Field Manual

on

Psychosocial Support in Crisis Situations

for

United Nations Staff Counsellors and Stress Counsellors

Inter-Agency Security Management Network (IASMN)
Critical Incident Stress Working Group (CISWG)

December 2021

Table of Contents

Acknowledgements

The 'Field Manual on Psychosocial Support in Crisis Situations for United Nations Staff/Stress Counsellors' is the result of a systemwide collaboration of UN counsellors through the IASMN CISWG (Inter-Agency Security Management Network, Critical Incident Stress Working Group), coordinated by the UNDSS CISMU (Critical Incident Stress Management Unit). I would like to express my deep appreciation and gratitude to all the professionals listed below who have contributed to the development of this comprehensive manual.

CISMU (Critical Incident Stress Management Unit)

- Abdalla Mansour Amer, Regional Stress Counsellor (Middle East and North Africa)
- Muhammad Sohail Ali, Regional Stress Counsellor (East and Southern Africa)
- Djeneba Coulibaly, Regional Stress Counsellor (West and Central Africa)
- Anne-Marie Serrano Banquet, Regional Stress Counsellor (Europe and Americas)
- Madhubhashini (Kalhari) Hewage, Regional Stress Counsellor (Asia Pacific & Russian Speaking Countries)
- Penelope Curling, Consultant
- Alvin Tay, Consultant

IASMN CISWG (Critical Incident Stress Working Group)

- Angelika Radax, Staff Counsellor/UNIDO
- Christine Goletto, Assistante sociale du personnel/UNESCO
- Daniela Menes, Staff Welfare Officer/ ILO
- Dawn Straiton, Chief Staff Counsellor SCO/DHMOSH
- Dubravka Suzic, Chief Psychosocial Wellbeing Section/UNHCR
- Dushayant Joshi, Chief of Section, Client Support and Special Situations Section/DOS
- Elizabeth Openshaw, Senior Staff Welfare Officer/IOM
- Esther Tan, Senior Medical Officer Public Health Section/DHMOSH
- Esra Dildar Gardner, Senior Programme Management Officer/Critical Incident Response Service/DMSPC
- Jorge Sierralta, Chief Staff Counsellor/UNOCHA
- Karen Abbs, Duty of Care Coordinator UNFPA
- Marianna Igelnik, Staff Counsellor/WIPO
- Michelle Strudwick-Alexander, Chief Staff Wellbeing Team/UNICEF
- Mounia Lakhdar-Hamina, Workplace Relations Advisor/UN Women
- Nancy Beaudouin, Staff Counsellor/UNAIDS
- Nathalie Casalis, Staff Counselor/WHO
- Paola Paoletti, Staff Counsellor OSHW Focal Point/UNDP
- Peter Butor, Staff Counsellor/ICC
- Regan Shercliffe, Chief, Staff Counselling Unit/WFP

- Rodney McBride, Staff Counsellor/FAO
- Stuart Fisher, Senior Psychologist/WB
- Sophie Montagnon, Senior Medical Officer/ UN Medical Emergency Response Team/DHMOSH
- Therese Fitzpatrick, Global Lead UN System Workplace Mental Health and Well-being Strategy/DMSPC

I am hopeful that this collaborative effort will be beneficial for all UN Staff/Stress counsellors in the field and will contribute to the systemwide harmonization and standardization of psychosocial support services for UN personnel and families.

Excellent teamwork!

Moussa Ba
Chief of CISMU and Chair CISWG

17 December 2021

Glossary of acronyms

AFPs: Agencies, Funds and Programmes

CBT: Cognitive Behavioural Therapy

CISG: Critical Incident Stress Working Group

CISIC: Critical Incident Stress Intervention Cell

CISMU: Critical Incident Stress Management Unit

CISWG: Critical Incident Stress Working Group

CMT: Crisis Management Team

COG: Crisis Operation Group

CPSU: Crisis Preparedness and Support Unit

CSA: Chief Security Advisor

DMSPC: Department of Management Strategy, Policy and Compliance

DO: Designated Official

DOS: Department of Operational Support

DPA: Department of Political Affairs

DPBA: Department of Political and Peace Building Affairs

DPA: Department of Political Affairs

DPPA: Department of Political and Peace Building Affairs

DPO: Department of Peace Operations

DSS: Department of Safety and Security

EMHP: External Mental Health Professionals

FFP: Family Focal Points

HQ: Headquarters

HR: Human Resources

IASC: Inter-Agency Standing Committee

IASMN: Inter-Agency Security Management Network

OAH: Offices Away from Headquarters

OHR: Office of Human Resources

MSCIS: Management of Stress and Critical Incidents Stress

PFA: Psychological First Aid

PPK: Personal Protection Kits

PTSD: Post-traumatic stress disorder

R&R: Rest and relaxation/recuperation

SMT: Security Management Team

UNAFPs: United Nations Agencies, Funds and Programmes

UNCMT: United Nations Country Management Team

UNCT: United Nations Country Team

UNDSS: United Nations Department of Safety and Security

UNISDR: United Nations Office for Disaster Risk Reduction

WHO: World Health Organisation

Chapter 1 Introduction to the Field Manual

1.1 Aim of the Field Manual

Lessons learned from UN psychosocial response to emergency situations affecting UN personnel have highlighted the need for a field manual to standardise professional support interventions and ensure that the provided services are comprehensive, culturally and situational appropriate and well-coordinated. On 18 January 2019, the Critical Incident Stress Working Group (CISWG) approved the development of a field manual intended as the guideline of operations for all UN counsellors based in or deployed to the field before, during and after crisis situations while under the supervision and/or coordination of CISMU. It will also guide other partners supporting UN-system employees in emergency situations, including Human Resources, Medical Services and the Crisis Preparedness and Support Unit.

The Critical Incident Stress Management Unit (CISMU) is responsible for the coordination of the Field Manual project in partnership with UN Secretariat Headquarters, Political and Peacekeeping Operations and Agency, Fund and Programme (AFP) counsellors, and in consultation and agreement on the main directions and mechanisms of coordination with other UN partners in crisis response such as Medical Services, Security and the HR Network and where relevant with other international humanitarian actors and academics.

As per its mandate, the CISWG will oversee the implementation of the United Nations Field Manual on Critical Incident Stress Management and its further development including annual updates and revisions based on lessons learnt. The manual includes evidence-based approaches and intervention protocols and modalities drawn from UN lessons learned, and literature reviews.

1.2: Core principles and guiding values of the Field Manual

Duty of care principle: The organisation has the obligation to anticipate risks and avoid any acts or omissions that can reasonably be foreseen to cause any injury or harm and to provide and facilitate the needed care to its employees.

Comprehensive model of intervention: WHO defines health 'as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' Mental health is an integral component of overall health and wellbeing, incorporating concepts such as self-efficacy, autonomy, and competence. The Field Manual is based on a holistic philosophy of occupational mental health aimed at engaging and developing the whole person, including the physical, psychological, social and spiritual dimensions, taking into account the multiple factors and interacting systems which impact the mental health and well-being of UN employees and their dependents. The comprehensive model is further based on an organisation-wide approach in which mental health and well-being is seen as being dependent on every sector of an organisation working together and not by UN counselling services alone. The comprehensive

model includes not only crisis response but also preparation both at the individual and the organisational level as well as follow-up and lessons learned after the crisis.

Human rights and equality: No UN employee shall be discriminated against, mistreated or deprived of their right to receive dignified, culturally appropriate psychosocial support. All interventions shall be carried out from a compassionate, non-judgemental approach with respect for human privacy and dignity.

Client orientation: UN employees are the most important asset of the organisation and should be the centre of the response strategy. This principle should be clearly reflected in all organisational procedures and operations.

Scientifically sound and culturally appropriate practices: Interventions and wellness programmes should be based on scientific evidence and best practices, taking into consideration the cultural context. All employees, whether national or international should have easy access to timely, evidence based, culturally appropriate interventions and programmes.

Positive psychology: The primary focus of interventions and programmes shall be on proactively facilitating empowerment and promoting mental health and well-being for all employees, not just the treatment of (mental) illness.

Self-monitoring and self-correcting: Intervention protocols must be flexible and self-correcting in order to prove sustainable across time and adaptable across circumstances. This includes assessment and monitoring mechanisms; creative initiatives for improvement; the setting of priorities, planning and implementation with ongoing feedback and effective internal and external communication.

1.3: Basic Concepts and definitions

The terms of crisis, emergency and disaster are frequently used interchangeably but it is important to understand the core components of each and the distinction between them. For practical reasons the terms “crisis” and “emergency” will be used reciprocally in the Field Manual.

Crisis: “A crucial or decisive point or situation, especially a difficult or unstable situation involving an approaching change.”

Emergency: “A condition of urgent need for action or assistance.” The word emergency always implies that it requires urgent intervention where the failure of providing the needed actions could conceivably lead to a disaster.

Disaster: “A situation which overwhelms the local capacity to withstand, cope and recover; necessitating external assistance and involving various stakeholders.” The United Nations Office

for Disaster Risk Reduction (UNISDR) highlighted that disasters occur as a result of a combination of hazards, vulnerabilities and lack or insufficient mitigating measures.

Hazard: A natural or human made phenomenon of incident which may cause physical damage, economic loss or threaten human life in a populated area.

Vulnerability: The extent to which an individual, an organisation, community, subgroup, or service in a geographic area is likely to be damaged or disrupted by the impact of a hazard.

Manageability: The capacity of the organisation or system to adapt to the crisis, the degree of help available and the ability of the survivors to adjust psychologically. Manageability is determined by different factors including:

- knowledge, attitudes and practices of the population,
- technology available for the affected population; and
- organisational measures available in the disaster.

Risk: The extent to which an event can disrupt the normal social or organisational structure and make it difficult for the usual mechanisms to manage the consequences.

Defining the scale of a crisis

The scale of an emergency operation in the UN is determined by several factors including the speed of onset, the impact of the incident on the local communities including the number of casualties and number of people displaced or dislocated and the outbreak of communicable disease. The impact on the UN including the number of casualties among UN employees is an additional, important factor.

Based on experience from previous emergencies, the UN approach in defining the scale of the crisis response can be described as follows:

Magnitude	Impact on the UN functionality	Recommended Response
1.High	Severe: UN can't function due to massive degree of physical destruction and loss of life	High level multidisciplinary crisis coordination team to take the lead Plan for multiple deployment of UN counsellors Avoid depletion of the community resources
2.Medium	UNCT can function with HQ support	Send multidisciplinary crisis team in coordination with the UNCT
3. Low	UNCT can function with coaching and direction	Provide clear directions and advice as needed.

1.4 Assessment of psychosocial needs and resources

Interventions in both the acute and post-emergency phases should be preceded by careful planning based on assessment of the local context including local perceptions and expressions of distress and illness, styles of coping, community needs and resources.
Annex 1: Assessment and mapping of psychosocial stressors and resources is a checklist which been derived from lessons learned and best practice drawn from previous UN emergency response.

1.5 Psychosocial Intervention Strategies

CISMU is responsible for maintaining an updated list of UN-system counsellors with the appropriate training and experience who are available and ready for deployment to the disaster site.

Counselling interventions shall be carried out according to a coordinated multi-layered, multi-disciplinary approach of psychosocial support, as outlined in the following table adopted from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings[1].

[1] Inter-Agency Standing Committee (2007) Available at: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings - World | ReliefWeb

Sharing of information and analysis with the other disciplines is critical. However, role definition must be clear as per the 2015 approved policy **Management of Stress and Critical Incidents Stress** (MSCIS) (Annex 12). Competing behaviour between representatives of different organisations and between disciplines is a risk to the successful functioning of the operation.

Psychosocial intervention strategies should cover all four levels which should be coordinated to work simultaneously to avoid duplication and maximise resources. Cross-cutting these levels are the three phases of interventions:

1.5.1 Preparedness and prevention phase

Prevention in mental health aims to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated disability. Preventive interventions are based on modifying risk exposure and strengthening the coping mechanisms of the individuals and building a positive healing environment at workplace.

The role of the counsellor in psychosocial preparedness is reflected in the Table: **Crisis Preparation: Psychosocial preparedness and prevention strategies for counsellors** (Annex 3).

1.5.2 Incident response phase

During the phase of incident response coordination with partners in the field, such as Medical, HR, Security and management should be through structured operational meetings of all disciplines. Role definition of each discipline is essential to avoid unnecessary conflict and confusion. The roles of the multi-disciplinary team, outlining the various levels of psychosocial support interventions can be found in the Table: **Crisis Response Phase: Psychosocial intervention strategies for multi-disciplinary team** (Annex 6).

The coordination and roles of UN psychosocial support in emergencies is outlined in **Annex 11** and described in greater detail in the policy document **Management of Stress and Critical Incidents Stress** (MSCIS) that was approved by the IASMN in 2015 (Annex 12).

For a step-by-step outline of activities for counsellors in in the incident response phase, refer to the Table: **Crisis Response Phase: Psychosocial intervention strategies for counsellors** (Annex 4).

1.5.3 Post-incident response phase

Mechanisms must be put in place to ensure the smooth follow-up of cases, continuity of care and appropriate referrals for late onset and long-term mental health sequalae through specialised support. Counsellors will continue to participate in interdisciplinary case management for complex situations.

Lessons learned from the crisis, including best practices, must be gathered and contingency plans and guidelines should be revised accordingly.

For a step-by-step outline of activities for counsellors in in the post-incident response phase, refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for counsellors** (Annex 5).

The roles of the multi-disciplinary team in the post-incident response phase can be found in the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for multi-disciplinary team. Follow up and lessons learned** (Annex 7).

1.6 Documentation and reporting

Documentation and reporting should take place at the different phases of a crisis as follows:

Preparatory phase: A routine assessment should be carried out of the psychosocial needs of the duty station, with emergency contingency planning, including a current list of active Peer Helpers, locally available mental health professionals and other relevant resources. These lists should be handed to the coordinator of the intervention team on activation of the emergency response.

Intervention phase: During the crisis response the psychosocial needs assessment should be updated on a daily basis, including the categories of affected personnel, levels of interventions which are being implemented, relevant clinical and social observations, urgent administrative issues for follow up, and notes of urgent clinical or social intervention needs.

During the crisis response the counselling crisis coordinator on the ground should ensure that all team members provide daily updates on all activities and achieved tasks, planned tasks and new or existing challenges. The crisis coordinator should summarise these and send regular updates to CISMU in HQ, along with relevant updates on the status of the counselling team. Special report should be made of any specific issues, for example the need to medivac an employee or the need for a specialist referral.

CISMU shall in turn share all the gathered information with counselling representatives of the UN AFPs and other relevant stakeholders in the CISWG. The frequency of meetings shall be determined by the need for such updates.

A reliable platform for information sharing between the relevant partners is needed. See Annex 8: **Matrix for daily activities of coordinated multidisciplinary-multi-layered interventions** for one such example.

