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Mental Health in UN Peace Operations: Addressing Stress, Trauma, and PTSD among Field Personnel

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Cover Photo: UN peacekeeper guarding the temporary operating base of the UN Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) in Mpati, North Kivu, 2012. Alexis Guidotti.

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ABBREVIATIONS

CAR	Central African Republic
CISMU	Critical Incident Stress Management Unit
DOS	UN Department of Operational Support
DRC	Democratic Republic of the Congo
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
OCHA	UN Office for the Coordination of Humanitarian Affairs
OIOS	UN Office of Internal Oversight Services
PTSD	Post-traumatic stress disorder
R&R	Rest and recuperation
SSAFE	Safe and Secure Approaches in Field Environments
TCC	Troop-contributing country
UNAMI	UN Assistance Mission in Iraq
UNDP	UN Development Programme
UNDSS	UN Department of Safety and Security
UNHCR	UN Refugee Agency
UNSMS	UN Security Management System
WHO	World Health Organization

Executive Summary

The challenging environments where many contemporary UN peace operations are deployed can take a toll on the mental health of both uniformed and civilian personnel. There is increasing evidence that rates of post-traumatic stress disorder (PTSD) and other mental health issues are higher among people who have deployed to UN peace operations than in the general population. This has serious consequences both for the performance, reputation, and finances of the UN and, more importantly, for the health and well-being of UN field personnel.

Three main stressors contribute to the high rates of mental health issues among UN field personnel. First, the environment where peacekeepers operate can be a source of stress, both in terms of the security risks they face and in terms of their living conditions. A second source of stress is the nature of peacekeepers' work, including their difficult mandates, restrictions on what they can do, and their multidimensional working arrangements. Finally, the UN's bureaucracy, including its rules and regulations, managerial culture, and human resources system, is one of the most acute stress factors.

Despite the prevalence of mental health issues, most UN staff have not received mental health support. There are several reasons for this. Mental health remains a sensitive topic, with persistent stigmas, cultural approaches that vary from country to country, and an institutional culture that has made "fitness for hardship" a core requirement for the job. The division of responsibilities for mental health support between the UN Secretariat, troop- and police-contributing countries, and individual staff members also remains subject to debate. Moreover, while the UN put in place a Mental Health and Well-Being Strategy in 2018, this strategy has been challenging to implement.

While the UN has established processes and structures to address mental health before, during, and after deployment, major gaps remain. Pre-deployment selection and training processes include only cursory elements to prevent and raise awareness of mental health issues and to help personnel manage stress. The architecture for psychosocial support in the field is inconsistent and fragmented, with three Secretariat departments all working on mental health and two separate counselling services. Post-deployment, when many long-term mental health issues manifest themselves, the UN provides few mental health resources to personnel.

To address these gaps, the UN system and UN member states urgently need to prioritize their duty of care to the troops, police officers, and civilians ready to live in dangerous, isolated duty stations with limited resources. To do so, they should consider taking the following steps:

- **Raising the profile of mental health in UN peace operations:** The Secretariat and member states should shed light on the difficult conditions facing peacekeeping personnel and better assess the prevalence of mental health issues among staff; strive to reduce the stigma associated with mental health; and come to a clear understanding of their roles and responsibilities in supporting mental health needs.
- **Providing more pre-deployment support**: There is a need to train and sensitize personnel on how to recognize mental health issues, symptoms, and coping mechanisms. Preparedness and pre-deployment training on PTSD, trauma, and mental health should be based on minimum standards so that all contingents are equally prepared and equipped.
- **Strengthening support during deployment**: Both the Secretariat and member states should uphold their duty of care for personnel in missions, including by fostering a culture of care, offering adequate psychosocial support, and improving human resources arrangements.
- **Continuing to provide support post-deployment:** The UN and member states should recognize that their duty of care does not end after field personnel return from deployment. They should continue following up with former personnel to ensure they are receiving the psychosocial support they need through dedicated structures and resources.

Introduction

Many contemporary UN peace operations are deployed in extremely challenging and non-permissive environments. Going far beyond traditional peacekeeping, where UN military observers were monitoring cease-fires and peace agreements in relatively peaceful conditions, the Security Council has pushed UN missions to new frontiers, deploying troops, police, and civilians to conflict zones where there is little peace to keep. In the Central African Republic, Iraq, Libya, Mali, and South Sudan, UN personnel operate in hostile theaters where they confront violent extremism, attacks by armed rebel groups, or threats from the host state itself. In addition to facing these hazardous conditions, most peacekeeping missions also have complex, ambitious mandates. They are often mandated to protect civilians from physical violence, requiring them to face and respond to mass atrocities, war crimes, and crimes against humanity with limited means.

> While the UN cannot change the fact that the environments where peace operations deploy are stressful, it can work to improve the mental health of its personnel.

These daily challenges can take a toll on the morale of both uniformed and civilian personnel. In this context, questions around mental health in peace operations, including the prevalence of stress and anxiety disorders, trauma, and post-traumatic stress disorder (PTSD) among UN staff, are receiving increased attention. In a comprehensive UN survey on mental health in 2015 and 2016, 18 percent of respondents were flagged for generalized anxiety disorder, 22 percent for major depressive disorder, 23 percent for hazardous drinking, and 20 percent for PTSD—rates much higher than the general population. Overall, 49 percent of respondents screened positive for at least one mental health issue, with those who had worked at the UN the longest more likely to experience poor mental health.[1]

The UN system cannot change the fact that the environments where peace operations deploy are stressful and emotionally straining or that witnessing the effects of war and atrocities can impact the mental health of any individual. Nonetheless, the UN can work to improve the mental health of its personnel and has taken important steps in this direction. The secretary-general has been vocal in promoting mental health, and the UN Mental Health and Well-Being Strategy, launched in October 2018, has elevated the issue to a strategic priority for all UN entities. The UN has developed action plans to reduce stigma related to mental health and change the organizational culture to create more supportive and caring environments and has developed guidelines to inform UN staff about mental health challenges. The COVID-19 pandemic has brought even more attention to mental health.

Two years after the issuance of the UN strategy, however, much remains to be done to improve mental health in missions. Counseling capacities remain limited, human resources rules and procedures are not always tailored to the needs of individuals in the field, and efforts to uphold the UN's duty of care have yet to trickle down to all levels of management.

This paper looks at the prevalence of PTSD, stress disorders, and other mental health issues among the military, police, and civilian personnel of UN peace operations. It analyzes the types of stressors and psychological factors affecting personnel in the field, explores the political and institutional challenges to instilling change, and reviews the UN's response to the mental healthcare needs of peace operations personnel. It concludes with recommendations for the UN to ensure its duty of care for field personnel. This study aims at increasing understanding and consideration of mental health needs in peace operations and informing the human resources reform announced by Secretary-General António Guterres, who identified staff morale and welfare as crucial areas of concern.[2] It follows previous IPI research on the human resources system for UN peace operations

1 UN General Assembly, *Overview of Human Resources Management Reform: Towards a Global, Dynamic, Adaptable and Engaged Workforce for the United Nations—Report of the Secretary-General*, UN Doc. A/71/323, August 23, 2016.

2 United Nations, "A Healthy Workforce for a Better World: United Nations System Mental Health and Well-Being Strategy," 2018.

and the challenges of medical support in the field.[3]

Prevalence of Mental Health Issues

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her own community."[4] The UN has also established that mental health is a "positive concept related to the social and emotional wellbeing of people and communities."[5]

There is a widespread misperception that only certain "fragile" individuals are prone to mental health conditions. In reality, as with physical health, there is a full spectrum of conditions. The Canadian armed forces describe a "mental health continuum," from healthy to "reacting," "injured," and "ill" (see Table 1).[6] Every individual experiences varying levels of mental health throughout their life, and mental health is therefore a concern for all.

Mental illness is diagnosed according to strict criteria, depending on the severity and other factors.There is a wide range of mental health conditions and illnesses, whose categorization and analysis are beyond the scope of this paper. The UN has issued guidance on the main mental health conditions that can manifest themselves among field staff and often focuses on stress, anxiety, and depressive disorders (see Box 1).

Data on the Mental Health of UN Staff

Until recently, the UN Secretariat had not collected comprehensive data on the mental health of UN staff. This changed when the UN, in cooperation with medical researchers, conducted a historic survey on staff well-being and mental health in 2015 and 2016 and issued a public report with comprehensive statistics in 2017. The survey had 17,363 respondents from eleven UN entities, as well

Box 1. Stress disorders

The UN medical manual details four types of stress reactions:[7]

- **Basic stress** is "minor stress encountered in daily situations that produces tension, frustration, anger and irritation. This is largely determined by an individual's physical and psychological attributes and can generally be overcome. However, if allowed to accumulate, it can escalate beyond the point where it can be controlled, affecting the individual's disposition and work."
- **Cumulative stress** "results from the accumulation of stress that occurs too often, lasts too long or becomes too severe, with the result that the individual is no longer able to cope with it. This leads to depression, work-related problems, and relationship problems with colleagues."
- **Traumatic stress** relates to "a traumatic experience in which an individual is exposed to a single, sudden and violent physical or psychological assault, in which there is threat or harm to himself/herself or to another individual."
- **Post-traumatic stress disorder** "refers to the persistence of symptoms arising from an episode of traumatic stress (analogy of a wound that does not heal), which continues to disturb the individual and prevents him from returning to a normal lifestyle."

3 See: Namie Di Razza, "People before Process: Humanizing the HR System for UN Peace Operations," International Peace Institute, October 2017; Lesley Connolly and Håvard Johansen, "Medical Support for UN Peace Operations in High-Risk Environments," International Peace Institute, April 2017.

4 World Health Organization (WHO), "Mental Health: Strengthening Our Response," March 2018, available at https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response#:~:text=Mental%20health%20is%20a%20state,to%20his%20or%20her%20community .

5 United Nations, "Understanding Mental Health," available at https://www.un.org/en/healthy-workforce/files/Understanding%20Mental%20Health.pdf .

6 Canadian National Defence, "Surgeon General's Mental Health Strategy—Canadian Forces Health Services Group: An Evolution of Excellence," 2017.

7 For a discussion on stress, see: George Fink, "Stress: Definition and History," in *Stress Science: Neuroendocrinology*, George Fink, ed. (San Diego: Elsevier, 2010).

Table 1. Mental health continuum[8]

	Healthy	Reacting	Injured	Ill
Mood	• Normal mood fluctuations • Good sense of humor	• Irritable/impatient • Nervous • Sad/overwhelmed • Displaced sarcasm	• Anger • Anxiety • Pervasively sad/ hopeless	• Angry outbursts/ aggression • Excessive anxiety/panic attack
Performance	• Performing well • In control mentally	• Procratination • Forgetfulness	• Negative attitude • Poor performance/ workaholic • Poor concentration/ decisions	• Depressed/ suicidal thoughts • Overt insubordination • Can't perform duties, control behaviour or concentrate
Sleep Pattern	• Normal sleep patterns	• Trouble sleeping • Intrusive thoughts • Nightmares	• Restless disturbed sleep • Recurrent images/ nightmares	• Can't fall asleep or stay asleep • Sleeping too much or too little
Physical Health	• Physically well • Good energy level	• Muscle tension, headaches • Low energy	• Increased aches and pains • Increased fatigue	• Physical illnesses • Constant fatigue
Physical and Social Activity	• Physically and socially active	• Decreased activity/ socializing	• Avoidance • Withdrawal	• Not going out or answering the phone
Addictions	• No/limited alcohol use/ deviant behaviors	• Regular but controlled alcohol use	• Increased alcohol use/hard to control negative consequences	• Frequent alcohol use/addictions/ deviant behaviors, inability to control severe consequences

8 Adapted from: Canadian National Defence, "Surgeon General's Mental Health Strategy."

as several UN peace operations, representing 17.7 percent of all UN personnel.[9]

The results of the study are stunning. Approximately half of respondents reported symptoms consistent with a mental health condition, a figure significantly higher than for the general population. Forty-nine percent of respondents screened positive for at least one mental health issue, and 22 percent screened positive for two or more. Around 18 percent of respondents were flagged for generalized anxiety disorder, 23 percent for major depressive disorder, 20 percent for PTSD, and 23 percent for hazardous drinking.[10] There was a strong association between poor mental health and the number of years working for the UN, low job satisfaction, and perceived incivility and conflict in the workplace.[11] More women and younger staff flagged positive for mental health issues: for male staff, the risk of mental health issues was 1.2 times lower than for female staff, and for staff who were fifty years old and above, the risk was 1.8 times lower than for staff younger than thirty-five.[12]

> In a UN survey on mental health in 2015 and 2016, 20 percent of respondents flagged positive for PTSD—a rate much higher than the general population.

Interestingly, UN staff at headquarters and offices outside peace operations also experience a variety of mental health issues. There was no significant discrepancy between staff in family and non-family duty stations for generalized anxiety disorder and PTSD. However, staff in family duty stations flagged more often for major depressive disorder and hazardous drinking, suggesting that these conditions may be more related to organizational and management issues than hardship. That said, trauma exposure increased the risk of having multiple mental health issues. Staff who reported not having been exposed to trauma during the previous twelve months had about a two times lower risk of simultaneously screening positive for generalized anxiety disorder, PTSD, and major depressive disorder.

Data on the Mental Health of UN Peacekeepers

As with UN staff in general, the prevalence of mental health issues in UN peace operations has long been neglected, or even ignored.[13] There have been a few quantitative studies in countries that deployed peacekeepers, especially in Australia, Canada, Japan, and the US.[14] All of these studies focused on military peacekeepers, and most of them analyzed the effect of deployment to peacekeeping operations in Rwanda, Bosnia, Somalia, and Timor-Leste in the 1990s and early 2000s.[15]

9 The UN population surveyed included staff from the UN Secretariat (UN headquarters, the Economic Commission for Africa, Economic Commission for Latin America and the Caribbean, Economic and Social Commission for Asia and the Pacific, Economic and Social Commission for Western Asia, UN Office at Geneva, UN Office at Nairobi, and UN Office at Vienna, as well as UN peacekeeping and special political missions and other field locations); the UN Development Programme (UNDP), UNICEF, and UN Population Fund (UNFPA). Almost 20,000 UN staff participated in the survey. United Nations, "Staff Well-Being Survey Data Report," 2017.

10 The prevalence in the general population is 7.3 percent for generalized anxiety disorder, 0.3 percent for PTSD, and 4.7 percent for major depressive disorder. Ibid. As a point of comparison for PTSD, the rate is 19.4 percent among human rights advocates, and one study found that the prevalence of PTSD among US soldiers who had fought in the First Gulf War was about 23 percent. James Rundell and Robert Ursano, "Psychiatric Responses to War Trauma," in *Emotional Aftermath of the Persian Gulf War: Veterans, Families, Communities, and Nations*, Robert Ursano and Ann Norwood, eds. (Washington, DC: American Psychiatric Press, Inc., 1996).

11 The UN survey on mental health found that working longer for the UN on more permanent contracts correlated with higher rates of mental health issues. Respondents on temporary or consultancy contracts were less likely to meet the criteria for generalized anxiety disorder (15 percent) compared with those on permanent or fixed-term contracts (19 percent). Twenty-nine percent of UN staff with PTSD reported trauma exposure during the previous twelve months. Staff who were the most satisfied with their job had a 10.5 times lower risk of simultaneously experiencing symptoms consistent with generalized anxiety disorder, PTSD, and major depressive disorder than those who were not at all satisfied with their job.

12 Fifty percent of women screened for no mental health issues, 28 percent for one, 12 percent for two, 8 percent for three, and 2 percent for all four. Fifty-six percent of men screened positive for none, 25 percent for one, 10 percent for two, 7 percent for three, and 2 percent for four. There was no disparity between men and women for hazardous drinking, but women were more likely to be flagged for PTSD, generalized anxiety disorder, and major depressive disorder.

13 PTSD has mostly been studied in the armed forces, particularly in the US. The wars in Vietnam, Afghanistan, and Iraq have drawn attention to PTSD among military personnel, sensitized the general public on the issue, and pushed many countries to develop psychosocial services for active members of the armed forces and veterans. PTSD has also been studied outside of the military as a mental injury that can affect anybody in the general population who experienced trauma.

14 Brett Litz et al., "Peacekeeping," in *Stress: Concepts, Cognition, Emotion, and Behavior*, George Fink, ed. (San Diego: Elsevier, 2016); Jitender Sareen et al, "Combat and Peacekeeping Operations in Relation to Prevalence of Mental Disorders and Perceived Need for Mental Health Care: Findings from a Large Representative Sample of Military Personnel," *Archives of General Psychiatry* 64, no. 7 (2007); Jun Shigemura et al., "Peacekeepers Deserve More Mental Health Research and Care," *British Journal of Psychiatry* 2, no. 3 (2016); Jun Shigemura and Soichiro Nomura, "Mental Health Issues of Peacekeeping Workers," *Psychiatry and Clinical Neurosciences* 56, no. 5 (2002).

15 Lars Mehlum and Lars Weisæth, "Predictors of Posttraumatic Stress Reactions in Norwegian U.N. Peacekeepers 7 Years after Service," *Journal of Traumatic Stress* 15, no. 1 (2002); Susan M. Orsillo et al., "Psychiatric Symptomatology Associated with Contemporary Peacekeeping: An Examination of Post-Mission Functioning

As a result, there is still a tremendous gap in the data on mental health in peace operations.[16] Notably, the relationship between the psychiatric status of personnel and the characteristics of specific missions has never been studied.[17] When the UN released its mental health survey, it refrained from breaking down the data by UN agency, mission, and duty station and did not single out specific UN peacekeeping operations or special political missions. UN officials and experts who worked on the survey acknowledged that there was little discrepancy among different UN entities.[18] Some interlocutors also recognized that disaggregating data by agency or mission could have touched on political and institutional sensitivities and damaged the reputation of specific entities. As it stands, the survey only distinguishes between personnel from family duty stations and non-family duty stations. Seventy-nine percent of the respondents were staff from family duty stations—a large proportion that may have skewed the results.

While further quantitative and qualitative research by medical and academic teams is needed, the data that does exist, along with the interviews conducted for this study, sheds some light on the types of mental health issues faced by UN uniformed and civilian peacekeeping personnel.

Although they are trained for combat, there is increasing evidence that exposure to traumatic events is associated with mental health disorders among military personnel, including troops deployed to UN peace operations. Lieutenant-General Roméo Dallaire, who commanded the UN operation in Rwanda during the 1994 genocide, was the first famous example of a UN peacekeeping official suffering from PTSD and suicidal behavior after his experience in the mission.[19] A study showed that Australian peacekeepers who served between 1989 and 2002 had "significantly higher 12-month prevalence of PTSD (16.8%), major depressive episode (7%), generalized anxiety disorder (4.7%), alcohol misuse (12%), alcohol dependence (11.3%) and suicidal ideation (10.7%)" compared to the civilian population.[20] A more recent study of Senegalese peacekeepers serving in the African Union–UN Hybrid Operation in Darfur (UNAMID) found that 25.7 percent suffered from PTSD and 19.8 percent from emotional exhaustion.[21]

The unique nature and limitations of peacekeeping can be additional stressors for soldiers trained to wage war, which can lead to even higher prevalence of mental health disorders in peace operations than in national militaries. A 2005 study comparing the prevalence of PTSD between Vietnam veterans and peacekeepers attending PTSD treatment units found that PTSD scores were higher for peacekeepers at intake, especially in terms of reexperiencing symptoms. Anger was also higher among peacekeepers.[22]

UN civilian staff also experience mental injury and illness. Some have spoken out, including at the highest levels. For example, Assistant Secretary-General Fabrizio Hochschild shared his experience with mental illness following his time in Bosnia.[23] A staff counselor from one of the biggest multidimensional missions mentioned that there were "several mental problems in substantive staff," including "harm to self, suicidal ideas, serious

among Peacekeepers in Somalia," *Journal of Traumatic Stress* 11, no. 4 (1998); Shigemura and Nomura, "Mental Health Issues of Peacekeeping Workers"; Siri Thoresen and Lars Mehlum, "Suicide in Peacekeepers: Risk Factors for Suicide versus Accidental Death," *Suicide and Life Threatening Behavior* 36, no. 4 (2006); Albert Wong et al., "Are UN Peacekeepers at Risk for Suicide?" *Suicide and Life-Threatening Behavior* 31, no. 1 (2001). For one of the few longitudinal studies, see: Inge Bramsen et al., "Predeployment Personality Traits and Exposure to Trauma as Predictors of Posttraumatic Stress Symptoms: A Prospective Study of Former Peacekeepers," *American Journal of Psychiatry* 157, no. 7 (2000).

