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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

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SECTION ONE

Introduction

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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

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[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.

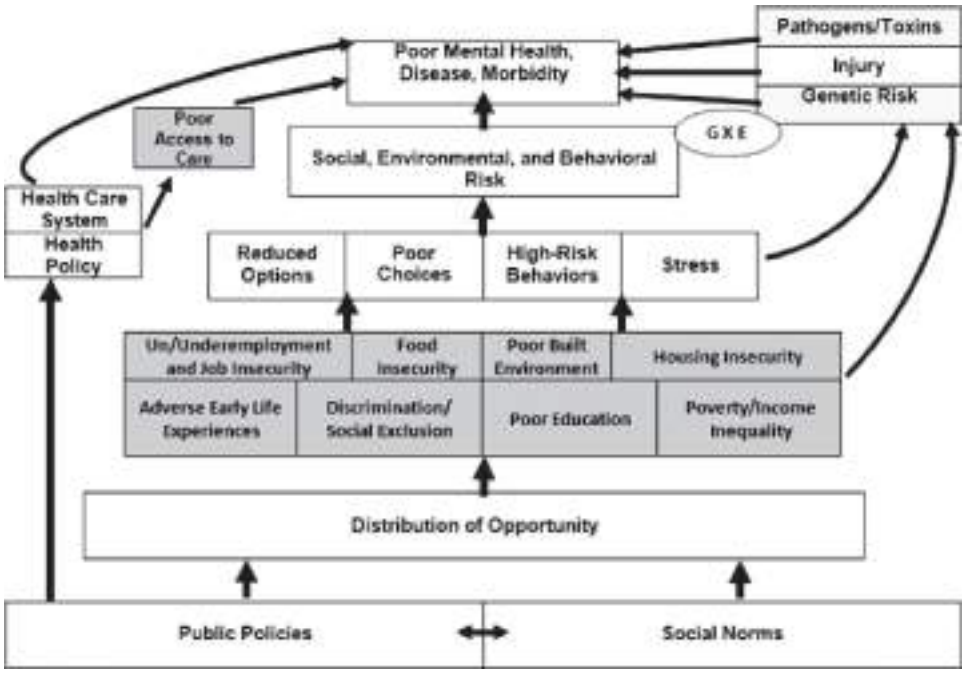

Figure 2.1: Social determinants of mental health. Reproduced with permission from Compton MT, Shim RS. The social determinants of mental health. Focus. 2015 Oct;13(4):419-25

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.