Follow-up phase: Following the crisis a final report should be compiled including recommendations and lessons learned, drawing on the input from all parties who were involved in the psychosocial response.

All reports must maintain absolute confidentiality of personal information and be directed only to relevant parties.

1.7 Self-care and care for the counsellors

Self-care is an essential element of the professional work of counsellors and becomes particularly important when counsellors are working under conditions of protracted high levels of stress. Counsellors are personally responsible to maintain healthy self-care habits and a flexible approach. A suggested resource is the IOM module on self-care: https://prezi.com/4tj1vapebjur/self-care/

However, in addition to individual counsellor responsibility for self-care, the organisation has a particular duty of care to ensure that all counsellors involved in crisis response to take care of the psychosocial well-being of the entire operation do not suffer as a result of this important task. Conditions on the ground can be challenging and the risk of vicarious trauma and burnout increases if counsellors do not have time to recover from the emotionally intense nature of their work.

A care-for-care-givers programme should be in place for the counsellors of each organisation. Every counsellor deployed to the field during an emergency must receive training and briefing on self-care including self-awareness and emotional regulation and must be supported in their self-care needs.

It is the responsibility of the counselling coordinator to ensure that each counsellor has sufficient time off from official duties (at least one full day off per week) to recover while on mission and to informally monitor the psychosocial functioning of the counsellors deployed in the crisis response. All counsellors who have been involved in crisis response should be granted proportional time off to recover once their role in the crisis is over.

1.8 Thematic areas and structure of the chapters

The Field Manual covers the following thematic areas:
Intentional or terrorist attack with mass casualties
Natural disaster with mass casualties
Protracted and complex emergency such as civil war, chronic civil unrest and chronic conflict
Evacuation & reception
Pandemic and epidemic
Hostage incident
Death in service

Within these thematic areas the following aspects have been included where relevant:

- Definitions relevant to the topic of the chapter
- A scenario or case study drawn from the UN context
- Psychosocial factors specific to the thematic area
- Categories of casualties and target population for psychosocial support
- Assessment of psychosocial needs and resources
- Psychosocial preparedness and prevention strategies

- Psychosocial intervention strategies
- Coordination with other counsellors and other disciplines and their roles
- Follow-up and lessons learned
- Documentation and reporting
- Self-care and care for the counsellors

The Mental Health Gap Action Programme (MHGAP) Intervention Guide module[2] Assessment and Management of Conditions Specifically Related to Stress (Annex 13) contains useful assessment and intervention guidance related to acute stress, post-traumatic stress and grief. This is not intended to be used by counsellors as a diagnostic tool, particularly as symptoms of distress in crisis contexts are likely to be transient and not indicative of a mental health disorder. Additionally, interventions must be carried out in a coordinated multi-layered, multi-disciplinary approach of psychosocial support as outlined in this Field Manual.

Further Resources are included in the other Annexes.

Protocols of coordinated psychosocial crisis response:
The following documents describe the coordination mechanism as suggested and approved by UN HQ in greater detail:

- **Coordination of global UN psychosocial support in emergencies** (Annex 11)
- **IASMN policy Management of Stress and Critical Incidents Stress** (MSCIS): Annex 12

[2] (World Health Organisation & United Nations High Commission for Refugees (2013)

Chapter 2 Intentional attack on the United Nations with mass casualties

2.1 What is a terror attack?

UN Resolution 1566 (2004), refers to "terrorism" as: "... criminal acts, including against civilians, committed with intent to cause death or serious bodily injury, or taking of hostages, with the purpose to provoke a state of terror in the general public or in a group of persons or particular persons, intimidate a population or compel a government or an international organization to do or to abstain from doing any act…." (UNODC, 2018[3])

Scenario: Abuja car bomb attack 2011
At about 11:00 on 26 August 2011 a vehicle broke through two security barriers in the diplomatic zone in the centre of the Nigerian capital Abuja. The driver detonated the car bomb after crashing it into the reception area of the UN building, which provided offices for about 400 UN personnel. The bomb caused devastation to the building's lower floors. At least 21 people were killed and 73 injured in the explosion and its aftermath.

2.2 Psychosocial factors specific to intentional attacks

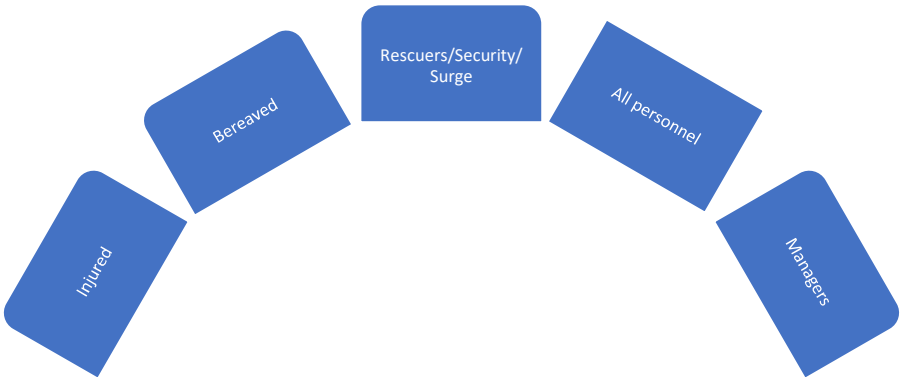
The aim of acts of terrorism is to produce collective fear, panic and uncertainty. At the microlevel the focus of the counsellor is on the impact of stress and trauma on the individual. However, the impact extends far beyond those who directly experienced the incident to the entire UN community, their families and to local communities. Acts of terrorism require systemic, organisational adjustment to the continuous risk of exposure to attacks, including the design of UN offices and accommodation, freedom of movement, interactions with local communities, security procedures and training. The need to adjust to the continuous level of threat can result in chronic and cumulative stress that can undermine the psychosocial resilience of UN employees.

Pre-existing factors: Degree of security preparedness; existing medical and mental health resources in the country; capacity of local and UN medical and counselling services; pre-existing ethnic or civil conflict; crime.
Incident-induced factors: Anger; helplessness; fear; despair; loss and grief; the number of deceased and ability to access and identify the deceased; the number and severity of injured; the level of destruction in infrastructure and logistics; disruption of social networks; ongoing levels of threat and uncertainty; lack of information.

[3] United Nations Office on Drugs and Crime Counter-Terrorism Module 4 Key Issues: Defining Terrorism (unodc.org) *July 2018*

Humanitarian factors: Role conflict; competing flags; security versus humanitarian priorities; national vs international tensions; helplessness and burnout among employees
Post-incident factors: Psychosocial resources available to support the survivors and their dependents in the long-term aftermath.

2.3 Categories of casualties and target population for psychosocial support



Physically injured
Psychologically injured
Mourning dependents / Colleagues
Surge/ Rescuers/ Security
Managers Field and HQ

In order to aid in planning the appropriate response and recommend suitable procedures and resources that are comprehensive and inclusive, survivors of traumatic incidents can be divided into the following categories:
First level: Those in the front line who experienced maximum exposure to the incident. All physically injured employees as well as employees who were in the location when the incident occurred and survived without any physical injuries.
Second level: Grieving relatives, close colleagues and friends of first level victims and survivors; Employees who were present in the duty station but were not in the site
Third level: Humanitarian aid and relief workers maintaining their functional efficiency with the demanding situation; they are at higher risk of vicarious trauma and of burnout.
Fourth level: Employees in HQ and other duty stations who are vicariously affected by the incident.

It is important to note that the above categories are not indicators of the severity of the psychological status of the survivor. For example, a person from the fourth level might experience a more severe reaction than one in the first category. The severity of reactions is influenced by the interaction of several factors that include: proximity, severity and duration of exposure to the incident; past history of trauma exposure; personality and pre-existing psychological problems including depression, anxiety or personality disorders; gender; social

and economic status and the availability and adequacy of social support systems. Therefore, prioritisation and recommended actions should be based on clinical assessment.

2.4 Assessment of psychosocial needs and resources

Interventions in both the acute and post-emergency phases should be preceded by careful planning and assessment of the local context such as culture, history and nature of problems, local perceptions and expressions of distress and illness, styles of coping, community needs and resources.

The on-site counselling crisis coordinator is responsible to carry out an immediate assessment within the first 24-48 hours after the attack to assess the immediate psychosocial needs of the organisation, survivors and other UN employees in the areas affected by the attack for planning purpose and initiation of the appropriate response. This task can be coordinated by counselling services, but assessments should be carried out collaboratively with other partners mainly: Medical Services, Human Resources and the Security Management Team (SMT) in order to maximize understanding of the situation and to develop and implement effective interventions.

It is important to differentiate between emotional reactions triggered by the incident and abnormal or "pathological" reactions, including have some understanding of the local culture and context.

Specific tools like standardised questionnaires, standardised focus groups or individual interviews should not be undertaken at the acute emergency stage of the crisis. However, psycho-social assessment in emergency should be seen as a continuous process, with observation and monitoring activities constituting part of daily operational work.

The following Annexes contain assessment checklists which been derived from lessons learned and best practice drawn from previous UN emergency response:
Assessment and mapping of psychosocial stressors and resources (Annex 1)
Assessment Checklist (Annex 2)

2.5 Psychosocial Intervention strategies

Interventions shall be carried out according to a coordinated multi-layered, multi-disciplinary approach of psychosocial support, as outlined in the Table in 1.5 **Psychosocial Intervention Strategies** above. Sharing of information and analysis with the other disciplines is critical. However, role definition must be clear as per the 2015 approved policy **Management of Stress and Critical Incidents Stress** (MSCIS) (Annex 12). Competing behaviour between representatives of different organisations and between disciplines is a risk to the successful functioning of the operation.

2.5.1 Preparedness and prevention

Prevention in mental health aims to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated disability. Preventive interventions are based on modifying risk exposure and strengthening the coping mechanisms of the individuals and building a positive healing environment at workplace.

The role of the counsellor in psychosocial preparedness for the impact of mass casualty incidents is reflected in the Table: **Crisis Preparation: Psychosocial preparedness and prevention strategies for counsellors** (Annex 3)**.** In the Table, for 'crisis' read: 'mass casualty incident/terrorist attack'.

2.5.2 Multidisciplinary team response

During the phase of incident response coordination with partners in the field, such as Medical, HR, Security and management should be through structured operational meetings of all disciplines. Role definition of each discipline is essential to avoid unnecessary conflict and confusion. Specific roles of HR, Medical, counsellors and CISMU are outlined in Annex 11: **Coordination of global UN psychosocial support in emergencies** and described in greater detail in the policy document **Management of Stress and Critical Incidents Stress** (MSCIS) that was approved by the IASMN in 2015 (Annex 12)

For a step-by-step outline of activities for counsellors in in the incident response phase, refer to the Table: **Crisis Response Phase: Psychosocial intervention strategies for counsellors** (Annex 4). In the Table, for 'crisis' read: 'mass casualty incident/terrorist attack'.

The roles of the multi-disciplinary team, outlining the various levels of psychosocial support interventions can be found in the Table: **Crisis Response Phase: Psychosocial intervention strategies for multi-disciplinary team** (Annex 6)**.** In the Table, for 'crisis' read: 'mass casualty incident/terrorist attack'.

Refer to Chapter 7: **Death in Service** for further information about the counsellor's role following a death in service.

2.5.3 Follow up and lessons learned

The psychological after-effects of traumatic events can take several years to heal. Furthermore, Depression, PTSD and other psychological conditions can develop with late onset, particularly once the surge response is over when resources are exhausted. In such cases it falls within the duty of care of the organization to ensure continuity of care. One of the main lessons learned after the attack on the UN offices in Algeria was to establish an HR focal point in the Secretariat to maintain documentation of such cases and to keep track on their status.

For a step-by-step outline of activities for counsellors in in the post-incident response phase, refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for counsellors** (Annex 5)**.** In the Table, for 'crisis' read: 'mass casualty incident/terrorist attack'.

For an outline of follow-up activities for counsellors collaborating with other disciplines in the follow-up phase refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for multi-disciplinary team. Follow up and lessons learned** (Annex 7)**.** In the Table, for 'crisis' read: 'mass casualty incident/terrorist attack'.

2.6 Documentation and reporting

Documentation and reporting should take place at the different phases of a crisis as follows:

Preparatory phase: As described in **2.4** above, a routine assessment should be carried out of the psychosocial needs of the duty station, with emergency contingency planning, including a current list of active Peer Helpers, locally available mental health professionals and other relevant resources. These lists should be handed to the coordinator of the intervention team on activation of the emergency response.

Intervention phase: During the crisis response the psychosocial needs assessment should be updated on a daily basis, including the categories of affected personnel, levels of interventions which are being implemented, relevant clinical and social observations, urgent administrative issues for follow up, and notes of urgent clinical or social intervention needs.

During the crisis response the counselling crisis coordinator on the ground should ensure that all team members provide daily updates on all activities and achieved tasks, planned tasks and new or existing challenges. The crisis coordinator should summarise these and send regular updates to CISMU in HQ, along with relevant updates on the status of the counselling team. Special report should be made of any specific issues, for example the need to medivac an employee or the need for a specialist referral.

CISMU shall in turn share all the gathered information with counselling representatives of the UN AFPs and other relevant stakeholders in the CISWG. The frequency of meetings shall be determined by the need for such updates.

A reliable platform for information sharing between the relevant partners is needed. See Annex 8: **Matrix for daily activities of coordinated multidisciplinary-multi-layered interventions** for one such example.

Follow-up phase: Following the crisis a final report should be compiled including recommendations and lessons learned, drawing on the input from all parties who were involved in the psychosocial response.

All reports must maintain absolute confidentiality of personal information and be directed only to relevant parties.

2.7 Self-care and care for the counsellors

Self-care is an essential element of the professional work of counsellors and becomes particularly important when counsellors are working under conditions of protracted high levels of stress and in times of crisis response. Counsellors are personally responsible to maintain healthy self-care habits and a flexible approach. A suggested resource is the IOM module on self-care: IOM Model: https://prezi.com/4tj1vapebjur/self-care/

However, in addition to individual counsellor responsibility for self-care, the organisation has a particular duty of care to ensure that all counsellors involved in crisis response to take care of the psychosocial well-being of the entire operation do not suffer as a result of this important task. Conditions on the ground can be challenging and the risk of vicarious trauma and burnout increases if counsellors do not have time to recover from the emotionally intense nature of their work.

A care-for-care-givers programme should be in place for the counsellors of each organisation. Every counsellor deployed to the field during an emergency must receive training and briefing on self-care including self-awareness and emotional regulation and must be supported in their self-care needs.

It is the responsibility of the counselling coordinator on the ground to ensure that each counsellor has sufficient time off from official duties (at least one full day off per week) and to informally monitor the psychosocial functioning of the counsellors deployed in the crisis response. Likewise, it is the responsibility of the counselling coordinator in HQ to ensure that the counsellor on the ground has sufficient time off from official duties to recover while on mission. All counsellors who have been involved in the crisis response should be granted proportional time off to recover once their role in the crisis is over.