16 Interviews with mental health experts in national armed forces, May–June 2020.

17 Shigemura and Nomura, "Mental Health Issues of Peacekeeping Workers."

18 Interviews with senior officials at UN headquarters, New York, November 2019–January 2020.

19 Roméo Dallaire, *Shake Hands with the Devil: The Failure of Humanity in Rwanda* (Toronto: Random House Canada, 2004).

20 David Forbes et al., "The Long-Term Mental Health Impact of Peacekeeping: Prevalence and Predictors of Psychiatric Disorder," *British Journal of Psychiatry* 2, no. 1 (2016).

21 Jean Augustin Diégane Tine et al., "Étude des facteurs de risque des états de stress post-traumatique (ESPT) chez les casques bleus sénégalais en mission de maintien de la paix au Darfour (Soudan)," *International Journal of Innovation and Applied Studies* 26, no. 2 (2019).

22 David Forbes et al., "Clinical Presentations and Treatment Outcomes of Peacekeeper Veterans with PTSD: Preliminary Findings," *American Journal of Psychiatry* 162, no. 11 (2005).

23 Fabrizio Hochschild, "Address on the Occasion of the Launch of the UN Secretary-General System Workplace Mental Health and Well-Being Strategy," October 16, 2018; "Facing Up to the Extreme Mental Health Pressures of Conflict," UN News, July 2, 2019.

addictions, depression, anxiety, [and] psychotic symptoms."[24]

The mental health of national staff in UN peace operations has been understudied in comparison with international staff. On the UN survey on mental health, around 22 percent of national staff flagged positive for PTSD, compared to 18 percent of international staff. National staff are an integral part of the local population, which has often been exposed to more traumatic experiences and stressors than international staff in conflict and post-conflict zones, including before the deployment of a UN mission. One staff counselor in a peacekeeping mission said that there is "a lot of [inter]generational trauma" among national staff who were raised by parents who suffered from PTSD, as well as "a lot of substance abuse."[25]

One of the main challenges in assessing the prevalence of mental health issues, and PTSD in particular, is timing. Symptoms generally appear months, or even years, after exposure to trauma. "Some who are highly relaxed and capable in the field may have delayed reactions to trauma," according to one mental health expert.[26] One military adviser from a troop-contributing country (TCC) said that there is a ten-year period for PTSD to manifest itself. The UN survey also found that "staff with 5 to 10 years of work experience in the United Nations system had a 2 times higher risk, and those with more than 10 years of experience had a 2.5 times higher risk, than the newest recruits."[27]

Mental health issues, and PTSD in particular, are therefore often "higher in ex-service populations than in currently serving cohorts."[28] This poses a challenge to reporting and follow-up, as former employees or veterans are not counted in the statistics. One representative of a TCC recognized that "there will be people who don't seek treatment for it, so we don't see the whole picture.… Sometimes we see someone commit suicide from a trauma that was experienced ten to twelve years ago."[29]

Individuals acknowledged this delayed effect of deployment on their mental health. One recalled, "I did not know that the depression was ongoing." Another said, "I did not realize I had trauma until I left Haiti, [after] the health insurance… [and] the contract [ran] out." A mental health expert confirmed that "mental health issues are not occurring directly after the mission." By the time they show up, "mental health support is gone."[30] People who "can't take it anymore and leave" are also not included in UN statistics.[31] More research is needed to assess not only current UN staff in peace operations but also retirees and other former staff.

The Impact of Mental Health Issues on the Effectiveness of Peace Operations

Poor mental health among UN personnel creates performance, reputational, and financial risks for the organization. Many interlocutors reported that mental health issues affect the performance of staff, though this is underreported. Individuals who are burned out are likely to be less effective. According to the UN medical manual, "Mental health and psychological well-being are key and integral parts of not only individual health, well-being and quality of life, but also of organizational resilience and productivity."[32] Mental health conditions can also impair cognitive functioning, which can have catastrophic effects on decision making in peace operations.

In addition, mental health issues can lead personnel to adopt negative coping mechanisms and deviant or dangerous behaviors such as

24 Phone interview with UN staff counselor, February 2020.

25 Ibid.

26 Phone interview with mental health expert, May 2020.

27 United Nations, "Staff Well-Being Survey Data Report."

28 David Forbes et al., "Treatment of Military-Related Post-traumatic Stress Disorder: Challenges, Innovations, and the Way Forward, *International Review of Psychiatry* 31, no. 1 (2019).

29 IPI virtual roundtable discussion, July 21, 2020.

30 Phone interview with mental health expert, June 2020.

31 Phone interviews with former UN staff member, January 2020, and former UN officials, April 2020 and January 2020.

32 UN Department of Peacekeeping Operations (DPKO) and Department of Field Support (DFS), "Medical Support for United Nations Missions: Third Edition," 2015.

substance abuse, compulsive sexual behavior, and other addictions. Military officers from major TCCs and staff counselors highlighted alcohol consumption in particular. Some interviewees also referred to workaholism, echoing the testimony of Dallaire, who described his behavior following his experience in Rwanda as "suicide by work": "I blindly worked as it was eating away at my mind and soul, attempting to drown it in an ocean of activity and responsibility."[33]

According to one mental health expert, another symptom and signal that needs to be tracked is "increased recklessness," which can be part of a pattern of self-destructive behavior. This can include performing risky activities that are not necessary and putting oneself in life-threatening situations that can indirectly put the organization at risk.[34] Some also suggested that more research is needed to examine the possible causality between well-being and misconduct, including sexual exploitation and abuse. One interviewee raised concerns that deploying military peacekeepers with poor mental health could lead to dangerous situations.[35] For example, although the board of inquiry reports have not been made public, a few isolated incidents in Mali that involved peacekeepers shooting at protesters, killing fellow soldiers, or defecting seem to have been associated with low morale and high levels of stress and hardship.[36]

The sick leave associated with mental health issues can also have a significant cost for the UN.[37] For many, using sick leave is the only way to take care of their mental health—or the only exit strategy for those who have spent years living and working in a container in a hazardous environment without any prospect of promotion or mobility despite dozens of applications. As one staff member suffering from PTSD put it, "I am now sitting on extended sick leave… as a senior staff. No one replaces me in [the mission], which is costly for the organization."[38] One former staff member recommended analyzing the prevalence and recurrence of sick leave to assess the impact of mental health issues on the effectiveness of the organization.[39]

The secretary-general has recognized these risks and included the "identification of duty of care issues to properly support all UN personnel when accepting the risk to stay and deliver" in the Enterprise Risk Management program's risk treatment plan.[40] The Special Committee on Peacekeeping Operations has also recognized "the importance of welfare and recreation for personnel serving in peacekeeping operations, bearing in mind that welfare and recreation also contribute to the strengthening of morale and discipline." The committee reaffirmed "the important role of troop-contributing and police-contributing countries in providing for the welfare and recreation of contingent personnel" and recommended that "the provision of facilities relating to welfare and recreation should be adequately prioritized during the establishment of peacekeeping missions." It requested "the Secretariat to provide a briefing on welfare and recreation in peacekeeping missions before its next substantive session."[41] However, welfare remains a divisive issue in the committee

> The UN needs to tackle mental health issues not only because doing so will improve its performance but also because it will make it a more humane organization.

33 Roméo Dallaire, *Waiting for First Light: My Ongoing Battle with PTSD* (Toronto: Penguin Random House Canada, 2016).

34 Phone interview with mental health expert, May 2020.

35 Interview with former UN staff member, New York, March 2020.

36 On the peacekeepers' shooting at protesters, see: Louis Charbonneau and Michelle Nichols, "Video Shows Rwandan Peacekeepers Shooting Protests in Mali," Reuters, May 5, 2015. On the peacekeeper who killed his commander, see: "Chadian UN Peacekeeper Held for Killing Own Commander," BBC, February 26, 2016. On the peacekeepers who left their position in Amachach due to low morale among troops living in difficult conditions, see: "Au Mali, près de 160 soldats tchadiens désertent leur position à Tessalit," Radio France Internationale, September 18, 2013.

37 The UN Secretariat does not have a mobility system in place to enable staff to rotate between duty stations. For an analysis of the structural issues of the human resources system at the UN, see: Di Razza, "People before Process."

38 Email communication with former senior peacekeeping mission staff member, May 2018.

39 Although there is no publicly available data on sick leave, data on three UN entities from the electronic medical records and occupational health management system, EarthMed, indicated that the total number of days lost for sick leave over the four-year period 2011–2016 was 550,033. Sick leave related to mental health diagnoses made up 14 percent of the total days lost per year, making mental health diagnoses the second biggest contributor to lost days.

40 UN General Assembly, *Fifth Progress Report on the Accountability System in the United Nations Secretariat: Strengthening Accountability under the New Management Paradigm—Report of the Secretary-General*, UN Doc. A/70/668, December 30, 2015.

41 UN General Assembly, *Report of the Special Committee on Peacekeeping Operations: 2018 Substantive Session*, UN Doc. A/72/19, 2018.

and has spilled over into negotiations on contingent-owned equipment, given that improving welfare would require additional resources.

However, seeing mental health from the perspective of performance and capability, as opposed to health and well-being, can be problematic and misleading.[42] This is often the way the issue is presented by armed forces that are eager to promote mental health to build a stronger, fitter, more resilient military. Strictly focusing on the financial cost of mental health issues and their impact on performance could lead to inappropriate, rules-based measures that limit the rights of UN staff. The UN needs to tackle mental health issues not only because doing so will improve its performance but also because it will make it a more humane organization. For an organization that is grounded in human rights and presents itself as "people-centered," any initiative, reform, or measure it adopts should be in line with duty-of-care principles.

Factors and Conditions Contributing to Mental Health Issues

There are several layers of job-specific factors that can impact one's mental health. For a soldier, for example, "occupational" stress can arise from the military culture, including the rigid hierarchy and the "sense of your own individuality tak[ing] a backseat."[43] Deployment can add duty-related stressors such as being away from home, family, and support structures. Deployment as a peacekeeper can also add UN-specific stressors due to the unique character of peacekeeping. Dealing with challenging, sometimes life-threatening crises adds another layer of stressors. This paper considers three categories of stressors that can impact mental health in peace operations:

1. The hardship environment, including changing and unpredictable levels of insecurity, attacks on UN staff, and harsh living conditions;
2. The nature of the roles and responsibilities of UN staff, particularly for those exposed to high levels of stress and traumatic events; and
3. The organizational culture with its rules, regulations, and support systems and processes that have often failed to properly protect staff well-being.

Each peace operation, and each team within a peace operation, poses a unique set of challenges for staff. Levels of risks and insecurity, the quality of infrastructure, the availability of staple supplies, and health hazards vary from one UN base to another. Even within the same base, accommodations and welfare can vary among contingents.[44] Stressors can also vary over time within each theater of operations. Moreover, "what is considered a stressor for one individual may not be a stressor for another one."[45]

Hardship Environments

The environment where peacekeepers operate can be a source of stress, both in terms of the security risks they face and in terms of their living conditions.

Security Risks and Hostile Contexts

UN peacekeeping operations are increasingly deployed to challenging and non-permissive environments where active conflicts are ongoing and where the UN flag does not necessarily protect them from attacks.[46] Missions that are facing violent extremist groups or that have become active parties to the conflict have been particularly targeted or subject to collateral damage.[47] Some special political missions deployed without uniformed components are also operating in hardship and active conflict zones, including in Afghanistan, Iraq, Libya, and Somalia.[48] These

42 Phone interview with mental health expert, May 2020.

43 IPI virtual roundtable discussion, July 21, 2020.

44 Communication with former senior military officer, November 2020.

45 Phone interview with mental health expert, May 2020.

46 As of December 2020, UN peace operations had suffered 126 fatalities due to malicious acts since 2017, accounting for 27 percent of all fatalities. UN Peacekeeping, "Fatalities," available at https://peacekeeping.un.org/en/fatalities .

47 Arthur Boutellis and Naureen Chowdhury Fink, "Waging Peace: UN Peace Operations Confronting Terrorism and Violent Extremism," International Peace Institute, October 2016.

48 In 2014, almost 90 percent of special political missions were deployed to countries experiencing high-intensity conflict. Sebastian von Einsiedel, "Major Recent Trends in Violent Conflict," UN University, November 2014.

missions, which mostly rely on diplomacy, good offices, monitoring, and reporting activities, have limited capacity to protect themselves.

These environments are characterized by different types of security risks and hostile actors. Armed groups have targeted UN mission staff in Afghanistan, the Central African Republic (CAR), the Democratic Republic of the Congo (DRC), Iraq, Libya, Mali, South Sudan, and Sudan. In CAR, Haiti, and some areas of the DRC, the local population has stoned or burned UN vehicles, compounds, and houses. In South Sudan and Sudan, UN staff, particularly national staff, have been threatened by host-state actors. Several high-profile attacks on the UN—in Baghdad in 2003, Algiers in 2007, Garowe in 2015, Kabul in 2019, and northern Mali on several occasions—have been particularly traumatic for UN personnel.[49] Beyond these attacks, criminality, gunshots, and spontaneous riots are daily features of mission life in many areas. Natural disasters can also take a toll on staff morale, including in Haiti, where many UN staff were killed by the 2010 earthquake. Exposure to death, in particular, is a major stressor.

Attacks, criminality, gunshots, spontaneous riots, and natural disasters can all take a toll on staff morale.

Many interlocutors indicated that this high-adrenaline work environment can make it difficult to retain some civilian staff while being a source of attraction for others. One mental health expert explained that although deploying to peace operations can be a positive coping mechanism and foster personal development, the constant search for adrenaline can also be a sign that someone is attempting to suppress mental health issues.[50] One interviewee highlighted that many people get "addicted" to the field and are "staying for the wrong reasons."[51]

Another stressor is the inability of staff to feel safe or to feel that they can defend themselves. A mental health expert confirmed that "the capacity to defend oneself plays a huge role in mental health."[52] This can be especially stressful for unarmed staff like military observers or police or for those who rely on private security companies or national forces for their compound's security.[53] National staff can also feel particularly vulnerable, as they do not have the option to leave or be evacuated and often receive a lower standard of care.

In many environments where peace operations are deployed, security protocols reduce the potential for interactions with the local population. Many peacekeepers "have virtually no relation with the community."[54] This tends to fuel a siege mentality and to deprive staff of healthy coping mechanisms such as interacting with others or feeling part of the community.[55] According to one former senior mission leader, in places like CAR, for example, the mission tends to depict the country and its population as threatening: "Every Central African was seen as the enemy. You are brainwashed into the idea [of a threatening host country]."[56]

Living Conditions

Beyond the hostile environment, living conditions that are challenging—or "primitive," as the UN itself has called them—can "conspire to create a stressful environment."[57] Peacekeepers often face unfamiliar endemic diseases, substandard sanitation, limited amenities, and scarce recreational facilities.[58] As one staff counselor described, "It

49 See, for example, the testimonies of UN staff who were in Baghdad: "Survivors Recall Terror Attack on UN's Baghdad Headquarters," UN News, August 14, 2009.

50 As one mental health expert said, "It is common to seek that high again, because they have lived it and survived it; although it wasn't enjoyable, it was extreme and it was addictive. In response, some take on more missions.… They are operationally keen… but in some cases they are being psychologically pulled, too." Phone interview, June 2020. See also: Nolan Peterson, *Why Soldiers Miss War: The Journey Home* (Havertown, PA: Casemate Publishers, 2019).

51 Interview with former senior UN staff member, New York, February 2020.

52 Phone interview with mental health expert, May 2020.

53 For an analysis of safety and security in UN peace operations, see: Haidi Willmot, Scott Sheeran, and Lisa Sharland, "Safety and Security Challenges in UN Peace Operations," International Peace Institute, July 2015.

54 Interview with senior UN official, New York, February 2020.

55 Phone interview with mental health expert, May 2020.

56 Interview with senior UN official, New York, February 2020.

57 United Nations, *Training Materials on Negotiation, Planning, Deployment, Sustainment of National Contingents for Senior National Planners of Troop and Police Contributing Countries to United Nations Peacekeeping Operations*, April 2019 Draft Version.

58 See: United Nations, "UN Global Staff Survey 2017: Summary Results," 2017.

takes a lot of effort [for people in missions] to remain healthy."[59] Such conditions can impact staff well-being, make it harder to attract or retain staff, and decrease motivation, morale, and efficiency.

Depending on the duty station, some civilians also live in militarized environments. This can mean living in heavily guarded compounds with limited mobility or engagement with outside communities, as discussed above. It can also mean sleeping in a container or a tent in a small military camp for months on end. This can be particularly challenging for women for logistical and social reasons. Several female staff mentioned the added stress of living in militarized, masculine, macho environments without separate bathrooms, proper medical care, or security arrangements that met their needs.[60] According to one former staff member, being "the only civilian and woman" in a mission's military base was challenging.[61] One staff counselor acknowledged that "toxic masculinity" extended beyond military bases to missions at large.[62]

The isolation of staff can be another factor impacting mental health. Most peacekeepers are deployed to areas designated as non-family, bringing them far away from their family and social support networks with limited means of communication. One former UN staff member described the organization as "being in the business of breaking up relationships."[63] A staff counselor highlighted the discrepancies that can become apparent between staff members and their family back home, sometimes resulting in attachment disorders.[64] The "transient lifestyle" of field personnel can also make it hard for them to maintain support networks.

While most uniformed personnel are deployed as part of units, military observers, individual police officers, and civilian staff are deployed individually. A military officer who served in several capacities in peace operations mentioned that "being part of the… contingent made everything easier, as [you are] with colleagues. But… as a military observer you are by yourself and don't have the same communication capabilities and support systems."[65]

As several mental health experts highlighted, being isolated in hostile environments with limitations on movement can be detrimental to mental health. For those deployed to remote areas, UN flights are the only way in and out, and they are dependent on weather and security conditions. Even in urban areas, transport issues were described as "huge." As one interviewee stated, "Just to get around is a challenge. People are stuck, and it is a big factor of stress.… We had massive meltdowns about sharing cars."[66] Being stuck in compounds in places like Colombia, Darfur, or Somalia can also be a stressor. "I was basically kidnapped by my own organization to work in [a] hotel," said a staff member of one UN mission.[67] The fact that UN staff are often prohibited from using local transportation for security reasons adds to the challenge.[68]

In crisis situations, even having access to basic resources like water and food was mentioned as a stressor. When violence erupted in Malakal, South Sudan, for example, many staff had to rely on their own stock of food for weeks.[69] As the mission opened its gates to shelter and protect thousands of civilians, the conditions for UN staff living in these compounds also deteriorated, and many were concerned about safety and security and the sharing of limited resources and space.

59 Phone interview with UN staff counselor, February 2020.

60 On taboos and stigmas affecting women peacekeepers, see: Lotte Vermeij, "Woman First, Soldier Second: Taboos and Stigmas Facing Military Women in UN Peace Operations," International Peace Institute, October 2020.

61 Phone interview with former UN staff member, June 2020.

62 Phone interview with UN staff counselor, February 2020.

63 Interview with former UN staff member, New York, January 2020.

64 Phone interview with UN staff counselor, February 2020.

65 IPI virtual roundtable discussion, New York, July 21, 2020.

66 Interview with former UN staff member, New York, March 2020.

67 Phone interview with special political mission staff member, April 2020.

68 See the question-and-answer session in the UN webinar, "What Is the UN Doing for Mental Health?" February 4, 2020, available at https://www.youtube.com/watch?v=n6vioGhbxlc&feature=youtu.be .

