

A HEALTHY WORKFORCE FOR A BETTER WORLD

UNITED NATIONS SYSTEM
MENTAL HEALTH AND
WELL-BEING STRATEGY



United Nations

Distress and suffering related to symptoms of mental illness and psychological pain can be as disabling as physical pain for United Nations staff. We need to care for both equally well.





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The Strategy has been approved by the High-Level Committee on Management (HLCM) of the Chief Executives Board for Coordination (CEB). It has been developed by a partnership between UN Staff and Stress Counsellors, the UN Medical Directors, the HR Network, UN Ombudsman and UN Staff associations. The Project Team included IAEA, ILO, IOM, UNAIDS, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNIDO, UNOG, UN Secretariat, UN-Women, WHO and the World Bank.

Individuals across the United Nations system have provided regular feedback to the project team throughout its work. The final stage of consultation, in August/September 2017, included feedback via SurveyMonkey, individual e-mails and collated group responses. These contributions have been critical to the process of strategy development.

Note

A report on the global mental health survey 2015 is available.



WE ALL NEED GOOD MENTAL HEALTH AND WELL-BEING

THE STRATEGY

Our mental health directly influences how we think, feel and act: it also affects our physical health. Work, in fact, is actually one of the best things for protecting our mental health, but it can also adversely affect it.

Good mental health and well-being is not a black and white, on-off experience. We can all experience days, weeks or months where we feel resilient, strong and optimistic, regardless of events or situations. Often, that can be mixed with or shift to a very different set of thoughts, feelings and behaviours; or not feeling resilient and optimistic in just one or two areas of our life. For about 25 per cent of us, that may shift to having a significant impact on how we think, feel and act in many parts of our lives, including relationships, experiences at work, sense of connection to peer groups and our personal sense of worth, physical health and motivation.



Working within the United Nations system of agencies is a unique experience. As United Nations staff members, it can provide us with a strong sense of purpose and opportunities for helping others. United Nations system staff contribute to enabling a safer, healthier, socially thriving, equitable and productive global community.

Doing our work well in the United Nations requires all of us to be giving the best of ourselves, while taking the best care we can of our colleagues, our families, the Organization and ourselves. The present workplace mental health and well-being strategy is for all staff, across diverse roles, contexts and environments, from deep-field missions to Headquarters in New York or the United Nations Office at Geneva.



A variety of organization-specific and inter-agency efforts have been made to address psychosocial well-being and mental health in the United Nations workplace. Staff seeking help for advice, access to treatment and support relating to concerns about their mental health and well-being can access this internally via staff and stress counsellors. They can also seek help via medical services, ombudsmen, staff association representatives and Human Resources staff. Access to health-care treatment and support is available via the 23 United Nations health insurance schemes. United Nations medical services provide medical, physical health care and guidance on well-being and mental health and are involved in return-to-work programmes.

A total of 131 counsellors are employed in United Nations agencies, funds and programmes for a total of 98,469 (2015) United Nations system staff. Counsellors are distributed across 45 countries, at 58 different duty stations. Counsellors deliver psychosocial services and support to staff, providing psychosocial promotion and prevention programmes within the organizations for which they work. Most counsellors work for the Department of Peacekeeping Operations (29 per cent), the Department of Safety and Security (20 per cent), the World Food Programme (WFP) (11 per cent), the United Nations Children's Fund (UNICEF) (9 per cent) and the Office of the United Nations High Commissioner for Refugees (UNHCR) (8 per cent). Most counsellor positions are in category E duty stations¹ (35 per cent, accounting mostly for Department of Peacekeeping Operations positions and a small number in the United Nations Department of Safety and Security, UNHCR, UNICEF, WFP and the World Bank), followed by Headquarters (26 per cent) and category A duty stations (15 per cent).

WHY DO WE NEED TO DO SOMETHING DIFFERENT?

In spite of this significant and ongoing investment in mental health and well-being, there is still a long way to go in addressing the needs of the wider United Nations workforce.

Results from the Global Survey and findings from internal sick leave and pension data indicate a clear need for more to be done to protect, improve and resolve the mental health and well-being of United Nations staff members.

Sick leave data from the electronic medical records and occupational health management system, EarthMed, reviewed for three United Nations entities, indicated that the total number of days lost for sick leave over the four-year period 2011-2016 was 550,033. An average of 137,508 days is lost per year among 5,328 staff members. Sick leave related to mental health diagnoses made up 14 per cent of the total days lost per year, i.e., 18,819 days among 264 staff members, putting it in second place for lost days in the top ten by diagnostic category.

¹ Duty station categories: all duty stations are placed by the International Civil Service Commission in one of six categories: H and A to E. The H category comprises Headquarters duty stations and other duty stations in similar locations where the United Nations has no developmental or humanitarian programmes. The A to E categories comprise all other duty stations, classified by order of difficulty of conditions of life and work. Category E has the highest risk element.

In 2015, just over 17,000 United Nations staff members across 11 United Nations entities completed the Global Well-Being survey. Overall findings suggest that approximately half of all United Nations staff members who responded to the survey reported experiencing symptoms that can be interpreted as being consistent with serious mental health conditions.

These results suggest that United Nations staff members report experiencing higher levels of common mental health conditions than we would expect to see in the general population for depression, anxiety, post-traumatic stress disorder and hazardous drinking.

The experience of personal suffering and potential decline in functioning in many life areas for the staff member, and often for their family, is significant, treatable and in many instances preventable.

The estimated economic productivity cost to the United Nations system using formula used by the treasury of one national Government was \$11,873,249.46.²

WHAT ARE WE GOING TO DO?

Implementing a workplace mental health plan is a prevention strategy in its own right, with a focus on both individuals and the environment in which they work. That means that the objectives and actions described in the present document have been selected to make a difference with regard to factors that protect against or contribute to poor mental health and declining well-being, while aiming to ensure a good match with the global staff member community of the United Nations.

The five-year United Nations workplace mental health strategy concerns not only the environment in which we work and our health, but also actions that strengthen our individual knowledge, skills and behaviour with regard to:

- Taking care of others – colleagues, family and friends.
- Taking care of our own mental health.
- Taking care of the people who look after the health of others.

