IASC Inter-Agency Standing Committee

Information Note

DISABILITY AND INCLUSION IN MHPSS

IASC Reference Group
on Mental Health and Psychosocial Support
in Emergency Settings

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IASC Inter-Agency Standing Committee

INFORMATION NOTE ON DISABILITY AND INCLUSION IN MHPSS

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This document contains guidance for strengthening the disability inclusiveness of MHPSS responses and programmes in emergency settings. It is intended to supplement the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007).

ACKNOWLEDGEMENTS

CONTENTS

SECTION 1
OVERALL OBJECTIVE

To consider and address the mental health and psychosocial support (MHPSS) requirements of persons living in emergency settings with all types of disabilities[1] on an equal basis to the MHPSS requirements of all persons, using a human rights-based approach and implementing social-ecological frameworks.

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1.1 Specific objectives

- Ensure that MHPSS programming in emergency settings is accessible and inclusive of persons with all types of disabilities.
- Support the deinstitutionalization of persons living in long-stay institutions and stand-alone hospitals.

1.2 Target audience

MHPSS actors and organizations implementing MHPSS programmes/activities and working in emergency settings, particularly members of the Inter-Agency Standing Committee MHPSS Reference Group (IASC MHPSS RG).

1.3 Frameworks

Social-ecological,[2] human rights[3] and United Nations Convention on the Rights of Persons with Disabilities (CRPD)[4] frameworks.

SECTION 2
THE CHALLENGES

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Globally, there is insufficient inclusion of persons with disabilities[5] in humanitarian MHPSS responses[6] and a lack of guidance on how MHPSS programming can be made more inclusive. Inclusion of persons with disabilities is particularly challenging where pre-existing mental health systems are not community-based or recovery- and human rights-oriented and are inadequate (i.e. a lack of policies to protect persons with mental health conditions and with disabilities, limited availability of trained human resources, discriminatory attitudes, poor conditions and limited accessibility).[7] This affects both persons with disabilities in the populations that programming aims to assist, and also workers in general services or in the humanitarian response who may themselves have disabilities.

Furthermore, the institutionalization of persons with disabilities across the world is alarming; frequently, in long-stay institutions care is not adequate, human rights are violated and persons with disabilities are at higher risk of violence and abuse, including sexual exploitation and trafficking.[8] During humanitarian crises, persons with disabilities living in institutions are at heightened risk of neglect.

2.1 Persons with disabilities in emergency settings

In emergency settings, persons with disabilities are disproportionately affected[9] as they are likely to face additional and exacerbated barriers,[10] further restricting their access to services and their participation in emergency responses, which frequently fail to consider their requirements.[11] Challenges include limited availability of key information in a format and language which are accessible by persons with disabilities, especially when they are migrants or displaced persons, inaccessible transportation systems and evacuation and emergency plans that are not inclusive. Consequently, persons with disabilities are exposed to heightened and multiple risks. Examples of the links between barriers to participation and heightened risks in emergency settings are presented in Table 1.

Table 1. Barriers to participation and heightened risks in emergency situations

Barriers to participation and to accessing services in emergency settings	Heightened and multiple risks in emergency settings
Exacerbation of pre-existing negative, discriminatory and sometimes overtly hostile societal attitudes towards persons with disabilities. Information and communication not provided in multiple formats and languages, and therefore not accessible to persons with disabilities.	Being left behind,[12] marginalized[13] or excluded. Violence, coercion, abuse and other violations.[14] Girls and young women with disabilities face up to 10 times more risk of gender-based violence (GBV) than those without disabilities[15] and are most at risk of marginalization, exclusion and discrimination.[16]
Difficulties in physically accessing persons with disabilities, who are often locked up, isolated or hidden (it is difficult to know how many such persons there are and where they are). Lack of identification within the community and lack of prioritization of persons with disabilities (e.g. the triage response to COVID-19). Late detection, limited and deprioritized access to treatment and care, particularly in pandemics.	Health problems worsened. Higher rates of premature mortality than for persons without disabilities,[17] higher rates of injury[18] and serious harm.[19] Higher risk of undernutrition for children under the age of five, leading to higher risk of intellectual disabilities.[20]
Diminished accessibility of essential services and individualized disability-specific support due to altered environment, damage and destruction of equipment and infrastructure as a result of conflicts and natural disasters. Humanitarian response and programmes often not inclusive of or accessible to persons with disabilities.	Health problems worsened. Higher rates of premature mortality than for persons without disabilities[21] and risks of injury[22] and serious harm.[23] Suicidal ideations and suicide attempts, especially among adolescents and youth with newly acquired disabilities.[24]
Reduced individual and community-based disability-specific support where essential staff/support persons are themselves affected by emergencies. Non-inclusive remote supports and services, hotlines and complaints/feedback mechanisms.	Children, adolescents and older persons with disabilities are more likely to experience abandonment, neglect, abuse and exploitation.[25] Children with disabilities have diminished opportunities to return to school,[26] and are more exposed to forced sterilization and to trading sex for food.

Barriers to participation and to accessing services in emergency settings	Heightened and multiple risks in emergency settings
Exacerbated pre-existing and contextual restrictions in being able to exercise legal capacity or make decisions about all aspects of life, including about medical treatment.	Violence, coercion, abuse and other violations.[27]
Disability-related services and supports, disability-focused INGOs and organizations of persons with disabilities (OPDs) themselves target more often and mainly persons with physical and sensorial disabilities.	Persons with psychosocial, cognitive and intellectual disabilities[28] and persons living in residential institutions are at increased risk of being left behind and at increased risk of discrimination, violence,[29] persistent violation of human rights, under-identification and being excluded and left extremely isolated.
In pandemics, distancing measures affect both households (because of high levels of stress within the household and isolation from community supports) and institutional residential settings (because families, including those who are actively protective and supportive, face restrictions on visiting).[30] In pandemics, children, adolescents and adults with psychosocial, cognitive and intellectual disabilities are affected by changed routines, restrictions on protective factors such as social interactions, physical activity, etc.,[31] and limited access to means of communication.	Violence, exploitation and abuse. Physical abuse, especially in households that are experiencing added socioeconomic stress.[32] Psychological distress. Spread of infection in residential settings and higher risk of death.

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A psychosocial disability arises when someone with a mental health issue interacts with a social environment that presents barriers to their equal participation in society. People may find great value in this identify and what can be learnt from the disability movement. However, some may choose not to identify themselves as having a psychosocial disability, and in humanitarian emergencies, people with time-limited distress associated with a particular experience may not choose to define themselves as having a psychosocial disability.

Furthermore, there are barriers to participation and to accessing services which may be specific to certain sectors. Barriers specifically hindering participation in the MHPSS response and access to MHPSS programmes and services include, but are not limited to, the following:

- Misconceptions, stereotypes, prejudices and stigmatizing beliefs held by MHPSS workers, policy-makers and health professionals (e.g. erroneous ideas about persons with disabilities being dangerous or being unable to make decisions or to contribute to the emergency response, especially in reference to persons with psychosocial, cognitive and intellectual disabilities).

- Limited resources, capacity and knowledge of MHPSS staff in terms of adapting infrastructure and service delivery to the requirements of persons with disabilities.

- Persons with disabilities being constrained (e.g. forced institutionalization, forced treatment and physical and chemical restraint), which violates human rights and prevents any form of participation in society and in the MHPSS response.

- Limited opportunities for persons with disabilities, particularly those with psychosocial, cognitive and intellectual disabilities, to participate in and influence the MHPSS response in terms of decision-making, planning/programming, monitoring and evaluation (M&E) and research.

> MHPSS response and programming that address barriers to access and which are informed by the participation (inputs, knowledge, expertise and experience) of persons with disabilities are likely to be more effective and more responsive to the requirements of persons with disabilities.

