NATIONAL CENTRE FOR RESILIENCE

Indispensable

Understanding the mental health impact of the COVID-19 pandemic on support staff in essential and voluntary service roles.

Research funded by The National Centre for Resilience

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Executive Summary

Since the first cases of Coronavirus (COVID-19) were identified in Wuhan, China in 2018, the virus has touched every corner of the globe, with almost half a billion confirmed cases leading to 6.25 million deaths as of May 2022 (Johns Hopkins, 2022). Scotland alone has registered 1.87 million cases with 12,157 confirmed deaths (Public Health Scotland, 2022). Ongoing responses to the virus have changed the working landscape for practically every profession with those in emergency response, health and social care and the volunteer sector acutely impacted by the privations of the pandemic. Research with first responders has highlighted negative mental health outcomes such as psychological trauma, post-traumatic distress disorder, burnout, emotional exhaustion, compassion fatigue, sleep disorder, panic attacks, weight loss/gain, anxiety and depression, and feelings of guilt, grief, and anger (Busch et al.,2021; Franklin and Gkiouleka, 2021; Montgomery et al, 2020) raising valid concerns about the potential for occupational risks in a plethora of frontline settings. But for staff in strategic and tactical positions, one step removed from the actual events, the picture is less well understood. This pilot study focussed on this underserved group and explored their thoughts on a diverse range of topics such as:

· strategies for maintaining mental health

· social relationships

· professional identities

· barriers to mental health and wellbeing

· organisational responses and leadership

· personal definitions of resilience

Participants came from a diverse range of organisations such as Local Authority Resilience and Civil Contingencies Officers, Forestry and Land, Health and Safety and the Red Cross in recognition that a bricolage of non-blue light services have contributed, and continue to contribute to, the pandemic response and recovery. Data from semi-structured interviews offers key insights the impact of the pandemic and the protective factors that enabled participants to maintain their mental health resilience over the last two years.

Participants framed the pandemic as presenting a series of evolving challenges to their mental health resilience; feelings of anger and frustration, changes in personal and professional circumstances, altered working practices, isolation and loss of social and organisational cohesion represented a threat to what Ungar (2020) has termed social-ecological resilience. The transition to new work environments was a particular challenge that altered relationships with colleagues, friends and family with some participants expressing reluctance to seek support from their organisations. Patterns of increased alcohol use and downward social comparison constituted coping mechanisms amongst this participant group, giving rise to concerns about strategies adopted to protect mental health. In contrast to these findings, participants also reported personal and professional growth over the period of the pandemic with feelings of enhanced inclusion in decision-making, more dynamic communication across and within organisations, the development of leadership skills and heightened sense of professional identity, serving to increase feelings of self-efficacy and bolster mental health resilience.

From these findings, the research makes a number of tentative recommendations designed to enhance approaches to mental health resilience in the organisations from which the participants are drawn, many of which are relevant to the broader resilience community

1. Introduction

1.1 Background

Since the first cases of Coronavirus (COVID-19) were identified in Wuhan, China in 2018, the pandemic has touched every corner of the globe, with almost half a billion confirmed cases leading to 6.25 million deaths as of May 2022 (Johns Hopkins, 2022). Scotland alone has registered 1.87 million cases with 12,157 confirmed deaths (Public Health Scotland, 2022). Ongoing responses to the virus have changed the working landscape for practically every profession with those in emergency response, health and social care and the volunteer sector acutely impacted by the privations of the pandemic. Not since the 1918 influenza pandemic have health and social systems been tested with overwhelming patient numbers, critical care requirements and a plethora of other extreme pressures affecting societies around the world. As the pandemic progresses, there is a growing need to understand mental health impacts at all levels of response, and in the resilience community in particular, in order to feedforward knowledge into future response models.

This report presents the findings of a pilot study that focuses on the mental health impact of the COVID-19 pandemic on support staff in essential and voluntary service roles. The participants in this pilot shared two common features, they worked throughout the pandemic in roles classed as essential by law or by their employing organisation, and they each held a strategic or tactical role in supporting frontline emergency services staff or volunteers responding to the pandemic and/or concurrent emergencies. Participants came from a diverse range of organisations such as Local Authority Resilience and Civil Contingencies Officers, Forestry and Land, Health and Safety and the Red Cross. Mental health has been identified as a key element of the Scottish Government's Preparing Scotland hub and spokes model (Care for People, see figure 1) but participants in this research also reported on other areas of the Preparing Scotland strategy such as responding to emergencies, risk assessment guidance and recovery.

The findings presented here represent participant's attitudes and opinions on topics such as self-reported mental health and wellbeing strategies, social relationships, professional identity, perceived barriers to mental health wellbeing, organisational responses and leadership, and personal definitions of resilience as viewed through the prism of the changing circumstances of the pandemic over the last two years. The findings contain significant insights for the organisations from which the participants are drawn, related essential service and voluntary organisations, and the broader resilience sector as a whole. The report provides evidence-based recommendations on transitions to new working environments, leadership styles, communication within organisations and mental health awareness as well as suggestions for further research on professional identity in the response community and the relationship between resilience and trauma.

1.2 Supporting response

Extant research has failed to account for the experiences of essential services staff in support and tactical roles, with much of the focus on first responders and those in operational roles. From research on the general population, we know that those with anxiety sensitivity are predisposed to report psychological distress related to COVID-19 (Paluszek et al. 2021). Worry about the dangers of the disease, socioeconomic costs and symptoms of traumatic stress are factors contributing to what researchers are now calling COVID Stress Syndrome (Taylor et al, 2020, Paluszek, 2021). From research conducted, both prior to and during the pandemic, we know that essential services staff in first responder roles are amongst the groups most likely to experience anxiety, depression, and post-traumatic stress disorder (Carbajal et al 2021; Hartley, 2011; Killikelly, Lenferink, Xie and Maercker, 2020; Substance abuse and Mental Health Services Administration, SAMHSA, 2018). This leads to questions about the mental health risks for staff in support or tactical roles and in broader areas of the resilience community such as risk and emergency management, response coordination and volunteer coordination, where vicarious stress and experiences of the pandemic are under-researched.

For first responders, outcomes such as psychological trauma, post-traumatic distress disorder, burnout, emotional exhaustion, compassion fatigue, sleep disorder, panic attacks, weight loss/gain, anxiety and depression, and feelings of guilt, grief, and anger (Busch et al.,2021; Franklin and Gkiouleka, 2021; Montgomery et al, 2020) raise valid concerns about the potential for occupational risks in a plethora of frontline settings. But for our participants, in strategic and tactical positions one step removed from the actual events, the picture is not so clear. Vicarious trauma and secondary traumatic stress have been identified among emergency medical dispatchers, where repeated and cumulative secondary exposure to traumatic events produced feelings of helplessness and increased operational stress (Adams, Shakespeare-Finch and Armstrong, 2015). Studies of other helping professionals, indirectly exposed to potentially traumatic events, have demonstrated that feelings of burnout are a strong predictor of the future development of secondary trauma (Cummings et al, 2021). During the pandemic, our participants regularly engaged in activities connected to traumatic events such as managing staff and resources through lockdowns, supply dispatch and organisation of vaccination programmes and compilation of additional death statistics. With inflammatory headlines describing mental illness as "Our Epidemic Within the Coronavirus Pandemic" (Miller, 2020) forming a backdrop of media misrepresentation and misjudgement about human capacity for resilience (See PeConga, 2020), we wanted to explore the mental health resilience of this underserved population.