² Four times salary (includes actual time out, cover, lost productivity on team, etc.).

- Seeking help earlier, to obtain access to a range of psychosocial support and interventions that we know make a difference; this will help with quicker recovery, so that we are able to carry out the work of the United Nations the best we can.

An adaptation of the Kaplan & Norton (balanced scorecard) strategic planning methodology was used as a framework for planning. Four perspectives shaped the strategic planning:

- Staff member experience (SE).
- Service Delivery and Business Approach (SBDA).
- Learning and development (LD).
- Use of resources (R).

The symptoms of poor mental health are treatable and in many instances preventable.

Making a positive difference to the mental health well-being of United Nations staff members across a global system is not a linear or straightforward process.

The strategic themes connect clusters of objectives together, enabling a multiplying effect for any intervention, with a clear interdependency across aspects of the strategy.

The strategy incorporates objectives and actions that link to factors in the work environment that may impact on our health and well-being, positively and adversely.



Cyclone "Nargis" victims receive UNHCR assistance • UN PHOTO/UNHCR

MENTAL HEALTH STRATEGY MAP 2018-2023

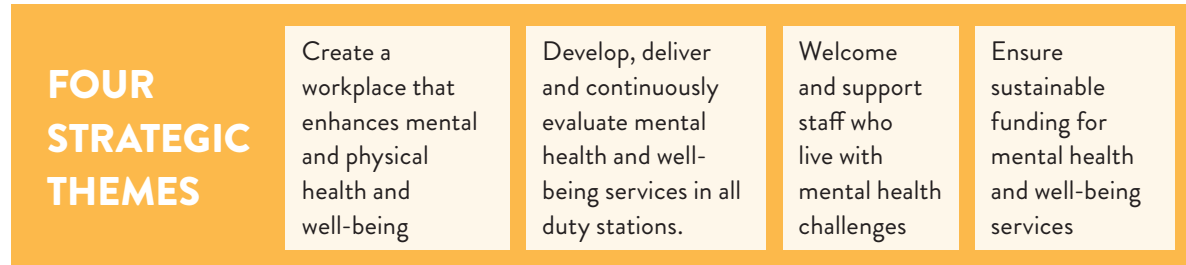
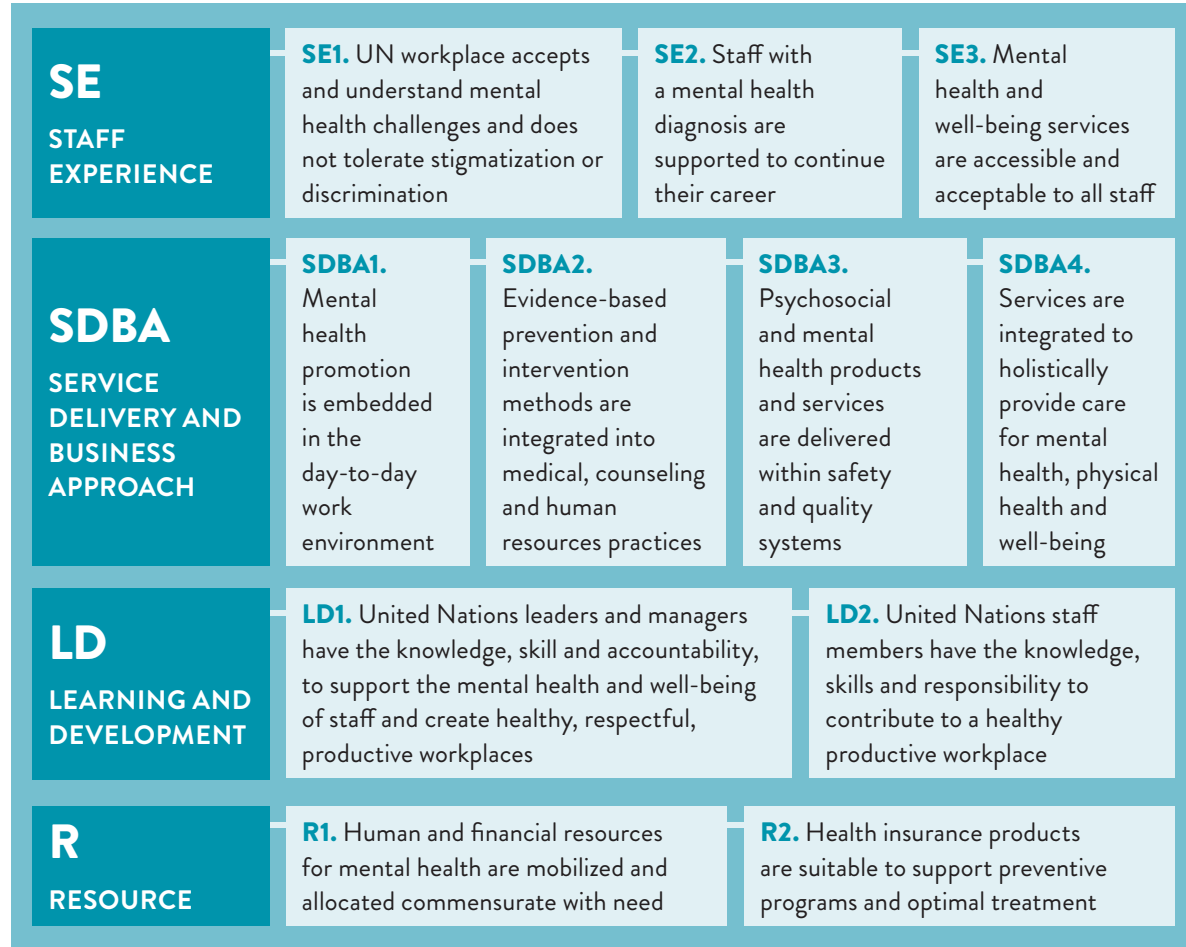
OUR PURPOSE

To increase the effectiveness of the United Nations by optimizing the psychological health of its personnel

O1

OUTCOMES

THERE IS AN INCREASE IN STAFF MEMBER RESILIENCE, PRODUCTIVITY AND ENGAGEMENT



Using a biopsychosocial model of health, the mental health strategy needs to link together a system of elements. It links social, cultural, psychological, environment, physiological, spiritual and workplace elements that can:

- Promote and strengthen our well-being and resilience.
 - Protect and help with recovery from and the resolution of physical and mental health of individuals.
- but also looks to
- Strengthen factors in the work environment that contribute to good mental health and well-being.