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2.2 Intersectionality and at-risk groups

Persons with disabilities form a diverse group, varying in age, race, colour, sex, sexual orientation, gender identity, language, religion, ethnic, indigenous or social origin, type and severity of disability, barriers faced and the settings in which they live.[33] As is the case for anyone, these factors determine how their well-being is affected by emergencies. Furthermore, the type of emergency (e.g. war, displacement, pandemic) can further aggravate the risks faced by persons with disabilities. For example, social distancing requirements imposed during a pandemic and the widespread use of technology in service delivery may exacerbate barriers to equal participation and access.

Intersectionality compounds the risks of discrimination faced by persons with disabilities and the impacts of these risks, creating a synergistically negative effect.[34] This means that, among persons with disabilities in emergency contexts, there are groups who face higher levels of risk, such as children; youth; older persons; girls and women; persons with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC); migrants and displaced persons; persons with intellectual, cognitive and psychosocial disabilities; persons with multiple disabilities and persons with newly acquired disabilities. In emergency settings, close attention should be paid to persons living in long-stay or residential institutions, who are exposed to extremely high and life-threatening risks.

2.3 Supporting the deinstitutionalization of long-stay institutions and stand-alone psychiatric hospitals in humanitarian settings

In most low- and middle-income countries, MHPSS systems are centralized and based on stand-alone mental health hospitals and long-stay institutions; in such settings, human rights violations are common, recurrent and extreme.[35] These institutions and hospitals typically absorb around 70% of the national mental health budget[36] but often they are inefficient and ineffective and deliver inadequate and sometimes inhumane care, irrespective of whether they are managed by government ministries or by non-profit, private or religious organizations. During humanitarian crises such settings tend to become even more abusive, neglectful, unhealthy and life-threatening: violations of human rights are exacerbated; all kinds of protection risks and health risks are heightened, and abandonment is likely to happen.[37] Furthermore, isolation from the outside world or from contact with family is extreme, leading to additional health problems and suffering, including suicidal ideation. One third of the deaths from COVID-19 in Europe have occurred in long-term residential settings.[38] The reform of hospital-based MHPSS systems, the closure of long-stay and residential institutions and the provision of supports for people with disabilities to live and participate actively in the community should be prioritized in all contexts.

Taking a positive view, emergencies may often help to prompt national mental health reforms by highlighting gaps and deficiencies, increasing awareness and strengthening political will, and providing resources linked to the humanitarian response.[39] Nevertheless, when an emergency occurs in a setting where the MHPSS system is still not community-based and human rights-oriented but includes long-stay residential institutions, it is essential that contingency plans are in place to ensure that the human rights of persons living in these facilities are maintained and that they themselves are protected and not forgotten, left behind, neglected or excluded from the humanitarian response.

SOGIESC is an acronym for sexual orientation, gender identity, gender expression and sex characteristics. It is used to refer to a diverse range of characteristics that are conceptualized and defined in widely varying ways internationally, hence a decision to move away from the more familiar term 'LGBTQ', which uses terms that are less commonly accepted in all parts of the world.

SECTION 3
DISABILITY-INCLUSIVE MHPSS RESPONSE AND PROGRAMMING IN EMERGENCY SETTINGS

Inclusive emergency response | South Madagascar

The inclusion and participation of persons with disabilities on an equal basis with others are supported by the **twin-track approach**[40] which, implemented in an MHPSS response, encompasses:

a. **Mainstreaming disability inclusion within MHPSS planning, programming and budgeting** in order to remove barriers to participation in the MHPSS response and to support access for persons with disabilities on an equal basis with persons without disabilities. In this regard, universal design (UD) is a key tool;[41] the concept is explored in more depth in Section 4 and examples are given throughout this document.

b. Designing and implementing **tailored and focused actions** as part of the MHPSS response to ensure that the specific and individual disability-related requirements of persons are met through reasonable accommodation (RA) measures;[42] examples of RA are also included throughout the document and in particular in Section 4.

Mainstream Disability

Tailored and Focused Actions
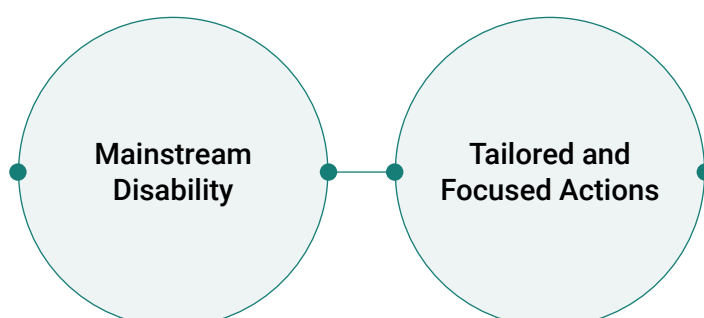
3.1 Disability-inclusive MHPSS response: *key action areas*

Based on the twin-track approach, **key action areas have been identified** to ensure that MHPSS response, programming and services are inclusive of persons with disabilities and that they address people's MHPSS requirements across sectors, throughout:

- the phases of the emergency, from preparedness to recovery;
- all elements of the humanitarian programme cycle (HPC),[43] including:

  emergency response preparedness

  needs assessment and analysis

  strategic response planning

  resource mobilization

  implementation and monitoring

  operational review and evaluation;

- the two "enablers" of the HPC:

  coordination

  information management.

The key action areas identified are summarized in Table 2.

Throughout this document, the term "disability actors" is used for the sake of brevity to refer to OPDs, self-advocates, persons with disabilities (representing disability diversity) and disability experts.

KEY ACTION AREAS

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Participation and inclusion of disability actors	Communication and information	Awareness-raising activities
Advocacy and lobbying initiatives	Emergency preparedness plans	Intersectoral and inter-agency coordination mechanisms
Needs assessments	Policy reviews and decision-making processes	Service planning and organization
Budgeting and fundraising	Implementation of MHPSS services and programmes	Existing MHPSS programmes/ protocols
Referral mechanisms	Recruitment processes	Human resources development
Staff care	Deinstitution-alization and reform process	Reporting/ complaints and feedback mechanisms on the MHPSS response
Data collection	Monitoring and evaluation (M&E) activities	Research initiatives

Table 2. Checklist: key action areas for disability-inclusive MHPSS response

Key action areas	Description	When? Phases of the emergency			Where? HPC elements and enablers
Participation and inclusion of disability actors	Disability actors are **consulted and meaningfully involved as partners and agents of change** in the core components of the MHPSS response and programming, namely in: • development of emergency preparedness plans; • intersectoral and inter-agency coordination mechanisms; • needs assessments and analysis; • awareness-raising activities; • advocacy and lobbying initiatives; • policy reviews and decision-making processes; • service planning and organization; • budgeting and fundraising; • implementation of MHPSS services and programmes; • adaptation of MHPSS programmes/protocols; • human resources development; • processes of deinstitutionalization, reform and building back better; • monitoring and evaluation (M&E); • research initiatives. For more detailed guidance on how to consult with persons with disabilities and meaningfully foster their participation, refer to the UNDIS guideline[44] (e.g. step-by-step guidance on consulting persons with disability[45]).	PREPAREDNESS	RESPONSE	RECOVERY	

Key action areas	Description	When? Phases of the emergency			Where? HPC elements and enablers
Communication and information[46]	Communication and information are available and provided in multiple languages (including those used by relevant groups of migrants and displaced persons), 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 versions, plain text accompanied by pictures, simplified versions of information, sign language videos, audio recordings, voiceovers, captions) through the most appropriate channels (radio, SMS, emails, TV, etc.) when required (UD).	PREPAREDNESS	RESPONSE	RECOVERY	
Awareness-raising activities	Awareness campaigns on the rights, capacities and requirements of persons with disabilities are led by OPDs and persons with disabilities and supported by MHPSS actors (UD).	PREPAREDNESS	RESPONSE	RECOVERY	
Advocacy and lobbying initiatives	Advocacy and lobbying initiatives are developed and implemented jointly by disability and MHPSS actors on the MHPSS requirements of persons with disabilities and on the urgent necessity of closing and replacing long-term residential institutions.	PREPAREDNESS	RESPONSE	RECOVERY	
Emergencypreparedness plans	Emergency preparedness plans include MHPSS requirements of persons with disabilities, universal design features and reasonable accommodation measures for facilities, environments, equipment, programmes, services and activities (UD, RA).	PREPAREDNESS			
Intersectoral and inter-agency coordination mechanisms	Coordination mechanisms are accessible to and support the participation of persons with disabilities at local, national, regional and global levels (where relevant) (UD).		RESPONSE	RECOVERY	

