shall adapt the

template for the MHPSS Action Plan (In chapter 4, Table 4.1), and refer to the National MHPSS Action Plan to develop the State MHPSS Action Plan.

c. The committee will coordinate identification of DDMA officials as nodal MHPSS Representatives for disaster MHPSS activities in each district of the state.

d. The committee will orient relevant SDMA, DDMA, and government officials; personnel from NGOs and other international agencies; educational institutes; and other stakeholders to the guidelines and priorities identified at the national and state level.

2. **Legal and Policy Framework:** The committee will create a task force responsible for identifying and executing the process of updating existing state policies, acts, rules and regulations to align them with the mandates outlined in this guideline.

3. **Funding framework:** The State MHPSS Working Committee is responsible for planning and allocating funds from the State Disaster Mitigation Fund and the State Disaster Response Fund for MHPSS activities at a state level. With support from the National MHPSS Working Committee, it shall access the funding available and allot funding for MHPSS activities across all phases of the disaster.

4. **Pre-disaster assessment:** The committee will organise the conduction of the pre-disaster assessment of MHPSS vulnerabilities and capacities within their States. It is encouraged that this is conducted at the district level. However, if there are time and resource constraints, this shall be conducted at the State level. The committee will incorporate findings and recommendations from the pre-disaster assessment of MHPSS vulnerabilities and capacities into the State MHPSS Action Plan. This information will be shared with DDMAs and officials at the district level to implement activities.

5. **Capacity-building**
   a. **Human Resources:** The committee will identify gaps and develop training as part of preparedness for disasters. Further, it shall translate the training curriculum into local languages and adapt existing capacity building and training content to the cultural context of their State. It will conduct training in coordination with DDMAs. Experts shall be identified and involved in the development and implementation of training activities.
   b. **Technological Infrastructure:** The committee will ensure coordination and inclusion of state information on the National MHPSS portal. This includes liasing with state mental health authorities (SMHAs) and regional bodies to encourage registration of state mental health professionals on the centralised MHPSS portal. The committee will ensure the identification and set up of at least one helpline providing MHPSS services in the State.
   c. **Institutional, Organisational and Material Infrastructure:** The committee will mandate the development of education courses and curriculum. This will be done in coordination with centres of excellence and other relevant institutes.

6. **Research:** The committee will encourage various stakeholders to conduct disaster mental health research by allocating grants for disaster mental health research.

7. **Post-disaster assessment:** Shortly post the disaster, the committee will coordinate the conduction of a rapid assessment to identify needs of the community, outline available resources, and current gaps. The committee shall also coordinate the conduction of an extended post-disaster assessment as per a suitable time. The committee will also ensure documentation of the assessment and uploading of reports of all assessments conducted to the centralised MHPSS portal.

8. **Service Delivery:**
    a. The committee will adapt the existing plan or develop a plan for MHPSS service delivery within larger disaster response activities. This should be done for all stages of post-disaster i.e. during response, recovery, rehabilitation and reconstruction. The plan should be flexible and adapted to changing needs based on the situation.
    b. The committee will plan and coordinate resource allocation for services and activities.
    c. The committee will support DDMAs and district-level administration to coordinate service delivery at all levels of the MHPSS service pyramid.
    d. The committee will liaison with relevant government bodies/ departments and other actors (NGOs, international agencies, hospitals and health centres, mental healthcare facilities, educational institutes, service providers) to carry out all activities in a consolidated and synchronised manner.
    e. The committee will also ensure documentation of service delivery.
    f. The committee will coordinate information for the media and other relevant government bodies to disseminate.

9. **Monitoring, Evaluation, Accountability and Learning:** The Committee shall set up mechanisms to ensure monitoring and evaluation of all capacity-building and service-delivery actions conducted at state level. The committee shall set up a protocol for independent and fair handling of any reports about ethical malpractice in MHPSS activities occurring within the state. An accessible mechanism shall be established by which all citizens and organisations in the state, regardless of their status, can report such malpractice to the Committee. The Committee shall also specify a protocol for when the handling of such reports may need to be escalated to the National MHPSS Working Committee (for example, ethical malpractice by an organisation in multiple states).

Table 4.1: Template For A MHPSS Action Plan

All relevant stakeholders at the national, state, and district level shall orient themselves to the National Disaster Management Guidelines for MHPSS in Disasters. Further, the National and State MHPSS Working Committees shall develop a national level and state-specific MHPSS Action Plan respectively for a timeframe of the next 3 years. The National MHPSS Working Committee shall use the template given below to develop a MHPSS action plan. The State MHPSS Working Committee shall develop the State MHPSS action plan referring to this template, and the action plan developed by the National MHPSS Working Committee. The action plans shall be informed by and include details from pre-disaster assessments of MHPSS vulnerabilities and capacities (especially information on vulnerability to disasters, burden of mental disorders, vulnerable populations, available social security schemes, available resources and gaps in the government, private, NGO sector). The implementation checklist (Chapter 12) shall also be utilised in developing the plans. Extensive, concrete details to include on operations and activities are provided in the relevant chapters: assessment (chapter 5 and 8), capacity building (chapter 6), research (chapter 7), service delivery (chapter 9), support service providers (chapter 9), and monitoring and evaluation (chapter 11). A template for the plan is as follows:

1. Dated title page with record of changes
2. Signature page for official purposes
3. Table of contents
4. Scope and objectives of the plan
5. Timeframe of the plan
6. Overview of operations and activities including National/State-level activities for:

a. Assessment
b. Capacity-building
c. Research
d. Service delivery
e. Supporting service providers
f. Monitoring and evaluation

7. Roles and responsibilities of various stakeholders in planning and implementing activities
8. Details of funding and the budgetary actions
9. Specific timelines for activities specified above

** This is a template of broad themes that need to be covered. It shall be adapted as per need.*

4.1.3 Funding Framework

Under the XVth Finance Commission recommendations, the National Disaster Risk Management Fund (NDRMF) and State Disaster Risk Management Fund (SDRMF) have been established for disaster activities at the National and State level respectively. Funds within the NDRMF are further earmarked as 80% for response related activities under the National Disaster Response Fund (NDRF) and 20% for mitigation activities under the National Disaster Mitigation Fund (NDMF) at the national level. This is replicated at the state level too, with the SDRMF organised as 80% for the State Disaster Response Fund (SDRF) and 20% for the State Disaster Mitigation Fund (SDMF).

Both the National and State Disaster Response Funds further apportion funds into the following windows: 10% is allocated for preparedness and capacity building activities, and emergency response facilities; 40% is reserved for response and relief disaster activities; and 30% is allotted for recovery and reconstruction activities.

Funds for disaster activities are also available through CSR and other grants by private sector organisations and international aid agencies.

1. NDMA shall ensure allocation of both NDRF and NDMF for MHPSS activities at the national level. Similarly, SDMAs shall organise and ensure allocation of funds from the SDRF and SDMF for disaster activities in their respective states.
2. NDMA and SDMAs shall include details of fund allocations for MHPSS activities within their annual budget.
3. The National MHPSS Working Committee and State MHPSS Working Committees shall make a budget and plan utilisation of funds for MHPSS activities at the national and state level respectively.
   a. MHPSS activities that occur prior to a disaster, such as pre-disaster assessments, training and capacity-building, planning of monitoring and evaluation, and research at a national and state level, shall be allotted funds from the NDMF and SDMF.
   b. MHPSS activities that occur once a disaster has occurred, such as the post-disaster assessments, service delivery, research, and monitoring and evaluation shall be allotted funds from the NDRF and SDRF. A minimum amount shall be earmarked for the same, with more detailed planning and allocation done, based on the scale of the disaster and the need for MHPSS.
   c. Details of this shall be included within the National and State MHPSS Action Plan.

Further, the National MHPSS Working Committee and State MHPSS Working Committees shall establish mechanisms to monitor and report utilisation of the funds allotted.

4.1.4 General Principles for a Coordinated Institutional Framework

For National and State MHPSS Working Committees to coordinate effectively, they shall function based on the following principles:

- **Shared responsibility with clear allocation of roles and responsibilities** to various stakeholders to avoid duplication and fragmentation of efforts.
- **Mutual cooperation and pro-information sharing** policy amongst the various stakeholders.
- **Agreement on and accountability towards common goals** despite differences in sectors. All participants shall strive to include MHPSS within activities in their sector.
- **Collective ownership** with linkages to other relevant sectors and ministries (especially between health, education, and protection, food, shelter, water, and sanitation) to coordinate MHPSS activities. This also includes the involvement of the wider community and civil society in activities.
- **Cultural and contextual sensitivity** in the planning, coordinating, and carrying out of all MHPSS activities, especially by accounting for the needs of vulnerable groups.

4.2 Legal and Policy Framework

This guideline builds upon the directives on legal and policy frameworks outlined in the preceding iteration of the guidelines[1]. MHPSS disaster preparedness and response activities should be integrated into national, state, and district policies, plans, programmes, and strategies. Governments shall ensure that MHPSS is mainstreamed across all sectors, especially through legal and policy instruments.

To do so, the National and State MHPSS Working Committees shall establish a task force at the national and state level respectively. The task force shall be responsible for identifying and reviewing alignment of existing policies, acts, rules, and regulations with the guidelines. The following actions shall be taken:

- MHPSS shall be included within the NDMA Minimum Standards of Relief during Disasters.
- Mental health and psychosocial support shall also be integrated within all guidelines and policies pertaining to disaster planning and management. This shall be based on information and recommendations from research, past experiences, and information about risks in the country. Further it shall take into account the culture and values across the country.
- All National, State, and District Disaster Management Plans shall incorporate MHPSS activities across all the domains (i.e. coordination, assessment of MHPSS vulnerabilities and capacities, capacity building, service delivery, research, and monitoring and evaluation)
- Clear linkages shall be established to integrate MHPSS disaster preparedness and response activities within the existing health and mental health structures in the country (e.g. NMHP, DMHP, National Rural Health Mission, National Urban Health Mission)

References

[1]National Disaster Management Authority, Government of India. National Disaster Management Guidelines, Psychosocial Support and Mental Health Services in Disasters, 2009

05 Pre-disaster Assessment of MHPSS Vulnerabilities and Capacities

5.1 Overview of MHPSS Assessment across the Disaster Management Cycle

5.1.1 Reference Models Of Assessment

MHPSS assessment occurs in all phases of a disaster, right from preparedness to relief, response, and rehabilitation activities. It provides concrete information on important data points such as available resources, the needs of the community, the community profile, the risks to the community, as well as gaps in existing systems, that can inform MHPSS actions. These guidelines introduce an assessment model based on a comprehensive review of various concepts and models including disaster risk reduction, Bronfenbrenner's Socio-ecological Model, Strategic Toolkit for Assessing Risks (STAR, World Health Organisation)[1], Assessing Mental Health and Psychosocial Needs and Resources: A Toolkit for Humanitarian Settings (WHO and UNHCR)[2], as well as IASC Reference Group Mental Health and Psychosocial Support Assessment Guide (IASC)[3].

5.1.2 Model For Assessment Of MHPSS Vulnerabilities And Capacities Across Disaster Phases

This guideline introduces a comprehensive assessment model that tailors the assessment to gather specific data and information related to mental health and psychosocial support during the different stages of a disaster: preparedness; response; and recovery, rehabilitation and reconstruction phases.

The assessment streamlines the collection of data indicators and effectively distinguishes between capacities and vulnerabilities. The terminology of 'vulnerabilities' and 'capacities' has been employed instead of 'needs' and 'resources' to establish a linkage between the fields of DRR and MHPSS.

Table 5.1 illustrates the assessments to be conducted in different disaster phases (preparedness, response, and recovery/ rehabilitation/ reconstruction) to gather information on the 2 domains: vulnerabilities and capacities of the district or state.

Table 5.1: Assessments In Each Disaster Phase

Domain Of Assessment	Preparedness	Response (Relief And Rescue)	Recovery, Rehabilitation And Reconstruction
Vulnerability			
Information is gathered on the	Through the pre-disaster	Through a rapid post-disaster assessment*	Through an extended post-disaster assessment at

psychosocial problems faced by individuals and the community	assessment	at the community level (for local-level disasters) and the state level (for state or national-level disasters)	the community level (for local-level disasters) and state level (for state or national-level disasters)
Information is gathered on the incidence and prevalence of emotional distress, trauma responses and mental disorders in the community as well as exposure to the disaster (bereavement, injuries, hospitalizations, displacement)	Through the pre-disaster assessment	Through early identification*. This is carried out for the purpose of service delivery, and making appropriate referrals. Further, this information is documented. Diagnosis and epidemiology is not expected at this stage. Early identification for vulnerable and at-risk groups shall be prioritised.	Through early identification and diagnostic assessment. This may be part of an epidemiological research study as well.
Capacity			
Information is gathered on what resources are available to individuals and the community, including availability of trained personnel	Through the pre-disaster assessment	Through a rapid post-disaster assessment* at the community level (for local-level disasters) and state level (for state or national-level disasters)	Through an extended post-disaster assessment at the community level (for local-level disasters) and state level (for state or national-level disasters)
**Priority assessments for states if resources for pre-disaster assessment are not available*			

Each disaster phase will have differing requirements and priorities with respect to MHPSS actions and activities. Correspondingly, the information gathered in the assessment of vulnerabilities and capacities will be tailored to the needs of the population in the specific disaster phase in which the assessment is conducted. Table 5.2 elaborates on the information to be collected prior to the disaster, immediately post the disaster and long-term post the disaster.

Table 5.2: Broad Aims Of Assessment In Each Disaster Phase

	Pre-Disaster Assessment (Preparedness)	Rapid Post-Disaster Assessment (Response)	Extended Post-Disaster Assessment (Recovery, Rehabilitation And Reconstruction)
Model for assessment	MHPSS Assessment of Vulnerabilities and Capacities		

Examples of key themes assessed	Social determinants of MHPSS in the community. The status of informal and formal services for MHPSS in the community. Socio-cultural beliefs, attitudes, and norms relating to MHPSS. Past humanitarian context of the community	Main sources of distress post the disaster. The mental health impact of the disaster. Damage to mental health and psychosocial resources and capacities post the disaster. The most vulnerable groups post the disaster	Problems and sources of distress that continue post the disaster. The continued and long term mental health impact of the disaster. Evaluation of MHPSS response in the disaster.

5.2 Pre-Disaster MHPSS Assessment Of Vulnerabilities And Capacities

While assessment of vulnerabilities and capacities occurs in all phases of a disaster, a proactive approach to preparing for disasters and reducing their impact on mental health and wellbeing involves the essential step of pre-disaster assessment of vulnerabilities and capacities in communities, and taking stock of all relevant available resources. This has been elucidated as a priority in the Sendai Framework too, which highlights that knowledge of vulnerability, capacity, exposure, hazard characteristics, and the environment should inform prevention, mitigation, and preparedness activities.

A comprehensive assessment acts as a clear, strategic, evidence-based process to document the vulnerabilities and capacities of a particular area and community. It provides a solid base and direction to governmental and non-governmental actors for planning and implementing MHPSS capacity building actions prior to a disaster by identifying mental health needs of the community as well as resources available. Further, it can assist in identifying existing barriers to accessing MHPSS services, and improve awareness and sensitisation about MHPSS for all stakeholders involved.

The information collected should include identifying:

- The types of hazards likely to occur in the area (hazard identification/ hazard profile).
- The psychosocial vulnerabilities and main sources of distress of the community in the area.
- The current capacities and resources of the community that can support them in overcoming or managing the psychosocial impact of the disaster.
- The overall impact on the mental health and wellbeing of the community in the event of the disaster occurrence.

This activity should be conducted routinely with the purpose of using information on the current status of needs, gaps, and available resources; to identify priorities in actions; and further develop and update disaster plans and activities. Some guiding principles for conducting MHPSS assessments are described in Table 5.3[4].

Table 5.3: Guiding Principles for Conducting MHPSS Assessments

1. Assessments should be designed with the primary purpose of forming the basis of action, and should not be viewed as merely an information collection exercise.
2. Assessment teams should coordinate with all stakeholders in the area to avoid duplication of efforts and repetition of questions to community members. There needs to be active efforts to identify and include already available information.
3. Assessments should be targeted and timely in nature.
4. Assessment teams should plan data collection keeping in mind the current situation, levels of conflict and crisis in the community. It is imperative to maintain neutrality, avoid escalating tensions, and taking measures to maintain the safety of participants and the team.
5. Measures should be taken to collect consent to participate, and ensure the privacy and safety of participant information both during the assessment and in data storage.
6. Assessment teams should be sensitised to the local culture, and include in their teams people who are familiar with the local population. Further, assessment methods, tools, and language used should be culturally relevant to the community being assessed.
7. Assessment should maintain flexibility in its process; and balance quick, practical collection of information with attending to the complex cultural nuances and socio-cultural reality of the community.
8. The assessment should ensure equal opportunity to participate, especially taking measures to include the views of those groups whose views are less likely to be captured (e.g. children, women, elderly, DBA people, gender and sexual minorities, religious minorities etc).
9. Finally, the assessment should be considered a living document with efforts made to revise and update it to capture changes in the situation.

The model introduced in these guidelines outline conducting an assessment of MHPSS vulnerabilities and capacities in the pre-disaster phase at the district or state level. The broad domains which the pre-disaster assessment of MHPSS vulnerabilities and capacities focuses on include:

Vulnerability: This includes information on the psychosocial problems faced by individuals and the community.

1. Includes information on the identification of pre-existing emotional distress, trauma responses and mental disorders present in the community

Capacity: This includes information about the resources available to individuals and the community, including availability of trained personnel.

5.2.1 Process of Conducting the Assessment

The steps to conduct the pre-disaster assessment are as follows:

Step 1: Review and gain familiarity with the information template for the pre-disaster assessment.

The team shall review and familiarise itself with the template for the information to be collected in the pre-disaster assessment (Table 5.4).

This template is also used for post-disaster assessments with modifications as per the timing of the assessment. While some of this information may be already available and can be accessed through a literature review, other information may be unavailable, and new data may need to be collected. Note that this information is collected and reported at the group or community level and it is not expected to collect individual-level data at this stage.

Table 5.4: Information To Be Collected For The Pre-Disaster Assessment

A pre-disaster assessment report shall be created, consisting of descriptions of the indicators below. This should be used as a template; and information can be collated based on feasibility and viability of data.

1. Clearly identify the **geographical area** that is being assessed (e.g. city, district, state or a local community)

2. Hazards

a. Describe the hazards that are likely to occur in that particular area.
b. Describe the likely scale (geographical area and population exposed to hazard), frequency, and seasonality of the hazard.
c. Describe the likely immediate and secondary MHPSS consequences of the different hazards (e.g. increased illness/ disability/ mortality leading to distress and bereavement reactions, forced displacement, economic and livelihood losses, potential trauma, distress and violence).

3. Social Determinants Of Mental Health

a. Describe the socio-demographic context of the area being assessed:
   i. Overall population size
   ii. Gender and age distribution
   iii. Gender and sexual minorities
   iv. OBC, SC and ST population size
   v. Persons with disability population size
   vi. Languages spoken
b. Describe the educational context of the area being assessed:
   i. Formal education levels and literacy rates
c. Describe the occupational context of the area being assessed:
   i. Main livelihoods of people
   ii. Unemployment rate
d. Describe the economic context of the area being assessed:
   i. Poverty rate
   ii. Income distribution
   iii. Land ownership
e. Describe the health context of the area being assessed:
   i. Common diseases
   ii. Malnourishment rates
   iii. Morbidity and mortality rates
   iv. Communicable diseases (including endemic diseases and epidemic prone diseases)
   v. Non-communicable diseases
f. Describe the familial and gender context of the area being assessed:

i. Family structure distribution in the area (e.g. nuclear, joint, single-parent) and average number of children and elders per household
ii. Prevalence of gender-based violence
iii. Prevalence of substance use

g. Describe the government context of the area being assessed:
   i. Describe the organisation of the state, district and local government in the area.
   ii. Describe the political initiatives for MHPSS as well as developmental schemes and programmes targeting social determinants of mental health in the area.
   iii. Inputs on CBOs and NGOs (especially those working in the domain of mental health)
h. Identify the most socially and occupationally vulnerable groups in the area (age/ gender/ religious/ sexual minorities, persons with disabilities, including mental health and neurodevelopmental concerns, SC/ST groups)

4. Mental Health and Psychosocial Context

a. Describe the prevalence of emotional distress, trauma responses and mental disorders in the area
b. Describe the role of informal and community-based services for MHPSS in the area (e.g. informal social, religious and community-based groups and infrastructure for MHPSS in the area)
c. Describe the role of the formal MHPSS services in the area
   i. Describe the human resources (level of trained personnel at Level 1, 2, 3 and 4) available in the area. Identify in which institution/organisation are these trained personnel located and the readiness of these personnel for deployment.
   ii. Describe the technological resources (helplines and teleconferencing capacities) available in the area.
   iii. Describe the institutional, organisational and material resources (number of healthcare institutions with functioning MHPSS capacities) available in the area. Describe the status of these services (availability, accessibility, rates of use, quality).
   iv. Describe the residential and rehabilitative services for people with disabilities and mental disorders available in the area.
   v. Describe the role of the educational sector, social sector, non-allopathic health system and private sector in MHPSS services in the area.
d. Describe the socio-cultural beliefs, attitudes and norms relating to MHPSS in the community:
   i. Local explanatory models, beliefs, attitudes towards emotional distress and mental disorders
   ii. Help-seeking behaviours and preferences for formal and informal health systems;
   iii. Help-seeking behaviours and preferences for allopathic and alternative healing practices

5. Describe the **humanitarian context** of the area being assessed:
   a. Past disasters experienced and their impact on the community
   b. Experiences with past humanitarian aid (MHPSS and non-MHPSS related)

Step 2: Conduct a literature review of all available data.

This method is low resource intensive, and involves collating and synthesising pre-existing information for as many aspects as possible from Table 5.4. It is important to verify the sources

of data, and identify and ensure representation of information for the community as whole. A scoping of academic literature; and review of data from epidemiological studies, systematic reviews, or annual reports are some useful sources. Some other common sources of governmental data in India include the National Mental Health Survey, Sample Registration System by Office of Registrar and Census Commissioner, Health Index by Niti Aayog, Composite Disaster Risk Index by MHA and UNDP Report: Disaster Risks and Resilience in India, Census, National Non-communicable Diseases Monitoring Survey, National Family Health Survey, State disaster management plans, and Annual Reports by disaster agencies, MOHFW, and State Health Departments.

Step 3: Contact all relevant stakeholders to gain more existing data and collate it.

In this step, there is a synthesis of information from secondary sources and supplementary information through requests for resources (outside the public domain). This includes gathering information from government bodies and ministries, relevant local, national, and international NGOs, and experts from academic and research institutions. Information can also be collected from interviews with relevant government officials, health and allied health coordinators, and MHPSS/health services programme managers, and mental health service providers. It is important to include organisations specifically aimed at persons with disabilities and other vulnerable groups here. Additionally, disaggregated data should be requested where available. A day-long workshop can be facilitated with expert stakeholders to gather information and collate resources.

Step 4: Summarise all data collected.

Prepare a summary of existing data gathered at step 1 and step 2. Further, identify domains that require additional information.

Step 5: Identify information areas for additional data collection.

Based on the process of synthesis of existing information and identification of gaps in the domains, outline objectives for further data collection collaboratively as a team.

Step 6: Select data collection methods and process.

Select methods of data collection (quantitative or qualitative tools like surveys, questionnaires, key informant interviews, group interviews; inclusions of questions in existing health or nutrition assessment and household surveillances), the facilitator (who will facilitate or conduct interviews) and the target members of the community (e.g. who will provide the data).

Methods need to be age, gender and disability sensitive (i.e. do not include only he/she; ensure accessibility at location). Care should be taken such that language and method of administration is appropriate. Additionally, interviewers should be trained in administering these specific questions about the culture of the community. This method requires advocacy with and support from relevant ministries or organisations and is likely to take a longer time to conduct.

Some tools for collecting new information include those given below in Table 5.5. Other tools that can be utilised are tools used to conduct the National Mental Health Survey. Assessors must develop a clear plan and identify what data collection method and tools are best suited for their context. For more detailed information, readers can refer to WHO and UNHCR's Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings and IASC Reference Group Mental Health and Psychosocial Support Assessment Guide.

Table 5.5: Tools for collecting new information: pre-disaster assessment of MHPSS[6]			
Tool Name	**Objectives**	**Constructs Measured**	**Method**
Participatory assessment: Perceptions by general community members	Mental Health and Psychosocial Context: To gain information about the different types of problems and resources in a community from general community members	Free listing of all concerns; in-depth exploration of mental health-relevant concerns around social relationships, thoughts, feelings, behaviours, coping methods, and impact on daily functioning	Interviews with general community members
Participatory assessment: Perceptions by community members with in-depth knowledge of the community	Mental Health and Psychosocial Context: To interview community members who are expected to have in-depth knowledge of the affected community	Questions on sources of distress; causes, consequences and impact; most at-risk groups; distress in children, women and men; death and mourning; people in the community with mental disorders; sexual abuse; substance use	Key informant interviews
Participatory assessment: Perceptions by severely affected people	Mental Health and Psychosocial Context: To gain more in-depth information about local perspectives on problems and coping	Free listing, probing for social and psychological distress, impact on daily life, support, and coping	Interviews with severely affected people
4 Ws Tool. Who is Where When Doing What.	Informal and community-based MHPSS services, Formal MHPSS services: To identify MHPSS resources that are available across sectors	Codes for various MHPSS activities that an organisation may be doing	Interviews with service managers Filling out spreadsheet based on interviews
NIMHANS Resource Mapping Tools (Psychosocial Preparedness Module)[7]	Informal and community-based MHPSS services, Formal MHPSS services: To involve community members in the mapping of resources available in the community	Free listing of available resources, discussing possible usages of available resources, and ways to strengthen available resources	Facilitation of a workshop; using activities and tools such as orientation, transect walk, picturing the resource, discussion, corrective feedback, designation; and documentation.

Template to assess mental health system formal resources in humanitarian settings	Formal MHPSS services: To identify gaps in formal mental health services	Information about patients, staff, impact of crisis from IP and OP psychiatric facilities, other psychological treatment centres like NGOs, residential facilities, general hospitals, PHCs, community services	Secondary data from review of documents, interviews with service managers

Step 7: Set a timeline for data collection.

Decide a timeline to collect the data based on the objectives and ensure data collection is completed within the timelines outlined.

Step 8: Synthesise data gathered.

The assessment team meets to review and synthesise all the data collected from literature review, expert stakeholders, and community stakeholders. To synthesise the data, the team collates the collected information, and identifies key vulnerabilities and key capacities of the target geographical area, in each category that information has been collected in.

Table 5.6 identifies possible vulnerabilities and possible capacities that are important to actively look for in the pre-disaster assessment. For example, if the information collected shows that the rate of unemployment is high in that particular area, it is an important vulnerability to identify in the category 'Social Determinants of MHPSS'. On the other hand, if there are development schemes that are successfully running in the area (for example, women's cooperatives), it is an important capacity to identify. Hence, the State MHPSS Working Committee shall use the template below as a guide to identifying vulnerabilities and capacities. Note that not all vulnerabilities and capacities will necessarily be present for a particular area.

Table 5.6: Guide For Collating Information Into Vulnerabilities And Capacities

Factors Assessed	Possible Vulnerabilities	Possible Capacities
Social Determinants of mental health	• High unemployment rate • High levels of poverty • High morbidity and mortality rates • High malnourishment rates • High rates of gender-based violence • High rates of substance use • Significant number of people working in the informal sector without access to formal and collective rights, benefits, job security • Presence of ongoing conflict	• State and central welfare schemes available to people in the area (e.g. Niramaya scheme for health insurance) • Financial resources for emergency preparedness and contingency funding for disaster response are available

	between groups in the community (e.g. gang violence; religious conflict)	
Informal and community-based services for MHPSS	• Fragmentation of and hierarchies between groups in the community	• Presence of community-owned infrastructure and public spaces (e.g. community centres) • Presence of community leaders, citizens and social groups who are invested in MHPSS and/or willing to volunteer for MHPSS actions
Formal services for MHPSS	**Human Resource Vulnerabilities** • Inadequate number of trained personnel available at Level 1 (Psychosocial considerations in essential services and security), Level 2 (Family and community-based care), Level 3 (Focused, non-specialized supports) and Level 4 (Specialised services) in the state or district (if district-level data is available) **Technological Resource Vulnerabilities** • Lack of technological infrastructure or low network connectivity to run helplines • Low penetration of mobile phones and Internet services within the community **Organisational, Institutional and Material Resource Vulnerabilities** • Insufficient healthcare and educational institutions that have MHPSS capacities • Inadequate presence of charities, NGOs and INGOs with MHPSS capacities in the area • Inadequate or disorganised emergency services infrastructure (police, fire, ambulatory) • Absence of/ limited disaster resilient health infrastructure, especially those catering to specialised psychiatric services	**Human Resource Capacities** • Adequate number of trained personnel available at Level 1, 2, 3 and 4 of MHPSS Service Pyramid in the state or district and rapid coordination mechanisms for deployment in the case of a disaster. **Technological Resource Capacities** • Presence of state, national and organisational (both private and NGO sector) operational helplines • Presence of teleconferencing capacities in healthcare institutions with MHPSS capacities **Organisational, Institutional and Material Resource Capacities** • Adequate number of healthcare and educational institutions with functional MHPSS capacities • Charities, NGOs and INGOs with MHPSS capacities with an active or developing presence in the area • Strong emergency services infrastructure (police, fire, ambulatory) • Disaster preparedness activities that have previously occurred and are ongoing in the area (MHPSS and non-MHPSS) • State MHPSS Action Plan for disasters has been drafted

Socio-cultural beliefs, attitudes and norms relating to MHPSS	• Stigma towards mental distress and mental disorder • Reluctance to seek help	• Good outreach of key MHPSS messages that normalise mental distress and mental health
Humanitarian Context	• Collective and intergenerational trauma from lived experience of past disasters • Difficult experiences with past humanitarian aid	• Local know-hows and learning about coping with psychosocial problems and mental distress from the lived experience of past disasters, especially for vulnerable populations • Sense of community spirit, togetherness and prosocial attitudes

Step 9: Estimate level of vulnerability.

The team estimates the overall level of vulnerability of that particular geographical area using the Table 5.7

Table 5.7: Level of Vulnerability[8]

Score	Level of vulnerability	Description
5	Very high	The National MHPSS Working Committee shall define and operationalise each level
4	High	
3	Moderate	
2	Low	
1	Very low	

Step 10: Estimate level of MHPSS capacity.

The team estimates the overall level of MHPSS capacity of that particular geographical area to respond to MHPSS needs in disasters using Table 5.8.

Table 5.8: Level of Capacity[9]

Score	Level of capacity	Description
1	Very high	All coping capacities are functional and sustainable, and have been utilised under real conditions before
2	High	All coping capacities are available but have never been utilised under real conditions before
3	Moderate	Some coping capacities required for the hazard are available, but functionality and sustainability have not been ensured, such as inclusion in the operational plan of the national health sector with secure funding.

4	Low	Core coping capacities required for the hazard (human, material, strategic and financial) are in the developmental stage. Implementation has started with some attributes achieved and others commenced.
5	Very low	Core coping capacities required for the hazard (human, material, strategic and financial) are mostly or completely not available.

Step 11: Estimate overall MHPSS impact of possible hazards.

The team estimates the overall MHPSS impact of likely hazards for that particular geographical area using table 5.9:

Table 5.9: Level of MHPSS Impact

Score	Impact level	Description
1	Negligible	Very low vulnerability, Very high capacity, Very low hazard
2	Minor	Low vulnerability, High capacity, Low hazard
3	Moderate	Moderate vulnerability, Moderate capacity, Moderate hazard
4	Severe	High vulnerability, Low capacity, High hazard
5	Critical	Very high vulnerability, Very low capacity, Very high hazard

Step 12: Outline recommendations for actions.

Based on the above synthesis, the team proportionately identifies recommendations for actions in each category, organised in order of priority.
The team should aim to identify key implementable, specific actions based on the assessment, along with suggested timelines. Additionally, for each priority action, corresponding responsible ministries or organisations should also be identified. It is suggested that an estimated budget be included for each action as well.

Hence, the pre-disaster assessment report will consist of the following sections:

1. Aim and objectives
2. Assessment methodology (people involved, tools used, sampling, steps followed)
3. Findings:
    a. Information across 4 categories
        i. Clearly identify the geographical area being assessed
        ii. Details of hazard likelihood and scale
        iii. Details of social determinants of mental health
        iv. Details of the mental health and psychosocial context
        v. Details of the humanitarian context
    b. Key capacities and vulnerabilities should be identified within each of these categories
    c. Overall level of vulnerability, capacity and MHPSS impact
4. Recommendations and timelines, in order of priority, with roles and responsibilities identified
5. Limitations of the process
6. Summary and conclusion

Ideally, it is suggested that the report be sent to at least one expert stakeholder and one community stakeholder residing within that particular district/state for their comments and verification.

5.2.2 Dissemination of the Pre-Disaster Assessment Findings

An important aspect of conducting the assessment is to translate it into actions to be carried out as part of the State MHPSS Action Plan. Hence, the pre-disaster assessment report should use non-technical, easy language, and be proactively shared with all relevant stakeholders, including state government actors involved in disaster response, as well as community members. This report should also be uploaded onto the centralised MHPSS portal. The pre-disaster assessment report should also be summarised and incorporated into the State MHPSS Action Plan.

5.2.3 Coordination of the Pre-Disaster Assessment

- The planning and implementation of regular pre-disaster assessments of vulnerabilities and capacities shall be coordinated by the State MHPSS Working Committees, with technical and administrative support from the National MHPSS Working Committee.
- The State MHPSS Working Committee shall take administrative and funding decisions to initiate the pre-disaster assessment and establish the team to conduct it. If there are any other pre-disaster assessments planned in the state (e.g. an HRV analysis), the MHPSS assessment can ideally be integrated with other assessments. The team, in coordination with the State MHPSS Working Committee, will develop the assessment plan, scope, and frequency.
- Additionally, based on the current climate, time constraints, and availability of resources, the committee will plan conduction at a district or state level.
    - Ideally, the assessment should be conducted at the district level by a team visiting each district. If a city has a population of over 10 million (like Mumbai, Delhi, Kolkata), its data can be disaggregated and a separate report prepared.
    - If there are not enough resources to do a district-level assessment, the assessment can be done at state level. If the assessment is done at state level, care shall be taken to ensure adequate coverage of districts and representations from various communities and vulnerable groups in data collection.

5.2.4 How Often Should the Pre-Disaster Assessment be Conducted?

The assessment should be updated once every 3 years to include any change in risk status, monitor progress in implementation of actions to bridge the previously identified gaps, and update existing plans[10]. Further, the following special circumstances may require an update of the MHPSS assessment outside of a routine schedule:

- Significant change in the parameters used in the assessment (which may require an update of just the specific section or overall)
- An emergency or disaster occurrence
- Sudden forced displacement or change in the socio-demographic characteristics of the concerned population.

References

[1]World Health Organization. Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment.

[2]World Health Organization. Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings. World Health Organization; 2012.

[3]Inter-Agency Standing Committee. Mental Health and Psychosocial Support Assessment Guide. Geneva, Switzerland: IASC 2013.

[4]These guiding principles are summarised from: World Health Organization. Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings. World Health Organization; 2012.

[5]This table is adapted with permission from: World Health Organization. Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings. 2012. Tool 9 Template for desk review of pre-existing information relevant to mental health and psychosocial support in the region/country, p. 60-62. We bear responsibility for the adaptation and the adaptation is not endorsed by WHO.

[6]Selected tools are summarised with permission from: World Health Organization. Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings. World Health Organization; 2012.

[7]National Disaster Management Authority and National Institute of Mental Health and NeuroSciences. National Disaster Management Training Module-3, Psychosocial Preparedness. 2023.

[8]World Health Organization. Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment.

