

Community Mental Health Good Practice Guide:

Inclusive Mental Health and Psychosocial Support (MHPSS) in Humanitarian Emergencies



Table of Contents

Summary	5
1. Introduction	6
2. What is MHPSS in Humanitarian Emergencies?	7
2.1 The impact of emergencies on mental health and wellbeing	7
2.2 MHPSS and related terminology	8
3. Disability Inclusion and MHPSS in emergencies	9
3.1 The IASC MHPSS Pyramid of Intervention	10
4. Key principles	14
4.1 Do No Harm	18
5. How does MHPSS fit into CBM Global’s broader humanitarian work?	22
5.1 Mainstreaming MHPSS in other sectors	23
5.2 MHPSS in field programmes, advocacy and external technical advice	24
6. Programme activities	25
6.1 Psychological First Aid (PFA)	27
6.2 Counselling	28
6.3 Peer support and self-help approaches	29
6.4 Community Mental Health Forums	29
6.5 Community Safe Spaces	29
6.6 Specialised support	30
6.7 Strengthening decentralised mental health services	30

7. Partner identification and capacity needs.32
7.1 Skills needed to provide MHPSS support in humanitarian contexts	33
8. Components of a MHPSS Response35
Case study: Tele counselling, PFA and follow up services in humanitarian emergencies, CMC Nepal39
Case study: MHPSS response to Cyclone Idai, Zimbabwe, CBM, REPSSI and MoHCC43
9. Advocacy and advisory support45
10. Preparedness, Disaster Risk Reduction and Building Back Better.47
Acknowledgements48
Annexes49
Annex 1: The role of stakeholders in the provision of inclusive MHPSS emergency response49
References53

Acronyms

CMH	Community Mental Health
CMHF	Community Mental Health Forum
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil Society Organisations
DRR	Disaster Risk Reduction
IASC	Interagency Standing Committee
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and others
M+E	Monitoring and evaluation
MHPSS	Mental health and psychosocial support
MSP	Minimum services package
NFIs	Non-food items
NGO	Non-governmental organisation
OPD	Organisation for persons with disabilities
PFA	Psychological First Aid
RNA	Rapid Needs Assessment
SGBV	Sexual and Gender Based Violence

Summary

This document provides guidance on inclusive MHPSS programming in humanitarian emergencies. It is designed to highlight essential frameworks and principles, and the need for robust and sustainable MHPSS programming, rather than to provide detailed MHPSS technical guidance.

MHPSS mainstreaming is identified as best practice where capacity exists and contextual conditions are in place, and it underpins CBM Global's work in community based MHPSS approaches which are holistic and person-centred, and go beyond the health sector only.

The Guide further highlights a number of standalone MHPSS interventions and explores how these can be facilitated in a way which supports persons with disabilities, including people with psychosocial disabilities, and outlines the approach needed in order to do no harm and maintain best practice in supportive inclusive MHPSS.

The core components of MHPSS responses outline the steps needed to ensure a participatory, inclusive MHPSS approach, and highlights the need to continue to develop a set of robust, appropriate and flexible indicators which can be used in MHPSS programming in humanitarian contexts.



1. Introduction

Mental health and psychosocial support is a core element of CBM Global's work when promoting disability inclusion, including in humanitarian action.

Supporting and promoting wellbeing means supporting access to equitable justice, education, social protection, livelihoods, family life and community.

The purpose of this document is to offer guidance on how programmes can be delivered to provide quality, appropriate and meaningful MHPSS support that is inclusive of persons with disabilities in humanitarian contexts.

CBM Global wants to see a world where people with mental health conditions and/or disabilities participate meaningfully and authentically in their communities, but also have a good quality of life and wellbeing, access to dignified quality care, and supports to address individual needs.

The Guide describes the negative consequences of emergencies on affected populations and explores the particular impacts which may be experienced by persons with disabilities. The role of MHPSS in CBM Global's work and key considerations to ensure inclusion of persons with disabilities is explored, followed by key principles, for example avoiding causing harm. The guide includes a section on identifying and supporting partners as well as the skills needed to implement MHPSS, followed by the core components of all MHPSS programming and some selected MHPSS activities which are typically implemented in CBM Global's programmes. Examples of work in Nepal and Zimbabwe are highlighted, followed by guidance on how MHPSS fits into advocacy and technical advisory support.

The guide links to, and adheres to the principles outlined in the following standards and policy documents:

- The IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action, 2019
- The CBM CMH Strategy and Disability Inclusive Humanitarian Strategy
- IASC Guidelines on MHPSS in Emergency Settings, 2007
- IASC Information Note on Disability and Inclusion in MHPSS, 2023

2. What is MHPSS in Humanitarian Emergencies?

2.1 The impact of emergencies on mental health and wellbeing

Emergencies can create a range of problems experienced at the individual, family, community and societal levels. The psychological impacts of emergencies can be significant in the short term, but can also undermine the long term mental health and psychosocial wellbeing of an affected population. It is essential to protect and promote the mental health of emergency affected populations, including persons with disabilities.

Emergencies erode normally protective supports and can also amplify pre-existing problems arising from social inequality. Some problems of a predominantly social nature which are exacerbated by emergencies include:

- Pre-existing (pre-emergency) social problems (e.g. extreme poverty; being in a group that is discriminated against or marginalised)
- Emergency-induced social problems (e.g. family separation; disruption of social networks; destruction of community structures, increased gender-based violence)
- Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms)

Similarly, problems of a predominantly psychological nature include:

- Pre-existing problems (e.g. mental health conditions; alcohol abuse)
- Emergency-induced problems (e.g. grief, distress; depression and anxiety, including post-traumatic stress disorder (PTSD))
- Humanitarian aid-related problems (e.g. anxiety due to a lack of information about food distribution)¹

In humanitarian emergencies, people can experience extreme stress and reactions which can impair daily functioning and social interaction.² The vast majority of people will adapt to the changes and overcome the difficult experiences due to innate human resilience, and community support. However, a smaller number of people may require additional MHPSS support beyond the provision of basic needs, safety and security. This includes people who may have pre-existing mental health conditions or psychosocial disability, people who have been severely impacted by trauma such as loss, death or displacement, or people who are in particularly vulnerable situations.

1 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, IASC, 2007

2 IASC Guidelines on the Inclusion of persons with Disabilities in Humanitarian Action, 2019

2.2 MHPSS and related terminology

The term **mental health** refers to a positive state of emotional and cognitive wellbeing and functioning, and is sometimes used to describe the health (as opposed to psychosocial) elements of emergency preparedness and response.

Psychosocial support is usually used to describe non-biological, psychological and social interventions to support mental health and wellbeing.

Wellbeing³ describes a subjective sense of satisfaction with life. It is usually understood to be more than just happiness, but includes achieving wider aims in life, and thriving emotionally, physically and socially.

Interpersonal wellbeing refers to nurturing relationships, a sense of belonging, and the ability to be close to others.

MHPSS (Mental Health and Psychosocial Support) is used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental health conditions.⁴

The composite term "MHPSS" should be used as it reflects a comprehensive approach, and the relationship between psychosocial and mental health

MHPSS is a multi-sectoral approach and is not solely a health intervention.

Resilience is the ability to cope relatively well in situations of adversity and quickly recover.

Psychosocial Disability arises when someone with a mental health problem (or impairment) interacts with barriers which hinder their full and effective participation in society on an equal basis with others.

The IASC guidelines on the inclusion of persons with disabilities in humanitarian action defines psychosocial disability as resulting "from barriers to social participation and access to rights linked to mental health or cognitive conditions or disturbance in behaviour that is perceived as socially unacceptable". The term is usually reserved for people with more persistent or recurrent functional impairment who are confronted with systematic exclusion and participation barriers. During humanitarian emergencies, distress leading to functional impairment is often transient and it is important not to label such response as a medical condition or disability,⁵ but more persistent mental health difficulties arising from an emergency can be classed as such.

3 UNICEF Interagency Guide to the Evaluation of Psychosocial Programming in emergencies, New York, 2011

4 IASC Guidelines on MHPSS in Emergency Settings, 2007

5 IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action, p74.

3. Disability inclusion and MHPSS in emergencies

Persons with disabilities represent a diverse group, varying in age, sex, sexual orientation, gender identity, language, religion, ethnic, indigenous or social origin, type and severity of disability, barriers faced and contexts.⁶ As is the case with everyone, these factors determine how the wellbeing of persons with disabilities is affected and impacted by emergencies. Furthermore, the type of emergency (i.e. war, displacement, pandemics) can further aggravate the risks faced by persons with disabilities. For example, the social distancing required in the COVID-19 pandemic and the widespread use of technology in service delivery may exacerbate barriers to equal participation and access.

In many humanitarian crises, people with disabilities do not access the support they need, and face significant barriers to their meaningful engagement. This increases their risk of mental distress compared to others in an emergency. People with disabilities are more at risk of discrimination, marginalisation and threats to their safety and security when exposed to humanitarian crisis, and can be prevented from accessing humanitarian support because of lack of access, barriers to their participation, and lack of capacity of humanitarian organisations to address their rights.⁷ This includes access to mental health and psychosocial support. A 2015 Humanity & Inclusion survey of people with disabilities in humanitarian crisis found that while 49% of respondents identified MHPSS support as a priority, only 24% said such support was available to them.⁸

Among persons with disabilities in emergency contexts, there are groups that face higher risks due to compounded and intersectional vulnerability, these include children, youth, older persons, girls and women, LGBTQ+ people, persons with intellectual, cognitive and psychosocial disabilities, persons with multiple disabilities, and persons with newly acquired disabilities.

People with pre-existing mental health conditions and psychosocial disabilities often experience particular difficulties if social supports and existing services break down (including medication supplies being disrupted). In addition they may struggle to cope with additional stresses of an emergency situation, including the need to isolate in outbreak responses. It is essential in emergency settings to also consider the needs of persons living in long-stay or residential institutions who may be particularly reliant on the institution and at very high risk if systems break down. These groups are often invisible and not included in humanitarian response.