Key action areas	Description	When? Phases of the emergency			Where? HPC elements and enablers
Needs assessments	Assessments include MHPSS requirements of persons with disabilities, barriers to access and participation in the MHPSS response, capacity-building needs, UD features and RA measures for facilities, environments, equipment, programmes, services and activities (UD, RA).		RESPONSE		
Policy reviews and decision-making processes	Policy reviews and decision-making processes are accessible to, inclusive of and informed by the input, experience and expertise of persons with disabilities (UD).	PREPAREDNESS	RESPONSE	RECOVERY	
Service planning and organization	Service planning and service organization are human rights-based, community-based and sensitive to disability from the design stage and onset of the emergency; if not, they are retrofitted and adapted to the requirements of persons with disabilities, applying UD features and RA measures across sectors and through the multiple layers of intervention (see the IASC MHPSS intervention pyramid in Annex 1), targeting disability diversity and intersectionality (e.g. dementia-friendly communities, child-friendly spaces inclusive of children with disabilities (UD), focused psychological support in primary health care settings, psychotherapy for adults and children who are deaf (RA), etc.) in all types of emergency (e.g. pandemics, natural disasters, armed conflict).	PREPAREDNESS	RESPONSE	RECOVERY	
Budgeting and fundraising	Budgeting and fundraising include considerations/items for removing barriers to accessibility and promoting the participation of persons with disabilities in the MHPSS response through mainstreaming disability and disability-focused/tailored actions, applying UD features and RA measures.		RESPONSE	RECOVERY	

Key action areas	Description	When? Phases of the emergency		Where? HPC elements and enablers
Implementation of MHPSS services and programmes	MHPSS services and programmes meet the requirements of persons with disabilities, applying UD features and RA measures across sectors and through the multiple layers of intervention (see the IASC MHPSS intervention pyramid in Annex 1), targeting disability diversity and intersectionality (e.g. dementia-friendly communities, child-friendly spaces inclusive of children with disabilities (UD), focused psychological support in primary health care settings, psychotherapy for adults and children who are deaf (RA), etc.), rehabilitation services (UD), respite services for family members and caregivers of persons with disabilities (RA), in all types of emergency (e.g. pandemics, natural disasters, armed conflict). The MHPSS services should be available in multiple languages or translation must be provided (including languages used by relevant groups of migrants and displaced persons). Furthermore, **case management** is accessible to and inclusive of persons with all types of disabilities (for example, case managers have knowledge about and competencies on the requirements of persons with disabilities (UD) and available disability-related services (RA); specific software solutions are in place (UD); listing/mapping of available services is provided in multiple and accessible formats (UD)).	RESPONSE	RECOVERY	
Existing MHPSS programmes/protocols	Existing MHPSS programmes and protocols are retrofitted with guidance and adequate support to foster the participation of children, adolescents and adults with disabilities (UD).	RESPONSE	RECOVERY	

Key action areas	Description	When? Phases of the emergency			Where? HPC elements and enablers
Referral mechanisms	An inter-agency and intersectoral MHPSS referral mechanism is in place, inclusive of persons with disability and sensitive to age, gender and disability (e.g. mainstream and disability-specific services (RA), service providers and suppliers of assistive devices are mapped and this information is disseminated in multiple and accessible formats; staff at entry points to services are trained on the requirements of persons with disabilities (UD)).	PREPAREDNESS	RESPONSE	RECOVERY	
Recruitment processes	Recruitment processes are inclusive of persons with disabilities at various levels of the MHPSS response, including frontline services.		RESPONSE	RECOVERY	
Human resources development	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 (UD).	PREPAREDNESS	RESPONSE	RECOVERY	
Staff care	Staff care is informed by persons with disabilities and conceptualized to be inclusive of employees with disabilities; for example, resources are available and provided in multiple and accessible formats through the most appropriate channels (radio, SMS, emails, TV, etc.) when required (UD); facilities where staff care is provided are accessible, as is transportation (UD); the activities offered address the assessed specific requirements of employees with disabilities (RA).		RESPONSE	RECOVERY	

Key action areas	Description	When? Phases of the emergency		Where? HPC elements and enablers
Deinstitutionalization and reform process	Joint efforts are focused on the closure and replacement of long-stay residential institutions and psychiatric hospitals with human rights-oriented and community-based MHPSS services, planned or upgraded to be inclusive of persons with disabilities (UD).	RESPONSE	RECOVERY	
Reporting/complaints and feedback mechanisms on the MHPSS response	Mechanisms are safe, confidential and effective, are co-designed by persons with disabilities and are available in multiple and accessible formats, ensuring accountability and informing decision-making processes, planning and retrofitting (UD).	RESPONSE		
Data collection	All data, including data on MHPSS, are disaggregated by age, gender and disability (UD).	RESPONSE	RECOVERY	
Monitoring and evaluation (M&E) activities	M&E activities consider indicators related to the disability inclusiveness of MHPSS programmes and services (UD).	RESPONSE	RECOVERY	
Research initiatives	Research initiatives are co-led by researchers and persons with disabilities and inform the development of inclusive programmes and evidence-based interventions (UD).	RESPONSE	RECOVERY	

EXAMPLES OF UNIVERSAL DESIGN FEATURES AND REASONABLE ACCOMMODATION MEASURES IN THE MHPSS RESPONSE, APPLICABLE ACROSS SECTORS

© CBM

Drought response | Kenya

Table 3. Universal design and reasonable accommodation

Universal design features applied to:	Some practical examples of how universal design can remove barriers to, and facilitate, accessibility
Environments, buildings, facilities where MHPSS meetings, capacity-building and activities are provided, across sectors (e.g. community-based organizations, schools, child-friendly/safe spaces, health services, etc.)	• Located in a reachable area and not isolated, adjacent to services • Not uphill • Reachable by accessible and safe transportation • Standardized ramps to entrance • Wide spaces and doors • Doors open automatically • Door and cupboard handles do not require a grip • Comfort height toilets and flush controls • Buildings painted in neutral colours • Signage and instructions to navigate the environment are provided in multiple accessible formats (e.g. signage is provided in visual, easy-to-read, tactile and audible versions) • Sudden and loud noises are minimized • Buttons and other controls can be recognized by touch • Adequate lighting in interior and exterior spaces • Safety and safeguarding procedures are in place for all, targeting disability diversity
Equipment	• Anti-slip and stable surfaces • Surfaces and furniture that can be easily disinfected • Height-adjustable service desks, shelves, lockers • Hardware and software that support disability inclusion (e.g. larger buttons, accessible websites, text-to-speech software, captioned videos) • Software that is compatible with assistive technologies • Universally designed software where digital barriers are removed, with simple language for instructions, prompts and outputs and, where possible, supplemented with pictorial information, colour coding or voiceover