Chapter 3 Natural disaster with mass casualties

3.1 What is a natural disaster?

A natural disaster is any force of nature such as a flood, hurricane, tornado, volcanic eruption, earthquake, tsunami that has catastrophic consequences. The severity of the economic damage depends on the resilience of the affected population and local infrastructure. Where the adverse event occurs against a background of vulnerability such as severe poverty, weak infrastructure, poor community structures or ongoing conflicts these vulnerabilities multiply the impact of the stress cause by the natural disaster.

Scenario: Haiti Earthquake 2010
On 12 January 2010 an earthquake struck the most populated area of Haiti and caused extensive devastation. It is estimated that 230 thousand people were killed and about three million people were affected. On that day, in addition to the catastrophic destruction of the infrastructure of the UN, the UN faced its greatest loss of life in a single incident: 101 UN personnel were killed and hundreds were seriously injured. In the days and weeks following the earthquake the UN family mobilised its entire personnel and resources to support dependents of deceased personnel, injured colleagues and mourning and traumatised survivors while simultaneously manging a huge surge response to support the country in managing one of the worst humanitarian crises under extremely challenging conditions.

3.2 Psychosocial factors specific to natural disasters with mass casualties

Ensuring basic needs and personal safety are an essential part of the immediate psychosocial response to a natural disaster. Not only is the target population affected by the natural disaster, but the disaster surge response, including the counsellors, are likely to be working under conditions of extreme hardship, such as lack of electricity, clean running water and exposure to other major health hazards.

Pre-existing factors: Degree of preparedness; existing medical and mental health resources in the country; capacity of local and UN medical and counselling services; pre-existing ethnic or civil conflict, crime and endemic disease
Incident-induced factors: Despair; helplessness; loss and grief; the number of deceased; the number and severity of injured; the level of destruction in infrastructure and logistics; disrupted social networks; loss of livelihood; lack of information
Humanitarian factors: Role conflict; competing flags; security versus humanitarian priorities; national vs international tensions; helplessness and burnout among employees
Post-incident: Psychosocial resources available to support the survivors and their dependents in the long-term aftermath.

Sudden extensive destruction of facilities including infrastructure, basic resources and services

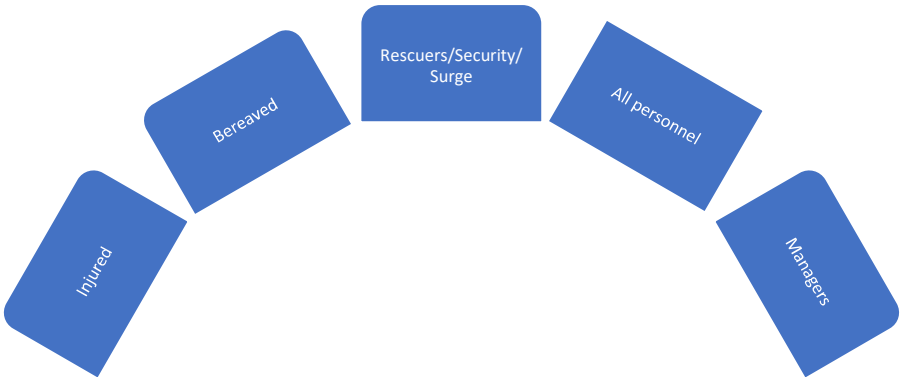
Mass casualities for both the UN organisations and the local community

Survivors & rescuers can be emotionally overwhelmed by the degree of devasation and trauma

Influx of humanitarian workers to assist and who may also require support

Overwhelming basic needs

3.3 Categories of casualties and target population for psychosocial support



Physically injured
Psychologically injured
Mourning dependents / Colleagues
Surge/ Rescuers/ Security
Managers Field and HQ

In order to aid in planning the appropriate response and recommend suitable procedures and resources that are comprehensive and inclusive, survivors of natural disasters can be divided into the following categories:

First level: Those in the front line who have experienced maximum exposure to the incident; All physically injured employees as well as employees who were in the duty station at the time of the natural disaster and survived without any physical injuries.

Second level: Grieving relatives, close colleagues and friends of first level victims and survivors; Employees who were present in the duty station but who were not in the location affected by the natural disaster (e.g., tsunami)
Third level: Humanitarian aid and relief workers maintaining their functional efficiency within the demanding situation who are at higher risk of vicarious trauma and of burnout
Fourth level: Employees in HQ and other duty stations who are vicariously affected by the disaster.

It is important to note that the above categories are not indicators of the severity of the psychological status of the survivor. For example, a person from the fourth level might experience a more severe reaction than one in the first category. The severity of reactions is influenced by the interaction of several factors that include proximity, severity and duration of exposure to the disaster; past history of trauma exposure; personality and pre-existing psychological problems including depression, anxiety or personality disorders; gender; social and economic status and the availability and adequacy of social support systems. Therefore, prioritisation and recommended actions should be based on clinical assessment.

3.4 Assessment of psychosocial needs and resources

Interventions in both the acute and post-emergency phases should be preceded by careful planning and assessment of the local context such as culture, history and nature of problems, local perceptions and expressions of distress and illness, styles of coping, community needs and resources.

The on-site counselling crisis coordinator is responsible to carry out an immediate assessment within the first 24-48 hours after the natural disaster to assess the immediate psychosocial needs of the organisation, survivors and other UN employees in the disaster-affected areas for planning purpose and initiation of the appropriate response. This task can be coordinated by counselling services, but assessments should be carried out collaboratively with other partners mainly: Medical Services, Human Resources and the Security Management Team in order to maximize understanding of the situation and to develop and implement effective interventions.

It is important to differentiate between emotional reactions triggered by the incident and abnormal or “pathological” reactions, including have some understanding of the local culture and context.

Specific tools like standardised questionnaires, standardised focus groups or individual interviews should **not** be undertaken at the acute emergency stage of the crisis. However, psycho-social assessment in emergency should be seen as a **continuous process**, with observation and monitoring activities constituting part of daily operational work.

The following Annexes contain assessment checklists which been derived from lessons learned and best practice drawn from previous UN emergency response:
Assessment and mapping of psychosocial stressors and resources (Annex 1)

Assessment Checklist (Annex 2)

3.5 Psychosocial Intervention strategies

Interventions shall be carried out according to a coordinated multi-layered, multi-disciplinary approach of psychosocial support, as outlined in the Table in 1.5 **Psychosocial Intervention Strategies** above. Sharing of information and analysis with the other disciplines is critical. However, role definition must be clear as per the 2015 approved policy **Management of Stress and Critical Incidents Stress** (MSCIS) (Annex 12). Competing behaviour between representatives of different organisations and between disciplines is a risk to the successful functioning of the operation.

3.5.1 Preparedness and prevention

Prevention in mental health aims to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated disability. Preventive interventions are based on modifying risk exposure and strengthening the coping mechanisms of the individuals and building a positive healing environment at workplace.

The role of the counsellor in psychosocial preparedness for the impact of natural disasters is reflected in the Table: **Crisis Preparation: Psychosocial preparedness and prevention strategies for counsellors** (Annex 3)**.** In the Table, for 'crisis' read: 'natural disaster'.

3.5.2 Multidisciplinary team response

During the phase of natural disaster response coordination with partners in the field, such as Medical, HR, Security and management should be through structured operational meetings of all disciplines. Role definition of each discipline is essential to avoid unnecessary conflict and confusion. Specific roles of HR, Medical, field counsellors and CISMU are outlined in Annex 11: **Coordination of global UN psychosocial support in emergencies** and described in greater detail in the policy document **Management of Stress and Critical Incidents Stress** (MSCIS) that was approved by the IASMN in 2015 (Annex 12).

For a step-by-step outline of activities for counsellors in the recovery phase, refer to the Table: **Crisis Response Phase: Psychosocial intervention strategies for counsellors** (Annex 4)**.** In the Table, for 'crisis' read: 'natural disaster'.

The roles of the multi-disciplinary team, outlining the various levels of psychosocial support interventions can be found in the Table: **Crisis Response Phase: Psychosocial intervention strategies for multi-disciplinary team** (Annex 6)**.** In the Table, for 'crisis' read: 'natural disaster'.

Refer to Chapter 7: **Death in Service** for further information about the counsellor's role following a death in service.

3.5.3 Follow up and lessons learned

The psychological after-effects of traumatic events can take several years to heal. Furthermore, Depression, PTSD and other psychological conditions can develop with late onset, particularly once the surge response is over when resources are exhausted. In such cases it falls within the duty of care of the organization to ensure continuity of care. One of the lessons learned from crisis recovery has been the need to establish an HR focal point in the Secretariat to maintain documentation of such cases and to keep track on their status.

For a step-by-step outline of activities for counsellors in in the recovery phase, refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for counsellors** (Annex 5)**.** In the Table, for 'crisis' read: 'natural disaster'.

For an outline of follow-up activities for counsellors collaborating with other disciplines in the follow-up phase refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for multi-disciplinary team. Follow up and lessons learned** (Annex 7)**.** In the Table, for 'crisis' read: 'natural disaster'.

3.6 Documentation and reporting

Documentation and reporting should take place at the different phases of a crisis as follows:

Preparatory phase: As described in **3.4** above, a routine assessment should be carried out of the psychosocial needs of the duty station, with emergency contingency planning, including a current list of active Peer Helpers, locally available mental health professionals and other relevant resources. These lists should be handed to the coordinator of the intervention team on activation of the emergency response.

Intervention phase: During the emergency response the psychosocial needs assessment should be updated on a daily basis, including the categories of affected personnel, levels of interventions which are being implemented, relevant clinical and social observations, urgent administrative issues for follow up, and notes of urgent clinical or social intervention needs.

During the emergency response the counselling crisis coordinator on the ground should ensure that all team members provide daily updates on all activities and achieved tasks, planned tasks and new or existing challenges. The crisis coordinator should summarise these and send regular updates to CISMU in HQ, along with relevant updates on the status of the counselling team. Special report should be made of any specific issues, for example the need to medivac an employee or the need for a specialist referral.

CISMU shall in turn share all the gathered information with counselling representatives of the UN AFPs and other relevant stakeholders in the CISWG. The frequency of meetings shall be determined by the need for such updates.

A reliable platform for information sharing between the relevant partners is needed. See Annex 8: **Matrix for daily activities of coordinated multidisciplinary-multi-layered interventions** for one such example.

Follow-up phase: Once the emergency surge is over a final report should be compiled including recommendations and lessons learned, drawing on the input from all parties who were involved in the psychosocial response.

All reports must maintain absolute confidentiality of personal information and be directed only to relevant parties.

3.7 Self-care and care for the counsellors

Self-care is an essential element of the professional work of counsellors and becomes particularly important when counsellors are working under conditions of protracted high levels of stress and in times of crisis response. Counsellors are personally responsible to maintain healthy self-care habits and a flexible approach. A suggested resource is the IOM module on self-care: IOM Model: https://prezi.com/4tj1vapebjur/self-care/

However, in addition to individual counsellor responsibility for self-care, the organisation has a particular duty of care to ensure that all counsellors involved in crisis response to take care of the psychosocial well-being of the entire operation do not suffer as a result of this important task. Conditions on the ground can be challenging and the risk of vicarious trauma and burnout increases if counsellors do not have time to recover from the emotionally intense nature of their work.

A care-for-care-givers programme should be in place for the counsellors of each organisation. Every counsellor deployed to the field during an emergency must receive training and briefing on self-care including self-awareness and emotional regulation and must be supported in their self-care needs.

It is the responsibility of the counselling coordinator on the ground to ensure that each counsellor has sufficient time off from official duties (at least one full day off per week) and to informally monitor the psychosocial functioning of the counsellors deployed in the crisis response. Likewise, it is the responsibility of the counselling coordinator in HQ to ensure that the counsellor on the ground has sufficient time off from official duties to recover while on mission. All counsellors who have been involved in the disaster response should be granted proportional time off to recover once their role in the response is over.

Chapter 4 Protracted and complex crisis

4.2 What is a protracted and complex crisis?

The term protracted and complex crisis is used to describe a situation of ongoing armed conflict or civil unrest against a background of a complex, fluid, political framework, as a result of which a significant proportion of the population is acutely vulnerable to death, disease or disruption of their livelihoods over an extended period of time (Harmer & Macrae, 2004.[4])

There are several and very diverse examples of protracted and complex crises. Current examples in 2021 include Afghanistan, Syria, Yemen, Libya, Somalia, Haiti and the conflict in the Occupied Palestinian Territories.

Scenario: Libya 2011
Libya experienced a full-scale armed uprising beginning in February 2011, ending on 20 October with the fall of Sirte and the capture and execution of its ruler, Colonel Gaddafi. However, the fall of the regime did not end the violence as various armed groups who fought against Gaddafi refused to surrender their weapons and proclaimed their political role as the "Guardians of the revolution", and dozens of local armed groups and militias emerged to fill the acute security gap at the local and national levels. UN Security Council Resolution 2009 (Sept. 2011) established the United Nations Support Mission for Libya (UNSMIL) as an integrated special political mission to support the country's transitional authorities to unite the nation under one representative legislative body. Despite intense political efforts from the UN, the above objectives were never fully achieved. Instead, Libya experienced increasing fragmentation and periods of severe deterioration of security and the UN itself became a frequent target of armed attacks by various groups. As a result, in an attempt to mitigate the security risk, UN personnel were forced to operate from a closed and armoured compound and over time endured several relocations, evacuations, downsizing of the mission and changes in the political structure and programme directions.

4.2 Psychosocial factors specific to a protracted crisis

When a crisis continues over an extended period of time national and/or local governance, public administration, social and security structures are typically weak, resulting in an unstable environment in which violence frequently thrives. As a result, humanitarian and peace-keeping operations, including psychosocial support programs need to frequently reframe their objectives and structure to meet the changing needs and context.

In this type of environment, the likelihood that UN employees are directly or indirectly impacted by the violence increases and insecurity becomes a daily concern which in turn increases the

[4] Harmer, A. and Macrae, J. (eds) (2004) *Beyond the continuum. The changing role of aid policy in protracted crises.* London: ODI

likelihood of tensions spilling over to and impacting on the work environment. Furthermore, in a protracted crisis where the conflict is between local ethnic, religious or political groups these tensions are usually reflected among locally recruited personnel within the UN system.

In chronic high-risk environments, additional layers of security restrictions are placed on both UN facilities and personnel as a result of which their movement and engagement with the community is restricted. Locally recruited personnel may have to commute through high-risk routes and cross several checkpoints every day to reach their workplace. As these locations are determined to be non-family duty stations, internationally recruited personnel are separated from their families and may have to live and work in a confined environment, spending weeks restricted within the walls of a highly secure compound.