6 IASC, [IASC Key Messages on Applying IASC Guidelines on Disability in the COVID-19 Response \(2020\)](#); IDDC, DRI et al., [Disability rights during the pandemic, A global report on findings of the COVID-19 disability rights monitor](#), COVID-19 disability rights monitor (2020); WHO and World Bank, [World Report on Disability \(2011\)](#)

7 CBM Disability Inclusive Humanitarian Action Strategy 2020-2024

8 [Study_HI_Inclusion_World-Humanitarian-Summit_2015 \(un.org\)](#)

Survivors of disasters, torture and armed violence may be particularly vulnerable because of a number of factors including becoming recently disabled in the context of a fractured health care system which is unable to respond to their needs, being unaware of their rights and supports which are available to them, or falling through the cracks through not having worked with OPDs prior to the emergency, or not having their MHPSS needs addressed whilst accessing rehabilitation or health care.

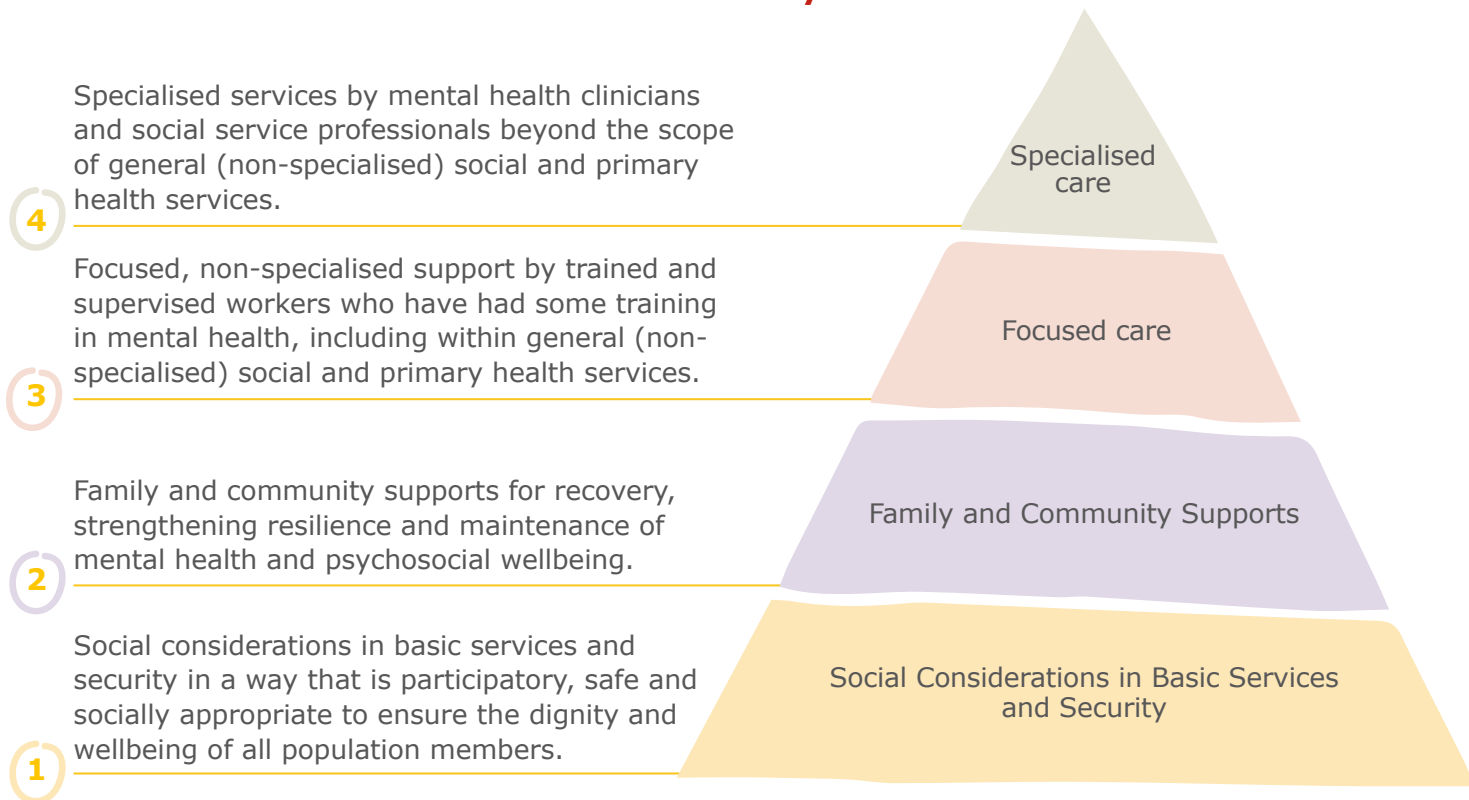
When persons with disabilities are able to access appropriate, targeted and holistic MHPSS, the benefits extend to their family members, community and society as a whole.

3.1 The IASC MHPSS Pyramid of Intervention

The IASC MHPSS pyramid of intervention identifies the complementary and multiple layers of support which are necessary to respond to the varying needs of communities and individuals following an emergency or a distressing event. All layers of the pyramid are important and should be implemented concurrently, responding to identified needs.

The size of the layer represents the typical proportion of people who require the type of support, for example, less people typically require specialized care than people who require community based supports or support to access basic services and security.

The IASC MHPSS Pyramid



MHPSS Pyramid of Intervention, IASC 2007

Layer 1. Social considerations in basic services and security

Following an emergency or crisis, communities are protected and recover better when their basic needs are met, and layer 1 of the pyramid is concerned with basic services and security. Inclusive MHPSS support can be provided at this layer through direct provision of food, cash support and/or through advocating for basic needs to be met. It is important to ensure that the provision of humanitarian support is fair, participatory, safe, and maintains dignity of all members of the affected populations, otherwise it can contribute to mental distress itself. For example, ensuring that information campaigns are accessible to include persons with disabilities, engaging persons with disabilities in designing and implementing initiatives to provide basic services, shelter, WASH, health, nutrition etc. as well as actively engaging with persons with disabilities in monitoring emergency responses to assure consistent quality (accountability).

Layer 2. Community and family supports

This layer represents further support which may be needed and includes family tracing, access to safe and supportive education, and support in regaining livelihoods. For example, activities on layer 2 of the intervention pyramid include the provision of accessible and inclusive safe spaces, establishing befriending services, activating community structures to support mental health and wellbeing of persons with disabilities, and awareness raising and stigma reduction. Recreational and cultural activities must be accessible and inclusive. Community based committees focusing on protection or disability are also included in this layer, as are community based forums and community led peer support groups for persons with disabilities.

Layer 3. Focused non specialised supports

A smaller number of people will require specific interventions despite provision of basic needs and community supports. Such support may be delivered individually or through group based interventions. It can be provided by non-specialist workers such as health, education and social workers, who have been trained and receive supervision by mental health specialists, or the services can be provided by specialists based on circumstances/available resources. Examples of layer 3 supports include structured group and individual interventions for people who require mental health support, or who have been particularly affected by distressing events, interventions such as integrating mental health into primary care (eg using mhGAP resources), and structured peer support programmes facilitated by trained personnel who have access to robust referral systems. Psychological First Aid (PFA) is sometimes referred to as a layer 3 intervention, but in fact forms a core set of skills useful for practitioners at any level.

Layer 4. Specialised services

This layer represents the small number of people who experience significant difficulties in day to day functioning due to poor mental health. People experiencing severe mental

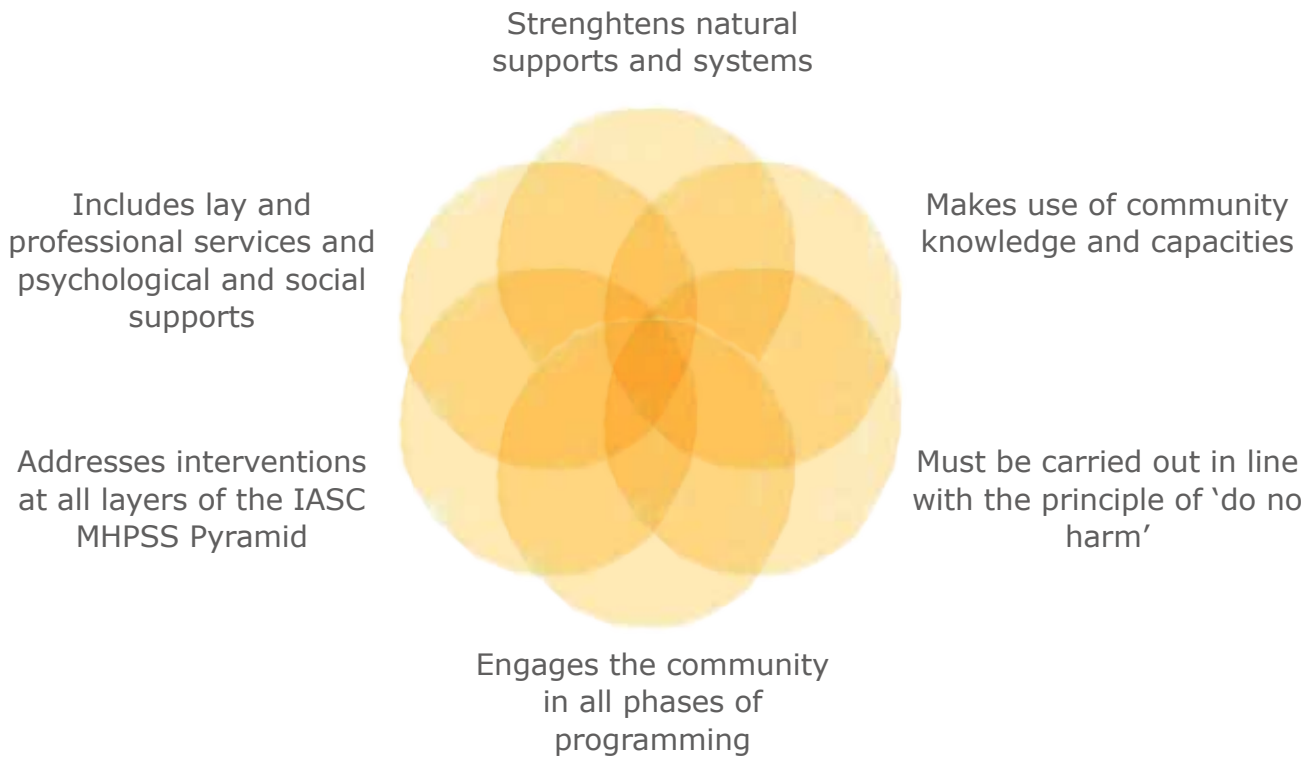
health conditions should have their previous access to psychological or psychiatric support maintained, and may need referral to specialised services. Examples of inclusive specialist support for persons with disabilities include medical support from mental health professionals in health centres, clinics or mobile mental health support.