Universal design features applied to:	Some practical examples of how universal design can remove barriers to, and facilitate, accessibility
Communication	Information, materials and resources are provided and disseminated in multiple languages (including those used by relevant groups of migrants or displaced persons), 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 versions, plain text accompanied by pictures, simplified versions of information, sign language videos, audio recordings, voiceovers, captions) through the most appropriate available channels (in person, radio, SMS, emails, TV, etc.)
MHPSS meetings, activities and interventions	• Co-planned and co-delivered by persons with disabilities and staff trained on disability inclusion, the requirements of persons with disabilities and adapted support • Variety of materials and formats used for activities to meet the requirements of all participants • Flexible schedule and duration of activities/interventions (e.g. considering the attention span and fatigue of persons involved) and of breaks (e.g. number of breaks required, disability-related requirements for beverages and food, time to use restrooms) • Ensure that all participants/users can take part in evaluation of the activities/intervention by providing multiple and accessible formats
MHPSS services/ programmes	• Psychoeducation is provided in multiple and accessible formats • Multiple models and options of service delivery are developed and offered, ensuring the privacy and informed consent of participants/users (e.g. mobile teams, home-based care, peer support) • Provision of multiple ways to participate in the decision-making process related to the services/programmes • Ensure flexible appointment systems • Ensure flexible duration and schedule of sessions • Ensure that M&E activities include indicators for disability inclusiveness of the services/programmes and that they inform planning • Ensure that disability inclusion policies are in place • Ensure that persons with disabilities have equal employment opportunities in the service/programme with individuals who do not have disabilities

Reasonable accommodation measures to promote participation, addressing individual requirements (through individual adjustments)
Some practical examples: At work, individually adapted or flexible working hours, extra time to complete tasks, time off when mental health care is needed, access to private spaces at work (e.g. to store medication or to rest when necessary) or redesigned jobs (e.g. to avoid interacting with clients if the worker finds this unduly stressful). More generally, disability-specific equipment, assistive technology devices, sign language interpreters, supported decision-making, safe and adapted transportation, allowances for transportation, delivery of food and non-food items to persons unable to reach distribution sites.
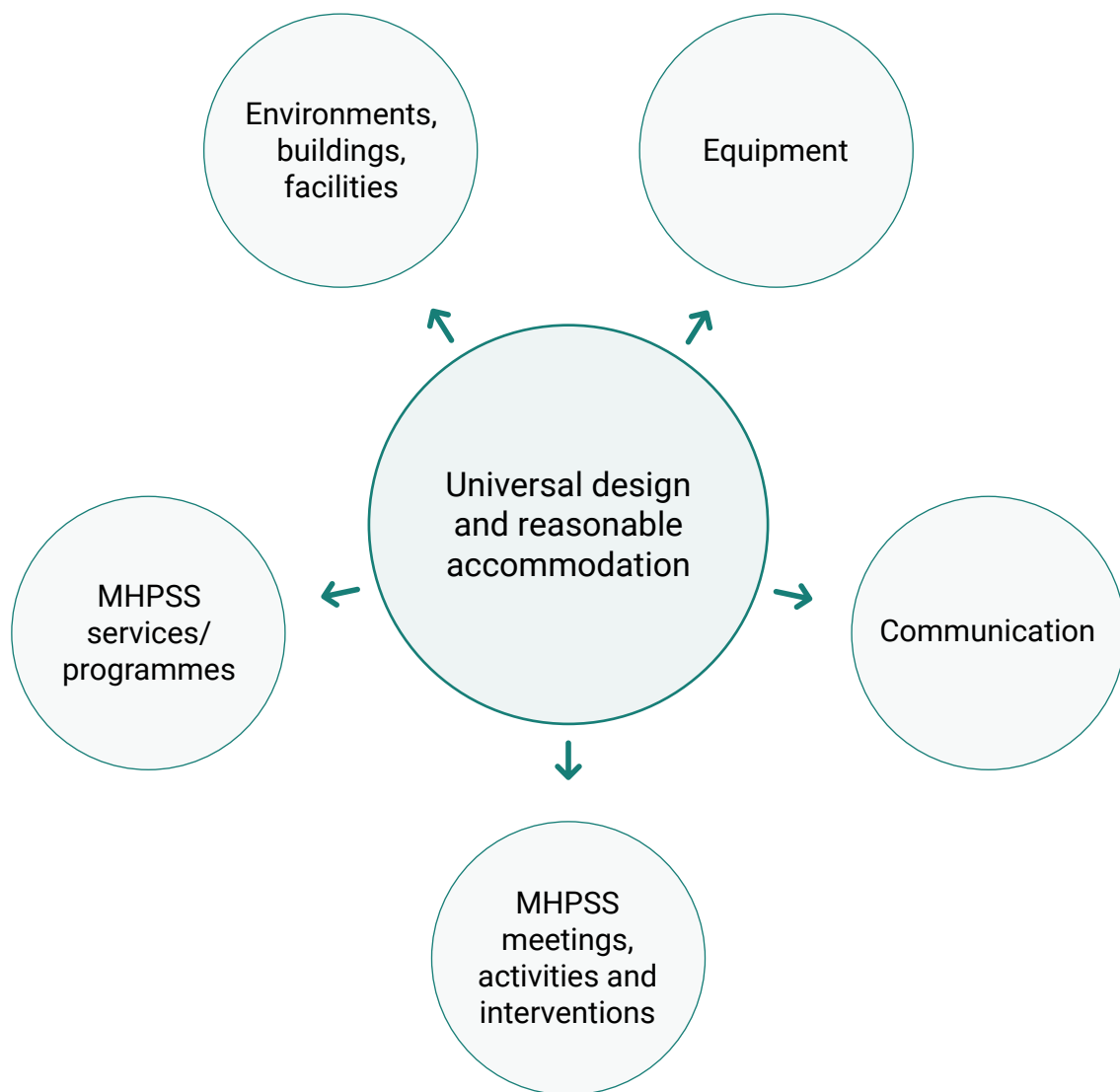
SECTION 5
DETAILED OPERATIONAL INSTRUCTIONS

Food crisis 2022 | Madagascar

Table 4 provides detailed operational instructions to ensure that the key action areas for inclusive MHPSS services are addressed across sectors and throughout any emergency, from the preparedness phase to the emergency provision of services and the recovery phase.

Emergency preparedness → Minimum responses during emergencies → Early recovery
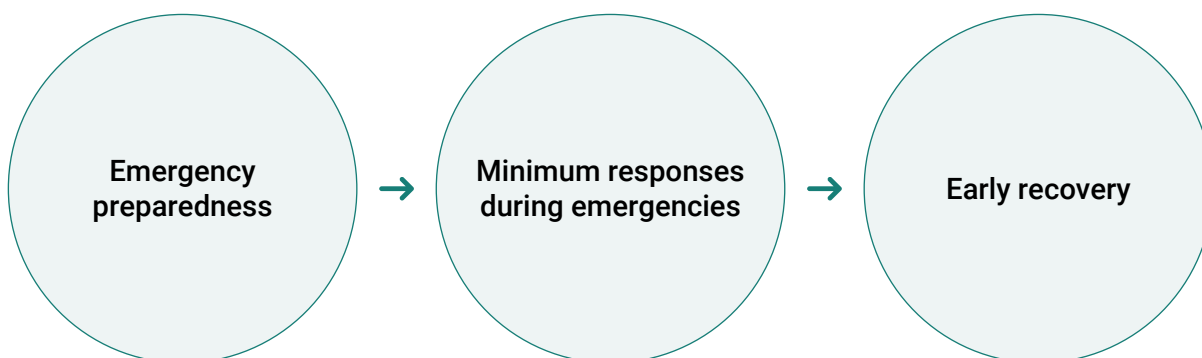
TABLE 4. Emergency preparedness, minimum responses in emergencies, and early recovery

Emergency preparedness

1. Obtain information on the country's position with regard to the CRPD (whether signed and ratified, the stage of implementation and adaptation of policies and plans), regional treaties and national laws on disability, and disability and inclusion/accessibility policies, and advocate for the implementation of these and for emergency actors to take account of (and not overlook) psychosocial, cognitive and intellectual disabilities. Initial information is available at: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

2. Conduct continuous mapping and identification of international, regional, national and local disability actors and the establishment of referral mechanisms and pathways.

3. Consult with and actively/meaningfully involve, as agents of change, identified national and local disability actors and experts in all phases of preparedness.

4. Promote effective inclusive coordination mechanisms, ensuring accessibility for and participation of persons with disabilities, applying universal design features and reasonable accommodation measures.