Effective prevention requires the implementation of multiple strategies for all United Nations staff that address the constellation of risk and protective factors associated with poor mental health and well-being (for descriptions, see the glossary).

HOW DOES THE STRATEGY FIT WITH OTHER GROUPS AND WORK PROGRAMMES?

The mental health strategy is not a panacea for all United Nations workplace issues and challenges. It should not and does not stand alone.

The strategy is multipronged, being implemented in a system in which all the parts need to link and work together. That means that implementing just one part will not achieve the improvement in mental health well-being that is being sought. Nor will working in isolation from other United Nations programmes and strategies.

The United Nations workplace mental health strategy is influenced by and influences other United Nations strategies and programmes, including:

- The United Nations Staff and Stress Counsellors Group (SSCG), the Critical Incident Stress Management Unit (CISMU), the Office of the United Nations Ombudsman and Mediation Services, the United Nations Medical Directors (UNMD), the Human Resources Network and staff associations are core groups with significant roles in the current services and support available to United Nations staff members and in the implementation of this strategy.
- The Critical Incident Stress working group of the Inter-Agency Security Management Network and the task force on duty of care of the High-level Committee on Management

MODEL OF CARE

WORKPLACE MENTAL HEALTH AND WELL-BEING STRATEGIC ELEMENTS: WIDER UNITED NATIONS STRATEGIES AND PROGRAMMES

UNITED NATIONS STRATEGIES AND PROGRAMS

- HR Network. Organizational development and management culture strategies
- Critical incident stress working group
- Duty of care strategy
- Staff associations workplace strategies
- CISMU*, SSCG*, UNMD*, UNOMS*
- UN OSH framework and international OSH standards

BIOPSYCHOSOCIAL MODEL OF CARE

- Environmental and physical
- Psychological
- Physiological
- Social
- Cultural and spiritual

MENTAL HEALTH STRATEGY ELEMENTS

- Workplace well-being and psychological safety
- Promoting positive mental health and reducing stigma
- Prevention, early intervention and psychosocial support
- Recovery, return to work, psychosocial support and protection

* CISMU: Critical Incident Stress Management Unit. SSCG: United Nations Staff and Stress Counsellors Group. UNMD: United Nations Medical Directors. UNOMS: Office of the United Nations Ombudsman and Mediation Services.

have a key influence and role in prevention and improvement with regard to staff member mental health. The task force has developed a diverse programme of improvements relating to staff safety, security and well-being, with some specific linkages between the two strategies.

- The United Nations occupational safety and health framework and international occupational safety and health standards.
- Existing and future Human Resources organizational development programmes that shape workplace culture, values, performance review and continuous development of management and leadership skills and competencies.
- Staff associations have a significant role in shaping and contributing to workplace culture development, including training and support of staff representatives in mental health (already under way).



SEVEN PRIORITY ACTIONS HAVE BEEN IDENTIFIED AS A STARTING POINT

WHERE WILL WE START?

Each action has been built from a wide variety of initiatives that the working group proposed. Drawn from their expert experience and knowledge of the United Nations environment and from international literature on the subject, they have been prioritized as the actions needed to work towards achieving the 11 strategic objectives.

Each action is scheduled for completion at various points over the five-year period, with staggered starting points in year one.



WHO, UNICEF, WFP visit flood-hit Sindh province, Pakistan • UN PHOTO/WFP/AMJAD JAMAL

1

Resource and distribute psychosocial support and mental health services to enable all United Nations staff who need it, especially those at higher risk, to have universal and equitable access to these services within 18 months of endorsement.

(Objectives : SE2, SE3, SDBA4. R1. Strategic themes 2, 3, 4.)

2

Implement stigma reduction and health promotion approaches over the five-year period, to strengthen the knowledge, skills and behaviour of all United Nations staff members with regard to staying psychologically fit and healthy and to ensure that concerns about stigma, anticipated and/or experienced, are not a barrier to achieving good mental health and well-being.

(Objectives: SE1, SBDA1, SDBA 2, LD2. Strategic themes 1, 2, 3.)

3

Initiate a suite of prevention interventions, informed by best practice and shown to influence positively the protective factors associated with good mental health and well-being, as well as avert or minimize harm from known risk factors, directly and indirectly for the staff member, and/or from the environment in which they work.

(Objectives SE1, SE2, SBDA 2. Strategic themes 2, 3.)

4

Establish a workplace well-being programme, with an agreed charter, practical support, training and recognition awards for teams and managers that enables the achievement of respectful, resilient, psychologically safe and healthy United Nations workplaces over a five-year timescale.

(Objectives SE1, SDBA1, LD1, LD2. Strategic themes 1, 2, 3.)

5

Complete a review of United Nations Health Insurance provision, and United Nations social protection schemes (for disability and compensation) within two years, to achieve equity of coverage for mental health, and ensure that provision is adequate, acceptable and appropriate.

(Objectives R1, R2, SE1, SE2, SE3, SDBA3, SDBA4. Strategic themes 2, 3, 4.)

6

Create systems to enable and oversee the safety and quality of psychosocial support programmes by the end of year one.