In some emergencies, mental health services can be disrupted or fail to provide ongoing support, so need to be strengthened to fill any gaps. Unfortunately, in many countries, psychiatric services are not always dignified or compliant with the Convention on the Rights of Persons with Disabilities (CRPD), and particular attention often needs to be paid to people in institutions, who may be at particular risk of neglect. Referral, and helping people to navigate sometimes complex services is important to ensure people access the right support at all levels of the MHPSS pyramid of intervention.

In MHPSS responses at all layers of the pyramid; ensure persons with disabilities are included in decision making processes related to their care, ensure specialist health providers are accessible and meet the communication requirements of persons with disabilities, and ensure policies are in place to prevent coercive treatment including forced institutionalisation, treatment and physical and chemical restraint.

CBM Global supported MHPSS work typically fits on the bottom layers of the pyramid, due to the focus on basic rights, community supports and front-line support for emotional wellbeing, protection and safeguarding. In general, CBM Global humanitarian work will include layer 1 and layer 2 MHPSS responses and be community-based. Depending on contextually specific needs, available resources, and local partner capacity, CBM will at times also support layer 3 and layer 4 MHPSS responses.



A community based MHPSS approach...

Many of the above actions are difficult to start in an emergency, particularly actions around deinstitutionalisation processes. However, the recovery phase can often present opportunities to “build back better”, and certain actions can be implemented after the crisis is over. System strengthening not only builds better systems after emergencies, but such systems are also more resilient and able to allow preparedness for future emergencies. Humanitarian crises are an opportunity to invest effort and resources to construct an equipped, comprehensive community-based system that is aligned with international human rights standards.

4. Key principles

MHPSS programming should be people centred, ensure a human rights approach, and be participatory. People affected must be facilitated to participate in decisions which affect them, be supported to make informed decisions and be agents in their own care and MHPSS support, regardless of the type of support they receive.

It is important to remember that MHPSS interventions have the potential to cause harm because of the possible focus on highly sensitive personal and emotional issues in contexts where people are very vulnerable. MHPSS programmes should therefore adhere to Do No Harm standards, and ensure safeguarding is central to all programming.

The IASC Guidelines on the Inclusion of Persons with Disabilities⁹ includes the following **Must Do actions** to ensure persons with disabilities are included in all stages of humanitarian action:

1. Promote meaningful participation
2. Remove barriers
3. Empower persons with disabilities; support them to develop their capacities
4. Disaggregate data for monitoring inclusion



9 IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action, 2019

Key considerations to ensure inclusion of persons with disabilities in MHPSS humanitarian response

Participation and Inclusion of disability actors: disability actors are consulted and meaningfully involved as partners and agents of change in all phases of the MHPSS response, namely:

- intersectoral and inter-agency coordination mechanisms
- assessments
- advocacy and lobbying
- policy reviews and decision-making processes
- planning, programming and budgeting
- human resources development
- service planning, organization and implementation
- MHPSS programmes adaptation
- services reform process if this is planned or taking place (for example deinstitutionalisation)
- monitoring and evaluation
- raising awareness
- research processes

Budgeting and fundraising: include resources for removing barriers to accessibility and promoting participation of persons with disabilities in MHPSS response through mainstreaming disability and disability focused/tailored actions, applying universal design features and reasonable accommodation measures.

Assessments: include MHPSS requirements of persons with disabilities, barriers to access and participation to MHPSS response, capacity-building needs, universal design features and reasonable accommodation measures for facilities, environments (accessibility), equipment, programmes, services and activities.

Service planning, organization and implementation: service planning and service organization is human-rights based, community based and sensitive to disability from the design and onset. If this has not been done, it can be retrofitted and adapted to the requirements of persons with disabilities, applying universal design features and reasonable accommodation measures across sectors and through the multiple layers of intervention (see the IASC MHPSS Intervention Pyramid in Annex 2), targeting disability diversity and intersectionality (for example, dementia-friendly communities, focused psychological support at primary health-care settings, psychotherapy for adults and children who are deaf, etc.) in all types of emergencies (i.e. pandemic, natural disaster, armed conflict).

Referral mechanism: an inter-agency and intersectoral MHPSS referral mechanism is in place, inclusive of persons with disability and sensitive to age, gender and disability (for example, mapping of mainstream and disability-specific services, service providers, suppliers of assistive devices is disseminated in multiple and accessible formats; staff at the entry points are trained on requirements of persons with disabilities).

Monitoring and evaluation (M&E) activities: consider indicators related to the disability inclusiveness of MHPSS programmes and services.

Intersectoral and inter-agency coordination mechanisms: are accessible to and support the participation of persons with disabilities at local, national, regional and global levels (where relevant).

Advocacy and lobbying initiatives: are developed and implemented jointly by disability and MHPSS actors on MHPSS requirements of persons with disabilities and on the urgent necessity of closing and replacing long-term residential institutions.

Policy reviews and decision-making processes: are accessible to, inclusive of and informed by the input, experience and expertise of persons with disabilities.

Recruitment processes: are inclusive of persons with disabilities at various levels of the MHPSS response, including frontline services, and are provided with the required capacity-building, accessibility requirements and accommodations.

Capacity-building: requirements for capacity-building of MHPSS humanitarian actors across sectors, including humanitarian agencies, ministries, private and non-profit sectors, universities and OPDs are assessed and addressed through inclusive capacity-building activities, co-developed and co-delivered by persons with disabilities.

Case management (CM): CM is accessible to and inclusive of persons with all types of disabilities (for example, case managers have knowledge and competencies about the requirements of persons with disabilities and the available disability-related services; specific software solutions are in place; the list/mapping of available services is provided in multiple and accessible formats).

Rehabilitation services: they are available, inclusive, accessible and affordable, targeting disability diversity and intersectionality, in all types of emergencies.

Report/complaints and feedback mechanisms on MHPSS responses: are safe, confidential and effective and are co-designed by persons with disabilities, are available in multiple and accessible formats, ensuring accountability and informing decision-making processes, planning and retrofit.

Adaptation of MHPSS programmes/protocols: are adapted with guidance and adequate support for accommodating the participation of children, adolescents and adults with disabilities.

Communication and information¹⁰: are available and provided in multiple (written, oral and pictorial) and accessible formats (Braille and large print, accessible web content by screen reader including image description, easy-to-read version, plain text accompanied by pictures, simplified version of information, sign language video, audio recordings, voice-over, captions), through the most appropriate channels (radio, SMS, emails, TV, etc.) when required.

Services reform process: joint efforts are focused to ensure that people in long-stay residential institutions and psychiatric hospitals have access to appropriate MHPSS support and are not left behind in situations where populations are forced to flee.

Awareness-raising activities: awareness campaigns about the rights, capacities and requirements of persons with disabilities are led by OPDs and persons with disabilities and supported by MHPSS actors.

Data collection: all data, including data on MHPSS, is disaggregated by age, gender and disability.

Research initiatives: are co-led by researchers and persons with disabilities and inform inclusive programme development and evidence-based interventions.

Safeguarding: measures to be tailored/inclusive of persons with psychosocial disabilities.



10 Based on the CRPD, Article 3, communication includes languages (spoken and signed), display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio.

Some common ethical challenges include:

- Ensuring adequate capacity to respond to the MHPSS needs of affected communities within the mandate of the organization and with the right personnel who can respond in the right way and at the right time.
- Confidentiality and informed consent - ensuring persons with disabilities, including psychosocial disabilities, are fully supported to make informed decisions on issues which affect them, including their care, their wishes, and the options available to them.
- False or unrealistic expectations by communities or partners, including about how long support will be made available.
- Issues of exclusion/ power dynamics and barriers to voice and participation of persons with disabilities.
- Embarking on an MHPSS programme without appropriate supports in place, including sensitive responses to disclosure, and availability of appropriate expert support if needed.
- The use of non-contextually or culturally appropriate tools.

The basic needs of the community should be met before MHPSS support should be offered. However, in coordination with other actors, CBM Global can provide MHPSS support where basic needs are met or are supported by other organisations.

4.1 Do No Harm

As stated in the IASC Guidelines on the Inclusion of Persons with Disabilities, **all actions should be carried out alongside persons with disabilities (including persons with psychosocial and intellectual disabilities), their families, and representative organisations (OPDs).**¹¹

Steps to ensure a Do No Harm approach:

- From the outset, collaborate with, and consult community members to ensure approaches are culturally relevant and appropriate.
- Collaborate with persons with disabilities and OPDs to ensure accessibility and participation of persons with disabilities.
- Establish and maintain a robust, flexible and responsive supervision practice which supports MHPSS staff and their wellbeing, and ensures MHPSS interventions are appropriate and adhere to best practice.

11 IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action, 2019

- Ensure disability analysis is included in multi sectoral or interagency assessments to ensure access to MHPSS programmes by all members of the community including persons with disabilities.
- Ensure vulnerable adults and child protection policies and procedures are in place with a designated focal point, and that children and adults with disabilities and their caregivers are fully able to participate in reporting mechanisms, complaint procedures or mechanisms which promote the safety of children, adolescents and adults.¹²
- Obtain informed consent from all caregivers, including caregivers of adults with intellectual disabilities, and ensure adolescents and children understand the implications of their participation in MHPSS programming and what the programme expects to achieve.
- Make sure all information is in languages and accessible formats which are understood by participants with disabilities.
- Ensure referral mechanisms are in place, and are accessible for persons with disabilities.
- Regularly provide feedback to participants and community members in a way which respects confidentiality and is accessible for everyone.



12 CBM does not typically engage in child focused programming. However, there needs to be child safeguarding/ complaint mechanisms in place in all contexts where CBM and partner staff come into contact with children

Do No Harm - Dos and Don'ts¹³

DO support a coordinated response and complement the work of other organisations.

DO NOT work in isolation or without thinking how one's own work fits with that of others.

- No one organization is expected to implement programmes across all layers of the IASC intervention pyramid. By engaging in coordinated responses in conjunction with other actors, it ensures that gaps are filled and there will be less risk of duplication of services. Join a MHPSS or Technical Working Group where it exists to aid coordination.

DO pay attention to gender differences and other intersectionality.