Concerns about the possibility of traumatic stress motivated the early development of this study, but it was the question of how participant successfully negotiated these stressors to maintain positive mental health and wellbeing that later propelled it. Much of the interview data explored the ways in which participants navigated the personal and professional challenges of the pandemic and overcame grief, anger, fear and self-doubt during a period in which they experienced legislative and organisational change, major disruption to their daily working practices and turmoil in their private lives. This report explores participants mental health resilience and highlights protective factors that bolstered mood states, raised self-confidence and self-efficacy and contributed to participants' overall sense of wellbeing. Although interviews were carried out on a one-to-one basis, the project is consonant with the place-based approach advocated by the Office of the Deputy First Minister, with resilience conceptualised within the context of organisations, communities and families as a dynamic social process. As such the findings presented here explore a myriad of personal, social and organisational themes as participants' share distinctive contextual narratives about their experience of the pandemic.

1.3 Research Justification and Methodology

This project was designed in response to a specific combination of knowledge gaps around mental health and wellbeing in the Scottish resilience sector:

1. Lack of qualitative data on the experiences of essential services and voluntary staff.
2. Underrepresentation of a full range essential services and volunteer organisations (e.g. volunteer organisations, Mountain Rescue, Forestry and Land).
3. Lack of knowledge of the effects of the pandemic on staff in strategic and tactical roles supporting frontline responders[1].

The COVID-19 pandemic proved the value of an extensive emergency management framework as the duration of the pandemic, prevalence of concurrent emergencies, and a failure to implement actions from previous pandemic preparedness activities (Audit Scotland, 2020) necessitated an integrated, coordinated, and sustained approach to response from a plethora of local and national organisations. Our participants had all contributed in some way to the pandemic response and a broader definition of response/responder organisations recognises that although the main emergency services play a prominent role in the initial stages, a bricolage of organisations

[1] 'Responders' is used here its broadest sense referring to category 1 responders (Police, Ambulance, Fire and Rescue services, Local Authorities, NHS Health Boards, the Scottish Environment Protection Agency and the Maritime and Coastguard Agency), category 2 responders and volunteers coordinated by third sector organisations. Preparing Scotland: resilience guidance - gov.scot (webarchive.org.uk)

and agencies contribute to response and recovery activity across the span of an emergency event and its aftermath. Reflecting this comprehensive approach, this research draws on Ungar's (2019) socioecological model and adopts a multisystemic definition of mental health resilience which is:

> "The process of multiple biological, psychological, social, and ecological systems interacting in ways that help individuals to regain, sustain, or improve their mental wellbeing when challenged by one or more risk factors".
>
> (Ungar and Theron, 2020, p441).

In this approach, mental health resilience results from multiple interacting promotive and protective factors and processes in a system that captures, individual, biological, psychological, social, and ecological complexity. Access to material resources, relationships with others, sense of identity, issues of power and control, cultural values and beliefs and perceived social cohesion all contribute to a scheme of disadvantage/enablement in terms of the level of resilience an individual experiences. We sought to explore participant perspectives on these themes and identify external enablers such as organisational and social support, that are often neglected in psychological studies of resilience (Ungar and Theron, 2020). As previously stated, research projects that focussed on frontline emergency responders provided little insight into the experiences of those in tactical and support roles who plan, organise and direct response activity. In this pilot we sought to develop context specific responses to Ungar's broader research question; "Which promotive and protective factors or processes are best for which people in which contexts at what level of risk exposure and for which outcomes?" (Ungar, 2019, p2).

As the pilot targeted a relatively under-researched population, a semi-structured interview design was developed with the interview schedule drawing on literature from research with first responders (see appendix 1 for a copy of the question schedule). A semi-structured design was deemed flexible enough to allow participants to explore the attitudes, feelings, and perceptions about a range of personal and professional issues while building on pre-existing research themes. The interviews provided a reflective space for participants to contemplate changes in their mental health, discuss sources of stress and identify protective factors and coping strategies while also providing latitude for discussion of personal and organisational sources of mental health support, definitions of positive mental health and the overall concept of mental health resilience.

Making use of existing links between the NCR and the Scottish Government's Resilience Division (SCoRDS), an initial approach was made to the heads of the three existing Regional Resilience Partnerships (RRPs) to gauge interest and publicise the project to RRP stakeholders. An approach was also made to the chair of the Local Authority Resilience Group (LARGS) for the express purpose of recruiting contingency planning and resilience officers. With approval granted, individual members of the NCR mailing list were contacted to participate in the study (see Appendix 2 for the contact letter template). This initial call was built on through word of mouth and snowball sampling (asking participants to recommend participation within their organisation) resulting in fourteen participants volunteering to take part in interviews: six Local Authority Resilience and Civil Contingencies Officers, four Forestry and Land Health and Safety Officers, a Red Cross Emergency Response Officer, a Fire and Rescue Group Commander, a Scottish Environmental Protection Agency Resilience Officer, and a community resilience manager for a flood recovery charity.

A thematic analysis (Clarke and Braun, 2017) was carried out on the interview data producing the following themes: Work Organisation, Professional Identity, Working Relationships, Organisational Change, Coping Strategies and Mental Health Resilience and Positive mental Health. Where convergences within a theme were noted, indicative quotes were chosen to reflect the broadest consensus among participants. Where accounts diverged or differed significantly, quotes were selected as a means of developing the overall theme, creating multi-vocal narratives that reflected complex lived experiences. It was decided that analytic content should be subordinate to the voice of the participants wherever possible, but in recognising the theoretical orientation of the researcher discourse analytic commentary, supplemented by established findings from cognitive and social psychology, framed the analysis.