5. Assess the competencies and knowledge of disability actors (including persons with disabilities, NGOs focused on disability and disability experts) to work in human rights-oriented MHPSS response at all levels (e.g. knowledge and competencies on main MHPSS guidelines, human resources, accountability, financial management, proposal writing, advocacy, M&E) to inform capacity-building planning.

6. Co-develop with disability actors a set of MHPSS considerations, ensuring that they are inclusive of persons with disabilities (UD/RA), and advocate for their integration into national preparedness plans.

7. Advocate for the replacement of residential institutions with quality alternative community-based care that respects the human rights of persons with disabilities. Meanwhile, where residential institutions still exist, co-develop emergency preparedness and response plans for them, including evacuation plans that specify disability-related requirements and that link with families and communities if evacuation occurs (RA).

8. Co-design with disability actors awareness-raising and capacity development initiatives for MHPSS actors on the rights of persons with disabilities.

9. Ensure/advocate (depending on the role of your organization) that data collection systems allow disaggregation by gender, age and disability (UD).

10. Advocate and fundraise for research initiatives on MHPSS and disability and facilitate user-led research that will inform the development of inclusive programmes and evidence-based interventions.

11. Ensure that persons with disabilities (representing disability diversity) have access to employment opportunities within your organization on an equal basis with persons without disabilities and that they are provided with the necessary UD features and RA measures.

Minimum responses during emergencies	
This section corresponds to the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007):[47] it is based on the same functions/domains and refers directly to the related Action Sheets in the Guidelines.	
A. Common functions across domains	

1.Coordination
 	
Action Sheet:
 	
1.1 Establish coordination of intersectoral MHPSS
	• Promote dissemination of experiences, knowledge, lessons learned and guidance on disability mainstreaming across the MHPSS response.
	• Identify a disability focal point within the MHPSS Technical Working Group (TWG) (which is set up in every emergency to coordinate MHPSS response and efforts) to:
	  • attend the Disability TWG, if any, and support the inclusion of MHPSS considerations and psychosocial, cognitive and intellectual disabilities;
	  • provide technical guidance to MHPSS actors on an inclusive MHPSS response;
	  • foster inter-cluster collaboration on disability inclusion, through cross-learning activities, referral pathways and training provided by disability actors.
	• Advocate for a disability focal point to be appointed in all relevant ministries to deal with disability-related requirements, especially in the ministries of health, education, social welfare, labour and justice, thus ensuring that any challenges can be addressed promptly and ensuring the sustainability of programmes initiated by organizations. The focal points will report to the national human rights authority.
	• Ensure that disability actors attend and contribute to the MHPSS TWG and cluster meetings and that the meetings are inclusive and accessible to persons with disabilities, both in person and remotely (UD/RA).
	• Advocate for the appointment of, or consultation with, staff with relevant expertise and experience in disability inclusion to ensure the quality and inclusiveness of MHPSS responses (e.g. disability focal points, members of humanitarian country teams, sector and cluster coordination mechanisms) (UD).
	• Integrate disability inclusion considerations into MHPSS appeals for funding, including universal design features and reasonable accommodation measures (UD/RA).
	• Identify and consult with the national human rights authority, advocating for the inclusion of MHPSS requirements of persons with disabilities.
	• Map mainstream and disability-specific services (including but not limited to rehabilitation services), service providers and suppliers of assistive devices, and disseminate mapping findings to facilitate effective referrals and comprehensive care.
	• Establish an effective MHPSS referral mechanism or strengthen existing mechanisms, inclusive of persons with disabilities, in every type of emergency setting and identify cross-sectoral entry points (e.g. mapping of mainstream and disability-specific services, service providers, suppliers of assistive devices). Ensure that this information is disseminated in multiple and accessible formats and that staff at entry points are trained on the requirements of persons with disabilities.

	• Consult with disability actors on the adaptation of MHPSS activities and structured evidence-based protocols and programmes (e.g. psychological first aid, or PFA) across sectors, considering universal design features and reasonable accommodation, the local context and culture, and the type of emergency (e.g. conflict, natural disaster, pandemic).
	• Identify key MHPSS response resources and materials and develop and disseminate versions in multiple accessible formats and languages, through the most appropriate channels (UD).
	• Advocate for, promote, support and join efforts for the deinstitutionalization of persons with disabilities who are secluded in all kinds of institutions, while ensuring their ongoing care and protection.
	• Advocate for and support the revision of national policies, plans and legislation to ensure that these are inclusive of persons with disabilities.
	• Advocate for and promote the strengthening and expansion of rehabilitation services, targeting persons with disabilities of all ages and all abilities (UD).

2. Assessment, monitoring and evaluation
 	
Action Sheets:
2.1 Conduct assessments of mental health and psychosocial issues
2.2 Initiate participatory systems for monitoring and evaluation
	• Consult with and meaningfully involve disability actors in key informant interviews, focus groups and needs assessment teams. This will involve:
	  • conceptualization, implementation and dissemination of assessments related to MHPSS requirements, inclusive of persons with disabilities;
	  • assessment, analysis and reporting of barriers that may prevent persons with disabilities from accessing MHPSS services, especially in terms of service provision and identification/reach;
	  • assessment of UD measures and RA solutions within organizations and at the service delivery level to inform design, adaptation, procurement and retrofitting;
	  • assessment of inclusive capacity-building needs/gaps;
	  • dissemination of assessment reports in a range of accessible formats and use of the findings to inform and adjust programming as needed (UD).
	
	• Consult with and meaningfully involve disability actors in monitoring and evaluation (M&E) teams for the:
	  • design or adaptation of information and knowledge management systems and facility registers, disaggregated by gender, age and disability (UD);
	  • monitoring and reporting on the availability, inclusion and accessibility of quality MHPSS services, disaggregating information by gender, age and disability (UD);
	  • evaluation of and participation in intersectoral evaluation of MHPSS programmes and processes, considering inclusiveness, accessibility and compliance with standards (UD);
	  • dissemination of M&E reports in a range of accessible formats and use of the findings to inform and adjust programming as needed (UD).

Minimum responses during emergencies	
This section corresponds to the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007):[47] it is based on the same functions/domains and refers directly to the related Action Sheets in the Guidelines.	
A. Common functions across domains	

3. Protection and human rights standards
 	
Action Sheets:
 	
3.1 Apply a human rights framework through MHPSS
 	
3.2 Identify, monitor, prevent and respond to protection threats and failures through social protection
 	
3.3 Identify, monitor, prevent and respond to protection threats and abuses through legal protection
	• Consult with and meaningfully involve disability actors to:
	
	  • systematically monitor the respect of human rights of persons with disabilities, including children, through the WHO QualityRights Tool Kit, the WHO QualityRights training and guidance modules and the WHO QualityRights module on transforming services and promoting human rights;[48]
	
	  • develop protocols to ensure the exercise of legal capacity and access to informed consent to prevent coercive treatment, including forced institutionalization, forced treatment, seclusion and physical and chemical restraint;
	
	  • build an accessible knowledge base so that persons with disabilities are aware of their rights and entitlements;
	
	  • set up and advertise accessible, effective and confidential intra- and inter-agency reporting/complaints mechanisms at all levels of the MHPSS response and across sectors, in multiple accessible formats and languages, through which persons with disabilities can safely report complaints and share information regarding their MHPSS requirements and protection (UD);
	
	  • develop and implement inclusive safeguarding, especially safeguarding related to protection against sexual exploitation and abuse (PSEA) policies, including prevention, response, coordination and management specific to persons with disabilities (representing disability diversity and age-specific);
	
	  • ensure that the protection risks faced by children (e.g. child labour, violence against children, recruitment by armed forces, migration and displacement, family separation during crisis) are addressed by inclusive interventions and initiatives, which are provided with UD features and RA measures;
	
	  • ensure support for at-risk caregivers and young children.