DO NOT assume that emergencies affect men and women or boys and girls, including those who have disabilities, in exactly the same way, or that programmes designed for men will be of equal help or accessibility for women.

- Children, adolescent girls and boys and men and women, including those with disabilities, are affected by emergencies in different ways, and it is important to ensure that any needs assessments reflect the situation of both genders and other intersectionalities.

DO after trainings on mental health and psychosocial support, provide follow-up supervision and monitoring to ensure that interventions are implemented correctly and staff and volunteers are supported with self-care strategies.

DO NOT provide stand alone or one-off trainings to staff and volunteers without follow up.

- Ensure debriefing, supervision and mentoring strategies are in place for all staff and volunteers.
- Ensure staff have access to regular capacity building and support mechanisms.
- Ensure staff and volunteers with disabilities have the necessary equipment, technology and support to perform their tasks, including reasonable accommodation.

DO support local capacities, supporting self-help and strengthening resources already present in selected groups, with the engagement and participation of organisations of persons with disabilities.

DO NOT organise supports that undermine or ignore local responsibilities and capacities of organisations for persons with disabilities.

- Ensure local capacities and existing supports are taken into account when implementing MHPSS programmes. These can include both formal and non-formal structures, such as community based organisations, NGOs, faith based structures and religious leaders, organisations such as youth groups and Government-run institutions/ structures.
- Include the capacities of persons with disabilities themselves and ensure opportunities are in place for them to be consulted and identify structures they can actively strengthen.

DO build Government capacities and integrate mental health care for persons with disabilities in general health services, and, if available, in community mental health services.

DO NOT create parallel mental health services for specific sub-populations.

DO organise access to a range of supports and establish effective referral systems.

DO NOT provide one-off, single-session psychological debriefing as an early intervention after exposure to conflict, natural disaster or other emergencies.

- Ensure a continuum of care is respected up and down the IASC MHPSS intervention pyramid, including access to different levels of support simultaneously.
- Do not implement stand-alone MHPSS interventions without ensuring access to other MHPSS supports including basic needs, and other sector referrals such as protection, health etc.

DO seek to integrate psychosocial considerations as relevant into all sectors of humanitarian assistance.

DO NOT focus solely on clinical activities in the absence of basic needs support and a multi-sectoral response.

5. How does MHPSS fit into CBM Global's broader humanitarian work?

CBM Global works to deliver inclusive MHPSS based on need and context. CBM Global typically works in a partnership approach with organisations for persons with disabilities (OPDs) and partners who are familiar with the context, and are experts in working with persons with disabilities. Programme activities are based on assessments of needs and available resources, as well as partner role in the community and the change that people identify as wanting to see in their community.

The following Inclusive Humanitarian Action programme pillars outline CBM Global's response structure:

Inclusive health care services

Primary Healthcare
Mental Health and Psychosocial Services (MHPSS)
Physical Rehabilitation
Eye Health Care

Inclusive basic needs assistance

Cash based interventions
Emergency livelihoods
Food/ Non-Food Item distribution (only if cash intervention is not possible)

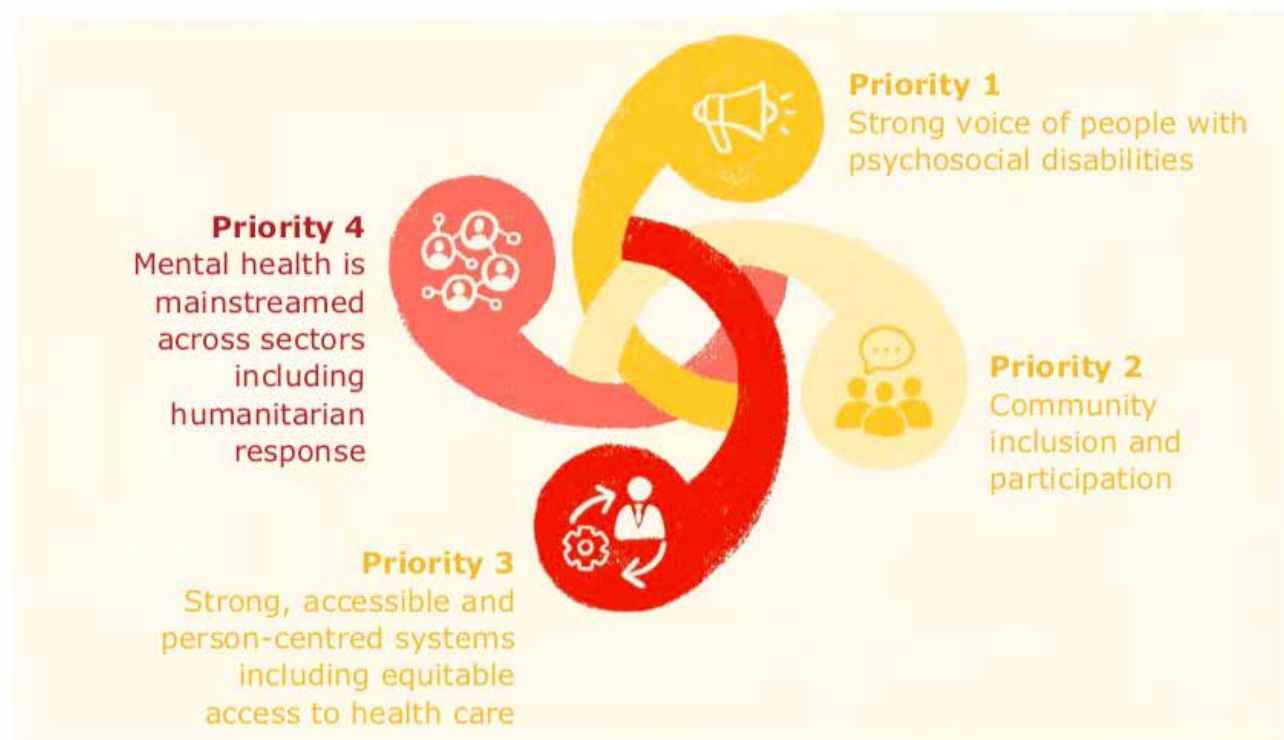
External advisory on disability inclusion

Technical assistance
Capacity building
Disability inclusion audits, reviews, assessments, and evaluation

MHPSS is cross cutting, and can be carried out under each pillar, and all sectors should promote MHPSS and the related benefits.

In 2019, CBM Global developed a Community Mental Health Strategy.

The Strategy's four priorities include:



CBM's CMH approach can be used in humanitarian contexts, and is particularly appropriate when working on humanitarian preparedness and can address the following:

- Reduction of stigma.
- Community awareness raising and community engagement.
- Capacity building of community workers who will be ready to respond in the event of an emergency or humanitarian crisis.
- Support for policies and systems in mental health support for persons with disabilities.
- Awareness and identification of persons with existing mental health conditions or psychosocial disabilities who can be supported in the event of a crisis or disaster.
- Partner identification, assessment of partner capacity to roll out MHPSS in emergencies.
- Mapping of emergency referral services and capacity building that is limited and specific to engagement in humanitarian action including humanitarian principals and awareness of guidelines including IASC, PFA etc.

In contexts where CMH approaches are used, it can be helpful in laying the foundations for future emergency response. This can be valuable to contribute to resilience, and Disaster Risk Reduction¹⁴, as well as building better systems for future mental health care (Building Back Better).

5.1 Mainstreaming MHPSS in other sectors

CBM Global humanitarian inclusive pillars above are underpinned by systematically mainstreaming meaningful participation, removing barriers and supporting persons with disabilities through developing their capacities. It is important to mainstream disability inclusion within MHPSS planning, programming and budgeting in order to remove barriers to participation and support accessibility of persons with disabilities on an equal basis with persons without disabilities.¹⁵

Mainstreaming MHPSS in other sectors means ensuring that mental health and psychosocial support is considered in other sectors, including how the programme will support the wellbeing of participants, including participants with disabilities, how participants will access MHPSS supports they need while participating in other sector programming, and how referral of programme participants takes place in a way which encourages agency and participation, and ensures that the basic needs of people are met and their dignity respected.

14 IASC Technical Note, Linking Disaster Risk Reduction (DRR) and Mental Health and Psychosocial Support (MHPSS), 2021

15 IASC Disability and Inclusion Technical Note, 2021

Standalone MHPSS programmes are implemented without integrating MHPSS into other sectors, but should link and liaise with other sectoral responses, including health, nutrition, education, protection, rehabilitation and livelihoods. It is important to be sure that MHPSS programmes do not replace government or community based MHPSS supports, and are not duplicating services which have been in place, or are newly in place following an emergency. While mainstreaming MHPSS has been agreed as best practice in humanitarian response among global MHPSS actors, the results of an MHPSS assessment will guide which approach suits the context.

5.2 MHPSS in field programmes, advocacy and external technical advice

The following table shows the roles of CBM Global's three vehicles of change in the provision of MHPSS support in humanitarian contexts.

Field Programmes

Assess the context and MHPSS needs.

Work through partners to provide an inclusive, appropriate and coordinated MHPSS response.

Ensure the dignity and agency of people with disabilities is maintained.

Advocacy

Ensure advocacy is integrated into field programmes as well as national level advocacy and advocacy with all duty bearers.

Promote and support the voice of OPDs in effectively communicating their priorities.

Ensure the MHPSS needs of people with disabilities is highlighted using appropriate language in MHPSS messaging for all affected populations.

Promote "disability inclusive MHPSS".

Ensure that persons with lived experience are involved in advocacy efforts.

Advocate to increase funding for persons with disabilities in humanitarian crises.

External Advisory

Work across the humanitarian architecture in country and globally and with high-level structures including the IASC Disability and Inclusion advisory group and CBM advisory group, BOND, Dóchas etc. to influence policy and practice to reflect the needs of persons with disabilities and to address barriers and blocks they face in accessing appropriate and targeted MHPSS support.

6. Programme activities

There are a number of MHPSS programme activities which can be implemented as part of integrated/ mainstreamed programming or stand-alone MHPSS activities.¹⁶ People can access support in groups or individually, and participants can self-identify, or be referred based on their specific circumstances. There are different activities and types of support, and these can be selected based on the specific context, the capacity available, and most importantly, the needs of the community themselves with support from OPDs and health care personnel, governments and community structures.