69 Phone interview with former UN staff member, June 2020.

The lack of work/life balance also affects mental health. Field personnel are often expected to work every day of the week and to remain alert and available anytime of the day in crisis situations. Many acknowledged being overworked. "In peacekeeping, the mission is your life," as one former staff member put it. "You are part of this institutional structure, which decides and dictates where you are going to live, what food you are going to get, your entire life."[70] A mental health expert explained that people are often "stuck in a compound with people from other places and don't necessarily like each other."[71] Having to live and share so much with strangers, with "a lot of forced intimacy," can be a challenge for mental health.[72] Former civilian staff highlighted the difference between military and civilian components in this regard. One of them mentioned that military units "don't have to worry about how to get home, where to live, who to befriend. There is this instant sense of camaraderie [in the military]."[73]

The COVID-19 pandemic has exacerbated many of these factors. To prevent the spread of the virus, the UN suspended the rotation of troops in some theaters, increasing the length of deployment beyond the regular six-month or one-year period. Travel bans and restrictions on movement have made personnel feel even more isolated and impacted the level of support provided to hardship duty stations

The lack of work-life balance affects mental health. "In peacekeeping, the mission is your life."

The Nature of Peacekeeping Mandates, Approaches, and Responsibilities

Beyond the nature of the environment, the nature of peacekeepers' work, including their difficult mandates, restrictions on what they can do, and their multidimensional working arrangements, presents another set of stressors.

The Weight of Crisis Management and Protection Mandates

In addition to operating in hardship conditions, peacekeepers are given what they often consider to be "impossible" mandates. Some mandates include dozens of tasks that overstretch the peace operation's limited capacity such as facilitating the success of a peace process, mitigating large-scale violence, and saving lives. Most missions are now mandated to protect civilians from physical violence. This means that mission personnel, including not only professional soldiers but also police officers and civilian experts, have to face and respond to mass atrocities, war crimes, and crimes against humanity.

Some individuals experience these challenges directly by protecting civilians in conflict zones, interviewing and supporting victims of atrocities, and working with armed groups, child soldiers, hostile state representatives, or unwelcoming communities. Human rights officers investigating war crimes and abuse, civil affairs officers trying to defuse ethnic and community tensions, or information analysts facing intimidation and threats due to the politicized nature of their job can be exposed to high levels of stress and trauma.

One does not have to directly experience a traumatic incident or be personally threatened to develop PTSD, as has been documented by mental health studies.[74] Aid workers, journalists, or social workers can develop mental health disorders through their secondhand exposure to trauma.[75] Similarly, human rights officers interviewing victims and witnesses of killing, mutilation, or rape all day long at regular intervals can experience trauma, anxiety, and PTSD. Most substantive staff in the civilian components of peace operations are doing daily work on traumatic events.

70 Phone interviews with former UN staff, June and August 2020..

71 Phone interview with mental health expert, May 2020.

72 Phone interview with mental health expert, June 2020; Phone interview with staff counselor, February 2020.

73 Interview with former UN staff member, New York, March 2020.

74 A study of seventy organizations in thirty-five countries recently revealed "a culture of unwellness" among human rights advocates: "Even though the horror is not happening to you, seeing, hearing, and working on it is likely to impact your body, mind, emotions, and your worldview. Vicarious trauma, chronic stress and burnout are occupational hazards of human rights work." Human Rights Resilience Project, "From a 'Culture of Unwellness' to Sustainable Advocacy: Organizational Responses to Mental Health Risks in the Human Rights Field," May 2019.

75 Brendan McDonald, "Humanitarian Agencies Need to Stop Failing Their Staff on Mental Health," *The Guardian*, July 31, 2015.

The human dimension of protection activities, and the relationships peacekeepers build with local populations, can exacerbate the emotional impact of traumatic events. As a former military observer recalled, "In Sudan, I interacted with communities often. When you… share their suffering, you start to develop emotional bonds with these communities. When these communities were attacked, I was very traumatized, and my mental health suffered."[76]

The weight of making difficult decisions or recommendations is another major stressor, especially for staff like POC advisers or human rights officers. As one former POC adviser explained, the fact that everybody in the mission would call to ask what to do during crises can be quite overwhelming for one individual without support structures.[77]

Other crisis-related tasks can also be emotionally depleting for civilian staff. For example, many of the internally displaced persons that the UN sheltered in its bases in South Sudan in 2013 died on a daily basis. A handful of essential staff who had stayed on the bases had to take responsibility for burying the dead, a task that had not been planned for and included in their official roles and responsibilities. As one staff member remembered, "There were dead babies… the smell of bodies that [were] decompos[ing]… and there was no protocol, nothing was happening.… There's a strong emotional component."[78]

> One does not have to directly experience a traumatic incident or be personally threatened to develop PTSD. Staff can develop mental health disorders through their secondhand exposure to trauma.

The senior mission leadership team is often neglected in discussions on mental health. Heads and deputy heads of mission, force commanders, and police commissioners have numerous responsibilities and little support. They are ultimately expected to bear responsibility for any failures of the mission and to make strategic decisions that can impact the lives of civilian populations and peace processes' chances of success. For heads of mission, who are responsible for the safety and security of staff and are expected to make decisions about evacuating staff members when crises erupt, the deaths of uniformed and civilian staff are a major stressor.[79] Dallaire described "the almost-omnipotent position" he was in as "horrifying," as it entailed making "decisions that mean some will leave and others will not."[80] As another former head of mission acknowledged, managing crises "is bloody stressful… exhausting and depleting." He also mentioned the emotional weight of representing the UN: "You are it. You are the UN. You can delegate, but ultimately you are the one [who is] responsible. It is a lot of pressure, particularly in times of crisis."[81]

Senior leaders' sense of isolation can impact their mental health and well-being. They are often expected to act as role models, and for heads of mission, even going for a walk requires a security detail and raises attention, which can place significant pressure on them. One former head of mission recalled constantly being "very careful" due to this level of scrutiny and refraining from social activities, gestures, and friendships that "could be perceived as abuse of authority."[82] Many senior leaders are also overworked and forced to deprive themselves of leisure activities, instead staying isolated in their private residence.

Peacekeepers' Dilemmas and Cognitive Dissonance

The responsibilities that fall on UN personnel can become overwhelming in places where there is little peace to keep and where the mission is not able to fulfill its mandate effectively. In hardship duty stations or situations marked by political stalemate,

76 IPI virtual roundtable, July 21, 2020.
77 Phone interview with former UN staff member, June 2020.
78 Ibid.
79 Ibid.
80 Dallaire, *Waiting for First Light*.
81 Interview with former head of mission, New York, February 2020.
82 Ibid.

UN staff can feel a decreasing sense of meaningfulness and pride in their work, or even an unbearable sense of failure and powerlessness. The UN medical manual lists the "difficult or unclear mission, giving rise to frustration and or [a] feeling of helplessness in carrying out the mission, as well as loss of confidence in leadership," as factors contributing to stress among peacekeepers.[83]

Many staff experience a sense of guilt when their mission fails to deliver on its mandates—especially its mandate to protect civilians. As Dallaire described, "People who mourn one death can feel incredible pain. Multiply the feeling by eight hundred thousand and imagine the weight of that."[84] Members of the Dutch battalion in Srebrenica also suffered from this feeling.[85] This sense of guilt and failure can go beyond theaters where egregious atrocities are committed; it can also result from recurrent exposure to injustice and humanitarian crises. In Haiti, for example, "soldiers felt very useless and couldn't do much [in the case of natural disasters]."[86] Similarly, Dutch peacekeepers in Cambodia "who reported higher levels of trauma were more affected by the poverty they saw, by a sense of injustice of the whole situation."[87]

In hardship duty stations or situations marked by political stalemate, UN staff can feel a decreasing sense of meaningfulness and pride in their work, or even an unbearable sense of failure and powerlessness.

Beyond the difficulty of achieving mission mandates, the passive posture and restrictions associated with peacekeeping can weigh on soldiers who were trained to wage war.[88] A US study found that "for combat-trained service members from larger nations, peacekeeping duty may feel incongruent with their training."[89] Similarly, an Australian study found that "where UN peacekeepers become targets to be threatened but are not allowed to fire back" due to their rules of engagement, they experience a high incidence of psychiatric disorders.[90] This feeling is especially prevalent among military observers and unarmed police officers, who "can only monitor and report and cannot directly intervene in the situations they are observing."[91]

Many interlocutors recognized that this stressor has been significantly reduced by explicit mandates to protect civilians, in contrast to the restrictive, unclear mandates of the UN missions in Rwanda and Bosnia in the 1990s. According to one expert, "Personnel can now respond to atrocities [and] are allowed to fire back and intervene where they couldn't, [which] has… taken the stress off of peacekeepers."[92]

But while more explicit POC mandates have removed the perceived pressure of seeking authorization to intervene, "there is still a cognitive gap—there is a sense of failure [and] underperformance."[93] For many UN staff, POC mandates remain unclear and have gray areas, especially around the use of force. Military personnel report being unsure "when we can shoot or not, intervene or not," as well as about missions' approaches to predatory armed groups, host states, and imperfect peace deals. For the staff who refused orders to abandon UN premises in Timor-Leste to protect civilians who took refuge there or to open the gates of UN compounds in South Sudan, this decision weighed heavily; they had to take responsibility for the lives of thousands

83 UN DPKO and DFS, "Medical Support for United Nations Missions: Third Edition," 2015.

84 Dallaire, *Waiting for First Light*.

85 See: Isabel Conway, "Dutch UN Troops Haunted by the Shame of Srebrenica," *The Independent*, April 5, 2014; and Journeyman Pictures, "Srebrenica: The Trauma of the Blue Berets," November 17, 2017.

86 IPI virtual roundtable discussion, July 21, 2020.

87 Karen Brounéus, "On Return from Peacekeeping: A Review of Current Research on Psychological Well-Being in Military Personnel Returning from Operational Deployment," *Journal of Military and Veterans Health* 22, no. 1 (2014).

88 J. Tobin, "Occupational Stress and UN Peacekeepers," *Irish Journal of Psychological Medicine* 32, no. 2 (2014).

89 Litz et al., "Peacekeeping."

90 Warren Ward, "Psychiatric Morbidity in Australian Veterans of the United Nations Peacekeeping Force in Somalia," *Australian and New Zealand Journal of Psychiatry* 31, no. 2 (1997).

91 UN DPKO and DFS, "Medical Support for United Nations Missions: Third Edition."

92 Phone interview with mental health expert, May 2020.

93 Ibid.

of civilians and make a tough call for which they were unprepared. "Moments like that are difficult," confided one former staff member from the mission in South Sudan.[94]

The need "to show impartiality to different parties in a conflict, despite personal beliefs and convictions" can also affect the mental health of UN personnel.[95] Personnel expected to support the host state in countries with poor governance and widespread corruption can find this mandate "overwhelming and quite devastating, especially if they don't have support systems."[96]

According to experts, having a sense of purpose plays "an immense role" in mental health. Personnel who are ready to risk their lives "need to feel like their work has value and meaning."[97] This feeling can be undermined by the "moral ambiguity and complexity" that can arise in peacekeeping contexts, especially when traumatic events transgress "deeply held moral beliefs or involve betrayal of 'what's right.'"[98] As a result, peacekeepers often experience cognitive dissonance—the mental discomfort that results from holding conflicting beliefs, values, or attitudes. The discrepancy between what personnel expect—both in terms of the UN's values and impact and in terms of their own role and function—and what they actually experience is often described as one of the main stressors in peace operations.

The many paradoxes that peacekeepers experience can fuel this cognitive dissonance. One of these paradoxes is the discrepancy between the objectives of a mission—protecting civilians, defending human rights, building peace—and its actual impact. For individuals who choose to deploy to a UN peacekeeping mission to make a positive contribution, the feeling that the UN is failing can undermine their sense of pride and purpose, ultimately impacting their mental health. This sense of failure can be exacerbated by the lack of appreciation and the discontent of local populations, criticism from the media, and, occasionally, hostility and lack of cooperation from local authorities in contexts where the UN is widely disliked and seen as an organization of overpaid civil servants. Some personnel also share the feeling that the mission is not doing enough. Boredom can also be an issue when missions' activities are limited—though periods of boredom may unpredictably alternate with periods of crisis. The COVID-19 pandemic, which led missions to suspend many activities, has added to this challenge.

Another source of cognitive dissonance is the tension between the lofty goal of protecting vulnerable populations and more trivial day-to-day requirements to comply with the UN bureaucracy and navigate politics. Many peacekeepers feel disillusioned and frustrated by jobs that are mostly about "feeding the beast in New York," writing reports, and going through convoluted bureaucratic processes.[99] This disconnect may be even greater for administrative and support personnel—the majority of peacekeepers—who focus on internal procedures and logistics.[100] This can make it difficult to nurture a sense of pride in what is being accomplished. In addition, the bureaucracy can make it difficult for staff to see the impact of their work. The gap between tactical decision making on how best to respond to a crisis and strategic decision making where political considerations may take precedence can further drive cognitive dissonance. On top of this, peacekeepers can feel cognitive dissonance due to "an exaggerated security posture" that limits their engagement with local communities, contradicting their aspiration to make peace operations "people-centered."[101]

94 Phone interview with former UN staff member, June 2020.

95 UN DPKO and DFS, "Medical Support for United Nations Missions: Third Edition."

96 Phone with mental health expert, May 2020.

97 Phone interview with mental health expert, May 2020; Phone interview with military mental health expert, July 2020. See also: Brounéus, "On Return from Peacekeeping"; and Jitender Sareen et al., "Is Peacekeeping Peaceful? A Systematic Review," *La Revue canadienne de psychiatrie* 55, no. 7 (2010).

98 Forbes et al., "Treatment of Military-Related Post-traumatic Stress Disorder."

99 Interview with senior UN official, New York, February 2020; Dallaire, *Waiting for First Light*.

100 Interview with senior official at UN headquarters, New York, February 2020.

101 Ibid.

The Effects of Multidimensional Environments

UN peacekeeping operations are, by nature, multinational and multidimensional. They mix staff and units from different countries and from different professional backgrounds and institutional cultures, whether civilian, police, or military. This creates an environment that many find stimulating and fascinating and that is often referred to as a major factor making UN jobs desirable.

However, being placed outside of one's comfort zone and being dependent on others who do not have the same points of references can also be a stressor. The UN medical manual mentions "cultural differences, language difficulties and dietary changes" as a potential stress factor.[102] Adding to these challenges, peacekeepers can also feel a sense of disconnect between the "field" and the "real world" and between home and the mission, as discussed above.[103] Some feel misunderstood by those "back home" and have a general sense that what is happening in the field is more important and meaningful.[104]

Another challenge is that multidimensional peacekeeping operations are siloed work environments. According to mental health experts, social connectedness is key to strengthening resilience. Cohesive and integrated units, trust and confidence in leadership, and shared values are associated with a lower prevalence of PTSD.[105] Building relationships in a context of high turnover of personnel can be challenging, however, and peacekeeping missions often lack cohesion and trust. Interviewees said that in some circumstances, staff organize themselves into groups based on nationality, resulting in exclusion and isolation that can impact both their professional and their personal lives.

Complex authority, command, and control structures and the many moving parts of peace operations can also reduce the sense of cohesion, security, and trust. For example, military personnel often depend on police and civilian components, including the mission support component for logistics, the management of air assets, and medical support. However, military personnel often have a poor perception of the UN bureaucracy represented by their civilian counterparts, which they see as an impediment to effective operations.[106] Conversely, some civilian staff have a poor perception of the capacity and performance of their uniformed colleagues, as well as of their civilian colleagues or leaders. Within the military component, differences in the level of performance between contingents from different countries can undermine cohesion. When individuals doubt that they can rely on their colleagues not only for their work but also for their safety, security, and well-being, they may experience stress and anxiety.

The UN Bureaucracy

The vast majority of those interviewed for this study indicated that the UN bureaucracy itself—the rules, regulations, and processes; the managerial culture; and the human resources system—is one of the most acute stress factors and has a tremendous impact on mental health.[107] "Most people know they're going to a hostile environment. They don't expect the bureaucracy, which is the most stressful," said one mental health expert who had served in both humanitarian and peacekeeping positions.[108]

102 UN DPKO and DFS, "Medical Support for United Nations Missions: Third Edition," 2015.

103 Upon his return from Rwanda, Dallaire was told, "Time to get to work; you're back in the real world, sir!" and describes in his book "the obliviousness of this 'real world.'" "Life back here at home made absolutely no sense at all." He also mentioned the sense of disconnect on several occasions: "I couldn't laugh, I couldn't feel happy even for a minute. I looked around me, and everything was affected by what I had seen in Rwanda. My values had changed and my criteria for what was positive or good in the world had changed, too. I just didn't want to engage in a way of life that didn't make any sense to me, with its hypocrisy, its unnecessary self-indulgence." Dallaire, *Waiting for First Light*.

104 Phone interviews, January 2020–August 2020. Dallaire found himself "increasingly intolerant of home life": "You are not supposed to grieve too much, or too long." As a result, peacekeepers "come back home, but now they perceive home not as the true reality but as a weird bubble of safety, a privileged place untouched by the chaos others endure....To me it all seemed so unimportant, so materialistic, so wasteful it was almost obscene." Dallaire, *Waiting for First Light*.

105 Phone interviews with mental health experts, May 2020. According to one expert, "When you're in circumstances of life and death, you need to feel comfortable in your own skin and with your team. Social connectedness is important.… It can be argued that risk of psychological injury increases when the primary relationships of small fighting units are poor or fractured, or the unit is rendered ineffective, and individuals become isolated and lose their sense of connection to a powerful group."

106 "Military can see [civilians] as a hindrance. Unless the civilian is a fellow national, they often don't gel," said one mental health expert. Phone interview with mental health expert, May 2020.

107 Interviews with former and current UN staff, February–August 2020. One staff member from the UN Support Office in Somalia stated in a recent survey that "management of that Mission is the main cause of stress for staff," United Nations, "UN Global Staff Survey 2017: Summary Results."

108 Phone interview with mental health expert, June 2020.

Rules, Regulations, and Standards of Care

UN rules, regulations, and processes are significant stressors. Many interviewees referred to the challenge of having to "constantly fight with the organization" while trying to carry out the mission's mandate.[109] The rigid bureaucracy is seen as an "unnecessary hardship" that adds to the sense of isolation, powerlessness, and lack of support. This has detrimental effects on mental health, especially for staff operating in crisis situations. As one former staff member explained, "You have so much pushback from your organization. It should be about protecting you from the hostile environment, not creating another hostile environment within."[110] Although they are put in place to protect UN personnel in volatile environments, security rules also tend to be perceived by substantive staff as being too stringent, hampering their work and adding more stress.

Many signaled that they expected the UN to demonstrate more care, flexibility, and support when dealing with personnel making sacrifices in hardship duty stations.[111] For example, staff who stayed behind on UN bases during the height of the crisis in South Sudan reportedly asked for additional leave, shorter periods between rest-and-recuperation (R&R) breaks, and greater baggage allowances on UN flights so they could bring food. Yet even though these staff had worked while "constantly under fire… 24/7, with calls at 3:00am, no weekends, and no suppl[ies] for months," the mission's support component reportedly dismissed their requests, invoking formal rules.[112] As a result, many personnel are forced to find ad hoc solutions and rely on personal, rather than institutional, support.

UN rules, regulations, and processes are significant stressors. "It should be about protecting you from the hostile environment, not creating another hostile environment within."