[9]This table has been adapted under the CC BY-NC-SA 3.0 IGO licence https://creativecommons.org/licenses/by-nc-sa/3.0/igo) from: World Health Organization. Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment. We bear responsibility for all adaptations and they are not endorsed by WHO.

[10]Adapted under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo) from World Health Organization. Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment.

06 Capacity Building

Capacity building is an ongoing process that equips officials, stakeholders and the community to perform their functions in a better manner during a crisis or disaster. It is the strengthening of institutions, mechanisms, and capacities of all stakeholders at all levels[1]. This includes human resource development as well as ensuring availability and quality of infrastructure, systems, equipment or any other resources needed to ensure appropriate and accessible service delivery to disaster affected communities. These guidelines focus on capacity building initiatives that build on and extend already existing resources so as to avoid duplication of efforts. Capacity building has been outlined here within the following domains:

- Human Resources
- Technological Resources
- Institutional, Organisational, and Material Resources

6.1 Human Resources (MHPSS Training and Capacity Building Pyramid)

The MHPSS Training and Community Capacity Building Pyramid (Figure 6.1) introduced in these guidelines attempts to ensure preparedness and availability of adequate knowledge and skills within the community to respond to the different MHPSS problems that communities experience in disasters (such as emotional distress, grief, feelings of loss, breakdown of family and community structures, a loss of livelihood and property, and lack of access to basics like food, water, shelter).

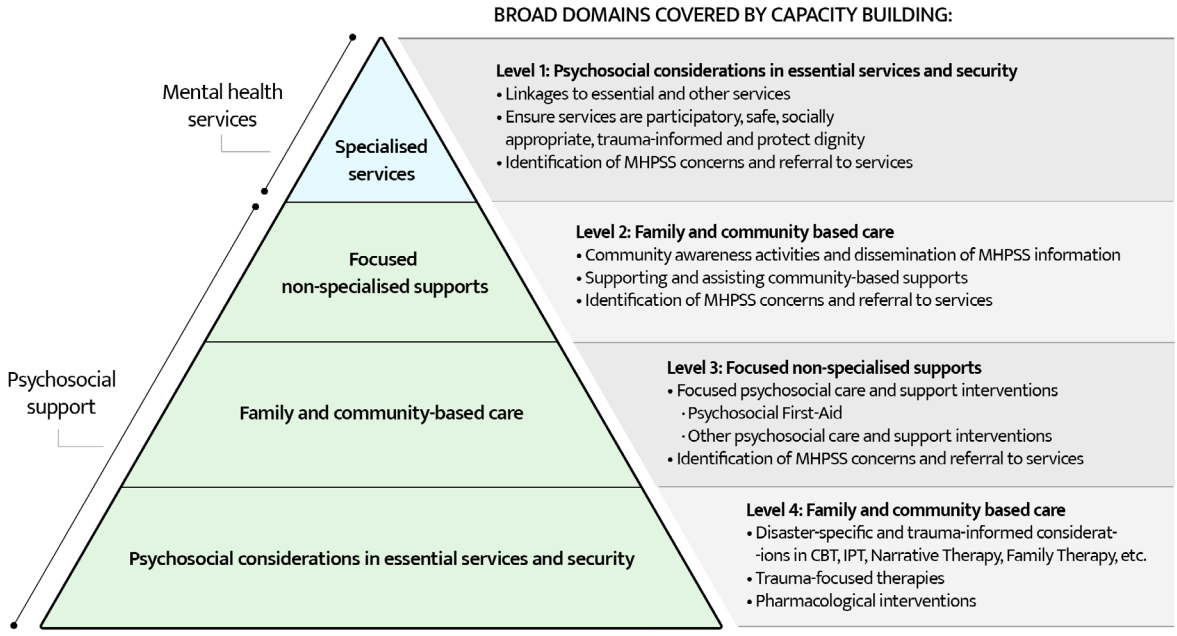

Figure 6.1: MHPSS Training and Capacity Building Pyramid

It recognises the importance of non-specialist and community-based sources of support, the need to empower community members, as well as to formally train non-mental health professionals to identify and provide basic psychosocial support to individuals. It acknowledges that the availability of mental health personnel to provide these differing levels of MHPSS services is inadequate, especially those trained to meet the unique needs of individuals exposed to disasters.

Thus, this section of the guidelines elucidates a framework for capacity-building to ensure the availability of a wide cadre of psychosocial and mental health responders in disaster settings. The guidelines propose capacity building actions at each level of the MHPSS Service Pyramid to ensure that services at all levels are equally prioritised and ready in disaster situations.

6.1.1 Stakeholders in the MHPSS Training and Capacity Building Pyramid

The MHPSS Training and Capacity Building Pyramid recognizes mental health and psychosocial support as a community exercise, and aims to equip the entire community with basic skills and knowledge to support themselves and others. Further, it aims to integrate MHPSS with other sectors through training of relevant players, and inclusion of MHPSS within other sector education and training programs. Table 6.1 highlights the cadres of individuals identified as instrumental to MHPSS activities.

Table 6.1: Stakeholders in the MHPSS Pyramid

Cadre	Name and Description	Members Involved
Cadre 1	**Citizens/ General Public** Individuals or citizen groups with no prior mental health training who are in close contact with the community.	Community healers, religious leaders, citizen volunteers.
Cadre 2	**Disaster Responders** This includes state or national level team members who are frontline personnel in situations of disasters and emergencies.	NDRF/ SDRF, Police, Firemen, Civil defence, Home guards, Medical responders, Aapda mitra volunteers, NCC and NSS youth groups, Scouts and Guides, Camp/ shelter/ temporary housing staff
Cadre 3	**Community Level Workers** Frontline health and welfare workers who are volunteers or employed members of the national/ state/ local government or related bodies; and work to implement health and welfare schemes and programmes.	ASHAs, ANMs, Anganwadi workers, Link workers, Mahila Arogya Samiti members, community social workers, zilla parishad teachers
Cadre 4	**Local, State And Central Government Personnel** Key personnel from local, state and central government bodies. This	Members of Panchayati Raj Institutions, Urban Local Bodies, leaders of traditional governing bodies (e.g. headmen).

	includes, both, those who have close contact with the community during a disaster (e.g. Incident Response Team personnel) or those who are in positions of administrative responsibility in sectors related to mental health or disaster response (e.g. in Disaster Management Cell of MoHFW) Government associated organisations like commissions, government corporations, and committees for disaster/ emergencies, health, mental health, food and nutrition, water, violence, vulnerable groups like women, children, SC/ST communities.	NDMA, SDMA, DDMA officials. Officials from all ministries, especially Ministry of Health and Family Welfare, Ministry of Home Affairs, Ministry of Labour, Ministry of Social Justice and Empowerment, Ministry of Education, Ministry of Women and Child Development, Ministry of Minority Affairs, Ministry of Human Resource Development, Ministry of Information and Broadcasting
Cadre 5	**Health and Allied Health Professionals** Members of professions that work in the field of medicine and allied health.	Doctors, Ayush doctors, Nurses, Medical Social Workers, Pharmacists, Occupational Therapists, Laboratory Technicians, Physiotherapists, Radiographers, Mammographers, Sonographers, Dietitians, Speech and Language Therapists, Podiatrists, Nutritionists.
Cadre 6	**NGO Personnel** Volunteers or employees at local and national non-governmental organisations, advocacy groups, or civil society organisations as well as international agencies in the fields of health, education, protection, child protection, gender-based violence, nutrition, shelter, WASH, food security, camp coordination and management, and mental health etc.	Personnel from local, national, And international agencies in the field of health, mental health, education, protection, child protection, gender-based violence, nutrition, shelter, wash, food security, and camp coordination and management, and so on.
Cadre 7	**Mental Health Practitioners** Individuals with recognised educational degrees (Masters or above) with a specialisation in clinical/counselling psychology or mental health, or specialised/ advanced training in psychotherapy approaches.	Counsellors, psychotherapists
Cadre 8	**Mental Health Professionals** Mental health professionals	Psychiatrists; Professionals registered with the State mental health authority such as clinical

	as identified under the Mental Health Care Act 2017	psychologists, psychiatric social workers, or mental health nurses; professionals having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.
Cadre 9	**Media** Individuals at various news or reporting outlets in various formats (traditional and social media) and those working in positions to share information to an audience. It includes individuals responsible for information communication.	Journalists/ Reporters on Radio, Newspapers, TV, Social Media etc. Ministry of Information and Broadcasting

Table 6.2 further elaborates on ministries, government-associated organisations or NGOs responsible for or linked to various personnel cadres. Responsible ministries, in collaboration with associated organisations, shall ensure cadres of personnel are provided the MHPSS training based on the level they have been allocated to, are deployed at the time of disasters, and deliver their allocated services.

Table 6.2: Cadres and Associated Ministries and Organizations

Personnel	Ministry Responsible
Cadre 2: Disaster Responders	
National Disaster Relief Force	Ministry of Home Affairs
State Disaster Relief Force	State Home Department
Civil Defence Personnel, Fire Services, Home Guards	Ministry of Home Affairs Directorate General of Fire Services, Civil defence, and Home guards
Aapda Mitra Volunteers	NDMA
Police	Ministry of Home Affairs
Cadre 3: Community Level Workers	
ASHA Workers	Ministry of Health and Family Welfare (MoHFW)
Auxiliary nurses and Midwives (ANMs)	Ministry of Health and Family Welfare (MoHFW)
Anganwadi Workers (AWW)	Ministry of Women and Child Development

Mahila Arogya Samiti Members	Ministry of Health and Family Welfare (MoHFW)
Social Workers	Ministry of Social Justice and Empowerment
Teachers	Ministry of Education
Cadre 4: Local, State and Central Government Personnel	
NDMA personnel	NDMA
SDMA personnel	SDMA
DDMA personnel	SDMA
Officials and personnel from state government	State Department of Health, Education, Social Justice and Empowerment, Women and Child Development
District Protection Officers	District Magistrate
Rogi Kalyan Samiti Members	Ministry of Health and Family Welfare (MoHFW)
Cadre 5: Health and Allied Health Professionals	
Doctors	Ministry of Health and Family Welfare State Health Department Department of Medical Education
Nurses	Ministry of Health and Family Welfare State Health Department State Department of Medical Education
Ayurvedic doctors	Ministry of Ayush Governing Body: All India Institute of Ayurveda State Department of Medical Education
Homoeopathic doctors	Ministry of Ayush State Department of Medical Education
Pharmacists	Ministry of Health and Family Welfare State Health Department State Department of Medical Education
Other allied professionals	Ministry of Health and Family Welfare State Health Department State Department of Medical Education
Paramedical staff	Ministry of Health and Family Welfare State Health Department State Department of Medical Education
Cadre 6: NGO Personnel	
Personnel from local NGOs and other international agencies	Local NGOs working on the ground (through District Magistrate/District Commissioner)

	Personnel through Inter-Agency Groups: Red Cross, UNDP-India, WHO-India, UNICEF-India and others
Cadre 8: Mental Health Professionals	
Mental Health Professionals	Ministry of Health and Family Welfare State Health Department
Cadre 9: Media	
Media	Ministry of Information and Broadcasting

6.1.2 Levels of the MHPSS Training and Capacity Building Pyramid

This section outlines the actions recommended for MHPSS training and community capacity-building. Table 6.3 provides a broad overview of the actions.

Table 6.3: Training and Community Capacity Building Actions

Level of the Pyramid	Training and Community Capacity Building Actions
Level 1: Psychosocial considerations in essential services and security	Action 1.1: Training on inclusion of MHPSS considerations in planning, preparing, and coordinating delivery of essential and related services and security Action 1.2: Training in inclusion of basic psychosocial support in service delivery Action 1.3: Trainings on inclusion of MHPSS considerations in disaster communication Action 1.4: Training on conducting MHPSS advocacy activities Action 1.5: Development of key MHPSS messages about : a. MHPSS and intersectoral services and referral pathways at local, state, and national level and, b. MHPSS self-help resources and IECs
Level 2: Family and community-based care	Action 2.1: Trainings on conducting community awareness programs about MHPSS Action 2.2: Training on facilitating community organisation and mobilisation Action 2.3: Training on developing skills to become a community mobiliser in disasters
Level 3: Focused, non-specialised supports	Action 3.1: Training in focused psychosocial care and support interventions
Level 4: Specialised services	Action 4.1: Training in mental health medical management

	Action 4.2: Training on inclusion of disaster-specific and trauma-informed considerations in mental health service provision Action 4.3: Training on supervision of personnel in delivering disaster MHPSS services

Each action specified in table 6.3 is described below, along with specifying the cadres to be trained, the broad training content, some available training modules, etc. The National MHPSS Working Committee, in coordination with NDMA; and the State MHPSS Working Committee, in coordination with SDMA shall collate and take stock of all available training and capacity building activities at the national and state level respectively.

Level 1 (Psychosocial Considerations in Essential Services and Security) Capacity Building Actions

Capacity building actions at this level aim to equip individuals with knowledge and skills to be able to provide safe, trauma informed, culturally appropriate basic and other sectoral services to disaster affected communities. This includes improving access and establishing linkages to essential and important services such as water, food, shelter, sanitation, basic healthcare, education, livelihood, social support, and welfare activities and services.

The capacity building actions carried out at this level include:

1. **Action 1.1: Training on inclusion of MHPSS considerations in planning and coordinating delivery of essential and related services and security**
   a. **Aimed at:** This training shall be provided to personnel in administrative decision-making capacities working within various essential services. This includes officials belonging to:
      i. Cadre 2 (Disaster responders)
      ii. Cadre 4 (Local, state and central government personnel)
      iii. Cadre 5 (Health and allied health professionals)
      iv. Cadre 6 (NGO personnel in the field of health, mental health, education, protection, child protection, gender-based violence, nutrition, shelter, WASH, food security, camp coordination and management)

   b. **Training Content:** Government officials and other stakeholders should be trained in integrating mental health and psychosocial considerations when developing and coordinating their respective services. Training should cover the domains of:
      i. Overview of MHPSS, its importance and how it is linked to outcomes in their area of work.
      ii. How to identify vulnerability to MHPSS concerns, emotional distress and trauma responses amongst people receiving and providing essential services.
      iii. Ethics in disaster management
      iv. Inclusion of MHPSS considerations in needs assessment in their respective services.
      v. Inclusion of MHPSS considerations in planning of their activities. This includes ways to ensure services are safe, participatory, trauma informed and culturally/socially appropriate.
      vi. Cultural sensitivity and consultation with vulnerable groups to plan their activities.
      vii. Ensuring accessibility of services and support to vulnerable groups.

viii. Planning for continuity of MHPSS services in aftermath of disasters
ix. Making use of available resources under government and private sector, and NGOs
x. Development and inclusion of MHPSS messages and cross-referral pathways in their information materials, guidelines developed, trainings organised, and service organisation
xi. Impact of working in disaster affected areas on the psychosocial and mental health of frontline personnel, including themselves: trauma responses, emotional distress, vicarious trauma and burnout.
xii. Being proactive and non-stigmatizing about mental health concerns in personnel, including themselves.
xiii. Pathways to support themselves, and developing support pathways for their teams.
xiv. Mock drills can be conducted to assist personnel in practising protocols and SOPs, as well as availability of necessary resource materials and equipment.

c. Scoping and development of training:

i. Some available training include the National Disaster Management Training Module 3: Psychosocial preparedness (jointly prepared by NDMA and NIMHANS) which includes some of the topics mentioned above. Further, the Disaster management cell of MOHFW, and NIMHANS (NIMHANS-DoC-MOHFW Project) have also developed training for health professionals within this action. Further scoping shall be conducted.
ii. The National MHPSS Working Committee shall mandate NIDM, nodal centre and other educational/ research institutes to develop the training content on topics that do not have training available.
iii. The National MHPSS Working Committee shall coordinate with relevant ministries and government disaster bodies at the national level (involved in disaster food, water, sanitation, shelter, education, livelihood, social welfare and support) to identify key decision makers and personnel to undergo this training.
iv. Similarly, the State MHPSS Working Committees shall coordinate with relevant ministries and disaster bodies at the State and district level to ensure training of key administrative personnel.
v. The National MHPSS Working Committee and State MHPSS Working Committees shall coordinate with relevant NGOs and other international agencies to organise this training for key decision makers and personnel in their organisations.
vi. Further, National and State MHPSS Working Committees shall ensure these training are included in inductions conducted for all officials in relevant departments at the national and state level respectively.

2. Action 1.2: Training on inclusion of basic psychosocial support in service delivery

a. Aimed at: This training shall be provided to frontline workers and personnel in direct contact with communities who provide essential and related services and security during disasters. This includes:

i. Cadre 2 (Disaster responders)
ii. Cadre 4 (Local, state and central government frontline personnel)
iii. Cadre 5 (Health and allied health professionals)
iv. Cadre 6 (NGO personnel)

This shall also include workers like security guards, cleaning staff, kitchen staff, receptionists, translators, etc. i.e those not in direct essential service provision roles, but working in structures where essential services are provided.

b. **Training Content:** Disaster frontline workers should be provided training on how to deliver essential and other sectoral services keeping MHPSS considerations in mind. The following topics shall be covered within the training:
   i. Understanding of MHPSS, its importance and how it is linked to outcomes in their area.
   ii. Stigma and help-seeking around mental health
   iii. How to identify vulnerability to MHPSS concerns, emotional distress and trauma responses amongst people receiving essential services.
   iv. Basic psychosocial support skills such as active listening, offering information and relaxation techniques such as progressive muscle relaxation and deep breathing[2].
   v. Importance of services being safe, trauma-informed, participatory, culturally/socially appropriate and accessible, and some ways in which frontline workers can use these ideas in their delivery of services.
   vi. Organising and providing referrals on MHPSS and intersectoral services available to service users and disaster personnel.
   vii. How to develop a database of referrals referred to in Action 1.5 as well as access to databases that already exist.
   viii. Impact of working in disaster affected areas on their own psychosocial and mental health: normalisation of trauma responses, emotional distress, vicarious trauma and burnout.
   ix. Pathways to support themselves, including specific information of contact persons and details about confidentiality.

c. **Scoping and development of training:**
   i. The National and State MHPSS Working Committees shall scope available training under this action.
   ii. The National MHPSS Working Committee shall mandate NIDM, the nodal centre, or other educational/research institutes to develop the training content (based on existing trainings content or new), in collaboration with community-based organisations.
   iii. The National MHPSS Working Committee shall coordinate with relevant ministries, government disaster bodies at the national level and NGOs (involved in disaster food, water, sanitation, shelter, education, livelihood, social welfare and support) to identify key frontline personnel to undergo this training.
   iv. Similarly, the State MHPSS Working Committees shall coordinate with relevant ministries, disaster bodies, and NGOs to ensure training of key frontline personnel at the state and district level.
   v. Further, National and State MHPSS Working Committees shall ensure these training are included in inductions conducted for all officials in relevant departments at the national and state level respectively.

3. **Action 1.3: Trainings on MHPSS considerations in disaster communication**
   a. **Aimed at:** This training aims to sensitise all individuals involved in communication and reporting of disasters to the public to account for MHPSS considerations. This includes personnel from:
      i. Cadre 4 (Local, state and central government personnel, especially Ministry of Information and Broadcasting),
      ii. Cadre 5 (Health and allied health professionals)

iii. Cadre 6 (NGO personnel involved in communication/ reporting/ news sharing)
iv. Cadre 9 (Media personnel)

b. Training Content: Training shall focus on building knowledge and skills to gather, consolidate and disseminate information keeping in mind a MHPSS approach. Training developed shall cover the following topics:
i. Effects of media on people's mental health during disasters
ii. Sensitivity in communication; making information accessible and widespread; using culturally appropriate language
iii. Trauma informed dissemination of information (e.g. use of trigger warnings; avoiding sensationalization)

c. Scoping and development of training:
i. Some available content includes the guidelines on 'Principles of Disaster Reporting' by NIDM, which includes aspects such as ensuring safety and dignity. Further, National Risk Communication Plan by National Center for Disease Control's (under MoHFW) also includes guidance on disaster risk communication, addressing information gaps, addressing rumors and misinformation. Further scoping shall be conducted
ii. The National MHPSS Working Committee shall mandate NIDM, the nodal centre, or other educational/research institutes to develop the training content by adapting the existing guidelines.
iii. The National MHPSS Working Committee shall coordinate with the Press Council of India to conduct training for media persons.
iv. The National MHPSS Working Committee and State MHPSS Working Committee shall make training available at state and national levels respectively.

4. Action 1.4: Trainings on conducting MHPSS advocacy activities

a. Aimed at: This training will be aimed at individuals and groups who carry out advocacy activities, or are in positions to receive information and advocate for the needs of disaster-affected communities. This includes:
i. Cadre 1 (Citizen/ general public)
ii. Cadre 5 (Health and allied health professionals)
iii. Cadre 6 (NGO personnel)
iv. Cadre 7 (Mental health practitioners)
v. Cadre 8 (Mental health professionals)

b. Training content: Training should include:
i. Key advocacy topics and issues
ii. Identifying service gaps in the community, and promoting the need for particular services and activities
iii. Need for a participatory approach to identifying needs and soliciting the input of community members on what kind of services they are looking for
iv. Identifying key stakeholders (government, media, donors, NGOs, coordinating bodies) and developing key messages around issues and gaps
v. How to identify distress, trauma, and provide referrals to available MHPSS and intersectoral services.
vi. How to develop a database of referrals referred to in Action 1.5 as well as access to databases that already exist.

c. **Scoping and development of training:**
   i. The National MHPSS Working Committee shall through multi-stakeholder partnerships, encourage community-based organisations and/or citizen groups to develop this training content (either from existing training content or new)
   ii. The National MHPSS Working Committee and State MHPSS Working Committees shall coordinate with community-based organisations and/or citizen groups to organise trainings for relevant cadres at the national and state level respectively

5. **Action 1.5: Development of key MHPSS messages on A) MHPSS and intersectoral services and referral pathways at Local, State, and National level B) MHPSS self-help resources and IECs (Information, Education, Communication)**
   a. **Aimed at:** This action aims to develop information on available MHPSS and intersectoral services at local, state and national levels as well as MHPSS self-help resources and IECs. The information and resources developed shall be shared with the entire community as well as all personnel (Cadres 1-9). This can be shared as part of training and awareness programs, or as IECs in different formats like brochures, videos, leaflets, or traditional/ social media communication. These resources aim to support individuals, families, groups, and members of the community to access verified information about a disaster's impact on mental health, and strategies, interventions and services to support themselves and others.

Action 1.5A: MHPSS and intersectoral services and referral pathways at Local, State, and National level

   b. **Information content:** Information on MHPSS and intersectoral services and referral pathways includes:
      i. Information about available mental health and psychosocial services in that particular area (local, district or state level)
      ii. Consolidated information (with contact information) about available government, community-led or non-governmental services to meet basic needs of disaster affected communities. This includes details of health centres/hospitals, food, water, sanitation, shelter/ temporary housing, livelihood opportunities/ schemes, education activities, social networks and welfare schemes/supports, legal support, protection and police, veterinary hospital, panchayat/ urban local body, agricultural office etc. This information shall be provided at a local, state, and national level.
      iii. Information on how to develop a database for referrals (including the provision of a template for the same). A sample template for a database is available in 'Psychosocial Support During the COVID-19 Pandemic: A Training Manual for Counsellors' (2021).

   c. **Scoping and development of information:**
      i. Information for this action is usually collated and dispersed once a disaster occurs. Development of consolidated information should occur as part of preparedness activities as well.
      ii. The State MHPSS Working Committees shall take assistance of DDMAs where available, to develop district-wise information of available MHPSS and intersectoral support services (both in the public and private sector) prior to a disaster.
      iii. The State MHPSS Working Committees shall collate and create information to be shared at the state level
      iv. The National MHPSS Working Committee shall collate and create information to be

shared at the national level

Action 1.5B: MHPSS self-help resources and IECs (Information Education, Communication)[3]

b. Information content: MHPSS Self-help resources and IECs that provide psychoeducation, build resilience, equip individuals/families/communities with strategies to improve their psychosocial wellbeing will be prepared and made widely available to everyone. Identifying already existing resources, identifying gaps in topics, developing further content and information resources, ensuring all resources are available in different languages and formats are all part of preparedness activities. MHPSS Resources shall be developed based on the following themes:

i. Information about signs of distress and trauma, and ways of coping in disasters, including normalising and reassuring messages
ii. Strategies to facilitate self-help or provision of support to loved ones/ in the community
iii. Information around mental health experiences and considerations and services for special populations (e.g. children, women, people with disabilities, elderly population, low income groups, people from SC/ST/OBC communities)

c. Scoping and development of information:

i. Mental health and psychosocial resources are available, however they are disseminated in a dispersed, decentralised manner by government bodies, NGOs, media, community level workers, and even citizen groups. This has led to a duplication of efforts and diffused messaging. Some examples of available resources are NIMHANS Tsunami psychosocial care for children, NIMHANS Tsunami Psychosocial care for women, and I support my friend (UNICEF, Save the Children, the MHPSS Collaborative and WHO). Scoping activity shall be conducted to consolidate all available information and resources.
ii. NDMA shall mandate the collation and synthesization of available MHPSS information and resources. The centralised MHPSS portal shall be used as a platform for this. Information shall be classified by topics and languages.
iii. NDMA, in coordination with SDMAs, shall mandate NIDM, the nodal centre, or other educational/research institutes to identify gaps in information and develop content for the same. There should be a focus on developing video-based and interactive resources for modalities with wider access and interest.
iv. NDMA shall consult community-based organisations, especially those organised around the needs of vulnerable groups, to ensure that IECs produced are accessible and sensitive.

Level 2: Family and Community Supports

Training and capacity building actions focus on upskilling personnel to facilitate establishment of family and community support for disaster affected communities. The capacity building actions carried out at this level include:

1. **Action 2.1: Training on conducting community awareness programs**
   a. **Aimed at:** Community awareness programs refer to community-wide, targeted awareness-raising activities that combat stigma and discrimination, and promote help-seeking behaviour. While the actions in Action 1.5 also aim to raise awareness, Action 2.1

refers to the conduction of synchronous activities targeted at awareness. Training on how to conduct such sensitization and awareness programs on MHPSS and disasters will be provided to personnel from:

i. Cadre 3 (Community level workers),
ii. Cadre 4 (Local, state and central government personnel), and
iii. Cadre 6 (NGO personnel).
iv. Cadre 7 (Mental health practitioners)
v. Cadre 8 (Mental health professionals)

b. Training content: Training on conducting awareness programs about MHPSS and disasters shall include the following topics:

i. The understanding and importance of MHPSS in disasters
ii. Stigma and stigma-reduction techniques and methods
iii. Understanding help-seeking behaviours for MHPSS
iv. Issues related to abuse and violence, how to recognize the same in the community, how to help others, and how to seek help for the same
v. How to identify signs of distress and trauma responses in community members; and symptoms and situations which prompt initiation of immediate referrals
vi. Available referral pathways (access to existing referral databases should be provided). The aim of this is also to transfer these skills to community members who attend the awareness activities, so that they may themselves identify and refer individuals in need of MHPSS services.
vii. Making use of available resources under the government and private sector, and NGOs

c. Scoping and development of training:

i. Some available training within this action include that by the Disaster management cell of MOHFW, and NIMHANS (NIMHANS-DoC-MOHFW Project). Training activities in community awareness programs are ongoing across India and are carried out by States and NGOs at a local level. Further scoping is required.
ii. The National MHPSS Working Committee shall mandate NIDM, the nodal centre, or other educational/research institutes to collate and integrate existing training information, taking inputs from community-based organisations about the content.
iii. The State MHPSS Working Committee shall ensure availability of trainings in regional languages. SDMAs can add additional modules or adapt content to be sensitive to their respective social and cultural environment
iv. The State MHPSS Working Committees, in coordination with DDMAs where available, shall ensure widespread training availability

2. Action 2.2: Training on facilitating community organisation and mobilisation[4, 5, 6]

a. Aimed at: This training shall be aimed at stakeholders who are members of governmental and non-governmental (professional or organised sectors) organisations that visit or engage with the community during times of disasters. This training shall aid them to recognise the importance of, and facilitate, community organisation and mobilisation for community-based MHPSS activities. These are activities that improve psychosocial wellbeing and mental health that are initiated and organised by the community, and are rooted in traditional community structures. These activities can include collective social activities (e.g. music activities, food-based gatherings), mourning activities (e.g. traditional memory ceremonies; prayer rites), childcare and child-friendly activities (e.g.

creches; informal activities such as drawing, sketching, singing), community kitchens and so on. Note that this training focuses on how to assist and facilitate organisation of these activities by the community, rather than personnel organising the activities themselves, as these activities are much more likely to be effective when organised by the community. Personnel who shall be trained include:

i. Cadre 4 (Local, state and central government personnel),
ii. Cadre 6 (NGO personnel)
iii. Cadre 7 (Mental health practitioners)
iv. Cadre 8 (Mental health professionals)

b. Training Content: Training developed shall focus on equipping individuals with skills and knowledge covering the following topics:

i. Importance of community mobilisation and supports for MHPSS in disasters
ii. Trauma-informed principles of engaging with community such as[7]
    - Acknowledge cultural, historical and gender issues
    - Safety: help ensure the physical site of any activities and meetings is safe
    - Trustworthiness and transparency: putting community voices first, not becoming defensive, compensate community-based partners for their time
    - Empowerment and choice: support active leadership by local community, empower community heroes rather than trying to become the hero
    - Peer support: promote local resources
    - Collaboration and mutuality: build in time for story-sharing and local knowledges and expertise
iii. Considerations and support for specific groups like children, women, elderly, people with disability etc.
iv. How to identify signs of distress and trauma responses in community members; and symptoms and situations which prompt initiation of immediate referrals
v. Available referral pathways to MHPSS and inter-sectoral services
vi. Maintaining continuity of services in the aftermath of a disaster

c. Scoping and development of training:

i. The disaster management cell of MOHFW, and NIMHANS (NIMHANS-DoC-MOHFW Project) have developed training for health professionals within this action. A guide to mental health for social workers by NHMP under National Health Mission, Ministry of Health & Family Welfare is also available.
ii. The National MHPSS Working Committee shall, through multi-stakeholder partnerships, encourage community-based organisations to develop the training content.
iii. Relevant ministries involved in employment, education opportunities and schemes, activation of social activities and networks (like Ministry of Human Resource Development, Ministry of Women and Child Welfare, Ministry of Minority Affairs etc) shall contribute to development of content based on expertise.
iv. The National MHPSS Working Committee and State MHPSS Working Committees shall ensure trainings are conducted and available to personnel from respective cadres at the national and state level respectively.

3. Action 2.3: Training on developing skills to become a community mobiliser in disasters

a. Aimed at: This training is conducted for members of the community such as private

citizens or voluntary citizen groups, who have interest in organising and convening community and social activities to re-establish social supports, empower community systems, and link the community to available resources during disasters. This includes organising the activities specified above in Action 2.2, including the organisation of support groups for community members.

i. Cadre 1 (Citizen volunteers)
ii. Cadre 3 (Community level workers)
iii. Cadre 5 (Health and allied health professionals)
iv. Cadre 6 (NGO Personnel)

b. Training Content: Training shall involve upskilling individuals to organise and mobilise activities. Trainings shall cover the following topics:

i. Assessing needs of their community and identifying vulnerable individuals/ groups requiring support
ii. Community-based activities and supports that can be organised to aid MHPSS during disasters
iii. How to organise and facilitate peer support groups, parent support groups, and other types of groups for MHPSS during disasters
iv. How to liaison activities with their local disaster management body / government
v. How to identify distress, trauma and symptoms, and situations which prompt initiation of immediate referrals to available MHPSS and intersectoral services.
vi. Making use of available resources under the government and private sector, and NGOs
vii. How to develop a database of referrals referred to in Action 1.5 as well as access to databases that already exist.

c. Scoping and development of training:

i. The National and State MHPSS Working Committees shall conduct a scoping to identify available training in this action.
ii. The National MHPSS Working Committee shall, through multi-stakeholder partnerships, encourage community-based organisations to develop the training content, since the focus of the training is for members of the community to mobilise themselves.
iii. The National MHPSS Working Committee and the State MHPSS Working Committees shall ensure trainings are conducted and available locally.

Level 3: Focused Non-Specialised Supports

Capacity building activities at this level aim to equip service providers with skills to carry out actions at Level 3 of the MHPSS Service Pyramid i.e Focused, non-specialised supports. This level provides care to the smaller number of individuals showing signs of distress and trauma and can benefit from receiving structured psychosocial interventions. Capacity building actions that need to be carried out include:

1. Action 3.1: Training in Focused Psychosocial Care and Support Interventions

a. Aimed at: These trainings should be made available for individuals belonging to the following cadres:

i. Cadre 1 (Citizen volunteers),
ii. Cadre 2 (Disaster first responders),
iii. Cadre 3 (Community level workers),
iv. Cadre 4 (Local, state, and central government personnel who are in frontline worker

positions),

v. Cadre 5 (Health and allied health professionals)
vi. Cadre 6 (NGO personnel)

b. Training Content:

i. Psychosocial First Aid: The IASC Committee (2007) defines psychological first aid as a humane, supportive response to a fellow human being who is suffering and who may need support. Training involves building key psychosocial skills that can be used to deliver brief individualised interventions. An important aspect of the training is building skills in early identification of distress, trauma responses, risk for harm and risk for MHPSS concerns, and referring them for intersectoral or MHPSS Services at Level 3 or 4. Ethical principles of practice should also be taught.

ii. Psychosocial Support and Care Interventions: There are multiple accepted interventions at this level and hence many different trainings and courses are available too. Trainings will be specific to the intervention that is being taught, but should broadly equip personnel with knowledge about distress, trauma, and common mental disorders; basic psychosocial skills; ethical principles of practice; how to deliver interventions in a disaster context; supporting individuals experiencing psychosocial problems, stressors and emotional distress; and considerations for vulnerable groups and specific problems. There should also be a focus on recognising signs of trauma and incorporating trauma-specific interventions and strategies into practice. Training should also include conducting early identification and facilitating referrals.

c. Scoping and development of training:

i. Psychosocial First Aid: Currently, there are some widely accepted trainings on psychosocial first aid. This includes the National Disaster Management Training Module 1: Psychosocial First Aid (developed by NDMA and NIMHANS), Psychological First Aid Training (online course by Johns Hopkins University), Psychological First Aid for Children (online course by Humanitarian Leadership Academy and Save the Children), and Psychological First Aid: Guide for field workers (Written guide by World Health Organization, War Trauma Foundation and World Vision International). The PFA Module developed by the National Child Traumatic Stress Network is trauma-informed. Training are also available under the disaster management cell of MOHFW, and NIMHANS (NIMHANS-DoC-MOHFW Project).

ii. Psychosocial Support and Care Interventions:

- Some available, recognised interventions include the National Disaster Management Training Module 2: Psychosocial Care in Disasters (prepared by NDMA and NIMHANS), Problem Management Plus (World Health Organization), Self Help Plus (World Health Organization), and Group Interpersonal therapy (World Health Organization). The manual for Psychosocial Support during the COVID-19 pandemic (NDMA and TISS) is also available specifically for counsellors. Further scoping shall be conducted.
- The National MHPSS Working Committee shall ensure constant updating of this list of trainings, and ensure internationally recognized trainings are adapted for the Indian context.
- The National MHPSS Working Committee shall ensure widespread dissemination of recommended training.
- The State MHPSS Working Committees shall ensure trainings are adapted and

available in local languages.

Level 4: Specialised Services

Capacity building actions at this level aim to support mental health professionals in building specialised skills to deliver mental health services or providing supervisory support to personnel delivering MHPSS services.