The MHPSS Minimum Services Package¹⁷ has been developed to guide MHPSS responses in humanitarian contexts, and outlines a checklist of actions which are necessary when implementing activities. The MSP includes tools and standards, as well as a costing tool which enables programme managers, planners and implementers to plan MHPSS responses.

Specific guidance is provided on infectious disease outbreaks and working with at-risk groups, and a comprehensive set of resources is available to work with people with disabilities, including survivors of armed violence, explosive ordinances and remnants of war, and survivors of torture.

Key activities identified by the MSP which are appropriate in MHPSS programmes, both standalone and mainstreamed include:

- Orient humanitarian actors and community members on inclusive MHPSS. This is particularly important, and can be done in collaboration with community organisations including OPDs to ensure maximum engagement and reduction of barriers for persons with disabilities and other more at-risk groups.
- Strengthen self-help and provide support to communities. Specific elements include the dissemination of key messages to promote wellbeing. Many persons with disabilities cannot access key, lifesaving messages, including messages on mental health and psychosocial wellbeing. It is essential to coordinate with other organisations and OPDs to ensure messages are adapted for the context and accessible for persons with disabilities.
- Provide focused support for psychological distress or mental health conditions. This includes guidance on supporting survivors of sexual violence and intimate partner violence, which includes persons with disabilities who may be particularly at risk following a disaster or emergency.

16 Please also refer to the key principles and minimum standards section of this document

17 WHO and UNICEF. The Mental Health and Psychosocial Support Minimum Service Package, 2022

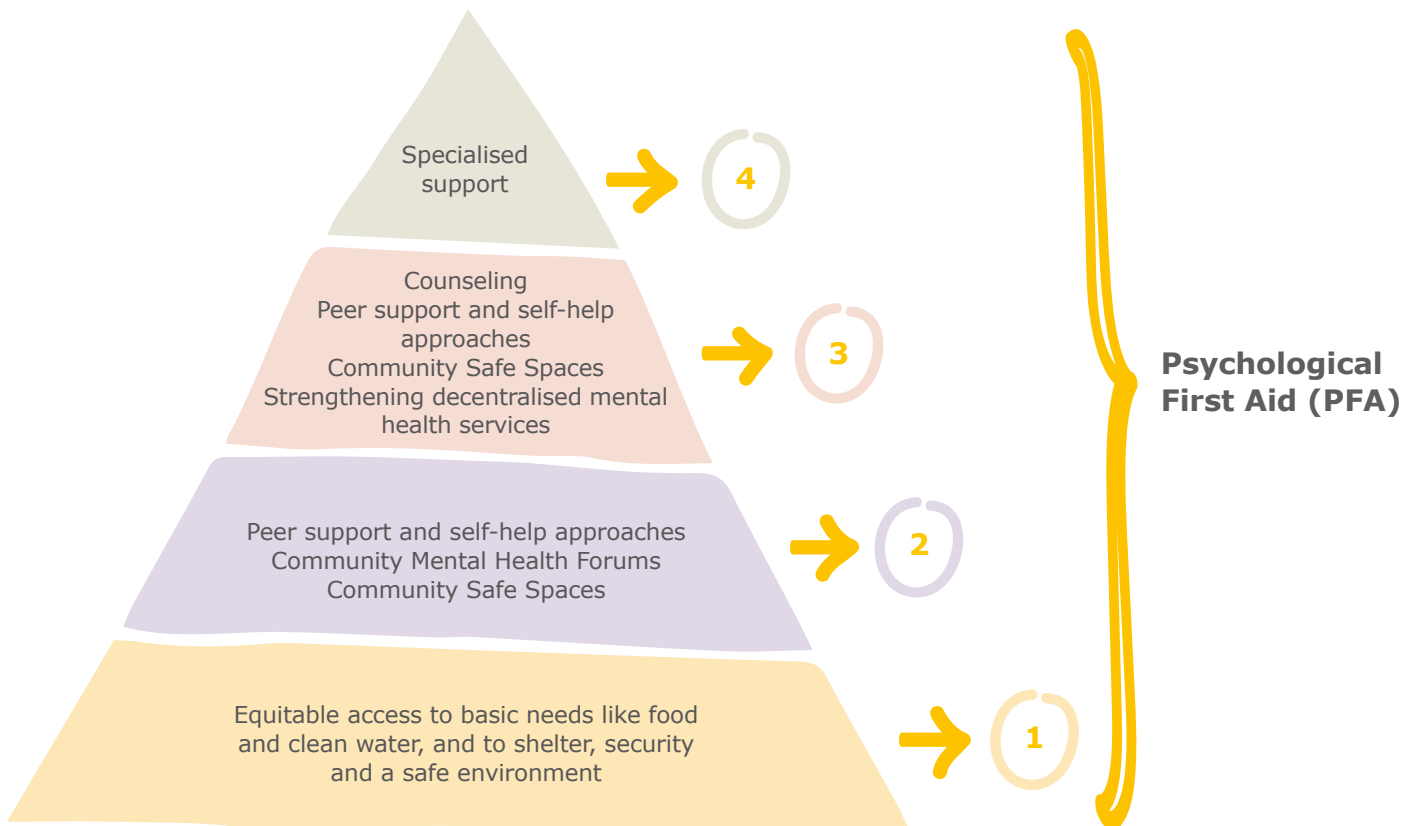
A key activity of the MSP guidance on activities is to protect and care for people in psychiatric hospitals and other institutions. During humanitarian crisis, people with mental, neurological and substance use (MNS) conditions or with physical, intellectual, developmental and psychosocial disabilities or cognitive impairments who are living in psychiatric hospitals and other institutions are at high risk of human rights violations such as physical or sexual abuse, punishment, neglect, abandonment and lack of shelter, food or medical care. Institutional care includes psychiatric hospitals, residential and social care homes, and the care provided in these structures is often inadequate even before the onset of a crisis. The MSP identifies a checklist to follow to ensure human rights are upheld and safety and security of people in institutions is maintained.

A selection of **MHPSS interventions and approaches are listed below.** These can be carried out in the context of other sectoral programming, or as stand-alone MHPSS interventions depending on the context, type of emergency and the capacity available. Ensure all personnel are appropriately trained and supported to facilitate the various interventions. Please see the section on partner identification and capacity in this document.



2022 Madagascar food crisis
CBM / Viviane Rakotoarivony

6.1 Psychological First Aid (PFA)



Psychological First Aid (PFA)¹⁸ is a valuable set of skills that are applicable at all layers of the IASC pyramid and in all MHPSS interventions and other sector programming. PFA involves communicating with people in a way which is empathetic, responsive and supportive of people in distress. PFA emphasises supporting people through active listening and linking to support. It enables staff and volunteers to provide practical, humane and supportive help to people in distress. It is based on the principles of "LOOK, LISTEN, LINK" and is useful for all contexts and situations where support is needed following an emergency or crisis event.

PFA supports people to help each other to assess immediate needs and access appropriate support safely and sensitively. Staff and volunteers who are trained in PFA learn to link people to services they may need following a crisis or emergency, and is appropriate following large scale crises and individual distressing situations. The fundamental principles of PFA can be used in all cultures and contexts, and are based on empathically responding to the common reactions of people affected by crisis. It includes strategies to support self-care and managing stress.

18 [Psychological First Aid: Guide for Fieldworkers \(who.int\)](#) Psychological First Aid: Guide for Fieldworkers, WHO, War Trauma Foundation. World Vision 2011

Applying PFA with individuals and communities is not the same as counselling, psychological or mental health support and it does not mean that someone is receiving therapy. It is not a mental health diagnostic tool or a method used to carry out a mental health assessment. It does not require experience in psychology, psychiatry, counselling or mental health, rather it is a basic foundational skill and set of principles for all who deal with people in distress, rather than an MHPSS response in isolation.

Anyone can be trained in PFA, and it is recommended for all humanitarian staff, regardless of sector, to be trained in PFA in order to improve communication with the community. People who require more specialised support should be referred to MHPSS specialist providers. PFA is appropriate at all layers of the MHPSS pyramid of intervention, and basic skills in empathic listening and sensitively responding to distress are useful competencies for any humanitarian response worker.

6.2 Counselling

Layer 3. Many MHPSS interventions include counselling, both individual and group based. Counselling can also be described as “talking therapy” or “talking support” and the type of counselling provided will depend on the needs of community members affected by the emergency and the level of expertise available to facilitate counselling sessions. Psychological counselling is a useful intervention depending on the context, and should only be carried out by professionals who have been trained, and are aware of the context and culture. During the COVID-19 pandemic, remote/ online counselling including helplines were found to be effective. Key considerations for counselling are as follows.

- Ensure that counsellors are well trained and have adequate competency in effective techniques, and ensure follow up support and referral is available.
- Ensure people receiving counselling and counsellors themselves have a contract in place where expectations are managed and boundaries are set.
- Ensure clear ethical frameworks are in place which adhere to counselling standards and best practice.
- Ensure safeguarding strategies are in place.
- Ensure people receiving counselling support can access community based and non-specialist support at the same time.
- Reduce the likelihood of participants of group based support being stigmatised for their participation in specific issue-related MHPSS support. For example, if running a group for survivors of SGBV, ensure a mix of participants can participate and the group is not identified as being solely for SGBV survivors. If further support is needed for participants, ensure confidentiality. When working with SGBV survivors, ensure gender sensitivity and be aware of the duty of care to practitioners and what they need to be able to support survivors, and their own wellbeing and safety.

6.3 Peer support and self-help approaches

Layer 2 and 3. Peer support is possible to facilitate online and in person. Many participants benefit from peer support approaches because of the guiding principles of shared experience. Shared experience can include age, gender, disability, or other issues participants may have in common. Participants can provide emotional and practical support to each other, share experiences and challenges, or learn new skills. It is important for participants in peer support initiatives to feel that they belong to a peer group, but just because people live in the same area, or share the same experience, for example, it does not necessarily mean that a group will bond or feel that they have something in common. Facilitators of peer to peer support groups can be a member of the group or an external facilitator with understanding of the group dynamics and issues they face. Peer support is particularly useful for many of CBM Global partners as they may already have various groups as a model for intervention, and OPDs can also make use of this method, as people with disabilities may appreciate the opportunity for support from others who have had similar experiences.