The feeling of not being understood or supported by colleagues or the mission as a whole can be aggravated by deficient internal communication. For example, the UN mission in CAR suspended R&R breaks for all staff during the COVID-19 pandemic "until further notice," without clarifying the modalities of this decision or opening channels of communication with staff for several weeks. As one interviewee suggested, staff morale could be boosted by occasional check-ins and messages to all staff during crises saying that the organization supports them and will ensure that they are rotated out and providing email addresses they could send questions to.[113]

Several interviewees said that fighting for benefits, entitlements, and administrative approvals was another stressor for staff operating in the middle of violent conflict and emergencies. The renewal of temporary contracts every three months, the payment of salaries and benefits, and requests to go on R&R or other leave can require extensive negotiations, justifications, and bureaucratic steps. This is especially a burden for staff who have limited Internet connection, time, and resources and are dealing with major crises.[114] The human resources system is especially stressful. Several interviewees described receiving inadequate support from the Regional Support Center in Entebbe, which centralizes human resources services for staff serving in peacekeeping missions in Africa.[115] A few interviewees reported

109 Interviews with former and current UN staff, February–August 2020.

110 As an essential staff member when the war broke out in South Sudan and civilians sought shelter in UN bases, she stated that the most important stressors were not being in the crossfire and having to deal with the crisis but the UN administration, which "refused to do anything outside the box." According to the interviewee, support staff responded that "I don't think IDPs should be there" and that "sign off by Entebbe [was] needed" to provide the wire and fencing needed for the security of the camp. Phone interview with former UN staff member, June 2020.

111 One respondent to the 2017 global staff survey from the Department of Field Support stated that "the attention given to us is below standard. The minimum things like... safety and sanitary/hygiene are ignored by management... We are discouraged and abused psychologically and mentally." United Nations, "UN Global Staff Survey 2017: Summary Results."

112 One staff member was told to "just pack responsibly, travel with perishables, use cargo [for the rest]." The process of cargo requests, however, is long, cumbersome, and difficult to comply with for field staff going back to a duty station outside of Juba. "How can't you realize the importance of food for your own staff?" Phone interview with former UN staff member, June 2020.

113 According to one interviewee, essential staff who were not evacuated and stayed behind to respond to the crisis during the war in South Sudan kept "receiving a lot of messages addressed to all staff about the payment of hazard pay and other benefits for those on administrative leave." Phone interview with former UN staff, June 2020. Communication with UN staff member, December 2020.

114 Interview with senior UN official, New York, February 2020; Phone interviews with mental health expert, May 2020; representative of a peacekeeping school, May 2020; and former peacekeeping mission staff member, June 2020.

115 "I didn't have to fight [at UNDP].… You get a reply—90 percent of the time—in less time than what they announced. In peacekeeping missions there's one

the onboarding process to be challenging, with cases of staff not getting picked up at the airport or lacking information about hotels or their health insurance coverage.[116]

The uncertainty of care, including limited medical care for those deployed to remote duty stations, adds to these challenges. For example, concerns about the mission's lack of preparedness for a possible Ebola outbreak in Mali reportedly raised anxiety among staff.[117] The fact that medical services, especially level-II and level-III hospitals, are often provided and run by the military component, also creates a sense that missions can only provide emergency care.

These concerns echo similar reports of insufficient attention to duty of care in non-UN organizations, including Amnesty International and other human rights organizations that have been criticized for their organizational culture and management failures.[118]

Workplace Incivility and Abuse

The prevalence of workplace incivility and abuse is another stressor in the field. The UN survey on staff well-being found statistically significant associations between perceived workplace incivility and conflict and mental health issues, including generalized anxiety disorder, major depressive disorder, PTSD, and hazardous drinking. However, the survey could not deduce "whether the incivility is a cause or an effect of mental health symptoms."[119]

Harassment and abuse in the workplace are particularly stressful for personnel in field environments, as they are often compounded by a sense of isolation and a lack of separation between professional and private issues, as mentioned above. Interviewees described a "lot of toxicity" and an "abusive mode of 'governance' within missions," including an atmosphere of toxic masculinity that can be demoralizing and push women away from peacekeeping.[120] According to one interviewee, "It is a political world of backstabbing. Friendships are built upon who has the car, who is bringing me back [equipment] from R&R… survivalist types of friendships."[121]

Management is key to ensuring well-being in the workplace, but missions struggle to retain good senior staff and managers in hardship locations and to hold ineffective managers accountable.[122] For example, managers who do not let staff go on R&R are not held accountable for potentially damaging their mental health. One senior staff member mentioned the discrepancy between UN peace operations and agencies like UNICEF and the UN Refugee Agency (UNHCR), where managers are transparently evaluated by staff and held accountable: "If you have negative ratings as a resident representative, you have problems. If there is a history of abuse in an agency, there will be consequences. There is nothing like that in the Secretariat. We need to take the quality of supervision more seriously."[123]

Employment Model and Working Arrangements

In contrast with UN agencies, funds, and programs such as UNHCR, UNICEF, and the UN Development Programme (UNDP), the Secretariat does not have a policy on staff mobility and promotion. As a result, staff serving in peace operations have few prospects of being promoted or moved from the

generic email, no name. You sent fifty reminders, they didn't bother to read your email, you have to re-explain." Interview with senior UN official, New York, February 2020.

116 Interviews with former UN staff, New York, January 2020. As one senior official who formerly served in the field regretted, "Nobody is taking ownership of taking care of new staff." Interview, New York, February 2020.

117 Email communication with former UN staff member, November 2020.

118 A review of the workplace culture of Amnesty International commissioned after two staff committed suicide revealed that the most important root cause of "stress, burnout, anxiety, depression, exhaustion and trauma among staff" was not the hardship environment or the content of the work itself but "organizational culture and management failures." Karen McVeigh, "Amnesty International Has Toxic Working Culture, Report Finds," *The Guardian*, February 6, 2019. Similarly, a study of seventy human rights organizations highlighted poor management and leadership and organizational dysfunction as having a significant impact on the mental health of human rights advocates. Margaret Satterthwaite et al., "From a 'Culture of Unwellness' to Sustainable Advocacy: Organizational Responses to Mental Health Risks in the Human Rights Field," *Southern California Review of Law and Social Justice* 28 (2019).

119 United Nations, "Staff Well-Being Survey Data Report."

120 Email communication with former UN staff member, January 2018. On toxic masculinity, see: Lotte Vermeij, "Woman First, Soldier Second"; and comments in United Nations, "UN Global Staff Survey 2017: Summary Results."

121 Interview with former UN peacekeeping mission staff member, New York, January 2020.

122 Interview with senior official at UN headquarters, New York, February 2020. See also: Di Razza, "People before Process."

123 Interview with senior official at UN headquarters, New York, February 2020.

most challenging duty stations to more comfortable ones. The mobility system established in 2015 was criticized for its separate treatment of headquarters and field staff and for limiting movement between headquarters and hardship duty stations. It ended up moving staff from Afghanistan to South Sudan, or from CAR to Iraq, which defeated the point of mobility. This mobility system was suspended by António Guterres three years ago, and no alternative has been put in place. A senior headquarters official highlighted the need for such a rotation system: "We do sign up to do tough jobs…. It is reasonable for the organization to expect a certain amount of risk taking.… But it is different if it is a one-way ticket. We need a rotation policy." One staff counselor noted that people going from mission to mission without breaks can carry a lot of emotional baggage that they have not had time and space to process.[124]

"We do sign up to do tough jobs…. It is reasonable for the organization to expect a certain amount of risk taking.… But it is different if it is a one-way ticket. We need a rotation policy."

By contrast, UNHCR has a mandatory mobility policy and restricts people from staying in hardship duty stations for more than five years. A UN official who has worked in the field with UN agencies and peacekeeping missions described the systems of agencies as healthier: "You are much closer to the purpose [of your mission].… You know you will come out, and you interact with the community."[125] Similarly, many NGOs build their business model on limited deployments to field operations. The International Committee of the Red Cross (ICRC), for example, promotes a "global workforce" and has promulgated policies to facilitate movement between its headquarters and field operations. Many foreign civil services have similar mobility arrangements in place.

Some interviewees said that their emotional state degraded over time, going through incremental changes and different phases over the course of their deployment.[126] Accumulating field deployments can contribute to the accumulation of mental health issues by increasing the length and frequency of exposure to stressors and traumatic events. As noted above, staff who had experienced a potentially traumatic event in the previous twelve months were significantly more likely to screen positive for generalized anxiety disorder, PTSD, major depressive disorder, and hazardous drinking. As explained by one mental health expert, "We know that the risk of developing a mental health issue depends on what a soldier is being exposed to and how much of it."[127]

Taken in isolation, many of the stressors described above can be managed with the right preparation and support. In peace operations, however, many of these stressors compound in a unique way. Fighting the bureaucracy can be more difficult to manage when staff feel that their life is being threatened every day. Not having transport to go home can feel particularly stressful after a day interviewing human rights victims and being exposed to workplace disputes. The isolation and distance from home can become unbearable in the face of local community members throwing rocks at UN cars.[128] In addition, physical health issues can add to mental health issues in environments with limited recreation and workout opportunities.

Institutional and Political Challenges to Addressing Mental Health

Despite the prevalence of mental health issues, the vast majority of the UN staff responding to the 2015–2016 survey (94 percent) had not received mental health support in the past year. While 50 percent said they would like to have an on-site counselor to speak

124 Interview with senior official at UN headquarters, New York, February 2020; Phone interview with staff counselor, February 2020..

125 Interview with senior official at UN headquarters, New York, February 2020.

126 A former military observer described three phases, with a first period when everything is "new and interesting"; a second more distressful phase, with growing exposure to suffering and risk and sometimes boredom due to routine work; and a third phrase in which "you are angry.… Stress at this point has accumulated." He also highlighted that after a few cycles of deployment, the first phases have tended to shorten. IPI virtual roundtable discussion, July 21, 2020.

127 Phone interview with mental health expert, May 2020.

128 On this point, see the testimony of the founder of Trauma Talk UN: Karoline Klose, "The Untold Story: Trauma and International Development Work," Atlantik-Brücke, January 25, 2020.

with confidentially from time to time, only 2 percent reported having received services from a UN counselor, while 10 percent sought mental healthcare outside the UN. Twenty-five percent of respondents reported not seeking the support of a mental health professional because of discomfort with the idea (15 percent) or the (possibly incorrect) belief that such services were unavailable (10 percent).

There are several reasons for this lack of support. Mental health remains a sensitive topic, with persistent stigmas and varying cultural approaches and sensitivities coupled with an institutional culture that has made "fitness for hardship" a core requirement for the job. The division of responsibilities for mental health support between the UN Secretariat, T/PCCs, and individual staff members also remains subject to debate. Moreover, while the UN put in place a Mental Health and Well-Being Strategy in 2018, it has been challenging to implement.

A Sensitive Topic

All interlocutors agreed on one thing: mental health remains a sensitive topic. Mental health issues are often misunderstood, viewed without empathy, or simply disregarded. Despite growing recognition of trauma and PTSD, especially in military circles in Western countries and among younger generations, mental health is widely stigmatized at the UN, both in New York and in the field. PTSD is still seen as "a shameful illness for a soldier" in many countries, and many people hide their mental health issues.[129] Strong gender norms also often encourage men to suppress and avoid showing their feelings.[130]

Mental health issues are often misunderstood, viewed without empathy, or simply disregarded.

On top of this, the military culture can discourage soldiers from recognizing mental health issues and seeking mental healthcare. As one mental health expert described, "The military trains you to take care for yourself—you need to respond, you need to perform, you need to be self-resilient, be a problem solver." This can be difficult to reconcile with the message "don't hesitate to seek healthcare."[131] As one mental health expert describes, the vulnerability associated with seeking help and engaging in treatment can be perceived as antithetical to the "warrior ethos universal to all militaries that prize self-reliance and strength in the face of adversity."[132]

These challenges can be even more acute for military personnel deployed to peacekeeping operations, which are often perceived as low-threat environments. According to one mental health expert who studied the prevalence of PTSD among peacekeepers, there is a widely shared perception that "peacekeeping is not as serious as combat deployments," and military peacekeepers often feel second-class compared to their colleagues deployed to traditional combat zones.[133] "People accept PTSD with combat veterans—in fact, it's considered a badge of honor"—but many disregard the possibility of PTSD following peacekeeping deployments. One senior military officer who attempted to raise attention on mental health in the peacekeeping mission he was deployed to reported having "all the generals against" him.[134] A mental health expert from another country said that "there's no recognition in national spheres that countries of deployment like South Sudan are stressful environments."[135]

There can also be prejudices related to the type of mental health issue experienced by peacekeeping personnel. One former civilian staff member regretted that people "set the bar very high" for PTSD. It may be recognized and respected if it is related to a "big traumatic event" like an attack, a kidnapping, the death of colleagues, or being shot at, but other reasons are not taken seriously.[136] As

129 Mental health experts working in national defence forces and interviewed for this study acknowledged the persisting stigma. Phone interviews, March and June 2020; Interview with mental health expert, June 2020.

130 On the effect of gender norms and stigma, see: Vermeij, "Woman First, Soldier Second."

131 Phone interview with mental health expert, May 2020.

132 Forbes et al., "Treatment of Military-Related Post-traumatic Stress Disorder."

133 Phone interview with mental health expert, May 2020.

134 Phone interviews with mental health experts and former peacekeeper, March and May 2020.

135 Phone interview with mental health expert, June 2020.

136 Interview with former UN staff member, New York, March 2020.

one former staff member put it, "You can talk about [PTSD] if it is about an ambush in Kidal, an evacuation.… Those are noble reasons. You can't if it is [related to] your boss,… your office."[137] PTSD also tends to get more attention than other mental health issues like anxiety and depression.

The lack of cultural consensus on mental health adds to the sensitivity of the topic in multinational peacekeeping operations. Mental health is not viewed the same way in all countries, and not everyone is sensitized to the issue or inclined to recognize it. As one mental health expert explained, culture is "a huge factor in addressing and understanding mental health."[138] One expert mentioned that in his country, "If you've been through a bad time, you don't talk about it—you're in denial."[139] Instead of talking directly about mental health, many people use euphemisms like "well-being." A former head of mission explained that in conversations with staff in the field he would ask about mental health only indirectly (e.g., in terms of welfare and access to leisure activities and R&R).[140]

As a result, staff generally avoid speaking out about their mental health struggles. Many of those who have raised public attention on the mental health of field staff have left the UN system or come from UN agencies, funds, and programs rather than peace operations.[141] Several interlocutors reported that speaking out is seen as risky in a rigid organization that has not provided support and could undermine opportunities to be offered contracts in the future.[142] Because part of the job is to protect and support others who are arguably in more difficult situations, there can also be a reluctance to "complain" about one's own discomfort and stress.[143] Many see mental health issues as inherent to their job and internalize the idea that they need to put their emotions aside. They develop an adaptive "operational mindset" that allows them to focus on the challenging tasks they have to undertake while deployed—a mindset unlikely to encourage positive attitudes toward help-seeking.[144]

Organizational pressure can also frame the way staff tackle mental health issues. Peers may discredit them for their "weakness" if they complain about conditions in the field. Both management and colleagues were reported to be dismissive about mental health issues. One staff member remembered sharing her concern about seeing a dead body in the streets with security staff and being sent back to her desk with a casual "this happens all the time."[145] A former civilian peacekeeper whose colleague was kidnapped for months remembers that in her team "nobody thought that what happened could generate trauma."[146] There is therefore a perception that "if you are stressed, you are not fit" to serve in a peace operation. Several interlocutors explained that the UN implied or signaled that people either need to be "fit for the job" or "leave the organization."[147] There is a widespread perception that staff chose this job and need to "toughen up."[148] This institutional culture can add to the sense of personal failure or guilt of staff experiencing difficulties in the field and result in self-censorship.

137 Ibid.

138 Phone interview with mental health expert, May 2020.

139 Phone interview with mental health expert, May 2020.

140 Interview with former head of mission, New York, February 2020.

141 See, for example, the Trauma Talk UN initiative: Klose, "The Untold Story." See also the podcast "Awake at Night" launched by UNHCR, available at https://www.unhcr.org/awakeatnight/ .

142 Phone interviews, March, June, July, and October 2020.

143 This is also common in the aid sector: "We have all put ourselves in harm's way at one time or another, but no one wants to be the special snowflake who is precious about their safety," said one aid worker: "In most situations you just put up and shut up." Holly Young, "Steve Dennis and the Court Case That Sent Waves through the Aid Industry," December 5, 2015. A study of mental health among human rights advocates also demonstrated a "culture of martyrdom" coupled with a "savior mentality" that can contribute to mental health stigma. Satterthwaite et al., "From a 'Culture of Unwellness' to Sustainable Advocacy."

144 Forbes et al., "Treatment of Military-Related Post-traumatic Stress Disorder."

145 Phone interview with former UN staff member, January 2020.

146 Phone interview with UN staff member, April 2020.

147 One respondent to the UN survey from the Department of Field Support reported that "at one Town Hall one of the top management was heard say[ing] 'if you don't like it here go get employment in New York or Paris.'" United Nations, "UN Global Staff Survey 2017: Summary Results." Phone interview with former peacekeeping mission staff member, May 2018.

148 This "toughen up culture" has generally been reported in the aid, humanitarian, and human rights sector. Liz Griffin, "Tough Up, or Get Out: The Truth and Trauma behind Human Rights Headlines," February 27, 2019.

The Division of Responsibilities with Member States

The healthcare of UN peacekeeping personnel involves many stakeholders, especially in peacekeeping missions with uniformed personnel. The UN Secretariat is responsible for providing medical support to civilian staff and ensuring the safety and security of all UN peacekeepers, including through the provision of operational support in the field. Troop-contributing countries (TCCs) are responsible for the preparation, screening, and self-sustainability of their units (see Box 2). This means that TCCs are responsible for the mental health of their soldiers through pre-deployment training and the provision of care post-deployment, while the Department of Peace Operations is responsible for providing care during deployment.[149] One TCC military representative described psychosocial care as a "shared responsibility" between the UN and member states, and two military advisers stated that it "should be seen as a collective effort."[150]

> Psychosocial care is a "shared responsibility" between the UN and member states and "should be seen as a collective effort."

Many UN member states see this division of responsibilities between TCCs and the UN as vague. There are no detailed guidelines on requirements for T/PCCs to take care of the mental health of peacekeepers. Screening processes, capacity, and openness to considering mental health issues vary from country to country.[151] Member states generally agree that T/PCCs have the responsibility and duty to deploy personnel who are "physically, mentally and emotionally fit."[152] However, they do not share a common understanding of what mental health and duty of care mean and what basic structures need to be in place.

Many interlocutors emphasized the need for the Secretariat to play a bigger role in defining standards to support member states in preparing their personnel and developing support structures and in fostering a culture of respect and understanding among different types and nationalities of personnel.[153] One mental health expert also recognized that UN headquarters could play a role in overseeing and coordinating among member states.[154] Another interlocutor regretted that the UN focuses on "technical qualifications and equipment" that do not speak to the potential mental fragility of personnel.[155]

On the other side, T/PCCs agreed that they "could be doing much better."[156] Pre-deployment training does not always inform peacekeepers about the kinds of challenges they could face in the field and how to cope with them. Unit commanders do not always demonstrate care for their peacekeepers, act as mentors, or offer support. It was also mentioned that T/PCCs could do more to foster internal cohesion.[157]

One obstacle, however, is member states' concerns over the financial repercussions of increased recognition and consideration of mental health. Representatives of major financial contributors to peacekeeping shared concerns over the cost of having dedicated resources for mental healthcare in UN missions and the inflation of peacekeeping budgets due to compensation claims by peacekeepers who suffered mental health injuries. As one military health expert explained, "This can be very expensive and include uniformed specialists and non-uniformed specialists.… Who is going to foot the bill?"[158]

149 Interview with mental health military expert and former UN peacekeeper, March 2020.

150 IPI virtual roundtable discussion, July 21, 2020.

151 As one mental health expert recognized, "UN TCCs/PCCs are not the countries that have the most money to provide psychosocial services to their contingents. There may also be a different level of recognition/understanding of mental health [and] different responses." Phone interview with mental health expert, May 2020.

152 UN DPKO, "Training Materials on Negotiation, Planning, Deployment, Sustainment of National Contingents for Senior National Planners of Troop and Police Contributing Countries to United Nations Peacekeeping Operations," April 2019.