1. **Action 4.1: Training in Mental Health Medical Management**
   MHPSS Providers trained at this level will support disaster affected individuals at risk of developing mental health problems or those experiencing distress and trauma. These are not specialised interventions, but are focused medical management interventions carried out by primary care doctors.
   a. **Aimed at:** Training and courses will be provided to:
      i. Cadre 5 (Health and allied health professionals), specifically, professionals who are allowed to prescribe medication.

   b. **Training content:** Training shall cover the topics of:
      i. Basic skills in psychosocial counselling.
      ii. Identification of mental health concerns.
      iii. Provision and monitoring of medication for psychosocial problems, with a focus on standard treatment guidelines for common mental disorders
      iv. Symptoms and situations that prompt initiation of immediate referrals and process to facilitate referrals.
      v. Ethical principles of practising in disaster settings should also be introduced.
      vi. Aspects of trauma-informed medication management, such as being aware of accentuated power dynamics and fearfulness/anger in response to authority figures, must also be covered in this training.
      vii. Maintaining continuity of mental health services in the aftermath of disasters.
      viii. Making use of available resources under government and private sector, and NGOs.
      ix. Creating community awareness on mental health problems.

   c. **Scoping and development of training:**
      i. Some available training manuals include the Handbook- Assessment and Management of Mental Health Problems in General Practice, and the Manual for Medical Officers - Assessment and Management of Mental Health Problems in General Practice by NMHP under the National Health Mission of MOHFW. NDMA and NIMHANS have developed the National Disaster Management Training Module 4: Disaster Mental Health Services as part of its efforts to standardise training in mental health medical management. MHGAP-IG is another useful guide in this area. Further scoping will be conducted.
      ii. The National MHPSS Working Committee shall ensure widespread availability of training for personnel.
      iii. The State MHPSS Working Committees shall ensure training are adapted and available in local languages.
      iv. The State MHPSS Working Committees shall identify and recommend personnel to undergo the training.

2. **Action 4.2: Training on inclusion of disaster-specific and trauma-informed considerations**

in mental health service provision

a. **Aimed at:** At this level, the goal of capacity building activities is to enhance the skills of Cadre 5 (Health and allied health professionals), Cadre 7 (Mental health practitioners), and Cadre 8 (Mental health professionals) to effectively provide services at Level 4 of the MHPSS Service Pyramid i.e Specialised Services. Individuals seeking services at this level have experiences of long term or severe distress, diagnosable mental disorders, require intensive care or managing of risk, or are those that have not benefited from support provided at Level 1, 2 and 3 of the MHPSS service pyramid. Thus this level includes provision of specialised clinical mental health services that address the specific needs of individuals impacted by disasters.

b. **Training Content:** Training should build disaster-specific and trauma-informed approaches to mental health service delivery of psychotherapeutic interventions such as Cognitive-behavioural therapy, Interpersonal therapy, Family therapy, Narrative Therapy, Psychodynamic therapy and pharmacological interventions. This shall also include training in trauma-focused psychotherapies. It shall focus on providing knowledge on topics like disaster-specific trauma reactions and mental health problems in the Indian context, cultural expressions of distress and grief, principles of trauma-informed service delivery, as well as ethical principles of practice in disaster settings. Mental Health Professionals can also be trained in the administration of standardised tools and questionnaires for early identification in disaster settings.

c. **Scoping and development of training:**
   i. The National MHPSS Working Committee, with support for the State MHPSS Working Committees shall conduct scoping activities to identify available training within this action.
   ii. The National MHPSS Working Committee shall mandate educational or research institutes with MHPSS expertise to develop training modules.
   iii. The National MHPSS Working Committee shall coordinate with various mental health professional bodies, mental health educational institutes, NGOs, and private mental health professionals to ensure widespread access to this training.
   iv. The State MHPSS Working Committees shall coordinate with the National MHPSS Working Committee to ensure availability of the training for all professionals in their States/UTs. Training shall also be made available in regional language. State MHPSS Working Committees shall also nominate mental health professionals to undergo the training.

3. **Action 4.3: Training on Supervision of Personnel involved in delivering disaster MHPSS services**

   a. **Aimed at:** This training is aimed at experienced Cadre 7 (mental health practitioners with advanced training in psychotherapies) and Cadre 8 (mental health professionals) with an interest in supervising other professionals.

   b. **Training Content:** Training should focus on building key competencies in supervision for experienced mental health professionals to supervise other personnel delivering MHPSS services. Key topics can include supervision of trainees and lay counsellors from non-mental health backgrounds, supervision in a context of high degrees of vicarious trauma and burnout as well as supervision in fast-paced and community-based working

environments.

c. **Scoping and development of training:**
   i. TISS has a Post-Graduate Diploma Program in Supervision for mental health professionals. The Rahbar Supported Supervision Program at TISS is another available program that uses a trauma-informed, social justice lens to provide accessible, strengths-based and reflective supervision. The Integrated Model for Supervision: Handbook (developed by IFRC and Trinity College Dublin, 2021) outlines a detailed framework and model for supervision of MHPSS personnel in disaster situations that can be adapted to the Indian context. Further scoping shall be conducted.
   ii. The National MHPSS Working Committee shall mandate institutes with MHPSS expertise to adapt existing training modules for supervision in disaster contexts.
   iii. The National MHPSS Working Committee shall coordinate with various mental health professional bodies, mental health educational institutes, NGOs, and private mental health professionals to ensure widespread access to this training.
   iv. The State MHPSS Working Committees shall nominate mental health professionals to undergo the training.

6.2 Technological Infrastructure

Technological advancements offer unique opportunities to enhance preparedness and response efforts, allowing for timely and accessible psychosocial and mental health services during emergencies. To this end, the current guidelines encourage the set up and development of two systems: A Centralised MHPSS Portal; and National and State MHPSS Helplines.

6.2.1 Centralised MHPSS Portal

Development and implementation of a centralised MHPSS portal is crucial to identify, consolidate, and provide access to disaster mental health and psychosocial support resources available in India. Such a portal would effectively identify and synthesise available resources for efficient deployment and utilisation during emergencies. This reduces response time by providing knowledge about available resources at a micro and macro level. Moreover, it would serve as an indicator of preparedness levels at the district, state, and national level.

Who should have access to the portal?

The portal shall have a section that is open access to the public, while a section would be limited to be accessed by authorised government officials only.

- **Public:** The portal would also serve as a one stop shop for information for the general public on MHPSS in disaster settings. This would encompass information relevant for disaster survivors, responders, NGOs and other organisations, government officials, and the community at large.
- **Authorised Government Officials:** The centralised MHPSS portal should encompass a repository of human resources with varying levels of experience and skills, equipment, infrastructure, and essential supplies. This data should be collected from private individuals and organisations, as well as district, state, and national government departments and agencies. Regular updates are necessary to maintain a comprehensive and up-to-date understanding of the current scenario.

What should the portal include?

The section of the portal that is accessible to the public shall include:

- **IECs (Information, Education, Communication)** on signs of distress; and tools for coping should be provided. This information should be made specific to different disasters, for different age groups, with special considerations for experiences of the various vulnerable and marginalised groups. These resources should be made available in different formats (brochures, videos, infographic, audio files etc).
- **Self-help resources:** The portal should provide booklets, manuals, and printable handouts/ worksheets to be used by individuals and groups experiencing distress in order to support themselves, their loved ones, or their communities. These resources can be created by the nodal centre, or other educational/ research/ technical mental health institutes, NIDM, NGOs, or international agencies. It should be ensured that the resources are culturally relevant and available in regional languages. These resources include those which are disaster specific (e.g. Tsunami Psychosocial Care for children by NIMHANS) or those applicable across disaster/ emergency settings (Self Help Plus by World Health Organization)
- **Referral/information for help-seeking:** The portal should also serve as a platform to provide information about available MHPSS services, and how to access them. Further this should include both mental health services, as well as information on intersectoral services and schemes available. The portal shall provide the option to filter according to location to provide access support closest to the individual.
- **Relevant guidelines and policies:** The portal shall include State and National guidelines and policies related to disasters and MHPSS.
- **Pre and post-disaster assessments of MHPSS vulnerabilities and capacities reports:** States and districts are mandated to regularly conduct pre-disaster assessment of vulnerabilities and capacities. This information is collated at a state level to map a statewide understanding of risk and resources available; and develop the State MHPSS action plan. Summary reports created at the state and district level should be uploaded here.
- **Project reports:** Reports by governmental and non-governmental organisations on capacity-building and service delivery activities should also be available on the portal. This is important for ensuring accountability and sharing of learnings.
- **Educational and upskilling opportunities:** Individuals can also access the portal to identify courses, workshops, and training organised by MoHFW, State Health Departments, NDMA, SDMAs, and all other organisations and agencies providing training at any of the levels of the MHPSS Training and Capacity Building Pyramid. Further, information on courses, training, certifications recommended by NDMA will be provided. Information on relevant conferences and seminars will also be provided. Lastly, recordings from webinars and seminars should also be provided for mass dissemination.
- **Registration:** Individuals can also register themselves on the portal as volunteers/service providers after undergoing training listed in the MHPSS Training and Capacity Building Pyramid. They will be mapped to the 4 levels of the MHPSS Service Pyramid based on the training they have received. Further, State MHPSS Working Committees, overseen and supported by the National MHPSS Working Committee, shall coordinate with SMHAs and regional bodies to encourage and ensure registration of mental health professionals (deemed under the mental health care act, 2017) on the portal.

The section that is accessible to only authorised government officials shall include:

- **Resource Inventory:** Government officials should have access to the list of all MHPSS resources (human resources, equipment, infrastructure, emergency supplies) specific at district, state and national level. Thus SDMAs can identify, and mobilise resources across

districts based on needs and availability.

Coordination of the portal

The National MHPSS Working Committee should coordinate with NIDM or another institute to add these elements to an already existing portal, such as the India Disaster Resource Network (IDRN). The National MHPSS Working Committee should allocate the responsibility of managing the portal to one member of the committee. Clear roles and responsibilities also need to be allocated for:

- Managing information at the national level, and ensuring timely updation of the portal to one member of the committee.
- Responsibility of uploading information at the state level (e.g. State MHPSS assessment reports) in a timely manner.
- Responsibility of uploading information at district level (e.g. cross-referral pathways data) in a timely manner.
- Responsibility of organising and conducting training for concerned SDMA/DDMA officials, government officials and departments on process to use the portal; and how to identify, mobilise, coordinate, and deploy resources from the platform in situations of a disaster.
- NDMA will identify a key team to establish a process of requisitioning human resources, infrastructural or essential physical supplies in disaster settings.

Processes to put in place to make the portal user-centric and accessible

The National MHPSS Working Committee will identify a coordinator to facilitate coordination of information resources to avoid replication, ensure coverage of topics, and to update resources and materials.

- Information on the portal should be available in multiple languages to cater to the wide linguistic diversity present in India.
- Information on the portal shall be made available in multiple formats (audio clips, videos, infographic, brochures etc) to ensure coverage.
- The portal should include refined search features to assist users in accessing information by location, content type, MHPSS topic, language, or modality.
- IT Support shall ensure that adequate security measures are taken to protect any private and sensitive information provided by or about individuals.

6.2.2 National and State MHPSS Helplines

The COVID-19 pandemic has seen a huge impetus to the use of digital technologies to provide MHPSS services. With a large number of people experiencing mental health problems, further compounded by restrictions imposed by social and physical distancing norms; mental health professionals, international and national agencies and NGOs had to quickly adapt to innovative technological methods to ensure support is provided. This included support through video call, telephones, use of chat interfaces or even emails in some cases.

The NDMA launched the Psychosocial Care Helpline during the COVID-19 pandemic in 2020 to respond to the growing distress in the community. It additionally ensured outreach by having counsellors contact all individuals who were diagnosed with COVID-19 to and check in about their psychosocial wellbeing and offer counselling and psychosocial support. Another nationwide, 24X7 toll-free helpline available had been initiated by NIMHANS to provide MHPSS during disasters. Similarly a national mental health helpline (Tele-MANAS) is available through the Ministry of Health and Family Welfare. This provides two levels of support with the first being basic psychosocial support by trained counsellor and the second being in-person or audio-visual consultations for individuals requiring specialised care. Helplines have also been set up by various

states to provide psychosocial care to people. The NDMA has further decided to encourage and assist with the setup of State helplines through a new scheme: State Level Psychosocial Care Helplines for people affected By COVID-19 and concurrent disasters which aims to set and scale up helplines in 10 states. One key barrier to the accessibility of helplines is that already existing helplines are often found by the public to be dysfunctional or unreachable[8].

- The National MHPSS Working Committee and the State MHPSS Working Committees shall ensure capacitation (human resources, technological infrastructure) for already functional MHPSS helplines, and equip general helplines (like SEOC, DEOC helplines) to deliver MHPSS specific information. Data on this should be available on the centralised MHPSS portal through mapping of resources as a part of assessment.
- The National MHPSS Working Committee and the State MHPSS Working Committees shall coordinate to ensure that reverse helplines can be immediately set up once a disaster occurs. The committees will ensure that processes are in place for a quick capacitation of at least one reverse helpline in a disaster occurrence.
- The National MHPSS Working Committee and the State MHPSS Working Committees shall ensure at least one functional helpline providing MHPSS services is available per state.
- Information and contact details of helplines should be widely distributed to the community at large as part of awareness programs, IECs on the websites of government ministries and non-governmental organisations, traditional and social media, brochures/ flyers in community spaces, health centres and waiting areas of clinics and hospitals. The focus should be on clearly disseminating a few key contacts of helplines that are functional rather than disseminating a large amount of contacts that individuals have to repeatedly access.
- The nature of services provided by helplines are described in detail in Chapter 9.

6.3 Institutional, Organisational and Material Resources

Pre-disaster activities encompass appraising currently available crucial resources like infrastructure, institutional systems, and essential supplies that are vital for delivering MHPSS services. The National MHPSS Working Committee and State MHPSS Working Committees must evaluate the readiness levels of these resources while identifying and bridging gaps in availability and quality to ensure preparedness for disaster situations.

6.3.1 Scientific, Technical and Healthcare Infrastructure Development

- NDMA in coordination with the National MHPSS Working Committee, MoHFW and SDMAs shall identify and develop at least one educational and technical institute in each state to support MHPSS activities during disasters. These could be institutes with already existing capacities for mental health (e.g. CIP, LGBRIMH). Departments or units focused on MHPSS during disasters could be established within these institutes, similar to the DPSSDM in NIMHANS. The new mental health teaching hospitals established as part of the scheme B in the 11th and 12th year plan, too, can be targeted for the establishment of PSSMHS units.[9]
- Identified technical and research institutions will liaison with the National MHPSS Working Committee and State MHPSS Working Committees to contribute to pre-disaster and post-disaster activities at the national and state level respectively. This includes providing expertise, developing or conducting mental health promotion, pre-disaster and post-disaster assessments of MHPSS vulnerabilities and capacities, resource mapping, technological infrastructure development, research, training, IECs and awareness, self-help resources,

service planning and delivery, and supervision of providers. Some of the above institutions may also be acting as healthcare institutions.

- As per the Ayushman Bharat initiative, Sub Health Centres (SHCs) and Public Health Centres (PHCs) transformed into Health and Wellness Centres (HWCs) shall provide expanded services including screening and basic management of mental health problems. Aligned with this, State Health Departments shall ensure provision of training for staff and availability of relevant equipment in HWCs in their respective states.
- Hospitals and other medical institutions shall ensure inclusion of MHPSS in their disaster management plans.
- As per the Indian Public Health Standards (IPHS, 2022) published by MOHFW, availability of psychiatrists in sub-district hospitals (with over 100 beds), and district hospitals (with over 50 beds) has been made an essential criteria. Further, availability of psychotherapeutic medicines and equipment for psychiatry OPDs (as listed in the IPHS) has also been mandated. State Health Departments shall coordinate with the hospitals to ensure the availability of quality infrastructure, psychiatrists, psychotropic medications, and any other supplies needed to meet the demands of the disaster affected community. If prior disaster assessments of MHPSS vulnerabilities and capacities have been conducted in the specific district the medical setup is located in, administration shall use findings to plan and prioritise resource establishment.
- Hospitals, with support from NDMA, in coordination with the National MHPSS Working Committee, SDMAs in coordination with the State MHPSS Working Committees, MOHFW, State Health Departments, and State Departments of Medical Education shall coordinate and organise all relevant MHPSS training outlined for all hospital staff, medical and allied health professionals in the MHPSS Training and Capacity Building Pyramid.
- SDMAs and the State MHPSS Working Committees, in coordination with State Health Departments respectively, shall ensure availability of medicines used in treatment of psychiatric disorders, as listed in the National List of Essential Medicines (NLEM, 2022) in disaster situations.
- Multiple health and social protection schemes exist at the state and national level. Some at the national level include Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, Pradhan Mantri Jeevan Jyoti Bima Yojna, Pradhan Mantri Fasal Bima Yojna, and Pradhan Mantri Suraksha Bima Yojna. Similarly, States provide State health insurance schemes or social protection schemes. NDMA and the National MHPSS Working Committee, in coordination with MOHFW shall advocate and facilitate mechanisms to be developed at the national level to access benefits from government schemes for MHPSS concerns. In the same manner, SDMAs and the State MHPSS Working Committees, in coordination with State Health Departments respectively, shall advocate and ensure access to state health insurance and social protection schemes for MHPSS problems at the state level.
- The private and corporate sector shall be encouraged to expand their infrastructural and system capacities to respond to disaster mental health needs.

6.3.2 Physical Infrastructure Development

The following actions should be taken:

- In coordination with the nodal ministry at the national level, National and State MHPSS Working Committee shall advocate for upgrading existing physical infrastructure and establishing physical infrastructure at the state and district levels in which disaster MHPSS activities can be conducted.
- In line with the Indian Public Health Standards (IPHS, 2022), as part of pre-disaster activities,

the SDMAs and State MHPSS Working Committees shall advocate for ensuring that healthcare facilities are capacitated to adequately support surges in healthcare needs; with a special focus on those near disaster-prone areas.

- National and State MHPSS Working Committee shall advocate for as well as take measures within its capacity to ensure infrastructure and resources shall be accessible to all individuals with disabilities. The planning, design and setting up of camps, temporary shelters, MHPSS related services will account for the need to make physical infrastructure accessible and safe. Measures such as clear visible signs, availability of ramps and wheelchairs, and mobile clinics should be implemented.

6.3.3 Higher Education Development

Building academic programs specific to disaster MHPSS, and inclusion of disaster MHPSS in educational curriculum plays an important role in mitigating and responding to psychosocial effects of disasters. The actions to be taken include:

- The National MHPSS Working Committee and the State MHPSS Working Committees, in coordination with nodal ministries, National Medical Commission, and State Departments for Medical Education, shall prioritise the development of an educational agenda upskilling all mental health related professionals in disaster MHPSS.
- The National MHPSS Working Committee shall set up mechanisms to facilitate networking and sharing of knowledge amongst institutions to provide quality educational programs across the country.
- NIDM or any other national or state level institution as recommended by ministries such as MOHFW, Ministry of Skill Development and Entrepreneurship, Ministry of Human Resource Development (in collaboration with the National MHPSS Working committee) shall provide MHPSS educational certifications, as well as integrate MHPSS in available disaster management related programs.
- Centres of excellence, central mental health institutes, and other private and public educational institutes shall develop and provide diplomas, graduate, post graduate and doctoral programmes in disaster mental health and related topics. Some existing programs include the Masters in Business Administration (Disaster Management) (Weekends course) and Post Graduate Diploma in Disaster Management by the Centre of Disaster Management Studies under Guru Gobind Singh Indraprastha University, Masters of Business Administration Master of Arts / Master of Science in Disaster Management by TISS; PhD in Psychosocial support in Disaster Management, and a Fellowship in Psychosocial Support in Disaster Management, Department of Psychosocial Support in Disaster Management, NIMHANS.
- National and State MHPSS Working committees will coordinate with bodies such as National Council of Educational Research and Training (NCERT), University Grant Commission (UGC), All India Council of Technical Education (AICTE) and National Medical Commission to ensure inclusion of MHPSS courses for possible disaster responders and related stakeholders.

6.3.4 Multi-Stakeholder Partnerships

Collaborative, well established multi-stakeholder partnerships go a long way in meaningfully planning, directing and making the best use of resources in the country. These partnerships require coordination between many players such as government bodies, NGOs, civil society, businesses/private sector, international agencies and donors. These partnerships play an important role in knowledge and expertise sharing, pooling in resources, coordinating to come up with innovative solutions, and even addressing challenges to achieve a greater impact in MHPSS activities across all phases of disaster. Throughout the guidelines, actions and activities have been

outlined that contribute to meaningful, streamlined multi-stakeholder partnerships towards an effective MHPSS response in disasters.

6.4 Coordination of Capacity Building Activities

All capacity building activities will be organised and coordinated by the National MHPSS Working Committee and State MHPSS Working Committee at the national level and state level respectively.

The National MHPSS Working Committee shall be responsible for including priorities and activities for training and capacity building within the National MHPSS Action Plan. Further it shall be responsible for:

1. **Human Resources:**
   a. In coordination with State MHPSS Working Committees, taking stock and collating all existing training and capacity building content and activities.
   b. Assigning the development of training curriculum that needs to be developed to NIMHANS, other institutes and community-based organisations for all levels of the MHPSS Training and Capacity Building Pyramid as outlined in Chapter 6, Section 6.1.2.
   c. Collating and disseminating the training curriculum that has already been developed.
   d. Appropriately involving SDMAs; NIDM, nodal centres; educational, research, healthcare institutions; community based organisations; NGOs; citizen groups in content creation for trainings.
   e. Conducting Level 4 trainings, by identifying expert facilitators to conduct these trainings and organising an in-person or online training schedule.

2. **Technological Infrastructure:**
   a. Identifying and managing the National MHPSS Portal.

3. **Institutional, Organisational and Material Resources:**
   a. Identifying centres of excellence and supporting infrastructural development as outlined in Chapter 6, Section 6.3.1.

4. **Higher education:**
   a. Coordinating with bodies such as National Council of Educational Research and Training (NCERT), University Grant Commission (UGC), All India Council of Technical Education (AICTE), National Medical Commission, etc. to ensure inclusion of MHPSS courses for possible disaster responders and related stakeholders.
   b. Setting up mechanisms to facilitate networking and sharing of knowledge amongst institutions to provide quality educational programs across the country.

The State MHPSS Working Committees shall be responsible for including training and capacity building priorities and activities within the State MHPSS Action Plan . Further it shall be responsible for:

1. **Human Resources:**
   a. Translating training into local languages and making adaptations to the socio-cultural

context.

b. Identifying personnel to be trained at all 4 levels of the MHPSS Training and Capacity Building Pyramid as outlined in Chapter 6, Section 6.1.2, making links to relevant ministries/organisations to organise this training, and identifying appropriate facilitators for each training.

c. Conducting training at Level 1, 2, 3 and 4 of the MHPSS Training and Capacity Building Pyramid as outlined in Chapter 6, Section 6.1.2 in online or in-person modalities.

2. **Technological infrastructure:**

   a. Ensuring timely updation and upload of training data to the centralised MHPSS portal.

3. **Higher education:**

   a. Coordinate with the National MHPSS Working Committee and bodies like National Council of Educational Research and Training (NCERT), University Grant Commission (UGC), All India Council of Technical Education (AICTE), National Medical Commission to ensure inclusion of MHPSS courses for possible disaster responders and related stakeholders.

References

[1]National Disaster Management Authority, Government of India. Capacity Development [internet]. [cited 2023 May 21]. Available from https://ndma.gov.in/about-us/division/Capacity-Building#:~:text=Capacity%20building%20is%20an%20ongoing,manner%20during%20a%20crisis%2Fdisaster

[2]Inter-Agency Standing Committee. IASC Guidance on Basic Psychosocial Skills – A Guide for COVID-19 Responders. Geneva, Switzerland: IASC 2020

[3]Protection Cluster, UNFPA, UNHCR. GBV and MHPSS Awareness Raising Messaging during the Time of COVID-19: Iraq [internet]. 2020 [Cited 2023 May 20] Available from https://resourcecentre.savethechildren.net/pdf/covid-19_gbv_mhpss_messaging_-_iraq.pdf/

[4]Seto M, Nemoto H, Kobayashi N, et al. Post-disaster mental health and psychosocial support in the areas affected by the Great East Japan Earthquake: a qualitative study. BMC Psychiatry. 2019;19(1):261

[5]Math SB, Nirmala MC, Moirangthem S, Kumar NC. Disaster management: mental health perspective. Indian journal of psychological medicine. 2015 Jul;37(3):261-71.

[6]United Nations Children's Fund. Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version). 2018 [cited 2023 May 23]. Available from https://resourcecentre.savethechildren.net/pdf/unicef-cb-mhpss-guidelines1.pdf/

[7]Rosenberg H, Errett NA, Eisenman DP. Working with disaster-affected communities to envision healthier futures: A trauma-informed approach to post-disaster recovery planning. International journal of environmental research and public health. 2022 Feb 2;19(3):1723.

[8]Joseph, J., Tajane, P, Mishra, N., Matthew, A. A. Disaster Mental Health and Psychosocial Support Services In the Context of COVID-19 in Latur, Maharashtra, India [Draft]. 2021. An Evaluation Report by the Tata Institute of Social Sciences, Mumbai.

[9]J. Joseph, Personal Communication, 2023

07 Research

Disaster mental health research can play a pivotal role in promoting mental health and reducing the mental health and psychosocial impact of disasters. Information and evidence from research can be used to identify the community's immediate and long term needs, as well as their mental health trajectory to inform services and interventions, thus supporting all sections of the affected community to receive appropriate, accessible, quality care.

While research methods used are similar to those in non-disaster settings, research in these turbulent times require special considerations. Disasters pose unique challenges to researchers and carry inherent complexities in managing logistics and resources, timelines, and security and safety of participants and the team. Research teams will face challenges in responding to safety concerns and preventing harm, providing detailed information, establishing fair participation, changing usual delivery timelines keeping in mind the nature of the disaster, and finally managing expectations and power imbalances. Additionally, this is a particularly vulnerable time for those affected by the disaster and it is essential that research prioritises the needs and safety of the community. Research in disaster settings should be conducted when it is the only way to gain knowledge.

This chapter outlines guidelines on disaster mental health research and aims to uphold researcher-community integrity by promoting targeted, well timed research that benefits communities; conducted in a manner that acknowledges the complexities of the situation and responds to these unique circumstances by planning and setting up responsive research processes. It builds on international guidance on research methods for health emergency and disaster risk management[1].

7.1 Encouraging Disaster Mental Health Research

- The previous guidelines (National Disaster Management Guidelines: Psycho-social support and mental health services in disasters, 2009) identified key focus areas for disaster mental health research. The National MHPSS Working Committee, in collaboration with NIDM and the national nodal centre, shall plan and allocate systematic reviews and meta-synthesis (quantitative and qualitative) of progress and work in various areas of disaster mental health research since the publishing of the previous guidelines (2009 onwards).
- Based on the systematic reviews and meta-synthesis, the National MHPSS Working Committee, in collaboration with the nodal centre shall identify new key research priority areas in disaster mental health in the Indian context and disseminate these priority areas to all stakeholders.
- Organisations, scholars, educators, researchers, government officials, funding organisations and all other relevant stakeholders shall be encouraged to plan, design and conduct research in disaster mental health and psychosocial wellbeing from an interdisciplinary perspective.
- Both quantitative and qualitative methods should be used and participatory action methods should be encouraged.

- Special focus should be given to research with vulnerable and marginalised groups such as children, sexual and religious minorities, elderly people, individuals belonging to SC/ST, etc.
- State MHPSS Working Committees are mandated to organise skill building opportunities like certificate courses, seminars, workshops on conducting disaster mental health research in their respective states.
- The National MHPSS Working Committee will organise an annual disaster mental health focused conference.
- Local, National, and International NGOs and agencies are encouraged to maintain records, and collect and publish data related to their functioning and services like needs assessed, processes implemented, services provided, or utilisation etc.

7.2 Establishment of Grants and Allocation of Funds

- It is essential to invest in a) conducting original research (primary and secondary) b) skill-building for research and c) translation of findings from research into practice.
- Funding organisations are encouraged to consider disaster mental health research as a priority area within mental health, emergency health, and disaster management; and to create grants, fellowships and doctoral funding specific to this.
- National and State MHPSS Working Committees should, in coordination with nodal centre and centre of excellence, allot funds towards disaster mental health research, determine mechanisms for allocating funds, and establish timelines for various projects related to disaster mental health research.
- Funding considerations need to carefully consider and develop adequate provisions for compensating members from the community who participate in research in an ethical manner, that does not pressurise them into consenting to research, but at the same time, adequately compensates them for their time and effort.

7.3 Ethical Research in Disaster Settings

Mental health and psychosocial research in disaster settings occur under unique circumstances. This requires Institutional Review Board (IRB) Committees to identify and follow internationally accepted research guidelines when reviewing research applications highlighting the ethical considerations in the setting[2]. ICMR guidelines such as National Ethical Guidelines for Biomedical and Health Research Involving Human Participants[3], and National Ethical Guidelines for Biomedical Research Involving Children[4] can be referenced. Some important considerations are:

1. IRB Committees shall expedite review of applications without compromising on the research rigour or ethical considerations required.
2. IRBs should consider the purpose and value of study, use of acceptable and appropriate methods, processes to ensure informed consent and confidentiality are maintained, inclusion of strategies to protect team and participant safety, coordination and partnerships with local stakeholders, maintenance of neutrality in the disaster situation, coordination with other organisations/research teams in the setting, declarations of all donor/researcher interests, and proposals for wide dissemination while reviewing applications
3. Priority should be given to the benefits and value of research to the community; and considerations should be given to possible harm while reviewing applications.

4. Duplication of research should be discouraged unless there is a clear rationale for duplication (e.g. verifying previous findings).
5. IRBs should ensure culturally and developmentally appropriate topics, tools, languages, and content is used.

7.4 Special Considerations for Teams Conducting Disaster Mental Health Research

- Researchers shall adhere to all relevant governmental and institutional requirements and comply with relevant regulatory mechanisms in India. They shall seek all appropriate approvals needed to conduct a research. This includes applying for approval from the Health Ministry's Screening Committee (HMSC), operated by the Department of Health Research/ ICMR (applicable to ICMR institutes, private entities, and NGOs) or from the Department of Health and Family Welfare's Screening Committee for Research Proposals (SCRP) (applicable to government institutions like state and central medical colleges, etc.) while undertaking health research that involves foreign collaboration or funding.
- Researchers should adhere to local ethical standards, and follow mandated ethical review procedures.
- Research teams should conduct studies based on identified gaps in knowledge, and give attention to topics that will make a meaningful contribution to the community.
- The local culture of the affected community should be accounted for in planning of research, data collections methods, tools used, sampling methods, and data analysis.
- Research should be conducted in partnerships with local organisations, service providers, and service users. Community representatives should inform all aspects of research from conceptualisation to dissemination. These individuals and organisations must be adequately compensated for their time and effort.
- Researchers should identify opportunities for involvement of community stakeholders like affected groups, local specialist and non-specialist MHPSS resources, and government members.
- Research teams should coordinate with other stakeholders in disaster settings (identified in Chapter 6, Section 6.1.1). This is to minimise duplication of efforts, and encourage shared knowledge and resources.
- Investigators should ensure provision of adequate, specific training, and ongoing supervision for their teams on working in disaster settings with a focus on ethical considerations, participant selection, informed consent, referral procedures, cultural competency, risk management and ensuring safety, and self care. Members of research teams should be competent to identify and take steps to respond to risks that may occur.
- Research teams should maintain neutrality and non-discrimination in disaster settings and be aware of possible biases while planning, conducting, and interpreting the study.
- A special note should be made to ensure fair opportunity for individuals to participate. Reasons for exclusion should have a scientific basis and not due to power, privilege, access, vulnerability or other factors.
- Research teams should ensure they follow appropriate but flexible processes to take informed consent and make accommodations when needed for participants, keeping in mind often occuring power imbalances, misinformation, vulnerability, and high levels of distress that prospective participants may be experiencing.

- Research teams should take steps to ensure confidentiality and anonymity of participants.
- Safety planning is an important obligation of all research teams. Measures should be taken including and not limited to monitoring risk, avoiding exposure to further harm, explaining benefits and possible risks, giving participants the right to withdraw at any point, secure storage of data, and de-identifying personal information.
- Referral pathways providing access to support within and outside the research team should be clearly outlined for those who are identified as requiring support during or after the research. Participant safety should be prioritised over conducting the study.
- Investigators should establish mechanisms and strategies for care and MHPSS support for researchers to deal with distress within the team.

7.5 Research Dissemination

- Dissemination activities should focus on both the scientific community as well as local and international decision makers, service providers, participants, and the community at large (academic papers and publishing in scientific journals and building awareness of findings in the community through seminars, workshops, use of media etc.).
- Dissemination of findings should be tailored by identifying effective formats of dissemination for different target audiences.
- Findings should be made available in non-technical language, in the language of the local community, and for specific groups requiring accommodations (e.g. visually impaired community) keeping in mind varied educational and developmental levels. Special consideration should be made to ensure findings are disseminated to participating children and the young population at large in an appropriate format.
- Confidentiality of participants must be maintained during dissemination activities.

7.6 Research Collaborations

- There is a need for coordination and partnerships amongst various research stakeholders including NDMA, NIDM and other educational/ research institutes, government bodies/ ministries, local and international agencies and NGOs, funding organisations, services providers and users to encourage collaborations, promote grants, share information, establish research networks, and encourage research in this area.
- There is a need to establish regular conferences and alliances to promote discussion on latest knowledge in disaster mental health and facilitate collaborations amongst interested stakeholders. A yearly conference (web-based or in-person) focused on disaster mental health research should be organised by the National MHPSS Working Committee.

References

[1] World Health Organization. (2021). WHO guidance on research methods for health emergency and disaster risk management. World Health Organization. https://apps.who.int/iris/handle/10665/345591. under Licence: CC BY-NC-SA 3.0 IGO.

[2] World Health Organization. (2021). WHO guidance on research methods for health emergency and disaster risk management. World Health Organization. https://apps.who.int/iris/handle/10665/345591. under Licence: CC BY-NC-SA 3.0 IGO.

[3] Indian Council of Medical Research. National ethical guidelines for biomedical and health research involving human participants. New Delhi: Indian Council of Medical Research; 2017. Available from: https://www.icmr.nic.in/sites/default/files/guidelines/ICMR_Ethical_Guidelines_2017.pdf

[4] Indian Council of Medical Research. National ethical guidelines for biomedical research involving children. New Delhi;. 2017 Oct. Available from:https://main.icmr.nic.in/sites/default/files/guidelines/National_Ethical_Guidelines_for_BioMedical_Research_Involving_Children_0.pdf

SECTION THREE

Mental Health and Psychosocial Support during the Response, Recovery and Reconstruction (Post-Disaster) Phases of Disasters

SECTION THREE

MHPSS in the Recovery phase is aimed at restoring and improving mental health outcomes, assets, activities, and systems for the benefit of the affected community, and reducing future risk of developing mental health concerns, based on the principles of sustainability and 'building back better'. These goals continue into the Rehabilitation and Reconstruction phases, with a focus on medium and long-term efforts towards rebuilding mental health systems and infrastructure to achieve full functioning within the affected community.

Across these phases, disaster management efforts are guided by four broad goals detailed in the following chapters:

Chapter 8: Post-disaster Assessment of MHPSS Vulnerabilities and Capacities
Chapter 9: MHPSS Service Delivery
Chapter 10: Practice Guidelines for Service Providers
Chapter 11: Monitoring and Evaluation

08 Post-disaster Assessment of MHPSS Vulnerabilities and Capacities

In any disaster, the assessment of threats, needs, and resources forms a critical foundation of the response, and guides multiple key actions like advocacy, priority-setting, resource allocation, programming, and evaluation. Response actions backed by effective assessments have the advantage of being detailed, context-specific, and participatory, as opposed to non-specific, blanket interventions. While general inter-sectoral assessments typically cover areas like health, safety, nutrition, education and so on, MHPSS assessments bring in an understanding of how the disaster has impacted people on a social, psychological, and behavioural level. They incorporate objective observations with subjective experiences as reported by disaster survivors, along with their concerns, priorities, coping methods, needs, and resources.