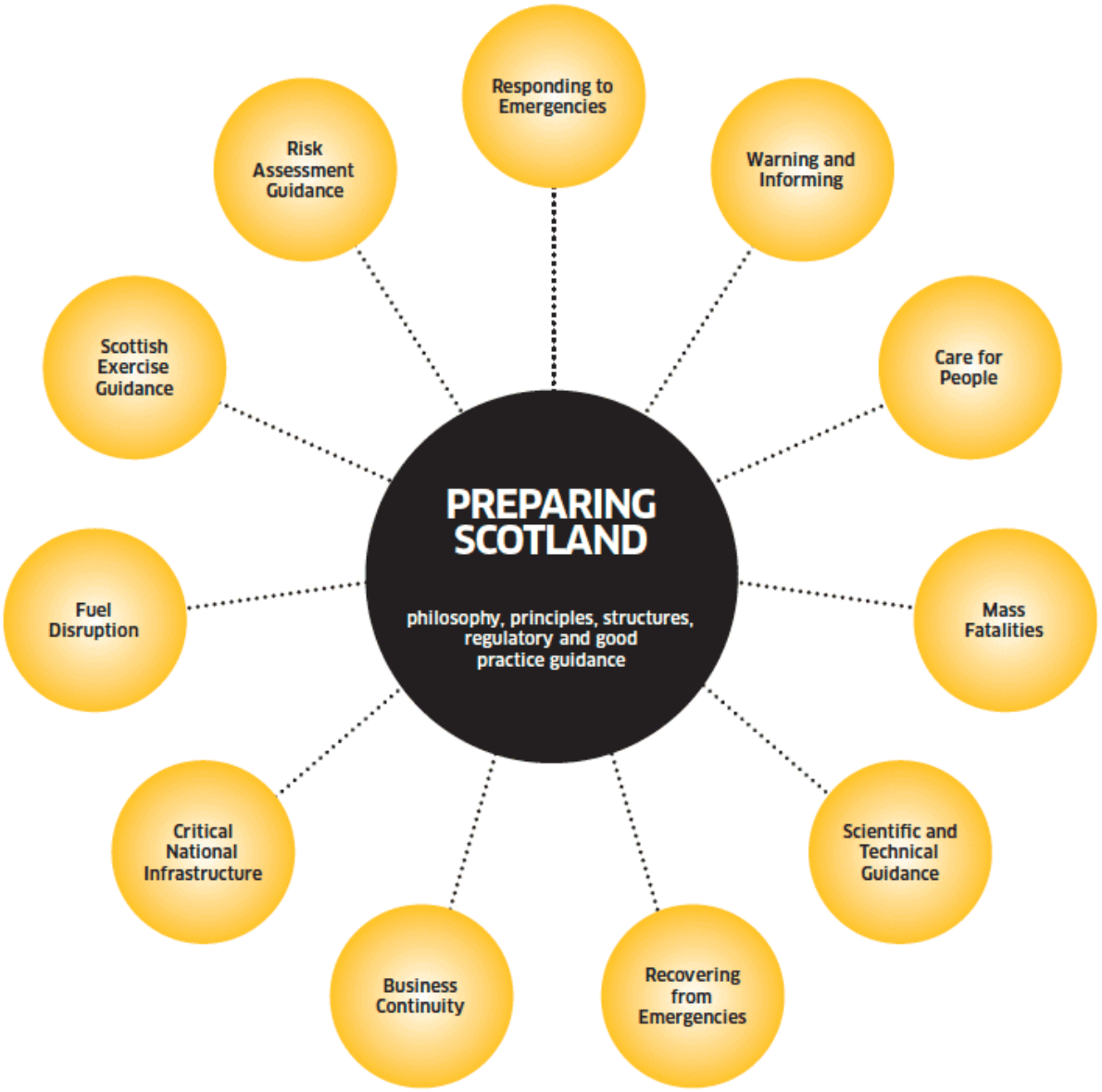

Figure 1- "Hub and Spokes" Model Preparing Scotland: Resilience guidance Section 1 – Resilience: Philosophy and Structures [Preparing Scotland: resilience guidance - gov.scot (webarchive.org.uk)]

2. Analysis

2.1 General impact of the pandemic

As part of the interview schedule, we asked participants to provide a broad reflection of their experiences over the last two years as it related to their mental health. This general, introductory section establishes some of the context of the pandemic and provides a flavour of the themes to be developed later in the analysis.

As participants reflected on their personal and professional experiences an initial source of frustration was a perceived lack of understanding of the essential nature of their work both by the public and members of their broader social circle:

> *"There's been so much recognition for NHS and so little for local government, our staff always seem to be…. even the joiners and electricians, nobody recognises, nobody is defending local government workers."*

Compounding this perceived lack of understanding, participants reported that during the early phases of the pandemic there were frustrations about members of the public not adhering to COVID-19 related regulations. When speaking about sharing public transport where mask wearing rules were being flouted, one participant articulates the intensity of those feelings:

> *"I lost a cousin… it was still this thing that we didn't understand, it was like a bad flu and then I got news that my cousin had died of it….Just devastated…and then a pal died a month later and that was a real kicking. So all the stuff that was kind of yeah I'll wear a mask when I can…it suddenly became…..real anger then when you saw people not wearing them, cos to me it was them that killed my pal. And I'm still like that when people haven't got it on…I'm like, you're not caring about me or all the old people….I've taken that side of it really personally"*

Compounding these frustrations, the early phases of the pandemic were characterised by anxieties about the disease itself, lack of knowledge of how to counteract it and a sense of acute worry for family, friends, and colleagues. Participants reported a shift in these sources of anxiety over time, as confidence grew in protective measures (some of the which participants themselves were responsible for managing and enacting), workload became a more salient challenge to wellbeing:

> *"If we had this conversation a year ago, I would say it's [stress] down to the pandemic but now I think it's down to the shear workload. I'm sure you've heard many times fatigue, exhaustion, burnout all of these words that are I suppose are a snapshot of how much additional work people have had put on them and the constant changes."*

Accompanying worries about the dangers of the disease and increased workload, the pandemic altered the fabric of social relations in a way that both hampered participants' working practices and impacted mental health. For one response officer who organised volunteers, the isolation of pandemic countermeasures (working from home, lockdowns) presented social, psychological and operational challenges:

> *"It's one of the barriers we have for our team's mental health...so volunteering… there's so many motivations for why people give up their time freely. One huge huge thing is social contact and the social network people build from sharing that common purpose, from being in a situation where you have to work together and you have all the team building, the communication, the leadership…. For some people I suspect they don't feel part of the team anymore…. So not being in the same room as each other has been a barrier and probably has demotivated, demoralised and decreased someone's sense of mental health resilience."*

The perceived mental health impact on colleagues often set parameters for what participants found stressful for their own mental health where loss of social contact and a sense of common purpose, and low controllability and low predictability all served to accentuate feelings of isolation both interpersonally and organisationally:

> *"It was this sudden loss of interaction coupled with the uncertainty of exactly what was happening, how bad this thing was, and it took quite a bit of time and I think we lost that connection in our team…. So I think the biggest thing was that loss of sense of what was actually happening in the organization"*

Participants framed the pandemic as an ever-evolving situation that presented a series of challenges to their mental health resilience; feelings of anger and frustration, changes in personal and professional circumstances, altered working practices, isolation and loss of social and organisational cohesion represent a threat to what Ungar (2020) has terms social-ecological resilience. Consonant with the idea that psychological, social and physical ecologies combine in a multisystemic way to underpin overall mental health wellbeing, our participants reported a complex array of covid related issues impacting their sense of resilience. With this basic context established, we present more detailed participant narratives over seven exploratory themes: work organisation, professional identity, management, relationships with colleagues, organisational change, coping strategies and definitions of mental health resilience.