153 IPI virtual roundtable discussion, July 21, 2020.

154 Phone interview with mental health expert, June 2020.

155 IPI virtual roundtable discussion, July 21, 2020.

156 Ibid.

157 Ibid.

158 Phone interview with mental health expert, May 2020.

Box 2. TCCs' responsibilities for the mental health of military units

TCCs are responsible for the medical preparation of their troops prior to deployment and are supposed to send the Department of Peace Operations a list of the preparations conducted.[159] TCCs are also responsible for ensuring that their units are self-sustaining, including by providing the medical supplies agreed to in their memorandum of understanding with the UN. Physicians in TCCs assess peacekeepers being deployed "on the basis of medical history, physical examination, laboratory and x-ray results, and an estimate of personality characteristics." "Past history of alcohol dependence or psychiatric disease" is included among the conditions that "are generally considered as precluding service in peacekeeping areas but must be carefully assessed on an individual basis."[160]

The UN manual states that "in the peacekeeping missions that tend to have fewer psychiatric resources and more risk factors for mental health problems, systematic measures to ensure mental health and psychological well-being of deployed staff are crucial." These include pre-deployment mental health assessments, pre-deployment planning for mental health support during deployment, in-mission follow-up, and post-mission support. "[The chief medical officer] and/or TCC/PCC need to make all possible efforts to ensure good mental health and psychological well-being for all staff in the pre-deployment, deployment and post-deployment phases."[161]

The manual also lists the components of stress-prevention programs:[162]

- Pre-deployment screening of the psychological and physical profile
- Pre-deployment training on what to expect and how to cope with stress
- Ongoing health education on work-related stress
- Planned program for social activities, sports, and recreation at the headquarters or unit level
- Group sessions for feedback and peer-sharing
- Debriefing of personnel following exposure to traumatic events
- Training of medical personnel to recognize and manage signs and symptoms of stress
- Access to professional counselling if required

In terms of mental health support during deployment, the UN framework on the operational readiness of TCCs includes one general provision on stress management: "Officers should be able to detect signs of stress within their units and resources/methods of treatment" and "[Non-commissioned Officers]/Equivalent Ranks and Soldiers should be informed about how to respond to stress."[163]

The cost of repatriation for medical reasons is borne by the UN, unless repatriation results from a preexisting medical or psychiatric condition and inadequate screening. Official UN documents include detailed provisions on death and disability claims submitted to the UN.[164]

159 Medical screening results of individuals are not required, unless requested.

160 UN DPKO, "Generic Guidelines for Troop Contributing Countries Deploying Military Units to the United Nations Peacekeeping Missions," 2008.

161 UN DPKO and DFS, "Medical Support for United Nations Missions: Third Edition."

162 "Additional details on how to manage stress can be found in the UN Stress Management Booklet, which is distributed to peacekeepers prior to deployment. UN DPKO, "UN Stress Management Booklet," 1995.

163 UN DPKO and DFS, "Guidelines: Operational Readiness Preparation for Troop Contributing Countries in Peacekeeping Missions," December 2018.

164 UN General Assembly, *Administrative and Budgetary Aspects of the Financing of the United Nations Peacekeeping Operations: Financing of the United Nations Peacekeeping Operations: Death and Disability Benefits—Report of the Secretary-General*, UN Doc. A/52/369, September 17, 1997.

A Focus on Self-Care

There is a widespread preconception that mental health starts with self-care and that people are responsible for their own well-being and for finding their own coping mechanisms. Dealing with mental health is therefore often framed in terms of individualized solutions, which can absolve the group, the community, or the organization of responsibility.

As a result, the UN's responsibility to deal with mental health as a collective issue is often "the missing piece" in conversations on this topic: "If you don't do self-care, it is your fault. If you have a problem, it is upon you: go to the counselor.… There is no recognition that it is systemic," explained one former humanitarian worker and mental health expert.[165] Another interviewee highlighted the prevalent notion that "[you are] the one responsible for cleaning it up, dealing with it… and when you are not functioning or able to do the job, you are out. There is a lot of self-blame."[166] One example is burnout. As one mental health trainer explained, "We say 'I burned out,' and not 'you burned me out'… but it is not the employee's fault, but [an issue of] chronic[ally] mismanaged workplace."[167]

> "If you don't do self-care, it is your fault. If you have a problem, it is upon you: go to the counselor.… There is no recognition that it is systemic."

Dealing with mental health requires the UN to put care at the forefront of its human resources and risk-management strategies rather than simply telling employees to "go and do yoga."[168] Some advocates explained that the UN should pursue well-being as an organizational strategy rather than through an individualized, medicalized model of mental health.[169] However, senior staff and management have yet to prioritize well-being, model behavior, and work toward structures and organizational plans for well-being.

The UN Mental Health and Well-Being Strategy

Following the survey conducted in 2015 and 2016 and published in 2017, an interdisciplinary mental health working group was established to examine the way forward for the UN system. In parallel, the duty of care working group of the High-Level Committee of Management examined high-risk duty stations. Consistent themes emerged from both processes: the need for greater prevention, early detection, access to care, and rehabilitation.

The UN subsequently developed a Mental Health and Well-Being Strategy for 2018–2023, and the secretary-general has publicly committed to improving mental health at the UN, saying "let us all be part of a healthier workforce as we work for a better world for us."[170] The strategy is a groundbreaking step: the first time the UN system as a whole has recognized the importance of mental health and promoted change at all levels of staff (see Box 3).

In October 2018, the assistant secretary-general for human resources chaired the first meeting of the strategy's implementation board. An advisory panel comprising forty people affected by mental health issues was also formed to provide advice to the board. A position was created to coordinate the implementation of the strategy for the whole UN system. Several activities were undertaken on World Mental Health Day, including webinars and other events, a website on mental health was launched, and guidance notes and sensitization tools were developed (logos, posters, factsheets, etc.). Steps were also taken to ensure equitable access to quality psychosocial support; develop a plan for reducing stigma and discrimination

165 Phone interview with former UN staff member, October 2020.

166 Phone interview with former UN staff member, January 2020.

167 Phone interview with mental health trainer, October 2020.

168 As a study on the organizational culture of different human rights organizations found, "Organizational well-being efforts that overly focused on steps that individuals can take for their own self-care—rather than viewing well-being holistically, relationally, culturally, and organizationally—could function to inhibit more structural and deeper responses." Satterthwaite et al., "From a 'Culture of Unwellness' to Sustainable Advocacy."

169 Phone interviews with former UN staff, January 2020, and mental health trainer, October 2020.

170 United Nations, "Mental Health Matters: A Healthy Workforce for a Better World," available at https://www.un.org/en/healthy-workforce/ .

(including a mapping of discrimination and educational activities); commence the development of mental health policies; and work with UN entities, duty stations, and regional offices to develop tailored action plans and resources.

The implementation board recommended training leaders and managers, making information more readily available to managers, disseminating personal stories to reduce stigma, and changing policies.[171] However, there are no plans to develop a

Box 3. The UN Mental Health and Well-Being Strategy (2018-2023)[172]

The UN's Mental Health and Well-Being Strategy is built on four themes:

- Creating a workplace that enhances mental and physical health and well-being;
- Developing, delivering, and evaluating high-quality psychosocial services;
- Welcoming and supporting staff who live with mental health challenges; and
- Ensuring sustainable funding for mental health and well-being services.

In addition, the strategy was shaped by four "perspectives," each with several associated objectives:

1. **Staff member experience** (the UN accepts and understands mental health challenges; staff with mental health diagnoses are supported to continue their career; and mental health and well-being services are accessible and acceptable);
2. **Service delivery and business approach** (mental health is promoted in the day-to-day work environment; evidence-based prevention and intervention methods are integrated into medical, counseling, and human resources practices; psychosocial and mental health services are delivered within safety and quality systems; and services are integrated to holistically provide mental and physical healthcare);
3. **Learning and development** (UN leaders and managers have the knowledge, skills, and accountability to support and contribute to the mental health and well-being of staff; and staff have the knowledge, skills, and responsibility to contribute to a healthy and productive work environment); and
4. **Use of resources** (human and financial resources for mental health are mobilized and allocated commensurate with need; and health insurance supports preventive programs and optimal treatment).

Specific actions have included:

- Better resourcing and distributing psychosocial support and mental health services;
- Implementing stigma-reduction and health-promotion activities;
- Initiating preventive interventions;
- Establishing a workplace well-being program, including tools for managers and teams;
- Reviewing UN health insurance provisions and social protection schemes;
- Creating systems to enable and oversee the safety and quality of psychosocial support programs; and
- Completing a multidisciplinary workforce development plan.

The expected outcomes (and associated indicators) include:

- Increased staff resilience, productivity, and engagement (sick leave);
- Workplace acceptance and understanding of mental health challenges (internalized stigma scale, training);
- Support for staff with mental health diagnoses to continue their career (managerial stigma, return to work, health accommodation, disability rate); and
- Availability, accessibility, and acceptability of mental health and well-being services.

171 Interview with UN official, New York, January 2020.

172 United Nations, "A Healthy Workforce for a Better World: United Nations System Mental Health and Well-Being Strategy."

UN-wide policy on mental health. Instead, the UN will develop framework documents that will be mainstreamed across future policies in other areas. The development of a manual is also being planned, and the UN Staff and Stress Counsellors Working Group is examining standards for staff counselors. In addition, the UN is defining minimum requirements for external healthcare services provided to UN staff.

The strategy, which was initially a priority for the secretary-general, has had a "liberating effect across the system" by promoting mental health more widely and openly.[173] However, buy-in among senior leaders in the UN Secretariat was described as "mixed," and the momentum seems to have been lost by 2019. As one UN official recognized, "People [got] excited about posters and pins," but profound change will require investment in the long run.[174] After its adoption, the strategy was not given the oxygen needed and was put at the bottom of the list of reforms.[175] Other human resources initiatives, including on disability, also reduced the bandwidth for taking forward the mental health strategy.

By early 2020, the implementation board was composed of lower-level staff, including ombudsmen, doctors, and staff representatives, who were committed but lacked decision-making power. Only one person is in charge of coordinating implementation of the strategy for the whole UN system alongside dedicated people responsible for executing implementation within UN agencies, funds, and programs. However, there was no one to follow up on the strategy's implementation in the Secretariat itself, and conversations between the Department of Operational Support and Department of Management Strategy, Policy and Compliance on the division of roles and responsibilities are still ongoing. Former staff were not included in the advisory board, and mission staff saw the strategy as "very centralized in New York." The lack of dedicated resources to implement the strategy was also mentioned as a challenge.[176]

Importantly, the strategy covers only civilian staff, not uniformed personnel contributed by member states to peacekeeping operations. One UN official called this a big gap worth examining, especially as civilians are already generally "more privileged," with higher salaries and better access to health insurance than troops and national staff.

The Current Response

Over the years, the UN has put in place processes and structures to address mental health before, during, and after deployment to peace operations. However, important gaps remain.

Preparedness and Prevention

Although the effectiveness of preventive measures like screening is debated, mental health should be part of efforts to prepare UN personnel going to the field. Selection and training processes currently include cursory elements intended to prevent and raise awareness of mental health issues and to help personnel manage stress.

Selection and Screening

The UN assumes some responsibility for the mental health of staff through screening and prevention before deployment. Medical clearance is required as part of the staff onboarding process. The screening form for prospective employees includes questions such as "Do you have any condition which will need medical, surgical or psychological intervention or treatment within the next 12 months?" and "Do you have any physical or mental health conditions which could make it difficult for you to live and work in, or travel to, a remote area with limited access to health care facilities?"[177] Otherwise, UN medical services do not undertake a mental health consultation or discussion at this stage.

Screening is controversial in the mental health field. Some advocate for a certain level of screening,

173 Interview with UN official, New York, December 2019.

174 Ibid.

175 Interview with UN official, New York, December 2019.

176 UNICEF contributed a staff member for six months, and UNDP contributed $100,000.

177 United Nations, "Employment Medical Review Questionnaire."

as is already common in the military services of some countries. Military security clearances may require prospective recruits not only to fill out self-declaration forms, as in the UN, but also to authorize the military to seek the medical opinion of their personal healthcare provider or to participate in direct medical consultations with military medical services that include a psychosocial element. Some interlocutors indicated that more robust screening could help identify those with a history of alcohol dependence or psychiatric disease, which precludes troops from participating in peacekeeping operations. As one mental health expert recognized, "Everything is not caused by the mission," and some staff members can come in with "complex emotional baggage."[178]

On the other hand, the effectiveness of screening remains an open question. Screening can be associated with the false idea that some people have mental health issues and others do not. There are also questions about what indicators would be used to screen people. A history of mental illness, for example, does not necessarily have to be a red flag. While some dispositional factors, behaviors, and triggers can indicate how someone might perform and help identify problem areas, "it is not an exact science," and predicting how people will react to the hardship environment is difficult.[179] As one mental health expert warned, it is important to "go beyond just the checklist [and get] a professional judgment as part of the screening process."[180] Many interviewees even indicated that they would rather have colleagues who had experienced traumatic events and mental health issues than colleagues who dismiss mental health.[181]

> Selection and training processes currently include cursory elements intended to prevent and raise awareness of mental health issues and to help personnel manage stress.

Several mental health experts therefore recommended focusing less on screening and more on mental health literacy and education: demystifying mental health, warning staff about stressors, providing tools to deal with stressful situations, teaching how to recognize and respond to mental health issues, and "institutionaliz[ing] resilience from recruitment to retirement."[182] While psychological assessments and cognitive tests could be part of this process, they could be used to help identify vulnerability and resilience factors and to design prevention, monitoring, and support plans rather than to screen out staff.

There is also an open question about whether to limit the number and length of deployments to hardship duty stations. One mental health expert indicated that "the number of deployments doesn't matter: you can have someone with ten or more deployments who isn't exposed to anything particularly traumatic. You can also have someone with one deployment who has witnessed or been exposed to something very traumatic."[183] Instead of putting an arbitrary limit on the number of deployments, the UN could ensure that medical doctors check the mental health of staff accumulating multiple deployments or transferring from mission to mission and provide tailored advice and clearance on a case-by-case basis.[184]

Training

All mental health experts interviewed for this study agreed that staff are at greater risk of developing mental health issues if they are unprepared. Training is thus an essential preventive tool.[185]

178 Phone interview with mental health expert, May 2020.

179 Phone interview with mental health expert, June 2020.

180 Ibid.

181 For example, one manager stated, "I'd prefer people who collapsed." Phone interview with staff member from a special political mission, April 2020.

182 Canadian National Defence, "Surgeon General's Mental Health Strategy."

183 Phone interview with mental health expert, May 2020.

184 Another mental health expert distinguished between robustness (based on the individual genetics and natural disposition) and resilience (based on what can be learned along the way, through capacity building). However, everybody has a limit to what they can take. The expert used a cup metaphor: "Some people have bigger glasses, others have smaller glasses. We accumulate traumas over time, which can be thought of as water dripping into a glass. When the cup is full, it forms a convex at the top of the cup. One more drop of water, and the cup overflows." As a result, individuals with hardened characters can have a small event overwhelm them. Phone interview, May 2020.

185 Phone interview with mental health expert, May 2020.

Generic military training often exposes troops to potentially traumatic scenarios. Although there has not been enough empirical data to prove that military training protects individuals' mental health, it generally increases their confidence and preparedness, which are critical factors of resilience.[186] By contrast, police and civilian staff generally do not feel as prepared for the level of exposure to risk they experience in peace operations (see Box 4).

Staff generally agree that simulation trainings are useful. One staff noticed that she was not well during the training, as she started crying during the simulated shooting. Another mentioned that a non-UN training helped her realize she had not recovered from a traumatic experience two years before, as she broke down during the evacuation scenario.[187] However, there is no monitoring or follow-up after these trainings. They are generally treated as a box to tick during the induction process, raising questions about their value.

Others criticized hostile-environment simulation trainings like SSAFE (see Box 4). "How many kidnapping simulations do I have to go through?" asked one staff member. "I have done lots of them, and I actually take issue with the way they are run.… [They are] not sensitive enough to existing trauma and issues people have."[188] SSAFE is usually conducted by military personnel in the mission rather than UNDSS, and according to one staff member, "They forgot that it was a simulation and that they were dealing with civilians.… They try to make them extreme to scare people." There were also concerns that the trainings did not address gender-specific needs and issues. One interlocutor described them as being delivered by a "boys' club" of former police or military personnel who took a macho approach.[189]

There is no mental health training specifically for leaders and managers. Heads of missions are often former diplomats and politicians, and many see them as lacking proper management training.[190] As a senior mission leader stated, "I have never been inducted or briefed on [mental health] as a leadership function.… No one taught me how to handle it."[191] The same is generally true for heads of field offices, who are on the frontlines of responding to the mental health needs of staff. In military components, the level of openness and preparedness of force commanders and commanding officers can significantly vary. As one mental health expert warned, "It is important to support the commanding officer, because if they melt down, the entire unit melts down."[192]

Support Systems in the Field

Training is not a panacea, and the best training will not make staff immune to stress and mental health issues.[193] Training thus does not preclude the UN from establishing robust support structures to address mental health during deployment (see Box 5). Support measures currently include rest and recuperation (R&R) leave, based on the hardship classification of each duty station, which offers mandatory breaks to all staff serving in the field. There is consensus that R&R is crucial to the mental health of staff. However, it is not enforced consistently, and some staff forfeit their R&R and stay in the field for long periods of time. Beyond R&R, there are staff counselors in missions and emergency structures that can be activated. In some missions, staff morale and welfare received increased attention after specific traumatic incidents. After hostilities broke out within a UN compound in Juba, South Sudan, for example, "the Secretariat initiated various measures to increase psychosocial support, resilience and trauma

186 Phone interviews with mental health experts, May–June 2020.

187 Phone interviews with UN staff, April 2020.

188 Phone interview with former peacekeeping staff member, July 2020.

189 Phone interview with former peacekeeping staff member, July 2020.

190 "The majority of heads of mission and deputy heads of mission appointed from outside the UN system have previously served as diplomats or in a national government. The remainder have served in another international organization, the military, academia, or an NGO." Kevin Kennedy and Laura Powers, "Senior Leadership Training in UN Peace Operations," International Peace Institute, February 2019.

191 Interview with former head of mission, New York, February 2020.

192 Phone interview with mental health expert, May 2020.

193 One mental health expert highlighted that "there is a difference between knowing and realizing. Knowing is intellectual, whereas realizing is more emotional." Phone interview, May 2020.

Box 4. Mental health training for UN peacekeepers

Training on mental health for UN peacekeepers has recently evolved. For military personnel, the UN Core Pre-deployment Training Module includes an introductory session on "stress management" for individual peacekeeping personnel.[194] It covers the definition of stress, how to distinguish between "useful" and "harmful" stress, phases in the "fight-or-flight" response, common symptoms of negative stress, sources of stress, types of stress, stress-management techniques, and negative coping mechanisms. A representative of a peacekeeping training school said they are attempting to make the module more practical and add more on how to prevent or resolve mental health issues.[195]

For civilian staff, for a long time there was only one short module on mental health in the mandatory computer-based training courses "Basic Security in the Field" and "Advanced Security in the Field," which were part of the staff onboarding process. The module provided information on the type of stress experienced in the field, symptoms, and negative coping mechanisms. However, many staff ended up doing this training after they had already joined the duty station, leaving little space for them to change their mind about their decision to deploy.

These trainings have since been replaced by BSAFE, a one-hour, online security-awareness training that is mandatory for all UN personnel and is also recommended for dependents and families. It includes a scenario-based story about a staff member experiencing flashbacks and stress related to a robbery and a staff member experiencing mood changes, exhaustion, and relationship issues. It also provides a basic introduction to health as "a state of physical, mental and social well-being, not merely the absence of disease." Parts of the training are problematic, however. A question is raised—"Can stress kill you?"—followed by photos with simplistic associations: one picture shows an individual laughing and is labelled "good stress," and another shows the same individual holding her head in her hands and is labelled "bad stress." There are then short explanations of cumulative stress and traumatic stress, including PTSD. The slide about getting help mentions the UN Department of Safety and Security's (UNDSS) Critical Incident Stress Management Unit (CISMU) and mission-based counselors, with a short reassurance that "seeing a counsellor does not mean you are crazy or abnormal." A breathing exercise is shown as an example of how to manage stress.[196]

In addition to BSAFE, a thirty-minute component of the in-mission induction training is generally dedicated to stress management. Staff who deploy to hardship duty stations are also provided a mandatory three-day training on "Safe and Secure Approaches in Field Environments" (SSAFE), which includes practical simulations based on potentially traumatic scenarios such as encountering checkpoints, experiencing a car-jacking, being taken hostage, and providing basic life support.[197] It is mission-specific and therefore needs to be held each time new staff join a mission. Some missions have suspended this training during the COVID-19 pandemic.