This chapter will detail the conduction of rapid and extended post-disaster assessments in the community, followed by a framework for conducting early identification of risk for mental health and psychosocial concerns, and corresponding referral mechanisms. The rapid and extended post-disaster assessments shall be conducted in coordination with the Post-Disaster Needs Assessment (PDNA) developed by the National Institute of Disaster Management, Ministry of Home Affairs in 2019[1]. The PDNA provides a comprehensive, standardised, scientific mechanism to identify recovery and reconstruction needs in the aftermath of disasters. The National MHPSS Working Committee and the State MHPSS Working Committees shall coordinate with relevant stakeholders to integrate MHPSS post-disaster assessments and PDNA.

8.1 Rapid and Extended Post-disaster Assessments

A rapid post-disaster assessment is a quick but comprehensive assessment that can be carried out with limited resources and tools to inform service delivery. This phase of the assessment is conducted within one or two weeks of the disaster having occurred[2]. The aim of a rapid post-disaster assessment is to develop a quick understanding of the disaster's immediate impact on the community as well as the status of resources available in the community, so that an effective service delivery response can be planned. Data from the pre-disaster assessment can also be used to inform the service delivery. If no such data is available, the post-disaster assessment becomes all the more crucial to inform decisions.

An extended post-disaster assessment, while focused on similar domains of information, is conducted once the immediate aftermath of the disaster has settled and recovery, reconstruction and rehabilitation efforts have begun. It is significantly more exhaustive, time-intensive, and

resource-intensive. Once immediate MHPSS services have been initiated on the basis of the rapid post-disaster assessments, a more detailed and rigorous extended assessment can be conducted to highlight the emerging impact of the disaster and the long-term needs of the disaster-affected community. An extended post-disaster assessment thus captures the shifts and changes in the impact or experience of a disaster across its various phases. Further, an extended assessment is also instrumental in reaching any groups that may have been missed during initial assessments and service delivery. Finally, it is in this assessment that the monitoring and evaluation of service delivery as well as detailed identification and diagnostic assessments for epidemiological purposes can be incorporated.

The same model as previously outlined in Chapter 5 is followed in the rapid and extended post-disaster assessments. The broad domains which the post-disaster assessment of MHPSS vulnerabilities and capacities focuses on include:

Vulnerability: Information on the psychosocial problems faced by individuals and the community.

- Information on emotional distress, trauma responses, and mental disorders in the community as well as exposure of the community to the disaster (bereavement, injuries, hospitalizations, displacement, damage to homes).

Capacity: Information on the resources available to individuals and the community, including availability of trained personnel.

8.1.1 Conducting Rapid And Extended Post-Disaster Assessments

The steps to conduct the post-disaster assessment are as follows:

Step 1: Review and gain familiarity with the information template for the Pre-disaster assessment.

The team shall review and familiarise themselves with the template for the information to be collected in the post-disaster assessment (Table 8.1). The domains of assessment are based on a comprehensive review of various models and concepts, including disaster risk reduction, Bronfenbrenner's socio-ecological model[3], Strategic toolkit for assessing risks (STAR, World Health Organisation)[4], Assessing mental health and psychosocial needs and resources: a toolkit for humanitarian Settings (WHO and UNHCR)[5] as well as IASC reference group mental health and psychosocial support assessment guide (IASC)[6].

While some of this information may already be available and can be accessed through a literature review, other information may be unavailable and new data may need to be collected.

Table 8.1: Post-Disaster Assessment: Template For Information To Be Collected[7]

Rapid Post-Disaster Assessment	Extended Post-Disaster Assessment
For a rapid post-disaster assessment, information shall be collected on the following indicators. A pre-disaster assessment, if conducted, should be	For an extended post-disaster assessment, information shall be collected on the following indicators. A pre-disaster assessment and rapid post-disaster assessment, if has been

accessed in order to support the collection of information, as some of the information below may already be available in the pre-disaster report or it may provide useful context to capture any differences in the current status.	conducted, should be accessed in order to support the collection of information, as some of the information below may already be available in the reports or it may provide useful context to capture any differences in the current status.
1. Clearly identify the **geographical area** that is being assessed (e.g. state, city, district, or a local community)	1. Clearly identify the **geographical area** that is being assessed (e.g. state, city, district, or a local community)
2. Hazards a. Describe the hazard that has occurred. b. Describe the current scale (geographical area and population exposed to hazard) of the hazard at the current time (Response phase).	2. **Hazards** a. Describe the hazard that has occurred, including any secondary hazards. b. Describe the current scale (geographical area and population exposed to hazard) of the hazard at the current time (Recovery phase).
3. Social determinants of mental health a. Socio-demographic context: Overall population size; gender and age distribution; persons with disability exposed to the disaster; SC, ST and OBC population exposed to the disaster: key languages spoken. b. Occupational context: Main livelihoods of people; unemployment rate. c. Economic context: poverty rate d. Health context: Common diseases in the aftermath of the disaster; Other health issues indirectly impacted by the disaster (e.g. increased wait-times for elective surgeries). e. Familial and gender context: Family structure distribution in the area (e.g. nuclear, joint, single-parent) and average number of children and elders per household. f. Administrative/ governance context: Current national, state and local government actors in the area in the aftermath of the disaster and the disaster funds available. g. Identify the most vulnerable groups in the area affected by the disaster.	**3. Social determinants of mental health** a. Socio-demographic context: Same as rapid assessment. b. Occupational context of the area: Main livelihoods of people post the disaster; Unemployment rate post the disaster. c. Educational context: Formal educational levels of population; literacy rates d. Economic context: Poverty rate post the disaster (have more families fallen below the poverty line?); Income distribution post the disaster e. Health context: Common diseases and health issues continuing in the aftermath of the disaster. f. Familial and gender context: Family structure distribution in the area (e.g. nuclear, joint, single-parent) and average number of children and elders household; rates of substance use and gender-based violence post the disaster. g. Administrative/governance context: Same as rapid assessment. h. Identify the most vulnerable groups in the area that continue to be severely affected by the disaster.

4. Mental Health and Psychosocial Context a. Prevalence of distress and trauma responses. This will be assessed through early identification, described in Chapter 8, Section 8.2. b. Number of individuals/families in the area experiencing bereavement, injuries, hospitalizations, damage to property, displacement and/or evacuation. This will be assessed through early identification, described in Chapter 8, Section 8.2. c. Informal and community-based services for MHPSS i. Identify informal social and community-based groups with willingness to provide MHPSS in the area. ii. Identify the community-based infrastructure currently available where this support can be provided. d. Formal services for MHPSS i. Identify the human resources (number of trained personnel at Level 1, 2, 3 and 4) available for immediate deployment to the area and the institutions to which they are linked. ii. Identify the technological resources (helplines and teleconferencing capacities) available in the area. iii. Identify the number of public healthcare institutions with functioning MHPSS capacities available in the area and where they are located. iv. Identify the number of educational sector, social sector, non-allopathic (ayush) sector and private sector institutions with functioning MHPSS capacities available in the area and where they are located. v. Identify the residential and rehabilitative services for people with disabilities and	**4. Mental Health and Psychosocial Context** a. Prevalence of distress, trauma responses and mental disorders. This can be assessed through detailed identification, diagnostic assessment and epidemiological research. b. Number of individuals/families in the area experiencing long-term disability, injuries or illness post the disaster. This can be assessed through detailed identification. c. Informal and community-based services for MHPSS i. Describe what has been the role of informal social and community-based groups and infrastructure in MHPSS for this disaster, including availability, accessibility, rates of use and quality of services. d. Formal services for MHPSS i. Describe what has been the role of disaster-specific MHPSS services (Level 1, 2, 3 and 4) in the area, including modality (in-person/remote), sites of delivery, availability, accessibility, rates of use and quality. ii. Describe how the infrastructure (physical and technological) has supported the service delivery. iii. Describe what has been the role of pre-existing mental health services in the area (e.g. DMHP, psychiatric hospitals, rehabilitative services), including availability, accessibility, rates of use, quality. iv. Describe what has been the role of the educational sector, social sector, non-allopathic health system and private sector institutions in MHPSS, including availability, accessibility, rates of use, quality. e. Socio-cultural beliefs, attitudes and norms relating to MHPSS i. Describe the community's attitudes towards mental health and mental distress post the disaster. ii. Describe the community's

mental disorders available in the area and where they are located. e. Socio-cultural beliefs, attitudes and norms relating to MHPSS i. Identify if there are any actions that service providers should avoid while delivering MHPSS in the community. **5. Humanitarian context** a. Identify the most common sources of distress and psychosocial problems for the community due to this disaster (immediate MHPSS consequences). b. Identify the perceived causes and expected consequences of the disaster for the community at the current time (Response phase). c. Identify the status of community-based coping in response to the disaster (Response phase).	attitudes towards help-seeking for mental health and psychosocial problems post the disaster. **5. Humanitarian context** a. A few months on, identify the most common sources of distress and psychosocial problems for the community due to this disaster (secondary MHPSS consequences). b. Identify the perceived causes and expected consequences of the disaster for the community (Recovery phase). c. Identify the status of community-based coping in response to the disaster (Recovery phase).

Step 2: Conduct a review of all available data.

For the rapid assessment, prioritise accessing reports from the pre-disaster MHPSS assessment (if conducted) or other MHPSS or intersectoral assessments previously conducted with the particular area/community/group.

For the extended assessment, review existing information or secondary data from sources such as government reports, reports by NGOs/INGOs, healthcare records of organisations and institutions who have been on the ground in the disaster. Projections about mental health trajectories and for vulnerable groups can be noted from research literature, which can also provide information about possible areas of concern in a long-term MHPSS program. This data can be reviewed along with data collected in previous assessments before or during the same disaster (pre-disaster assessment and rapid post-disaster assessment).

Step 3: Summarise all data collected.

Prepare a summary of existing data gathered at step 1 and step 2.

Step 4: Identify information areas for additional data collection.

Identify domains that require additional information, and outline objectives for further data collection collaboratively as a team.

Step 5: Select tools and methods of data collection.

These include quantitative or qualitative tools like surveys, questionnaires, key informant interviews, group interviews; MHPSS-relevant questions in other intersectoral assessments. When planning for the rapid assessment, ensure that tools and methods of data collection are highly focused and selective, a manageable amount of data that is easy to analyse is collected, and affected populations are not intruded upon anymore than required. During the extended assessment, tools assessing indicators for the monitoring and evaluation of services can also be added (see Chapter 11).

Some tools for collecting new information include those given below in the table below (Table 8.2). For more detailed information, readers can refer to WHO and UNHCR's Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings.

Table 8.2: Tools and Methods for Post-Disaster MHPSS Assessments[8]

Source/ Tool	Objective	Topics/ Sample Questions	Method
Participatory: Perceptions by community members with in-depth knowledge of the community Question A	Humanitarian Context: Understanding the experience of the disaster (perceived causes and expected consequences)	What do people in your community believe has caused the current [NAME OF DISASTER]? According to community members, what are the furtherc onsequences of the [NAME OF DISASTER]?	Interviews with community members who have in-depth knowledge of the affected community.
Participatory: Perceptions by community members with in-depth knowledge of the community Question B	Social Determinants of Mental Health: To identify the most vulnerable groups	Which people in your community are suffering the most from the disaster. Who else? . . . and who else?	Interviews with community members who have in-depth knowledge of the affected community.
Participatory assessment: perceptions by general community members Questions 1 and 2	Humanitarian Context: To identify and prioritise MHPSS consequences of the disaster	What kind of problems do people have because of the disaster? Please list as many problems as you can think of. You mentioned a number of problems, including [READ OUT PROBLEMS NAMED ABOVE]. Of these problems, which is the most important, second most important, third most important problem? Why?	Free list and ranking (individuals; general community members living in the humanitarian setting).

Participatory: Perceptions by community members with in-depth knowledge of the community Questions C1-C7	Humanitarian Context: To identify community-based coping and support	What are community members doing right now for each other to reduce their upset/distress? Where do people who are upset/distressed seek help?	Interviews with community members who have in-depth knowledge of the affected community.
The Humanitarian Emergency Settings Perceived Needs Scale (HESPER)	Humanitarian Context: To assess MHPSS consequences and problems caused by the disaster This tool involves conducting community household surveys so requires more resources than other tools	26 needs (physical, social, psychological), rated as a serious problem/ not a serious problem/ no response or NA Among unmet needs, respondent asked to identify 3 most serious problems Respondents can include additional unmet needs that are unlisted	Community household survey (representative/ convenience sample).
SAMHSA Needs Assessment Tool[9]	Mental Health and Psychosocial Context: To assess the number of people missing, dead, hospitalised, injured as well as damage to homes and displacement.	This needs assessment template can be edited and adapted to meet the requirements for the particular disaster.	Interviews, surveys, observations, official statistics.
Checklist for integrating mental health in primary health care (PHC) in humanitarian settings	Formal MHPSS services: To assess MHPSS services in PHCs	Indicators for health information systems, worker competency, psychotropic medicines, referrals, staff and workload, social access, main barriers, recommended actions to reduce barriers	Site visit, interviews with PHC programme/ clinic managers and staff.
Template to assess mental health system formal resources in humanitarian settings	Informal and community-based MHPSS services; Formal MHPSS services: To assess formal mental health system resources to	Details of formal mental health systems in the area of mental health in general and primary health care clinics (general hospitals, PHCs) and community care (community health and mental health workers).	Review of documents and interviews with managers of service.

	plan programming for (early) recovery and reconstruction	Impact of the disaster on these services: Fully functioning/partially functioning/ not functioning	

Step 6: Allocate and orient assessment teams.

The State MHPSS Working Committee shall coordinate the allocation of the assessment with local NGOs or CBOs and other on-the-ground organisations to avoid duplication of efforts. The Committee shall also ensure that the assessment teams are adequately apprised of ethical principles, sociocultural considerations, safety recommendations, basic interviewing skills, and basic psychosocial support skills, including referral, as needed. If possible, the same assessment team who conducts the rapid assessment in a particular community/geographical area may also conduct the extended assessment to maintain the rapport and comfort established with the participants.

Step 7: Set a timeline for data collection.

Decide a timeline to collect the data based on the objectives and ensure data collection is completed within the timelines outlined. For the rapid assessment, detailed surveys or data collection is not expected.

Step 8: Synthesise data gathered.

The assessment team meets to review and synthesise all the data collected from the literature review, expert stakeholders and community stakeholders. To synthesise the data, the team collates the collected information and identifies key vulnerabilities and key capacities of the target geographical area, in each category that information has been collected in.

Table 8.3 below identifies possible vulnerabilities and possible capacities that may be particularly relevant in a rapid and extended post-disaster assessment. For example, if the information collected shows that there is an increase in gender-based violence post the disaster, it is an important vulnerability to identify in the category 'Social Determinants of MHPSS'. On the other hand, if there are reverse helplines that are operational on the ground and delivering MHPSS services, it is an important capacity to identify. Hence, the State MHPSS Working Committee shall use the template below as a guide to identifying vulnerabilities and capacities. Note that not all vulnerabilities and capacities will necessarily be present for a particular area.

Table 8.3: Post-Disaster Assessment: Guide for Collating Information into Vulnerabilities and Capacities

	Rapid post-disaster assessment		Extended Post-Disaster Assessment	
Factors Assessed	**Current Vulnerabilities**	**Current Capacities**	**Current Vulnerabilities**	**Current Capacities**
Social determinants of mental health	Presence of ongoing violence or conflicts in the	Financial aid announced by central, state and international	Significant impact of the disaster on livelihoods, poverty, health	Continuing funds and financial aid for recovery and

	area post the disaster	sources	(malnourishment, diseases) Increase in gender-based violence and substance use post the disaster	reconstruction efforts
Informal and community based services for MHPSS		Informal social and community organisations and groups who are trained in and willing to provide MHPSS services currently	Multiple and/ or significant barriers to the community organising themselves to deliver MHPSS Level 2 services (e.g. lack of coordination and/ or infrastructure)	Community is effectively organising themselves to deliver MHPSS Level 2 services in the disaster (e.g. social activities, collective mourning)
Formal services for MHPSS	Significant damage sustained by key infrastructure such as hospitals, emergency services infrastructure, transport access that would impact MHPSS service delivery	**Human Resource Capacities** Adequate availability of trained personnel at Level 1, 2, 3 and 4 in the disaster-affected area and quick readiness for deployment **Technological Resource Capacities** Presence of national, state and organisational helplines (both private and NGO sector) that are currently operational. Presence of teleconferencing capacities in institutions with MHPSS capacities that are currently operational **Organisational, Institutional**	Multiple and/or significant gaps in service delivery and accessibility e.g. certain vulnerable groups have not accessed services Multiple and/ or significant barriers to service delivery continue e.g. transport accessibility of the area is poor	Adequate coverage of services and good accessibility for vulnerable groups

		and Material Resource Capacities Adequate number of healthcare, educational institutions, NGOs and INGOs in the disaster-affected area that have currently functioning MHPSS capacities and good accessibility (e.g. location)		
Socio-cultural beliefs, attitudes and norms relating to MHPSS			Stigma towards mental distress and mental disorders post the disaster Reluctance to seek help post the disaster	Good outreach of key MHPSS messages that normalise mental distress and mental health
Human-itarian Context	Complex and difficult MHPSS consequences (e.g. trauma, bereavement, forced displacement) Feelings of anger and injustice (e.g. around perceived cause of the disaster)	Sense of community spirit, togetherness and prosocial attitudes fostered by the disaster Community-centric coping strategies being used by the community	Continuing MHPSS consequences (e.g. persistent trauma responses) Feelings of disillusionment (as relief/resource materials start weaning, humanitarian presence reduces; reality of complex post disaster rebuilding starts)	Community-centric coping strategies continuing to be used by the community

Step 9: Estimate levels of vulnerability and MHPSS capacity.

Based on the above synthesis, the team estimates the overall level of vulnerability to MHPSS impact of the current hazard, overall level of capacity for addressing MHPSS needs of the community as well as overall MHPSS impact of the current hazard, by using the same framework as outlined in Chapter 5, Section 5.2.1.

Step 10: Outline recommendations for actions.

The team proportionately identifies recommendations for actions in each category, organised in order of priority. The team should aim to identify key implementable, specific actions, along with suggested timelines. Recommendations must clearly specify who will carry out the various recommendations as well i.e. the roles and responsibilities of various stakeholders. After the extended assessment, recommendations can also include steps for filling service delivery gaps, planning for long-term MHPSS service delivery, key lessons learnt for other hazards and future priorities, and gaps in capacity-building.

Hence, the **post-disaster assessment report** will consist of the following sections:

1. Aim and objectives
2. Assessment methodology (people involved, tools used, sampling, steps followed)
3. Findings:
    a. Information across 4 categories
        i. Clearly identify the geographical area being assessed
        ii. Details of hazard likelihood and scale
        iii. Details of social determinants of mental health
        iv. Details of the mental health and psychosocial context
        v. Details of the humanitarian context
    b. Key capacities and vulnerabilities should be identified within each of these categories
    c. Overall level of vulnerability, capacity and MHPSS impact
4. Recommendations and timelines, in order of priority, with roles and responsibilities identified
5. Limitations of the process
6. Summary and Conclusion

While reporting the data, care must be taken to protect the privacy of the individuals and communities. Identifying information should not be disclosed, nor should any other information that would endanger members of the affected population or staff.

8.1.2 Dissemination of Post-Disaster Assessment Findings

Results of the assessments should be disseminated in a timely and accessible manner. For a rapid post-disaster assessment report, it will be necessary to proactively share the report with stakeholders working on the ground so that it may be effectively used for planning service delivery.

For an extended post-disaster assessment report, it will be necessary to disseminate the report to government and non-governmental stakeholders involved in long-term service delivery as well as preparedness and capacity-building for future disasters.

These reports should also be uploaded onto the centralised portal so that community members and experts from the field are able to view it and provide feedback. Presentations or discussions on the summary of results can be conducted with the affected community, and their inputs should be recorded for the purpose of monitoring and evaluation, and future service delivery planning.

8.1.3 Coordination of Post-Disaster Assessments

Ensuring that assessments are coordinated and integrated is a critical task in the response to any disaster. Such an approach would address a number of recurring issues associated with the

collection and application of data in emergencies. Firstly, it has been noted that there is not so much a lack of data as a lack of its proper validation, synthesis, and analysis, which in turn renders it ineffective for its main purposes of prioritising and planning interventions. Secondly, populations or sections of it are over-assessed, while others are not measured at all. This can make the analysis non-representative, further adding to the vulnerabilities of certain subgroups. Thirdly, the data collection process is cumbersome as it is, and repetitive assessments by different organisations with the same groups can create a burden on the survivors and lead to wastage of precious resources. Fourthly, a lack of agreed upon tools and methods means that data sets are not easily comparable between different disasters, or different phases of the same disaster. Lastly, a lack of coordinated data dissemination by a centralised body means that all sectors and stakeholders do not get sufficient access to it, thereby reducing its application.

To address these challenges, a coordinated approach to post-disaster assessments is essential. Thus the following steps shall be taken to bridge these concerns:

- The overall coordination of the assessment process would be the responsibility of the State MHPSS Working Committee. State MHPSS Working Committee shall coordinate with local NGOs and CBOs as well as other organisations on the ground to collect data for the assessment.
- The State MHPSS Working Committee, in collaboration with the District Commissioner and Inter-Agency Groups, shall establish a team to conduct the post-disaster assessment of MHPSS vulnerabilities and capacities in the disaster affected area. The team will develop the assessment plan and follow the steps of conducting a post-disaster assessment.
- The State MHPSS Working Committee shall also coordinate with educational or research institutes to ensure availability of expertise on methods of assessment.
- Any organisation planning to conduct MHPSS assessments should inform the State MHPSS Working Committee so that efforts can be coordinated and unnecessary and repetitive data collection is avoided.
- The assessment can occur at a local level (for a local disaster restricted to a small geographical area), at a district level (for a disaster that affects one or multiple districts) or at a state level (if the disaster affects the entire state or more than one state).

8.2 Early Identification and Support

While community-wide needs assessments in a disaster help plan programs and services for the entire affected population, it is also essential to develop an understanding of mental health and psychosocial impact at the individual level. A well-coordinated and effective mechanism of early identification and referrals ensures that all individuals coming in contact with services are appropriately assessed for risk of psychosocial and mental health concerns and connected with the required appropriate levels of mental health and psychosocial care.

Early Identification: This component involves making an informed judgment about whether an affected individual is at risk of developing severe symptoms of distress, trauma, or mental disorders. This assessment is based on multiple factors including pre-existing and disaster-induced vulnerabilities, subjective and observed experience of distress, presence of trauma reactions, and risk of harm. The goals of early identification are to provide timely support and care by making recommendations to individuals based on results and deciding on the necessity of further referrals.

Referrals: Support post early identification can involve immediate intervention or making a recommendation to the individual about accessing another service, possibly an intersectoral service at the same level (PFA →livelihood support), or a service at another level (PFA → trauma-focused psychotherapy). The latter is called a referral. Referrals are initiated when services or support at a particular level are found to be inadequate for the individual's concerns, and exceed the scope or expertise of the service provider.

8.2.1 Framework for Early Identification

The framework below outlines the factors which can be assessed in the early identification process. These are suggested domains for early identification, and service providers may need to adapt them to their context and the nature of the on-the-ground situation.

8.2.1.1 Domains of Early Identification

A comprehensive assessment conducted for the purpose of identifying risk of developing mental health and psychosocial concerns in disaster-affected people must include the following four domains: vulnerability factors, emotional distress, trauma responses, and risk of harm:

Vulnerability factors: Vulnerability factors are defined as "variables that, if experienced or triggered, affect the probability that an individual will develop a condition, disorder, or disease" (American Psychological Association, 2015)[10]. These factors are particularly useful as a component in the framework of early identification as affected people may not always express distress or trauma in noticeable ways. As such, it becomes important to consider all external and internal factors that may signal the presence of concerns and the subsequent need for MHPSS services. The three categories of vulnerability factors included in the framework are as follows:

1. **Nature and level of exposure to the disaster**
   The Population Exposure Model[11] identifies level of exposure to the disaster as the primary predictor of distress, trauma, and the development of mental disorders. This exposure can be physical as well as psychological. Based on this criteria, people suffering the following consequences of the disaster are considered vulnerable or at-risk:
   a. Loss of close family members
   b. Severe injuries and hospitalizations
   c. High exposure to disaster-related trauma (e.g., witnessing violence or evacuation from disaster zones)
   d. Loss of homes, jobs and/or possessions, displacement, damage to homes and businesses
   e. Loss of extended family members or friends
   f. Prolonged exposure to the disaster situation, both directly (in case of first responders and other relief workers) and vicariously (e.g. government officials or MHPSS service providers who hear about the disaster from affected people)

2. **Individual and family psychosocial vulnerabilities**
   Important individual and family psychosocial vulnerabilities include: having a pre-existing physical or mental illness; presence of substance use and/or violence in the family; lack of social support as well as social vulnerability factors (e.g. belonging to a vulnerable caste group; belonging to a vulnerable occupational group). These vulnerability factors unique to each individual can interact to create varying levels of distress and mental health consequences. For example, an individual with disability, belonging to a low socioeconomic background, and

currently experiencing violence at home will be at much higher risk of developing mental health concerns as compared to another individual without any disability, belonging to a high socioeconomic background, and not experiencing violence at home.

3. **Community and environmental psychosocial vulnerabilities**
   These include mental health services coverage, poverty rate, education and literacy rates, employment rates, status of gender and other minorities, rates of malnourishment, mortality, morbidity, local government effectiveness, available mental health service providers, stigma and discrimination, prevalence of mental health disorders, substance use etc.

Emotional distress: Individuals can experience significant emotional distress during or after a disaster. Emotional distress (alternatively referred to as mental or psychological distress) refers to a range of negative and/or painful symptoms and experiences, both physiological and psychological. These negative feelings or experiences may be short-lived or long-term, mild or severe. The effects of emotional distress can also be experienced at a physiological, cognitive, and behavioural level, and can include:

1. **Emotional symptoms:** stress, agitation, anxiousness, depression, grief, and fear for their safety and the safety of their loved ones
2. **Cognitive symptoms:** constant worrying, racing thoughts, forgetfulness, difficulties with concentration and judgement
3. **Behavioural symptoms:** impairment in daily functioning, loss of interest in pleasurable activities, social isolation and avoidance
4. **Physiological symptoms:** disturbances in patterns of sleep and appetite, fatigue

Hence, identification of emotional distress and its cognitive, behavioural and physiological manifestations is important.

Trauma responses: Many survivors of a disaster are at risk of experiencing severe distress, intense fear, helplessness, and hopelessness as a result of direct or indirect exposure to the disaster, and therefore may develop trauma responses. It is important to specifically identify trauma responses because they indicate that the experience of the disaster has overwhelmed the individual's coping skills, worldview, and sources of safety. This can lead to prolonged distress and impaired functioning, thus necessitating higher levels of dedicated care. Trauma responses also evade identification by the individual, their family or service providers, given that there might be a lack of awareness about specific signs and behaviours, and especially because some individuals may be responding to the traumatic stress by avoiding talking about it, or by feeling numb. It is therefore important to include the following trauma responses in tools used for early identification:

- Intrusive thoughts
- Flashbacks
- Distressing dreams
- Avoidance of people, places, activities, objects and situations that may trigger distressing memories
- Negative thoughts about oneself or others (eg. "I am to blame for what happened", "The world is an unsafe place")
- Ongoing negative feelings of fear, horror, anger, guilt or shame
- Difficulty experiencing positive emotions or enjoying pleasurable activities
- Irritability, anger outbursts, reckless behaviour
- Hypervigilance
- Difficulty concentrating or sleeping

- Being easily startled

Risk of harm: Risk of harm refers to the risk of an affected individual experiencing a severe level of distress that might lead to threatening behaviour against their own selves or others around them. It is usually characterised by signs such as expression of intense anger towards self or others, extreme agitation, etc.

- Risk of harm to self (e.g. suicide, self-harm)
- Risk of harm to others (e.g. violence, homicide)
- Risk of both (e.g. people who are so upset that they cannot care for themselves or their children

8.2.1.2 Personnel Conducting Early Identification

Personnel at different levels of the MHPPS services pyramid will have varying levels of training and capacity to conduct early identification.

Level 1 and Level 2 personnel (from cadres 1, 2, 4, and 6) may have basic training in early identification such as 'looking' and 'listening' for signs of mental health and psychosocial concerns. This identification can then be followed by referral or 'linking' to appropriate services.

Personnel from Cadres 1-6 who have Level 3 training can conduct early identification through Look and Listen, as well as through formal assessments with the use of questionnaires and interviews. Mental health practitioners (Cadre 7) and mental health professionals (Cadre 8) with Level 4 training can conduct early identification through various standardised tools as well as conduct extended diagnostic assessments at a later stage. Personnel from both these levels can then follow the identification with interventions and referrals as required.

Table 8.5: Personnel And Mechanisms Of Early Identification And Referral

MHPSS Pyramid Level	Cadre	Early Identification And Referral	
		How To Identify?	Then What?
Level 1 and 2	All Cadres, but specifically: • Cadre 1 (Citizen volunteers/General Public) • Cadre 2 (Disaster Responders) • Cadre 4 (Government officials) • Cadre 6 (NGO Personnel)	Using 'Look and Listen'	Refer or 'Link'
Level 3	Cadres 1-6 who are trained in Level 3 interventions	Using 'Look and Listen' Formal identification (e.g. through structured interviews and/or questionnaires)	Intervene Refer or 'Link'
Level 4	• Cadre 7 (Mental Health Practitioners)	Formal identification (e.g.	Intervene

	• Cadre 8 (Mental health professionals)	through structured interviews, questionnaires and other standardised tools)	Refer or 'Link'

8.2.1.3 Population at Whom Early Identification is Aimed

Early identification in on-site locations: All affected people present in on-site locations can be assessed for the purpose of early identification. Early identification with displaced populations affected by disasters like earthquakes, floods, etc. can take place in temporary shelters, relief camps, and other community spaces. Populations affected by more localised disasters or disasters that have not caused displacement may be reached through door to door home visits if feasible. Home visits for outreach and early identification can also be employed for people who are confined to their homes for other reasons such as quarantine, disability and lack of transport. Early identification and referral at all of these sites can be conducted by personnel from all cadres present at these sites with appropriate training.

Early identification in healthcare settings: All affected people accessing services in healthcare facilities like PHCs, general hospitals, tertiary hospitals, etc. must be assessed by available personnel from Cadres 5, 7, and 8.

Early identification in remote settings: Outreach and early identification through remote channels can occur through helplines, especially reverse helplines (described further in Chapter 9). Trained helpline staff can contact the affected community using databases of survivors' information, and conduct early identification and referrals.

8.2.1.4 Considerations for Conducting Early Identification

- All personnel conducting early identification should ensure that they are sufficiently familiar with the affected community's language and cultural norms. The community may not be receptive or trusting towards the early identification process due to associated stigma, and may prefer a community member or trusted outsider to accompany personnel.
- While the process of early identification is conducted with specific objectives in mind and the time available may be short, it should not become limited to only asking questions from a questionnaire, checking off symptoms from a checklist, or getting the survivor to fill out forms. The process should involve intentional efforts towards building rapport, ensuring the survivor's comfort, and making general enquiries about their health and wellbeing before moving on to specific topics related to the various domains included in early identification.
- Some survivors may welcome the opportunity to discuss their concerns at length, while others may be more reserved in sharing their struggles. The early identification process should hold space for both of these preferences. Their narratives should neither be interrupted nor forced, and questions should be weaved into the narratives.
- Early identification should not include asking people to recount what occurred or describe what happened, as this may retraumatize them.
- While it is important to keep the process conversational and comfortable, providing information about the purpose of the early identification and gaining consent should be explicitly included.

- Personnel conducting early identification should be mindful of not reacting to survivors' narratives with shock, mistrust, apathy, or minimisation as this may increase their distress and discomfort.

8.2.1.5 Methods of Early Identification

Early identification of the risk or presence of mental health and psychosocial concerns is carried out on the basis of multiple forms and sources of data. A preliminary form of early identification can be conducted using informal interviews with the individual, and observation of non-verbal signs. More formal early identification is conducted through the use of structured interviews and validated assessment tools administered by trained personnel, such as personnel with Level 3 or 4 training. This section lists example questions as well as suggested tools for the four domains of early identification detailed above. This list is neither intended to be exhaustive or indicative, but rather illustrative, and service providers are encouraged to use tools that are appropriate and suitable to their particular cultural contexts.

Table 8.6: Methods of Early Identification

Early Identification Framework Component	Suggested Tools	Sample Questions
Nature and level of exposure to the disaster	No tool identified	• How close were you to [the disaster]? • Are you or someone you know hurt or injured? • Is anyone you know missing? • Is your house/home damaged? Do you currently have a safe place to live?
Individual and family psychosocial vulnerabilities	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)[12] Ongoing Violence Assessment Tool (OVAT)[13] SuFP-GBV Quick Screening Tool[14] Perceived Social Support Scale (PSS)[15]	• Do you feel supported at home? Do you have someone you can share your worries with? • How have you been coping with this stress? • Are you able to manage your important day-to-day tasks? • Has there been any instance of violence within your family against you or someone else? Do you feel safe with your family members? • Have you ever been diagnosed with depression, anxiety, or any other mental disorder before? • Are you currently taking any medications to manage your psychological concerns/ distress? • Have you used any substances (non-medical use only) in the past? Have you started/ increased any use of substances lately?

Community and environmental psychosocial vulnerabilities	Information about this domain to be accessed from pre and post-disaster assessments	
Emotional distress	Self-Reporting Questionnaire-20 (SRQ-20)[16] Patient Health Questionnaire-4 (PHQ-4)[17] WHO-UNHCR Asessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS)[18]	• Are you feeling unhappy or hopeless? • Are you feeling nervous or afraid? • Are you experiencing pain in your body, like headache or stomach ache? • Are you able to concentrate on and enjoy your daily activities? • Are you able to participate in social events? • Are you having concerns related to sleep or appetite?
Trauma responses	Primary Care PTSD Screen for DSM-5 (PC-PTSD 5)[19]	• Have you had nightmares about the event(s) or thought about the event(s) when you did not want to? • Have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? • Have you been constantly on guard, watchful, or easily startled? • Have you felt numb or detached from people, activities, or your surroundings? • Have you felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?[20]
Risk of harm	Columbia Suicide Severity Rating Scale (C-SSRS)[21] Item 9 in Patient Health Questionnaire 9 (PHQ-9)[22] Item 17 in Self-Reporting Questionnaire-20 (SRQ-20)	• In the past week, have you been having thoughts about killing yourself? • Are you so angry about what has happened that you have considered hurting someone else? • Are you currently able to care for yourself and your child/children?

8.2.1.6 Determining Level of Risk Of MHPSS Concerns and Providing Referrals

Based on the specific tools used for early identification, service providers will also need to determine a process for judging the overall level of risk of MHPSS concerns, for streamlining referrals. Definitions of three types of risk are provided below to assist service providers in specifying this process.

A **high risk** of developing mental health and psychosocial concerns is indicated if the individual

is found to have high scores across all or most early identification domains, for example, high level of exposure to the disaster, high individual and community vulnerability, heightened distress or trauma responses, or high risk of harm. Any indication of a risk of harm to self or others will automatically be categorised as high risk, even without high scores in other domains. Once a high level of risk is determined, referrals to Level 3 and 4 MHPSS services must be made within 24 hours, the referral should be documented and follow up must be conducted to ensure that appropriate services have been provided.

A **moderate risk** of developing mental health and psychosocial concerns is indicated in case of low-moderate scores in most of the early identification domains accompanied by moderate-high scores in the remaining domains (without risk of harm). Individuals with this risk level must be connected to appropriate services within a week or a fortnight, at most, and regular follow ups must also be ensured.