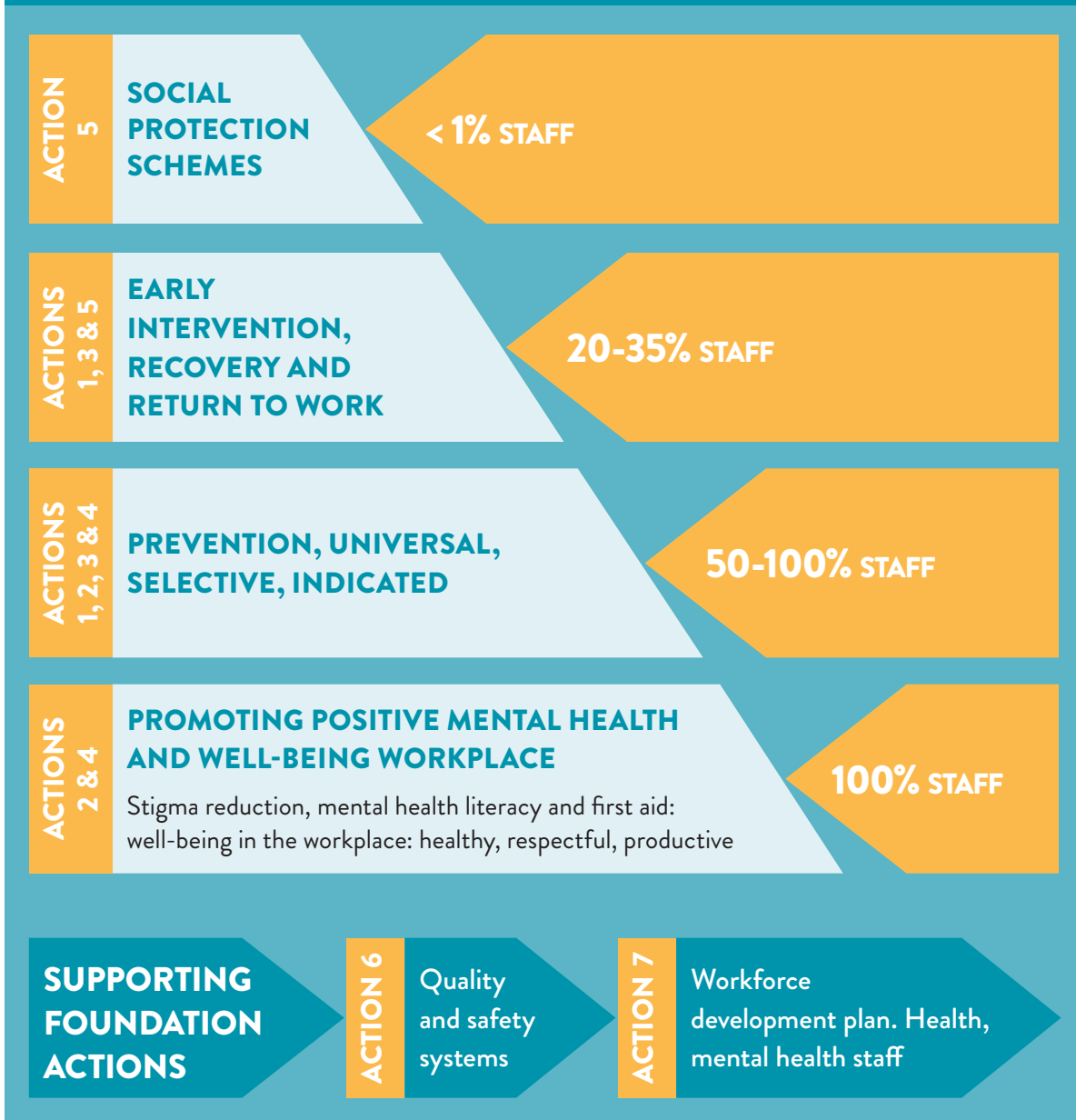
(Objectives SE3, SDBA2, SDBA3, SDBA4. Strategic theme 2.)

7

Complete a multidisciplinary workforce development plan, supported by a business case, submitted to the High-level Committee on Management by the end of year one. The business case is informed by a data-supported assessment of the capacity, capability and quality of in-house and external resources.

(Objectives SE2, SE3, R1, SDBA4. Strategic themes 2, 3.)

LEVEL OF REACH AND POTENTIAL TO BENEFIT



Actions two, four, five, six and seven are designed to have **an impact on the workplace environment**. Actions two, three and four are directed to actual workplace environments, with actions five, six and seven being set in a more broadly organizational context.

Actions one, two, three, four and five are designed to have an **impact on and benefit to individuals** (including colleagues and families), but with different levels of reach in terms of the numbers of staff likely to access them and benefit from them.



Postnatal and Maternal Health in Mongolia • UNFPA/FRANCINE EGBERTS

Action four includes social protection schemes. This is specifically for the very few staff members who, despite access to support, treatment, work redesign and/or redeployment options, suffer permanent harm and/or are no longer able to work or to eventually return to work. United Nations social protection schemes include pension fund disability and Appendix D (or equivalent) compensation schemes. While the number of staff who must eventually leave work because of ill health is very small in number, being in this situation has very significant, sometimes life-changing, impacts for staff members and their families. It also has a large impact for the organization. From a human rights perspective, it is therefore imperative that mental health and physical health are managed equitably and justly.



ACTION ONE

WHAT WILL BE THE BENEFITS?

Resource and distribute psychosocial support and mental health services so that all United Nations staff who need it, especially those who are at higher risk, have universal and equitable access to these services within 18 months of strategy endorsement.

The difference that this could make

- Staff members, their unique characteristics, and their level of health need – not where they work – determine their access to help. This includes access to advice, psychosocial support and mental health treatments which are responsive to their personal characteristics – and are equitable and acceptable.
- Staff members who need support and/or treatment are able to return to work fit and healthy, to continue their United Nations careers.
- Staff members are able to access and engage with services regardless of where they are working.
- Staff members are able to actively participate, with support if needed, in proactive return-to-work programmes that are coordinated and integrated across professional groups and in terms of mind and body health needs. For some, this may also include spiritual health. Time away from work is reduced.



ACTION TWO

Implement stigma reduction and health promotion approaches over the five-year period, to strengthen the knowledge, skills and behaviour of all United Nations staff members with regard to staying psychologically fit and healthy and to ensure that concerns about stigma, anticipated and/or experienced, are not a barrier to enjoying achieving good mental health and well-being.

