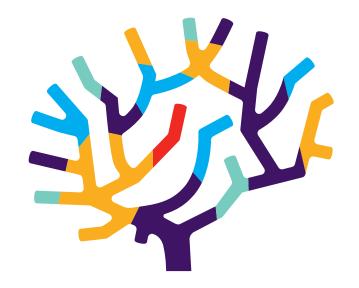# Declaration

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On 8 October 2019, Ministers and high-level representatives from countries and international organizations convened in Amsterdam to address the importance of addressing the mental health and psychosocial support needs of people affected by emergency situations and protracted crises.

High-level participants recall, amongst others, the right to the highest attainable standard of health as part of the *Universal Declaration of Human Rights* of 1948; the *Convention on the Rights of Persons with Disabilities (CRPD)*, which was opened for signature in 2007, and the World Health Organization's *Mental Health Action Plan 2013-2030*, and the inclusion of mental health and well-being in the *Sustainable Development Goals*.

They further recall the Global Ministerial Mental Health Summit of 9 and 10 October 2018 in London and the *Global Declaration on Achieving Equality for Mental Health in the 21st Century*, that was adopted during that Summit. The Declaration underlined the right for everyone to enjoy the highest standard of physical and mental health. The Declaration also marked the commencement of a series of annual Global Ministerial Summits on mental health of which the Amsterdam Conference was the second.

Participants in the Amsterdam Conference stress that armed conflicts, natural disasters and other emergencies take an immense toll on people's mental health and psychosocial wellbeing. It is impossible to quantify the full range of emotional, behavioral and psychosocial impacts of such situations on girls, boys, women and men, across the life course. Nevertheless, best estimates suggest that these experiences more than double the prevalence of depression, anxiety, and other mental health conditions that impair daily functioning.

People with pre-existing mental health conditions and psychosocial disabilities are disproportionately affected in situations of risk and humanitarian emergencies, often experiencing exclusion, human rights violations and facing immense barriers in accessing protection, appropriate care and life-saving interventions. These barriers include physical, attitudinal, cultural, social, structural and financial barriers. They might also be at higher risk for separation from caregivers or family members, as well as targeted violence, exploitation and abuse, including sexual and gender-based violence.

Participants express their strong concern that the vast majority of people in need of adequate mental health and psychosocial support affected by humanitarian crises do not have access to evidence based, quality and human rights based services. Participants note that mental health and psychosocial needs have thus far had low priority on humanitarian agendas at national and international levels and recognized the urgency of addressing these needs in humanitarian action.

Mental health and psychosocial support is essential to restore people's day-to-day functioning on all levels, to help those affected access life-saving services, to support resilience after an emergency and to rebuild peaceful societies. Participants stress that mental health and psychosocial support needs to be given adequate attention in all sectors of humanitarian response with the aim of individual and collective recovery. Affected persons and communities should be enabled to participate in the development and delivery of services for their benefit.

Participants recognize the importance of focusing on wellbeing and reducing stress in order to support peoples' own coping mechanism and resilience. Given the protracted nature of many crises, participants also recognize the need for longer-term MHPSS-approaches, and the importance of development cooperation in this context. The Inter-Agency Standing Committee *Guidelines on Mental Health and Psychosocial Support in Emergency Situations* (2007) as well as the WHO Mental Health Gap Action Plan give guidance on what kind of supports should be made available. Special attention should be paid to peoplewho are vulnerable to violations of their basic human rights in crisis situations.

Participants agree to integrate and seek opportunities to further scale up mental health and psychosocial support in humanitarian responses and recognize the need for evidence and innovation to accelerate responses at all levels of support.

Participants welcome the important work by the Technical Working Groups, consisting of humanitarians, policy makers in international organizations, researchers and scholars, mental health and psychosocial support experts, including people with lived experience. They welcome the recommendations prepared in these documents, as summarized in Annex 1. Participants agree to collectively assess progress on the recommendations by the Technical Working Groups at the next conference.

Participants agree to continue to look for opportunities to draw attention to the mental health and psychosocial needs of people affected by emergencies and, wherever feasible, add these needs to the humanitarian agenda at the national and international level.