Self-help techniques and strategies have proven to be very helpful in contexts such as infectious disease outbreaks, or contexts where people cannot meet because of conflict or safety and security risks. Self-help approaches may also be appropriate in conjunction with other types of MHPSS support on all layers of the intervention pyramid. For persons with disabilities who may not be able to access certain types of support on a regular basis, self-help strategies can be helpful and easy to integrate into daily routines, including fitting into other types of targeted support they may access. Persons with disabilities may benefit from peer support in their homes, particularly for individuals who may struggle with mobility or access issues.

6.4 Community Mental Health Forums

Layer 2. CBM Global implements Community Mental Health Forums¹⁹ (CMHF) in development contexts, and they have a role to play in humanitarian response. The objectives of CMFHs include debunking myths and assumptions around causes of mental ill health, informing community members about formal and informal levels of care with clear referral pathways for evidence based care, and information on after-care support from community based actors including reintegration and inclusion. In the contexts of a humanitarian crisis or emergency, existing or newly established community mental health forums could be used to identify the needs of persons with pre-existing mental health conditions, to assess possible MHPSS responses or interventions, or address messages related to services and policies for people with mental health needs.

6.5 Community Safe Spaces

Layer 2 or layer 3, depending on context. Community safe spaces are places where people can go to feel safe, access information, access targeted support and

strengthen relationships with peers. Safe spaces can often offer a range of integrated supports in humanitarian contexts. For people with disabilities who may face increased challenges following an emergency or humanitarian crisis, safe spaces can provide essential MHPSS support and other supports under one roof, including legal, health, parenting etc.

MHPSS approaches such as self-help, peer support groups, outreach and resilience building activities can be facilitated in safe spaces.

6.6 Specialised support

Layer 4. A small number of people will need further support in contexts of emergency or crisis. This may be because of a pre-existing mental health condition, psychosocial disability or a mental health problem caused by an emergency, conflict or natural disaster. Specialised support is provided by mental health professionals such as psychiatrists, psychologists and mental health specialist social workers in conjunction with support available through community and lower layer supports. CBM Global provides capacity building for MHPSS specialist service providers, including in inclusive and rights-based practices. Any element of comprehensive MHPSS activities may identify people who require specialist care, so understanding how to link and refer people to these services is important (see Cyclone Idai case study below).

6.7 Strengthening decentralised mental health services

Layer 3. The mental health Gap Action Programme (mhGAP)²⁰ is a set of resources developed by WHO to enable provision of good, evidence-based mental health care. The target user group of the mhGAP-Intervention Guide is non-specialized healthcare providers working at first- and second-level health-care facilities. This includes primary care doctors, nurses and other members of the health-care workforce. Although mhGAP is primarily for non-specialists, mental health care specialists may also find it useful in their work. In addition, specialists have an essential and substantial role in training, support and supervision, and the mhGAP package indicates where access to specialists is required for consultation or referral. The mhGAP Humanitarian Intervention Guide is a version that is particularly focused on humanitarian contexts and may be the most appropriate option to consider. CBM Global has extensive experience in using mhGAP. As with other specific interventions, it must be based on comprehensive programming where adequate ongoing support and supervision is provided, and other system components are available.²¹ CBM Global always, for example, includes peer support and other non-clinical and community-based elements alongside health system strengthening work.

20 [WHO mhGAP Intervention Guide- Version 2.0](#)
21 [CBM System Strengthening Good Practice Guide](#)

Further resources, discussions and support on issues related to MHPSS for persons with disabilities, and communities of practice surrounding manualised interventions and MHPSS approaches can be found at www.MHPSS.net. Members can establish groups of interest based on type of emergency, area of interest, geographic location or thematic focus.

The CBM [Humanitarian Hands-On Tool](#) and [Inclusive Disaster Reduction](#) mobile apps are a valuable guide to practical inclusive approaches in emergency settings.

A set of resources for mental health and wellbeing during the COVID-19 crisis can be found at www.mhinnovation.net, including specific resources focused on disability and inclusion.



Rohingya Camps
CBM / Matthieu Lunard

7. Partner identification and capacity needs

CBM Global works with partners (local, national and/or international organisations), and develops a partnership model appropriate to the context, in order to achieve efficiencies and impact at scale and to strengthen local capacity for emergency response.²²

CBM Global works closely with partners to respond to the specific identified needs of persons with disabilities using their expertise and knowledge of the context. When identifying partners to work with, CBM Global develops a relationship which:

- Achieves complementary efforts and goals
- Fosters learning and exchange
- Supports capacity strengthening and building
- Promotes ownership and responsibility
- Avoids dependency

Partners engaged in MHPSS must adhere to the basic standards and principles of Do No Harm in humanitarian programming and MHPSS. Strong capacity and experience in MHPSS is essential in emergency response, though CBM will support partner capacity building in the preparedness phase. Different contexts will result in different partnership models and approaches, including the development of a standalone or mainstreamed approach.

Please see Annex 1: The role of different stakeholders in the provision of inclusive MHPSS emergency response



22 CBM Disability Inclusive Humanitarian Action Strategy 2020-2023

7.1 Skills needed to provide MHPSS support in humanitarian contexts

The IASC Pyramid of intervention identifies the different levels of complimentary supports, it is important to remember that no one organisation is expected to provide services on all layers of the pyramid.

Each layer of the pyramid requires specific skills and competencies from partners and MHPSS staff members. The higher up layers of support require more specialist skills and experience, and the greater the extent of formal training required²³.

For more information on competencies needed, please refer to [EQUIP- Ensuring Quality in Psychosocial Support](#). The [EQUIP platform](#) makes freely available competency assessment tools and e-learning courses to support governments, training institutions, and non-governmental organizations, both in humanitarian and development settings, to train and supervise the workforce to deliver effective psychological support to adults and children.

Intervention layer	Examples of personnel, skills needed	Examples of activities
4: Specialized care	MHPSS and health professionals with medical, psychological or clinical backgrounds who can respond to the needs of people who experience difficulty in daily function or coping due to a mental health condition (pre-existing or in response to an emergency or crisis). Specialists with experience and knowledge of treating mental health disorders, as well as knowledge of complementary approaches to support specialised care	Medicalised mental health support Psychiatric services referral Mental health treatment programmes
3: Focused care	Facilitated by qualified / certified health workers, social workers, mental health workers with knowledge and experience in individual and group counselling	Outreach activities and activities in health care settings Support for survivors of SGBV

23 Competencies table adapted from the IFRC MHPSS Framework: [The MHPSS Framework – Psychosocial Support IFRC \(pscentre.org\)](#)

	Medical/ primary health care personnel working to prevent further harm or exacerbation of existing mental health conditions	Group counselling Individual counselling Group based psychological support
2: Family and Community Supports	Trained community members, community leaders, OPD field workers. Knowledge and awareness on rights and entitlements and access to support such as family tracing or supports for families and community members at risk.	Promotion of activities which uphold wellbeing and resilience and positive mental health. Facilitation of group activities, including peer led awareness raising campaigns and initiatives to reduce stigma
1: Social considerations and basic services and security	Trained community members, community leaders, OPD field workers. All humanitarian staff and volunteers should be trained in PFA, communication, knowledge on basic supports in place, knowledge of the context and culture.	Outreach to ensure including of persons with disabilities in all campaigns regarding rights and entitlements etc. Identification of marginalised groups including persons with disabilities.



8. Components of a MHPSS Response

The MHPSS Minimum Service Package (MSP)²⁴ identifies the key activities to implement an MHPSS response, and include:

1. Interagency coordination and assessment

It is important to coordinate with other MHPSS organisations in order to avoid duplication, ensure the needs of persons with disabilities are included in all MHPSS responses, to develop a functioning and effective case management and referral system which is accessible for person with disabilities and facilitates their active and engaged participation. In many larger emergencies, IASC facilitates local MHPSS situation analysis and ongoing coordination. Identifying the MHPSS pillar and participating in meetings can be a helpful way of keeping track of activities on the ground, as well as influencing the work of others to promote inclusive practices.

Based on assessment findings, in the response and recovery phase: *Develop or update national mental health policies, strategies, plans and legislation. Ensure the national MHPSS system is community-based and aligned with human rights.*

IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action, 2019

Questions to consider in MHPSS assessments:

- Partner capacity - are partners available who can deliver the type of MHPSS support which is needed? For example, professionally/ clinically trained mental health care workers, community volunteers trained in MHPSS in emergencies interventions etc.
- Types of MHPSS and community supports which were available before and can be strengthened
- What other sectoral interventions are in place which could be integrated with MHPSS approaches?
- Presence of other actors engaged in MHPSS programming for persons with disabilities- is there a risk of duplication?
- Are MHPSS assessments already available? Have assessments been integrated into other rapid assessments? Has mental health been identified as a gap or significant need?
- Are referral systems in place, and structures/ supports in place to support people in need of specialised mental health care?

24 www.mhinnovation.net

If it is not possible to coordinate MHPSS assessments, they can be carried out in isolation - ensure that MHPSS questions do not contribute to feelings of distress or

cause further harm, and that people carrying out MHPSS assessments are aware of referral systems.

CBM Global has integrated MHPSS elements into a rapid needs assessment following Typhoon Odette, for example and includes elements of the Washington group questions to identify people with a disability. In the needs assessment, questions are included on feeling nervous and anxious, the level of anxiety experienced, and how often a respondent feels depressed. CBM Global and partners should use the [Washington Group Short Set on Functioning](#) (WG-SS Enhanced) as a minimum standard when identifying prevalence of persons with disabilities in needs assessments.

The IASC MHPSS reference group assessment guide suggests²⁵ including questions relating to functioning, feelings and thinking following assessment into relevant contextual information. It is important to ensure that persons with disabilities are included in assessments on their MHPSS needs, and that data is collected in ways which enable them to participate and promote safety, dignity, agency and full access.

2. Designing and planning programmes

Following an assessment of needs and depending on the context, availability of resources, presence of implementing partners with the capacity to deliver, gaps identified and knowledge of coordination systems, design the programme/ intervention. Adhering to Do No Harm approaches, consider:

- Who is doing what, where, when? Avoid duplication. In major emergencies this may have been done by IASC MHPSS Ref Group or other agencies.
- What is the capacity of the partner organisation and are structures for support, mentoring, staff training and monitoring in place?
- What outside technical support is needed, if any?
- What is the hand over strategy/ sustainability plan in place?
- How can all stakeholders participate at all stages of the process including the design, monitoring and evaluation- how will you know if the programme is working?
- Have government and community structures been involved?