The difference that this could make

- All United Nations managers and leaders have the opportunity to show leadership and action in minimizing the resultant impacts of stigma associated with mental ill health by:
 - Enforcing a United Nations workplace culture that does not tolerate, or condone through non-action, stigmatizing attitudes, behaviour and processes related to the mental health and well-being of all staff members.
 - Ensuring that misunderstandings, myths and beliefs held by others or themselves do not get in the way of changing the experience of staff members seeking to resolve the suffering, distress and hardship that can be associated with poor well-being and/or significant mental ill-health.
- All staff members have the opportunity to learn and be updated on:
 - How to stay mentally fit, resilient and psychologically healthy for work and life.
 - What they might notice or look out for in themselves and others to alert to a need to pay more attention to well-being.
 - Strengthening their personal and family tool kit with skills that can make a difference.
 - Knowing when, how and from whom to seek if needed.



ACTION THREE



Initiate a suite of prevention interventions, informed by best practice and shown to influence positively the protective factors associated with good mental health and well-being, as well as avert or minimize harm from known risk factors, directly and indirectly for the staff member, and/or from the environment in which they work.

The difference that this could make

- All United Nations staff members, through their workplace, have the opportunity to enjoy and strengthen their resilience and health through access to universal prevention interventions that assist and protect good mental health and well-being.
- Workplaces and staff groups exposed to known risk factors have access to selective prevention approaches that help protect against the risk of the development of poor mental health, with the aim of reducing the incidence and prevalence of mental health issues in the United Nations workforce.
- Staff members with early, detectable signs of mental ill health, stress or distress, to achieve earlier and quicker recovery, minimizing any adverse impacts of ill health and prolonged time away from work.

Top five key messages from the 2015 United Nations staff well-being survey

- **Approximately half of all respondents reported symptoms consistent with a mental health condition:** 49 per cent of all respondents reported symptoms consistent with a diagnosis of at least one of the four common mental health conditions (depression, anxiety, post-traumatic stress disorder and hazardous drinking), while 22 per cent screened positive for at least two.

An association between poor mental health and

- **The number of years worked for the United Nations:** the lowest levels of mental health problems by far were reported by those staff with the least amount of experience working for the United Nations.
- **Exposure to traumatizing events in the previous 12 months:** both on-duty and off-duty – there may be a correlation between the number of years worked and the risk of exposure to trauma.
- **Low job satisfaction, perceived incivility and conflict in the workplace:** A cluster of undesirable workplace outcomes correlated with mental health symptoms – lower levels of job satisfaction strongly correlated with higher levels of reported mental health symptoms. Similarly, higher levels of perceived incivility and occupational conflict in the workplace were strongly associated with higher levels of reported symptoms.
- **Low levels of help-seeking or receiving any mental health services, internally and externally (around 94 per cent of respondents):** while 50 per cent of staff responded that they would like to have an on-site counsellor to speak with confidentially from time to time, only 2 per cent of staff reported that they had recently received services from a United Nations counsellor.



UNMIL Peacekeeping Troops Withdraw From Liberia • UN PHOTO/ALBERT GONZÁLEZ FARRAN

ACTION FOUR

Establish a workplace well-being programme, with an agreed charter, practical support, training and recognition awards for teams and managers that enables the achievement of respectful, resilient, psychologically safe and healthy United Nations workplaces over a five-year timescale.

The difference that this could make

- Managers and leaders have access to practical guidelines, training, leadership development and coaching to help build skills and confidence in attending to staff members' mental health in the workplace.
- Managers are confident in starting the conversation, supporting their staff and knowing what to do when help may be needed.
- Managers and leaders are role models in taking care of their own mental health and fitness.
- Risk factors and hazards to well-being and mental health are identified and managed appropriately through prevention programmes.
- Staff members are proactively supported in their workplace to recognize and talk about their well-being and mental health, feel able to confidently support others as colleagues and seek help without fear of consequences or stigma.
- Time away from work is reduced and returning to work after time out is easier.
- Managers and teams feel acknowledged and rewarded for putting in the extra effort in creating exemplars of healthy workplaces through an annual awards programme.



ACTION FIVE

Complete a review of United Nations resources that enables access to health insurance coverage and social protection schemes (disability/pension) within two years, to achieve equity of coverage for mental health and ensure that provision is adequate, acceptable and appropriate.

The difference that this could make

- United Nations staff members have insurance coverage that meets their needs for specific evidence-based interventions and psychosocial support for poor mental health when unwell, and also practical support for prevention and health promotion.
- Processes for accessing return-to-work programmes and, if required, social protection schemes are applicable and compatible with current mental health diagnostic criteria and prognoses.
- There are incentives and support for the adoption of healthier habits, strengthening resilience and proactive engagement with health-care providers, i.e., professional counselling services.
- Minimum standards are included in insurance plans, with clear guidelines for access to and provision of care by providers.
- Equity of coverage for mental health and physical health, regardless of the United Nations agency for which a staff member works.



ACTION SIX

A collaborative multidisciplinary group, led by the United Nations Staff/Stress Counsellors Special Interest Group, will establish quality and safety systems for psychosocial end products and services within 12 months. Quality and safety systems will underpin standardized quality assurance systems across the United Nations, including clear processes for consumer/staff feedback within a supportive complaints process and mutually agreed standards of care, training and competencies for mental health staff, with a plan for professional development, skills maintenance and licensing.

The difference that this could make

- Confidentiality of information is monitored through quality and safety systems and any breaches are acted upon.
- Clear oversight for each profession ensures that mental health staff deliver quality services, have access to regular supervision, peer review, support and access to psychosocial support themselves if required.
- Unjustified variation in clinical care is minimized and variation in clinical skill set and scope of practice of mental health staff is minimized.
- Access to evidence-based high-quality psychosocial support and treatment within an agreed confidentiality framework is not reliant on where staff members seek help and from whom.
- Staff members have the opportunity to give honest feedback on satisfaction or dissatisfaction with their experience of mental health support in a safe confidential and protected process.



ACTION SEVEN

A collaborative workforce development plan and business case is submitted to the High-level Committee on Management by the end of year one after a validated assessment of the capacity, capability and quality of in-house and external resources.