2.2 Work organisation – "it contaminated our private life"

A primary disruptive force for participants was the change to home working and the management of work time. The pressures of the pandemic had reshaped participants' relationship with their job and for some the defining feature of this shift was the weight of emotional labour involved in working hours beyond pre-pandemic levels:

> *"In short term response a reliance on good will is all fine and dandy because it's over and done with relatively quickly, so everyone knows they're going to get a lie down in a week or so. The reliance on goodwill has continued and continued and no one has mitigated the effect of that, it's two years later and we're still relying on good will…Relying on goodwill isn't quite as resilient as it was…people are just exhausted."*

The lack of down time from duties left participants feeling "completely and utterly overwhelmed" and communication difficulties arose "because people are tired and are shorter and less fun". One of the more serious concerns for participants was the lack of time to carry out basic functions of their role due to the extraordinary duties placed upon them:

> *"I feel as if I'm not 100% sure of what I'm supposed to be doing….The plans that we put in place, people were managing based on those and I suppose that's flattering but it looks like I haven't been meeting my targets because those plans are now three and four years old and I haven't had time to update them….it all got paused because of covid."*

Having little time to identify learning and integrate pandemic contingencies into future plans was a further source of concern arising from increased workloads, which combined with working from home, had distinct effects on participant wellbeing:

> *"I have a bit of an issue with control, but now I need to delegate or I'll end up of sick, I'm pushing myself far too hard and…..I think in the past you'd be getting away from the house when you're on leave and we've not really been away….but I feel stuck trying to update plans that you know it's all going to change anyway."*

All participants described changes in their working environment, from reduced office hours, prohibitions on meetings and conferences, changes in working practices in the field and shifting to home working. Unsurprisingly, home working was the most prevalent factor effecting participant's day-to-day lives, beyond the psychosocial entailments of isolation, the establishment of a physical workspace within the home presented difficulties for most:

> *"At first, I'd sit in the dining room or living room, but if I have a bad day, I want to go to that room to separate…. you do need to be able to detach from work and you're not unwinding, when you couldn't travel, it had an effect that I couldn't detach from work, and I think that built up."*

Another participant adds a sense of urgency to leaving the home workspace:

"I've got a husband who makes dinners and in the beginning he was bringing me coffee and lunch up to my desk and I was like, no, no, do you know what I actually need to leave this room and eat downstairs, get out of this space for half an hour even, just eat my sandwich downstairs with you and or even take out into the garden."

Everyday features of a house structure and mediate our experiences of space (see Bachelard, 1958 for a complete analysis), a 'House is much more than shelter. It implies a territory, a small sovereignty with its own laws and customs, its own history, its own jealously guarded boundaries' (Jackson, 1994, p.189). By bringing the trappings of work home and imbuing a particular area as a workspace, participants experienced a fundamental shift in how they perceived their homes. The visual cues of work-based stressors such as a flashing light on a laptop, a desk or chair in an unusual position or the transformation of an entire room (all discussed by participants), created, for some, a sense of invasion. Participants had invited extrinsic sources of stress into an environment that stands for family or that is designed for relaxation, leading to a feeling that their home lives had become contaminated:

"You're seeing it on the news all the time and constantly reminded about the subject that you're dealing with. It was literally impossible to escape from it at that time because we couldn't go out. So, the frame of our life had changed …. it contaminated our private life because we weren't able to separate your private life from your working life."

The metaphor of contamination conveys the extent to which some participant's felt this negative impact. Consistent reminders of COVID-19 from sources such as news media, work emails and online meetings combined to create a sense of all pervading viral contagion that was "literally impossible to escape". This transposition from broader medical crisis to the virus contaminating the home (both metaphorically and literally in cases where participants or family members had contracted the disease), lead to enervation and compaction of work-related stress:

"I don't know if it's quite mental health. I think fatigue was a big thing and that's one of my triggers. If I'm tired, I don't sleep well. Then it starts, you know, the stress things start to compound, and they manifest and loads of different ways."

Findings – Participants experienced confusion about their altered roles, found it difficult to "switch off" from work and felt their home lives had been "infected" which had discernible impacts on their mental health in terms of emotional and physical labour, and lack of covid free physical and mental space.

Recommendation 1 – Clearer definition and planned prioritisation of crisis management roles differentiated from core operations to alleviate stress and confusion.

Recommendation 2 – Managed transition between working environments and awareness training around physical and visual cues for work-based stressors in the home.

2.3 Professional identity - "you became part of the battle"

When asked directly about their mental health, the overwhelming response from participants was that they had no mental health issues with work often cited as a protective factor:

"Dealing with covid from a work perspective has given me a mental health buffer from the wider societal impacts, I think it's less stressful for me than somebody who works in the hospitality sector."

For this participant, stable employment and working in the resilience sector (broadly defined) formed grounds for optimism. One almost ubiquitous aspect of participant narratives was that they felt that their role allowed them to take action to counteract the pandemic, and occupations that included resilience and contingency

planning, response co-ordination and preparedness activities, helped mitigate negative mental health impacts by providing a means of rationalisation:

> *"In the industry we work in, our Job is all about analysing risk, I've been able to look at it in history, virology understanding what the new normal actually is, covid's now been added to that list of things we deal with already".*

By acclimatisation to the new normal and developing a sense of privileged understanding of what that "actually is", this participant links their level of risk perception to professional identity thereby reducing their anxiety. The novelty of the virus was diminished to the extent that it became something to be "added to that list" of other risks that the participants' described as core to their normal working life. But not all participants were as emphatic about the impact their profession had on their personal feelings of preparedness:

> *"More prepared than the average person yes, but you always find with these things that you're never quite as prepared as you think…. It's still a psychological blow or a shock, some people were excited, somebody actually said I've prepared all my life for this"*

Most participants discussed positive psychological states such as feelings of preparedness, self-efficacy, satisfaction, and happiness in relation to broader familial, social and professional ties. This link between the personal impact of the pandemic and professional identity is important because, even though the participant acknowledge a negative psychological impact, *"blow or shock"*, they report feelings of preparedness beyond the "average" person. This indicates that working in a profession that involves counteracting a crisis event is itself a protective factor for mental health resilience.

One further protective factor linked to professional identity, and perhaps particular to the culture of resilience work, was that of acting on risks that had previously only been planned for in the abstract. For some participants acting on these plans contributed feelings of increased self-efficacy which in turn supported mental health resilience as expanded on here:

> "As health and safety people you train for emergency scenarios and *to me that's an emergency scenario, it's a long term one* but our sort of *instinctive, right I need to go into emergency mode kicks in….. I don't know how to say this and I'm not saying it was exciting or that I really enjoyed it… there was a real purpose to what I was doing, there was a focus, it focussed me….. so it didn't affect my mental health."*

Most participants reported that their work mitigated negative mental health impacts where professional competencies, a degree of planning and psychological and physical preparations, brought focus to their activities, which in turn helped bolster their mood. The above participant, while denying that they found the shift from abstract planning to concrete action "exciting", emphasised feelings of invigoration of finding "a real purpose" which again supported mental health resilience. Some participants went even further in describing how work acted as a distraction from extreme personal stress:

> *"I think if anything it's had a positive impact on my mental health. We used to plan for these things a lot in emergency planning. We're now doing them and so the planning is coming to fruition. It provides me with more of a sense of purpose. I enjoy what I do so it really helps. I love problem solving and things like that, so it's created lots of problems we've had to resolve. I'm not saying it's all good, obviously….my mother died in a care home on her own in the middle of lock down ….she died from cancer, but so you know the pandemic has a big impact on me personally, so I'm not dismissing how other people deal with that."*

And:

> "[describing the situation where a family member succumbed to COVID-19] *my father was incredibly ill throughout the whole of this, and the testing program was a great distraction."*

For others the feeling that they were actively counteracting the pandemic extended to the communities in which they worked, framing a broad concept of response and underpinning a growing sense of joint purpose:

> *"Us doing something, being able to show that we were doing something to combat the pandemic… So we weren't passive victims we were active participants in resisting covid so you became part of the war you became part of the battle……it all feeds into us all being able to combat it together rather than suffering it in isolation."*

A well supported finding in the cognitive linguistic tradition is that concrete conceptual metaphors help structure thought about abstract concepts (Lakoff and Johnson, 1999). Drawing on a familiar metaphor related to lay understandings of virology, the 'fight' against covid is framed above as a socially connective experience with the contrast between passive victims and active 'combatants' creating feelings of collective empowerment. The aptness of this bellicose metaphor aside, the "battle" against the virus constituted a protective factor because it provided a means of bolstering positive self and social self-concept at a time when other forms of psychological and social cohesion may have been lacking.

Finding - Participants' sense of professional identity underpinned personal resilience, modulated their level of risk perception, and contributed to the maintenance of positive mental health to varying degrees.

Recommendation 3 – further research on professional identity of resilience practitioners with particular concentration on how elements of the role can bolster mental health resilience and engender community empowerment (i.e., understanding how a range of roles impact mental health in both staff in the resilience sector and in the wider community).

2.4 Working relationships

Relationships with Managers – "you don't realise how much a coach effects a team until you get a bad coach"

Discussions about relationships with colleagues inevitably included the topics of management, decision making processes and working procedures. A consistent theme emerged across these conversations was that mangers came to embody the ethos of the organisation, influencing how participants related to their job, and in some cases, engendering a sense of personal loyalty:

> *"My boss Alex [pseudonym] is one of the best bosses I've ever had, he's really people person orientated. The first thing he asks you when he phones you up, it's not about work, it's like how you doing, how's the kids and then we'll end up talking a wee bit about work. It makes a huge difference, you see it in staff who haven't got an Alex and how much of a hinderance it is to folk…I wouldn't work for a non-Alex I'd vote with my feet."*

The participant further emphasised the sense of collective identity their manager engendered as the conversation continued:

> *….I'll tell you the other thing about having a good boss, because he's a good boss he has a good team, you've got good support from the other team members, so that leadership….. you don't realise how much a coach effects a team until you get a bad coach."*

In the climate of isolation and lockdowns, managers who displayed socio-emotional intelligence and promoted group identity were praised by participants. Those who took time to develop interpersonal connections were perceived as acting from an ethos of care which in turn supported informal mechanisms of mental health support (active listening, group discussion, attitude mirroring). The importance of these socio-organisational relationships is clear in the following extract:

"The daily team meetings were really beneficial. Two of the four in our team lived on their own so it was a 'how are you' disguised as a team meeting and that may have been the only interaction that we had that day. I found then I didn't have an issue with mental health that I might have had."

Managers that provided space for socialisation prior to engaging in task-orientated were perceived by participants to be more effective in reducing work-based stress. This coincides with findings from research on leadership styles where relative employee satisfaction is dependent on how a leader combines management styles in specific contexts (Casmir and Ng, 2010) with inclusive leadership associated with successful navigation of crisis events and reduced psychological trauma (Fawad, Fuqiang and Ahmad, 2020). Being able to put the social before the professional seemed to resonate most effectively at times when social contact was limited:

"So, it's about creating the right atmosphere. That's the right word for these conversations … these little interesting chats I had with the folks, you know we're drifting off into subjects that got nothing to do with work, but often work-related stuff comes back through that, and I think that's really important…"

Visible leadership on mental health and wellbeing was another factor that built on the foundations of an inclusive and supportive approach where senior managers who discussed their own mental health were perceived to contribute to an ethos of care. Several participants discussed the humanising effect of this form of candour:

"You know those people who are the standout people who you don't expect to talk about mental health and never talk about these things. But suddenly when they do it's such a massive catalyst and I think that's a big thing for stigma, and I think you know we're talking senior leadership here"

For some, this shift towards socio-emotional communication and frank discussion of mental health was a marked change from pre-pandemic conditions:

"I think you know, if you look at a positive came out of it [the pandemic], mental health and well-being became a massive topic and you know I can think about the people that I never expected to open up about it, but we're now opening up and asking questions, talking about it, sharing their experiences…and that's kind of credit to those people being prepared to talk about that."

This combination of heightened sensitivity to emotional needs and "stand out" leadership on issues surrounding mental health formed a protective factor for participants, even displays of honesty and vulnerability in a distant leader became a source of inspiration:

"I think it was the prime minister of Norway who actually took time off because of stress. Now that would be unheard of because the perception is that at a leadership level, you can't have these things because you're responsible for leading people. But actually, I think the flip side of that is going to be better because if you have the quality to say as a human being, I've hit my level and I need a break. I think that'll be on massive, massive thing…. You know they are a human being and that for me is a big thing and it's that human centred approach to this kind of stuff that needs to be appreciated more."

Finding – A socio-emotional, inclusive leadership style combined with visible leadership on mental health issues created effective protective factors for participants mental health resilience.

Recommendation 4 – Awareness raising about the benefits of socio-emotional leadership in hazard event management especially when managing remote workers.

Recommendation 5 – Development of further opportunities for open discussion of mental health in the workplace with particular emphasis on an inclusive, stigma reducing approach.

Relationships with colleagues – "they need people that have been through the journey"

Changes to work practices meant that all participants experienced less social contact with colleagues during the pandemic and there was a ubiquitous sense of loss about the decline in opportunities to socialise. This is not to say participants framed their past working relationships as harmonious or were eager to return to office setting, but two years into the pandemic the sense of social isolation had taken on a personal significance:

> *"I'll probably miss building those memories, there's so many different occasions where I've been out and something has happened and over a few beers, four years down the line you have a laugh and a joke about it, there's not that opportunity to build memories and experiences, not having that social contact."*

When asked about the effects of covid on their colleagues, some participants perceived a division between those who held essential roles and attended work, and those who were furloughed or working from other locations and were therefore absent from the workplace:

> "[referencing essential workers] *They've still got their routine but for staff who haven't got that routine I think it's massive, working from home is not for everybody….Our admin support is really struggling for the fact that she's not getting to engage with us anymore."*

Further source of division in social relations developed as the pandemic went on between those who were making themselves available to work and those who engaged in perceived "laziness". One local authority worker had this to say about this difference:

> *"…..she was out the back door and she had a great tan. You know you should get paid. It's not your fault, you're not working. But there were other things that probably they could have done, but they chose not to….The relationships between those that worked and those that didn't, that'll never be the same again."*

Beyond the divisive nature of these comparisons, most participants spoke about the mental health and wellbeing of their colleagues in concerned detail. For some, the negative effects of lack of engagement and other forms of isolation were amplified by gender:

> *"I think that sense of involvement effects women more than men that's always been my experience anyway. They like or seem to, and they're all individuals I get that, but they like the collective feel of things. They like to be involved in teams, they like the huddles if you like, whereas most men I worked with and were less enthusiastic about that."*

The pattern of stereotypical thinking that supports this assertion was repeated by four participants (all identifying as male with armed services or policing backgrounds) in a dichotomy between concern and othering which is rooted in social gender expectations. This complex scenario is difficult to address in a short pilot of this kind, but it does indicate scope for training/discussion around gender expectations as it relates to mental health resilience.