A **low risk** of developing mental health and psychosocial concerns is indicated in case of low scores across most of the early identification domains. Individuals with this risk level must be provided referrals to other supportive services at Level 1 or 2 as needed, and must be included in long-term follow-ups.

8.2.2 Early Identification and Referrals

Early identification: State MHPSS Working Committee shall create protocols for early identification as part of the State MHPSS Action Plan for their states by reviewing and selecting available tools. The Committee, in coordination with the nodal centre, will create an 'early identification packet' that can be distributed to organisations working on the ground when a disaster occurs. The Committee will endeavour to include culturally appropriate tools in local languages.

Referrals: State MHPSS Working Committee shall create referral protocols for their states by taking stock of available services, coverage of these services, service providers. It shall ensure that information about referral services is made available to all service providers from all Cadres. The State MHPSS Working Committee must oversee the coordination of the established identification and referral protocols on the ground between agencies, sectors, and organisations.

References

[1]Standard Operating Procedures Post Disaster Needs Assessment India. National Institute of Disaster Management (NIDM) (Ministry of Home Affairs, Government of India) [Internet]. Available from: https://nidm.gov.in/PDF/pubs/sop_pdna.pdf

[2]Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

[3]Bronfenbrenner, Urie. Ecology of human development: Experiments by nature and design. Cambridge: Harvard University Press, 2009.

[4]World Health Organization. Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment.

[5]Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings, World Health Organization & United Nations High Commissioner for Refugees, (2012). Accessed from: https://apps.who.int/iris/handle/10665/76796 on June 10, 2023.

[6]Inter-Agency Standing Committee. IASC Reference Group Mental Health and Psychosocial Support Assessment Guide. 2013.

[7]This table is adapted with permission from: World Health Organization. Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings. 2012. Tool 9 Template for desk review of pre-existing information relevant to mental health and psychosocial support in the region/country, p. 60-62. We bear responsibility for the adaptation and the adaptation is not endorsed by WHO.

[8]Tools are summarised and sample questions reproduced with permission from: World Health Organization & United Nations High Commissioner for Refugees, (2012). Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings, Accessed from: https://apps.who.int/iris/handle/10665/76796 on June 10, 2023.

[9]Needs Assessment [Internet]. Substance Abuse and Mental Health Services Administration; updated 2022 Sep 27; cited 2023 Aug 22. Available from: https://www.samhsa.gov/sites/default/files/needs-assessment-template.docx

[10]American Psychological Association. (2015). APA Dictionary of Psychology (2nd ed.).

[11]DeWolfe DJ. Mental health interventions following major disasters: A guide for administrators, policy makers, planners, and providers. Emergency Services and Disaster Relief Branch, Center for Mental Health Services, and Substance Abuse and Mental Health Services Administration, Washington, DC. 2002.

[12]The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): manual for use in primary care / prepared by R. Humeniuk, R. Ali, et al. World Health Organisation. (2010).

[13]Ernst AA, Weiss SJ, Cham E, Hall L, Nick TG. Detecting ongoing intimate partner violence in the emergency department using a simple 4-question screen: the OVAT. Violence and Cictims. 2004 Jun 1;19(3):375-84.

[14]GBV/VAC SCREENING QUESTIONS [Internet]. Cited 2023 Aug 22. Available from: https://www.engenderhealth.org/wp-content/uploads/2022/11/SuFP-GBV-Quick-Screening-Tool.pdf

[15]Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment 1988;52:30-41.

[16]A User's Guide to Self Reporting Questionnaire (SRQ). Division of Mental Health World Health Organisation. Geneva. (1994).

[17]Kroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ–4. Psychosomatics. 2009 Nov 1;50(6):613-21.

[18]World Health Organization & United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO, 2012.

[19]Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G., Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2015). The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). [Measurement instrument].

[20]These questions are from the Primary Care PTSD Screen for DSM-5. This measure was developed by staff at VA's National Center for PTSD and is in the public domain and not copyrighted.

[21]Posner K, Brent D, Lucas C, Gould M, Stanley B, Brown G, Fisher P, Zelazny J, Burke A, Oquendo MJ, Mann J. Columbia-suicide severity rating scale (C-SSRS). New York, NY: Columbia University Medical Center. 2008;10:2008.

[22]Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. Journal of general internal medicine. 2001 Sep;16(9):606-13.

09 MHPSS Service Delivery

This chapter details the principles, components, and operational mechanisms of the proposed MHPSS services framework. Key MHPSS actors, target populations, services and service locations across the four levels of the MHPSS pyramid are identified. Specific considerations for the planning and delivery of services in three key settings- on-site, in healthcare institutions, and remote are also outlined. Finally, the concerns and challenges faced by MHPSS service providers in these unique circumstances are described, and steps to support them are suggested.

9.1 Guiding Principles of Service Delivery

While efforts are made to ensure that all services, including MHPSS services, being provided to an affected community are in accordance with international and national standards, often these services have to be modified based on contextual realities, resource constraints, logistical concerns, etc. In order to maintain the quality and effectiveness of services even with such factors at play, it is important to develop an understanding of the following key principles that should guide their planning and delivery:

Stepped care approach: This approach of delivering MHPSS aims to deliver the most effective, yet least resource-intensive services first, and steps up to progressively more intensive and specialist services as required based on the individual's need and level of distress. It is based on the following principles: people should be able to receive immediate services without having to rely on and wait for intensive treatments; different people experience varying levels of distress and therefore require different levels of care; and offering services from lower to higher levels of care increases their effectiveness and decreases costs[1]. The service delivery framework is also envisioned to be multi-purpose i.e. the same organisation, modality or service provider is equipped to provide multiple levels of support to different people. For example, a tertiary hospital can provide Level 3 and Level 4 support. This approach streamlines the use of resources both during capacity building and service delivery, and also increases the sustainability of these services.

Social justice informed: A social justice[2] informed approach refers to the service provider being aware of people's social identities and how they impact their lived realities, as well as the impact of systems and structures on mental health outcomes of individuals and communities. This also translates into accommodating all affected groups and sub-groups through the use of advocacy, and ensuring that services promote equity, dignity, access, participation, and safety for all.

Sensitivity to culture and context: Culturally and contextually-sensitive MHPSS services involve adapting, instead of merely replicating, western models and ideas. This includes being respectful and open-minded towards the cultural ways of meaning-making that people may use, as well as the traditional systems of healing functioning in their communities, without endorsing any harmful practices. Cultural sensitivity also includes recognition of the fact that instead of a

shared, homogenous culture across the country, different regions and communities have their own unique cultures and subcultures.

Recognizing strengths: Strengths-based practice refers to the idea that there is more to a person than their problems i.e. all individuals and communities have positive assets, strengths and resources that they can and are drawing upon. This is reflected in the overall approach in the current guidelines as well as in service delivery when people's capacities, and not only vulnerabilities, are taken into account.

Protecting dignity: Promoting and safeguarding the dignity of the affected community refers to engaging with people and communities in a respectful manner, taking informed consent for services and ensuring privacy and confidentiality (including data security).

Increasing access[3]: Increasing access means ensuring that services are available to all individuals and groups, especially to vulnerable groups. Accessibility can be understood as being based on four dimensions. Non-discrimination means that all affected people have equal and equitable access to services without facing discrimination or further marginalisation. Physical accessibility means that services are within safe physical reach of all members of the affected community. Ensuring physical accessibility can look like designing service delivery sites with ramps, wider doors, etc and facilitating transportation services for people who are unable to access service facilities. Economic accessibility or affordability means that the cost of services is not a deterrent for people who want to seek services, especially people from economically or socially disadvantaged groups. Information accessibility means that all affected people have access to information services and are able to participate in feedback mechanisms. Ensuring information accessibility can look like creating accessible communication channels like community meetings, notice boards, suggestion boxes in multiple locations, disseminating information in local languages through multiple mediums like radio, SMS, television, and social media, and in multiple formats such as audio, visual, sign language, Braille, etc.

Continuity of care: The guidelines propose integrated, cohesive MHPSS services for all individuals and users where care is taken to coordinate information sharing and delivery of MHPSS interventions. Further, MHPSS services shall be made available even after the response phase; well into the recovery, rehabilitation, and reconstruction phase to ensure long term availability of needs-based services for the community. This shall be available for those with pre-existing mental health concerns as well as those experiencing post-disaster distress, trauma reactions, or mental disorders.

Promoting participation: Increasing participation means that all members of the affected community are fully, equally, and meaningfully involved in the decision-making process for services that impact their lives. It refers to the ethical principle of autonomy and respecting that people are the decision-makers of their own lives. In the context of service delivery, promoting participation can look like involving community members and community-based organisations to plan and deliver services and ensuring that under-represented population groups like women, people with disabilities, adolescents etc. are included in these participatory processes.

Facilitating safety: Ensuring that all groups within the affected community are able to seek services in ways that protect their physical and psychological safety. Safety is an important aspect of being trauma-informed. Safety involves ensuring safe food distribution sites; sanitation

facilities with adequate locks and lighting; safe routes and transport to service delivery sites; the prevention of violence committed against a person because of their sex or gender; protecting children from all forms of violence, abuse (including sexual abuse), neglect, maltreatment, and exploitation; and promoting the rights and safety of people within organizations that provide services to them (e.g. ensuring confidential mechanisms of reporting harassment by a staff member).

Ethical practice: The ethical principles to be adhered to while delivering MHPSS services include the principle of doing no harm, respecting the autonomy of people, beneficence (doing good and being helpful), ensuring justice (providing all people equal and fair treatment) and fidelity (meeting obligations and commitments made).

Upholding accountability: Accountability refers to the idea that all people supported by MHPSS services can hold service providers accountable for protecting their rights, ensuring effectiveness of services, taking into consideration their needs and preferences, and respecting their dignity[4]. This may also involve committing to ongoing monitoring and evaluation, creating mechanisms to determine effectiveness of services and ensuring that MHPSS services are overseen by appropriately trained personnel[5].

9.2 MHPSS Service Delivery Pyramid

The MHPSS service delivery framework introduced in this section provides details of service delivery across four levels of the MHPSS pyramid previously described in Chapter 2, Section 2.3.1 with unique actions at every level. The target population, service description, service providers, and service delivery sites for each action are clearly outlined. Service delivery actions at each level are linked to capacity-building actions described in Chapter 6.

Table 9.1: Service Delivery Actions

Level of Pyramid	Service Delivery Actions
Level 1: Psychosocial considerations in essential services and security	**Action 1.1:** Including MHPSS considerations in essential services and security **Action 1.2:** Including MHPSS considerations in disaster communication **Action 1.3:** Conducting MHPSS Advocacy Activities **Action 1.4:** Disseminating key MHPSS messages about: a. MHPSS services and intersectoral services b. MHPSS self-help resources and IECs
Level 2: Family and community-based care	**Action 2.1:** Conducting community awareness programs about MHPSS **Action 2.2:** Community organisation and mobilisation
Level 3: Focused, non-specialised supports	**Action 3.1:** Focused psychosocial care and support interventions

Level 4: Specialised services	**Action 4.1:** Mental health medical management by medical practitioners **Action 4.2:** Disaster-specific and trauma-informed mental health services provided by mental health professionals and mental health practitioners

Level 1: Psychosocial Considerations in Essential Services and Security

Action 1.1 Including MHPSS considerations in essential services and security

a. Aimed at: Entire population directly or indirectly exposed to the disaster

b. Service description: Government officials and frontline personnel should integrate mental health and psychosocial considerations when delivering their respective services. For example, while officials are advising or helping families with procedures to access official compensation or basic necessities, they must communicate sensitively and empathetically and use basic psychosocial skills such as active listening. Interactions with injured individuals and bereaved families must be especially sensitive and reassuring, and immediate support and assistance must be provided to them. While distributing food and other aid items, psychosocial considerations such as community preferences for type of food and manner of interaction must be taken into account.

c. Action conducted by:

i. Frontline workers: Cadre 2 (Disaster Responders), Cadre 6 (NGO Personnel in the field of health, education, protection, child protection, gender-based violence, nutrition, shelter, WASH, food security, camp coordination & management, and mental health)

ii. Officials having administrative decision-making capacities: Cadre 4 (Local, State & Central government personnel), Cadre 5 (Health and allied health professionals), and Cadre 6 (NGO Personnel)

d. Service delivery sites: This service is not a separate service and is integrated with essential and other intersectoral services. Hence, service delivery sites are expected to be similar to those of all other services.

i. In-person modalities:

- At site of disaster
- Government offices and set ups
- NGO set ups
- Community spaces (schools, workplaces, old age homes, orphanages)
- Rescue camps and shelters

ii. Remote modalities:

- National and State helplines (both MHPSS and non-MHPSS related)
- Government websites and mobile phone applications

e. Timing of action: This should be integrated with all outreach and services immediately after the disaster occurs and should be continued in the recovery, reconstruction and rehabilitation phase.

Action 1.2: Including MHPSS considerations in disaster communication

a. **Aimed at:** Entire population directly or indirectly exposed to the disaster.

b. **Service description:** The objective of this action is to ensure that all disaster-related communication reaching the affected community and the general population is responsible and helpful, rather than adding more distress and stigma. This includes making the communications trauma-informed by including trigger warnings, limiting the use of images that are likely to be highly distressing, and eliminating sensationalised ways of reporting. Survivors must not be asked to recount details of their experience unnecessarily. Images or videos covering casualties/burials should be especially sensitive. Language used must be respectful such as using 'survivors' instead of 'victims', 'died by suicide' instead of 'committed suicide'. The inclusion of survivors' accounts, interviews, and images must be contingent on their consent. Communication must also be culturally sensitive and functionally accessible by all groups.

c. **Service provided by:**
   i. Cadre 4 (Local, State & central government personnel, especially Ministry of Information & Broadcasting),
   ii. Cadre 5 (Health and allied health professionals)
   iii. Cadre 6 (NGO Personnel involved in communication/ reporting/ news sharing),
   iv. Cadre 9 (Media)

d. **Service delivery sites:**
   i. **In-person modalities:**
      - Any site displaying or communicating information about the disaster e.g. government offices and set-ups
      - Press conferences

   ii. **Remote modalities:**
      - Print and digital media (newspaper, TV, radio)

e. **Timing of action:** This service should be started immediately after the disaster occurs and should be continued in the recovery, reconstruction and rehabilitation phase.

Action 1.3: Conducting MHPSS advocacy activities

a. **Aimed at:** Entire population directly or indirectly exposed to the disaster.

b. **Service description:** While the provision of basic services to the affected community is ongoing, another key need is for stakeholders to advocate for MHPSS related needs and concerns. This includes highlighting the community's needs and priorities at relevant platforms as well as communicating any other concerns they might have. This can also include advocating for their human rights, legal rights, and the rights of vulnerable groups. As the programming continues, advocates can also relay the community's feedback to organisers and service providers, and seek more suitable forms of support. These advocacy efforts may be targeted towards government agencies, NGOs/ INGOs, other humanitarian actors, and the general public as well.

c. **Action done by:**
   i. Cadre 1 (Citizens/ General Public)

ii. Cadre 5 (Health and allied health professionals)
iii. Cadre 6 (NGO Personnel)

d. Service delivery sites:

i. In-person modalities:

- Can be at various sites depending on the action.

ii. Remote modalities:

- Government grievance redressal mechanisms such as Aaple Sarkar[6]
- Social media platforms of government and non-governmental actors

e. Timing of action: This action should be carried out at all phases of a disaster, including pre and post-disaster. It should be continued in the recovery, reconstruction and rehabilitation phase.

Action 1.4 Disseminating key MHPSS messages about a) MHPSS services and intersectoral services b) MHPSS self-help resources and IECs

a. Aimed at: Entire population directly or indirectly exposed to the disaster. Self-help resources and IECs can be targeted towards both the general population as well as specific sub-groups (parents, service providers, children, students, etc.).

b. Service description: Since it is not feasible to connect with every individual or group from the affected community, asynchronous ways of relaying important information are required. This includes the dissemination of verified and up-to-date information about relevant and available MHPSS and intersectoral services, service delivery sites, and contact information. Referrals can also be made directly by service providers from various cadres when they interact with various people in the disaster-affected area. MHPSS self-help resources and IECs are described in Chapter 6, Section 6.1.2 and can broadly include information about signs of distress and trauma and ways of coping in disasters and strategies to facilitate self-help or provision of support to loved ones and in the community. They can also include key prosocial messages and information around mental health experiences and considerations and services for vulnerable populations (e.g. children, women, people with disabilities, elderly population, low income groups, SC/STs).

c. Service provided by: Cadres 1-9. It is recommended that these resources are developed prior to the disaster.

i. MHPSS and intersectoral services: Once the disaster has occurred, SDMAs of respective states in coordination with DDMAs will collate or update information (based on previous availability) on available services in a rapid manner and make this available to all organisations working on the ground.

ii. MHPSS self-help resources and IECs: SDMAs in coordination with DDMAs will also select relevant IECs or adapt relevant IECs to the current disaster and make them available to all organisations working on the ground.

d. Service delivery sites:

i. In-person modalities: Distribution of flyers and sticking posters at:

- Rescue camps/ temporary shelters
- Trauma centres and emergency rooms

- Mobile Clinics in the disaster-affected area
- NGO set ups
- Community spaces (schools, offices, old age homes, orphanages, home visits)
- Government offices and set ups

ii. Remote modalities:

- Digital posters and short videos on social media
- Official government websites of MOHFW, State Health Departments, NDMA, NIDM
- Centralised portal
- SMS Messages to people in disaster-affected area
- Information about services can be shared on national/state helplines when people call the same
- Media outlets: TV, radio, newspapers

e. Timing of action: This service should be carried out at all phases of a disaster, including pre and post-disaster. It should be continued in the recovery, reconstruction and rehabilitation phase.

Level 2: Family and Community-based Care

In any emergency or disaster situation, there is a high likelihood that community and family networks that people rely on have been disrupted by displacement, loss, structural damage, etc. Moreover, in emergencies of a certain nature, these networks further break down due to an atmosphere of panic, distrust, and fear. Therefore, interventions at this level are designed to restore these supportive networks, as well as put in place additional ones that may be necessary. The five broad actions at this level include:

Action 2.1 Community awareness programs on MHPSS

a. Aimed at: Entire population affected by the disaster, especially vulnerable groups and those at risk for developing severe distress, trauma or mental disorders

b. Service description: Community-awareness programs refer to community-wide, targeted awareness-raising activities that combat stigma and discrimination, and promote help-seeking behaviour. This could include activities such as group discussions, experiential activities, art-based exhibitions about mental health themes and so on. They are further described in Chapter 4, Action 2.1

c. Service provided by:

i. Cadre 3: (Community Level Workers),
ii. Cadre 4 (Local, State & central government personnel), and
iii. Cadre 6 (NGO personnel).
iv. Cadre 7 (Mental health practitioners)
v. Cadre 8 (Mental health professionals)

d. Service delivery sites:

i. In-person modalities:

- Community spaces (community centres and social gatherings, old age homes)
- Schools, colleges and workplaces
- Home visits

ii. **Remote modalities:**
- Interactive programs on social media
- Web-based programs through video-conferencing apps

e. **Timing of action:** These awareness programs can be commenced once the rescue and relief operations have concluded, and can continue into the long-term recovery, rehabilitation and recovery phase. They may also be conducted pre-disaster as preparedness activities.

Action 2.2 Community organisation and mobilisation

a. **Aimed at:** Entire population affected by the disaster, especially vulnerable groups and those at risk for developing severe distress, trauma or mental disorders.

b. **Service description:** Communities are likely to have pre-existing supports established by different stakeholders, which can be from the organised or unorganised sectors. These activities include collective social activities (e.g. gatherings that involve singing, storytelling, shared meals, etc.), mourning activities (e.g. traditional memory ceremonies; prayer rites), childcare and child-friendly activities (e.g. creches; informal activities such as drawing, sketching, singing), community kitchens and so on. These activities also include informal social groups and support groups run by CBOs, schools and workplaces for women, parents, caregivers, people with disabilities, religious and gender minorities, etc. Post-disaster, it is important to ensure that community groups are still functional, offer necessary support and resources, and encourage linkages to survivors and other liaisons. Stakeholders based in the community are encouraged to mobilise and organise these community supports, while stakeholders who are members of governmental and non-governmental (professional or organised sectors) organisations that visit or engage with the community during times of disasters are encouraged to assist and facilitate community-based stakeholders in organising these community supports. Support is also specifically provided to ensure that these community-based, community-organised services are safe, inclusive, transparent, collaborative, and prioritising the choices and rights of survivors.

c. **Service provided by:**
i. Organising and mobilising community supports: Cadre 1 Citizen Volunteers; Cadre 3 Community Level Workers (CLWs); Cadre 6 (NGO Personnel: Local NGOs and CBOs)
ii. Assisting and facilitating community-based stakeholders: Cadre 4 (Local, State & central government personnel); Cadre 5 (Health and allied health professionals), Cadre 6 (NGO Personnel: non-local NGOs and INGOs), Cadre 7 (Mental health practitioners), and Cadre 8 (Mental health professionals)

d. **Service delivery sites:**
i. **In-person modalities:**
- Community spaces (community centres and social spaces, community sports or activity centres, public parks and greenspaces, workplaces, schools, old age homes, orphanages)

ii. **Remote modalities:**
- Community groups on social media

e. **Timing of action:** This service should be carried out at all phases of a disaster, including pre and post-disaster. It should continue into the long-term recovery, rehabilitation and recovery phase.

Level 3: Focused, Non-Specialised Supports

Services at this level are designed such that they can be provided by supervised professionals and volunteers even without years of specialised training. This ensures that a wider net of services and service providers are available to meet the needs of affected people efficiently.

All interventions at this level can be one-time interventions or can involve follow-up contact. Follow-ups are conducted after the first instance of service delivery to check progress and need for further support, and are encouraged for all interventions at this level. They can be conducted either by the same service provider or a different one. Follow-ups should be based on clearly established protocols regarding time and frequency of contact, nature of contact, scheduling, and consent. Service providers should be proactive in planning follow-ups, and should take confirmation for them in the first instance of contact itself.

Action 3.1 Focused Psychosocial Care and Support Interventions

a. Aimed at: Individuals with distress and trauma responses

b. Service description: The following services can be delivered to individuals as well as groups by service providers who have completed the requisite trainings.

i. Psychosocial First Aid is an initial disaster response intervention that aims to reduce the immediate distress caused by traumatic events, promote safety, stabilise survivors, and connect individuals to help and resources. It can be provided to both children and adults, and is usually administered at the first instance of contact with the distressed individual. PFA is not meant to be a long-term, professional intervention, but a first step towards improved mental health outcomes. The key aspects of PFA include assessment of needs and concerns, providing comfort, facilitating access to information, services, social supports, and protecting the individual from further harm.

ii. The National Disaster Management Training Module 2 (developed by NDMA and NIMHANS) includes techniques like ventilation, active listening, empathy, maintaining routine, coping strategies, social support, yoga and relaxation, recreation, spirituality, and externalisation of interests.

iii. The manual 'Psychosocial Support during the COVID-19 pandemic (NDMA & TISS)' includes modules on addressing basic needs, sharing information, reducing emotional distress, containing anxiety, responding to low mood, regulating anger, assuaging guilt, working with grief, managing risk for suicide, mitigating stigma and nurturing narratives of resilience for helpline counsellors.

iv. The WHO Problem Management Plus (PM+) programme provides individual psychological help for adults impaired by distress in communities exposed to adversity. It combines problem management skills and behavioural strategies to address both psychological problems like stress, helplessness, as well as practical problems like livelihood challenges, conflict, etc.

v. The WHO Self Help (SH+) is a five session, group-based stress management course for adults affected by adversity. It has been shown to be effective in reducing psychological distress in adults with moderate to severe psychological distress and in preventing the onset of mental disorders in distressed populations affected by adversity. Other outcomes included reductions in symptoms of common mental disorders (e.g. depression and post-traumatic stress) and personal problems identified by participants as well as improvements in general health, functioning and subjective well-being (WHO, 2021).

c. **Service provided by:**
   i. Cadre 1 (Citizen Volunteers),
   ii. Cadre 2 (Disaster First Responders),
   iii. Cadre 3 (Community Level Workers),
   iv. Cadre 4 (Local, State & central government personnel who are in frontline worker positions),
   v. Cadre 5 (Health & allied health professionals),
   vi. Cadre 6 (NGO Personnel)
   vii. Cadre 7 (Mental health practitioners)

d. **Service delivery sites:**
   i. **In-person modalities:**
      - Mobile clinics in affected area
      - Rescue camps/ temporary shelters
      - Home visits
      - Healthcare settings: PHCs, CHCs, private clinics, general hospitals
      - NGO Set ups
      - Community spaces: schools, offices, old age homes, orphanages, home visits

   ii. **Remote modalities:**
      - National/State helplines

e. **Timing of action:** PFA should be provided immediately in the response phase (alongside rescue and relief operations). Other services mentioned above can be initiated in the response (rescue and relief) phase and can continue into the long-term recovery, rehabilitation, and reconstruction phase.

Level 4: Specialised Mental Health Services

Specialised mental health services offer tertiary-level care to individuals, families, groups, or communities with severe distress, trauma, or mental disorders. It includes medical management provided by health professionals; and further specialised support by mental health practitioners and mental health professionals. Service users who do not benefit from medical management by health professionals shall be referred to service providers listed with action 4.2 below.

All interventions at this level should involve follow-up contact and when needed, long-term care. Preferably, the same service provider should be involved in follow-up or long-term care with the individual. Follow-ups and long-term care should be based on clearly established protocols regarding time and frequency of contact, nature of contact, scheduling, and consent. Service providers should be proactive in planning follow-ups and long-term care, and should take confirmation for them in the first instance of contact itself.

Action 4.1 Mental health medical management

a. **Aimed at:** Individuals with distress and trauma responses

b. **Service description:** These services are not specialised interventions, but are focused medical management interventions carried out by primary healthcare doctors.
   i. The National Disaster Management Training Module 4 (developed by NDMA and

NIMHANS) is aimed towards enabling primary care doctors (PCDs) to provide psychosocial care, and outlines various skills and techniques which they can suggest to individuals in their care. It also includes a list of drugs and dosages that PCDs can prescribe to manage common or severe mental disorders.

ii. The WHO Mental Health Gap Action Programme (mhGAP) is a programme aimed at providing care to people suffering from mental, neurological and substance use (MNS) conditions. It outlines interventions for the prevention and management of certain priority conditions like depression, schizophrenia and other psychotic disorders, epilepsy, suicide, dementia, disorders due to the use of alcohol or illicit drugs, and mental disorders in children. It is designed for use by non-specialised healthcare professionals like primary care doctors, nurses, etc.

c. Service provided by:

i. Cadre 5 (Health & allied health professionals), specially those who are allowed to prescribe medication

d. Service delivery sites:

i. In-person modalities:

- Healthcare settings like: PHCs, general hospitals, tertiary care hospitals, community clinics, private clinics

ii. Remote modalities:

- TeleMANAS
- eSanjeevani, and other tele-conferencing platforms equipped to provide medical management

e. Timing of action: This service can be provided in all phases of the disaster response once need has been established based on early identification and/or referral.

Action 4.2: Disaster-specific and trauma-informed mental health services

a. Aimed at: These interventions will be aimed at the small percentage of affected people who experience continued and severe distress which is not sufficiently alleviated by support services at the previous three levels or through action 4.1 medical management offered at level 4. These individuals are likely to have significant difficulties in basic daily functioning, diagnosable mental health disorders, and might require inpatient services and intensive risk management.

b. Service description: These services can be provided to individuals, families, groups, or communities.

i. DMH sensitised psychotherapies like CBT, IPT, Narrative Therapy, Family Therapy are traditional therapies that can provide affected individuals more sophisticated and long-term support in dealing with concerns resulting from disaster situations. Disaster mental health services are brief, task-oriented, and focus on meeting the clients' urgent needs rather than offering long-term support.

ii. Trauma-focused psychotherapies include Prolonged Exposure (PE) therapy, Cognitive Processing Therapy (CPT), Narrative Exposure Therapy (NET), Eye Movement Desensitization and Reprocessing (EMDR), Trauma-focused Cognitive Behavioural Therapy (TF-CBT), the Seeking Safety model, the Attachment, Self-Regulation and Competency

(ARC) model and others. These therapies support children and adults in processing traumatic experiences and their unique impact on mental, behavioural, emotional, physical, and spiritual well-being. Key goals of these therapies include building psychological safety and stabilisation, and the prevention or treatment of severe post-traumatic symptoms like flashbacks, intrusive thoughts, physical distress, etc.

iii. Pharmacological therapies involve the use of medication for the management of disorders like schizophrenia, bipolar disorder, depression, anxiety, and substance withdrawal, insomnia. The acute phase of pharmacological treatment aims to reduce symptoms, prevent the occurrence of harm to self or others, or improve biological functions such as sleep and appetite. The maintenance phase aims to prevent relapse, and to improve the individual's level of functioning.

c. Service provided by:

i. Cadre 7 (Mental health practitioners)
ii. Cadre 8 (Mental health professionals)

d. Service delivery sites:

i. In-person modalities:

- District Mental Health Programme centres
- Private and public healthcare settings (CHCs/ PHCs, clinics, outpatient and inpatient services at psychiatric departments of public and private general hospitals, tertiary hospitals and psychiatric hospitals)
- NGO set ups equipped with providing specialised mental health services.

ii. Remote modalities:

- Public video conferencing services like teleMANAS, eSanjeevani and private platforms

e. Timing of action: These services can be provided immediately in the response phase based on the needs of affected individuals post-early identification, and should continue into the long-term recovery, rehabilitation, and reconstruction phase.

Box 9.1: Important Considerations for the Service Delivery Framework

This framework is proposed as a general all-hazards model of service delivery, and it is crucial to adapt its elements to the specific disaster that is being responded to. These adaptations will be based on a variety of factors like needs, vulnerabilities, available resources, barriers, service usage, etc. It is recommended that states also incorporate these considerations into their MHPSS plans and adapt the model to their unique geophysical, social, and political features.

The phased service delivery and other timelines outlined in the framework are tentative, and will not be uniform across different types of disasters. All timelines must be adjusted to the specific scale, duration, and impact of the disaster.

The functionality and availability of human resources like ASHA workers, DMHP staff, SDRF personnel, trauma therapists, etc. will differ within each state. Hence, each state must identify the specific personnel within each cadre who would be selected for training and service delivery at each of the four levels within their state. Therefore it is the imperative of the states

to identify, locate, and train their human resource in a manner that ensures that services from all levels of support are available to the affected population. States can also coordinate with other districts/states/centre for seeking further human resources.

Public human resources should be augmented by establishing multi-stakeholder partnerships across sectors, that lead to including personnel from the non-governmental and private sector for training and service-delivery. This will ensure a collaborative coordination of service provision and an efficient use of available resources.

The penetration of DMHP and available professionals in each district will vary. Service planning and allocation should best utilise available infrastructure. Remote modalities should be fully utilised to ensure all levels of the service model are available.

9.3 Coordinating Service Delivery

A well-organised coordination mechanism between all involved authorities, sectors, agencies, and actors is vital for effective programming of MHPSS. The following chain of events has been provided as a broad guideline for the Response, Recovery and Rehabilitation phases:

- Response phase activities are initiated as soon as the DEOC or the SEOC receive warning of the disaster or the confirmed news of the disaster having occurred.
- The State MHPSS Working Committee immediately coordinates a rapid post-disaster assessment of vulnerabilities and capacities (as outlined in Chapter 8).
- The State MHPSS Working Committee coordinates with the District Commissioner/Magistrate of the district/s where the disaster has occurred and understands the on-the-ground efforts, if any, already occurring through the Inter-Agency Group. NGOs and civil society organisations working on the ground must report their efforts to the District Commissioner, including those organisations delivering remote services.
- Based on the results of the post-disaster assessment and the on-the-ground efforts already occurring, the State MHPSS Working Committee coordinates with the Incident Commander to coordinate service delivery. This includes the deployment of available personnel, as coordinated through information available on the centralised portal and on the ground communication with international and national NGOs, local government bodies, community members, and leaders.
- Experts from the national nodal centre, other academic/research institutions with MHPSS capacities as well as NGOs and civil society organisations will be deployed to orient, provide refresher training and supervise all MHPSS personnel on processes and SOPs to follow.
- During the immediate rescue phase, personnel from cadre 1 and cadre 2 including first responders (NDRF/SDRF) and community volunteers, who are already on-site and trained will provide Level 1, Level 2 and Level 3 support. One experienced mental health professional with Level 4 training in supervision must be deployed to the site to supervise these services immediately.
- Within a few days to weeks of the disaster, personnel from cadres 1, 2, 3, 4, 5, 6 and/or 7 and 8 will be deployed to provide services at Levels 2, 3, and 4 on the basis of the scale of the disaster, information from the assessment, and availability. On-site supervision by a Level 4

professional will be mandatory during this phase too.

- The administrative supervision of these service delivery phases will be carried out by the State MHPSS Working Committee in collaboration with the District Magistrate/Commissioner , who will also be responsible for ensuring that regular updates about the status of deployment and further need are being forwarded to relevant agencies and organisations.
- In the Recovery and Reconstruction phase, the State MHPSS Working Committee will continue to coordinate the required service delivery, with the involvement of cadres 1-9, and also coordinate the extended community-based needs assessment which will determine the gaps in programming and further requirements at the levels of policy, resources, planning, and delivery.

9.4 Setting Up Service Delivery Sites

This section outlines the various actions that can be taken to establish service delivery sites within the community, in healthcare institutions, and through helplines. This is explained at all levels of the MHPSS Pyramid. Note that this is not an exhaustive list of service delivery sites; rather, service delivery sites that are commonly used are described.

9.4.1 On-Site Service Delivery Checklist

Onsite services are likely to be set up in locations such as relief camps, community centres, schools and other community spaces in proximity to the disaster location. The following actions are priority actions in the provision of onsite MHPSS services.

MHPSS Pyramid Level 1: Psychosocial Considerations in Essential Services and Security[7]

In relief settings, the provision of access to equitable food and nutrition, safe and clean drinking water, culturally appropriate hygiene facilities, basic healthcare services, shelter and clothing and other necessities is of paramount importance. Essential services also include the provision of appropriate shelter and site planning as well as ensuring physical and psychological security. Ensuring the well-being of individuals and communities as we provide essential services is a first step for MHPSS. Hence, essential services need to be provided, keeping in mind the principles of dignity, access, participation, safety, cultural appropriateness and being trauma-informed.

1. Site planning:

Safety

a. Ensuring physical and psychological safety and reducing risk of harm is important. Hence, relief services must be established at sites, where conflict with the host community and permanent residents around the camp is less likely to occur.
b. Safety for vulnerable groups
    i. To create a sense of safety for children, child-friendly spaces with soothing play and art material should be established within the site.
    ii. Specific safe spaces for women should be designated within the site, which should be inclusive of trans women.

Dignity

a. Accommodation within the site, if present, should be organised in a manner that keeps

families together. Privacy and social support should be maximised, hence family-sized tents and shelters are preferred to multi-family ones.

b. All persons, including managers and frontline workers at the site, must communicate sensitively with survivors and ensure non-discrimination in their actions. They should adhere to the principles of 'do no harm'. Training Actions 1.1 and 1.2 (Chapter 6) describes the provision of training to personnel in administrative decision-making roles and frontline workers on the importance of MHPSS and how to communicate sensitively with survivors.
c. Strict regulations around taking interviews, photos or videos of survivors, especially in moments of distress and suffering must be enforced. Any such actions by media personnel, citizens, etc. must be identified and reported to relevant authorities.

2. Food, nutritional support and water and sanitation (WASH):

The way in which food and nutrition, water, sanitation and hygiene facilities are delivered has a significant relationship with the psychosocial and mental health of community members. The following actions focus on including considerations in the provision of essential services, such as food and nutritional support, water and sanitation.