194 Integrated Training Service, "Core Pre-deployment Training Materials," available at https://research.un.org/revisedcptm2017/Module3 .

195 Phone interview with senior representative of a peacekeeping training center, May 2020.

196 UNDSS, "BSAFE," available at https://training.dss.un.org/course/category/6 .

197 Peacekeeping, "SSAFE Training Held in Abyei," October 3, 2018.

Box 5. UN mental health support structures[198]

At the headquarters level, the UN mental health support structure comprises:

- UNDSS's Critical Incident Stress Management Unit (CISMU), including the chief of CISMU and regional counselors;
- Staff counselling or welfare units or sections in the organizations that are members of the UN Security Management System (UNSMS), including chiefs and heads of sections or units and staff counselors and staff welfare officers;
- The Psycho-social Crisis Coordination Centre, a subgroup of the Crisis Coordination Centre, which coordinates the provision of psychosocial services to UNSMS personnel and their families in crisis settings and is activated in crisis situations, operating twenty-four hours a day; and
- The Critical Incident Stress Working Group (CISWG).

At the field level, the support structure comprises:

- Critical incident stress intervention cells;
- CISMU field counselors managed by UNDSS;
- Staff counselors managed by the Departments of Peace Operations, Operational Support, and Political and Peacebuilding Affairs; and
- Staff counselling or welfare units or sections in UNSMS organizations.

There are two main coordination mechanisms for critical incident stress management in the UN system: the Critical Incident Stress Working Group and the UN Stress/Staff Counsellors Group. The former, established in 2012, includes the UN Medical Emergency Response Team, the Emergency Preparedness and Support Team, the Staff Counsellor's Office, and counselors from twelve UN agencies, funds, and programs and the World Bank. It evaluates issues and develops policies related to staff emergency psychosocial needs. The latter includes all staff and stress counselors in the UN system and explores problems, develops and reviews guidance documents, and provides guidance and support to staff and stress counselors. The Office of Internal Oversight Services (OIOS) "was unable to conclude on the effectiveness of both… as there was little evidence of their activities."[199]

counselling in field missions, as well as for staff morale and welfare."[200]

Nonetheless, the architecture for psychosocial services in the field remains inconsistent and fragmented. Headquarters officials recognized that the structure is "chaotic," without a centralized UN health service. The Department of Management Strategy, Policy and Compliance, Department of Operational Support (DOS), and UN Department of Safety and Security (UNDSS) all work on mental health, resulting in duplication, incoherence, and accountability gaps. There are two counselling services: the Staff Counsellor's Office in the Office of Human Resources Management for headquarters and offices away from headquarters; and UNDSS's Critical Incident Stress Management Unit (CISMU) for all other duty stations, including peace operations. The Office of the UN Ombudsman and Mediation Services and staff associations can also play a role due to their involvement in addressing workplace problems.

198 UNDSS, "UN Security Management System: Security Policy Manual," October 2017, Chapter VI.

199 OIOS, "Audit of the Effectiveness and Efficiency of the Critical Incident Stress Management in the United Nations Secretariat in New York," OIOS Report 2019/065, July 24, 2019.

200 Some of the programs include expanded individual in-person and tele-counselling across the mission, including in deep field locations; additional training on emergency and crisis management and self-care; and expanded options for staff welfare, including enhanced accommodations and office and recreational facilities. Internal staff rotation policies are under review to allow staff in the most difficult duty stations to be rotated within the mission to help manage their stress and trauma. UN Security Council, *Letter Dated 17 April 2017 from the Secretary-General Addressed to the President of the Security Council*, UN Doc. S/2017/328, April 17, 2017.

Critical Incident Stress Management Unit

UNDSS's Critical Incident Stress Management Unit (CISMU) was created in 2001 and has been operational since 2003. The unit serves "as the central body responsible for ensuring the adequate and timely coordination and provision of psychosocial services" for staff at non-headquarters offices at risk of experiencing stress or critical incident stress in the UN system.[201] It works closely with the UN Medical Services Division; human resources officers; counselors in UN agencies, funds, and programs; and senior and line managers across the UN system.

> The UN's architecture for psychosocial services in the field is "chaotic," without a centralized UN health service.

CISMU is primarily responsible for developing policies, standardized methods, and procedures for managing stress; developing training and certification courses; coordinating interagency critical incident stress management and rapidly responding to incidents; maintaining a roster of stress counselors for rapid deployment; and researching and monitoring stress-related issues.[202] The unit also has responsibilities related to preparing for and responding to emergencies and managing hostage incidents. For example, under the guidelines for staff and stress counselors in the field on preparing for the COVID-19 pandemic, CISMU coordinates the global psychosocial response for UN personnel.[203]

An audit into CISMU by the Office of Internal Oversight Services (OIOS) in 2019 highlighted many shortcomings. In particular, there is no guidance on whether and how to set up a critical incident stress intervention cell, report incidents to CISMU, refer individuals to medical support, or design contingency plans.[204] Coordination among UN entities in the field, including through the sharing of preparedness plans, was reported to be limited.[205] OIOS also indicated that CISMU has not mapped existing internal capacities and external mental health providers; does not collect data on hardship duty stations, the number and location of critical incidents, or the level of psychosocial support needed; and has not analyzed the effectiveness of its training program. Moreover, while CISMU manages field operations, it is based in New York, which has raised some concerns.

Mission Staff Counselors

UN agencies and peacekeeping missions employ their own staff counselors and welfare officers, who respond to day-to-day counselling needs and assist the medical services with mental health cases.[206] A lot of the work done by staff counselors is related to prevention, training, and resilience programs, including outside of mission headquarters. In South Sudan, for example, the UN mission rolled out an eight-module training in several duty stations and provided opportunities for staff to meet with counselors and discuss mental health stigmas and challenges.

In some missions, the staff counselor's office reports to the medical unit in the mission support component. However, these offices also report to CISMU and operate under its technical guidance.

201 UNDSS, "Security Policy Manual," Chapter VI. See also OIOS, "Audit of the Effectiveness and Efficiency of the Critical Incident Stress Management in the United Nations Secretariat in New York," OIOS Report 2019/065, July 24, 2019.

202 On CISMU's mandate, see: UNDSS, "Management of Stress and Critical Incident Stress," available at https://www.un.org/en/safety-and-security/stress-management ; and OIOS Report 2019/065.

203 UNDSS, "Novel Coronavirus (COVID-19) Psychosocial Contingency Plan Preparation Guidelines for Staff/Stress Counsellors in the Field," February 2020.

204 Although five of the twelve documents developed by CISMU had been finalized by 2019, "there was no guidance on important elements of critical incident stress management identified in the UNSMS Security Policy Manual, including: a) needs assessments for psychosocial services; b) criteria on whether and how to set up a Critical Incident Stress Intervention Cell (CISIC)…; c) maintaining a functional network of peer helpers, peer support volunteers, and family focal points for relevant UNSMS counsellors; d) gathering, recording and reporting data for analysis and performance measurement; e) developing a psychosocial contingency plan; and f) criteria on when an individual should be referred for medical support." OIOS Report 2019/065. According to CISMU, a Field Manual for UN Counselling Services to address these gaps was being developed by the Critical Incident Stress Working Group. OIOS Report 2019/065.

205 CISMU was notified of 145 incidents in 2017 and 101 incidents in 2018 and directly responded to 59 incidents. Stress and staff counselors performed 14,035 counselling "acts" in 2017 and 9,169 between January and September 2018. OIOS Report 2019/065.

206 The UN human resources webpage describes what staff counselors can offer, including: "Confidential psychological 'first aid' for staff and families requiring immediate psychological or emotional support; Confidential short-term individual and group counselling sessions provided by highly qualified mental health professionals; Confidential consultations to managers on issues related to the well-being of staff; Training programmes to help staff build emotional resilience and cope with personal stressors; Confidential, supportive and caring approach so that you feel comfortable in seeking the assistance you need." United Nations, "HR Portal: Mental Wellbeing/Psychological Support," available at https://hr.un.org/page/mental-wellbeing-psychosocial-support .

The critical incident stress management cell, a mechanism used at the field level to coordinate psychosocial services, includes both UNDSS counselors and a mission's staff counselors and can be activated permanently or according to need. This results in a confusing and complex structure for psychosocial support in the field.

There are also issues with reporting on mission-level psychosocial support. There is no system for keeping records, which often depends on the individual initiative of staff counselors.[207] While there is data on the medical cases treated, there is no unified system for monitoring mental health cases. In the case of critical incidents, OIOS found that "the information covered in the reports was inconsistent" and that there was a need to improve post-incident reporting and follow-up.[208] The limited reporting that does exist focuses on generic information and is not always useful for staff counselors.

Capacity is also limited. One staff counselor can cover hundreds of people, and there are few external resources for mental healthcare in hardship duty stations.[209] Some duty stations have no counselors despite a high level of need. According to OIOS, "Of the 16 duty stations with an average certified sick leave per person of 16-20 days only one had a counselor. Of the seven duty stations with an average certified sick leave per person of 21 days or greater, there was only one duty station that had a counsellor."[210] This is particularly true in smaller missions. One former staff member explained that staff counselors were only available at the UNDP office on the other side of the capital, which was difficult to reach without easy access to a vehicle.[211]

One of the main issues raised about staff counselors relates to their positioning: they are embedded with their colleagues and experience the same stressors. As a result, they are themselves affected by the environment and lack psychosocial support. "It is difficult to be isolated and support traumatized people," said one staff counselor. She described how seeing so many people during one particular crisis "was unhealthy for us.… Nothing is put in place through the organization in terms of support to staff counselors. I need more."[212] Like other UN staff, counselors often resort to individual coping mechanisms and self-care, including personal communication with external counselors.

The positioning of staff counselors can also make it difficult for them to remain professional, credible, and trustworthy in the eyes of colleagues. Their proximity to those they are treating raises concerns over confidentiality, discretion, and protection.[213] Some staff mentioned that seeing the counselor attending the same parties and social events made them uncomfortable, as they suspected that their stories would be shared and be the subject of gossip. "At the UN, people talk, vent.… Everybody knows the intimate details of your life," said one former staff member. Staff counselors have to walk a fine line to reassure colleagues about their professionalism. As one counselor said, "The benefit [of internal staff counselors] is that we understand the system. But if we are too close, there is no trust." As a result, some choose to limit their social activity.[214]

Staff counselors embedded in missions have to walk a fine line to reassure colleagues about their professionalism.

Similarly, this positioning of embedded staff counsellors can create challenges for personnel trying to access psychosocial care in a safe, accept-

207 OIOS also noted that CISMU did not have a secure and protected mechanism to maintain records such as client contacts and counselors' activities. OIOS Report 2019/065.

208 Ibid.

209 In the mission in South Sudan, the staff counselling unit is "headed by a Chief at the P-4 level who reports to the Chief Medical Officer at the P-5 level and is supported by one international staff, four United Nations volunteers and five national staff." OIOS, "Audit of Staff Welfare and Counselling Activities in the United Nations Mission in the Republic of South Sudan," OIOS Report 2019/131, December 19, 2019.

210 OIOS, Report 2019/065. In 2017 and 2018, the average certified sick leave per person was four days for duty stations in category A (minimal level of hardship), compared to eleven days for those in category E (maximal level of hardship).

211 Interview with former UN staff member, New York, January 2020.

212 Phone interview with staff counselor, February 2020.

213 Interviews with UN staff counselor, February 2020, and with UN staff, January–July 2020. See also: OIOS, "Audit of Medical and Staff Counseling Services in the United Nations Assistance Mission for Iraq," OIOS Report 2013/135, December 19, 2013.

214 Interview with former UN peacekeeping mission staff member, January 2020; Phone interview with UN staff counselor, February 2020.

able way. Staff who did not want colleagues to know about their mental health struggles mentioned that there was no way to discreetly go to the staff counselor's office. A 2018 OIOS report on the UN Support Office in Somalia, for example, found that "counsellors were not always available, and the rooms they used for counselling services lacked privacy."[215] Because most staff counselors are at the P3 or P4 level, some senior staff and leaders hesitate to go to them, preferring to seek support outside of the mission. Striking the right balance between ensuring access and maintaining professional boundaries is also a challenge for staff counselors. One counselor reported facing challenging situations when staff only wanted to meet outside of office hours or outside of the counselor's office—a particular concern for women counselors expected to support their male colleagues or senior leaders.

In addition, the fact that staff counselors are mostly civilians can be an impediment for military staff to consult them. The quality of the therapeutic relationship is important, and to work effectively with military and veteran populations, practitioners may need to understand the military culture.[216] Though offering tailored support to each category of personnel would be expensive and difficult, experts agreed that having a uniformed psychologist for uniformed personnel could be useful.

Another barrier is that mission counselors do not always have the cultural proximity and language fluency needed to create a "comfort zone" to discuss mental health. As one mental health expert explained, "There are going to be cultural barriers—language differences, body language differences, cultural differences, social differences, translation gaps. Even in countries that speak the same language, mental health language gaps will persist."[217]

Some interviewees also raised concerns about the standards for staff counselors and doubted their level of accountability, including for violating confidentiality agreements. One headquarters official recognized that job descriptions for staff counselors are inconsistent, and they lack professional supervision.[218] OIOS highlighted that "CISMU did not establish a formal mechanism to ensure that qualified professionals were recruited, technically supervised and trained," and there was no evidence that external mental health professionals were vetted.[219]

Medical Services

There are two types of medical services in UN peace operations: the military medical cell, which manages hospitals deployed by T/PCCs and is under the authority of the force commander; and the medical services section, which manages UN clinics and contracted hospitals and is under the authority of the head of mission support.[220] Military medical cells have uniformed clinical psychologists or psychiatrists, and some troop contingents also bring their own experts to provide mental health and psychosocial support. On the civilian side, the medical service section also have psychiatrists. Staff counselors can submit "staff counselors' reports" referring patients to these medical services for consultations, psychiatric evaluations, or sick leave.

Some interviewees emphasized the importance of medical services in providing psychosocial care, in part because going to doctors is often perceived as "less stigmatizing" than going to staff counselors. However, the number of psychiatrists in missions is limited. Medication is also limited and may not fit the mental health needs of staff.[221] Medication in level-I and level-II hospitals is sometimes limited to sedatives, which some described as a serious issue, as these can impair staff functioning in unpredictable and risky environments.

215 OIOS, "Audit of the Conduct and Discipline Function, Staff Welfare Activities and Counselling Services in the United Nations Support Office in Somalia and the United Nations Assistance Mission in Somalia," OIOS Report 2018/114, November 27, 2018.

216 Forbes et al., "Treatment of Military-Related Post-traumatic Stress Disorder."

217 Phone interview with mental health expert, May 2020.

218 Interview with UN senior official, New York, December 2019.

219 OIOS Report 2019/065.

220 Connolly and Johansen, "Medical Support for UN Peace Operations in High-Risk Environments."

221 One staff member reported that her diagnosis was wrong, as she was given psychiatric medicine that was not the right treatment for her occupational stress. Phone interview with UN staff member, April 2020.

Welfare Units

Some missions have welfare units that are separate from the staff counselor's office. In others, like the mission in Darfur, the staff counselor's office and welfare unit are merged. Lumping together staff counselors and welfare officers can be misleading, diminish the credibility of counseling services, and lower the quality of support when welfare officers are put in the position of acting as a counseling resource.[222]

Indeed, rather than psychological support, welfare officers are expected to develop programs to improve the quality of life and manage the recreational and social opportunities for staff: securing a staff recreation space and facilities like gyms, fitness centers, restaurants, and bars; setting up Internet and satellite connections; and organizing outings, trips, film nights, yoga classes, weekly markets, and other social events. They may also organize memorial services and serve as resources for families following deaths among staff.

Staff generally recognized the importance of the activities organized by these units. They "made the environment better… [and] helped clear your mind," remembered a former peacekeeper. Gyms, workout classes, and markets are particularly appreciated. Some, however, pointed to an overfocus on "happy hours" and parties and regretted that such activities could encourage negative coping mechanisms like heavy alcohol consumption.[223]

> Mission leaders have a significant role to play in protecting the mental health of their staff. "You can't delegate everything to counselors."

Others recommended more training for welfare officers to enhance their professionalism and ensure more sustainable and holistic welfare strategies. This recommendation is echoed in several audit reports by OIOS. For example, OIOS highlighted the need for the UN missions in Somalia to "formulate a strategy and action plan for staff welfare activities" in 2018 and noted the lack of a welfare strategy in the UN mission in South Sudan in 2019.[224] OIOS has also pointed to the lack of staff input into welfare activities, the lack of monitoring and assessment of the adequacy and effectiveness of welfare initiatives, and concerns about the management of these units and their control of expenditures.[225]

The Role of Managers and Senior Leaders

Mission leaders have a significant role to play in protecting the mental health of their staff. Some managers recognize this role. As one senior leader stressed, "You can't delegate everything to counselors."[226] Some leaders have taken it upon themselves to prioritize staff well-being on an ad hoc basis by visiting remote locations and engaging in discussions with staff. One manager who used to suffer from PTSD explained that she never denied vacation and studied systemic and organizational psychology to better manage her team.[227]

However, the duty to ensure staff welfare is not established in the compacts of heads or deputy heads of mission or the instructions given to senior mission leaders. "It was not in [the] performance indicators—nobody told us that we were the custodians of well-being," said one former mission leader.[228] Many staff reported the need to improve the quality of management and to sensitize leaders to mental health so they can create healthy workplaces. One staff member of a special political mission pointed to the lack of understanding and care from managers: "They don't understand how you live, they have no field experience.… Managers are

222 Welfare officers who have a degree in sociology, social work, social science, or a "similar discipline" and with experience in "planning large scale recreational and welfare events" might be in positions to act "as a non-clinical counseling resource to any staff member within mission area requiring non-judgmental support and assistance in resolving any personal and/or work-related problem(s) in consultation with the Staff Counselors as necessary." UN Careers, "Job Opening: Staff Welfare Officer, P3," 2020, available at https://careers.un.org/lbw/jobdetail.aspx?id=132255&Lang=en-US .

223 IPI virtual roundtable discussion, July 21, 2020.

224 OIOS, "Audit of Staff Welfare and Counselling Activities in the United Nations Mission in the Republic of South Sudan," OIOS Report 2019/131, December 19, 2019; OIOS Report 2018/114.

225 Ibid.

226 Interview with official at UN headquarters, New York, February 2020.

227 Phone interview with UN official, April 2020.

228 Ibid.

burning out people." Examples were given of managers canceling staff's trips to the capital (the only place where they could get their medication); refusing to establish telecommuting arrangements; denying vacation requests; and constantly putting their staff in crisis mode even when it was unnecessary. One staff counselor mentioned that managers sometimes refuse to send their staff to counselling training sessions "because there is so much work."[229]

The UN has recently recognized that "leaders and managers play an essential role in ensuring that the UN System supports good mental health. This includes implementing the UN System Workplace Mental Health Strategy, creating a positive work environment, and supporting personnel who are experiencing a mental health condition."[230] Managers are advised to raise awareness and knowledge of what promotes well-being and good mental health; review the workplace for risks or vulnerabilities and understand the need for sick leave; establish routines; and talk to counselors about what resources are available. They are also given tips on how to notice changes in the behavior or work performance of staff members, start conversations about mental health, and act early.[231] However, such management skills have yet to be fully integrated into the selection and recruitment processes of prospective leaders.

Informal Support Structures

Beyond counselling, having informal, everyday systems of support can make a difference for staff who are isolated in the field. One former civilian peacekeeper emphasized that having "a good group of friends helped [with] keeping each other sane."[232] Although many interlocutors mentioned the supportive role of colleagues, colleagues can also become detrimental to mental health in toxic work environments, especially when the boundary between professional and personal life is blurred.