One more ubiquitously held concern among participants was the effect the pandemic had on pre-existing anxieties and work stressors which had impacts on perceived self-efficacy and intrinsic motivation. For one participant, an external locus of control accentuated feelings of helplessness in terms of managing their team:

> *"I feel as if when I took this job on five years ago, we've had constant change and constant interruptions so it's hard to keep motivated it hard to keep motivating a team when there's impacts from outside your organisation."*

In contrast, others felt that the pandemic presented opportunities for growth in their relationships with colleagues:

"From a professional perspective while it's been incredibly stressful, incredibly tiring, and incredibly demanding…. I've loved it……I probably take too much on myself but that was an issue precovid as well, but I have learned to trust others to do things, so I have built up my ability to lead a team, my leadership skills… and engage with people at a strategic level… that's not something that you can necessarily get taught it just happens, it develops."

Participants who had the opportunity to develop leadership skills and new ways of engaging with colleagues, experienced positive changes such as increased self-efficacy and a reinvigorated commitment to their role. But for others a perceived loss of control and team cohesion furthered division and lead to decidedly negative mental health outcomes. Perhaps most surprisingly the mental health support strategy of the organisation formed grounds for mistrust and negative comparison for one participant:

"They're trying to build a team to drive this [mental health strategy] forward. The problem we've got is self-promotion. So, what you'll find is there'll be people volunteer for that because they know it's a sexy topic just now, let's get onboard with that let's get my name out there…. whereas they need people that have been through the journey, accessed services and relied heavily on my colleagues…. some real honest, genuine background knowledge."

Wider trust issues were evident in organisations where staff had been trained in mental health awareness, with participants feeling reluctance to speak to a "mental health champion" instead preferring to contact those they had a personal relationship with. Most felt they had to be strategic about who they spoke to within their organisation because of the possibility of breaches of confidentiality or other negative consequences. For one participant who was "acting up" temporarily, fulfilling a higher pay grade role, the fear of being perceived as incapable of doing their job was most salient:

"In the first instance I would speak to my boss because I have a good relationship with him and sometimes that be all it takes, to just to actually get it out of your system….You're always weary about showing signs of weakness in the work context you have to be careful sometimes…you want to say I want a degree of permanence working at this level, you have to be mindful of that by then holding your hands up and saying you're not coping because it's almost like an admission you can't [continue to work at your level] …. There is signposting to other mental health supports but it would have to be really bad before I would go down that route"

This distrust in internal sources of mental health support was part of the reality for our participants where stigma around mental health issues and uncertainty about who to turn to with particular problems, lead many to seek alternative sources of support outside the organisation:

"It's all good in theory but it's finding the right people to talk to, and I've learned over the years its actually better not to talk to anybody about it in work because you don't know who actually to trust…I've got a friend who I speak to"

Some participants felt that responses to mental health issues we're not acted on quickly enough, without the requisite sensitivity or in a way that truly protected their privacy. For those who did speak out they were often frustrated by the response which, for the following participant, was slow to the point of endangerment:

"I sent an email on that Monday it was called Mental Health and I explained how I was feeling, and it was five weeks later I phoned the person and said did you get my email… [mimics reply] 'I've been very busy'…I had to hang up. So, yes if I was going to give advice I'd say let's listen to people when they're actually screaming out. We have 6-8 week turn around on a health and safety referral and if it's mental health they may not be here in 8 weeks time."

This raises questions about how mental health issues are communicated and acted on in the organisations from which are participants were drawn, the forms of internal support offered (and the informal, external support many participants relied on) and the culture of mistrust around mental health support.

Findings – Most participants reported that relationships with colleagues had suffered during the pandemic with social comparison, lack of engagement and gender stereotypes forming a complex range of negative perceptions. Reluctance to come forward and difficulty in finding the right people to speak to within an organisation created perceived barriers to accessing mental health support.

Recommendation 6 – Analysis and possible revision of services and reporting mechanisms with the goal of providing the broadest opportunity to engage in confidential forms of mental health support.

Recommendation 7 – A defined time limit for responses to staff who communicate mental health issues.

2.5 Organisational change - Silos and signals

Participants typically came from large organisations where much of their work pre-pandemic was conducted within the bounds of a single department such as health and safety or emergency planning/management. For some, the pandemic had a drastic effect on communication which altered perceptions of the organisation as a whole:

> *"These are large bureaucratic organizations, and they're very much predicated on …. They're very silo based, very rigid and you've got your own wee patch and one thing that has changed significantly with covid is a far more collegiate approach to dealing with things…A lot of the organisation has started to revert to type now but during that first six months it opened people's eyes to about how things could be done differently."*

Fears about returning to the *status quo* pre-pandemic weighed heavily on some participants:

> *"It certainly gets things done compared to older ways of doing things. It's really fun working in an environment where innovation and new ideas is the thing, and that's what's so good about the [covid specific work] it was just ..any idea can be put in place if it's good, validating, and I don't think I'll have that in the future because I would be working with maybe, umm….institutionalized people who have a set way of doing things."*

This change in work dynamics and vertical communication also altered relationships with senior leaders, engendering a sense of inclusion which in turn had a positive effect on mood:

> *"I probably started to talk more to senior level staff … I would have had access to [the management team] but now I'm sort of pulled into their meetings as a member of that group so I've got more access to the higher-level management. And I think that was because they were looking to us to tell them how to manage this…. Its brilliant because that's where everybody wants to be, that's where you want to be as a safety person, and I think it's a bit of a shame it hadn't happened before."*

However, a sense of inclusion was not universally felt by all participants:

> *"You are relatively small cog in the organization, when you had all the COVID stuff and they had this covid committee and I was watching Chernobyl at a time, you know, the series. Where you had all these top bosses on the committee in their ivory tower sort of thing….In the past we didn't see that top down control as much and now we're busy going hang on a minute guys it's not really like that, the reactor has melted down…You realised how out of touch they were."*

Closed, distant decision-making groups and processes worked to undermine the sense of inclusion that for others had helped raised self-esteem and self-efficacy. This was particularly acute in organisations where participants felt managers were acting out of loyalty to the organisation rather than in the interests of the individuals' they managed or particular expertise in the area. Changes in working practices were felt so acutely by some that they hoped the pandemic (or at least the altered working environment that it effectuated) would endure:

"Its tiring…. but I don't really want it to completely go away, because I know there's an element of comedown post response and its natural, it's the same as any other high you experience in life, there is a down side to it, and as you transition back to a normal way of operating nothing else ever seems the same and it's difficult to get back into a normal track, particularly from a work perspective because everything's dull and boring."