MHPSS programmes should be based on **principles of engagement and participation**, and this is crucial when working with persons with disabilities. Working to enhance participation and engagement means recognising the skills, experience and capacity of people with disabilities to guide, influence and have agency

25 [IASC_reference_group_psychosocial_support_assessment_guide.pdf \(who.int\)](#)

over MHPSS support. It involves recognising that people have skills and capacities to support their wellbeing.

Community engagement means:

- Understanding the context, culture and dynamics which exist
- Working closely with community members, not just community leaders and spokespersons. Strategies to consult, include and engage people with disabilities are essential
- Starting from the strengths which exist and building on them rather than replacing or undermining
- Partnering with people with disabilities at all stages of the project cycle, from planning to monitoring and evaluation

3. Considerations for inclusive MHPSS programme implementation

When implementing inclusive MHPSS programmes which include persons with disabilities, the IASC Guidelines on the Inclusion of Persons with Disabilities²⁶ outlines the following among other recommendations:

- Raise awareness among community members of the rights of persons with disabilities as part of MHPSS programming
- Make evidence-based psychological interventions available and accessible to persons with disabilities at all levels of care
- Build the capacity of specialists and non-specialists, including OPD representatives, volunteers and peer supporters. Training should include the human rights framework; multidisciplinary approaches in MHPSS; community-based care; task sharing; and Psychological First Aid.

4. Development of a monitoring and evaluation (M+E) system

The IASC MHPSS common monitoring and evaluation framework provides guidance on assessment, monitoring and evaluation of MHPSS programmes in emergency settings.²⁷ The suggested overall goal of the common framework is *reduced suffering and improved mental health and psychosocial wellbeing*.

26 IASC Guidelines on the Inclusion of Persons with Disabilities

27 <https://app.mhpss.net/?get=393/iasc-common-monitoring-and-evaluation-framework-for-mental-health-and-psychosocial-support-in-emergency-settings-with-means-of-verification-version-2.0.pdf>

Suggested goal impact indicators:

- **Functioning** - the ability to carry out essential activities for daily living
- **Subjective wellbeing** - feeling calm, feeling happy, capable, not feeling sad etc.
- **Extent of prolonged distress and/ or presence of mental health condition**
- **Ability of people with MHPSS difficulties to cope with problems** they may face- stress management strategies, communication skills, vocational and conflict management skills
- **Social behaviour** - helping and supporting others, level of self-care
- **Social connectedness** - the quality and number of connections a person has in their own family and communities, and other communities

Indicators can be used to measure programme/ project reach including numbers of people reached, attitudes to mental health etc.

5. Care for staff and volunteers providing MHPSS

Ensure staff and volunteers, including of partners, are supported when implementing MHPSS programmes. It is important for staff working in MHPSS to have access to regular supervision/ mentoring in order to avoid burn out, ensure best practice and maintain their own wellbeing. Organisations employing humanitarian workers must recognise increased risks to their wellbeing, and provide supports to reduce workload, provide health working culture and environments, and systems of early identification of distress and opportunities for receiving support without negative judgement. MHPSS personnel should be encouraged to engage in self-care, with training provided to enable them to build this into their lives. Staff and volunteers need access to professional development opportunities on a regular basis. This can include in-person or online training and capacity building, as well as opportunities to follow areas of interest or specialisation. Staff should be consulted regularly to self-identify gaps in knowledge and practice. Consider implementing inter agency training in specific approaches. In order to provide good staff care, including rest and recuperation, it is necessary to include these costs into budgets when designing programmes.

6. Supporting the competencies of MHPSS staff and volunteers

Skills need to be developed in partnerships in advance of emergencies, as part of emergency planning. This includes supporting application of inclusive approaches in MHPSS in state and civil society emergency preparedness and response actors. Please see "Skills needed to provide MHPSS support in humanitarian contexts" and MHPSS and DRR resources below.

Case study

Tele counselling, PFA and follow up Services in Humanitarian Emergencies, CMC Nepal

Centre for Mental Health and Counselling Nepal (CMC-Nepal)

Introduction

During the COVID 19 pandemic, CMC-Nepal provided mental health support (telephone counselling and mental health consultation services) both online and by telephone.

Objectives

The objectives of online and telephone MHPSS interventions were as follows:

1. To ensure basic mental health and psychosocial support is available to persons with mental health conditions and psychosocial disability during the pandemic
2. To help people in distress following the pandemic to cope with mental health and psychosocial consequences of the pandemic by providing PFA
3. To support delivery of quality and updated mental health and psychosocial support services during the pandemic through local health facilities
4. To help frontline development workers, community mental health workers and health workers to manage the stress of working in pandemic



The primary services included in online and telephone mental health and psychosocial support services included:

- Psychological First Aid (PFA) skills for front-line staff
- Psychiatric Consultation Services
- Psychosocial Counselling Services
- Follow up services
- Linkage with psychotropic medicines and relief providers
- Distance Supervision
- Stress management sessions for front line service providers

The direct target groups of the online and telephone MHPSS support services were:

- Persons in distress because of the pandemic
- Persons with mental health conditions and psychosocial disability
- Community Mental Health Workers and Health workers involved in mental health and psychosocial support services
- Health workers involved in the COVID 19 response
- Employees of development organization
- Students, teachers and parents

Service reach

CMC-Nepal trained 95 health workers and 27 teachers on training of trainers on PFA. 82 persons received telephone counselling support through Toll Free services. 51 persons received telephone counselling services and 141 received telephone PFA support. 844 persons with mental health conditions and psychosocial disability who were registered in mental health and psychosocial support services of Inclusive Community Mental Health Programme (ICMHP) received telephone follow up support.

Telephone psychosocial counselling sessions

CMC-Nepal established two separate toll free number in Kathmandu and Surkhet. Mobile numbers of counsellors and psychologists were shared with community stakeholders and services users.

- Following greetings and proper introductions, information is provided on the duration and objectives of the session. Client is informed about the confidentiality of the session.
- The sessions during the COVID 19 pandemic primarily focused on emotional problems experienced by clients due to the COVID 19 pandemic, discussions on daily life routine of the clients and psychoeducation on different aspects of the COVID 19 pandemic.

- The primary skills used were verbal reflection of feelings, validation and universalization of emotions.

Methodology

All online and telephone counselling services were provided by qualified and trained mental health professionals including psychiatrists, psychologists, counsellors and staff from the Ministry of Health and Social Welfare. CMC-Nepal provided orientations and guidelines to everyone involved in the intervention.

Reflections of counsellors and psychologist involved

- Solution focused approaches are more appropriate in telephone counselling during emergencies, as follow up are not always possible.
- As both parties are not able to see facial experiences, verbal feedback and reflection of feelings needs to be frequent.
- Counsellors and psychologists need to be regularly updated about the pandemic situation, and links for referral to support for basic needs etc.
- Clients need to be reassured that they are not being recorded and anonymity is assured.
- Users need to be supported and motivated to reach out for support, and this should happen at the community level.
- Users found discussions on practical solutions, psychoeducation and "here and now" activities helpful.

"I would not be able to approach for support, if it is not a telephone counselling. It is far easier for me to talk with you over phone than face to face." *Service user*

"I feel youth are more open to virtual medium and mobiles now. People are less hesitant to seek telephone and online counselling services as it is easy to approach and less stigmatized. So this needs to be continued. Among my clients 42 to 45 % expressed they have reduced stress post session. I found that people have fear of being recorded in telephone counselling so we should clarify that." *Pratima Khatiwada, (Psychologist)*

"Telephone counselling is possible even when face to face counselling is not possible. I found that people are more comfortable talking over phone during pandemic. They used to sound calm and open with me over phone during session. I also felt that using telephone counselling we can reach more people and area that are not accessible. In the telephone counselling most helpful for clients is information on the pandemic." *Gagan Bd. Oli (MHSW)*

Opinions of the service users on telephone counselling services during the COVID 19 pandemic

“I feel that my own family has distanced me after COVID 19 infected me. I feel relieved talking with you. You asked about my wellbeing and helped me to come up with practical solutions of my problems during isolation.” *Service user.*

“The counselling with you had really helped me. I can now focus on my work and thinking to return to Kathmandu and start my job again. I regularly practice deep breathing and here and now that you taught me.” *Service user.*

“I would have left my medication following lockdown if you had not contacted me. After receiving your call I got to know Dullu Hospital is providing mental health services even during lockdown.” *Service user.*

Learning and recommendations

Tele MHPSS services are more affordable, convenient and accessible during times of emergency. Services users are more comfortable sharing their concerns over the phone, and workers can continue to receive training even when mobility is restricted.

- Toll free or other tele MHPSS services with field follow up are more effective than standalone services.
- Toll free numbers should be short and easy to remember.
- Advertisement of toll free services is essential to increase reach of the services. A wide range of print and audio visual media should be used for this.
- It is necessary to include brief introduction on ways to use toll free services as part of disaster preparedness and response in all community level programmes before and during emergencies.
- Clear and uniform guidelines are necessary for effective response using tele and online methods with provision of regular supervision.

Case study

MHPSS response to Cyclone Idai,²⁸ Zimbabwe, CBM, REPSSI and MoHCC

Background²⁸

Zimbabwe was affected by Cyclone Idai in March 2019, resulting in a reported 344 deaths and 270,000 people affected. The devastating impact on infrastructure resulted in negative impacts on the psychological, emotional and social wellbeing of survivors.

Goal

In 2019, CBM Zimbabwe, REPSSI and the Ministry of Health and Child Care (MoHCC) established a project with the **goal of building the capacity of nurses and key community stakeholders on MHPSS in order to support the well-being of individuals and communities** affected by Cyclone Idai and this was continued in the context of COVID-19.

Approach

The project sought to address issues of stigma and discrimination in relation to both mental health and disability, to increase awareness of mental health issues, and to improve capacity for delivery of mental health services. The MHPSS Emergency Response to Cyclone Idai project is as follows:

1. Used the IASC intervention pyramid model focusing on improving service delivery of mental health care and improving access to services through community awareness and training in MHPSS.
2. Targeted Primary Health Care workers with training based on the mhGAP-Humanitarian Intervention Guide and trained 253 community health workers and professionals.
3. Built capacity of community influencers and leaders in MHPSS in Chipinge and Chimanimani districts, to improve MHPSS in their communities.
4. Engaged communities to ensure strengthening of existing community and family support structures.