The difference that this could make

- Local and international staff members can access appropriate mental health staff and psychosocial support at the right time (without extended delays) in the right place (as close to them as possible), with access to digital support options, i.e., e-mental health support, if in-situ support is not directly available.
- The mental health workforce has the skill mix, distribution, capacity and capability to meet the mental health needs of a diverse global United Nations workforce in terms of gender, age, ethnicity, language, culture and sexuality.
- Up-to-date, accurate data is available on all staff providing mental health and psychosocial support, their location, skill set, workload demand, outcomes and pressures.
- Benchmarking is available for an affordable, data-informed workforce plan for mental health and psychosocial support for the next five years. We will aim to minimize variation across the globe and the United Nations system in terms of availability, access and acceptability.





FOUR FUNDAMENTAL OUTCOME MEASURES

WHAT OUTCOME MEASURES WILL BE COLLECTED?

STRATEGIC OBJECTIVE

OVERALL OUTCOME	There is an increase in staff member resilience, productivity and engagement
PROPOSED MEASURE	All sick leave: average days per staff member
Description	The mean (average) of all types of sick leave taken by United Nations personnel – certified, uncertified for any reason
Desirable direction	Reduction
PROPOSED MEASURE	Mental health sick leave: average days per staff member taking leave.
Description	The mean sick leave duration for mental health diagnoses: aiming for a decrease in the duration of absence from work (number of days), not the number of people taking sick leave
Desirable direction	Reduction in duration



Scene from High-level Week at UN • UN PHOTO/MARK GARTEN

STRATEGIC OBJECTIVE – STAFF EXPERIENCE

SE1	The United Nations workplace accepts and understands mental health challenges and does not tolerate stigmatization or stereotyping
PROPOSED MEASURE	Internalized stigma scale
Description	Percentage of staff with a mental health diagnosis that report feeling stigmatized
Desirable direction	Reduction
PROPOSED MEASURE	Social stigma
Description	Percentage of General United Nations staff that report stigmatizing beliefs, attitudes and behaviours
Desirable direction	Reduction
PROPOSED MEASURE	Stigma awareness training
Description	Percentage of staff who complete mandatory mental health stigma awareness training
Desirable direction	Increase



STRATEGIC OBJECTIVE – STAFF EXPERIENCE

SE2	Staff with a mental health diagnosis are supported to continue their United Nations career
PROPOSED MEASURE	Managerial stigma beliefs
Description	Percentage of United Nations managers who report stigmatizing beliefs, attitudes and behaviours
Desirable direction	Reduction
PROPOSED MEASURE	Mental health return to work
Description	Percentage of staff with a known mental health diagnosis who continue full workforce participation
Desirable direction	Increase
PROPOSED MEASURE	Mental health accommodation
Description	Percentage of staff with a mental health workplace accommodation that is successfully implemented
Desirable direction	Increase
PROPOSED MEASURE	Mental health disability rate
Description	A rate per 10,000 staff of individual cases of disability for mental health causes
Desirable direction	Reduction



UNDP staff walking along side school students in the 'Walk Against Corruption' • UN PHOTO/UNDP

STRATEGIC OBJECTIVE – STAFF EXPERIENCE

SE3	Mental health and well-being services are available, accessible and acceptable to all staff
PROPOSED MEASURE	Health promotion access – organization
Description	Percentage of United Nations system organizations which have implemented a plan for mental health promotion
Desirable direction	Increase
PROPOSED MEASURE	Health promotion access – duty station
Description	Percentage of United Nations duty stations which have implemented a plan for mental health promotion
Desirable direction	Increase
PROPOSED MEASURE	Mental health services access – duty station
Description	Percentage of United Nations duty stations which have a mental health support plan with guaranteed access to a mental health professional within 72 hours
Desirable direction	Increase





WORDS, TERMS AND CONCEPTS

GLOSSARY

Common mental health problems: Using a medical diagnostic frame of reference – a range of mental health problems that are of higher prevalence in the population and which includes depression, generalized anxiety disorder, post-traumatic stress disorder, but also panic disorder, phobia, social anxiety disorders and obsessive-compulsive disorder. The impact on people, families and communities can range from very mild and often self-remitting to a very significant impact on people's lives, health and ability to work. They can vary in duration and numbers of episodes. Depression, for example, could be a one-off episode, or the experience of long periods of remitting and relapsing episodes (episodic).

Early intervention: This term has a number of meanings and/or uses; in the context of this strategy we are using it to mean responding to early signs of distress, stress and ill-health. Prognosis and suffering can worsen if help, and/or treatment is not applied or sought early in the onset and course of the period of ill health. It works best when people have a basic level of mental health literacy and take notice of changes in their own mental health and well-being, or others close to them do, they have some personal health tools to manage their own recovery, they are open to talking and seek help early from others, who may be their manager, a work colleague, counsellor, ombudsmen or doctor. Effective interventions and support are applied to reduce acute symptoms and provide tools and strategies for the person and family, where appropriate, to learn how to manage their health, including recognizing early warning signs and obtaining ongoing psychosocial support. Duration of ill health can be reduced, including extended time away from work, as well as minimizing harm and suffering.

E-Mental Health: Use of information and communications technologies/ digital technology used to promote, prevent and/or assist in the recovery from mental health problems, regardless of where people live or the type of local support and services available to them. As tools, they can be used as stand-alone technologies, or blended/moderated with professional and/or peer support, e.g., combining technology and personal or therapist participation

and support. There is a growing literature on and evidence for these tools and interventions supporting better outcomes in common mental health problems for peer support, access to information, self-management literacy and education, via podcasts/e-learning, and improved relapse prevention. It can range from telephone support, telemedicine, digital wearables (e.g., Apple Watch or Fitbit), apps, mobile devices, i.e., smartphone, mobile phone, iPad and internet websites, etc. In this context, we are not describing the use of virtual reality devices, owing to limited early research and general access.