There is no established "buddy system" for staff in UN peace operations. Since 2007, the UN volunteer program has included an optional "buddy scheme" to support incoming volunteers to adjust and settle, and although it does not focus on mental health, it offers social support to newcomers in challenging environments.[233] More broadly, in the framework of the Mental Health and Well-Being Strategy, the UN is seeking to promote peer support and recommends that staff be "looking after others and yourself."[234] These initiatives reflect the WHO's recommendation that "all aid workers, and especially health workers, should be able to provide psychological first aid."[235]

Lack of social support can especially be a challenge for senior leaders. They often lack support and mentorship from UN headquarters, creating a sense of being at the top of the responsibility chain without backup or advisers to turn to. One mission leader complained that "nobody at HQ calls to ask how you are doing… as if as [under-secretaries-general], [assistant secretaries-general], [and] directors, we did not have emotions or a need to connect."[236] However, senior mission leaders have recently been given informal access to peer-to-peer consultations and to a "mentor" through the Leadership Partnering Initiative.[237]

Communication with friends and family at home is another key coping mechanism. DOS has striven to improve communication technologies in all duty stations and to ensure access to the Internet even in the most remote areas. In some missions, however, staff reported that communications were restricted. For example, during the COVID-19 pandemic, the UN mission in the Central African Republic had

229 Phone interview with UN staff counselor, February 2020.

230 United Nations, "Mental Health Matters: A Healthy Workforce for a Better World," available at https://www.un.org/en/healthy-workforce/ .

231 United Nations, "Creating a Mentally Healthy Workplace: What Can Managers and Leadership Do?"

232 Phone interview with former UN staff member, August 2020.

233 The program formally lasts one month and can then continue on an informal basis. UN Volunteers, "A Buddy Scheme for UN Volunteers."

234 United Nations, "Supporting a Colleague," available at https://www.un.org/en/healthy-workforce/files/Supporting%20others.pdf .

235 "Psychological first aid is a humane, supportive response to a fellow human being who is suffering and who may need support that can be delivered by anyone who is trained… In a minority of cases, a chronic mood or anxiety disorder will develop. The person should receive appropriate care as part of a more comprehensive aid response. Clinical treatment will probably be needed," including medication. DPKO and DFS, "Medical Support Manual For United Nations Field Missions," p. 104.

236 Interview with former head of mission, New York, February 2020.

237 International Forum for the Challenges of Peace Operations, "Strengthening the Selection, Preparation, Support and Appraisal of Senior Leadership in UN Peace Operations," 2017.

limited bandwidth, and staff who had to work from their private homes in Bangui had limited or no access to the Internet. In addition, staff do not necessarily want to use Internet at the office to seek care through tele-health services or have private conversations.

Post-deployment: Administrative and Legal Processes

According to one study, "Over a quarter of peacekeeper veterans are likely to continue to have a need for some kind of mental healthcare and support over the long-term."[238] However, the UN provides few mental health resources to personnel post-deployment.

Long-Term Resilience and Continuous Mental Healthcare

There is consensus among mental health experts that follow-up care is key, especially for PTSD, which can appear months after deployment. One expert even stated that "there is a duty for organizations to keep their doors left open for personnel after deployment for five years—civilians, military, consultants, temporary staff—so that they know they're taken care of. Even just the knowledge of this increases confidence and security."[239]

> "There is a duty for organizations to keep their doors left open for personnel after deployment for five years… so that they know they're taken care of."

The end of a mission and repatriation can also pose professional and personal challenges that may be detrimental to mental health. This has been well-documented for military personnel. For example, a British survey found that many soldiers who went back to civilian life post-deployment developed mental health issues.[240] They were taken out of a supportive, cohesive environment and had skills that were not transferrable or understood. The isolation can be especially acute for senior leaders. "Most soldiers on mission live the experience together and come back together and can tap that bond. That is not the experience of a general. I came home alone," explained Dallaire. Civilian staff often experience similar feelings after leaving a mission.

However, psychosocial support provided by the UN often stops when a contract ends. As one staff member explained, "We get a medical checkup before heading out to check if we are fit to deploy, but no one checks in what state we come back. Your contract and health insurance just run out."[241] Others mentioned that the insurance kept challenging sessions with psychologists and that it was impossible to get ahold of staff counselors in New York for a suicidal colleague who had come back from a field deployment.[242] There is also a lack of follow-up with former staff for the purposes of human resources strategic planning and duty of care. As previously mentioned, staff who left the UN were not counted in the survey on mental health, and there is no public data on mental health issues among retirees and other former staff.

Claims by Troop- and Police-Contributing Countries

With the limited availability of follow-up care, filing compensation claims is often the only way to get support and reparation for mental health issues induced by UN service. Some soldiers have sued their state. Most recently, Irish peacekeepers from the UN Disengagement Observer Force sued the Irish government for the physical and psychological injury they suffered following a 2013 ambush, including PTSD.[243] T/PCCs can also file claims with the UN on behalf of the personnel they contributed to a peacekeeping operation.

Within the Secretariat, DOS's Uniformed Capabilities Support Division processes PTSD claims and is currently undertaking a study on PTSD requested by the General Assembly's Advisory Committee on

238 Forbes et al., "The Long-Term Mental Health Impact of Peacekeeping."

239 Phone interview with mental health expert, May 2020.

240 Kim Gordon, Karen Burnell, and Clare Wilson, "Outside the Military 'Bubble': Life After Service for UK Ex-armed Forces Personnel," *Front Public Health* 8 (2020).

241 Phone interview with former UN staff member, January 2020. Insurance coverage ends on the last day of the month of separation.

242 Interviews with current and former UN staff, January 2020.

243 Conor Gallagher, "Irish Peacekeeping Veterans Sue the State over Ambush of Convoy in Syria," *Irish Times*, July 15, 2020.

Administrative and Budgetary Questions and Fifth Committee. One of the challenges with PTSD claims is the difficulty of planning for them in budgets, as PTSD is often discovered years after deployment, including after a mission has closed and the Secretariat no longer has financial resources. There is currently a significant backlog of PTSD claims from T/PCCs to the UN. DOS "received 342 cases in 2019, of which only 24 cases have been reviewed, owing to a lack of required capacity.… 304 cases of the 342 pending cases originate from closed peacekeeping operations where resources are not readily available to compensate the claimant."[244] The Secretariat also "anticipated receiving at least a few hundred additional PTSD claims in the future but could not estimate their amount and timing since the submission of claims was solely within the purview of Member States and often occurred long after the traumatic events."[245]

Recognizing these challenges, in 2020, the secretary-general proposed providing dedicated funding for PTSD compensation as well as creating three new positions and using consultancy services to manage and process PTSD claims. This provision is included in his report's section on "major changes in regular activities," demonstrating the growing profile of the issue.[246] The Advisory Committee recommended against including the proposed resources for PTSD compensation in the support account. Instead, it recommended that the General Assembly request the secretary-general to conduct "a holistic analysis of the policy, legal, administrative and financial aspects of the matter, including the procedures for processing claims, medical standards, budgetary methodology for liability estimation and source of funding," including data on PTSD claims. It recommended the approval of the proposed positions for processing PTSD claims of uniformed personnel, including support staff to process PTSD claims and a P4 psychiatrist mental health officer expected to provide expertise and advice on the determination of causality and degree of permanent loss of function of claimants due to UN duties. However, it recommended against the creation of a new PTSD Unit, pending the results of the holistic study it recommended.[247]

Claims by Civilian Personnel

Civilian staff can claim "compensation in the event of death, injury or illness attributable to the performance of official duties on behalf of the United Nations."[248] An Advisory Board on Compensation Claims considers claims and makes recommendations to the secretary-general.[249] However, there is no explicit mention of mental health conditions as grounds for compensation, and some staff have experienced challenges having their PTSD or other mental health issues recognized. One staff member was told, for example, that PTSD could only be considered under existing rules if it resulted from abduction or a suicide attack.[250]

In addition, the timeframe for filing claims is limited to one year, which is a challenge for PTSD and other mental health conditions that may arise months after the end of a deployment. Although claimants can apply for a waiver to the one-year deadline for certain types of claims, including for loss of function, staff have reported that timing is an issue.[251] In the case of loss of function, which could include, for example, not being able to serve in the army anymore due to PTSD, claimants have

244 Of the 342 pending cases, 288 were from the UN Protection Force deployed to Bosnia.

245 UN General Assembly, *Budget Performance for the Period from 1 July 2018 to 30 June 2019, Financing for the Period from 1 July 2019 to 30 June 2020 and Proposed Budget for the Period from 1 July 2020 to 30 June 2021 of the Support Account for Peacekeeping Operations—Report of the Advisory Committee on Administrative and Budgetary Questions*, UN Doc. A/74/809, May 1, 2020.

246 UN General Assembly, *Budget for the Support Account for Peacekeeping Operations for the Period from 1 July 2020 to 30 June 2021—Report of the Secretary-General*, March 9, 2020.

247 UN General Assembly, *Budget Performance for the Period from 1 July 2018 to 30 June 2019, Financing for the Period from 1 July 2019 to 30 June 2020 and Proposed Budget for the Period from 1 July 2020 to 30 June 2021 of the Support Account for Peacekeeping Operations—Report of the Advisory Committee on Administrative and Budgetary Questions*, UN Doc. A/74/809, May 1, 2020. See also: UN General Assembly, *Reform of the Procedures for Determining Reimbursement to Member States for Contingent-Owned Equipment: Death and Disability Benefit—Report of the Advisory Committee on Administrative and Budgetary Questions*, UN Doc. A/52/410, October 1, 1997, para. 13.

248 United Nations, *Staff Regulations and Rules of the United Nations—Secretary-General's Bulletin*, UN Doc. ST/SGB/2018/1, January 1, 2018, Appendix D.

249 De minimis claims can also be managed by a different delegated authority rather than the board.

250 Interview with UN staff member, New York, January 2020.

251 The deadline is one year from the date on which the staff member becomes aware, or reasonably should have been aware, of such injury or illness. Interviews with former staff member, New York, January 2020, and with UN officials, August 2020. This applies to de minimis claims, which are limited to the reimbursement of medical expenses, funeral expenses, compensation for permanent disfigurement or loss of function, or granting of sick leave credit.

to go through treatment and show that they have "reached maximum medical improvement" and recovered as much as possible before the UN will determine how much it is liable for. One interviewee mentioned that the year-long, Kafkaesque process of asking for sick leave, compensation, and entitlements—from Umoja requests to administrative processes between human resources, medical services, the Office of Staff Legal Assistance, ombudsmen, and the UN Joint Staff Pension Fund—was in itself anxiety-provoking and traumatizing, especially as she was suffering from PTSD.[252]

The UN tribunal has received claims related to mental health illnesses (see Box 6), and claims and litigation related to the mental health of staff are likely only to increase in the future. Recent court decisions have established the liability of organizations for the mental health of their staff. A groundbreaking 2015 court decision in the UK found that Norwegian Refugee Council was liable for physical and psychological injuries suffered by a staff member who was kidnapped, suffered a leg injury,

Box 6. PTSD cases at the UN Dispute Tribunal

Four cases directly related to PTSD have been brought to the UN Dispute Tribunal, one of which is particularly relevant for mental health in peace operations: Porter v. Secretary-General of the UN.[253]

The applicant, an employee of the UN Assistance Mission in Iraq (UNAMI), was anxious to return to work and had his psychologist send a medical report recommending him to be posted in a "non-conflict area," as he had had "more than his fair share of being exposed to situations which were life threatening." The UN doctor informed the applicant that this report could not be received, as a psychologist was not considered a medical practitioner or doctor, and that the Medical Services Division would require a medical report from a psychiatrist. The applicant's psychiatrist found that the applicant had a mild version of PTSD and cleared him for work but not in a conflict zone. UNAMI's offices in Jordan and Kuwait, instead of Iraq, could therefore have been options. However, the Medical Services Division stated that the applicant was "not medically fit to return to UNAMI." The applicant's psychologist wrote again that it was his professional opinion that the Applicant was cleared to return to work and that "even a short return to duty would have been therapeutic in itself."

The UN, however, informed that all vacancy options had been explored and exhausted, put the claimant on special leave without pay upon the expiration of his sick leave, pending the review and decision by the Advisory Board on Compensation Claims. The applicant was subsequently cleared to return to UNAMI in either Jordan or Kuwait, was sent on mission to Kuwait, and then was told to return to and remain in Jordan. His requests for final administrative decisions were not answered.

The tribunal found that "the contested abuse of authority in this case does not arise from a singular, detachable, stand-alone decision by any of the officials in Administration but rather that it is a series of actions and inactions spanning a period of over two years." It established that "UNAMI's decision not to return him to duty was improper and that the [Medical Services Division] abused its authority when it cleared him for return to duty and then changed that decision four months later in spite of the professional opinion of three doctors clearly stating otherwise." "Most of the 20-month period in which the Applicant was estranged from the Organization was gravely marred by contradicting decisions, counter-decisions, non-decisions, miscommunications and non-communications all perpetuating the Applicant's confusion as regards his standing in the Organization." He was paid $5,000.

252 Phone interviews with former UN peacekeeping staff member, May 2018 and January 2020.

253 UN Dispute Tribunal, *Porter v. Secretary-General of the United Nations*, Case No. UNDT/NBI/2012/012, December 4, 2013; UN Appeals Tribunal, *Porter v. Secretary-General of the United Nations*, Case No. 2014-577, February 26, 2015; UN Dispute Tribunal, *Porter v. Secretary-General of the United Nations*, Case No. UNDT/NBI/2012/012, July 1, 2016. 255 The Norwegian Refugee Council had to pay compensation for gross negligence. Young, "Steve Dennis and the Court Case That Sent Waves through the Aid Industry."

and was diagnosed with PTSD and depression.[254] Amnesty International was found liable for the suicides of two staff members in 2019.

In another groundbreaking case in 2019, an Australian court ordered a media company to compensate a journalist who suffered from PTSD following repeated exposure to traumatic events. The plaintiff had complained that the newspaper "had no system in place to enable her to deal with the trauma of her work, failed to provide support and training in covering traumatic events, including from qualified peers, did not intervene when she and others complained, [and] transferred her to court reporting after she had complained of being unable to cope with trauma experienced from previous crime reporting."[255] These same shortcomings could be pointed to in UN peace operations.

Conclusion: Upholding the UN's Duty of Care to all Peacekeepers

By their nature, peace operations are stressful work environments, and war, atrocities, and hardship can take a toll on any individual. Nonetheless, the UN system has to fulfill its duty of care to the troops, police officers, and civilians ready to live in dangerous, isolated duty stations with limited resources. It should approach mental health with the same sense of urgency that the 2017 Santos Cruz report brought to the safety and security of peacekeepers—an operational stress injury should be treated with the same level of seriousness and credibility as a physical injury.

The COVID-19 pandemic has brought growing attention not only to medical support but also to mental health support in peace operations. In response, the UN has been developing promising new initiatives to strengthen literacy on mental health, fight stigma, and offer more flexible working arrangements (see Box 7). Yet major gaps remain. The system of care offered to UN personnel in the field needs to be revamped and to be brought up to the level of hardship they face. This is not an individual issue that staff members should tackle alone. It requires the UN to take a holistic, organizational approach. As debates on the funding and performance of peace operations intensify, UN member states should also increase their focus on the well-being of the people implementing peacekeeping mandates in hardship duty stations, recognize the human cost of peacekeeping, and back robust frameworks to support them.

There is not one overarching solution to the mental health challenges posed by UN peacekeeping, and different people will need different things at different times. Some mental health experts favor psychosocial support and wellness, while others prefer medical, psychiatric, and illness-centered approaches.[256] Rather than identifying the specific methods that should be used to tackle stress disorders, trauma, and PTSD in peace operations, the following are recommendations for UN member states, the Secretariat, and missions to better divide their roles and responsibilities in preventing and responding to mental health issues before, during, and after deployment to peace operations.

Raising the Profile of Mental Health in UN Peace Operations

To reduce the stigma associated with mental health, both the Secretariat and member states should raise the profile of mental health issues and shed light on the difficult conditions facing peacekeeping personnel, emphasizing that UN peacekeeping missions and special political missions are not low-threat environments.

- **As a priority, the UN should demonstrate its commitment to the Mental Health and Well-Being Strategy.** It should extend the strategy to uniformed personnel; establish a dedicated

254 The Norwegian Refugee Council had to pay compensation for gross negligence. Young, "Steve Dennis and the Court Case That Sent Waves through the Aid Industry."

255 "Media Companies on Notice over Traumatised Journalists after Landmark Court Decision," *The Conversation*, March 5, 2019. Beyond the human rights and humanitarian sectors, in May 2020, Facebook was also required to pay $52 million to content moderators suffering from PTSD—the "first time a social media company will be required to compensate workers for their trauma." Elizabeth Dwoskin, "Facebook Content Moderator Details Trauma That Prompted Fight for $52 Million PTSD Settlement," *Washington Post*, May 13, 2020.

256 Phone interview with mental health expert, May 2020.

Box 7. Improved support systems during the COVID-19 pandemic

The UN has dedicated significant energy and resources to strengthening its duty of care for staff during the COVID-19 pandemic. It has developed several webpages to promote mental health, stating that "UN staff's physical and mental health and well-being is a priority" and recognizing that "easy access to quality care may be unavailable in some duty stations."[257]

The Secretariat has issued more guidance for staff and information to demystify mental illness and promote peer support. It has offered online courses on stress management and reduction, meditation, and yoga and improved the visibility of staff counselors' offices, especially on i-Seek, the UN's intranet. The UN website also offers more guidance on how to access staff counselors, external medical care, and tele-health services. In addition, the UN ensured that staff insured by the UN would have unlimited access to doctors, including psychiatrists, around the world, arranged phone or video consultations, and made sure that insurance plans would also cover consultations with psychologists. The UN Department of Healthcare Management and Occupational Safety and Health can also facilitate shipments of medication to staff in duty stations that are difficult to reach.[258]

For peace operations specifically, the Secretariat quickly adopted flexible working arrangements following the outbreak of the pandemic, allowing field staff to work remotely and to continue being fully paid while outside of their duty stations.

focal point on mental health within the Secretariat (in addition to the focal point in charge of coordinating system-wide implementation); and commit to annual, system-wide surveys, open consultations, and the sharing of best practices and lessons learned from different UN entities. Future strategies should be informed by more granular analysis of mental health needs in the field.

> The UN should treat an operational stress injury with the same level of seriousness and credibility as a physical injury.

- **More detailed and regular research, including clinical research, should be conducted on mental health in UN peace operations.** This research could assess the prevalence of mental health issues in specific peacekeeping and special political missions, context-specific stressors, and the robustness of psychosocial support services. Research should also break down data between entities, missions, components, and sections and by type of personnel, gender, and duty station. It could be done through partnerships between the UN and external research institutes. Any research should involve independent, external experts, and its results should be shared transparently to ensure the UN's accountability to its workforce. Any mental health surveys, consultations, monitoring, and evaluations should include both current and former staff. These steps would allow the UN to base future planning on mission-specific mental health considerations, disaggregated data, concrete lessons learned from individuals, and assessments of clinical experiences.

- **The UN and T/PCCs should come to a clear understanding of their division of labor over providing psychosocial services to peacekeeping personnel.** These roles and responsibilities should be clearly defined and delineated throughout all phases of deployment, and official UN guidance and policies should be developed or revised accordingly.

257 United Nations, "COVID-19 and Mental Health and Wellbeing," available at https://www.un.org/en/coronavirus/mental-health-and-wellbeing .
258 Ibid.

The UN should develop a policy, standards, and guidelines for preparedness and support related to mental health across the board—for civilian staff as well as uniformed personnel—and create a body to advise T/PCCs on standards for providing services. The UN Secretariat should work toward a holistic support system for mental health that includes psychological, medical, social, and administrative support. Each country and culture has a different approach to mental health, and a formal standardization of psychosocial support and methods is not warranted. Nonetheless, the UN could better define common objectives, principles, values, and standards to inform and encourage change within each T/PCC, including through a mental health training package.