Impact

The nurses gained skills to assess and manage mental health conditions in order to come up with the accurate diagnosis and care plans. The training equipped the participants with assessment principles and processes. The combination of strengthening health systems, building of informal networks of support and addressing community attitudes and exclusion (multiple levels of the IASC MHPSS pyramid) was found to be particularly important, and each complemented each other.

28 Addressing mental health and wellbeing in the context of climate change: Examples of interventions to inform future practice. Field report. Intervention, 2022

The nurses are now aware of significant symptoms of mental health conditions, for example acute stress, which is characterized by disabling anxiety that lasts up to one month. The training also looked at grief, psychosis, and epilepsy. The nurses will now be able to make informed decisions in making referrals for further support of people affected.

Evaluation findings were of an improvement in awareness and knowledge related to mental health. Community cadres were trained in conducting assessments and had learnt to articulate issues to do with mental health very well. What was also inspiring to see was trained cadres coming together and going out of their way to assist fellow community members through the assessments, psychosocial support and referring cases for additional service.

Sustainability

The intervention focused on capacity building and the strengthening of systems, which will likely continue to exist in health facilities and the community. During monitoring visits, the monitoring team gathered that Primary Health Care Workers previously trained in mhGAP were still using the skills and referring to the mhGAP handbook. Implementation of the intervention happened alongside the Department of Mental Health housed in the Ministry of Health and Child Care, including the monitoring and mentoring for health care facilities and their staff, and community engagement.

Lessons learned

Areas that needed to be improved included a component focused on removing some of the barriers affecting vulnerable groups, including persons with disabilities and people with mental health conditions. Livelihood support was expressed as a vital component to enable communities to realise economic recovery and address existing gaps in acquiring basic needs, including and not limited to medicine, food and education.

The implementation period was short. There was also a need for refresher training and more than one dialogue per group of community members to ensure that continued learning happens and an MHPSS and disability inclusion shift occurs and the process of transforming these communities.

9. Advocacy and advisory support

CBM Global advocates for MHPSS to be accessible and appropriate for all affected populations in an emergency, including people with disabilities. This includes advocating to combat stigma, remove barriers, ensure accessibility for persons with disabilities and uphold rights such as decision making, agency, dignity and participation.

It is always best if people with disabilities themselves are given the opportunity to speak and engage in emergency response, in preparedness and in post-emergency phases. Strong and effective representative organisations (OPDs) can do this, and we work to support their capacity to do so.

When networking and advocating with governments, policy makers, national and local bodies, CBM Global will use appropriate language when discussing disabilities, mental health and people affected by mental health issues or psychosocial disabilities. Using overly medicalised language risks pathologising of normal reactions and can potentially lead to a medicalized clinical-focused approach where a community based response would be more appropriate. By using correct terminology, the risk of stigmatisation of someone accessing support is also reduced, and we ensure that clinical support is not undermined or unavailable.

Examples of recommended terms (Can be used in place of terms to the right)	Examples of terms that are generally NOT recommended to be used outside clinical settings	Why? The problems with using non-recommended terms
Psychological and social problems/ effects/difficulties Distress, anguish, tormented, overwhelmed	Trauma (including PTSD)	PTSD is a clinical diagnosis. By referring to people as suffering from PTSD, there is a risk that community supports may be overlooked and specialist support provided as the first response. A small number of people typically require specialist support, and will benefit from community support and return to basic security
Adverse events, adversity Terrifying, life-threatening, horrific events	Traumatic events	People experience humanitarian crises and difficult events in different ways, and not everyone will be traumatised or affected in the same way

Severely distressed people People with extreme/severe reactions to the emergency	Traumatized people Victims	Risks pathologising normal reactions to abnormal events, which can cause stigma, discrimination or shame. It also may result in a medicalised response which is unnecessary, or carried out in isolation of community supports Risks disempowering people and removing agency
Reactions to difficult situations Signs of distress	Symptoms	Symptoms may suggest that people present with a “set” list of responses to a difficult event, or experience mental health difficulties in the same way. Different people respond in different ways, and every person will experience a crisis or mental health condition according to a number of factors, including the supports they have in place and the challenges they experience in their daily lives
Structured activities	Therapy, psychotherapy to describe non-clinical activities	The term “therapy” describes clinical support which can be medical, and is necessary for a small percentage of affected populations
Care/ support	Treatment	There is no one-size-fits all response to people who need support- support which is needed in different ways, at different times, and can be provided in a number of ways. People may need help with accessing basic needs, livelihoods support, rehabilitation support or shelter alongside support with their mental health difficulties or challenges, which can be longer or shorter term. The intervention pyramid is based on the continuum of care, and as such, is based on a holistic model of care and goes beyond “treatment”

10. Preparedness, Disaster Risk Reduction and Building Back Better

The capacity to respond well to an emergency depends on how well prepared systems and communities are prior to the emergency. It is essential to build this resilience in advance of emergencies. This might include the capacity of health or social systems to respond to an outbreak, the strength of infrastructure and buildings to withstand floods of earthquakes, or how well communities are able to support vulnerable members when there is an emergency. Disaster Risk Reduction is the process of building such resilience and preparing for future emergencies. Although often unpredictable in timing, certain regions are more prone to disasters so can be a focus of this work. This is particularly the case with the climate crisis, and one example of preparedness is documented in the CBM [Climate Change, Mental Health and Wellbeing](#) publication, where the advanced training of nurses in Sierra Leone was a valuable contribution to emergency response.

New [IASC guidance on DRR and MHPSS](#) is now available and will be a valuable contribution to the increasing need to prepare for the likely negative impacts of climate change in many countries.

Emergencies are also a time when mental health and wellbeing are recognised by populations and political leaders as important. This enables investment in systems during and after emergencies so that longer-term services are better. This is an important time to support OPDs to advocate for inclusive services so that investment is used well. This has been called [Building Back Better](#).

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CBM Global Disability Inclusion

CBM Global Disability Inclusion works alongside people with disabilities in the world’s poorest places to transform lives and build inclusive communities where everyone can enjoy their human rights and achieve their full potential.

Website: www.cbm-global.org

Community Mental Health Technical Area in CBM Global

Many people experiencing mental health conditions and/or psychosocial disabilities face stigma, discrimination, even abuse. Those living in poverty are at greatest risk and least likely to access treatment or support. With decades of experience in the field of global mental health, CBM Global recognises the central role of mental health in wellbeing and works to promote good mental health, challenge the exclusion of people with mental health and/or psychosocial disabilities, and strengthen mental health systems, so that mental health needs are recognised and addressed.

This is one of a number of guides that CBM Global will be producing to share our work and experience in community mental health.

Annexes

Annex 1: The role of stakeholders in the provision of inclusive MHPSS emergency response

Stakeholder	Example of Role
Governments	<p>Ensures MHPSS support is available to all persons with mental health difficulties and/or a disability in all communities</p> <p>Promotes strategies to reduce stigma, ensure accessibility and promote inclusion for persons with disabilities in all aspects of life</p> <p>Ensures systems are able to withstand an emergency or crisis, or that preparedness strategies are in place so that emergencies do not exacerbate the barriers faced by people with disabilities who require MHPSS support</p> <p>Meets their obligations to persons with disabilities following an emergency or crisis by engaging with/ supporting social services, health, NGOs and civil society to strengthen capacity to respond to MHPSS needs of affected populations</p>
OPDs with MHPSS capacity	<p>Implements and mainstreams MHPSS programmes</p> <p>Coordinates with other MHPSS/ other sector service providers</p> <p>Advocates for persons with disabilities with other humanitarian actors</p> <p>Facilitates MHPSS preparedness</p> <p>Works with communities and services to identify persons with disabilities</p> <p>Ensures best practice, including supervision, mentoring, ongoing capacity building</p> <p>Is aware of context, culture and uses Do No Harm approach</p>

	<p>Knowledgeable on existing supports and structures in place, including practices which may be harmful</p>
Schools	<p>Ensures that students and staff with disabilities are supported to learn in a way which supports their wellbeing</p> <p>Ensure an environment which is free from discrimination or stigma around persons with disabilities, including mental health problems</p>
Health services	<p>Ensures that MHPSS services in place are professional, meet best practice to promote inclusion for person with disabilities and provide MHPSS support on all layers of the MHPSS pyramid</p> <p>Ensures that communities have access to holistic mental health support</p>
Social Services, including broader social care and social support services	<p>Ensures MHPSS best practice integrated into social service delivery and structures</p> <p>Liaises with OPDs and other sectors to ensure equal and active engagement in social supports by people with disabilities</p> <p>Ensures services are accessible and approachable</p> <p>Advocates with local and national structures to ensure resources in place to support people with disabilities in a way which enhances their mental health and wellbeing and ensures their rights are upheld</p> <p>Engages in capacity building as required</p> <p>Ensures social supports are available at community level</p>
NGOs/ Civil Society Organisations (CSOs)	<p>Implements MHPSS programmes</p> <p>Coordinates with other MHPSS/ other sector service providers</p> <p>Works with communities and services to identify persons with disabilities in need of MHPSS support</p>

Ensures best practice, including supervision, mentoring, ongoing capacity building and uses Do No Harm approach

Is aware of context, culture

Knowledgeable on existing supports and structures in place, including practices which may be harmful

Advocates for the rights, agency and dignity of persons with disabilities to be upheld

Supports OPDs to advocate for their rights and/or highlights issues faced by persons with disabilities and to improve access to supports they need

Works to combat and reduce stigma and discrimination faced by persons with disabilities

Provides technical support which is current, meets best practice and appropriate when implementing MHPSS support

Annex 2: MHPSS Interventions/ Packages

[EQUIP- Ensuring Quality in Psychosocial Support, WHO](#)

[mhGAP Intervention Guide - Version 2.0, WHO](#)

[mhGAP Humanitarian Intervention Guide \(mhGAP-HIG\), WHO](#)

[Group Problem Management Plus \(Group PM+\), WHO](#)

[Humanitarian Hands-On Tool \(HHoT\) \(CBM Global Disability Inclusion\)](#)

[Inclusive DRR Hands-On Tool \(iDRR\) \(CBM Global Disability Inclusion\)](#)

[Psychological First Aid: Guide for field workers, WHO](#)

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