Finding – Participants benefitted from feelings of inclusion in decision making and enhanced communication with senior colleagues, which raised self-esteem and self-efficacy. Fears about returning to pre-pandemic modes of communication and transition back to 'normal' represented a challenge to some participants wellbeing.

Recommendation 8 – Consideration of a strategy for maintaining dynamic communication across departments, vertically within organisations and with partner organisations.

Recommendation 9 – Phased transition from extraordinary events acknowledging that crises can precipitate personal and professional growth.

2.6 Coping strategies

Participants adopted a variety of coping strategies to maintain positive mental health two of the most salient of which were alcohol use and downward social comparison.

The role of alcohol – "A glass of wine is fine"

None of the participants signalled that they had a problematic relationship with alcohol and no participant intimated abuse of illegal or prescription drugs. Alcohol use was almost exclusively discussed in the broader context of coping strategies, where drinking was used as a tool to mitigate stress or as a personal signifier of a shift from work to leisure time. A number of participants discussed a changing relationship with alcohol in relation to the new circumstances they found themselves in when working from home during lockdown. Narratives were typically constructed in the backdrop of self-reward rather than dependency but, perhaps unsurprisingly, participants reported finding more frequent opportunities to drink and using alcohol to detach from the stresses of work or home life. One participant described how changes in their work pattern facilitated a rise in alcohol use:

"…… not to the extent I get drunk every night. I have a glass of wine most nights and I didn't do that before, and again I drove to work every day, so I didn't, but now I'm not driving to work anymore, most nights it's one glass, some nights it's two glasses."

For this participant, working from home afforded them more opportunities to drink relative to their pre-pandemic levels and although no justification is offered for additional drinking other than their freedom from driving responsibility, a reticent tone coloured the last phrase "some nights it's two". Participants often spoke about alcohol use in the context of "winding down", "relaxing" or as a signifier for "switching off" from the stresses of work:

"My whiskey subscription, which I had before, went quicker so I don't know if that's a strategy and it's probably a negative strategy, but it's about recognising the times when you can shut down and taking those to advantage, so having a whiskey and going, my phone will not be operating just now, and those were few and far between but definitely….yeah just actually allowing yourself to say no….yeah shut down, you have to identify those shut down times."

Alcohol was often used to delineate a time where participants felt able to "shutdown" and sever their connection to work, a form of escapism that is especially relevant considering that COVID-19 felt inescapable to many. Above, by emphasising infrequency ("few and far between") and the function of drinking as a personal signifier ("allowing yourself to say no"), creates a justification for raised alcohol use in overarching narrative of self-care and the compartmentalisation of work stress. The fact that the participant highlights a possible pitfall of their

approach ("probably a negative strategy") mirrors the self-moderation reported by others, recognising alcohol use as one of a number of coping strategies normalises the activity for the following participant:

> *"You know sometimes simply reading a book on a night, or you know, I say having a glass of whiskey, or having a drink sometimes that you know, a glass of wine is fine, but then sometimes you just need something peaceful, tranquil, going for walk with some music going for walk without any music, so I think you know those are just some of my kind of mechanisms."*

Placing alcohol use a broader constellation of activities that constitute self-care presents further psychosocial benefits while sharing experiences of potentially traumatic events:

> *"You know it's not just you that's feeling the way you're feeling, it's a shared experience. You appreciate that you're entirely normal if you're feeling bothered by this, everybody is feeling bothered, but you know some people are better at covering it. So, when you start talking and the tongues loosened by a few drams and you know people talk about things and they're much more open."*

Crucially some of these perceived psychosocial benefits we're lost during the pandemic

> *"It never happens now, it couldn't happen now but after every big incident you'd all sit down at the table with a bottle of whiskey and have a good dram and a blether and it's amazing the effect that had, you'd walk into it feeling like crap and you'd walk out feeling great. You did have had a laugh."*

Social Comparison – "we should appreciate what we've got"

When discussing the difficulties of living through the pandemic, participants often weighed their experiences against others they perceived to be in a less fortunate positions. Discussion of relatively more acute hardship allowed participants to contextualise their negative experiences and bolster responses to their own feelings of adversity. Comparisons typically took the form of empathy about housing conditions ("we're luck where we stay"); empathy for people living alone ("*That would be a completely different ball game if you were on your own*"); and fulfilment of basic needs (*"I'm inside my house, I still have a job, I've had a meal this evening"*). For one participant, this form of social comparison allowed them to make sense of the broader context of the pandemic by perceiving the impacts of COVID-19 in other countries as more severe:

> *"I've worked in Africa, I've worked in war torn ravaged countries so I know every day two thirds of the world's population struggle to get a decent meal, struggle to get an education, so that helps me to contextualise the emergency in a global context…..I'm not saying that helped to normalise it for me but it helped me to understand it and understand the impacts of it as well."*

Participants were often keen to avoid trivialising the impacts of covid by "normalise[ing]" their experiences, instead downward social comparisons were used to communicate a sense of privilege and an awareness of the relatively more stringent impacts felt in less affluent or stable areas of the world, other parts of the country or in other sectors. Such downward social comparisons have proven effective in improving mood in those who perceive external threats and are particularly effectual in those experiencing low self-esteem (Reis, Gibbons and Gerrard, 1993). Some of these comparisons took an extreme form as participants accentuated the distance between their experiences and those in other contexts:

> *"I think that sometimes, thinking that we're not in a third world country….. Watch the Blood Diamond [Film], that will help you because you realize that your kids haven't had to shoot you, I sometimes think I haven't been raped into incontinency. I think at the end of the day we are in a country where we get free tests, and we get freed vaccines, and we should be appreciative of that. So! we should appreciate what we've got instead of thinking, ohhh we're in such a terrible position because we could be in a different country. We could have to pay for our tests. We could have to pay for our vaccines we're incredibly, incredibly lucky. When it comes to my positive mental*

attitude, I always think that there are people in worse situations and I'm very, very lucky not to be in that situation."

Above the participant links maintenance of a "positive mental attitude" to a conscious strategy of downward social comparison to ameliorate negative emotions. The concurrent chiding of those who don't recognise perceived privileged ("ohhh we're in such a terrible position") bolsters the comparison for this participant creating a sense of gratitude (…*"very, very luck not to be in that situation"*). Concern about this strategy arises from the degree of othering it entails in relation to the subject of comparison, the effect on self-esteem if the circumstances on which the comparison rests are suddenly reversed and the possibility that forms of social comparison may decrease pro-social behaviour (Yip and Kelly, 2013).

Findings – Participants reported a changing relationship with alcohol as they detached from work stresses, rewarded themselves or engaged in perceived self-care. Downward social comparison was a prevalent coping mechanism that raised self-esteem and ameliorated negative emotions.

Recommendation 10 – Awareness raising around increases in alcohol use for staff working from home and signposting for alcohol abuse support.