Protracted and complex crises may take an episodic course with periods of greater peace and stability interspersed with periods of more intense disruption which may require relocation or evacuation of personnel and discontinuity of the UN's programmes. The chronic behavioural and attitudinal change required to meet the cumulative effect of all these factors leads to chronic stress, depleting employee resilience over time, resulting in an increased risk of burnout, anxiety disorders and depression.

When an evacuation is declared employees, particularly those on short-term contracts, face heightened uncertainty regarding their job security. Other concerns are focused on the return to homes, ability to continue work, feelings of guilt around abandonment of colleagues who are forced to remain in the duty station, abandonment of projects, etc.

Pre-existing factors: Disrupted social networks; poverty; endemic disease; civil conflict; crime
Incident-induced factors: Level of risk; degree of isolation; infrequency of R&R; lack of availability and inaccessibility of health and wellbeing services; intergroup national conflicts; gender factors specific to the environment; communication difficulties
Humanitarian factors: Job insecurity against a background of chronic economic instability for locally recruited personnel; national vs international tensions; political versus humanitarian priorities; role conflicts; competing flags; helplessness and burnout among employees.

4.3 Categories of casualties and target population for psychosocial support

In order to aid in planning the appropriate response and recommend suitable procedures and resources that are comprehensive and inclusive, it is necessary to distinguish between employees directly impacted by a security incident such as a hostage incident, hijacking, direct or indirect attacks, and those employees whose mental health is impacted as a result of the chronic stress factors related to working in a protracted crisis as described in 4.2 above.

Target populations for psychosocial support by counsellors can be divided into the following categories:
First level: Those who have directly experienced a security incident. Those who have been evacuated and those who remain in the duty station when an evacuation has taken place.

Second level: Relatives, colleagues and friends of first level victims and survivors.
Third level: UN employees maintaining their functional efficiency within the demanding situation who are at higher risk of burnout, depression, substance abuse, relationship problems and chronic physical conditions due to the chronic stress and unhealthy living conditions.

It is important to note that the above categories are not indicators of the severity of the psychological status of the employee. For example, a person from the fourth level might experience a more severe reaction than one in the first category. The severity of reactions is influenced by the interaction of several factors that include proximity, severity and duration of exposure to a security incident; past history of trauma exposure; personality and pre-existing psychological problems including depression, anxiety or personality disorders; gender; social and economic status and the availability and adequacy of social support systems. Therefore, prioritisation and recommended actions should be based on clinical assessment.

4.4 Assessment of psychosocial needs and resources

Interventions should be preceded by careful planning and assessment of the local context such as culture, history and nature of problems, local perceptions and expressions of distress and illness, styles of coping, community needs and resources. This task can be coordinated by counselling services, but assessments should be carried out collaboratively with other partners mainly: Medical Services, Human Resources and the Security Management Team in order to maximize understanding of the situation and to develop and implement effective interventions. It is important to differentiate between emotional reactions triggered by a security incident and abnormal or "pathological" reactions, including have some understanding of the local culture and context.

Psycho-social assessment should be seen as a **continuous process**, with observation and monitoring activities constituting part of daily operational work.

The following Annexes contain assessment checklists which have been derived from lessons learned and UN best practice:
Assessment and mapping of psychosocial stressors and resources (Annex 1)
Assessment Checklist (Annex 2)

4.5 Psychosocial Intervention strategies

Interventions shall be carried out according to a coordinated multi-layered, multi-disciplinary approach of psychosocial support, as outlined in the Table in 1.5 **Psychosocial Intervention Strategies** above. Sharing of information and analysis with the other disciplines is critical. However, role definition must be clear as per the 2015 approved policy **Management of Stress and Critical Incidents Stress** (MSCIS) (Annex 12). Competing behaviour between representatives of different organisations and between disciplines is a risk to the successful functioning of the operation.

4.5.1 Preparedness and prevention

Prevention in mental health aims to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated disability. Preventive interventions are based on modifying risk exposure and strengthening the coping mechanisms of the individuals and building a positive healing environment at workplace.

A likely scenario in a protracted and complex emergency is the sudden deterioration of the security situation that may result in the evacuation or relocation of UN personnel and dependents. Relocation and evacuation plans for UN personnel and dependents should include planning for the particular needs of individuals of different ages and genders, with attention to particular health and psychosocial needs.

The role of the counsellor in psychosocial preparedness is reflected in the Table: **Crisis Preparation: Psychosocial preparedness and prevention strategies for counsellors** (Annex 3)

The role of the counsellor in psychosocial preparedness specific to evacuation can be found in the Table: **Evacuation Reception: Preparation, Intervention and Follow-up** (Annex 9)

4.5.2 Multidisciplinary team response

During the phase of incident response coordination with partners in the field, such as Medical, HR, Security and management should be through structured operational meetings of all disciplines. Role definition of each discipline is essential to avoid unnecessary conflict and confusion. Specific roles of HR, Medical, field counsellors and CISMU are outlined in Annex 11: **Coordination of global UN psychosocial support in emergencies** and described in greater detail in the policy document **Management of Stress and Critical Incidents Stress** (MSCIS) that was approved by IASMN in 2015 (Annex 12).

For a step-by-step outline of activities for counsellors in in the incident response phase, refer to the Table: **Crisis Response Phase: Psychosocial intervention strategies for counsellors** (Annex 4).

The roles of the multi-disciplinary team, outlining the various levels of psychosocial support interventions can be found in the Table: **Crisis Response Phase: Psychosocial intervention strategies for multi-disciplinary team** (Annex 6).

The role of the counsellor in evacuation can be found in the Table: **Evacuation Reception: Preparation, Intervention and Follow-up** (Annex 9).

Refer to Chapter 6: **Hostage Incident Management** for further information about the counsellor's role in hostage incident management.

Refer to Chapter 7: **Death in Service** for further information about the counsellor's role following a death in service.

4.5.3 Follow up and lessons learned

The psychological impact of working in protracted crises can be insidious leading to chronic stress resulting in an increased risk of burnout, anxiety disorders and depression. UN employees who are exposed to potentially traumatic events may require particular follow up. In all such cases it falls within the duty of care of the organisation to ensure continuity of care in collaboration with HR and/or Medical Services.

For a step-by-step outline of activities for counsellors in in the recovery phase, refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for counsellors** (Annex 5)**.**

The role of the counsellor in recovery phase following an evacuation can be found in the Table: **Evacuation Reception: Preparation, Intervention and Follow-up** (Annex 9).

For an outline of follow-up activities for counsellors collaborating with other disciplines in the follow-up phase refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for multi-disciplinary team. Follow up and lessons learned** (Annex 7).

4.6 Documentation and reporting

Documentation and reporting should take place at the different phases of a crisis as follows:

Preparatory phase: As described in **4.4** above, a routine assessment should be carried out of the psychosocial needs of the duty station, with emergency contingency planning, including a current list of active Peer Helpers, locally available mental health professionals and other relevant resources. These lists should be handed to the coordinator of the intervention team on activation of the emergency response.

Intervention phase: During the evacuation and/or a crisis response the psychosocial needs assessment should be updated on a daily basis, including the categories of affected personnel, levels of interventions which are being implemented, relevant clinical and social observations, urgent administrative issues for follow up, and notes of urgent clinical or social intervention needs.

During the evacuation and/or a crisis response the counselling crisis coordinator on the ground should ensure that all team members provide daily updates on all activities and achieved tasks, planned tasks and new or existing challenges. The crisis coordinator should summarise these and send regular updates to CISMU in HQ, along with relevant updates on the status of the counselling team. Special report should be made of any specific issues, for example the need to medivac an employee or the need for a specialist referral.

CISMU shall in turn share all the gathered information with counselling representatives of the UN AFPs and other relevant stakeholders in the CISWG. The frequency of meetings shall be determined by the need for such updates.

A reliable platform for information sharing between the relevant partners is needed. See Annex 8: **Matrix for daily activities of coordinated multidisciplinary-multi-layered interventions** for one such example.

Follow-up phase: Following an evacuation, lessons learned should be gathered from all UN counsellors, who were involved in the evacuation. These should be recorded and the relevant chapter of this manual updated as appropriate.

All reports must maintain absolute confidentiality of personal information and be directed only to relevant parties.

4.7 Self-care and care for the counsellors

Self-care is an essential element of the professional work of counsellors and becomes particularly important when counsellors are working under conditions of protracted high levels of stress and in times of crisis response. Counsellors are personally responsible to maintain healthy self-care habits and a flexible approach. A suggested resource is the IOM module on self-care: IOM Model: https://prezi.com/4tj1vapebjur/self-care/

However, in addition to individual counsellor responsibility for self-care, the organisation has a particular duty of care to ensure that all counsellors working in protracted and complex crises and who are responsible for the psychosocial well-being of the entire operation do not suffer as a result of this important task. Conditions on the ground can be challenging and the risk of vicarious trauma and burnout increases if counsellors do not have time to recover from the emotionally intense nature of their work.

A care-for-care-givers programme should be in place for the counsellors of each organisation. Every counsellor deployed to work in a duty station where there is a protracted and complex crisis must receive training and briefing on self-care including self-awareness and emotional regulation and must be supported in their self-care needs.

It is the responsibility of the counsellor's supervisor to ensure that each counsellor has sufficient time off from official duties (at least one full day off per week) and to informally monitor the psychosocial functioning of the counsellors. All counsellors who have been involved in the evacuations and other crisis response should be granted proportional time off to recover once their role in the crisis is over.

Chapter 5 Pandemic and epidemic

5.1 What is a pandemic and an epidemic?

An epidemic is an outbreak of a disease that affects many individuals and spreads rapidly. According to Columbia University Mailman School of Public Health[5] the difference between an epidemic and a pandemic is not the severity of the disease but the disease's spread. As opposed to regional epidemics, a pandemic cuts across a wide geographical area and international boundaries, affecting a large proportion of the population and resulting in large-scale social disruption, economic loss, and hardship.

Scenario: COVID-19 pandemic 2020

In early 2020, the World Health Organization classified the COVID-19 outbreak as a 'Public Health Emergency of International Concern' and on March 11th 2020 as a pandemic. In February 2020 CISMU developed the 'Novel Coronavirus (COVID-19) Psychosocial Contingency Plan Preparation Guidelines for Staff/Stress Counsellors in the field' drawn from the 2007 Critical Incident Stress Working Group [1] (CISWG) psychosocial contingency planning guidelines for UN offices to prepare for the Avian Influenza pandemic. The guidelines were successfully implemented and were later used to respond to other epidemics such as Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory syndrome (MERS) and Ebola.

Globally, UN personnel carried a double burden throughout the COVID-19 pandemic, delivering vital humanitarian assistance to vulnerable populations around the world while also trying to protect themselves and their loved ones from the virus. In 2020, 336 UN personnel from 82 nations lost their lives in the line of duty due to all causes including COVID-19, as compared to 117 in 2019.

In 2021 the CISWG reviewed the 2020 guidelines, based on the collective experience of counsellors supporting personnel through a year of the pandemic, drawing on lessons learnt and best practices.

5.2 Psychosocial factors specific to pandemics and epidemics

Ensuring basic needs and personal safety are an essential part of the psychosocial response to an epidemic or a pandemic. Not only is the target population affected by the outbreak of disease but those involved in the pandemic response, including the counsellors, risk exposure to major health hazards while also facing challenges related to lockdowns and other prescribed public health restrictions. The combination of these factors can lead to an increased risk for all mental health conditions, particularly depression and anxiety.

[5] **Columbia University Mailman School of Public Health** Epidemic, Endemic, Pandemic: What are the Differences? | Columbia Public Health Updated 30 September 2021

Pre-existing factors: Degree of preparedness; existing medical and mental health resources in the country; capacity of local and UN medical and counselling services
Incident-induced factors: Lockdown challenges (social isolation, inability to travel home resulting in extended separations from families, restricted access to basic services; increased risk of domestic violence; depression); loss and grief; fear of infection; anxiety; the number of deceased; disrupted social networks; loss of livelihood; lack of information
Humanitarian factors: Logistic challenges related to lockdowns (poor ergonomics and communication networks when working from home, difficulty traveling to access population groups in need and to implement programmes); national vs international tensions; worry around job insecurity; helplessness and burnout among employees
Post-incident: Psychosocial resources available to support the mental health of UN employees and their dependents in the long-term aftermath.

5.3 Categories of casualties and target population for psychosocial support

In order to aid in planning the appropriate response and recommend suitable procedures and resources that are comprehensive and inclusive, the target population can be divided into the following categories:
First level: UN employees who are infected by the disease; Those who experience maximum impact from pandemic restriction measures
Second level: Grieving relatives; close colleagues and friends of first level victims
Third level: Humanitarian aid and relief workers maintaining their functional efficiency with the demanding situation who are at higher risk of depression and of burnout
Fourth level: Employees in HQ and other duty stations who are vicariously affected by the impact of the pandemic, or who are themselves indirectly affected by the pandemic measures.

It is important to note that the above categories are not indicators of the severity of the psychological status of the individual. For example, a person from the fourth level might experience a more severe reaction than one in the first category. The severity of reactions is influenced by the interaction of several factors that include degree of exposure to the disease, severity of symptoms and ease of access to appropriate health care; proximity to and severity and duration of pandemic restriction measures; personality and pre-existing psychological problems including depression, anxiety or personality disorders; gender; social and economic status and the availability and adequacy of social support systems. Therefore, prioritisation and recommended actions should be based on clinical assessment.

5.4 Assessment of psychosocial needs and resources

Interventions should be preceded by careful planning and assessment of the local context such as culture, history and nature of problems, local perceptions and expressions of distress and illness, styles of coping, community needs and resources. This task can be coordinated by counselling services, but assessments should be carried out collaboratively with other partners mainly: Medical Services, Human Resources and the Security Management Team in order to

maximize understanding of the situation and to develop and implement effective interventions. It is important to differentiate between emotional reactions triggered by factors related to the pandemic/epidemic and abnormal or "pathological" reactions, including have some understanding of the local culture and context.

Psycho-social assessment should be seen as a **continuous process**, with observation and monitoring activities constituting part of daily operational work.

The following Annexes contain assessment checklists which have been derived from lessons learned and UN best practice:
Assessment and mapping of psychosocial stressors and resources (Annex 1)
Assessment Checklist (Annex 2) In the Assessment Checklist, for 'physically injured' read: 'infected by the epidemic/pandemic disease.'

5.5 Psychosocial Intervention strategies

Interventions shall be carried out according to a coordinated multi-layered, multi-disciplinary approach of psychosocial support, as outlined in the Table in 1.5 **Psychosocial Intervention Strategies** above. Sharing of information and analysis with the other disciplines is critical. However, role definition must be clear as per the 2015 approved policy **Management of Stress and Critical Incidents Stress** (MSCIS) (Annex 12). Competing behaviour between representatives of different organisations and between disciplines is a risk to the successful functioning of the operation.