Hazardous drinking: hazardous use – a pattern of substance use that increases the risk of harmful consequences for the user. Some would limit the consequences to physical and mental health (as in harmful use); some would also include social consequences. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user. The term is used currently by WHO but is not a diagnostic term in its International Statistical Classification of Diseases and Related Health Problems (ICD-10).³

Individual and workplace protective factors: associated with good mental health and well-being include:

- Good social skills
- Supportive relationship with another adult
- Positive work climate
- Good physical health
- Opportunities for success and recognition of achievement
- Secure and stable family life
- Sense of belonging
- Economic security
- Access to support services
- Attachments and networks within the community

Mental health and well-being: Mental health is defined as a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community. The positive

³ See <http://apps.who.int/classifications/icd10/browse/2016/en>.

dimension of mental health is stressed in the World Health Organization (WHO) definition of health as contained in its constitution: health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.⁴

In this context, we are generally using:

(a) Mental health: as referring specifically to a person's psychological, emotional, cognitive, behavioural and social state of health or ill health.

(b) Well-being: as referring to broader good health and all that contributes to that.

Mental health prevention: While some approaches are similar to mental health promotion, the focus on outcome is different – preventive interventions work by focusing on reducing risk factors and enhancing protective factors associated with mental ill-health.

There is a wide range of evidence-based preventive programmes and policies available for implementation. These have been found to reduce risk factors, strengthen protective factors and decrease psychiatric symptoms and disability and the onset of some mental disorders. They also improve positive mental health, contribute to better physical health and generate social and economic benefits.⁵

Prevention efforts can be described as primary, secondary and tertiary or based on levels of reach to population or subgroups, i.e., universal, selective, indicated. In this strategy, we are using the latter.

Levels of prevention (MHF 2017 UK)

- **Universal:** for everyone; targeting the whole population, groups or settings where there is an opportunity to improve mental health, such as schools or workplaces.
- **Selective:** for people in groups, demographics or communities with higher prevalence of mental health problems; targeting individuals or subgroups of the population based on vulnerability and exposure to adversity, such as those living with challenges that are known to be corrosive to mental health.
- **Indicated:** For people with early, detectable signs of mental health stress or distress; targeting people at highest risk of mental health problems.

⁴ See www.who.int/features/factfiles/mental_health/en/.

⁵ Ibid.

Mental health promotion: Mental health promotion activities imply the creation of individual, social and environmental conditions that enable optimal psychological and psychophysiological development. Such initiatives involve individuals in the process of achieving positive mental health, enhancing quality of life and narrowing the gap in health expectancy between countries and groups. It is an enabling process, done by, with and for the people. Prevention of mental disorders can be considered one of the aims and outcomes of a broader mental health promotion strategy.⁶

Mental health stigma: Stigma relating to mental illness and misuse of substances is difficult to overcome. Sources of stigma can come from our own knowledges, beliefs, attitudes and behaviour (self-stigma), that of those around (external sources – societal and institutional stigma). It can be experienced or anticipated.

Mental ill-health: specifically refers to being unwell, or in a state of ill-health similar to the way in which it is used for physical health or ill-health.

Psychological safety: a psychologically healthy and safe workplace:

- Promotes positive culture and staff well-being
- Prevents stigma and discrimination
- Contributes to a productive and positive working environment⁷

Psychosocial approaches: range of support and treatments that work to assist the promotion of well-being, the prevention of ill-health and early and sustained recovery, including psychological first aid, talking therapies such as counselling, cognitive behaviour therapy, solutions-focused therapy, problem solving; and community and social support to resolve practical life circumstances etc.

Psychosocial health: psychosocial health recognizes determinants of health and thus treatments and support need to address the psychological and social context and impacts, i.e., emotional experiences, social, family and close relationships, cognition/thinking, work, home, finances, political, community connections, sleep, habits, behaviours and lifestyle.

Recovery: The recovery model describes a journey of healing, change and transformation in a very individual process towards health and well-being. The end point of that journey is defined by the empowerment of the individual, and their family/or loved ones, to their aspiration of living

⁶ See Hosman, C. and Jané-Llopis, E, “Political challenges 2: mental health”, in *Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe* (ECSC-ECEAEC (1999), pp. 29-41.

⁷ See Mental Health Commission of Canada, Declaration of commitment to psychological health and safety in health care. Available from www.mentalhealthcommission.ca/English/workplace-healthcare-declaration.



well in the presence or absence of mental illness. The model is essentially one that encompasses all aspects of a person's life – not just clinical symptoms. It is founded on the principles of hope, personal empowerment, respect, social connections and self-responsibility.

Resilience: the ability of individuals, families, teams, groups, communities, organizations and systems to endure and bounce back after adversity

Risk factors: these are factors that can create a personal vulnerability to developing a mental health problem if exposed to adversity, high stress and/or additional traumatic events later. They also have the potential to make an existing mental health problem worse. Risk factors can be related to the individual and/or environmental.

(a) Individual risk factors: include a complex interplay between biological/genetic, psychological and social factors. These may be pre-existing (before employment) and arise during employment owing to the impact of environmental factors or personal circumstances.

Personal risk factors can include:

- Infancy (poor bonding and attachment)
- Parental mental illness

- Genetic vulnerability
- Development (poor psychological coping strategies)
- Displacement
- Poor physical health
- Adverse childhood experiences and parenting (including exposure to violence, sexual abuse, directly or indirectly, e.g. domestic abuse between parents, child sexual abuse)
- Psychological trauma (loss of loved one, bullying, emotional abuse)
- Social determinants, e.g. poverty, poor housing, poor nutrition

Co-occurring physical health issues are strongly associated with mental health problems, e.g. diabetes, cardiovascular risk and disease, respiratory disorders, pain, somatic complaints (list not exhaustive). Poor mental health, low psychological resilience and well-being can impact on physical health and vice versa.

Individual risk factors can create enhanced vulnerability, as an adult, in the workplace in terms of exposure to trauma, humanitarian disasters, war and conflict and high stress, conflict and incivility in the workplace. They may not emerge or be apparent until such exposure has occurred once or built up over multiple events as resilience wanes and/ or help is not sought. Strength of personal resilience is a key factor in the impact and response to these external events in terms of an individual's mental health and well-being.

(b) Environmental: Factors associated with development of mental health problems in the workplace include:⁸

- Workload (both excessive and insufficient work)
- Monotonous or unpleasant tasks
- Lack of recognition at work
- Poor interpersonal relationships
- Poor leadership and communication
- Lack of participation and control in the workplace
- Role ambiguity or conflict
- Inequity

⁸ WHO, *Mental Health Policies and Programmes in the Workplace* (Geneva, 2005).