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| 4. Human resources

Action Sheets:

4.1 Identify and recruit staff and engage volunteers who understand local culture

4.2 Enforce staff codes of conduct and ethical guidelines

4.3 Organize orientation and training of aid workers in MHPSS

4.4 Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers | • Ensure that persons with disabilities have access to inclusive employment opportunities within organizations on an equal basis with persons without disabilities and that they are provided with the necessary UD features and RA measures.

• Ensure that staff care is informed by persons with disabilities and conceptualized to be inclusive of employees with disabilities: for example, resources are available and provided in multiple and accessible formats through the most appropriate channels (radio, SMS, emails, TV, etc.) when required (UD); facilities where staff care is provided are accessible, as is transportation (UD); activities offered address the assessed specific requirements of employees with disabilities (RA).

• Jointly with disability actors, co-design and co-deliver inclusive and accessible capacity-building initiatives to MHPSS actors and professionals across sectors (e.g. protection, health, education, livelihoods, etc.) and intervention layers (see the IASC MHPSS intervention pyramid in Annex 1) and to implementing teams (e.g. community workers, first responders and volunteers working with individuals, groups and communities), on:
   • the conceptualization of disability, the rights-based approach to disability, the twin-track approach, UD features and RA measures;
   • the diversity and intersectionality of disabilities and related barriers, stigma and discrimination;
   • the abilities and the MHPSS and communication requirements of persons with disabilities;
   • the adaptation of the MHPSS response and interventions to be inclusive of persons with disabilities, in all types of emergency setting;
   • the provision of supported decision-making to persons who require it (RA).

• More specifically, for MHPSS professionals and related actors, provide:
   • assistance to persons with disabilities to draft advance directives[49] in case they become unable to make decisions for various reasons;
   • protocols and measures to ensure the exercise of legal capacity and accessible informed consent to prevent coercive treatment, including forced institutionalization, forced treatment and physical and chemical restraint.

• Provide inclusive and accessible capacity-building to MHPSS professionals, community and lay workers and school staff on the WHO QualityRights training and guidance modules, a human rights-based approach to disability, recovery-oriented and inclusive MHPSS services and disability-specific psychological interventions.

• Provide inclusive and accessible capacity-building activities, such as training, supervision and training of trainers (ToT) to disability actors and their support persons on:
   • human rights and reporting systems;[50]
   • inclusive MHPSS response and approaches;
   • use of technology and digital tools (which are particularly relevant in the case of pandemics);
   • provision of peer support (peer-to-peer and peer support groups);
   • gaps identified through related assessments. |

Minimum responses during emergencies
This section corresponds to the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007):[47] it is based on the same functions/domains and refers directly to the related Action Sheets in the Guidelines.

B. Core mental health and psychosocial support domains	

5. Community mobilization and support
 	
Action Sheets:
 	
5.1 Facilitate conditions for community mobilization, ownership and control of emergency response in all sectors
 	
5.2 Facilitate community self-help and social support
 	
5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices
 	
5.4 Facilitate support for young children (0-8 years) and their caregivers
	• Consult with and meaningfully involve disability actors to co-design and co-deliver the activities foreseen in Action Sheets 5.1, 5.2, 5.3 and 5.4, adapting them to ensure accessibility and inclusion through UD features and RA measures, including in the case of pandemics.
	
	• Ensure the incorporation of UD features and RA measures in programmes related to:
	  • community mobilization, ownership and control of emergency response;
	  • self-help, peer support, social support and religious activities.
	
	• Raise awareness in communities through campaigns in multiple and accessible formats on:
	  • positive representation of persons with disabilities, their rights, their capacities, their MHPSS requirements and their communication requirements;
	  • the heightened risk of GBV against persons with disabilities, especially women and girls with disabilities, and the need for protection, specialized support, services and referrals.
	
	• Raise the awareness and literacy of family members and support persons about the MHPSS requirements and strengths of persons with disabilities.
	
	• Implement strategies to reduce stigmatization and discrimination against persons with disabilities and promote positive representation.
	
	• Initiate outreach and provide protection and support mechanisms for individuals (including children) with disabilities who are institutionalized, live in confinement or receive traditional/religious healing in their homes, and support their safe transition into the community (RA).
	
	• Promote and provide rehabilitation opportunities for persons with disabilities of all ages (UD).
	
	• Ensure adequate support for persons with disabilities where known support persons are temporarily or permanently unavailable due to the emergency.
	
	• Promote and support individual and peer support groups of family members and support persons or networks (e.g. emotional peer support groups of youth).
	
	• Strengthen the capacity of and provide support and respite care for caregivers of children and persons with disabilities to enhance their well-being, strengthen their coping skills and support them in creating a resilient and healthy family environment which respects dignity and promotes the autonomy of the person with a disability.
	
	• Strengthen the capacity of parents and caregivers on positive caregiving practices, self-awareness and self-care.
	
	• Build the capacity of and establish collaboration with traditional and religious leaders on the identification, inclusion and referral of persons with disabilities.

6. Health services	• Strengthen the health information system (HIS) to cover MHPSS data, disaggregated by age, gender and disability (UD).
Action Sheets:	• Consider the introduction of accessible mobile health (m-health), where the required infrastructure is available or feasible and is sustainable (UD).
6.1 Include specific psychological and social considerations in provision of general health care	• Ensure the identification of and outreach to persons with disabilities.
	• Consult with and meaningfully involve disability actors to design (or adapt) and implement community-based, recovery and human rights-oriented MHPSS services throughout all layers of care (see the IASC MHPSS intervention pyramid in Annex 1), ensuring the application of UD features and RA measures. For guidance on community-based MHPSS services targeting children and families, see UNICEF's "Operational Guidelines on Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered support for children and families".[51]
6.2 Provide access to care for people with severe mental disorders	• Promote and support the participation of persons with disabilities in decision-making processes related to their care plans, through trained staff and communication in multiple and accessible formats (UD).
6.3 Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions	• Ensure that protocols, measures and advance directives[52] are in place and implemented by trained staff to enable the exercise of legal capacity and accessible informed consent and to prevent coercive treatment, including forced institutionalization, forced treatment and physical and chemical restraint.
	• Ensure that comprehensive rehabilitation is coupled with focused psychosocial support, and refer for physical and functional rehabilitation.
	• Raise awareness and literacy in the community on the MHPSS and health requirements of persons with disabilities, including menstrual and reproductive aspects.
6.4 Learn about and, where appropriate, collaborate with local indigenous and traditional health systems	• Integrate disability-inclusive MHPSS considerations in particular into sexual and reproductive health services (e.g. provide psychoeducation about menstruation to girls with intellectual disabilities).
	• Educate and disseminate information on MHPSS promotion and prevention in multiple accessible formats (UD).
6.5 Minimize harm related to alcohol and other substance use	• Consult with and meaningfully involve disability actors to support deinstitutionalization processes and the replacement of long-stay residential institutions (for children and adults) and psychiatric hospitals with human rights-oriented and community-based MHPSS services targeting all ages.
	• While supporting deinstitutionalization, ensure protection and care for persons and children with disabilities who are secluded in institutions (for details, see Action Sheet 6.3 of the IASC Guidelines).

Minimum responses during emergencies
This section corresponds to the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007):[47] it is based on the same functions/domains and refers directly to the related Action Sheets in the Guidelines.