Dignity

a. Acknowledge and accommodate cultural practices and values of the community while providing food and nutritional support. For example, the kind of food being distributed should be determined by the eating habits of the community and must not offend their cultural or religious sensibilities.
b. Ensure dignity in considering how help is provided, for example, food aid should be organised in a way that does not require people to queue for long hours and does not treat people as dehumanised and passive recipients of help.
c. Areas for bathing and washing should have provisions for privacy. Toilet facilities should be designed in a culturally appropriate manner.

Access

a. Drinking water and sanitation facilities must be close and easily accessible from the site and must not require long walks. Other basic services like schools, healthcare institutions, places of worship, etc. must also be easily accessible from the site.
b. Access for vulnerable groups:
    i. Leaders and managers should make active efforts to ensure that there is no caste and gender-based discrimination in WASH facilities. For example, toilets should be trans inclusive. Ensure that toilet and bathing facilities are physically accessible to people with disabilities.
    ii. Menstrual hygiene and incontinence management considerations should be incorporated into the planning of onsite WASH services. For example, culturally appropriate menstrual hygiene products should be made available.

Participation

a. Promote community participation in planning of food and nutritional support.
    i. Engage community members as site supervisors or managers of food and nutritional services.
    ii. Consult community members, both men and women, in the planning and distribution of food aid.
    iii. Community discussions on long-term food security planning can be held to solicit

community members' opinions and advice.

Safety

a. Toilets and sanitation facilities should be well-lit and have locks available to ensure security, as poorly lit toilets could increase the risk of gender-based violence. If possible, guards should be stationed near these areas.
b. Linkages can be made with the Ministry of Women and Child Development to set up safety protocols for women and children.

3. Physical and psychological security

a. Facilitate reports of abuse. Survivors may be reluctant to report any acts of harassment or abuse that are occuring onsite. Mechanisms should be set up to facilitate safe and trustworthy reporting systems (e.g. inclusion of community members in handling of reports; confidentiality), especially for historically marginalised groups.
b. Survivors should proactively be informed of confidential reporting channels for any abuse by staff, and appropriate mechanisms should be set up for the safe handling of such complaints.

4. Information provision

It is important to ensure that all information being provided to the affected community is accurate and credible, since rumours, misinformation and disinformation can lead to confusion, fear, and even marginalisation and violence. Hence, actions at this level focus on including MHPSS considerations in disaster communication and disseminating key messages about a) MHPSS services and intersectoral services b) MHPSS self-help resources and IECs. These actions ensure that all affected people have access to information about the disaster and available relief services in a way that facilitates psychosocial and mental health. It also ensures that vulnerable groups have equal access to information and are able to participate in feedback mechanisms.

Clarity and completeness: Ensure that detailed information is provided about:

a. The disaster itself; any recurrences (e.g. earthquake aftershocks); any ceasefire or peace initiatives
b. Major decisions taken by government and non-government stakeholders (e.g. about financial compensation; shelter)
c. The nature and location of various services (e.g. food, legal aid, MHPSS services), including how to access them
d. The various staff present onsite and their roles
e. The location of safe spaces on the site and who they are for
f. The rights and entitlements of people (e.g. legal rights; rights to quantity of food)

Accuracy: Ensure that the information shared is accurate and fact-checked, and actively combat misinformation and disinformation. Keep updating the information as information changes.

Transparency: Acknowledge the uncertainty surrounding the situation and be transparent in sharing what your sources of information are. Be clear about what is known, what is not known, and what procedures are being followed to get more information.

Consistency: Ensure that briefing sessions are conducted on a daily basis with onsite survivors regarding their situation. Hence, information will also need to be collected and verified on a daily basis, as the situation may be changing.

Accessibility: Ensure that information is provided in various languages and through various formats (e.g. verbal, written, pictorial, sign language, Braille). Ensure that information provided is not through only SMS or other written means; not everyone may have access to mobile phone technology or may be able to read.

Safety: Identify any harmful media practices or abuses of information that should be addressed. This could include the dissemination of prejudicial/hate messages, the aggressive questioning of people about their emotional experiences, stigmatising people by interviewing them in inappropriate ways and the use of images, names or other personally identifying information without informed consent or in ways that endanger survivors[8].

Trauma-informed: Ensure that any information that could lead to re-traumatization is shared with trigger warnings (for example, do not mention suicides or abuse without a trigger warning). Avoid including pictures in written material that could be triggering for survivors. Avoid using language that is pathologizing such as 'diagnosis' or 'symptoms'.

Ensure that all onsite staff is aware of, trained in and able to facilitate referrals of survivors to MHPSS and intersectoral services:

- Ensure that onsite staff is trained in the early identification of mental health and psychosocial concerns (as outlined in Chapter 8).
- Ensure that onsite staff has access to a database of referrals and is aware of referral mechanisms between them and mental health specialists, community level workers, protection services (like in instances of domestic violence), education actors, food security and livelihood support, and, when appropriate, traditional healers and faith leaders.
- Have handy flyers printed and ready, with information about available MHPSS and intersectoral services (helplines, in-person services with address and location) that staff can disseminate as well as sensitise staff to the need to explain this information verbally.
- Disseminate key MHPSS messages using the same above principles outlined of clarity and completeness, accuracy, transparency, consistency, accessibility, safety and trauma-informed. Some examples are outlined in Box 9.1. These should be translated to local languages and disseminated through various modalities and mediums.
- More detailed MHPSS IECs in the form of posters, brochures, social media messages can also be disseminated. These IECs can cover topics like the psychological impact of disasters, symptoms of distress or trauma, self-help tips, available services and resources in various local languages.

Box 9.1: Key MHPSS Messages

Key messages aimed towards a disaster-affected community should be designed in a way that ensures that the following objectives are being covered: expressing empathy, explaining risks, addressing rumours, describing response efforts, and promoting vigilance and action. Sample MHPSS messages include:

1. "You may be experiencing a lot of difficult feelings like worry, fear, and confusion, as well as disruptions in your daily life, relationships, or work as a result of the disaster.

These symptoms of distress are a normal reaction to an abnormal situation, and struggling with them does not mean you are weak."

2. "Help and support in dealing with these challenges is available. [Information about whom to contact and useful links can be added here]"
3. "Just like it is crucial to take steps to protect your physical safety and health, it is also equally important to know how to protect your mental and emotional health and wellbeing. Engaging in meaningful activities, maintaining a routine, and staying connected with others can be helpful."
4. "Being part of a community is especially helpful during difficult times. Check in on your friends, family and community members, and offer support and hope. If you come across useful information or resources, share them with others in need."
5. "Sometimes, we may feel like using alcohol, tobacco or other drugs to cope with our distress. However, this may adversely affect our health. If you would like help with use of substances, please contact [Link to services for substance use]."
6. "Stay informed through trusted and reputable sources such as health ministry advisories, government websites, etc. Be aware of misinformation and rumours being circulated online or through word of mouth."
7. "Develop emergency plans for your family and place of work, and review them regularly, especially with children and people with disabilities."
8. "Children may show symptoms of distress that are different from symptoms in adults, like bedwetting, stomach aches, being very afraid, clingy or withdrawn, etc. Listen to their concerns, answer their questions, provide comfort and affection, and assure them that they will be safe."
9. "Watch out for signs of extreme distress or marked changes in behaviour in yourself and those around you. If you or someone you know is experiencing thoughts of self-harm or suicide, seek immediate help."
10. "If you are concerned for your safety or the safety of someone else, or are experiencing harassment or abuse of any kind, please contact [numbers provided]"

MHPSS Pyramid Level 2: Family and Community Based Care

This action describes how stakeholders can help and facilitate community organisation and mobilisation for MHPSS through encouraging community-centric activities aimed at improving psychosocial and mental well-being. Different activities may be appropriate at different times post a disaster.

1. Facilitate community social support

a. Facilitate meaningful community activities onsite such as culturally-appropriate recreational activities, food-based gatherings, and activities and play opportunities for children that offer chances for social support.
b. Promote the functioning of support groups (e.g. informal men's and women's groups; youth groups) on site.

2. Facilitate community mobilisation

a. Promote community mobilisation processes, such as discussion groups, collective reflection spaces and facilitation of workshops which connect the past history of the community to the present conditions and plans for the future[9]. These activities should be organised in culturally appropriate, engaging and creative ways,

3. Facilitate community cultural, spiritual and religious healing practices

a. Promote community healing and mourning practices, such as group prayer and chanting. Ensure that mourning practices of all religions and faiths are respected.
b. Make sure that there is no discrimination in terms of provision of spaces for praying and rituals.
c. Support the community's organisation of traditional or religious coping systems such as rituals and festivals.
d. Religious leaders from the community can be engaged to offer support, monitor and reduce religious discrimination.
e. Ensure that community practices are in compliance with international human rights and are not causing harm.

MHPSS Pyramid Level 3 and 4: Focused, Non-Specialized Supports; and Specialised Services

These actions focus on considerations while delivering focused non-specialized supports (Focused Psychosocial Care and Support Interventions) as well as specialised services (disaster-specific and trauma-informed mental health services) onsite post a disaster. These services may be delivered in relief camps and community centres and spaces by trained personnel from various cadres.

1. Accessibility

a. Ensure that the MHPSS station within the camp is established in a location that is both accessible and discrete. Access points to these services can be established near other essential service stations like ration, medical care, or camp administration to increase ease of access.
b. Since the often crowded living conditions, heightened emotions, fear of stigma, and lack of privacy can deter camp residents from seeking services, a dedicated space for longer interventions can also be facilitated in a more private area.
c. Ensure the essential psychotropic medications are available.

2. Availability of personnel

a. Ensure that an adequate number of personnel trained in MHPSS are available onsite. More personnel should be available for Level 3 (focused, non-specialized services).
b. Qualified mental health specialists (trained at Level 4) in sufficient numbers depending on the size of the facility and the number of service users should ideally be available to manage survivors who have more intensive needs.

3. Support for service providers

a. Ensure that staff delivering MHPSS services in camps and community sites have required trainings
b. Organise refresher training as required for MHPSS service providers.
c. Ensure that a qualified mental health specialist (trained at Level 4) is available to provide supervision or refresher training to the staff.

9.4.2 Healthcare Settings-based Service Delivery Checklist

Healthcare institutions like emergency rooms, PHCs, tertiary care hospitals, etc. are frequently accessed spaces during times of disasters, and are often the first point of contact for survivors.

Offering MHPSS services at these sites therefore makes them more visible and accessible. Such an integration of mental healthcare with general healthcare also ensures that the stigma, cost, and other additional challenges of seeking out these services is reduced. The following considerations are important in MHPSS service delivery that occurs at healthcare settings.

MHPSS Pyramid Level 1: Psychosocial Considerations in Essential Services and Security

Basic healthcare is an essential service and a human right. The actions below describe MHPSS considerations to be kept in mind while delivering basic healthcare services.

1. MHPSS Considerations in basic healthcare[10]

a. All healthcare services must be delivered in ways that are inclusive, respectful, and rights-based. Privacy, confidentiality, and informed consent must be upheld at all times.
b. Healthcare services must be culturally appropriate for all genders, ages, and disabilities.
c. Service users must be allowed to choose a healthcare provider of their preferred gender.
d. Healthcare providers must communicate clearly with survivors and share accurate information regarding their health. They must also be trained in delivering distressing news sensitively, in dealing with individuals who may be anxious, angry, disoriented, withdrawn, or at risk of harm, as well as in responding appropriately to disclosures that may be private or emotional.
e. Healthcare providers must try to support and empower survivors by encouraging agency, problem-solving, decision-making, and healthy coping.
f. Healthcare providers must attempt to learn about local, indigenous and traditional healing systems of the affected community, and be open to dialogue and collaboration with them if it can provide benefit.

2. Ensure that healthcare staff is aware of, trained in and able to facilitate referrals of patients to MHPSS and intersectoral services

a. Ensure that healthcare staff is trained in the early identification of mental health and psychosocial concerns (Chapter 9), by including MHPSS considerations in health assessments.
b. Ensure that healthcare staff have access to a database of referrals and are aware of referral mechanisms between them and mental health specialists, community level workers, social services (like in instances of domestic violence), education actors, food security and livelihood support, and, when appropriate, traditional healers and faith leaders.
c. Have handy flyers printed and ready, with information about available MHPSS and intersectoral services (helplines, in-person services with address and location) that staff can disseminate as well as sensitise staff to the need to explain this information verbally.
d. Disseminate MHPSS IECs in the form of posters and brochures within the healthcare facility. These IECs can cover topics like the psychological impact of disasters, symptoms of distress or trauma, self-help tips, available services and resources, etc. These can be used for staff themselves or for staff to distribute to service users as well.

MHPSS Pyramid Level 2: Family and Community Based Care

1. Healthcare staff must be trained in delivering distressing news to survivors and their family members with empathy and sensitivity. Immediate referrals to supportive services must be made for bereaved families.

MHPSS Pyramid Level 3 and 4: Focused, Non-Specialized Supports and Specialised Services

Focused non-specialized supports (Focused Psychosocial Care and Support Interventions) as well as specialised services (disaster-specific and trauma-informed mental health services) may be delivered in healthcare settings post a disaster. The actions below describe considerations to be kept in mind while delivering such services post a disaster.

1. Accessibility

a. Conduct a quick assessment of the healthcare facility to understand what MHPSS-related resources exist in the facility and what are needed. For example: a private, designated space for MHPSS consultations, trained staff, etc. Ideally, arrange separate, private spaces in clinics and healthcare institutions where longer consultations for MHPSS services can be held.
b. Consult members of vulnerable groups from the affected community, like people with disabilities, women and gender minorities, adolescents, etc. to understand the specific barriers that each group may face in accessing timely and adequate services. Address and resolve these barriers as much as possible.
c. If children are also likely to be recipients of MHPSS services, ensure that rooms are child-friendly and welcoming with some play material and toys available.
d. Sensitise staff to the need for offering psychosocial support and services to the family members or friends who have accompanied the patient and not only the patient.
e. Maintain adequate supplies of essential psychotropic drugs as listed in the IPHS.

2. Availability of trained personnel

a. Ensure that an adequate number of personnel trained in MHPSS are available in the healthcare institution. More personnel should be available for Level 3 (focused, non-specialized services).
b. Qualified mental health specialists (trained at Level 4) in sufficient numbers, depending on the size of the facility and the number of service users, should ideally be available to manage survivors who have more intensive needs.

3. Support for service providers

a. Ensure that staff does not become overburdened with additional MHPSS duties by clearly defining roles and responsibilities, and creating flexible and sustainable work schedules.
b. Ensure that a qualified mental health specialist (trained at Level 4) is available at least part-time to provide supervision and refresher training to the staff.

9.4.3 Helpline-Based Service Delivery Checklist

Helplines provide an accessible and affordable avenue to disaster mental health services for a large number of people. They also have the benefit of being more widely accepted as they can be accessed anonymously, protect privacy, and allow service users to circumvent the stigma associated with availing in-person services.

MHPSS Pyramid Level 1: Psychosocial Considerations in Essential Services and Security

Several government-run or NGO-run helplines that provide general information about essential services as well as information about the disaster are active as part of the disaster response. These

actions refer to how MHPSS considerations can be incorporated in general helplines providing aid post a disaster.

1. MHPSS considerations in information provision about the disaster and available MHPSS and intersectoral services. Callers on general helplines may ask for information about the disaster, protocols, rules and regulations, relief efforts and so on.

    a. **Dignity:** Responders at these helplines must communicate with the callers with sensitivity, respect, and compassion, especially when they have reached out in a state of panic, confusion or even anger. Their queries must be adequately handled and efforts must be made to provide helpful information.
    b. **Clarity and completeness:** Based on the function of the helpline, ensure that helpline staff are updated on and have detailed information about:
        i. The disaster itself; any recurrences (e.g. earthquake aftershocks); any ceasefire or peace initiatives
        ii. Major decisions taken by government and non-government stakeholders (e.g. about financial compensation; shelter)
        iii. The nature and location of various services (e.g. food, legal aid, MHPSS services), including how to access them
        iv. The various staff present onsite and their roles
        v. The location of safe spaces on the site and who they are for
        vi. The rights and entitlements of people (e.g. legal rights; rights to quantity of food)
    c. **Accuracy:** Ensure that the information shared is accurate and fact-checked. Do not share misinformation or disinformation or information based on rumours. Keep updating the information as information changes.
    d. **Transparency:** Acknowledge the uncertainty surrounding the situation and be transparent in sharing what your sources of information are. Be clear about what is known, what is not known, and what procedures are being followed to get more information.
    e. **Accessibility:** Ensure that staff are available who speak various languages.
    f. **Safety:** Ensure that staff are adequately trained in and adhering to helpline protocols for asking for and storing any personally identifying information. Ensure that staff are trained to not disseminate any prejudicial/hate messages and to not aggressively question people about their emotional experiences[11].
    g. **Community benefit:** The key needs, concerns, and sources of distress being shared by survivors accessing the helplines must be recorded and shared on relevant platforms so that adequate responses to them are planned and delivered.
    h. **Trauma-informed:** Ensure that any information that could lead to re-traumatization is shared with trigger warnings (for example, do not mention suicides or abuse without a trigger warning). Avoid 'debriefing' approaches, wherein people are asked to narrate what happened. Avoid using language that is pathologizing such as 'diagnosis' or 'symptoms'.
    i. **Ensure that helpline staff is aware of, trained in, and able to facilitate referrals of callers to MHPSS and intersectoral services:**
        i. Ensure that helpline staff in pre-existing helplines as well as newly operational ones are trained in the early identification of mental health and psychosocial concerns (as outlined in Chapter 8).
        ii. Ensure that helpline staff has access to a database of referrals and is aware of referral mechanisms between them and mental health specialists, community level workers, protection services (like in instances of domestic violence), education actors, food

security and livelihood support, and, when appropriate, traditional healers and faith leaders.

iii. Ensure that helpline staff is aware of escalation protocols in case of a crisis or emergency.

iv. Ensure that helpline staff is trained to disseminate key MHPSS messages outlined in Box 9.1.

MHPSS Pyramid Level 2: Family and Community-Based Care

1. Ensure that helpline staff is trained in how to respond to calls about family violence or substance use in families.
2. Ensure that helpline staff is aware of community-based support for MHPSS as part of their referral database and encourage the same.

MHPSS Pyramid Level 3 and 4: Focused, Non-Specialised Supports and Specialised Services

Focused non-specialized supports (Focused Psychosocial Care and Support Interventions) as well as specialised services (disaster-specific and trauma-informed mental health services) may be provided through helplines post a disaster. These may be both direct and reverse helplines.

1. Accessibility

a. Extensively advertise both MHPSS and intersectoral helplines in the early stages of the disaster response to ensure that the affected people are aware of their availability and the nature of services. Focus on advertising a few, but operational helplines that have been verified as receiving calls, rather than advertising many, non-operational helplines. Clearly mention the time slots, if any, that the helpline is operational and the nature of services provided.

b. Ensure that there is at least one operational helpline for MHPSS services post a disaster per state. Ensure that this helpline is adequately staffed.

c. Operate a reverse helpline post the disaster. A reverse helpline is a helpline in which the service provider proactively calls up people who have been exposed to the disaster or determined to be at risk for mental health concerns. Reverse helplines can promote access of people to MHPSS, as this reduces burden on people to reach out to the service, especially for people and communities who may traditionally find it harder to reach out.

2. Availability of trained personnel

a. Ensure that helplines advertising Level 3 services are staffed with personnel trained in Level 3 psychosocial services.

3. Support for service providers

a. Ensure breaks for service providers and schedules of shift work that allow rejuvenation and prevent burn-out.

b. Organise refresher trainings as required for MHPSS service providers.

c. Ensure that a qualified mental health specialist (trained at Level 4) is available at least part-time to provide supervision or refresher trainings to the staff.

9.5 Supporting MHPSS Service Providers

As MHPSS service providers navigate highly challenging circumstances, roles and responsibilities in the aftermath of a disaster, it is a moral as well as organisational imperative to provide them with adequate support throughout the different phases of their service. This support can enhance professional skills and development, increase the quality and effectiveness of services, and most importantly, protect the personal safety and wellbeing of providers.

9.5.1 Systemic Support for Service Providers

9.5.1.1 Before Service Provision

Challenges Faced: During this phase, MHPSS service providers mainly face challenges around confusion and lack of information about the scale of the disaster, the on-ground circumstances, and their specific roles and responsibilities. Apprehensions about their personal safety significantly compound the stress, especially if the disaster is ongoing or elements of violence and conflict are present. A lack of knowledge about local customs, language or the vernacular terms that survivors might use to communicate their experience also adds to the challenging nature of the role.

Support in dealing with such challenges shall include:

- Cadre 5 personnel (Local, State or Central Government) shall conduct orientations about the situation, responsibilities, local customs and practices for all personnel to be deployed to work on the ground.
- Clear roles and expectations shall be defined for all personnel while also preparing for the possibility of having to assist survivors with basic supportive tasks.
- Guidelines and protocols for escalations and reporting, especially in crisis situations shall be established and communicated to service providers.
- Staff code of conduct, ethical guidelines and relevant legal considerations shall be briefly reviewed. Personnel should clearly be informed about a mechanism for redressal of any grievances they have, including complaints about sexual harassment.
- SDMA MHPSS Working Committee shall ensure that resources required (e.g. IECs, Information about intersectoral services, early identification packets) are available to all personnel. In case of chemical, biological, nuclear and radiological hazards, they shall be provided with necessary protective equipment and gears to ensure their safety.
- Respective organisations where personnel are being deployed from shall be encouraged to arrange for suitable travel and safe accommodation.
- Peer support mechanisms and self-care opportunities shall be facilitated.

9.5.1.2 During Service Provision

Challenges Faced: Actively providing services to disaster survivors, whether in-person or remotely, exposes the service providers to highly distressing accounts of loss and suffering, and such repeated exposures can lead to a variety of psychological concerns like vicarious traumatisation, compassion fatigue, stress reactions, and even symptoms of depression and anxiety. Additionally, work schedules in disaster situations can be exerting and erratic, and on-site conditions may not always allow for private space and time. Professionally, service providers, especially those with lesser experience, may feel isolated and unclear about their work with survivors.

Support in dealing with such challenges shall include:

- Regular debriefing (for non-MHPSS personnel) and supervision opportunities (for MHPSS

personnel) should be conducted. For MHPSS personnel, at least one experienced mental health specialist at Level 4, trained in supervision, must be deployed on the ground.
- Officials, team leaders and managers of various frontline personnel must proactively bring up and normalise emotional distress and help-seeking with their team members. Information and resources for psychosocial support should be readily provided. The privacy and confidentiality of the service providers seeking this support should be maintained.
- Flexible work schedules and rotation of providers between high-stress and low-stress duties shall be encouraged.
- Regular breaks during shifts should be mandated.
- State MHPSS Working Committee should arrange for safe food and hygiene facilities for onsite service providers.

9.5.1.3 After Service Provision

Challenges Faced: Even after concluding service delivery in the response phase of a disaster, service providers may still experience significant emotional, behavioural, cognitive or physical concerns as a stress reaction. There is also a high risk of burnout[12].

Support to address these challenges during this phase shall include:
- State MHPSS Working Committee, in coordination with educational/ research institutes, shall facilitate spaces for the service providers to process their experience and give feedback.
- State MHPSS Working Committee, in coordination with educational/ research institutes, shall set up infrastructure for peer support programs (web-based or phone-based) to continue post-deployment as well.
- Leave policies shall be reviewed to allow for time off or slow reintegration to work if needed.
- Officials, team leaders and managers of various frontline personnel must proactively bring up and normalise mental distress and help-seeking with their team members.
- Officials, team leaders and managers (who have been trained in identifying signs of distress and trauma) shall proactively check in their team members and facilitate referrals where needed.

9.5.2 Supervision

Supervision is of critical importance in supporting the practice of frontline workers, mental health professionals, and mental health practitioners in disaster contexts (Martin & Snowdon, 2020). Supervision is a multi-dimensional process through which practitioners, with the support of a mentor, have the opportunity to enhance their knowledge, learn relevant skills and promote their own professional well-being while working with vulnerable populations. Beyond training in psychosocial first aid, ongoing supervision ensures ethical, accountable and competent practice in disaster settings. A Model of Supportive Supervision (Duggal et.al, 2022) was developed in the Indian context, specifically focused on supporting mental health professionals in navigating the unique challenges of mental health work in disaster and crisis settings. Based on this model, some principles and focus areas of supervision in disaster contexts are outlined below:

Principles of Supportive Supervision

1. Supervision must be **responsive and supervisee-centred,** i.e. the focus of supervision should be guided by the needs of practitioners. The challenges of frontline workers may be understood through pre-session needs assessment forms and subsequently incorporated in the development of training and supervision content. Post-session feedback should also be integrated to ensure that the process remains responsive and accountable to supervisees'

needs.

2. A **strengths-based approach** is essential to ensure that supervisees are acknowledged as active collaborators in their learning process. The supervisor is encouraged to offer a safe and affirming relationship which is respectful of the strengths, skills and values of supervisees. This is contrasted with a top-down, hierarchical approach which sees supervisees as passive learners.
3. **Reflective practice** is essential in making meaning of learnings and challenges in disaster settings and therefore, supervision must not only focus on building knowledge and skills but also create reflective spaces for practitioners to process dilemmas posed in crisis work. Supervisory spaces should regularly include reflective sessions which promote learning from the service provider's own experience as well as the experiences of their peers. Creative and experiential activities using art and somatic approaches can be well utilised to enhance reflection.
4. A **trauma-informed approach to** supervision is essential in disaster contexts, one which acknowledges that those working in such settings require ongoing support to manage feelings of helplessness, burnout, and vicarious trauma. Trauma-informed activities like body scans, feeling checks, etc. should also be practised in supervisory sessions with the providers. The emotional safety and wellbeing of the service provider should be prioritised, and they should be encouraged to step away from the session and ground themselves if they feel overwhelmed.

Focus Areas of Supervision

Supervision should balance the aims of building theoretical knowledge, practising skills, and enhancing reflection. The following areas may serve as focal points around which the development of knowledge, skills and attitudes may be supported through supervision:

1. MHPSS service providers should be trained in **trauma informed approaches** to identify and manage individual's distress through trauma-informed conceptualisations and interventions. These include building knowledge and skills in supporting persons who are experiencing severe emotional distress, grief, dissociation, self-harm etc.
2. Service providers should be encouraged to **build awareness about systemic inequities and oppression** and their impact on vulnerable and marginalised groups. Supervision must support personnel in creating systemic change through advocacy, allyship, and rights-based services. Practical steps towards these goals include sharing databases of available support systems, advocating for policy action, and amplifying service users' voices in circles of authority and influence.
3. Supervisors should aid service providers in **understanding and following the legal and ethical protocols** of working with specific populations like children, and persons at high-risk.

References

[1]The Centre for Innovation in Campus Mental Health. Stepped Care Approach [Internet]. Ontario; [cited 2023 July 7]. Available from: https://campusmentalhealth.ca/toolkits/campus-community-connection/models-frameworks/stepped-care-model/

[2]Psychosocial Support during the COVID-19 pandemic: A training manual for counsellors by Rahbar, a field action project of the School of Human Ecology in collaboration with the National Disaster Management

Authority (NDMA). (2021)

[3]The International Federation of Red Cross and Red Crescent Societies. (2018). (IFRC) Minimum standards for protection, gender and inclusion in emergencies.

[4]https://mhpssmsp.org/en/lesson/uphold-accountability-affected-populations#page-1

[5]https://mhpssmsp.org/en/lesson/do-no-harm#page-1

[6]Aaple Sarkar is an initiative by the Government of Maharashtra aiming to provide a direct and user-friendly platform to citizens for various government-related services.

[7]Inter-Agency Standing Committee (IASC) Camp Coordination and Camp Management Cluster and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. (2013). Mental Health and Psychosocial Support in Humanitarian Emergencies: What should Camp Coordination and Camp Management Actors Know? Geneva.

[8]Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

[9]Inter-Agency Standing Committee (IASC) Camp Coordination and Camp Management Cluster and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. (2013). Mental Health and Psychosocial Support in Humanitarian Emergencies: What should Camp Coordination and Camp Management Actors Know? Geneva.

[10]IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. (2010). Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know? Geneva

[11]Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

[12]Burnout: "A syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed, characterised by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy." (International Classification of Diseases, Eleventh Revision (ICD-11), World Health Organization (WHO) 2019/2021 https://icd.who.int/browse11. Licensed under Creative Commons Attribution-NoDerivatives 3.0 IGO licence (CC BY-ND 3.0 IGO)).

10 Practice Guidelines for Service Providers

Effective and responsible delivery of MHPSS services requires adequate preparation and orientation before, during, as well as after the interaction with service users. The guidelines presented below aim to help service providers from all levels of the MHPSS services model navigate these three phases. Note that these guidelines are intended to be a supplement to the detailed training and orientations conducted for service providers as specified in Chapter 6.

10.1 Preparing for Service Delivery

10.1.1 For Personnel At All Levels (1,2,3,4) Of The MHPSS Service Pyramid

Orient to important and relevant information about the disaster. This includes information about the scale and impact of the disaster, including major concerns of survivors. If the rapid post-disaster assessment report is available, it can act as a quick reference to the aforementioned information.

Orient to important and relevant information about the affected community. This includes socio-demographic information about the community or group you will be interacting with (their gender, age, socio-economic status, educational level, cultural norms) as well as information about how the disaster has impacted this particular group. These factors must be kept in mind when planning interventions and methods of delivering them. For example, cultural norms of the community dictate whether it is appropriate for a male service provider to be present with a female service user in a private room. The language preference, level of education and literacy will inform development of resource materials.

Ensure language compatibility. Services should preferably be offered by service providers who speak the same language as the service user, and if they are not available, translators must be arranged. Having a good understanding of vernacular terms and expressions to describe feelings and behaviours can also contribute to rapport-building. For people with functional disabilities, appropriate forms of communication like sign language, audio resources etc. must be facilitated.

Prioritise safety. Look out for any signs of danger that could jeopardise safety, such as an unstable building, active conflict, weather warnings, etc. Interventions must be delivered when there is no threat of physical harm to service providers and service users. In case of any threats, personnel are advised to wait until a safer time, or don appropriate safety gear and take precautions before entering the area.

Choose an appropriate time to initiate interaction. Timing of services must not interfere with

the service user's livelihood activities, community events, or other important commitments. Offer to reschedule the session to a more convenient time if possible.

Ensure privacy. Privacy is essential for maintaining confidentiality and enhancing the survivor's feelings of comfort and trust. When conducting on-site or remote sessions, find a quiet and private space. If finding a separate space is not possible in remote sessions, headphones can be used so that the conversation remains private. If the session is to be conducted remotely, ensure that the service user has access to a private space and is comfortable participating in the session.

Minimise distractions. While it may not be feasible to turn off devices in a situation of emergency, they can be put on silent mode. Any distracting objects from the surroundings must be removed.

- For remote interventions, test out devices, softwares, and network connection beforehand so that no disturbances arise during the session.
- For video calls, ensure that lighting is appropriate and that your face is visible. A neutral background without any personal objects visible can be chosen. Service providers should dress as they would for an in-person session in video sessions. Finally, the electronic device can be set on a stable surface to avoid shaking to the image during the call[1].

Keep all necessary materials and resources handy. These may include assessment tools, psychoeducational material, database of referrals, activity packs, guidance booklets (for instance when a prepared script is followed over telephonic sessions), as well as necessary stationery items like paper, pen, colours (if working with children) etc.

Orient self to the service to be delivered and the purpose of the same. The focus of the interventions should be on the immediate and most pressing needs of the survivors rather than trying to address all their concerns in one session. Drastic and immediate changes in their mood must not be expected. Instead, the goal should be to reduce distress and uncertainty, and to build safety and hope. Any notes about previous sessions must be reviewed if conducting a follow-up session.

Do a quick self check-in. This includes the service providers being aware of their physical and emotional state, and noticing whether they are feeling relaxed and confident enough to conduct the session. Asking questions like "What am I feeling right now?", "What am I thinking about?" and "What do I need?" can build this awareness. If they notice that they are stressed or tense, practising preferred relaxation techniques like deep breathing, muscle relaxation, listening to music etc. can be helpful.

10.2 During Service Delivery

This section is relevant to personnel delivering MHPSS services at Level 1, 2, 3 or 4 of the MHPSS Service Pyramid to help understand how to identify individuals or groups requiring support, and deliver interventions. Note that this section provides only a general overview and needs to be supplemented with formal training identified in Chapter 6.

The actions and activities described here cover steps to undertake on meeting an individual, family, group, or community affected by the disaster. These steps can be understood within the

framework of Look-Listen-Link-Intervene. Look-Listen-Link[2] are basic action principles outlined by the World Health Organisation as essential for providing Psychosocial First Aid. This is described below keeping in mind that different professionals are engaged in disaster response activities; all of whom may perform different functions and roles within the MHPSS Service Pyramid. This section provides a description of steps to be taken based on the level of the MHPSS Service Pyramid personnel are functioning at.

10.2.1 For Personnel At All Levels (1, 2, 3, 4) Of The MHPSS Service Pyramid

Look

Actions at this stage are carried out after entering the disaster affected area or areas where the disaster affected community is present but prior to any interaction with the community. Personnel should:

Identify individuals with immediate needs: Personnel should be observant and notice individuals in the community requiring support. This includes those having:

- Physical safety and security needs: This could include disaster affected individuals in need of medical help, food, shelter, water, and protection from abuse, discrimination, or violence. Some individuals may also be in need of special assistance (e.g. those with physical or cognitive disabilities, elderly population, pregnant women, infants etc.)
- Signs of distress and trauma responses: Personnel should identify members of the community showing overt signs of distress. These signs can manifest in different ways and include: crying, anger or aggression, tired, fearful or panic-like expressions, blank expressions, being immobile or frozen, clinging to someone, and physical signs of exhaustion like slowness of limbs or dizziness etc.

Individuals with any of these immediate needs mentioned above should be identified and prioritised for provision of services.

Listen

At the listen stage, personnel have identified and begun interacting with members of the community. Steps to follow include:

Approach people respectfully and according to their culture: It is important that personnel are mindful of people's cultural and religious beliefs when meeting with them. This includes customs around greeting people, customs around physical contact or touch, or even maintaining the appropriate distance while approaching them.

Introduce self and purpose of conversation: This includes providing name, role in the organisation/ agency, and a brief description of the purpose of the conversation. An example of this is:

"Hello. My name is _____. I work with _____. I am meeting with people to see how they are doing, and to see if I can help in any way. I am here to hear you out and provide assistance."

Additionally, it is important to provide information about the service or support that will be provided, the personnel's role with respect to what they can do as well as limits to their role.

Take permission to speak with the individual: This gives people the option to decide if they are willing to speak or not; or if they would even prefer to speak at a later time. Individuals should not be coerced or pushed to interact.

"Is it okay if I talk to you? May I ask your name?"

It is generally not advisable to record interactions, whether remote or in-person. However, if a conversation is being recorded for any purpose, it is vital to inform the individual and seek their permission about the same as well as provide information about how and where the recording will be used. Similarly, if another person (e.g. a supervisor) is present while the service is being conducted, it is vital to introduce them as well. The service user must be introduced to all persons who are present during the interaction.

Ensure physical comfort: This can include organising water or food, assisting to ensure their urgent medical needs are met first, or that the physical space where the conversation is being conducted is clean and safe. If the person is standing or appears to be physically uncomfortable, the service provider can check if the individual would like to sit or offer another action that could who are present during the interaction.

If the service provider is speaking to the person remotely, they must ensure to[3]:

- Identify a backup option to resume the conversation in case the call or connection gets disrupted. For example:

"If our video call gets interrupted, can we switch to using a phone?"