5.5.1 Preparedness and prevention

Prevention in mental health aims to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated disability. Preventive interventions are based on modifying risk exposure and strengthening the coping mechanisms of the individuals and building a positive healing environment at workplace.

The role of the counsellor in psychosocial preparedness for pandemics is outlined in the Table: **Crisis Preparation: Psychosocial preparedness and prevention strategies for Counsellors** (Annex 3). In the Table, for 'crisis' read: 'pandemic/epidemic'.

5.5.2 Multidisciplinary team response

During the phase of incident response coordination with partners in the field, such as Medical, HR, Security and management should be through structured operational meetings of all disciplines. Role definition of each discipline is essential to avoid unnecessary conflict and confusion. Specific roles of HR, Medical, field counsellors and CISMU are outlined in Annex 11: **Coordination of global UN psychosocial support in emergencies** and described in greater detail in the policy document **Management of Stress and Critical Incidents Stress** (MSCIS) that was approved by IASMN in 2015 (Annex 12).

For a step-by-step outline of activities for counsellors in in the pandemic response phase, refer to the Table: **Crisis Response Phase: Psychosocial intervention strategies for counsellors** (Annex 4)**.** In the Table, for 'crisis' read: 'pandemic/epidemic'.

The roles of the multi-disciplinary team, outlining the various levels of psychosocial support interventions can be found in the Table: **Crisis Response Phase: Psychosocial intervention strategies for multi-disciplinary team** (Annex 6)**.** In the Table, for 'crisis' read: 'pandemic/epidemic'.

Refer to Chapter 7: **Death in Service** for further information about the counsellor's role following a death in service.

5.5.3 Follow up and lessons learned

The psychological impact of responding to a pandemic or epidemic can be insidious leading to chronic stress resulting in an increased risk of burnout, anxiety disorders and depression. UN employees who are infected and suffer long term health sequelae and those who suffer long term mental health consequences as a result of pandemic containment measures may require particular follow up. In all such cases it falls within the duty of care of the organisation to ensure continuity of care in collaboration with HR and/or Medical Services.

For a step-by-step outline of activities for counsellors in in the pandemic recovery phase, refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for counsellors** (Annex 5)**.** In the Table, for 'crisis' read: 'pandemic/epidemic'.

For an outline of general follow-up activities for counsellors collaborating with other disciplines in the follow-up phase refer to the Table: **Crisis Recovery Phase: Psychosocial intervention strategies for multi-disciplinary team. Follow up and lessons learned** (Annex 7).

5.6 Documentation and Reporting

Documentation and reporting should take place at the different phases of a crisis as follows:

Preparatory phase: As described in **5.4** above, a routine assessment should be carried out of the psychosocial needs of the duty station, with emergency contingency planning, including a current list of active Peer Helpers, locally available mental health professionals and other relevant resources. These lists should be handed to the coordinator of the intervention team on activation of the emergency response.

Intervention phase: During the crisis response the psychosocial needs assessment should be updated on a daily basis, including the categories of affected personnel, levels of interventions which are being implemented, relevant clinical and social observations, urgent administrative issues for follow up, and notes of urgent clinical or social intervention needs.

During the crisis response phase of the pandemic/epidemic the counselling crisis coordinator on the ground should ensure that all team members provide daily updates on all activities and achieved tasks, planned tasks and new or existing challenges. The crisis coordinator should summarise these and send regular updates to CISMU in HQ, along with relevant updates on the status of the counselling team. Special report should be made of any specific issues, for example the need to medivac an employee or the need for a specialist referral.

CISMU shall in turn share all the gathered information with counselling representatives of the UN AFPs and other relevant stakeholders in the CISWG. The frequency of meetings shall be determined by the need for such updates.

A reliable platform for information sharing between the relevant partners is needed. See Annex 8: **Matrix for daily activities of coordinated multidisciplinary-multi-layered interventions** for one such example.

Follow-up phase: Following the crisis response phase of the pandemic/epidemic a final report should be compiled including recommendations and lessons learned, drawing on the input from all parties who were involved in the psychosocial response. All reports must maintain absolute confidentiality of personal information and be directed only to relevant parties.

5.7 Self-care and care for the counsellors

Self-care is an essential element of the professional work of counsellors and becomes particularly important when counsellors are working under conditions of protracted high levels of stress and in times of crisis response. Counsellors are personally responsible to maintain healthy self-care habits and a flexible approach. A suggested resource is the IOM module on self-care: IOM Model: https://prezi.com/4tj1vapebjur/self-care/

However, in addition to individual counsellor responsibility for self-care, the organisation has a particular duty of care to ensure that all counsellors involved in pandemic or epidemic response and who are responsible for the psychosocial well-being of the entire operation do not suffer as a result of this important task. Especially for those counsellors deployed to the field or working in the duty station directly impacted by an outbreak of an epidemic or pandemic, conditions on the ground can be challenging and the risk of vicarious trauma and burnout increases if counsellors do not have time to recover from the emotionally intense nature of their work.

A care-for-care-givers programme should be in place for the counsellors of each organisation. Every counsellor deployed to work in a duty station where there is an outbreak of an epidemic or pandemic must receive training and briefing on self-care including self-awareness and emotional regulation and must be supported in their self-care needs.

It is the responsibility of the counsellor's supervisor to ensure that each counsellor has sufficient time off from official duties (at least one full day off per week) and to informally monitor the psychosocial functioning of the counsellors. All counsellors who have been

involved in crisis response should be granted proportional time off to recover once their role in the crisis is over.

Chapter 6 Hostage Incident Management

Note:
All basic concepts and definitions in this chapter will be reviewed in accordance with the revised HIM policy after its approval by the IASMN.

6.1 What is a Hostage Incident?

The United Nations Security Policy Manual[6] defines hostage-taking as "the seizure or detention with a threat to kill, injure or to continue to detain individuals (hostages) in order to compel a third party, namely a State, an organization of the United Nations Security Management System, a natural or juridical person or group of persons, to do or to abstain from doing any act as an explicit or implicit condition for the release of the hostages".

Scenario:
A senior UN staff member in a non-family duty station was reported missing 48 hours after last being seen in the UN Mission area. After receiving a call from the hostage-takers requesting $5 million for the release of the hostage, UNDSS established a full Hostage Incident Management response.
The hostage had a partner and child and a second child from another marriage. The mother and stepfather of the hostage were living in a third country. The Family Liaison and Support Officer maintained contact with all family members and hired two private counsellors to provide additional support to the family. Additionally, a UN Stress Counsellor was deployed to the UN Mission to provide psychosocial support to the UN colleagues.
The hostage was finally released after 8 months of captivity during which the family received several threats from the hostage-takers including videos of the staff member pleading for his release with evidence that he had been seriously physically injured. After the release of the hostage, he and his family members received specialised psychological counselling for more than a year.

6.2 Psychosocial factors specific to hostage incidents

From the psychological perspective a hostage incident is one of the most stressful and tormenting experiences, not only to the hostages and their direct family members, but to the entire UN community, particularly their direct colleagues.

In addition to counselling support, the family of the hostage benefits from coaching and practical guidance by (or through) the Family Liaison and Support Officer and some cases by a

[6] undss-security_policy_manual_e-book.pdf

security expert especially when they are faced with the uncertainty of a long incident, the demands by the hostage-takers or when they are in the lead in responding to the incident.

A hostage incident does not simply end with the safe release of the hostage, as the traumatic impact of captivity can last for several years for the hostage and the family.

6.3 Definitions of key terminology

***Missing person*:** A missing person has been defined as "anyone whose whereabouts are unknown whatever the circumstances of disappearance. They will be considered missing until located and their wellbeing or otherwise established

Hostage taking: "the seizure or detention with a threat to kill, injure or to continue to detain individuals (hostages) in order to compel a third party, namely a State, an organization of the United Nations Security Management System, a natural or juridical person or group of persons, to do or to abstain from doing any act as an explicit or implicit condition for the release of the hostages".

Abduction: Refers to the physical act of taking a person against his/her will. The perpetrator may have different motives to abduct a person, such as for ransom, to kill the victim, etc.

Crisis Coordination Centre (CCC)
Upon notification of a hostage taking situation involving a UN employee, the UNSMS engages in specific direct or indirect response processes to secure their speedy and safe release. In cases where the UNSMS is in the lead and engages in direct **response CCC may be activated** in New York. It is comprised of representatives of the Department of Peace Operations *(DPO)*, Department of Political and Peace Building Affairs *(DPBA), Medical, HR and legal advisors,* Department of Public Information, and involved or interested Agencies, Funds, Programmes and Organisations, as well as the Permanent Representatives of the countries/nationalities concerned. This CCC is normally chaired by the UNDSS Under-Secretary-General but in most cases, it is delegated to the Director of the Division of Regional Operations.

6.4 Roles of the Hostage Incident Management Team members

When the UNSMS takes the lead in responding to the Hostage Incident case, a Hostage Incident Management Team is usually deployed to the country to support the Designated Official (DO) and the Chief Security Advisor (CSA) of the country. The composition and roles with the HIM Team are laid out in the SMOM chapter on HIM.

The Staff/Stress ***Counsellor***:

- provides necessary psychological support to the other team members whenever required.
- advises the HIM Team in the development of the reception plan, ensuring that necessary psychological support is provided to the former hostages in the post-release period.

- performs the initial assessment of the mental health status of the former hostages after their release, provides group and individual counselling sessions to them and advises on recuperation modalities and activities.

The role of the ***Family Liaison and Support Officer (FLSO)***

- In HIM, the Team deals with life and death issues and the role of the appointed FLSO is to provide support to the HIM Team with the aim of supporting the family with taking the most constructive decisions to facilitate the safe release of the hostages. As such, general confidentiality rules binding counsellors do not operate. Actions or decisions that may jeopardise the negotiation process need to be reported and advice on mitigating measures should be provided to the HIM manager.
- During the entire process, the FLSO should keep a log of all activities, calls or visits to the family members with date, time beginning and end of the call or intervention with a succinct summary of the key issues, conclusions, and recommendation to the HIM Team if any.
- In proportionate response, the main role of the FLSO is to provide confidential psycho-social support to the family members and connect them with other community and organizational resources as needed.

Annex 10 outlines the various roles of the counsellor and the Family Liaison and Support Officer in Hostage Incident Management, along with some related lessons learned from previous hostage incidents.

6.5 Psychosocial Intervention strategies

6.5.1 Family Support during the hostage incident

UNSMS organizations have an accountability and responsibility for their personnel and their eligible family members. In addition to the Family Liaison and Support Officer, the organisation might assign a private or a UN counsellor to provide psychological support to the affected family throughout the process.

The family members are crucial component in the system. They may have an urge to act, feel guilty of not making enough efforts, think that the UN is not taking the necessary actions or making enough effort. They are frequently targeted by the hostage takers. They may even present attitudes and feeling like the Stockholm Syndrome.

Under the guidance of the incident manager or the HIM team leader, the FLSO may be called upon to brief the family and to make arrangements to protect them from media harassment including social media, as well as from the direct approach that the hostage-takers might make with the aim of bringing pressure on the negotiators. Family members should be carefully instructed on how to react in the event they are the first point of contact by the hostage-takers (which is often the case) and prepare the family for **all the scenarios including the worst ones.**

In close coordination with the incident manager, the FLSO needs to explain the UN policy on hostage incident management to the family. The family must be aware of the whole range of options at the earliest convenience. After considering and understanding all the different factors at play, the family will make a balanced and hopefully objective decision.

If the family decides they will conform to the demands and pay a ransom, the UN may indirectly and confidentially support the family in managing other elements such as taking measures to protect their own security, dealing with media and avoiding actions that would unnecessarily complicate and lengthen the duration of captivity. In such cases, the UN can only support the family and not be directly involved in the actual negotiation process because the United Nations cannot have its name associated with the direct payment of a ransom. In global terms that is the safest option for the 400,000+ employees and dependents for whom the UN is responsible. However, one should understand that the best option for one family at a particular given time may not match the UN stance. The broader support process will remain in place regardless of the option chosen by the family.

6.5.2 The role of the counsellor in hostage release

The release plan is usually devised by the Crisis Coordination Center (CCC), the Hostage Incident Management (HIM) Team, the Host Government and a representative of the government of the hostage's nationality/home country. The Designated Official will be the responsible officer for? After consultation with the Designated Official, the UNSMS organization Representative or Country Director will notify family members of the release of the former hostage, either directly or through the Family Liaison and Support Officer.

Depending on the circumstances and location of the release, the former hostage will be transported for protection and medical care. The counsellor will be part of the reception team at the airport or reception area. If severely injured, medically evacuated as quickly and most direct route as possible to medical facilities. The counsellor and/or a UN colleague will accompany the former hostage if feasible.

An important element of release for the former hostage is access to washing facilities, toiletries, clean clothing, and food. Mobile or Satellite Telephone must be made available at all potential locations for the former hostage to make telephone calls to family members or friends. This point is of high priority to ensure contact between the former hostage and his family. Maximum security and privacy will be in place in the reception area to protect the former hostage from media or other unnecessary attention.

Depending on the security situation and the status of the hostage, the Designated Official will determine if, when and where it is appropriate for personnel to meet with the former hostage. A security debriefing may be carried out at the reception area by a member of the HIM Team or representatives from the former hostage's home country, as per the discretion of the Designated Official.

After security debriefing, the priority will be for a rapid repatriation of the former hostage to re-join his/her family. The former hostage will be accompanied by a stress counsellor and, should he/she wish so, a UN colleague. Should medical conditions require, a doctor will also accompany them. The counsellor should prepare the former hostage for the emotional impact of the reunion. Psychoeducation materials for potential psychological reactions and ways to manage them should be provided, as well as contact details for psychological support.

Similarly, a counsellor should meet with the family members prior to the family reunification and prepare them for the emotional impact of the reunion. Psychoeducation materials for potential psychological reactions and ways to manage them should be provided to the family members, as well as contact details for psychological support for the former hostage and for themselves.

6.5.3 Hostage Incident worst-case scenario plan

The purpose of this plan is to prepare for the possibility that the hostage may not be released alive. The Counsellor should devise a strategy to prepare the families for the worst-case scenario. If the UN employee is killed, the UN will follow the guidelines and discharge the duties and responsibilities referenced in the Department of Management Strategy, Policy and Compliance's Office of Human Resources (OHR) publication **Handbook for action in cases of death in service**[7].

Refer to Chapter 7: **Death in Service** for further information about the counsellor's role following a death in service.

6.6 Follow up and lessons learned

After the release the counsellor should link the staff member and the family with psychosocial support resources in their organization and/or their community. The counsellor will continue to monitor the psychosocial needs of the former hostage and the family as long as appropriate and continue to collaborate with Medical and HR where relevant on guidance around assessment for return to work and recommendations on reassignment or disability if needed. Further, a review and evaluation of the Hostage Incident Management Plan and the way personnel responded must be conducted. The lessons learned not only enable the DO to make improvements to the local plan, but also can help other duty stations in reviewing or preparing their plans. UNSMS "Guidelines on Hostage Incident Management" provide methods for conducting and reporting on this evaluation in which counselors will be asked to contribute to the evaluation process.