B. Core mental health and psychosocial support domains	

7. Education
 	
Action Sheet:
 	
7.1 Strengthen access to safe and supportive education
	• Consult with and meaningfully involve disability actors in order to:
	   • assess barriers that prevent children, adolescents and adult learners with disabilities from accessing educational opportunities;
	   • adjust education curricula, teaching methods, materials and activities to make them accessible, affordable, available and inclusive (e.g. social and emotional learning (SEL) with accessible materials), taking account of the type of emergency (UD/RA);
	   • adapt the facilities, equipment, programmes and activities of any informal or formal educational setting (e.g. kindergartens, public and private schools, temporary learning spaces, remote distance learning, child-friendly spaces) to make them accessible and inclusive of all children, adolescents and adult learners, applying UD principles and RA measures;
	   • strengthen the capacity of school staff and teachers and raise their awareness on the importance of reducing stigma and discrimination around disability in schools; on minimum standards of child protection; on structured MHPSS school-based programmes inclusive of children, adolescents and adult learners with disabilities; on identifying and responding to the MHPSS requirements of children, adolescents and adult learners with disabilities on an equal basis with others, through training and supervision; on identifying children, adolescents and adult learners who require more structured MHPSS and referring them to accessible services and follow-up (UD);
	   • promote and advocate for, design/adapt and deliver inclusive early childhood education activities and inclusive recreational activities, applying UD principles and RA measures;
	   • educate communities and families about the importance of inclusive education and the need to fight stigma and discrimination;
	   • identify and mobilize local resources (e.g. accessible transport, sign language interpreters, etc.) to increase access to inclusive education (UD/RA).
	• Ensure that children, adolescents and adult learners with intellectual, cognitive and psychosocial disabilities are not overlooked and are included in classrooms, both in person and during remote distance learning, providing the necessary reasonable accommodations.
	• Advocate with the ministry of education for integration of the Washington Group/ UNICEF Child Functioning Module (CFM)[53] to collect disability-disaggregated data (UD).

8. Dissemination of information	• Ensure that information on the emergency, aid, legal rights, MHPSS response and positive coping methods is disseminated in, multiple languages (including those used by relevant groups of migrants or displaced persons), multiple and accessible formats through the most appropriate channels (radio, SMS, emails, TV, etc.) and that it reaches the most vulnerable (UD).
Action Sheets:	• Ensure that information on assessment and reporting tools, on MHPSS response across sectors (including targeting criteria, duration, assistance arrangements, etc.) and on positive coping methods is made available in multiple languages (including those used by relevant groups of migrants or displaced persons), in multiple and accessible formats, through the most appropriate channels (UD).
8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights	
8.2 Provide access to information about positive coping methods	
C. Social considerations in sectors	
9. Food security and nutrition	• Consult with and meaningfully involve disability actors to ensure that food assistance and delivery are disability-inclusive in all types of emergency, including pandemics, and apply UD features and RA measures.
Action Sheet:	• Ensure that the nutritional and eating requirements of persons with disabilities are addressed (RA).
9.1 Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support	• Ensure that staff are informed about the MHPSS services available and have the capacity to appropriately refer persons with disabilities, when needed.

Minimum responses during emergencies
This section corresponds to the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007):[47] it is based on the same functions/domains and refers directly to the related Action Sheets in the Guidelines.

C. Social considerations in sectors	
10. Shelter and site planning *Action Sheet:* 10.1 Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner	• Consult with and meaningfully involve disability actors in site planning and provision of shelter to ensure that they are disability-inclusive and accessible in all types of emergency, including pandemics, and apply UD features and RA measures. • Train shelter staff on disability inclusion, best practices, standards and tools. • Provide shelters that respect dignity, privacy, safety (including equal social distancing in the case of pandemics), security and mitigation of protection risks, and apply UD features and RA measures. • In particular, ensure that persons with long-term psychosocial disabilities have access to shelter on an equal basis with others, and that they are not overlooked and discriminated against because of stereotypes and prejudices (e.g. other people considering them dangerous). • Advocate for transitional shelters for persons with disabilities to be located near to accessible sanitary facilities, water points, entrances and services (UD). • Ensure that shelter staff are informed and are keeping track of the location of persons with disabilities within the site. • Ensure that shelter staff are informed about available MHPSS services and have the capacity to appropriately refer persons with disabilities, when needed. • Ensure that shelter management includes safeguarding and preventive measures to avoid harm and abuse, more frequently involving persons and children with disabilities, that social distancing is ensured where needed and that an inclusive referral mechanism is in place and works effectively (e.g. staff at entry points are trained on the requirements of persons with disabilities).

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11. Water and sanitation
 	
Action Sheet:
 	
11.1 Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation
	• Consult with and meaningfully involve disability actors in water and sanitation (WASH) planning and provision in order to:
	
	   • train WASH staff on disability inclusion, best practices, standards and tools;
	
	   • co-design and co-deliver inclusive and safe WASH services and interventions (UD).
	
	• Provide psychoeducation in multiple and accessible formats to girls and women with intellectual, cognitive or psychosocial disabilities about hygienic measures during menstruation (RA).
	
	• Provide clear information in multiple and accessible formats and languages through the most appropriate channels about hygiene and protection measures required in the case of pandemics (UD).

Early recovery

During this phase, actions are taken to ensure the sustainability, stabilization and institutionalization of emergency programmes and services to strengthen the national mental health system and to review policies, plans and legislation.

Please refer to the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) for the related operational instructions and ensure their inclusiveness by following the key action areas for a disability-inclusive MHPSS response, outlined in Section 3.1 of the current document

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ANNEX 1
RECOMMENDED RESOURCES AND TOOLS TO SUPPORT DISABILITY INCLUSION IN MHPSS RESPONSES

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Corona response | Nigeria

Accessibility

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- UNICEF. Toolkit on Accessibility: Tools to apply universal design across premises and programmes and promote access for all. https://accessibilitytoolkit.unicef.org/

Camp coordination and camp management

- IASC (2014). Mental Health and Psychosocial Support in Emergency Settings: What Should Camp Coordination and Camp Manager Actors Know? https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings/documents-public/iasc-mental-health-and

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- Sphere (2018). The Sphere Handbook. https://www.spherestandards.org/handbook-2018/

- UNHCR. Education in Emergencies - Camps. https://emergency.unhcr.org/entry/114386/education-in-emergencies

Forced displacement

- UNHCR (2019). Working with Persons with Disabilities in Forced Displacement. Need to Know Guidance 1. http://www.unhcr.org/4ec3c81c9.html

Gender-based violence (GBV)

- IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery. https://gbvguidelines.org/en/

- UNFPA (2018). Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-based Violence and Sexual and Reproductive Health and Rights for Women and Young Persons with Disabilities. https://www.unfpa.org/featured-publication/women-and-young-persons-disabilities

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ENDNOTES

[1] Persons with all types of disabilities include persons with physical, sensorial, psychosocial, cognitive, intellectual and multiple disabilities.

[2] See, for example: Bronfenbrenner U (1994). Ecological Models of Human Development. In International Encyclopedia of Education, pp. 37–42. Oxford, UK: Elsevier; Bronfenbrenner U (1979). The Ecology of Human Development. Boston, MA: Harvard University Press; and Kousoulis AA and Goldie I (2021). A Visualization of a Socio-Ecological Model for Urban Public Mental Health Approaches. Frontiers in Public Health, 9:654011. doi: 10.3389/fpubh.2021.654011

[3] See, for example, Funk M and Bold ND (2020). WHO's QualityRights Initiative: Transforming Services and Promoting Rights in Mental Health. Health and Human Rights. Jun;22(1):69-75. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348459/; Mahdanian AA, Laporta M, Bold ND, Funk M and Puras D (2022). Human rights in mental healthcare; A review of current global situation. International Review of Psychiatry. doi: 10.1080/09540261.2022.2027348; and Office of the United Nations High Commissioner for Human Rights. Mental health and human rights: OHCHR and the right to health. https://www.ohchr.org/en/health/mental-health-and-human-rights

[4] United Nations. Convention on the Rights of Persons with Disabilities (CRPD). https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html. The CRPD, which is a legally binding document, considers persons with disabilities as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (art. 1). The CRPD refers also to humanitarian crises and requires responses to be inclusive of persons with disabilities (art. 11). However, in reality, persons with disabilities are too often left behind and do not receive fair and equal assistance. See Charter on Inclusion of Persons with Disabilities in Humanitarian Action (2016). http://humanitariandisabilitycharter.org/

[5] Updated key concepts, definitions and knowledge related to disability and its impact on persons living in humanitarian contexts are available in IASC (2019). IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action. https://interagencystandingcommittee.org/iasc-task-team-inclusion-persons-disabilities-humanitarian-action/documents/iasc-guidelines

[6] United Nations General Assembly (2018). Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (A/73/216). New York: UNGA. https://digitallibrary.un.org/record/1640250; Smith F, Jolley E, Schmidt E (2012). Disability and Disasters: The Importance of an Inclusive Approach to Vulnerability and Social Capital. UNDRR, The World We Want. https://www.preventionweb.net/publication/disability-and-disasters-importance-inclusive-approach-vulnerability-and-social-capital; UNISDR (2014). Living with Disability and Disasters: UNISDR 2013 Survey on Living with Disabilities and Disasters – Key Findings. https://www.unisdr.org/2014/iddr/documents/2013DisabilitySurveyReport_030714.pdf; Handicap International (2015). Global Report: Disability in Humanitarian Context. https://www.hi-us.org/disability_in_the_humanitarian_context; UNICEF (2018). Children with Disabilities in Situations of Armed Conflict. https://reliefweb.int/report/world/children-disabilities-situations-armed-conflict-discussion-paper

[7] UNICEF (2018). Children with Disabilities in Situations of Armed Conflict, op. cit.