- **The UN should make mental health an integral part of T/PCCs' operational readiness criteria.** Through the force generation and selection processes, the UN should encourage T/PCCs to demonstrate their duty of care to troops and units deployed, including by integrating mental health experts into their contingents and ensuring the mental health readiness of personnel.

- **Member states should champion mental health and well-being in their peacekeeping contributions.** They should share best practices on prevention and effective responses before, during, and after deployment. They should also support more mental health training and capacity building for T/PCCs. The next peacekeeping ministerial conference is a key opportunity for this.

- **Member states should allocate more resources to building the UN's mental health capacity.** Beyond the recent addition of staff to the Department of Operational Support's Uniformed Capabilities Support Division to process PTSD claims, the Fifth Committee should support the creation of dedicated posts within medical services in headquarters and missions to address mental health issues, including psychiatrists and psychologists.

Pre-deployment Support

There is a need to train and sensitize staff on how to recognize mental health issues, symptoms, and coping mechanisms. Preparedness and pre-deployment training on PTSD, trauma, and mental health should be based on minimum standards so that all contingents are equally prepared and equipped.

- **As a priority, the UN Secretariat should integrate specific skills and competencies related to respect for, sensitivity to, and consideration of mental health into the terms of reference for staff, particularly for managers.** This could be done by revising the competency framework used in recruitment. Support to the mental health of supervisees and colleagues should also be included in the e-Performance indicators for all staff.

- **The UN should be cautious about any attempt to set up pre-deployment screening related to mental health.** Every individual is susceptible to mental health issues. Although medical screening should include a mental health component, candidates should not be disqualified for having experienced mental health conditions and illnesses. Rather, the emphasis should be on sensitizing staff on mental well-being, informing them about stressors and conditions in the field, and allowing them to opt out of postings without being precluded from future professional opportunities.

- **The UN Integrated Training Service, in coordination with T/PCCs, should revise the mandatory pre-deployment training to include a mental health module.** The module should counter stigma and prejudice against mental health; address specific stressors encountered in the field based on concrete examples; share well-being and stress-management techniques, including how to prevent, identify, and cope with stress, trauma, and other mental health issues; and provide information on support systems in the country of origin and in the mission. The Integrated Training Service should also develop a leader-

ship course for management on staff well-being and mental health.

- **The Integrated Training Service should revise simulation trainings such as the BSAFE and SSAFE trainings, in coordination with the UN Department of Safety and Security and the medical and staff counselling services.** It is important to ensure that these trainings are relevant and tailored, do not convey biases or contradictory messages on mental health, are professionally conducted, and allow staff to reconsider their deployment, understand their mental health, and receive mental health support if needed.

Support During Deployment

Both the Secretariat and member states should uphold their duty of care for personnel in missions, including by fostering a culture of care, offering adequate psychosocial support, and improving human resources arrangements.

- **Member states should set up robust mobile teams that can be deployed to offer mental health support to commanding officers and personnel, especially following major traumatic incidents.** They should also embed mental health experts with contingents to provide psychosocial assistance and provide remote support through tele-health services with military psychologists and psychiatrists and other psychosocial support personnel.

- **The UN should strengthen in-mission training and sensitization.** Induction trainings for all staff should consistently integrate guidance and information on stressors, symptoms, and support structures. They should also demystify and destigmatize mental health issues and provide an opportunity for sharing real-life experiences—not only by staff counselors but also by mission personnel and leaders. A flyer or pocket card on symptoms and support structures should be widely distributed. Beyond induction trainings, regular sessions on understanding mental health, building resilience, and reducing stigma should be developed to change the institutional culture. As with the induction trainings, these should include briefings not only from staff counselors and representatives of the UN Department of Safety and Security but also from colleagues from the same field unit and from mission leaders who could acknowledge that mental health issues exist, affect all staff, and are an occupational risk.

- **Missions should conduct more regular mental health surveys.** These surveys should assess the prevalence of mental health issues and stress factors and the effectiveness of support structures. The results could be used to better inform planning and activities related to prevention, counseling, and medical support.

- **Missions and managers should put in place "trauma-aware workflows."**[259] This could include developing guidelines to ensure that staff are not processing graphic or violent material at night or alone; breaking up potentially traumatic tasks such as human rights investigations into smaller time periods and dividing them among staff; giving staff breaks from directly working with witnesses and survivors; and creating space to debrief about the impact of work on mental health.

- **The UN Secretariat and member states should provide more support, guidance, and supervision to staff counselors embedded in missions.** The UN should ensure that staff counselors meet minimum qualifications, establish minimum standards for monitoring and recording cases and for ensuring the confidentiality of clients, and hold counselors accountable for adhering to these standards. To complement internal counseling services, the UN should also establish a 24/7 network of UN and non-UN counselors who can tailor their support to individuals on the basis of their gender, language, nationality, and cultural background. This network could include both fly-in, outsourced psychologists and contracted tele-health counselors.

259 This has been recommended as a way to mitigate harm in the human rights sector. Satterthwaite et al., "From a 'Culture of Unwellness' to Sustainable Advocacy."

Moreover, non-embedded counselors provided by UN member states, UN headquarters, or regional offices should regularly check in with in-mission counselors, provide them advice and support on how to build relationships with mission leaders and commanding officers, and provide resources for effective care.

- **All staff, and particularly leaders and managers, should be mobilized to create a safe and supportive work environment.** Collectively, UN managers and other personnel should work to deconstruct the institutional culture that encourages staff to "toughen up" or leave the organization, demystify mental health, and support positive coping mechanisms. This requires robust leadership on mental health. To that end, support to staff mental health should be included in senior mission leaders' compacts and 360-degree evaluations. Managers should set up regular and safe ways to communicate with staff and mainstream attention to well-being into one-on-one, team, and organizational meetings. Missions should set up peer support and mentoring structures, both formally and informally, to build resilience. Managers should also be provided guidance on how to manage and prevent overwork, burnout, stress, and trauma in their team, with the support of staff counselors.

- **Mission leaders, support staff, and substantive staff should strive to be positive and supportive in their communications with each other.** Particularly in crisis situations, leaders and support staff should regularly check in with their colleagues dealing with the crisis. Staff should also be encouraged to discuss their achievements and the impact of their work more regularly to build a sense of meaning and foster recognition of their efforts and successes.

- **The Secretariat and mission leaders should put in place supportive human resources arrangements.** Missions should facilitate remote working, flexible hours, compensation time, R&R, and other leave for those involved in crisis situations, including post-COVID-19. The Secretariat and missions should do their utmost to provide staff with the means to communicate with their families and support networks and lift restrictions that limit communication. The Secretariat should provide more guidance and support to the families and dependents of staff and look to set up a psychosocial service for family members. Finally, as a matter of urgency, the Secretariat should put in place a rotation and mobility system to allow field staff to take positions outside of hardship duty stations or take breaks when needed for mental health purposes.

Post-deployment Support

The UN and member states should recognize that their duty of care does not end after field personnel return from deployment. They should continue following up with former personnel to ensure they are receiving the psychosocial support they need through dedicated structures and resources.

- **The UN and T/PCCs should conduct post-deployment evaluations to assess the exposure of personnel to trauma and facilitate their transition back from peace operations.** The Secretariat should put in place mechanisms to follow up with staff who experience mental health issues after they leave, ensure they receive appropriate individual support plans, and assess their fitness for redeployment. It should also ensure that staff going from one mission to another go through such evaluations and are given time between deployments to receive psychosocial support if needed. T/PCCs should check in with personnel six months after deployment, and as regularly as they can after that, to monitor for mental health issues that may develop post-deployment. They should also provide clear information about how staff can access psychosocial services post-deployment.

- **The Secretariat should explore measures and structural changes to improve psychosocial support for former staff.** Former staff should

have access to UN support structures and insurance coverage for mental health conditions induced by UN service that persist after they leave the organization. It should also facilitate a network of former staff to support and mentor each other.

- **The UN should clarify and simplify processes to claim compensation for mental health issues.** It should ensure that these processes are people-oriented and supportive.

Annex 1. Approaches to Mental Health in Troop- and Police-Contributing Countries

UN member states take a wide range of approaches to the mental health of their uniformed personnel. Below are a few good practices pursued by countries to uphold the duty of care for their military forces in general, and peacekeepers in particular.

In some countries, military preparedness includes preventive measures for mental health. US troops receive counseling and a health assessment to determine their "physical and mental health status prior to a deployment in a combat, contingency, or other operation outside of the United States, and to assist health care providers in administering present or future care."[260] In France, military personnel are given information on mental health before deployment and encouraged to engage in exercise and leisure activities.[261] In Belgium, prevention advisers are legally required for all employers and are present in the armed forces to screen and sensitize personnel and analyze their risk of mental health issues.[262] India's Defense Institute of Psychological Research provides "psychological support to the armed forces… to enhance mental health and operational efficiency of the armed forces."[263] The focus of its research is on optimizing the selection, placement, categorization, and training of soldiers and officers and boosting the morale of troops.

Some countries have sought to adopt a holistic approach to mental health. The US Department of Defense has been developing robust policies, structures, and programs to tackle mental health issues in the armed forces and among veterans.[264] The Canadian surgeon-general's mental health strategy for the Canadian Forces Health Services Group calls for multidisciplinary, comprehensive, high-quality mental healthcare. Commanding officers are encouraged to "take responsibility for promotion of health and physical fitness," "lead by example," "support access to health promotion programs," "work with health services staff to identify issues," "respect employment restrictions recommended by medical officers," and "create a climate of information, trust and understanding." The comprehensive mental health system includes strategic, operational, and tactical services for health surveillance and mental health research ("understand"), mental health education and training ("educate"), and clinical programs and services ("care"). This triad of care also mobilizes leaders, who should be supportive and engaged; health services; and individual service members, who should be actively involved in their own healthcare.[265] Belgium's defense forces have also adopted a comprehensive, holistic approach to psychosocial care, including services for prevention, psychological support, social and administrative support, and religious and moral assistance.[266]

Other good practices have been developed to ensure adequate support and accompaniment for troops during their deployment. In some NATO countries, psychologists are embedded within units. A few European countries also have counselors or crisis teams ready to be deployed to UN missions or to visit contingents and participate in post-deployment processes to assess mental healthcare needs. For example, Belgium provides remote psychologists, in addition to medical teams trained to recognize cumulative stress and other

260 See DD Form 2795 at: Psychological Health Center of Excellence, "Pre-deployment Health Assessment," available at https://www.pdhealth.mil/treatment-guidance/deployment-health-assessments/pre-deployment-health-assessment .

261 Phone interview with military mental health expert, February 2020.

262 Phone interview with military psychologist, July 2020.

263 See Defence Institute of Psychological Research website, available at https://www.drdo.gov.in/labs-and-establishments/defence-institute-psychological-research-dipr .

264 US Department of Defense, "DOD Instruction 6490.03: Deployment Health," June 19, 2019.

265 Clinical research aims to reduce self-termination of care and increase tolerance to therapies, expand understanding of mental health, and explore novel therapeutic modalities. It also entails surveillance and reviews. Training comprises leadership courses, pre-deployment training for service members and their families, aide-memoires, military transition and reintegration training, family transition and reintegration training, and military and family post-deployment follow-up. Care includes tactical clinical programs and services; periodic health assessments; psychosocial and mental health services, including addiction treatment programs, operational trauma and stress support centers, and the involvement of chaplains, veteran affairs, and family services. Canadian National Defence, "Surgeon General's Mental Health Strategy."

266 Phone interview with military psychologist, July 2020.

mental health conditions.[267] In the French armed forces, psychiatrists are deployed with the troops, a human environment officer is available in each battalion, a psychological focal point is trained in each section, and an emergency psychosocial support cell can be deployed.[268] Other countries have made psychiatrists available to their troops. For example, Niger has one psychiatrist and mobile psychosocial experts available, and Gabon has one psychiatrist and five psychologists.[269]

Some countries have also strengthened post-deployment support. One dimension of this support is robust mental health evaluations and follow-up. In the US, the post-deployment health assessment includes a substantive mental health section.[270] The assessment aims at "establishing policy, assigning responsibilities, and prescribing procedures for the referral, evaluation, treatment, and medical and command management of Service members who may require assessment for mental health issues, psychiatric hospitalization, and risk of imminent or potential danger to self or others."[271] Other countries have established dedicated psychosocial structures for armed forces post-deployment. French forces coming back from deployment are put in a *sas de décompression*, a psychological structure aimed at facilitating the transition and readaptation of soldiers through debriefings and psychosocial support.[272] For example, Uganda has built a service to care for soldiers returning from peace operations, especially from Somalia; the Republic of the Congo has established a psychological cell that supported soldiers returning from CAR in 2017; and Burundi has developed its capacity to support soldiers who were deployed in CAR and Somalia (although no cases of PTSD have been reported yet).

Annex 2. Approaches to Mental Health in Other UN and Non-UN Entities

One senior leader at UN headquarters regretted that the "Secretariat is too arrogant to learn from agencies."[273] There is a sense that agencies, funds, and programs are doing better in managing human resources and fulfilling their duty of care to personnel. As the UN seeks to improve mental health through system-wide initiatives following the adoption of the Mental Health and Well-Being Strategy, some lessons can be learned from UN agencies and entities outside of the UN system.

UN Refugee Agency

In 2016, the UN Refugee Agency (UNHCR) published the results of its first-ever comprehensive Staff Wellbeing and Mental Health Survey measuring the risk of anxiety, depression, PTSD, secondary stress, burnout, and hazardous drinking, as well as the use of mental health services. Of the respondents, 31 percent were classified as at risk for anxiety, 36 percent for PTSD, and 25 percent for depression. Nearly half (49 percent) indicated that they needed to consult mental health services, but only 26 percent had actually done so.[274]

The survey recommended continuing efforts to address the effects of exposure to trauma, including through implementation of standard operating procedures for supporting personnel following critical incidents, mandatory psychological preparation and end-of-assignment debriefings, recording of critical incidents and case management, and development of a strategy for protecting

267 Phone interview with military psychologist, July 2020.

268 Phone interview with military mental health expert, February 2020.

269 Sonia LeGouriellec, "Gestion du trouble de stress post traumatique (PTSD) dans les armées africaines engagées dans les opérations de maintien de la paix," 2021 (forthcoming).

270 The assessment form is available at https://www.esd.whs.mil/Portals/54/Documents/DD/forms/dd/dd3024.pdf .

271 US Department of Defense, "Mental Health Evaluations of Members of the Military Services," Instruction 6490.04, March 4, 2013, available at https://www.esd.whs.mil/Portals/54/Documents/DD/Issuances/dodi/649004p.pdf .

272 Psychological support in combat zones was ordered as of 2009. See: Centre de doctrine d'emploi des forces, "Le SAS de fin de mission: Théorie et pratiques," January 2016.

273 Interview with senior UN official, New York, February 2020.

274 UNHCR, "Staff Well-Being and Mental Health in UNHCR," 2016.

the mental health of national staff. It also recommended developing an organizational approach with support measures (preparation, education, support, self-care plan, access to mental health services) and revised working methodologies and managerial practices.

Based on the results and recommendations of this survey, UNHCR developed a People Strategy (2016–2021).[275] The strategy calls for developing practical strategies and solutions for monitoring, preventing, reducing, and mitigating key risks that affect staff health and well-being; improving occupational health and well-being services; and developing tools to build the resilience of individuals and teams. UNHCR issued administrative instructions to support personnel in high-risk duty stations in 2018 and developed a "Mental Health Guidebook." Communication packages have been developed to inform colleagues about the support available in duty stations. In addition, half of applicants to high-risk duty stations have taken psychosocial preparedness and field security webinars to enable them to make an informed decision on their choice of assignment. In parallel, UNHCR is assessing mandatory health support in high-risk operations.[276]

Office for the Coordination of Humanitarian Affairs

In 2018, the UN Office for the Coordination of Humanitarian Affairs (OCHA) launched a People Strategy (2018–2021) to improve the work culture and commissioned an evaluation of its duty-of-care system.[277] The strategy followed an evaluation of OCHA's system of care, which highlighted unhealthy coping mechanisms among staff (e.g., postponing leave or losing vacation days), stress factors (e.g., benefits and entitlements, accommodation, the use of temporary contracts), and the risk of burnout for staff rotating among high-risk duty stations. Staff reported getting good support from peers following critical incidents (and to a lesser extent from their direct supervisors), but only 18 percent of staff involved in such incidents rated the quality of psychosocial support as "satisfactory" or "very satisfactory." It was found that OCHA's reliance on the Secretariat's procurement and human resources processes impacted its ability to provide adequate care and that other service providers (including at other UN agencies) would be better equipped to provide this support.

Recommendations included developing a duty-of-care framework with a definition, a statement on how the organization will manage and minimize risks, minimum standards, and established responsibilities, including organizational workplans; involving all personnel in fulfilling the office's duty of care; and improving guidance, training, and awareness-raising efforts. It was also recommended that OCHA develop a case-management process for staff, develop a more proactive and strategic psychosocial support system (including outsourced mental health support services), and fast-track processes in cases of critical incidents. The study also suggested creating a mechanism within OCHA to track personnel rotations, identify possible burnout, and ensure access to support.[278]

ICRC and IFRC

The International Committee of the Red Cross (ICRC) published a brochure on "coping with stress" for staff and humanitarian professionals working in conflict zones and emergency situations in June 2020.[279] It focuses on the constant stress aid workers face while deployed in conflict zones and emergency situations; describes stress and provides information on how to identify, prevent, and respond to it; and gives guidance on what sort of help to seek from friends and close relatives, colleagues, and the ICRC.[280]

As of mid-2020, there was no data on specific

275 UNHCR, "UNHCR's People Strategy 2016–2021," December 2015.

276 Executive Committee of the High Commissioner's Programme, *Human Resources, Including Staff Welfare*, UNHCR Doc. EC/70/SC/CRP.21, August 28, 2019.

277 OCHA, "People Strategy 2018–2021," 2018; OCHA, "Evaluation of Duty of Care," June 2018.

278 OCHA, "OCHA Evaluation of Duty of Care: Final Report," June 2018.

279 ICRC, "Humanitarian Action and Armed Conflict: Coping with Stress," June 2020.

280 Roles and responsibilities are described for staff (to learn about stress and first aid measures before deployment); staff, colleagues, and heads of delegation (to recognize and manage stress and offer support during assignment); specialists at headquarters (to provide advice and support); the personnel department (to offer rest periods and new activities or postings); families (to understand and provide moral support); and staff (who may also prefer to leave the ICRC) after an incident.

stressors and the prevalence of mental health issues among ICRC staff, and a survey was planned to be conducted by the end of 2020. Mental health is included in the ICRC's health support ecosystem, including the ombuds network, staff associations, diversity inclusion provisions, and career center. A clinical psychologist at headquarters administers medical evacuations and establishes the responsibilities of staff health officers, while regional psychologists mainstream preventive measures and train staff and health officers. While there is no internal support system for one-on-one, 24/7 mental healthcare, the ICRC was planning to develop a mental health staff support system under the lead of an organizational psychologist in its Staff Health Centre of Expertise in Geneva.

The International Federation of Red Cross and Red Crescent Societies (IFRC) issued a handbook for humanitarian workers on "Managing Stress in the Field" in 2009.[281] Different types of stress and symptoms are described. It highlights the importance of identifying and understanding personal, team, and organizational resources. The booklet also contains a questionnaire to assist delegates with identifying stress and provides the contact information of stress counselors. The handbook indicates that managers should be capable of recognizing the early signs of cumulative burnout and should realize the importance of adequate support and action, and top management should look into ways of reducing stress coming from inside the organization. A Psychosocial Support Program was also set up in response to these needs. In 2012, the IFRC Psychosocial Centre issued a Psychosocial Support Toolkit providing guidelines for national red cross and red crescent societies to monitor and evaluate the stress of individuals and teams, including through peer support and referral measures.[282]

281 IFRC, "Managing Stress in the Field," 2009.

282 IFRC, "Caring for Volunteers: A Psychosocial Support Toolkit," August 2012.

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