- Speak slowly and clearly.
- Check in with the individual to ascertain if they can hear and whether they have correctly understood what the individual has conveyed.
- Provide acknowledgment of what the person is saying through words like 'Mmm', 'I see' (as they are unable to see body language and visual cues)
- Provide summaries at regular intervals
- Minimise distractions and focus on the person.
- Avoid taking notes during the conversation so that they can be fully present. If maintaining notes, they must ensure it does not interfere in paying full attention to the individual.
- Proactively check in with the individual if they sense the person is feeling uncomfortable or awkward in some manner, Questions like, *"Are you in a position to speak with me right now? Is there anything that is making it difficult to speak at this moment?"* can be asked.
- Pause enough to allow for the individual to respond.

Identify the concern:

- Personnel should spend some time speaking to individuals and exploring their immediate and important concerns. It is essential to encourage them to express themselves in a manner that they are comfortable in and listen carefully to their experiences. To facilitate this, it is important to first ask open-ended questions such as "How are you?" or "How are things going for you and your family?" rather than asking closed-ended questions. Additionally, using technical mental health terminology such as 'anxiety' or 'mood' etc should be avoided. While the individual is speaking, it is important to listen to their words as well as their non-verbal cues such as tone of voice, silences, body posture and language to understand what they

want to convey. Personnel should modify the duration of the conversation based on the purpose of the interaction and comfort of the individual. Further, they should try not to fill silences and allow for space for the person to express themselves.

- It is important to stay calm, and not get defensive in the interaction (especially in scenarios where the individual may express anger, irritation, disinterest etc). If people are feeling distressed, attempts should be made to help them feel safe and calm.
- Questions asked should be relevant to the individual's current state. Some questions that can be asked to understand the individual's problems include:

  "Can you help me understand more about what you are feeling?
  What is the primary/main feeling you are experiencing?
  How is your sleep?
  How is your appetite?
  How are your day-to-day activities going?
  Are you able to function as well as you would like?
  Do you have any physical concerns such as headaches or body aches?
  Do you ever feel that your heart is beating fast?
  Do you ever feel breathless?

  I would like to ask you about your experience of using alcohol, tobacco and other drugs. I understand that others may think you should not use alcohol or other drugs at all but it can help us understand your health better.

  In the past few weeks/months, how often have you consumed tobacco, alcohol or cannabis? (Ideally, ask separately for each substance)

  Have you had thoughts of wanting to harm yourself? Have you had thoughts of not wanting to live anymore?

  If so, have you acted on those thoughts or thought of how you would act on those thoughts?"

Box 10.1 Basic Skills To Use During MHPSS Service Provision

Disaster affected individuals would be grappling and coping with the effects of the disaster and will have a broad spectrum of reactions. It is important to prioritise the individual, and provide accessible, meaningful, tailored support by using certain basic skills in the interaction. This includes:

Empathic presence: In disaster situations, people may often be traumatised and may not be able to process verbal information. Hence, one of the most important skills for service providers is that of an empathic presence, wherein the service provider uses their body language and posture to communicate safety and comfort to people. This also involves being slow-paced and non-verbally communicating that there's no rush (e.g. not checking the watch, not looking here and there for the next task) is important. Trying to have an imposed agenda (e.g. asking a lot of questions), rushing people to respond quickly, dismissing concerns, or being inattentive should be avoided. When interacting with children, the service provider may communicate empathic presence by quietly observing what the child is doing, or taking a toy or play material to parallel what the child is doing.

Active listening: This important skill involves being fully present in the moment and focusing on what the individual is saying (words spoken and non-verbal behaviour). Some examples of non-verbal cues include curled up posture, heavy breathing, hesitations, or a choked voice; all of which communicate what the person is feeling. Active listening includes not interrupting them as they speak, and allowing for natural pauses in conversation. You can also convey your attentiveness by nodding, making appropriate eye contact, or through facial expressions. In remote settings, it can be conveyed by making statements and sounds like by saying 'Hmm', 'uh-huh', and 'I see'.

Non-judgemental attitude: Being non-judgemental is an active stance which reflects openness and acceptance to an individual's thoughts, feelings, and actions. It is important to avoid being critical and project opinions of what they 'should' have done or felt. An example is, *"No problem is too big or small. I can understand that this is bothering you and is important to talk about."*

Reflection: Reflection is mirroring the individual's feelings and verbal content back to them to demonstrate we have understood what they are communicating. This includes using different words than the individual to communicate the gist of what they have shared. Statements beginning with *"sounds like"*, or *"I am getting the sense...is that right?"* are useful ways to reflect.

Validation: This involves genuinely making sense and understanding the reason behind the individual's feelings. It is important to avoid minimising, dismissing, rejecting, or judging another person's emotional experience. For example, if an individual expresses anger related to the situation, personnel must be careful to avoid asking them to not feel angry or giving them reasons to be grateful. Instead, time should be spent to understand the reasons behind the anger and support them in feeling heard.

Open-ended and close-ended questions: Open ended questions are those which are broader in nature and allow the individual to share what they think is important. They are questions that begin with 'what', 'how', 'could', 'can' and 'would'. Examples of open ended questions include: *"How have you been feeling lately",* or *"Can you tell me more about how things are with your family?"*. On the other hand, close-ended questions are questions asked to gather specific information, and provide the individual with limited scope of response (e.g. yes or no). Close ended questions include,*"Did you recover any of your belongings after the disaster?"* or, *"Did you feel scared when that happened?"*

Both types of questions are important in interactions. However, it is important to pay attention to the framing of questions and tone used, give the individual space to express themself, and not make assumptions of what they must be feeling or thinking.

Summarising: Summarising involves stating the key takeaways and actions from the conversation and checking in with the individual if any essential information has been missed out. An alternative is also asking the individual to recap the conversation. Summarising is usually used after the person has shared a lot of information or at the end of the conversation.

In conversations with individuals, groups, or families, some of the concerns that may be expressed include:

- **Physical distress:** This can include previously diagnosed concerns that are continuing or exacerbated by the disaster such as injuries or chronic pain. It can also include new medical conditions or concerns such as developing a viral infection, headaches, exhaustion, loss of appetite, difficulty sleeping, nightmares, or body aches.

- **Emotional distress:** This covers a wide range of emotional responses such as anxiety, low mood, guilt, anger, irritability, fearfulness, or grief. This can be expressed through various physiological and bodily signs such as crying, or difficulty in making eye-contact. They may demonstrate aggressive behaviour. Some individuals may excessively use substances like alcohol or drugs. All of these are signs indicating need for support. Some individuals may even express that they are 'fine' while communicating withdrawnness through their non-verbal body language. Service providers must proactively take a combination of verbal and non-verbal cues into account while judging whether the individual requires further help.

- **Trauma responses[4,5]:** Our bodies maintain an optimum state of alertness and arousal for us to function well. Responses to trauma can present itself through hyper-arousal or hypo-arousal. Hyperarousal is when individuals may be over-aroused than optimal. In these situations, individuals may show trauma responses like agitation, anger outbursts, or tenseness in the body or widening of eyes. They may feel anxious, out of control, overwhelmed, or feel like they want to fight or run away. On the other hand, hypoarousal is when individuals are under-aroused than optimal and feel like they have 'shut down' or 'collapsed'. This is shown through muscles being loose, decreased heart rate, unresponsive or not being able to speak, having a blank stare, feeling numb or detached from their own body. They may also seem detached from the external world, and in some cases even have fainting spells.

- **Psychosocial concerns:** Psychosocial problems are closely linked to and contribute to distress and trauma responses. Psychosocial problems post a disaster can be understood within the following categories: health, disability and treatment concerns (e.g. impact of injuries, need for surgery, difficulty walking/ moving, hospitalisation, access to treatment, illnesses, diseases, loss of functioning), Impact on livelihood and family income (e.g. loss of income, belongings, house, job, illness related limitations on employment), change in family networks and available support (e.g. change in family dynamics, no access to community support/ activities), spiralling negative life events (events that occurred as a result of the disaster - dropping out of school, shutting down of business), pressures of new roles and responsibilities (having to support parents by taking care of younger siblings, seeking employment after the death of the sole breadwinner), ex gratia & economic support concerns (e.g. no insurance or difficulties with insurance, limited or no knowledge of government aid)[6].

Link

This stage follows after identifying the priority concerns the individual, family, or group are facing. It aims to connect them with support needed. Steps in this stage include:

Provide appropriate information: It is important to provide factual, relevant information. This could be information about the disaster that occurred, the effects and impact on people and loved ones, steps being taken to support and provide safety to the community, their rights, support and resources available, what they can look forward to. Information should be specific, tailored and provided in formats that are easiest for the individual to understand. Care should be taken to avoid providing ambiguous information or overwhelming them with too much

information. Additionally, it is important to give them space to ask questions and clarify about what was shared. Another essential aspect is to combat any misinformation that persists without debating or pushing the person to change their opinion. Lastly, personnel must avoid making up information or speculating if they do not have information for questions that are asked. Instead, service providers can assure the individual they will get back to them and outline a process to do so.

Connect with loved ones and social support: Social and community support plays a big role in helping people cope in disaster situations. Taking measures to ensure families stay together, assisting them in contacting and communicating with loved ones, linking them to preferred religious or spiritual support, providing access to community related activities and social groups all assist in recovery[7].

Making referrals: Individuals may express physical or emotional distress, trauma responses, or psychosocial problems (in the categories mentioned above) and should be guided to access appropriate support. Personnel should ensure they have information ready to direct people to services such as legal aid, police, employment and education support, insurance, government aid, ration, medical or ambulatory aid. Having a list with services and contact details would be beneficial in providing information in a prompt manner. Also, it is important to recognize contextual factors that contributed to the disaster and validate the person's emotional response.

Additionally, for individuals requiring emotional distress and trauma related support, it is important to refer them to level 3 (focused non-specialised support) or level 4 (specialised services) of the MHPSS Services Pyramid. Permission can also be sought to pass on the details to the relevant MHPSS service provider who can then facilitate the session. Care should be taken to make the process easy for the individual and convey the referral information in a clear and concise manner.

10.2.2 For Personnel At Level 3 And Level 4 Of The MHPSS Service Pyramid

Intervene

In addition to following the Look-Listen-Link steps mentioned above, an additional step of intervene can be followed. This is for personnel providing Level 3 or 4 level services of the MHPSS Service Pyramid to use any of the following interventions to support people in distress. The information below provides a glimpse of some interventions that can be used. Examples are also included for each intervention to further elucidate the possible supports. It is important to note that interventions should be chosen and tailored based on the specific concerns the individual, family, or group is experiencing. For further information on interventions, the Psychosocial Support during the COVID-19 pandemic - A Training Manual for Counsellors[8] can be referenced.
The interventions that may be provided to include:

Physiological interventions: Physiological interventions focus on utilising the body to manage and regulate distress. Individuals may experience hyper-arousal or hypo-arousal; both of which would require different interventions and support.

For individuals experiencing hyperarousal:

1. Grounding: For individuals who seem confused, disoriented and agitated, it can be helpful to use grounding techniques like asking them to focus on a familiar voice and soothing them.

Asking them simple and closed questions may also be beneficial.

2. Guided imagery: This technique involves assisting the individuals to visualise themselves in a place associated with a feeling of safety and calmness in great detail (e.g. beach, mountain, library, bedroom etc). Cues can be provided to build the imagery such as, *"What do you see there? What do you hear? What do you smell? What do you feel on your skin?"* In some cases, the service provider may have to provide details if the individual is unable to do so. This could include, *"Focus on what it feels like to feel the warmth from the sun on your face"* or, *"Imagine the feel of a cool, gentle breeze around you"*. This technique should not be used with individuals who have difficulty visualising or if this contributes to them feeling more distressed.
3. Breathing exercises: Regulating breathing can be helpful with stress. Some breathing techniques include:
    a. 4-5-6 breathing: In this technique, the service provider asks the individual to gently breathe in for 4 counts, hold their breath for 5 counts, and breathe out for 6 counts. The counts can be modified to lower or higher counts based on the comfort of the individual.
    b. Triangle breathing: The individual is asked to imagine a triangle. They are then asked to inhale for 3 counts as they trace or draw one side of the triangle, hold their breath for 3 counts as they draw the next side, and lastly breathe out for 3 counts as they trace the last side of the triangle.
4. The service provider can also breathe along with the individual to demonstrate the technique and support them when distress is high.

For individuals experiencing hypoarousal:

1. Grounding: In this technique, physiological arousal and distress is regulated by using the senses to help the individual feel rooted in the present. Some ways to ground the individual are:
    a. 5-4-3-2-1 technique: In this technique service providers ask the individual to name 5 objects that they can see that are of a specific colour (e.g. blue) or beginning with a specific letter (e.g. 't' or 's'). Next, the service provider encourages them to describe 4 things they can feel either in front of them or where they are sitting and noticing how it feels on their skin (soft, rough, smooth etc). You can then ask the individual to focus on 3 sounds they can hear around them followed by noticing 2 scents they can smell. Lastly, you ask the individual to focus on 1 taste in their mouth. Care should be taken to give sufficient time to notice these sensations and prompts can be given if need be. Additionally, even just one of the preferred senses can be focused on.
    b. Dropping the anchor: In this technique, the service provider asks the individual to plant their feet firmly on the ground, focus on how the ground feels under their feet, and notice the support it is providing.
2. The service provider can use a combination of grounding, breathing, and minor movements tailored to the person's current state. This includes using a soft melodic tone and providing an anchor to them such as, *"You can stay with me right here"*. Encouraging the individual with questions like, *"Can you nod?"* or, *"Can you blink your eyes"* or, *"Could you try to slowly look as far right as possible?"* can introduce small body movements. Care should be taken to get the person moving, but not too quickly. Once the person seems less frozen, the grounding and breathing techniques described above can also be used. Exhalations are particularly helpful in regulating the arousal here. Lastly, do not initiate physical contact.

Emotion-focused interventions: These interventions centre around understanding, noticing, naming, validating, and sometimes tolerating the presence of distressful emotions.

1. Reflection and labelling: This involves supporting the individual to express their emotions and naming what they are feeling. It is important to use language and remember the nuances of emotions (e.g. guilt, shame, sad, apathetic, anxious, nervous etc). An example of this is:

   "I understand that you are feeling anxious about what will happen in the future."

2. Separating emotion from behavioural response: In this technique the service provider supports the person in separating how they feel from what action to engage in. It provides a sense of control and choice over what action they would like to take when they feel a particular emotion.

   "We can feel anxious about the impact of the disaster and constantly look for news about it. Or we can choose to do something differently when we feel anxious that might help us feel more regulated"

3. Psychoeducation: Individuals may have varying beliefs about what they are experiencing. It is important to provide correct information in a simple and concrete manner. Again, keep in mind that we do not forcefully contradict or pressure the individual to change their beliefs.

Cognitive interventions: Cognitive interventions involve evaluating and modifying thoughts about a situation or emotion, and engaging in problem solving.

1. Stop-Think-Go: This problem solving technique can be understood through its 3 steps. At Stop, the person is assisted to pause and notice which problem they would like to prioritise working on. It is useful to choose a problem which is within the person's control and they can influence through action. Next, at Think, the person is encouraged to come up with possible solutions with the help of prompts. This step also includes identifying how they will carry out the solutions, and who can help them with it. Lastly, at Go, the person evaluates the solution generated (their advantages, disadvantages, resources needed, how feasible it is to carry out), and chooses a solution to carry out.

Behavioural interventions: These interventions support individuals to plan and modify their actions and behaviours

1. Structuring the day: Organising and planning activities during the day can help provide some control, especially in disaster situations which carry a lot of uncertainty. Service providers can ask the individual if they would like to plan their days in some way and prioritise inclusion of rituals or actions that bring calmness, or safety. This includes:

   "Could you tell me about your current routine?"

   "What are small activities and steps you can do that would make you feel calm?" (e.g. giving your children a hug, drinking a cup of tea, praying, calling your loved ones, etc.)

2. Physical activity: Service providers may also encourage the individual to engage in or re-introduce some physical activity in their routine. Again, do not force the individual to participate in something they do not find interesting or comfortable. Additionally, they can also begin with small things like walking for a couple of minutes, stretching, skipping etc.

10.3 After Service Delivery

This section provides information about steps and actions to be taken after the service is delivered to the individual, family, or community.

Provide a summary of key actions: After the interaction and linking the individual to another relevant service or delivering an intervention, it is essential to provide a concise summary. This should include an overview of what was discussed, any actions that the service user is advised to continue post the interaction, and any pending actions that the service provider needs to take (including a timeline). If another session or meeting has been scheduled with them, the service provider must confirm the date, time, location, and any other relevant information. Again, it is important to reiterate services available to support them and provide information on how to access it. In a remote setting, service providers must speak clearly and check in with the individual at regular intervals if they have understood what was communicated. They should be given time to make note of what is shared, if they require it.

Seek feedback: Create space for the service user to provide any inputs, feedback, suggestions about the services available, the interaction, or any measures that need to be taken to better support the community.

Maintain a record of the interaction: Once the service provider has completed the service delivery, it is important to maintain a record of the topics covered, key takeaways, action points, referrals made during the discussion. Additionally, feedback and suggestions provided by the service user should also be written. This documentation should be submitted and stored as per protocols outlined for disaster response.

Follow up on action points and referrals: Follow up could include getting back to them with information, scheduling another session or meeting with the service user, or linking them to another relevant service provider. If the individual has consented to their details being shared with a relevant service provider, ensure that the details are passed on and the referral is documented. Follow up can also include advocating for changes or escalating issues based on feedback provided by the individual.

Self check-in: At the end of the interaction, the service provider should keep some time aside to check in on their own physical and emotional state.

10.4 Considerations for working with vulnerable groups

While a disaster causes all affected people to experience distress, different subgroups of the affected population experience unique combinations of stressors, risks, and needs. These factors influence whether such groups are able to know of, access, and benefit from services. Therefore, in order to ensure that MHPSS programming offers adequate and equitable support and services to all, it is important to include special considerations when working with vulnerable groups. These can include bringing in specific technical expertise, additional steps in general MHPSS service planning, targeted outreach and awareness-building activities, as well as additional training and supervision for service providers. This guideline envisions the assessment of every group's needs and concerns, however, specific responses for every group are beyond its scope. General

guidelines when working with vulnerable groups are outlined below, with four focus areas of dignity, access, participation and safety (DAPS). Additionally, guidelines for working with four vulnerable populations, including women and gender minorities, children and adolescents, older people, and people with disabilities are also presented.

10.4.1 Women And People Identifying As A Gender Minority Group

Dignity:

- Service users belonging to this vulnerable group (eg. women, transgender people) should be able to seek services from service providers of their preferred gender.
- Efforts must be made to be inclusive of women and people identifying as gender minorities in the provision of consulting rooms, waiting rooms, toilets to ensure comfort and privacy according to cultural norms.

Access

- Outreach activities must especially focus on these groups and ensure that they are aware of available services.
- Services should be provided at times that are suitable and safe for vulnerable groups so that they are not deterred from accessing them.

Participation:

- Women and people identifying as from a gender minority group should be consulted when key decisions about service provision are being made, and community assessments should include their specific needs and concerns.
- Services focused on maternal mental health, like reducing depression rates in pregnant and postnatal women, should also be designed.
- Childcare facilities should be provided so that women's participation in services and activities can be increased.

Safety:

- Service provision sites should be set up in safe locations near the community, and should have adequate lighting and security.
- Early identification and other types of assessments should check for signs of domestic violence and other forms of gender-based violence.

10.4.2 Children and Adolescents

Dignity:

- Service providers must respect the autonomy and confidentiality of the child and adolescent. Hence, they must take assent from them for services even if parents have given consent. They must not offer a service without the child/adolescent's go-ahead.
- Support the child or adolescent in expressing cultural beliefs and values that may be important to them, and respect these while planning and delivering interventions.

Access

- When disseminating key messages, awareness sessions, psychoeducational resources and IECs in the affected community, ensure that age-appropriate material is also especially designed for children and adolescents.
- Increase outreach efforts towards 'hard to reach' groups of children like adolescent girls,

young children, children with disabilities, etc.
- Support caregivers and schools in understanding signs of distress and trauma in children, and ways to support their wellbeing.

Participation:
- Design child friendly spaces within community sites where age-appropriate activities like art, sports, music, etc. are offered.
- Organise peer support groups for adolescents to facilitate discussions on their needs and concerns, and encourage them to offer ideas and suggestions for better services.

Safety:
- Advocate against the separation of children from their families, and provide linkages to family tracing and reunification services for separated families.
- Ensure that all service staff are aware of the rights of children as per international humanitarian standards, and national laws related to the protection of children, for example, POCSO Act. Staff must also be trained in the identification of child abuse and neglect, and the pathways to appropriate protective services.

10.4.3 Older Adults (Especially Those Not Cared For In Families, Living Alone And In Elderly Homes)

Dignity:
- Ensure that the rights of older people are integrated into organisational policies and codes of conduct, and staff is adequately sensitised on the same.
- Be mindful of the community's cultural norms when addressing older people and interacting with them. Refrain from using titles that they may perceive as disrespectful.

Access
- Ensure that the site of service delivery is accessible, and services are offered at locations within the site that are convenient for older people to reach, such as on the ground floor if the building does not have an elevator. If the site is inaccessible to them, check whether home visits can be offered instead.
- Older adults may not always have access to technology like phone service, email, etc. Ensure that methods of communication that work for them are used so that information about services or community events can be relayed to them. .

Participation:
- Engage directly with older people in the community or with their representative organisations (like homes for the elderly) to gather inputs regarding the sites, planning, and delivery of services.
- When organising or facilitating community meetings, rituals or events, ensure that older people are able to reach the location, either through public transport or community volunteers, etc.

Safety:
- Allow older people to access services accompanied by a person of their choice if needed, like a caregiver or a family member.
- Staff should be sensitised to the risk of abuse and neglect faced by older people, and ensure that they are aware of mechanisms in place for reporting such incidents and seeking help.

10.4.3 People with Disabilities

Dignity:

- Sensitise all staff and service providers to the rights of persons with disabilities, and address negative attitudes like stereotyping and prejudice that can lead to discriminatory behaviours.
- Ensure that respectful and accepted terms are used to refer to the disability as well as the person with the disability, and avoid labels that are stigmatising or disrespectful.

Access

- Carry out accessibility audits of service delivery sites and assess whether national accessibility standards are enforced. Identify barriers to accessing the facility (absence of ramps, inaccessible site location, lack of transportation facility etc.) as well as barriers to accessing the services (fear of discrimination, inconvenient scheduling, lack of support staff to accompany them etc.).
- All outreach and information sharing should be carried out through multiple communication channels and formats to accommodate for visual impairments, hearing impairments or cognitive impairments. For example, people with visual impairments may require large-print versions of informational items, Braille versions, audio versions, or screen readers. People with hearing impairments may require captioned video IECs, sign language communication. People with cognitive impairments may require that communication does not include very technical language, long sentences.

Participation:

- Gather and include input from people with disabilities and their representative organisations on how to plan, design, and deliver services in a way that is inclusive and effective.
- Have systems in place to collect their feedback on services, service delivery sites, as well as service providers, and accommodate it in future planning and evaluation.

Safety:

- Allow people with disabilities to access services accompanied by a person of their choice if needed, like a caregiver or a family member.
- Within the vulnerable group of people with disabilities, certain subgroups are at heightened risk of abuse or neglect, such as girls and women with disabilities, orphaned or separated children with intellectual disabilities, and older people with disabilities. Ensure that these populations are acknowledged and supported at all stages of MHPSS services, from assessment, planning, delivery, and evaluation.

References

[1]International Medical Corps. Remote MHPSS service delivery in humanitarian settings. 2022 June 15. [Training PowerPoint]

[2]World Health Organization, War Trauma Foundation and World Vision International (2011). Psychological first aid: Guide for field workers. WHO: Geneva.

[3]Psychosocial Support during the COVID-19 pandemic: A training manual for counsellors by Rahbar, a field action project of the School of Human Ecology in collaboration with the National Disaster Management Authority (NDMA). 2021.

[4] NICABM. How to Help Your Clients Understand Their Window of Tolerance. [Cited 21 Aug 2023]. Available from https://www.nicabm.com/trauma-how-to-help-your-clients-understand-their-window-of-tolerance/

[5]NICABM. [Infographic] How to Differentiate Between the Freeze and Shutdown Trauma Responses. [Cited 21 Aug 2023]. Available from https://www.nicabm.com/the-difference-between-freeze-and-shutdown-trauma-responses/

[6]Joseph, Jacquleen, and Surinder Jaswal. "Psychosocial framework for understanding psychological distress among survivors of the November 26, 2008 Mumbai terror attack: beyond traumatic experiences and emergency medical care." Prehospital and disaster medicine vol. 29,3 (2014): 330-8. doi:10.1017/S1049023X14000478

[7]World Health Organization, War Trauma Foundation and World Vision International (2011). Psychological first aid: Guide for field workers. WHO: Geneva.

[8]Psychosocial Support during the COVID-19 pandemic: A training manual for counsellors by Rahbar, a field action project of the School of Human Ecology in collaboration with the National Disaster Management Authority (NDMA).

11 Monitoring, Evaluation, Accountability and Learning

A crucial element of MHPSS is monitoring and evaluation (often abbreviated to M&E) of the various activities, for example, capacity building and service delivery activities, that are conducted.

Monitoring is the systematic gathering of information that assesses progress over time, whereas **Evaluation** involves collecting specific information at specific time points to understand if the actions taken have led to expected results[1]. Two other terms have recently been added to this framework in the context of humanitarian responses[2]:

- **Accountability** involves participation, information sharing, and development of feedback mechanisms with members of the community and various stakeholders.
- **Learning** involves a commitment to use what has been learned from monitoring, evaluation and accountability mechanisms to improve upon the service being delivered and to publish and communicate results internally and externally.

The framework is sometimes referred to as MEAL (Monitoring, Evaluation, Accountability and Learning). MEAL activities are important in order to:

- Improve service delivery and adapt it to the changing needs and priorities of the situation
- Assess whether or not an activity or service is achieving its desired results[3]
- Provide learnings for future work to all stakeholders
- Increase accountability and transparency to stakeholders, and ensure that the program is effective and not wasteful and harmful

A robust MEAL process will include the data to show if changes have occurred, whether they are positive or negative, direct or indirect, and sufficient or lacking. MEAL must be built into activities from the very beginning of program design; it cannot be an afterthought after the program has already been implemented.

11.1 Guiding Principles

Avoiding bias, and ensuring neutrality. Independent parties in partnership with the NDMA or the MHPSS Working Committee should ideally be involved in MEAL activities to ensure transparency and neutrality. The persons or organisations conducting the evaluation must be clearly disclosed in any reports, along with mention of funding sources and any potential conflicts of interest.

Culturally appropriate and participatory measures. Locally developed and culturally specific measures may often be more appropriate to measure distress, well-being and other indicators than globally used measures. Hence, decisions to select a particular measure must be taken keeping cultural appropriateness in mind. Further, community members must be consulted when

indicators and tools are selected and must be involved in the design and implementation of the MEAL process.

Doing no harm. MEAL processes and activities must not be intrusive for service users, must not add additional burden to them and should not interfere with or take away time from service delivery.

Protection, safe storage and respectful use of data. It is crucial to protect the rights and dignity of people who have shared information. Hence, clear protocols for data storage and how confidentiality will be ensured must be followed. Informed consent must be taken for any data that is collected as part of MEAL. Any information shared in the form of reports or publications must protect the anonymity and confidentiality of people who responded.

Disaggregation of data. When collecting information to measure results against a goal and/or outcome, it is important that data are inclusive of vulnerable groups. Hence, it is important to collect data that are disaggregated based on gender, age, disability, education, caste etc to ensure that access and impact on vulnerable groups can be adequately measured.

Integration of efforts and avoid duplication. As much as possible, an attempt must be made to avoid repeatedly collecting data from people. Hence, MEAL data collection can be integrated as part of the pre and post-disaster MHPSS assessment.

11.2 Process of Monitoring, Evaluation, Accountability and Learning

MEAL is generally a cyclical process which starts from before the program is implemented. MEAL will overlap with aspects such as assessment and service delivery. The steps involved in MEAL are[4]:

Step 1. Develop Or Adapt Program Objectives.

In this step, the MHPSS activity to be conducted is designed or adapted from an already-designed activity. This could include capacity-building activities or service delivery activities, elucidated in Chapter 6 and Chapter 10. In this step, the activity is adapted to the local context based on any pre or post-disaster assessments conducted.

Step 2. Develop Or Adapt Logical Framework, Indicators And Select Tools To Be Used To Measure Indicators.

M&E is generally conducted using indicators. An indicator is a unit of measurement that can be quantitative or qualitative, that is intended to provide answers to whether the MHPSS activity has produced the desired outputs, outcomes and impacts. These indicators should be based on the goals of the programme and feasibility of data collection. Indicators chosen are also recommended to be SMART (Specific, Measurable, Achievable, Relevant and Time-bound), and "few but powerful".

Key terms to understand in this context include[5]:

- **Impacts (or overall goal).** This refers to the end result of the activity and is typically a long-

term effect on individuals or communities. For example, improved mental health could be an overall goal or impact of an MHPSS activity. Impact indicators are used to measure impact. Many times, the same questionnaires used in early identification (Chapter 8) could also be used to measure impact when used at follow-up.

- **Outputs.** Results at the level of an activity are called outputs i.e. whether the tasks of the activity were implemented as intended. For example, a capacity-building activity that aimed to train 25 ASHA workers in PFA could have an output '25 ASHA workers were trained in PFA'. Output indicators are used to measure outputs.

- **Outcomes.** Outcomes are the changes that occur as a result of the MHPSS activity. For example, if the 25 trained ASHA workers could deliver PFA to 100 people post a disaster, it is an outcome. Outcome indicators are used to measure outcomes.

- **Logical framework.** Also sometimes called logic model or theory of change, this refers to the theory and hypotheses behind why and how the MHPSS activity leads to the desired outcomes and impacts. For example, the theory behind how PFA can lead to improved psychosocial and mental health for people. Although not a necessary aspect of MEAL, it is often useful and comprehensive to include it.

- **Means of verification (or tools).** This refers to the instrument used to measure the indicator. For example, interviews and surveys may be used to collect data on output, outcome and impact indicators.

Table 11.1 describes key impact indicators that can be used to evaluate an MHPSS activity as well as summarises the broad range of tools that can be used to collect this data.

Table 11.1: Impact Indicators[6]

Key Impact Indicators	Tools to Collect Data on Impact Indicators
Functioning (the ability to carry out essential activities for daily living, which will differ according to factors such as culture, gender and age)	**Qualitative:** Mapping (e.g. social mapping, transect walks); group discussions; interviews; observation and documentation; creative data-generating methods (e.g. diary entries) **Quantitative:** questionnaires; surveys; diagnostic schedules; checklists
Subjective well-being (can measure quality of life, feeling calm, safe, happy)	
Extent of prolonged disabling distress, trauma and/or presence of symptoms/ disorder (e.g. number of people reporting a reduction in distress, trauma responses or mental health symptoms)	
Coping abilities (e.g. problem-solving skills, communication skills)	

Social behaviour (e.g. prosocial behaviour, aggressive behaviour, discrimination)	**Qualitative:** Mapping (e.g. social mapping, transect walks); group discussions; interviews; observation and documentation; creative data-generating methods (e.g. diary entries) **Quantitative:** questionnaires; surveys; diagnostic schedules; checklists
Social connectedness (the quality and number of social connections an individual has)	

Table 11.2 describes six key outcomes that are relevant for MHPSS activities conducted in disaster settings. However, it must be noted that other outcomes can be envisioned, this must not be taken to be an exhaustive list.

For each MHPSS program:

- At least one impact indicator must be selected and measured.
- At least one outcome and corresponding outcome indicator must be selected and measured.

Table 11.2 Outcome Indicators[7]

	Key Outcomes	Examples of Outcome Indicators*	Possible Tools That Can be Used To Collect Data On These Indicators
MHPSS Pyramid Level 1 and 2	MHPSS responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable	1. Percentage of affected people who report that MHPSS responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully 2. Percentage of affected people who report being actively involved in different phases of MHPSS response 3. Number of negative events perceived by service users to be caused by MHPSS activities 4. Number of affected people who know how to raise concerns about violations by service providers	Project documentation, Service delivery records, Training records, key informant interviews, focus groups with service providers and service users; session notes and records; referral records
	People are safe, protected, and human rights violations are addressed	1. Number of reported human rights violations 2. Number of members of vulnerable groups (such as children or survivors of sexual violence) who use safe spaces and/or report feeling safe. 3. Percentage of staff who, after	

MHPSS Pyramid Level 1 and 2		training, use new skills and knowledge for prevention of risks and referral	Project documentation, Service delivery records, Training records, key informant interviews, focus groups with service providers and service users; session notes and records; referral records
	Family, community and social structures promote the well-being and development of all their members	1. Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development 2. Percentage of formal and informal groups that include specific mental health and psychosocial activities or supports	
	Communities and families support people with mental health and psychosocial problems	1. Number of people with mental health and psychosocial problems who report receiving adequate support from family members 2. Perceptions, knowledge, attitudes and actions of community members and/ or service providers towards people with mental health and psychosocial problems	
MHPSS Pyramid Level 3 and 4	People with mental health and psychosocial problems use appropriate focused care	1. Improved competency of stakeholders in PFA and other individual interventions for MHPSS 2. Number of service delivery sites that are providing MHPSS focused care interventions (e.g. helplines, onsite delivery, healthcare settings etc) 3. Percentage of service delivery sites that have designed and implemented early identification mechanisms for MHPSS 4. Percentages of service delivery sites that have designed and implemented referral mechanisms for MHPSS services 5. Percentage of service delivery sites that have staff receiving	

MHPSS Pyramid Level 3 and 4		supervision for MHPSS services 6. Number of people who have received focused care interventions (e.g. PFA) 7. Level of satisfaction of people with the focused care interventions they received	Project documentation, Service delivery records, Training records, key informant interviews, focus groups with service providers and service users; session notes and records; referral records
	People with mental health and psychosocial problems use appropriate specialised care	1. Improved competency of mental health professionals and practitioners in delivery of specialised interventions (trauma therapy or disaster-specific training) 2. Percentages of service delivery sites that have designed and implemented referral mechanisms and pathways to MHPSS Level 4 services (e.g. psychiatric hospitals, OPDs) 3. Number of people who have been referred to specialised MHPSS interventions 4. Number of people who have received specialised MHPSS interventions 5. Level of satisfaction of people with the specialised interventions they received	

Step 3. Collect Baseline Data.

Once the indicators and tools have been decided, the next step is to collect baseline data before the MHPSS activity is implemented. This is important to understanding whether the MHPSS activity actually produces a change or an effect. For example, before implementing a capacity-building activity on PFA training, the state may collect baseline data on how many professionals in the state are already trained in PFA and their competency in PFA to see if the activity actually improves capacity to deliver PFA.

However, it may not always be feasible to collect baseline data, for example, in post-disaster settings. In such situations, secondary data can be utilised (e.g. from NGOs or other organisations that may have baseline data) or recall techniques can be used (e.g. asking staff to recall what was the situation at baseline).

Step 4. Conduct The MHPSS Activity And Monitor It.

The next step is to conduct the MHPSS activity. For example, PFA may be offered to the affected population. In this step, it is important to build in a mechanism of systematic monitoring of the

activity. Systematic monitoring of MHPSS activities (both pre and post-disaster) are primarily the responsibility of the governmental, non-governmental or community-based organisation that are conducting MHPSS activities.

- As such, each organisation conducting MHPSS activities needs to specify:
  - A standardised mechanism for documentation of each MHPSS activity conducted at an individual as well as an organisational level. For example, in the case of an organisation offering PFA services, all service providers in the organisation should be expected to document each PFA session conducted and should be provided clear information as to the nature and style of documentation expected.
  - The storage of this documentation must be clearly specified and must be confidential.
- The organisation as a whole should also document the overall activity (number of sessions conducted, number of service users, number of service providers and other details) in the form of a project report or similar official document.
- The State MHPSS Working Committee must be kept apprised of any MHPSS activity that is conducted by an organisation, including changes to its scope, nature or duration.
- All organisations involved in conducting MHPSS activities must specify a mechanism for documenting and handling any reports of ethical malpractice by any stakeholder. They must also specify and follow a protocol for when issues shall be escalated to the State MHPSS Working Committee as well as the National MHPSS Working Committee.