Annex 1 – Recommendations from the Technical Working Groups

Scaling up of MHPSS during and after emergencies

1. Support individuals, families and communities across a continuum of care involving complementary psychosocial and mental health supports.
2. Implement mental health and psychosocial support (MHPSS) in crisis situations with a long-term programme vision and capacity building approach, as well as integrate such support into national response systems and plans, and across sectors.

Mobilizing and supporting displaced and host populations within communities

3. Address and assess the mental health and psychosocial support needs of displaced and host communities in humanitarian crises in an inclusive, comprehensive and sustainable way.
4. Facilitate and encourage community-based MHPSS in which local actors, including displaced people and members of host communities, are enabled to build their resources and competencies to support the wellbeing of all crisis-affected people.

A just and inclusive society: supporting societal shifts, addressing stigma and discrimination

5. Promote wellbeing and recovery during and after emergencies by shifting to a greater focus on the things that promote mental wellbeing (like security, justice and strong communities), and addressing risk factors for mental ill health (like poverty, unemployment and exposure to violence). Policies and practices to do this must ensure that all groups are equally able to meaningfully participate and access response and recovery activities.
6. Strengthen the voice and representation of people with disabilities and other excluded groups so that MHPSS programming addresses their particular needs.

A just and inclusive society: Addressing Sexual Gender-based Violence

7. Ensure that mental health and psychosocial support is integrated into health and community services, not only for victims/survivors of sexual and gender-based violence, but also wider community services.
8. Ensure provision of mental health and psychosocial support for female and male victims/survivors of GBV and ensure that these take into account gender vulnerabilities.

Children, Adolescents and their families

9. Ensure that funding is targeted to MHPSS programmes that incorporate the broader social environment of children, including a focus on care providers, families, schools, community structures, resources, and the local context and environment. Special attention should go to promoting family-centered care that benefits the mental health of parents: focused and tailored MHPSS should be provided to parents/caregivers, particularly mothers, in humanitarian settings that are dealing with an overwhelming amount of additional stress factors, such as having to care for a child under extreme duress and in highly resource-limited settings.
10. Provide multi-year funding that includes evidence-informed capacity development for carers, which includes self-care/staff care mechanisms for carers (including parents, other primary caregivers, teachers and others).
11. Use human-centered design approaches: Children and adolescents, caregivers and community members should be effectively and meaningfully engaged in the design and delivery of MHPSS programmes within their contexts to meet their unique needs
12. Acknowledge and emphasize early detection and prevention of MHPSS problems occurring in childhood.
13. Ensure dedicated proportion of health, education and protection/social services budgets to focus on MHPSS for children of different ages and development stages – with tailored promotion, prevention, treatment approaches from pregnancy to infancy and through to adolescence.
14. Prioritize funding to multi-sectoral programming initiatives, ensuring mainstreaming and integration within health, education and protection/social services in particular. Child protection and education services should increasingly be used as entry-points for non-

specialised MHPSS services for children and adolescents by orienting duty bearers on how to integrate MHPSS into their action plans.

15. Ensure that all relevant sectors include MHPSS considerations and commonly agreed indicators in their sectoral plans, programming and routine monitoring.
16. Scale-up response strategies combined with a focus on quality of care, by ensuring that the workforce is properly trained and supervised in delivery of evidence-informed approaches and integrated within structures to better reach children, adolescents and families, including through health, education, protection and social services.
17. Adhere to an evidence-based approach when working on MHPSS for children and adolescents.
18. Focus on establishing and translating evidence based MHPSS interventions for children and adolescents. This includes strategies to overcome barriers to care and support, and strategies towards maintaining quality care at scale.
19. Base MHPSS programs on up-to-date information on the vulnerability and resilience of different groups of children, adolescents and their carers for a better understanding of their unique needs for MHPSS and other services.
20. Ensure that MHPSS programmes utilize the most effective delivery platforms for children, adolescents and families within communities (e.g. to reach children and adolescents both in and out of school).