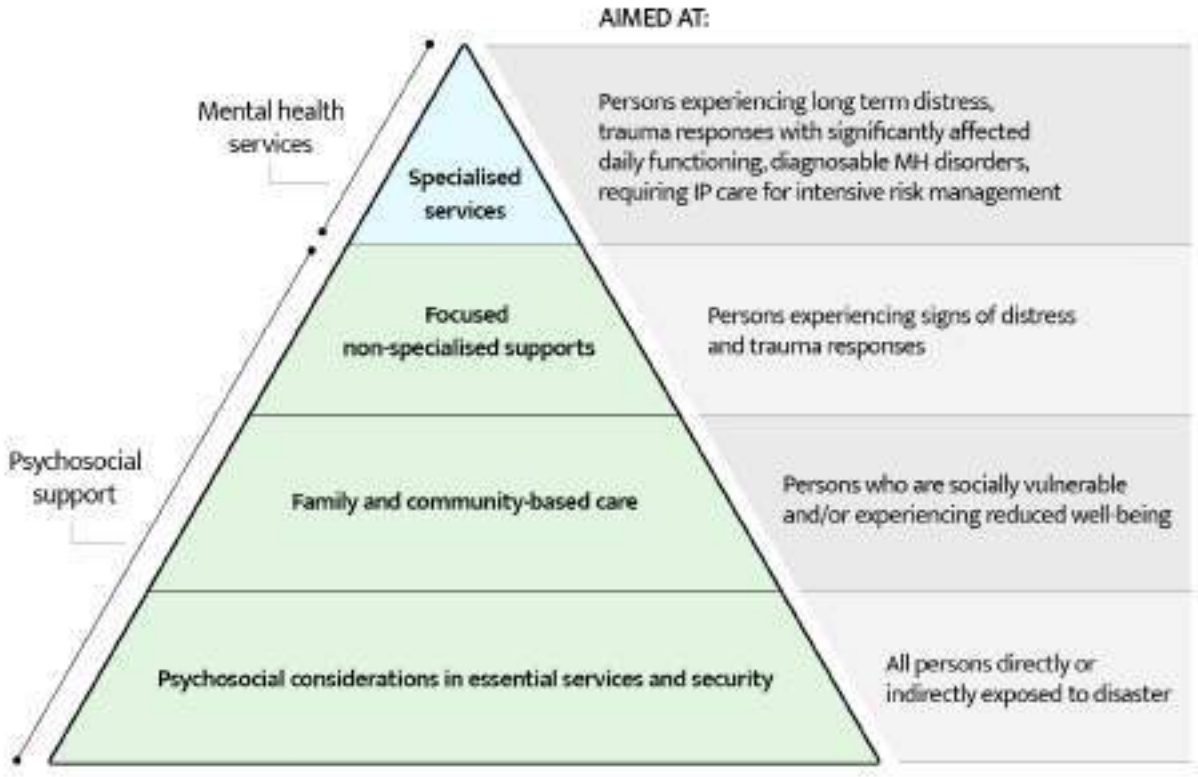

Figure 2.2: MHPSS Pyramid for disasters

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.

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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.

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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)

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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.

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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).

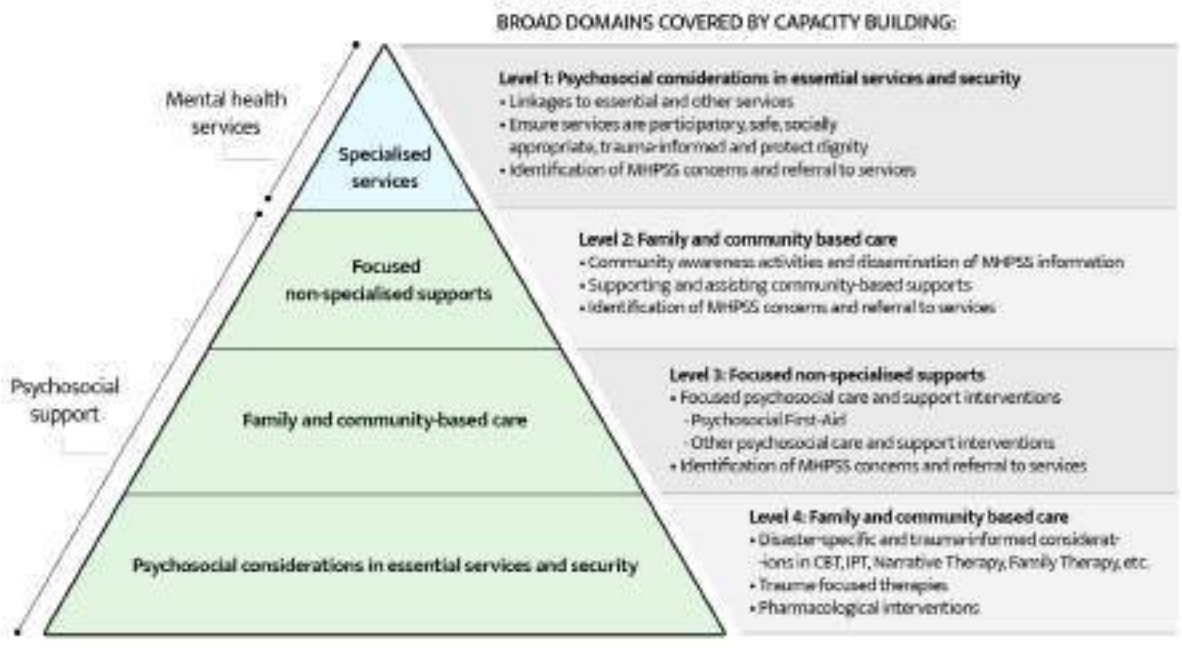

Figure 6.1: MHPSS Training and Capacity Building Pyramid

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.

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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.

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