[7] United Nations (2012) *Handbook for action in cases of death in service* Available at: Handbook for Action-death in service_0.pdf (un.org) ***Note: Outdated and under revision - December 2021***

6.7 Documentation and Reporting

The Family Liaison and Support Officer should keep a log of all activities, calls or visits to the family members with date, time beginning and end of the call or intervention with a summary of the key issues, conclusions, and any recommendation to the Hostage Incident Management Team.

On conclusion of the Hostage Incident a final report should be compiled including recommendations and lessons learned, drawing on the input from all parties who were involved in the psychosocial response.

All reports must maintain absolute confidentiality of personal information and be directed only to relevant parties.

6.8 Self-care and care for the counsellors

Self-care is an essential element of the professional work of counsellors and becomes particularly important when counsellors are working under conditions of protracted high levels of stress and in times of crisis response. Counsellors are personally responsible to maintain healthy self-care habits and a flexible approach. A suggested resource is the IOM module on self-care: IOM Model: https://prezi.com/4tj1vapebjur/self-care/

However, in addition to individual counsellor responsibility for self-care, the organisation has a particular duty of care to ensure that all counsellors involved in hostage incident management to take care of the psychosocial well-being of the entire operation do not suffer as a result of this important task. Hostage incident management demands considerable time and effort from the counsellor and can be extremely emotionally taxing. The risk of vicarious trauma and burnout increases if counsellors do not have time to recover from the emotionally intense nature of their work.

A care-for-care-givers programme should be in place for the counsellors of each organisation. Every counsellor deployed to the field during an emergency must receive training and briefing on self-care including self-awareness and emotional regulation and must be supported in their self-care needs.

It is the responsibility of the counselling coordinator in HQ to ensure that each counsellor involved in hostage incident management has sufficient time off from official duties (at least one full day off per week) to recover while on mission and to informally monitor the psychosocial functioning of the counsellors involved in the hostage incident response. All counsellors who have been involved in the hostage incident response should be granted proportional time off to recover once their role in the crisis is over.

Chapter 7 Death in service[8]

7.1 What is death in service?

- *On 19 August 2003, a truck bomb was detonated at the offices of the United Nations Assistance Mission for Iraq, killing 22 UN personnel and wounding more than 100.*
- *On 12 January 2010, an earthquake destroyed several United Nations offices in Port-au-Prince, Haiti taking the lives of 102 UN personnel and injuring numerous others.*
- *On 1 April 2011, a protest at the UNAMA office in Mazar-e-Sharif, Pakistan, became chaotic and violent, causing the deaths of seven UN personnel.*
- *On 4 April 2011, a United Nations plane crashed in perilous weather in the Democratic Republic of Congo, claiming the lives of 32 people including 22 UN personnel on board.*

These incidents are but a few tragic examples of employees who died while in service of the United Nations.

When a UN employee dies while in the service of the organisation the UN has a particular duty of care to their families as well as to the survivors of these events. UN counsellors play an important role in assisting and providing support to family members and to colleagues of those who die in service to the organisation and can also offer guidance to managers on supporting their teams with managing grief and loss.

The role of the Family Focal Point is to forge a supportive relationship with the family of a deceased personnel and to provide navigational guidance through the benefits claims process in consultation with a Human Resources specialist who will be assigned to assist the Family Focal Point.

7.2 Death notification

Death notification should be conveyed personally unless circumstances make it impossible to do so. The appropriate way to notify the next of kin of the death of a loved one varies from one culture to another. In some cultures, it is preferable to notify a community leader who will select which family member to inform. That family member will visit the immediate family alone or accompanied by the community leader. In other cultures, an official from

[8] Some of the material in this chapter is copied directly from the United Nations (2012) *Handbook for action in cases of death in service* Available at: Handbook for Action-death in service_0.pdf (un.org) ***Note: Outdated and under revision - December 2021***

the organisation has the obligation to inform the family. In such cases, the most senior official and the Family Focal Point may be designated to play a role in the notification visit.

The counsellor should offer to accompany the designated official to provide support to the family, as well as to support the official and the Family Focal Point in their roles.

7.3 The role of the counsellor following a death in service

7.3.1 Counsellor's role in the initial phase

When a UN personnel dies while in the service of the organisation, once the next of kin have been notified, the counsellor can:

- Reach out to the next of kin after notification has been provided
- Activate the Peer Support Group if available
- Send condolence messages to colleagues and invite them to reach out to you for support
- Organise a group session in the section the colleague used to work
- Organise an open group session for those who wish to attend
- Empower personnel to provide mutual support and care for each other
- Support those involved in the organisation of the funeral and memorial service
- Support the Family Focal Point
- Visit the family and offer condolences if appropriate and if possible
- Connect family members to support available in the community
- Advise managers that colleagues may need time to grieve and process the loss
- Advise managers to act as a role model and demonstrate care and support to colleagues.
- Support colleagues of the deceased who may wish to prepare a lasting tribute that in some way reflects the personality or interests of the deceased.
- Ensure that the family has access to care and support.
- Support those colleagues who would represent the organisation at the funeral or commemoration ceremonies.

The Counsellor should respect privacy and consider the wishes of the family before approaching individuals. People all grieve differently and should be supported in their grieving in a personal way. The following factors can impact the way one grieves:

- Method of death (violence, accident, illness, suicide)
- Time to prepare for the death
- The survivor's relationship with the person who died (close, strained, unfinished business)
- The survivor's life situation at the time (financial pressures, job pressures)
- Support of family, friends, community colleagues, supervisors
- The survivor's previous experience with loss and death
- Spiritual beliefs
- The survivor's personality and resilience
- The survivor's cultural attitudes towards death

When a UN personnel dies under suspicious or unclear circumstances (including death as a result of an accident or a suicide) the counsellor should refrain from making any comment related to the cause of the death to colleagues and remind personnel to avoid gossip and rumours in the workplace.

7.3.2 Memorial service

Holding a memorial service for personnel who have lost their lives in the line of duty or while in the service of the organisation, while a sad duty, is an important action by which the organisation pays its respects to the life and work of personnel who have dedicated their lives to the Organisation, and helps the bereaved families cope with the loss of their loved ones.

In planning a memorial service, it is important to take into account the wishes of the family, even if the service will be attended primarily by the colleagues of the UN personnel as well as the cultural background of the deceased. Be mindful that each family is different and may or may not choose to participate in the memorial service.

The Family Focal Point will act as the liaison between the family and the organisation. The Counsellor's role in the memorial service can include:

- Providing information to personnel on the arrangement that have been made and inviting them to attend.
- Involving Peer Helpers if available. Organise a meeting in advance and remind them about their role and tasks during the memorial service.
- Providing grief support to family members and colleagues, as needed.
- Supporting the Family Focal Point and other officials involved in the memorial service.

7.3.3 Counsellor's role in the long term

In the longer term following a death in service the counsellor can:

- Provide supportive counselling to family members if needed.
- Link family members to available resources and bereavement groups if appropriate.
- Refer colleagues or family members facing complicated grief to specialised mental health professionals.
- Discuss with staff representatives and managers ways to support the family in the long term if needed.
- Honour the colleague who has died in an appropriate way. Some colleagues could decide to collect money for a charitable donation, create a memorial book or bulletin board or share a tribute in a newsletter.
- Pay special attention to holiday seasons and anniversaries. Check how the family is coping with the loss and offer support.

7.4 Self-care and care for the counsellors

Self-care is an essential element of the professional work of counsellors and becomes particularly important when counsellors are supporting others with grief and loss while also dealing with their own emotions related to the death of a colleague. Counsellors are

personally responsible to maintain healthy self-care habits and a flexible approach. A suggested resource is the IOM module on self-care: IOM Model: https://prezi.com/4tj1vapebjur/self-care/

However, in addition to individual counsellor responsibility for self-care, the organisation has a particular duty of care to ensure that all counsellors involved in supporting others following a death in service do not suffer as a result of this important task. The risk burnout increases if counsellors do not have time to recover from the emotionally intense nature of their work.

A care-for-care-givers programme should be in place for the counsellors of each organisation. Every counsellor must be supported in their self-care needs.

It is the responsibility of the counsellor's supervisor to informally monitor the psychosocial functioning of the counsellor involved in duties related to a death in service. Where counsellors are required to deploy on mission related to a death in service it is the responsibility of the counselling coordinator in HQ to ensure that the counsellors on the ground have sufficient time off from official duties to recover while on mission and to ensure that the counsellors be granted proportional time off to recover once they return from mission.

References

Association of Chief Police Officers for England and Wales, National Policing Improvement Agency (ACPO NPIA) (2010) *Guidance on the Management, Recording and Investigation of Missing Persons, 2nd Ed.* London: NPIA. Available at: Guidance on Missing Persons 2nd Ed (npcc.police.uk)

Columbia University Mailman School of Public Health (2021) *Epidemic, Endemic, Pandemic: What are the Differences?* Available at: Epidemic, Endemic, Pandemic: What are the Differences? | Columbia Public Health

Harmer, A. and Macrae, J. (eds) (2004). *Beyond the continuum. The changing role of aid policy in protracted crises.* London: ODI

Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: IASC. Available at: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings - World | ReliefWeb

United Nations (2012) *Handbook for action in cases of death in service.* New York: United nations. Available at: Handbook for Action-death in service_0.pdf (un.org) ***Note: Outdated and under revision - December 2021***

United Nations Office on Drugs and Crime (UNODC) (2018). *Counter-Terrorism. Module 4: Criminal Justice Responses to Terrorism.* Available at: Counter-Terrorism Module 4 Key Issues: Defining Terrorism (unodc.org)

United Nations Department of Safety and Security (UNDSS) (2017). *United Nations Security Management System. Security Policy Manual.* Available at: undss-security_policy_manual_e-book.pdf

World Health Organisation (WHO) & United Nations High Commission for Refugees (UNHCR). (2013) *Assessment and Management of Conditions Specifically Related to Stress: mhGAP Intervention Guide Module (version 1.0).* Geneva: WHO. (Annex 13)

Annex 1: Assessment and mapping of psychosocial stressors and resources

1. Factors to consider in the assessment:

1.1 Environmental stress and security risks:
- Poor hygiene, difficulty accessing food and clean water
- Extreme weather conditions
- Confinement: living and working in isolated compound
- Security risks: levels of crime, terrorism, kidnapping; likelihood of natural disaster
- Ethnic or other civil conflicts; war
- Poor working conditions: insufficient space, lack of privacy, poor lighting, excessive noise
- Poor infrastructure, traffic congestion
- Limited recreational resources
- Local anti-UN sentiment

1.2 Work-related stress:
- Work overload or under-load, high levels of time pressure
- Inflexible work schedules, unpredictable hours, long or unsociable hours
- Inadequate equipment availability, suitability or maintenance
- Low participation in decision making, lack of control
- Poor communication
- Lack of definition of or agreement on organisational objectives
- Interpersonal conflict, lack of social support, bullying/ harassment/violence
- Role ambiguity, role conflict
- High level of responsibility
- Career stagnation
- Lack of variety, fragmented or meaningless work, under-use of skills
- Job insecurity
- Conflicting demands of work and home

1.3 Available Services (quantity and quality):
- Current list of active Peer Helpers
- Mental health professionals available within the UN
- External mental health professionals available in the community
- Are psycho-pharmacological medications available in the duty station?
- What level of clinic / hospital available for UN personnel?

2. Assessment methods of personnel's psychological status and concerns

- Survey/questionnaire
- Semi-structured interview with personnel
- Focus groups with personnel
- Meetings with stakeholders and managers
- Direct observations: "Walk, observe and listen to people"
- Meetings with health professionals and other counsellors

3. Specialised assessment tools

Important note: Before using any of these assessment tools there must be a conscious and justifiable decision about the purpose for using them and what will be done with the information gathered. Clinical assessment tools should only be used in situations where specific reliable and validated data is needed. The counsellor should under all circumstances avoid simply rolling out a battery of tests to employees who are already working under pressure.

- Generalized Anxiety Disorder (GAD-7)
- Post-Traumatic Stress Disorder (PCL-6)
- Major Depressive Disorder (PHQ-9)
- Hazardous Drinking (AUDIT-C)
- Workplace incivility and occupational conflicts (Workplace Incivility Scale)
- General Health Questionnaire
- Effort Reward Imbalance
- Maslach Burnout Inventory
- Organisational Constraints Scale (OCS)
- Secondary Traumatic Stress Survey (STSS)

Annex 2 Assessment Checklist

The following **is a checklist** of the main areas in order to inform the plan of action for crisis response.