Research and innovation: Adapting to the future of mental health

21. Where positive effects of MHPSS programs have been identified, implement these programs and conduct research to improve their design and delivery.
22. The development of new interventions for humanitarian settings should consider their implementation in settings of highly constrained resources and damaged health systems.
23. MHPSS program design, implementation, and evaluation should be supported by strong relationships between MHPSS practitioners, research scholars, and decision and policy makers working in humanitarian support.

Workforce development

24. Ensure a competent MHPSS workforce to deliver quality MHPSS services across the humanitarian development nexus by working with and building local capacity; assuring competency-based training with supervision; and financially supporting the immediate and long term MHPSS workforce needs of programmes.

Protection and Promotion of Mental health and Wellbeing of Staff and Volunteers in the Face of Trauma, Hostile Environments and Chronic Stress

25. Apply systemic approaches that address both routine sources of stress and unexpected stressful situations, while not interfering with the natural recovery processes that most staff and volunteers will experience.
26. Equip staff and volunteers with the necessary skills to cope with stressful situations and encourage them to take responsibility towards their own wellbeing and the wellbeing of others.
27. Ensure that a mental health professional contacts all surviving staff/volunteers one to three months following a critical incident. The professional should assess how the survivor is feeling and functioning and make referrals for clinical treatment for those with substantial mental health issues, such depression or alcohol use that are not improving over time.
28. Ensure that policy makers and donors play a vital and active role in minimizing and addressing the barriers and thus in supporting more efficient, sustainable and higher-quality programmes for staff and volunteers. This role can actively be played out through: 1) advocacy for the inclusion of staff and volunteer mental health and wellbeing programs and initiatives; 2) establishment of funding preconditions that require the inclusion of budget lines and/or activities in projects and programs that promote staff and volunteer mental health and wellbeing; and 3) support for quality research into the effectiveness of these initiatives and interventions. Published research is urgently needed to support both activities on the ground and to promote wider advocacy efforts to raise awareness and put this on the agenda for managers, organisations, stakeholders, and other donors and policy makers.

Investment in mental health: increase funding for immediate and longer-term needs

29. Place MHPSS financing on a more secure foundation via a) resource needs estimation and budgetary planning (e.g. as developed for a Minimum Initial Service Package) by those participating in a MHPSS response; b) return on investment analyses to better establish and monitor funding requirements plus returns over time; c) longer or extended funding duration (using both humanitarian and development sources); d) alignment of proposals with cluster-level needs overviews and response planning as well as existing guidelines (e.g. IASC) and international human rights norms and standards; and e) coordination with MHPSS national coordination mechanisms and alignment with national plans where available.

30. Dedicate funding and include budget code tracking for MHPSS within large budget requests in a) humanitarian response plans and needs overviews; b) central emergency response funding requests; and c) budgets of operational agencies and organisations (e.g. UN agencies).

31. Consider making use of existing trust funds that could be directed towards mental health; and develop for discussion terms of reference for a new trust fund and /or matched funding initiatives to encourage greater government and nongovernmental (non-profit) funding.

Delivering MHPSS in Public Health emergencies: Specific Needs & Requirements

32. Sustain rosters that identify specialized MHPSS personnel in public health emergencies, able to deploy at short notice, with relevant technical, language and cultural competence.

33. Provide funding for the development of MHPSS programmes that contribute to the prevention, detection and response to the disease, as well as stigma reduction during and after the outbreak.

34. Ensure adequate ongoing psychological support for international and national responders (including pre- and post-tour/outbreak).

35. Ensure that bilateral and multilateral donors support countries in integrating MHPSS into the National Emergency Preparedness Plans, as the importance of interventions are often only realized after the crisis; and to promote greater collaboration among agencies responding to the crisis in planning, resources and information sharing.

36. Work with national or local governments to: manage stigma reduction from the outset; collaborate in the design and delivery of MPHSS interventions; ensure a whole of government approach to the long-term needs of all affected individuals and communities including long-term mental health impacts and the re-integration of survivors into the community.

37. As the emergency begins to wane, have in place recovery strategies that encompass "building back better" mental health services, because the mental health consequences of public health emergencies are long-term.