[8] UNICEF/Terre des Hommes (2006). Action to Prevent Child Trafficking in South Eastern Europe: A Preliminary Assessment. https://resourcecentre.savethechildren.net/pdf/1628.pdf/; Devandas Aguilar C (2017). A/72/133: Sexual and reproductive health and rights of girls and young women with disabilities - Note by the Secretary-General - Report of the Special Rapporteur on the rights of persons with disabilities, para 29–31. https://www.ohchr.org/en/documents/thematic-reports/a72133-sexual-and-reproductive-health-and-rights-girls-and-young-women

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[10] Barriers can be categorized as institutional, environmental or attitudinal. For more details and some examples, see IASC (2019). IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action, op. cit.

[11] WHO (2012). QualityRights Toolkit. https://www.who.int/publications/i/item/who-qualityrights-tool-kit; IASC (2019). IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action, op. it.

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[13] Mitchell D and Karr V (eds) (2014). Crises, Conflict and Disability: Ensuring Equality. New York: Routledge.

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[16] Women's Refugee Commission and UNICEF (2017). Disability Inclusion in Child Protection and Gender-Based Violence Programs. https://www.womensrefugeecommission.org/research-resources/disability-inclusion-in-child-protection-and-gender-based-violence-programs/

[17] WHO (2010). Mental Health and Development: Targeting people with mental health conditions as a vulnerable group. https://apps.who.int/iris/bitstream/handle/10665/44257/9789241563949_eng.pdf; Hughes K, Bellis MA, Jones L, Wood S, Bates G, Eckley L et al. (2016). Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. Lancet (9826), pp. 1621–29. https://pubmed.ncbi.nlm.nih.gov/22377290/

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[22] Fujii K. (n.d.). The Great East Japan Earthquake and Disabled Persons, op. cit.

[23] Rohwerder B (2013). Intellectual disabilities, violent conflict and humanitarian assistance: advocacy of the forgotten, op. cit.

[24] UNFPA (2018). Young Persons with Disabilities: Global Study on Ending Gender-based Violence and Realizing Sexual and Reproductive Health and Rights, op. cit.; UNFPA (2018). Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-based Violence and Sexual and Reproductive Health and Rights for Women and Young Persons with Disabilities. https://www.unfpa.org/featured-publication/women-and-young-

persons-disabilities

[25] Ibid.

[26] Save the Children International (2020). Protect a Generation: The impact of COVID-19 on children's lives. https://resourcecentre.savethechildren.net/library/protect-generation-impact-covid-19-childrens-lives

[27] IASC (2019). IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action, op. cit.; United Nations (2016). One Humanity, Shared Responsibility, op. cit.

[28] Persons with psychosocial, cognitive and intellectual disabilities are a more marginalized group among persons with disabilities and they are likely to be overlooked in emergency settings, as well as within broader disability planning and programming (e.g. persons with psychosocial disabilities are often excluded from livelihoods or cash transfer programmes).

[29] United Nations (2016). One Humanity, Shared Responsibility, op. cit.; UNICEF (2013). State of the World's Children: Children with disabilities. https://www.unicef.org/reports/state-worlds-children-2013

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[33] IASC (2020). IASC Key Messages on Applying IASC Guidelines on Disability in the COVID-19 Response, op. cit.; IDDC, DRI et al. (2020). Disability rights during the pandemic: A global report on findings of the COVID-19 Disability Rights Monitor. https://www.internationaldisabilityalliance.org/sites/default/files/disability_rights_during_the_pandemic_report_web_pdf_1.pdf; WHO and World Bank (2011). World Report on Disability. https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/world-report-on-disability

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38 European Centre for Disease Prevention and Control (2021). Surveillance of COVID-19 in long-term care facilities in the EU/EEA. Stockholm: ECDC. https://www.ecdc.europa.eu/en/publications-data/surveillance-COVID-19-long-term-care-facilities-EU-EEA

39 WHO (2013). Building Back Better: Sustainable Mental Health Care after Emergencies. https://apps.who.int/iris/bitstream/handle/10665/96378/WHO_MSD_MER_13.1_eng.pdf?sequence=8

40 The "twin-track approach" encompasses two complementary strategies for the inclusion and participation of persons with disabilities on an equal basis with others: mainstreaming disability in the humanitarian response and supporting disability-targeted activities. It is commonly used to help advance the rights of marginalized populations and is also applied when promoting disability-inclusive humanitarian action. See, for example, CBM/Humanitarian Hands-On Tool. Step-by-step practical guidance on inclusive humanitarian fieldwork. https://hhot.cbm.org/en/card/twin-track-approach

41 Based on the CRPD, "universal design" (UD) means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. Universal design does not exclude assistive devices for particular groups of persons with disabilities where these are needed. For more, see, for example, Centre for Excellence in Universal Design. What is Universal Design. https://universaldesign.ie/what-is-universal-design/

42 "Reasonable accommodation" means necessary and appropriate modification and adjustments that do not impose a disproportionate or undue burden, where needed in a particular case to ensure that persons with disabilities are able to enjoy and exercise all human rights and fundamental freedoms on an equal basis with others.

43 IASC (2015). IASC Reference Module for the Implementation of the Humanitarian Programme Cycle. Version 2.0. https://reliefweb.int/sites/reliefweb.int/files/resources/the_humanitarian_programme_cycle_version_2.0_1.pdf

44 United Nations Disability Inclusion Strategy (UNDIS). https://www.un.org/en/content/disabilitystrategy/assets/documentation/UN_Disability_Inclusion_Strategy_english.pdf

45 United Nations (2021). Guidelines on Consulting Persons with Disabilities: Indicator 5. https://www.un.org/sites/un2.un.org/files/un_disability-inclusive_consultation_guidelines.pdf

46 Based on the CRPD, Article 3, communication includes languages (spoken and signed), display of text, Braille, tactile communication, large print and accessible multimedia as well as written, audio, plain-language, human reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology.

47 IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings-0/documents-public/iasc-guidelines-mental

48 WHO (2012). WHO QualityRights Tool Kit, op. cit.; WHO (2019). WHO QualityRights materials for training, guidance and transformation. https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools; WHO (2019). WHO QualityRights module on transforming services and promoting rights.https://www.who.int/publications/i/item/9789241516815

49 Advance directives are a tool designed to detail a person's preferences for treatment and care, if the person becomes incompetent or unable to communicate these preferences to service providers in the future. See Srebnik DS and La Fond JQ (1999). Advance Directives for Mental Health Treatment. Psychiatric Services (Washington, DC), 50, 919-25. 10.1176/ps.50.7.919

50 See WHO QualityRights training and guidance modules.

51 UNICEF (2018). Operational Guidelines on Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered support for children and families. https://www.unicef.org/media/52171/file

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INFORMATION NOTE ON DISABILITY AND INCLUSION IN MHPSS