1. Specific challenges and risk factors:
- Safety and security issues
- Ethnic, racial, religious, or political conflicts
- Health risks (communicable diseases including vector borne and zoonotic diseases; climate- and weather-related risks; access to clean water and healthy nutrition etc.)
- Logistics: lack of appropriate venue for confidential counselling; problems with phone, internet and other communication systems; mobility problems
- Negative attitudes towards counselling support
- Role conflict among different support disciplines
- Ambiguity regarding policy/regulations or political agenda

2. Impact of the incident:
- Degree of destruction and impact

2.1 Deceased.
In collaboration with HR determine:
- The number of casualties
- Contact details for the bereaved families /dependents

2.2 Survivors with physical injuries
In coordination with the responsible UN Medical Officer, determine:
- The number of injured
- Degree of injury
- National / international employees
- Current locations of the injured personnel (Hospital, home, UN clinic, site, etc)
- Contact details of family members
- Immediate needs

2.3 Survivors without any physical injury.
- Number of UN employees who were in the duty station but not on-site at the time of the incident
- Number of national and international employees
- Current locations and contact details, including for family members where relevant
- Agencies, Funds and Programmes operating in the duty station

3. Availability of internal social support system:
- Group cohesion and team spirit among UNCT
- Cohesion and mutual support between National and International personnel
- Availability of trained Peer Helpers and Family focal points (How many, names, contact details, organisations and level of training)
- Number of dependents in the duty station

4. Availability and accessibility of internal specialised support:

- Availability of UN counsellors
- UN medical capacity in the duty station
- Availability of HR emergency specialists

5. Availability and accessibility of external specialised mental health services:

- Availability of external clinical psychologists, psychiatrists, psychiatric nurses, social workers
- Availability of mental health facility

6. Local resources:

- Community resources: churches, mosques, NGOs, volunteers, specialised clinics, hospitals etc.
- Availability of basic services including communication, health services
- Relevant local coping styles and cultural aspects

Annex 3 Crisis Preparation: Psychosocial preparedness and prevention strategies for counsellors

Step by step planning for targeted attacks, natural disasters, pandemics/epidemics and other crises and emergencies

Crisis Preparedness phase *(compatible with the DHMOSH readiness phase)*		
No	**Strategies**	**Activities**
1	Assess the psychosocial needs of the UN population and associated risks	✓ Prepare checklist, indicators and tools for monitoring ✓ Quantitative & qualitative data collection to assess needs and risks. (See Assessment and mapping of psychosocial stressors and resources: Annex 1) ✓ Data analysis (i.e., sources of stress, impact on personnel, trends, coping strategies (universal & culture specific) Impact analysis (i.e., crisis severity and reach; psychological and social impact) (See Assessment Checklist: Annex 2) ✓ Make recommendations based on the assessed impact
2	Psychosocial support resource mapping and mobilisation	✓ Mapping of in-country, regional and global resources (up-to date and available to respond at any time) – including counsellors, peer helpers, family focal points/client centre volunteers and other well-being professionals. ✓ Engage with mental health facilities and mental health professionals present in the Host country and with partners such as NGOs. ✓ Mobilize CISMU certified External Mental Health Professionals (EMHPs) in each country to supplement UN counselling resources. ✓ Have agreements in place with EMHPs, host government facilities and with NGO partners to support each other if needed. ✓ Creation/activation of the local Critical Incident Stress Intervention Cell (CISIC) composed of counsellors, trained peer helpers and trained family focal points. ✓ Recruitment of a country-based Staff/Stress Counsellor (part-time or full time).
3	Preparation/updating of technical guidelines and contingency plans.	✓ Operational guidelines for the Staff/Stress Counsellors, mental health referral networks and peer helpers will be prepared and disseminated by CISMU. ✓ Development of a psychosocial contingency plan based on the psychosocial needs assessment in anticipation of the crisis. ✓ Briefing about the contingency plan for UN management fora at the duty station, such as the security management team, crisis management team, operations management team etc. ✓ Approval and integration of the psychosocial contingency plan into the UNCT/mission/UNAFP's crisis contingency plan/ country security plan ✓ Commitment from UN management in the AFP or in the country, to provide the resources for implementation of the contingency plans.
4	Coordination and planning of psycho-social support services. Strengthen partnerships with stakeholders (Medical,	✓ Create a coordination mechanism specific to the duty station and define roles and responsibilities. ✓ Organize preparatory meetings of coordination bodies at all levels, such as the CISWG (global level), Regional Cells (regional level), and CISIC (at the country level).

	HR, Security, Global Communications, etc.)	✓ CISMU will conduct preparatory meetings to build a global mental health referral network of professionals to facilitate culturally appropriate psychosocial support services for UN employees and their dependents. ✓ Teamwork with medical, security and HR should include: o Role definition o tabletop exercises and simulations of possible scenarios o Rehearsal of emergency plan and crisis management protocols o Review of logistics o Review of evacuation and relocations procedures and logistics
5	Develop and initiate a communication strategy related to psychosocial wellbeing in the context of the crisis.	✓ Awareness raising for employees and managers on psychological aspects including what to do in case of a crisis (targeted attack, natural disaster, pandemic etc.), risks awareness raising of typical symptoms and self-care. ✓ Ensure the dissemination and advertisement of contact details for mental health care providers, including, where relevant: local and international UN counsellors, local mental health professionals and approved tele-mental health providers. ✓ Develop and disseminate information, education, and communication materials on psychosocial aspects of the crisis including addressing myths, beliefs and stigma for employees and dependents in English and/or the UN languages applicable to the country and local languages. ✓ Use multiple channels of communication to convey essential information to employees e.g., townhalls, webinars, podcasts, i-seek sessions, flyers, ebulletins, authorized social media platforms etc.
6	Capacity building at the global, regional, and country level to equip the organization to manage the psychosocial impact of the crisis.	✓ Advocate for psychosocial support ✓ Organize initial or refresher training for: o all psychosocial support personnel and external mental health professionals, on topics such as the psychosocial dimensions of the crisis, principles of tele-psychosocial support, care of vulnerable client groups etc. o partners such as HR and medical personnel and personnel with focal point functions and other critical personnel on topics such as psychosocial aspects of the crisis, self-care during remote working etc. o managers and leaders on topics such as crisis communications, leading teams in crisis situations and supporting distressed team members etc. o first responders on topics such resilience building, psychological first aid, and self-care skills, o all UN employees on stress management and self-care ✓ Conduct additional Peer Helper and Family Focal Point workshops to expand the pool of psychosocial support resources.

Annex 4: Crisis Response Phase: Psychosocial intervention strategies for counsellors

Step by step planning for targeted attacks, natural disasters, pandemics/epidemics and other crises and emergencies

Crisis Response Phase *(compatible with the DHMOSH active risk reduction phase and the emergency phase)*		
1	Strategies that are ongoing from the crisis preparation phase (Annex 3): a) Ongoing assessments and monitoring of personnel psychosocial needs b) Coordination, collaboration, joint initiatives, and partnerships in psychosocial support provision. c) Communication, outreach, and awareness raising efforts to address emerging needs as the crisis evolves.	✓ These strategies will continue, but the pace and intensity will increase in the crisis response phase. ✓ The local or deployed counsellors will be required to: o Provide regular updates to UNDSS, CMT and SMT, and other key actors as required. o Liaise with CISMU, CMT, SMT, security officers, HR, UNAFP counsellors, medical doctors, Peer Helpers, senior and line managers. o Attend coordination meetings at the country level. o Liaise with local mental health professionals in their respective locations for coordination of care.
2	Culturally appropriate psychosocial support services (preventative and reactive) will be made accessible to personnel in need at headquarters and country levels.	✓ Activation of the Regional Cells and the in-country CISIC. ✓ Conduct psychological triage of those affected by the crisis and provide psychological first aid where needed. ✓ Provide technical advice to UN managers and leaders, on managing their employees and teams in these high stress situations. ✓ Deliver group and individual stress counselling sessions in-person or online as applicable. ✓ Provide grief counselling for families, friends, and colleagues of deceased personnel. ✓ Appoint designated peer helpers and family focal points to support vulnerable groups. ✓ Ensure employees and dependents requiring specialist mental health care or specific organizational support are promptly referred to the relevant service providers. ✓ Pay special attention to vulnerable groups such as: o quarantined and isolated personnel, o personnel taking care of vulnerable family members, o personnel with children and dependents, o orphans and widows/widowers in case of death of UN personnel, o families living away from the staff member's place of assignment etc.
3	Adjust modalities of service delivery depending on evolving needs and constraints e.g., tele-counselling, micro-learning, online outreach, micro-psychoeducation, and other innovative approaches.	✓ Guidance to psychosocial support service providers in the field about best practices and ethical requirements of using online platforms and other innovative approaches. ✓ CISMU and the AFP senior counsellors are responsible for monitoring and evaluating the delivery of these innovative approaches, to ensure professional standards of care are maintained.

4	Plan self-care services for the wellbeing of front-line employees and care givers in anticipation of the crisis becoming protracted.	✓ Scaling up or replenishing psychosocial support resources, managing compassion fatigue, vicarious trauma, and burnout among service providers, and organising online surge support mechanisms.
5	Managing secondary stressors stemming from the crisis (for example an increase in domestic conflicts and intimate partner violence during protracted lockdowns.)	✓ Specific programs will need to be designed and implemented at the global, regional, and local levels to manage these hazards. ✓ Complex issues such as intimate partner violence, and domestic abuse will require a multi-disciplinary approach with partners from counselling, HR, medical, safety and security. ✓ Specific duty of care commitments, training programs and awareness raising campaigns will need to be organised.
6	Managing overall stigma (for example stigma associated with a pandemic/epidemic.)	✓ Culturally appropriate stigma management programs need to be organised in a systematic manner. ✓ Disseminate information, education, and communication materials on myths, beliefs and stigma for employees and dependents in English and/or the UN languages applicable to the country and local languages.

Annex 5: Crisis Recovery Phase: Psychosocial intervention strategies for counsellors

Step by step planning for targeted attacks, natural disasters, pandemics/epidemics and other crises and emergencies

Crisis recovery phase and return to the duty station/office/new normal.		
1	Strategies that are ongoing from the crisis response phase (**Annex 4**): a) Monitoring and assessment of psychosocial needs. b) Coordination, collaboration, joint initiatives, and partnerships in psychosocial support provision. c) Communication, outreach, and awareness raising efforts to address emerging needs as the crisis evolves. d) Self-care for frontline employees and care providers. e) Managing secondary stressors stemming from the crisis (for example an increase in domestic conflicts and intimate partner violence during protracted lockdowns.)	✓ These activities will need to be maintained throughout the recovery and return to office/new-normal phase.
2	Mechanisms to ensure smooth follow up of cases, continuity of care, appropriate referrals for late onset and long-term mental health sequalae of the crisis through specialised support, and interdisciplinary case management for complex situations.	✓ As the attention of the UN managers and leaders moves away from the crisis counsellors will need to maintain their advocacy efforts to ensure that the leadership support and resources for addressing the long-term psychosocial needs of affected UN employees and their dependents are available and budgeted. ✓ A reliable case management and tracking system, such as an online database, will be required to ensure follow up care and continuity of care for affected UN employees and their dependents. The CISMU global database has been designed for this purpose.
3	Assimilation of lessons learnt and best practices from the crisis and using these to revise contingency plans and guidelines.	✓ Lessons learnt exercises will be carried out by the CISIC at the local level, the Regional Cells at the regional level, and by the CISWG at the global level. Lessons learned should be gathered from all UN counsellors who were involved in the crisis response. ✓ These lessons learned and best practices should be recorded and the CISWG Psychosocial Contingency Plan Preparation Guidelines for Staff/Stress Counsellors as well as the relevant chapter of this manual updated as appropriate.

4	Collaboration with partners such as HR, medical, occupational safety and health, administration, etc. for planning and implementation of the return to duty station, or the office, or new normal phase as relevant.	✓ Counsellors will be required to actively contribute to the planning and implementation of return-to-office procedures. ✓ Provide technical advice to UN managers on best practices in support to personnel during the recovery period. Training for managers may be needed in recognising symptoms among team members. Team building activities may be needed when teams have been fractured for example following evacuations or work-from-home scenarios. ✓ Participating in inter-disciplinary working groups and committees planning for the recovery phase.

Annex 6: Crisis Response Phase: Psychosocial intervention strategies for multi-disciplinary team

Category:	Counsellors	HR/ Management	Medical	Security
Deceased	✓ Call/visit the family for psychological support. ✓ Prepare and coach family focal point	✓ Death notification ✓ Provide information related to entitlements and logistics. ✓ Repatriation of the remains	✓ Follow up on the status of the remains. ✓ Death certificate and forensic report.	✓ Security report ✓ Death certificate
Physical injury	✓ Mandatory check-in ✓ Culturally appropriate brief supportive counselling if needed ✓ Referral to specialised mental health services if needed (psychotherapy and tele-psychiatry in coordination with medical services) ✓ Provide psychoeducation (including handouts to share with dependents) about basic stress reactions and coping mechanisms. ✓ Contact dependents ✓ Tele- or personal counselling to dependents	✓ Entitlements ✓ Appendix D	✓ Stabilisation ✓ Comprehensive medical assessment. ✓ Follow up treatment plan and progress with the medical facilities. ✓ Facilitate Med-vac when needed	✓ First aid ✓ Security report
Psychological injury	✓ Culturally appropriate brief supportive counselling where needed ✓ Referral to specialised mental health services if needed (psychotherapy and tele-psychiatry in coordination with medical services) ✓ Provide psychoeducation about basic stress reactions and coping mechanisms.	✓ Flexible work arrangements ✓ Reassignment ✓ Entitlements / compensation in coordination with counsellors and MD ✓ Problem solving with health insurance	✓ Sick leave ✓ Return to work plan in coordination with counsellor and HR ✓ Disability should be considered as a last choice	
Humanitarian workers and rescuers involved in crisis response	✓ Provide psychoeducation (including handouts to share with dependents) about basic stress reactions and coping mechanisms. ✓ Culturally appropriate brief supportive counselling where needed ✓ Referral to specialised mental health services if needed (psychotherapy and tele-psychiatry in coordination with medical services)	✓ Ensure that personnel avail themselves of R&R ✓ Flexible work arrangements ✓ Logistics ✓ Accommodation ✓ Recreation facilities	✓ Preventive measures (vaccination and health education) ✓ Ensure supplies for medical and preventative needs of personnel	✓ Detailed security briefing ✓ Ensure enough PPK for security of personnel

Managers and team leaders	✓ Provide psychoeducation (including handouts to share with dependents) about basic stress reactions and coping mechanisms. ✓ Counselling support as needed	✓ Ensure that personnel avail themselves of R&R ✓ Flexible work arrangements	✓ Preventive measures including vaccination and health education ✓ Ensure supplies for medical and preventive needs of personnel	✓ Detailed security briefing ✓ Ensure enough PPK for security of personnel
General UN community	✓ Provide psychoeducation (including handouts to share with dependents) about basic stress reactions and coping mechanisms. ✓ Counselling support as needed ✓ Encourage mutual support and personnel participation in welfare programmes and other psychosocial support initiatives	✓ Ensure that personnel avail themselves of R&R ✓ Flexible work arrangements ✓ Facilitate healthy and supportive work environment	✓ Preventive measures including vaccination and health education ✓ Ensure supplies for medical and preventive needs of personnel	✓ Detailed security briefing ✓ Ensure enough PPK for security of personnel

Annex 7: Crisis Recovery Phase: Psychosocial intervention strategies for multi-disciplinary team. Follow up and lessons learned

Category	Counsellors	HR/ Management	Medical
Families of deceased	✓ Follow up with the dependents of the deceased personnel can include referral to resources in the community and inside the respective organization; facilitate communication with HR regarding entitlements.	✓ Documentation on the status of the dependents, facilitate their entitlements (pension, compensations, education grants, insurance)	
Injured staff	✓ After providing supportive counselling during the response phase, counsellor should link the personnel with psychosocial support resources in their organisation and/or their community.	✓ Keep track of all the cases ✓ Assessment for return to work ✓ Facilitate reassignment if recommended ✓ Facilitate entitlements	✓ Continuous assessment and monitoring of the medical condition of the personnel; facilitate access to the best available relevant services ✓ Recommend return to work program or disability if needed ✓ Decide on compensation and disability issues

Annex 8: Matrix for daily activities of coordinated multidisciplinary-multi-layered interventions

Discipline	Action priorities	Indicators	Time frame	Focal point	Observations
Security/SMT					
HR					
Medical					
Psychosocial					