- Poor working conditions
- Conflicting home and work demands

In addition to these generic workplace risks, other environmental risks or psychological hazards relevant to the United Nations workforce can include exposure to:

- Violence
- Trauma
- Poverty of resource
- Conflict
- Humanitarian despair
- Duty station type

See also United Nations Global Well-being survey results

Understanding and recognizing risks is intended to guide prevention interventions and risk management in terms of type of support, selection of appropriate prevention approaches and harm minimization strategies. It is not intended to be used to exclude or disadvantage staff.



Secretary General meets with Female Heads and Deputy Heads of Mission • UN PHOTO/ESKINDER DEBEBE

Serious mental health conditions: A range of mental health conditions can impact on a person's life to very different degrees and for different durations. Serious mental health conditions is a term usually applied to diagnostic conditions of psychosis (including schizophrenia); mood/affective disorders that have had a very significant impact on a person's level of life and personal functioning and may continue over time or relapse and remit over time (e.g., major depression, bipolar disorder, etc.); some would add significant and hazardous misuse of substances such as alcohol and illicit drugs, where addiction to those substances has become harmful to the person's physical and mental health, behaviour, lifestyle and family. Mostly, serious end-of-spectrum mental ill health is of low prevalence but has a high personal impact on individuals, families and society.

Workplace accommodation: For staff experiencing a mental health disability, all reasonable efforts should be made to assist and support them to return to the workplace, with workplace accommodation being at the forefront of that planning. Most organizations have their own policies and procedures related to accommodation. All should be, at a minimum, compliant with relevant human rights legislation. Reasonable accommodation allows employees to perform the essential duties of the job. The types of accommodation that may be requested may be varied and if two solutions will work, but one is more reasonable in terms of practicality, it should be considered.⁹

⁹ See www.workplacestrategiesformentalhealth.com/managing-workplace-issues/the-duty-to-accommodate.

SUMMARY OF MENTAL HEALTH PROMOTION AND PREVENTION EFFORTS FOR INDIVIDUALS AND WORKPLACES (ENVIRONMENT) THAT COULD BE SELECTED FOR UN WORKPLACE*

PSYCHOLOGICALLY HEALTHY, SAFE, PRODUCTIVE WORKPLACE

Requires multi-strategy input: human resources, staff associations, mental health staff, Medical Services Division, occupational safety and health specialists, ombudsmen

Healthy Workplace Positive Practice Program e.g., Agreement on workplace charter/standards, including:

- High staff engagement/involvement; empowering and rewarding workplace culture, including clear processes for participation and control in the workplace.
- Workload management and effective job design.
- Supportive, respectful management culture; training in conflict resolution; clear accountability for workplace culture and safety; training, coaching and guidelines for managers on supporting positive mental health in the workplace, supporting people through health problems and return to work with access to effective management/leadership supervision and mentoring.
- Access to collegial and specific buddy/peer support.
- Occupational safety and health processes in place for risk/hazard assessment, management and reporting.
- Job preparation, mission/duty station preparation, debriefing.
- Recognition and award program for workplace/team exemplars.
- Support with managing work and home-life demands effectively.

PROMOTING WELL-BEING, RESILIENCE AND PROTECTIVE FACTORS

- Reinforcement of and integration with existing healthy lifestyle promotion, including adequate sleep, nutrition, exercise, time out/ holidays, social contact/connectedness.
- Mental health promotion and well-being program focused on building positive mental health, resilience and well-being, e.g., psychological first aid/mental health literacy/five ways to well-being - available to all staff.
- Universal (all workplaces/ all staff) mental health stigma reduction campaign (building on evidence base internationally (e.g., contact with people with lived experiences: leadership and credible known champions: reinforce by communications, information and marketing promotion: learning from and leverage off known successes of UN CARES stigma reduction work).
- Team and collegial social connectedness.
- Safe accommodation.

* The specifics for UN program will be confirmed as part of implementation logistics and planning.

This table lists examples of potential promotion and prevention interventions.

PREVENTION

- Needs to be considered within cultural context.
- Uses some similar programs and interventions as health promotion but with different outcome focus.
- Implementation planning would build on current strengths of services and supports.
- Some of these are already available in some agencies.
- Selective and indication prevention efforts need to be finalized during implementation stage.

UNIVERSAL

Whole staff group

SELECTIVE

Specific subgroups at greater risk or vulnerability

INDICATED

Where early or clear signs of poor mental health, stress or distress are evident

INDIVIDUAL AND ENVIRONMENTAL

- Universal mental health literacy/psychological first aid for early recognition of problems and ability to respond to oneself, and or seek help early.
- Universal and selected: availability of programs or courses, (individual and group) via the workplace (in situ and or virtual/digital), e.g., stress management, coping with change, personal coping strategies, problem solving, coping with trauma exposure, evidence-supported mindfulness programmes (i.e., mindfulness-based stress reduction and /or mindfulness-based cognitive therapy programmes, for depression) in situ, digital options.
- Accessible information on support services available in-house, via insurance, via other providers, supported digital/web-based resources.
- Quick, easy access to help, advice, psychosocial support, counselling, appropriate involvement in psychological therapies and medical and pharmacological treatments where appropriate.
- Peer support/buddy scheme at field duty stations.
- Mission/duty station preparedness (see duty-of-care initiatives).
- Appropriate job, role and duty station matching.
- Targeted health checks for people in known psychosocial risk situations (e.g., family duty stations, exposure to trauma and hardship, at third anniversary with the United Nations for example (list not exhaustive).
- Training, mentoring and practical guidelines for managers on mental health literacy; confidence in starting a conversation.
- Training and workshops on conflict resolution in the workplace.
- Actions and policies that protect human rights in the context of the workplace including zero tolerance of discrimination, violence, bullying and harassment.

This table lists examples of potential promotion and prevention interventions.



Security Council Unanimously Adopts Resolution on Syria • UN PHOTO/MARK GARTEN



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