Step 5. Evaluate the MHPSS Activity

As mentioned above, in an evaluation, data is collected on outcome and impact indicators at specific time points to understand whether the activity is meeting its desired goals. An evaluation can be conducted while the activity is still ongoing (e.g. after two months of the start of PFA delivery) and after the completion of the activity as well (e.g. after all PFA sessions have been concluded).

Step 1-5. Accountability and Learning.

Accountability and Learning occur throughout Steps 1-5. Accountability and learning can be enhanced through:

- Promoting community participation and engagement through discussions about the MHPSS activity and its MEAL plan
- Mechanisms for providing feedback in a safe and dignified manner and reporting any harmful practices
- Mechanisms to ensure registration and monitoring of all MHPSS service providers with a central authority
- Mechanisms to share learning about the MHPSS activity and its outcomes and impacts internally (e.g. with other government departments) as well as externally (e.g. published on the centralised portal)

Lastly, it is essential to maintain documentation of the MEAL steps as well as learning and data collected through this process. This aids in determining the quality of the MHPSS activities/ programs carried out, helps identify best practices, and serves as references for future programs The National MHPSS Working Committee, with support from the nodal centre and other institutes, shall develop a protocol for the documentation of MEAL. Further, it shall support State MHPSS Working Committees to use, or if needed adapt, the documentation protocols to their context.

References

[1] Inter-Agency Standing Committee. The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0). 2021. Licence: CC BY-NC SA 3.0 IGO

[2] International Medical Corps. Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings. 2018. https://www.mhpss.net/toolkit/emergency/resource/mental-health-into-general-healthcare-in-humanitarian-settings

[3] IASC Reference Group on Gender and Humanitarian Action. Policy Gender Equality and the Empowerment of Women and Girls in Humanitarian Action. 2017. Available from https://interagencystandingcommittee.org/system/files/2020-11/IASC%20Policy%20on%20Gender%20Equality%20and%20the%20Empowerment%20of%20Women%20and%20Girls%20in%20Humanitarian%20Action.pdf

[4] These steps are summarised based on the steps outlined in: International Medical Corps. Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings. 2018. https://www.mhpss.net/toolkit/emergency/resource/mental-health-into-general-healthcare-in-humanitarian-settings

[5] These terms and their definitions are summarised from the Inter-Agency Standing Committee. The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0). 2021. Licence: CC BY-NC SA 3.0 IGO

[6] The information in this table is reproduced and adapted from the Inter-Agency Standing Committee. The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0). Licence: CC BY-NC SA 3.0 IGO. Please see the original document for a complete list of suggested tools.

[7] The information in this table is reproduced and adapted from: Inter-Agency Standing Committee. The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0). Licence: CC BY-NC SA 3.0 IGO. Please see the original document for a complete list of outcome indicators

SECTION FOUR

Implementation

12 Guidelines Implementation Checklist

The pre-disaster implementation checklist is to be used by national and state disaster management authorities, and specifically the National and State MHPSS Working Committees to bring these guidelines into practice.

The key provided below highlights whose purview the action falls under:

	Action to be taken in coordination by National and State MHPSS Working Committees
	Action to be taken by National MHPSS Working Committee in coordination with relevant stakeholders
	Action to be taken by State MHPSS Working Committees in coordination with relevant stakeholders

PRE-DISASTER CHECKLIST		
Checklist action	**Indicators to complete**	**Timeframe**
Domain: Institutional Framework		
Disseminate the guidelines to all stakeholders at the national level	☐ Orientations will be held with all key personnel at NDMA and relevant national ministries. ☐ Orientations will be held with all SDMAs and State health departments about the vision of the guidelines and the concrete steps expected. ☐ NDMA will disseminate guidelines to all relevant stakeholders at the national level like ministries, NGOs, international agencies, and academic/ research institutions including the nodal centre.	3 months
Disseminate the guidelines to all stakeholders at the state, district and local level	☐ SDMAs will disseminate guidelines to all relevant stakeholders at the state level, like ministries, NGOs, international agencies, and academic / research institutions as well as to DDMAs, district-level officials and local authorities.	6 months

Constitute and establish the National MHPSS Working Committee	☐ NDMA shall constitute the National MHPSS Working Committee. ☐ NDMA shall conduct a systematic mapping to identify and include key representatives from all relevant ministries and bodies. NDMA shall appoint the chairperson. ☐ NDMA, in coordination with committee members, shall clearly outline and communicate the committee's functioning and scope. Roles and responsibilities shall be clearly defined. ☐ Advisory members and experts will be identified and onboarded. ☐ The committee shall identify budgetary allocations and funding for all activities. ☐ Committee shall hold regular meetings.	6 months
Develop the National MHPSS Action Plan	☐ The National MHPSS Working Committee will build on this implementation checklist and clearly outline a National MHPSS Action Plan for the upcoming 3 years and for every 3 years henceforth. It will cover the domains of assessment of vulnerabilities and capacities, capacity building, research, service delivery, and monitoring and evaluation, with timelines specified. Mechanisms will be established to monitor and review progress yearly. ☐ It will be integrated with the Disaster Management (DM) Plan and Health/Hospital DM Plans.	1 year
Constitute and establish State MHPSS Working Committees	☐ Under the direction of the NDMA and the National MHPSS Working Committee, all SDMAs shall establish State MHPSS Working Committees in their respective States. ☐ SDMA and the State health departments will appoint the State MHPSS Working Committee chairperson. Key representatives from all departments and bodies, and DDMAs will be identified and included. ☐ SDMA, in coordination with committee members, shall clearly outline and communicate the committee's functioning and scope. Roles and responsibilities will	1 year

	be clearly defined. ☐ Advisory members and experts shall be identified and onboarded. ☐ The committee will identify budgetary allocations and funding for all activities. ☐ The committee will hold regular meetings.	
Develop funding framework	☐ NDMA shall ensure allocation of both NDRF and NDMF for MHPSS activities at the national level. Similarly, SDMAs shall organise and ensure allocation of funds from the SDRF and SDMF for disaster activities in their respective states. ☐ NDMA and SDMAs shall include details of fund allocations for MHPSS activities within their annual budget. ☐ The National MHPSS Working Committee and State MHPSS Working Committees shall plan utilisation of funds for pre-disaster and post-disaster MHPSS activities at the national and state level respectively.	1 year
Domain: Legal and Policy Framework		
Ensure integration of MHPSS guidelines with existing disaster or MHPSS policies, programmes, and plans at the national level	☐ The National MHPSS Working Committee shall set up a task force for periodic review of alignment of existing national legal and policy frameworks with the guidelines. ☐ The task force will periodically review and ensure the inclusion of MHPSS activities, and alignment of existing policies, acts, rules, and regulations with the guidelines mandated at the national level. It will identify policy changes that need to be made, and advocate for the same. ☐ The taskforce will advocate for the integration of disaster MHPSS in the DMHP, and General Health Programme as part of the hospital and district health plan. ☐ The taskforce will advocate for establishing linkages with the National Rural Health Mission and the National Urban Health Mission. ☐ The taskforce, in coordination with the National	5 years

	MHPSS Working Committee, shall advocate for inclusion of MHPSS activities in the NDMA Minimum Standards of Relief during Disasters.	
Ensure integration of MHPSS guidelines with existing disaster or MHPSS policies, programmes, and plans at the state level	☐ State MHPSS Working Committees shall set up a task force for periodic review of alignment of existing state legal and policy frameworks with the guidelines. ☐ The State task force will periodically review and ensure the inclusion of MHPSS activities, and alignment of existing state policies, acts, rules, and regulations with the guidelines mandates. It shall identify policy changes that need to be made, and advocate for the same.	5 years
Domain: Capacity Building		
Set up a National centralised MHPSS portal	☐ The National MHPSS Working Committee shall identify a centralised portal to be used for all MHPSS disaster related information. ☐ The National MHPSS Working Committee should allocate the responsibility of managing the portal to one member of the committee. Clear roles and responsibilities will also be allocated for other tasks, hiring a team if necessary. ☐ The centralised portal will include updated public section containing: 1. IECs 2. Self-help resources 3. Information for help-seeking/ referrals 4. Guidelines and policies 5. Disaster assessment reports of MHPSS vulnerabilities and capacities 6. Service reports 7. Educational and upskilling opportunities 8. Registration section 9. Authorised government section (resource inventory) ☐ The Centralised MHPSS portal shall be user friendly. ☐ Relevant government officials (e.g. from SDMAs, DDMAs) will be oriented on using the centralised portal. ☐ Relevant stakeholders (e.g. government officials, team managing portal) shall ensure timely updation of assessment reports, capacity-building reports, service	1 year

	reports, and all other resources on the portal. ☐ Information about the availability of the centralised MHPSS portal will be disseminated to the general public.	
Domain: Assessment		
Conduct pre-disaster assessments of vulnerabilities and capacities at the state or district level	☐ The State MHPSS Working Committee shall identify and recruit a team to conduct the assessment. ☐ The team, in coordination with the State MHPSS Working Committee, will develop the assessment plan, scope, and frequency. ☐ The team will identify tools, sources of information, processes, and carry out assessment. ☐ Pre-disaster assessment shall be conducted in a rigorous and ethical manner. ☐ The pre-disaster assessment report shall be prepared. Key gaps and strengths will be identified following the assessment. ☐ The State MHPSS Working Committee shall set the date for the next assessment.	2 years
Disseminate pre-disaster assessment findings	☐ The pre-disaster assessment report shall be uploaded to the Centralised MHPSS portal, and made publicly available. ☐ The report will be translated into the state's local languages, with key findings highlighted. ☐ The State MHPSS Working Committee shall share the report with key stakeholders and the general public. ☐ The State MHPSS Working Committee shall use information about strengths and gaps, and recommendations from the report to identify priorities and plan MHPSS activities.	2 years
Domain: Institutional Framework		
Develop State MHPSS Action Plan	☐ The State MHPSS Working Committee will build on the MHPSS Action Plan template (provided in Chapter 4), and the National MHPSS Action Plan to clearly outline a State MHPSS Action Plan every 3 years. It will cover the domains of assessment of vulnerabilities and capacities, capacity building, research, service delivery and monitoring and evaluation, with clear timelines specified.	2 years

	☐ The committee will establish mechanisms to monitor and review progress yearly. ☐ It will be integrated with the state Disaster Management (DM) Plan and Health/Hospital DM Plans.	
Domain: Capacity Building		
Develop a training and community capacity building plan at the National level	☐ The National MHPSS Working Committee, in coordination with NDMA, will take stock and collate all existing capacity building activities. ☐ All capacity building activities shall be organised in the framework of the MHPSS pyramid, using the following framework: 1. Currently ongoing capacity building activities (level of MHPSS pyramid and Stakeholders targeted) 2. Concluded capacity building activities (level of MHPSS pyramid and stakeholders targeted) ☐ Gaps shall be identified with respect to which capacity building activities need further development, using the following framework: 1. No capacity building content or training module exists for this particular action and level of MHPSS Pyramid 2. Capacity building content or training module exists for this action and level of MHPSS Pyramid, but training needs to be carried out. ☐ Based on this, the national capacity building plan will be developed and clearly communicated with all relevant stakeholders. ☐ Monitoring indicators shall be developed and utilised to track progress in plan implementation. ☐ Annual review and update of capacity building plan will be carried out.	2 years
Develop a training and community capacity building plan at the state level	☐ The State MHPSS Working Committee, in coordination with SDMA, shall take stock and collate all existing capacity building activities. ☐ All capacity building activities shall be organised in the framework of the MHPSS pyramid, using the following framework: 1. Currently ongoing capacity building (level of MHPSS pyramid and stakeholders targeted)	2 years

	2. Concluded capacity building activities (level of MHPSS pyramid and stakeholders targeted) ☐ Gaps will be identified with respect to which capacity building activities need further development, using the following framework: 1. No capacity-building content or training module exists in this particular action. 2. Capacity-building content or training module exists, but training needs to be carried out. ☐ The State MHPSS Working Committees shall coordinate with the National MHPSS Working Committee to gain information about capacity building activities at a national level. ☐ Based on this, the state capacity building plan will be developed and clearly communicated with all relevant stakeholders. ☐ Monitoring indicators shall be developed and utilised to track progress in plan implementation. ☐ Annual review and update of capacity building plan will be carried out.	
Develop content and materials for human resource training and community capacity building activities available at the national level	☐ The National MHPSS Working Committee, in coordination with State MHPSS Working Committees, will take stock and collate all existing training and capacity building content and activities. ☐ In line with the capacity building plan, the National MHPSS Working Committee shall mandate and ensure development of capacity building content across all 4 levels of the MHPSS Training and Capacity Building Pyramid at the national level. This will be done by collaborating with NIDM, and the national nodal centre, and others. ☐ SDMAs, community based organisations, NGOs, citizen groups will be appropriately involved in capacity building training content creation. ☐ The National MHPSS Working Committee shall coordinate with education regulatory authorities (like RCI, NCERT, UGC, AICTE, NMC) to ensure inclusion of MHPSS courses for prospective disaster responders and related stakeholders.	3 years

Conduct human resource training and community capacity building activities available at the national level	☐ Training and capacity building activities will be carried out across all levels of the MHPSS training and capacity building pyramid. ☐ Active dissemination will be carried out to ensure widespread availability of all capacity building activities to target prospective service providers. Care shall be taken to make it available in different languages and modalities. ☐ Registration of all trained individuals shall be done on the centralised portal	3 years
Adapt content and materials for human resource training and community capacity building activities at the state level	☐ State MHPSS Working Committees shall adapt nationally developed capacity building content across all 4 levels of the MHPSS Capacity Building Pyramid to state-specific considerations (including language or frequently occurring disaster scenarios). ☐ NIDM, education/ research/ technical institutes, community based organisations, NGOs, citizen groups shall be appropriately involved in capacity building training content adaptation.	3 years
Conduct human resource training and community capacity building activities at the state level	☐ Training and capacity-building activities will be carried out across all levels of the MHPSS pyramid in the State. ☐ State MHPSS Working Committee, in coordination with relevant government departments and DDMAs, shall identify personnel to be trained across all 4 levels of the MHPSS training and community capacity building pyramid. ☐ Active dissemination will be carried out to ensure availability of all capacity building activities to the target prospective service providers. Care shall be taken to make it available in different languages and modalities ☐ Registration of all trained individuals will be done on the centralised MHPSS portal. ☐ Documentation shall be clearly maintained of capacity building activities conducted.	3 years
Set up a process for updating and quickly requisitioning resources in the event of a disaster	☐ The authorised government section of the centralised MHPSS portal shall be designed in a way that officials from SDMAs and DDMAs can login and update their latest MHPSS resources (human resources, infrastructural resources, physical supplies) on the portal.	2 years

	☐ Government officials from SDMAs and DDMAs will be oriented to use the authorised government section of the portal. ☐ Relevant stakeholders (e.g. government officials, team managing portal) shall ensure timely updation of MHPSS resources on the portal. ☐ NDMA will identify and mandate a team to establish a quick and user-friendly process of requisitioning human resources, infrastructural or essential physical supplies in the event of a disaster.	
Set up helplines at the National and the State level	☐ National MHPSS Working Committee and State MHPSS Working Committees shall identify and review available functional helplines (MHPSS-specific and general disaster support helplines) at the national and state level respectively. ☐ National MHPSS Working Committee and State MHPSS Working Committees will ensure capacitation of well connected, functional MHPSS and general disaster helplines at the national and state level respectively. 1. Committees will ensure availability of at least one functional MHPSS helpline in each state with capacitation needs met. 2. Committees will ensure that processes are in place for a quick capacitation of at least one reverse helpline in a disaster ☐ Information about the availability of the helplines shall be disseminated to the general public.	2 years
Develop institutional, organisational, and material resources	☐ NDMA in collaboration with the National MHPSS Working Committee, MoHFW and SDMAs shall identify at least one academic/ research institute for MHPSS in each state. ☐ Linkages and partnerships shall be clearly established with experts at technical and research institutions, and community based organisations. ☐ Hospitals and medical institutions will include MHPSS in disaster management plans. ☐ National and State MHPSS Working Committees shall collaborate with the MoHFW and State health departments respectively to advocate for existing healthcare and physical infrastructure to be upgraded	1-5 years

	at the district, state, and national level. ☐ Partnerships shall be established with NGOs, international agencies, companies, private professionals, citizens, private educational/ technical/ research institutions, and private healthcare centres.	
Domain: Monitoring, Evaluation, Accountability and Learning		
Ensure monitoring, evaluation, accountability and learning at a national level	☐ The National MHPSS Working Committee shall set up mechanisms to ensure monitoring and evaluation of all capacity-building and service-delivery actions at a national level before the start of the activity. ☐ The National MHPSS Working Committee shall also support State MHPSS Working Committees to set up mechanisms for ensuring monitoring and evaluation of all MHPSS activities conducted at state level. ☐ The National MHPSS Working Committee shall set up a protocol for independent and fair handling of any reports about ethical malpractice in MHPSS activities. ☐ The National MHPSS Working Committee shall design an accessible mechanism by which all citizens and organisations in India, regardless of their status, can report ethical malpractice to the Committee.	2 years
Ensure monitoring, evaluation, accountability and learning at a state level	☐ The State MHPSS Working Committees shall set up mechanisms to ensure monitoring and evaluation of all capacity-building and service-delivery actions at a state level before the start of the activity. ☐ The State MHPSS Working Committees shall set up a protocol for independent and fair handling of any reports about ethical malpractice in MHPSS activities. ☐ The State MHPSS Working Committees shall design an accessible mechanism by which all citizens and organisations in India, regardless of their status, can report ethical malpractice to the Committee. ☐ The State MHPSS Working Committees shall also specify a protocol for when the handling of such reports may need to be escalated to the National MHPSS Working Committee (for example, ethical malpractice by an organisation in multiple states).	2 years
Domain: Research		
Encourage disaster mental	☐ The National MHPSS Working Committee will provide or coordinate funding for various systematic reviews	2 years

health research	(both quantitative and qualitative) to be done that synthesise research done in disaster mental health over the past two decades in India. ☐ The National MHPSS Working Committee, in collaboration with the nodal centre and other academic/research institutes shall identify new key research priority areas in disaster mental health in the Indian context based on the systematic review. ☐ The National MHPSS Working Committee, in collaboration with the State MHPSS Working Committees, shall provide or coordinate funding for capacity-building opportunities in research such as certificate courses, seminars, workshops on conducting disaster mental health research. ☐ National and State MHPSS Working Committees will allocate funds for conducting original disaster mental health research, as per the priority areas identified from the systematic reviews. ☐ State MHPSS Working Committees shall organise skill building opportunities like certificate courses, seminars, workshops on conducting disaster mental health research in their respective states. ☐ Partnerships shall be established between various research stakeholders (NDMA, SDMAs, NIDM, educational/ research institutes, government bodies/ ministries, local and international agencies and NGOs, funding organisations, services providers and users) to encourage collaborations, promote grants, share information, establish research networks, and encourage research ☐ The National MHPSS Working Committee will organise an annual disaster mental health focused conference. ☐ IRB Committees of governmental/academic/research institutes will outline processes to expedite review of applications on disaster mental health research while ensuring ethical consideration, rigour, and value and benefits of study are considered.	
Make disaster mental health related research accessible	☐ Systematic reviews of existing disaster mental health research, as mandated by the National MHPSS Working Committees will be uploaded on the centralised MHPSS portal.	2 years

	☐ Research findings shall be disseminated to the scientific community as well as local and international decision-makers, service providers, participants, and the community at large. ☐ Research findings will be made available in effective formats, non-technical language, in the language of the local community, and for specific groups requiring accommodations keeping in mind varied educational and developmental levels.	

The post-disaster implementation checklist is an easy to use summary of the guidelines, and highlights actions to be taken once a disaster occurs. It can be used by decision-makers at the state and national level to carry out MHPSS actions in the post-disaster phase.

POST-DISASTER CHECKLIST		
Checklist action	**Indicator of completion**	**Timeframe**
Domain: Assessment		
Conduct a rapid post-disaster assessment of MHPSS vulnerabilities and capacities	☐ State MHPSS Working Committees, in collaboration with the District Commissioner and Inter-Agency Groups, shall establish a team to conduct the rapid post-disaster assessment of MHPSS vulnerabilities and capacities in the disaster affected area. Efforts will be made to integrate this and the PDNA. ☐ The team will develop the assessment plan and follow the steps of conducting a post-disaster assessment. Care shall be taken to avoid duplication of efforts and resources and to access (if any) prior assessment reports. ☐ The post-disaster assessment report of MHPSS vulnerabilities and capacities will be created. It will be clear, concise, easy to understand and provides specific information on actions to be taken. ☐ Post-disaster assessment reports shall be collated by the National MHPSS Working Committee, in coordination with the respective State MHPSS Working Committees, for disasters involving more than one State. ☐ The post-disaster assessment report shall be rapidly disseminated, especially to stakeholders planning and	Within a few weeks post the disaster

	implementing disaster response (SDMA or NDMA, NGOs etc.) ☐ The post-disaster assessment report shall be uploaded on the centralised portal.	
Domain: Service Delivery		
Organise mental health services and deploy personnel	☐ On declaration of a disaster, the State MHPSS Working Committee Chairperson shall connect with the Incident Commander to coordinate service delivery. ☐ The State MHPSS Working Committee will connect with the District Commissioner/Magistrate of the district/s where the disaster has occurred and shall understand the on-the-ground efforts, if any, already occurring through the Inter-Agency Group. ☐ Based on the post-disaster assessment and the information about the on-the-ground efforts, the State MHPSS Working Committee in collaboration with the District Commissioner/Magistrate and Inter-Agency Groups will organise and coordinate availability of MHPSS personnel. 1. Information will be accessed from the centralised MHPSS portal when needed. 2. Personnel will be deployed ensuring systematic coverage of all sites where disaster affected individuals are present, including community settings, healthcare settings, and remote services. 3. Personnel shall be deployed covering all levels of the MHPSS Service Pyramid ☐ Experts from the nodal centre, other academic institutions with MHPSS capacities, as well as NGOs and civil society organisations will be deployed to orient, provide refresher training, and supervise all MHPSS personnel on processes and SOPs to follow. ☐ All personnel delivering MHPSS services shall be provided with an appropriate orientation about the disaster, as well as available intersectoral and intra-sectoral services for referrals. ☐ All resources required (e.g. IECs, Information about intersectoral services, early identification packets, medication, safety equipment) shall be made available.	Within a few days to a few weeks post the disaster

Deliver MHPSS services at Level 1 and 2 of the pyramid	☐ Level 1 MHPSS services will be provided. 1. Essential services shall be provided with MHPSS considerations incorporated. 2. Frontline workers and their managers will be aware of MHPSS and will be able to access MHPSS services if required. 3. Disaster communication shall occur sensitively keeping MHPSS considerations in mind. 4. Information about available MHPSS and intersectoral services (both in-person and remote) will be shared widely with the disaster-affected community. ☐ Level 2 MHPSS services will be provided. 1. Community-based stakeholders will be encouraged to mobilise and start community-centric activities focused on pyschosocial support. 2. Community-based stakeholders will be encouraged to mobilise and advocate for the needs for the community. 3. Community awareness programs about MHPSS will be conducted. ☐ All services shall be documented and monitored.	Within a few days to a few weeks post the disaster
Facilitate early identification and referrals	☐ State MHPSS Working Committees, in coordination with the academic/ research institutes, shall create an 'early identification packet' that can be distributed to organisations working on the ground when a disaster occurs. Tools selected will be culturally appropriate. organisations working on the ground when a disaster occurs. Tools selected will be culturally appropriate. ☐ State MHPSS Working Committees shall ensure that referral databases are available at the district level, by coordinating with DDMAs or the District Commissioner/Magistrate. ☐ MHPSS service providers will be oriented to early identification processes and will be given access to the referral database.	Within a few weeks post the disaster
Deliver MHPSS services at Level 3 and 4 of the pyramid	☐ Level 3 MHPSS services will be provided: 1. People showing signs of distress and trauma, as identified above, will be provided PFA or other psychosocial care and support interventions ☐ Level 4 MHPSS services will be provided: 1. People requiring more intensive support, as	Within a few months post the disaster

	identified above, will be linked to formal disaster-specific and trauma-informed mental health medical management by health professionals; or specialised mental health services by mental health practitioners and professionals. 2. SDMAs and the State MHPSS Working Committees, in coordination with State Health Departments, shall ensure availability of medicines used in treatment of psychiatric disorders, as listed in the National List of Essential Medicines ☐ All services shall be documented and monitored.	
Ensure availability of supervision for service providers	☐ Mechanisms and process of supervision of service providers shall be outlined and organised. ☐ Regular supervision at all levels of the MHPSS service pyramid shall be provided. ☐ Emotional safety and wellbeing of the service providers will be prioritised.	Within a few weeks post the disaster
Ensure continued support for service providers	☐ State MHPSS Working Committee, in coordination with educational/ research institutes, shall facilitate spaces for service providers to process their experience and give feedback. ☐ State MHPSS Working Committee, in coordination with educational/ research institutes, shall set up infrastructure for peer support programs (web-based or phone-based) to continue post-deployment. ☐ Leave policies shall be reviewed to allow for time off or slow reintegration to work. ☐ Officials, team leaders, managers to team leaders and managers (trained in identifying signs of distress and trauma) will normalise mental distress and help-seeking, proactively check in their team members and facilitate referrals where needed.	Within a few months post the disaster
Domain: Assessment		
Conduct an extended post-disaster assessment of MHPSS	☐ State MHPSS Working Committee shall establish a team to conduct the extended post-disaster assessment of MHPSS vulnerabilities and capacities in the disaster affected area. This will be to identify long term MHPSS needs of the community. Efforts will be	Within a few months to a year post the disaster

vulnerabilities and capacities	made to integrate this and the PDNA. ☐ The team will develop the assessment plan and follow the steps of conducting a post-disaster assessment. Care shall be taken to avoid duplication of efforts and resources, and to access (if any) prior assessment reports. ☐ The post-disaster assessment report of MHPSS vulnerabilities and capacities will be created. It shall be clear, concise, and easy to understand. and provide specific information on actions to be taken. ☐ The post-disaster assessment report will be rapidly disseminated, especially to stakeholders planning and implementing disaster response (SDMA or NDMA, NGOs etc). ☐ The post-disaster assessment report will be uploaded on the centralised MHPSS portal. ☐ MHPSS Services shall be further organised based on an extended post-disaster assessment report of MHPSS vulnerabilities and capacities.	

About Rahbar

Rahbar is a field action project of the School of Human Ecology, Tata Institute of Social Sciences, which aims to promote training, supervision, and professional development for mental health practitioners in India to ensure quality mental health care for all.

Acknowledging the acute pressures on mental health practitioners during the pandemic, Rahbar launched a special initiative in March 2020. Through this initiative Rahbar offered training and supervisory support to 450+ practitioners (counsellors, psychologists, educators, psychiatrists, social workers etc.) through telephonic and video-based consultations. Rahbar focused on attempts to reach out to practitioners working in geographically remote and resource constrained contexts across India and Nepal, as well as organisations and individuals working with vulnerable populations.

In June 2020 Rahbar collaborated with the National Disaster Management Authority (NDMA) to provide training and supervision support to volunteer counsellors leading NDMA's psychosocial care helpline for persons diagnosed with Covid-19. Based on this work, Rahbar further collaborated with NDMA to develop 'Psychosocial Support during the COVID-19 pandemic: A training manual for counsellors' (https://ndma.gov.in/sites/default/files/PDF/covid/RAHBAR_%20NDMA-manual.pdf). NDMA and Rahbar also documented this work through the research titled 'Psychosocial Support for Individuals Diagnosed with Covid-19: Experiences of Volunteer Counsellors from India' (https://ndma.gov.in/sites/default/files/PDF/covid/Psychosocial-Support-for-Individuals-Diagnosed-with-Covid-19.pdf).

The paper titled "Holding space for those who heal: Reflections from the Rahbar Supportive Supervision Programme during the Covid 19 pandemic" was published in 2022 in the journal Clinical Supervisor documenting Rahbar's work with providing supportive supervision for mental health practitioners during COVID-19.

Rahbar offers a comprehensive post graduate diploma programme for supervisors. The 'Post Graduate Diploma in Supervision for Mental Health Practice' offers a contextually sensitive perspective on the knowledge, skills and attitudes required to undertake the role of a supervisor for mental health practice. The 7 month programme uses intensive theoretical training, learning labs, individual and group practicums to help develop evidence based and contextually responsive supervisory competencies in participants.

Apart from offering training and supervision programmes, Rahbar supports organisations to develop supervision practice guidelines. Rahbar also coordinated mental health and psychosocial support for those affected by the train accident in Balasore, Orissa.

In early 2023, Rahbar was invited by the National Disaster Management Authority (NDMA) to update the National Disaster Management Guidelines: Psychosocial Support and Mental Health Services in disasters from 2009. The Rahbar team worked on developing the updated guidelines from March to September 2023.

Author Bios

Dr. Chetna Duggal is the Project Director of Rahbar. She is an Associate Professor in the School of Human Ecology, Tata Institute of Social Sciences (TISS), Mumbai. She has completed her Ph.D. from TISS, Mumbai and her M.Phil. in Clinical Psychology from National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore. She is a psychotherapist with over 18 years of experience and has worked with children, adolescents, couples and families. She is the programme coordinator for the Masters in Applied Psychology (Clinical and Counselling Practice) programme, as well as anchors the Post graduate diploma in Supervision for Mental Health Practice and the Post graduate diploma in Psychotherapy and Counselling for Children and Adolescents. She is also the Project Director of the School Initiative for Mental Health Advocacy (SIMHA), an initiative that endeavours to promote well-being of young people in schools and other institutes through advocacy, research and capacity building. She has been a J1 scholar at The Chicago School of Professional Psychology and the recipient of the Faculty Mobility Initiative Grant by the Embassy of France. Her research focuses on psychotherapy training, practice and supervision, social justice and trauma perspectives in psychotherapy, child and adolescent mental health, religion and spirituality.

Ritika Chokhani is a psychologist and researcher based in Mumbai. She has a combined experience of 7 years working in government-run, NGO-run and privatised mental health- and disability-focused healthcare institutions and private practice. She has an MPhil in Clinical Psychology from National Institute of Mental Health and Neurosciences (Bangalore), an MSc in Developmental Psychology and Clinical Practice from University College London (Dean's List), and a BA in Psychology from the University of Mumbai (Gold Medal). She was an Inlaks Scholar in 2014 and was awarded a full scholarship to pursue her MSc at University College London. Through her work as a therapist and researcher, she advocates for mental health to be informed and guided by principles of social justice and people's own lived experiences and know-hows.

Tejaswi Shetty is a mental health practitioner, project coordinator, and researcher working in the field of mental health for the past 8 years. She has worked in different settings like research organisations, hospitals, government schools, and clinics. She has an International Diploma in Mental Health, Human Rights, and Law from the Indian Law Society; an M.A. in Applied Psychology from the University of Mumbai; and a B.A. from Sophia College for Women. She has a deep interest in a rights-based approach to mental health, and the improvement of systems and structures in society to support mental health and wellbeing.

Author Bios

Tooba Iftikhar is a counselling psychologist and mental health researcher based in Bhopal. She has an MA in Counselling Psychology from TISS, Mumbai. Her experience includes working as a counsellor in a private EAP organisation with clients from various national and multinational corporate companies on a range of concerns related to employee motivation, productivity, mental health, marital and family relationships. She has also been a part of other projects associated with TISS Mumbai, such as the field action project SIMHA, and a research project on the psychological impact of Covid-19. Her key interest areas include positive psychology, mental health advocacy, emotional awareness and management, and interpersonal neurobiology among others.

Prachi Pal is an enthusiastic development sector practitioner. She graduated with a Bachelo'r's degree in Economics from Lady Shri Ram College, Delhi University, and furthered her education with a Master's degree in Development Studies from the Institute of Development Studies in the UK. Prachi has over 5 years of experience and has worked in the diverse areas of strategy, research, editing, thought leadership, PR and communications. Her fervour lies in enhancing organisational capacity, forging robust partnerships, refining communications strategies, and devising effective plans for grassroots NGOs to accelerate social change in India.

Guideline Development Process

These guidelines update the National Disaster Management Guidelines: Psychosocial Support and Mental Health Services in Disasters from 2009. The process was completed between March-September 2023 by Rahbar, a field action project of the Tata Institute of Social Sciences, Mumbai. The original guidelines from 2009 were reviewed and summarised chapter by chapter. Three types of gaps were identified: content gaps, approach gaps and structural gaps.

Extensive literature review was conducted to map global developments in the field of disaster mental health and MHPSS services. Further, the relevant legislative and institutional frameworks in India since 2009, capacity-building initiatives, resources, and priorities were also reviewed. Policy guidelines of other countries such as Malaysia, Philippines, New Zealand, Australia, the Caribbean, Iraq and South Africa were examined. Selected state disaster management plans and SDMA websites were also perused.

Step 1: A detailed revision framework was prepared with: previous chapter headings and subheadings; gaps identified; proposed headings and subheadings with themes/areas to be covered.

Step 2: The gaps identified and proposed revision framework was reviewed by NDMA.

Step 3: For each chapter, detailed scoping was done and clear conceptualizations were created, before the chapter was written. For example, for Chapter 5 and Chapter 8, an assessment framework was developed by the team based on detailed review of various global frameworks. This was then further refined through discussions within the team and through one-on-one video consultations with experts from India as well as an email consultation with an international expert.

Step 4: One-on-one consultations were conducted with expert stakeholders from disaster management and mental health to seek inputs on specific sections of the guidelines and stakeholders' inputs were also duly considered to produce a first draft of the guidelines. At times, multiple consultations were conducted with the same stakeholder to refine the conceptualizations.

Step 5: Feedback on the first draft was provided by NDMA in a meeting.

Step 6: A stakeholder workshop was conducted with practitioners and leaders of NGOs and civil society organisations working on the ground, and their feedback was sought on service delivery guidelines.

Step 7: NDMA constituted a review committee composed of experts from within the ministry, and from other institutes and agencies. Feedback received was incorporated.

Step 8: The final draft of the guidelines were sent to be typeset and designed.

The Rahbar team would like to sincerely acknowledge and convey their gratitude to Shri Krishna Vatsa for his invaluable guidance and the NDMA team for their support through the development of the guidelines.

The team would also like to express gratitude for the contribution of the following experts in the development of these guidelines:

Ms. Maitreyee Mukherjee (Senior Consultant (ex), National Disaster Management Authority of India)

Prof. Jacquleen Joseph (Professor, Tata Institute of Social Sciences, Mumbai)

Dr. Jayakumar C (Associate Professor, National Institute of Mental Health and NeuroSciences, Bengaluru)

Dr. Pratheesh Mammen (State Programme Coordinator, KSDMA-UNICEF Programmes)

Ms. Hvovi Bhagwagar (Psychologist and Psychotherapist, Founder, Manashni)

Mr. Gobinda Ballava Dalai (Executive Director, Yuva Vikas Foundation, Odisha)

Mr. Sidharth Rath (Founder & CEO, Swasthya Plus Network; Executive Director, IFI Foundation)

Mr. Siddhant Khurana (Co-founder and CEO, Mind Piper)

Ms. Sukanya Ray (Assistant Professor, Tata Institute of Social Sciences, Mumbai)

Dr. Brandon Gray (Technical Officer, World Health Organization)

Experts from the Institute of Human Behaviour and Allied Sciences (New Delhi), Kerala State Disaster Management Authority, National Institute of Mental Health and NeuroSciences, (Bengaluru), and Odisha State Disaster Management Authority who were part of the NDMA Review Committee

The team would like to acknowledge the contribution of Ms. Divya Padmanaban (M. Des. Interaction Design) in designing and typesetting the guidelines.

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Mental Health and Psychosocial Support Services in Disasters

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