Annex 9: Evacuation Reception: Preparation, Intervention and Follow-up

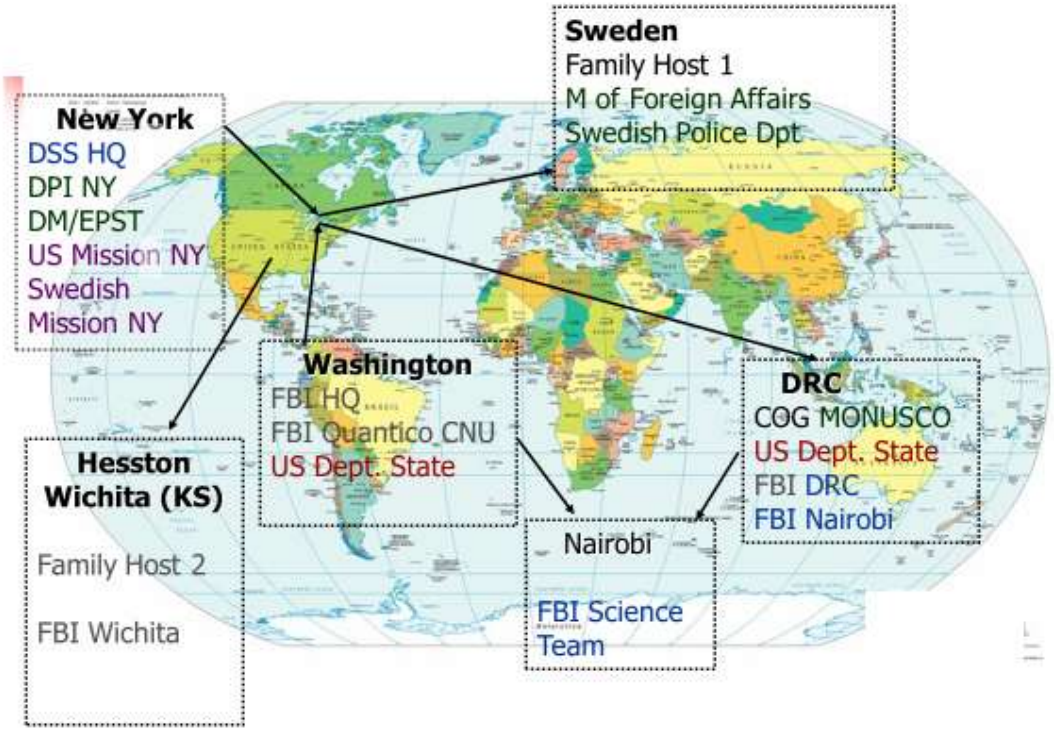
Preparedness Phase	**Actions** • Relocation and evacuation preparedness for UN personnel and dependents requires planning for the particular needs of individuals of different ages and genders, with attention to particular health and psychosocial needs. • Peer Helpers at the Safe Haven (evacuation reception sites) should be trained in preparation for reception of evacuees. The counsellor based in the duty station with the protracted crisis should ideally be involved in their training and supervision in order to establish a working relationship before an eventual evacuation takes place. • Preparation plans should be made in coordination with HR, Security and Medical colleagues
Response Phase	**Actions** • UN counsellors must be part of the reception team on the ground in the evacuation location. The counsellors from the duty station being evacuated should either remain in the duty station during the evacuation or be part of the reception team but should be counted as evacuees themselves, bearing in mind that they have also been exposed to the event triggering the evacuation. They should therefore be relieved by other counsellors, preferably those familiar with the duty station, as soon as logistically possible. • In cases where the evacuation follows a sudden, violent or potentially traumatic event (such as a terrorist attack, an outbreak of conflict directly affecting the UN or a natural disaster) UN personnel who have been evacuated must not be released from the Safe Haven (evacuation reception sites) until they have each had a mandatory psychosocial check-in with a counsellor. No exceptions, including management. • During the check-in provide psychoeducation (including handouts to share with dependents) about basic stress reactions and coping mechanisms. Where number of evacuees is too great to arrange individual check-ins with a counsellor, the counsellor can meet with evacuees in small groups and provide psychoeducation with handouts. Handouts must include current contact details for counsellors who will be on call on a (rotational) 24/7 basis, bearing in mind time zone differences. • Culturally appropriate brief supportive counselling should be provided if needed. • Referral to specialised mental health services if needed (psychotherapy and tele-psychiatry in coordination with medical services). • Ensure that evacuees have access to HR information related to entitlements and logistics. • Regular contact should be maintained with all UN personnel who remain in the duty station once their colleagues have been evacuated to monitor their coping mechanisms and psychosocial needs.
Return Phase	**Actions** • Particular attention should be paid to the possibility of feelings of resentment among those who were not evacuated, and guilt of those who were evacuated. • Team building activities may be particularly needed. • Continue to provide follow up care to those who were directly impacted by the event triggering the evacuation, those with particular mental health sequalae, or other special psychosocial needs, in collaboration with HR and Medical as needed.

Annex 10: Psychosocial support roles during Hostage Incident Management and lessons learned

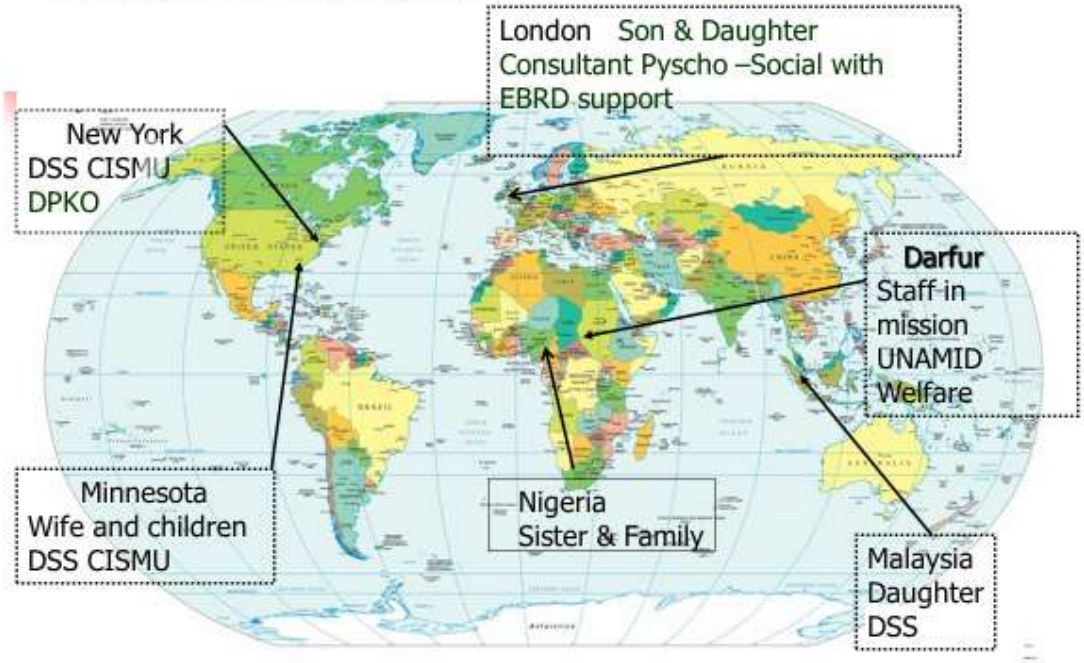
Psychosocial support roles		Role	Lessons learned
UN Counsellor	Crisis Operation Group Headquarters (COG HQ)	• Advises and supports the COG HQ at the strategic level • Supports the Family Liaison and Support Officer in the field (if any) • May be the Family Liaison Coordinator if certified to take on this role	• May be the only Family Liaison and Support Officer in some sensitive cases • In some instances, and based on training, may support with conducting the profiling of the hostage takers • Should be prepared to spend a tremendous amount of time working exclusively on the hostage case
UN Counsellor	COG Duty Station	• Supports the COG at Country level with operational matters related to psychosocial issues at the duty station • Supports with monitoring the psychosocial wellbeing of the team members	• Should be prepared to spend the entire time with the team working exclusively on the hostage case • May play the role of Family Liaison and Support Officer based on profile and number of hostages
Family Liaison and Support Officer (FLSO)	Is ideally a counsellor based at UNHQ. Sits in the COG HQ	• Advises the COG HQ at the strategic level • Ensures that the families of hostages are equally provided with all possible information concerning the hostages and the Organisation's efforts to achieve their release • Coordinates and organizes a family focal points system ensuring that all affected family members receive appropriate information and adequate psychosocial support • Provides information on the progress of the negotiations to the family, and information from the family to the Hostage Incident management Team • Helps the family deal with approaches from the hostage takers • Protects the family from harassment from the media	• The FLSO should be prepared to devote considerable time and effort to coordinate with the family members and this must be the incumbent's priority, possibly to the exclusion of other duties • FLSO should not also be appointed as a Family Focal Point in cases where there is more than one hostage • In sensitive cases, like the DRC case in 2017, only one mental health professional was appointed as the FLSO and also played the role of Family Focal Point and supported HQ at the strategic level. • Families talk to each other, therefore updates must be coordinated and provided to all families at the same time. (In the DRC case coordination allowed the provision of updates and sensitive information to both families almost at the same time. Local mental health professionals were mobilised by the respective governments to provide ongoing counselling and psychosocial support in the respective counties of the hostages, coordinating with the FLSO. Those mental health professionals received very little information on the negotiation process. They focused on their psychosocial support and counselling role.

			• In the case of UNAMID in 2010, the FLSO identified mental health professionals who were used as Family Focal Points in various countries where family members were residing (UK, Malaysia, UK, Nigeria, US) • FLSO liaises and coordinates with the AFP Counsellors or Family Focal Points especially in cases where there are many hostages or where one of the AFP Counsellors is appointed as Family Focal Point (e.g., in the case of Maiduguri and the case of Pakistan in 2009). • In some cases, such as DRC 2007, the government of the hostages preferred to handle the family liaison directly without the UN getting involved with the families at all. In another case, the government preferred to handle the family liaison but requested the UN to coach the team they put in place back home. The FLSO worked with the Family Focal Points through the member state government
Family Focal Point	A colleague who: • can easily navigate the UN system • has good listening and interpersonal skills • is trusted by colleagues • is cognisant of cultural sensitivities and practices Who can be appointed as Family Focal Point: ○ The CISMU local Counsellor ○ A good, trained Peer Helper ○ A good HR Officer ○ A colleague who is trusted by the family and the colleagues	• Maintains the loop of communication between the HIM team and the family • Assesses and manages the family dynamics, tries to understand the family expectations, needs and fears • Defuses/prevents the family potential frustrations and anxiety • Helps prevent, rationalise, or coordinate family members' potential solo initiatives that may be disruptive to the negotiation process. • Gathers intelligence from the family • Projects the image of the UN as a caring organisation • Prepares the family for the best or the worst • Follows up and advises the family and UN after the release	• Assists the family navigate through the system • In one case in 2009, the brother of the hostage was close to a Senator and wanted to launch a campaign. An email was created by DSS to channel his urge for action. The FLSO worked with the media team, to coach and prepare the mother, who recorded a declaration that was aired as part of a media strategy. • In the 2017 DRC case, after 7 days without any contact with the abductors, the FLSO designed a strategy to prepare the families to the worst scenario, which unfortunately happened

Example of Family Liaison DRC 2017



Example of Family Liaison UNAMID



Annex 11: Coordination of global UN psychosocial support in emergencies

The **Management of Stress and Critical Incident Stress Policy** (MSCIS, 2015) governs the coordination and provision of psychosocial services by counsellors contracted or employed by United Nations Security Management System (UNSMS) organizations, to support those UN employees who are at risk of experiencing or experiencing stress or critical incident stress.

Overall coordination (Headquarters)

- ✓ CISMU, as Chair of the IASMN CISWG, will coordinate global psychosocial support services with the Division of Healthcare Management and Occupational Safety and Health (DHMOSH) - the lead for all medical emergencies in the UN.

- ✓ The counsellors based in UN Agencies, Funds and Programs (UNAFPs) are responsible for the identification, planning, implementation, and evaluation of psychosocial activities within the AFP, in coordination with CISMU.

- ✓ The Staff Counsellor's Office (SCO) IN UNHQ is responsible for the identification, planning, implementation, and evaluation of psychosocial support activities in UN Headquarter locations, Offices Away from Headquarters (OAH's) and the UN Regional Commissions, in coordination with CISMU.

- ✓ CISMU is responsible for the identification, planning, implementation, and evaluation of psychosocial support services in Political and Peacekeeping missions.

- ✓ CISMU will disseminate accurate and timely information to the CISWG members, the counsellors in crisis affected countries and other UN stakeholders[9]

- ✓ In an event that requires increased psychosocial support services for UN employees and their dependents, CISMU will work towards the establishment of a global referral list of mental health professionals (both internal or in-house counsellors and external mental health professionals).

- ✓ CISMU will coordinate the network of global mental health professionals to facilitate psychosocial support service access to all UN employees and their dependents based upon needs. These psychosocial support services will consist of in person consultations where possible and remote tele-psychosocial support services when in-person access is not possible.

Implementation at the regional level

- ✓ The CISMU Regional Stress Counsellor is responsible for the implementation of the guidelines in his/her region, in collaboration with regional partners and UN stakeholders

[9] Designated Officials and UNDSS Security Advisor's in affected countries, UNDSS Regional Desks of the Dept. of Regional Operations (DRO), Client Support and Special Situations Section (CSSSS), Dept. of Operational Support (DOS) in New York et al.

such as the Regional Staff Counsellors of the UNAFPs, UNDSS Regional desks, medical and HR colleagues in the region.

✓ The Regional Cells will be activated in line with the UN Policy on the Management of Stress and Critical Incident Stress (MSCIS, 2015).

Implementation at the country level

✓ The local counsellor recruited by the UN, as a member of the Crisis Management Team (CMT) of the UN, is responsible for the coordination, planning, implementation and evaluation of psychosocial services at the country level, in coordination with the country specific medical service section affiliated to the UN and the WHO office.

✓ The local CISIC will be activated in line with the UN MSCIS policy (2015). The local CISIC will be extended to the First Responders from all AFPs and mission operating in the country (Peer Helpers, Family Focal Points)

✓ The local counsellor will report to the Regional Stress Counsellors of CISMU and the Chief of CISMU through the CMT.

Annex 12: Management of Stress and Critical Incidents Stress (MSCIS)

United Nations Security Management System Security Policy Manual Chapter VI: Administrative and Logistics Support for Security Operations
Section G: **Management of Stress and Critical Incidents Stress (MSCIS)**

CISMP MSCIS
Policy_23 No 2015.pd

Annex 13: Assessment and Management of Conditions Specifically Related to Stress

This Annex contains a copy of the mhGAP Intervention Guide Module: *Assessment and Management of Conditions Specifically Related to Stress.*

Note: This is not intended as a diagnostic tool. Symptoms of distress in crisis contexts are likely to be transient and not indicative of a mental health disorder. Additionally, interventions must be carried out in a coordinated multi-layered, multi-disciplinary approach of psychosocial support as outlined in this Field Manual.

WHO & UNHCR
Assessment and Mana