Recommendation 11 – Further research on the use of social comparison as a coping strategy for essential services staff.

2.7 Resilience and Positive Mental Health

At the end of each interview, participants were asked to discuss their personal definition of mental health resilience and positive mental health. Many of the responses focussed on a simple premise of navigating difficult circumstances:

"It would be your ability to withstand disruption, unexpected and unwelcome influences on your mental health, because we get them throughout our working life and our general life, it's about how you cope with taking a knock a mentally. It's about coping with the demands and coming out of it at the other side in one piece and doing well."

And:

"I think it's the ability of an individual to deal with pressures, and these pressures can be from personal health, social interactions, it can be from family life it can be work related. You know we can all bumble along pretty much on a day to day basis, it's what our individual capacity is to ramp up, work, deal with or respond to a new normality, major things like divorce, moving house, loss of a family member all sort of add to these pressures….mental health resilience is having these mechanisms in your make up and coping with additional burdens that are far in excess of a day to day basis."

This frames resilience as an ability, faculty, or trait possessed by the individual, allowing them to adapt to sources of disruption, accommodate to a 'new normality' and flourish in harsh conditions. Adding to this trait-like description, almost all participants discussed a level of reflexive self-awareness of their own mental state as an important component of mental health resilience. Reflective statements such as: *"I have suffered in the past from depressions. I think it's acknowledging that and then realizing that I'm not going back there."* And: *"recognising when you need to step back and look at yourself and then understanding and recognising what you need to do to recover"* denote this introspective skill. For some participants, enhanced communication and increased self-awareness underpinned new ways of storying their experiences as they sought formal mechanisms for coping with stress:

> *"Know your triggers. I did my stress awareness course and that told me this is what stress looks like, when you turn that up that's anxiety, when you turn that up even more that's panic, so that for me visually gave me a scale. I can go from one to ten on stress, I can go to eleven on anxiety and then I can go to woosh …..total panic. And that was good for me, so what sits at one, two, three, four and how to manage that, so triggers are a big thing for me. Then honesty comes into that, if you're struggling at work that you have the confidence to say it but also that you have a manager that supports you."*

The extract above also introduces a second perspective, that of resilience as a social phenomenon, where socio-cultural factors impact one's ability to speak out and the degree to which individuals feel supported by colleagues, friends and family. Other participant definitions also placed strong emphasis on this interpersonal, social dimension: *"I would see mental health resilience as about people, people, and people and the connections we make to each other as human beings".* The true importance of this social aspect was clear even when discussing the death of a loved one:

> *"I'd say mental health resilience is the ability to deal with the shit and it doesn't tip you over the edge, having the balance and knowing that you're not on your own...because I've got a good boss and a good team around me… [breaks down]…. the way they stepped up, they took stuff off you, but they knew that letting you do work is as beneficial as stopping. They we're just like what can we do to help you? What do you want to do? And just kind of that whole level of understanding… it just made such a difference."*

The support of colleague's sensitive to individual needs signalled a form of collective strength that, for this participant, made the difference between coping and "tip[ping] over the edge".

One further strand of description focussed on participants sense of control over their lives, work and how negative experiences were interpreted. When asked about positive mental health during the pandemic, the following participant related their sense of control to workload:

> "My first feeling is control, control over what I'm doing and not having huge demands on me. That's when I start to suffer is when I lose that control. Definitely in this job there's an element of not having control because the work demands are high."

Remembering that none of the participants explicitly discussed negative mental health outcomes such as post-traumatic stress or debilitating anxiety, it was the power to normalise events, real or imagined, that provided some with a sense of control. And it was often the more speculative aspects of this process that shaped participants' thoughts about their own mental health resilience:

> "*After a spell, bad things become normal so when I said try to maintain a sense of normality, I often speak to my wife and some family members …I have nightmares every night in life, I never have a full night's sleep and I often put that down to things I've dealt with but it doesn't bother me, I'm so used to it….I've buried my wife and kids hundreds of times, but I'm so used to it, it doesn't bother me….. Is it resilience or is it suffering?.. not sure."*

A complex relationship between resilience and trauma underpins this description where dreams are framed as preparation for further traumatic events. But the effect of this preparation is questioned with the repeated affirmation "it doesn't bother me" immediately overturned by doubt in "is it resilience or suffering?..not sure". It may be the case that, for this participant, the drive to control negative emotions is a constant stressor in both "periods of routine and periods of emergency" (see Nuttman-Schwartz and Green, 2021) hence "bad things become normal". The participant above referred to a previous career when describing traumatic events, but other participants spoke about forms of psychological preparation specifically related to controlling negative emotions during the pandemic:

"I was actually prepared or thinking I was prepared or trying to be prepared for losing close members of my family and friends, I probably wouldn't have been as prepared as I thought I was, but I had sort of resigned myself to the fact ….I think it was quite a rational response"

These forms of psychological preparation may contribute to what theorists have described as a psycho-behavioural immune system comprising a range of protective responses to biological disease (Taylor, 2009). However, attempts to control negative emotions in this way increase the psychological impact of disease beyond its real-world medical impact and may lead to negative outcomes such as intrusive memories (Lyadurai et al., 2019) or maladaptive self-appraisal (Gomez et al., 2019).

One final discourse characterised participant's descriptions of mental health resilience, that of self-care. For the following participant, allowing themselves guilt free breaks from response was of keen importance something which resonates with previously discussed discourses on self-awareness and compartmentalisation of work time:

"I think the only way to be mental health resilient is to allow yourself to not be guilty about not responding to covid at certain times. You're allowed your time off. You're allowed to turn off your phone occasionally and you're allowed to just go, NO. I am needing this time. I am shutting down for a moment and then I'm going to come back. It's acknowledging that and knowing that and not feeling guilty for it. Everyone deserves it."

Assessing the full impact of the pandemic on mental health resilience is beyond the scope of a pilot study, but participants offered some tantalising suggestions on how their mental health could be improved post-pandemic. This final section presents some definitions of positive mental health. For one participant, a simple change of scenery was a catalyst for psychological change in a description verging on the spiritual:

"I didn't actually realise how miserable and closed down I'd become until quite recently, it was just when I went away down to a meeting, and it was just being out smelling a different kind of air, having a breeze on my face and seeing different things, it was almost like…it might sound ridiculous to say it, it was almost like a rebirth. Almost like a rediscovery of things that you'd probably just took for granted before and had forgotten about. It's almost like becoming institutionalized you know, until you adjust to new circumstances, but you have to readjust"

For others positive mental health had much more tangible correlates:

"Clarity of vision, knowing what's expected of you, clear communications, being able to separate different elements of your life so you get a break from what's stressing you…….being able to speak to somebody who's been through it"

And for others it was simpler still, positive mental health was a low stimulus state which contrasted with the constant pressure of the pandemic:

"Totally switched off, not thinking about it, not waking up during the night, not worrying about it on the weekends, doing nothing, sitting with the tv on, doing nothing"

For most participants, there was broad recognition that both positive and negative experiences informed their sense of mental health wellbeing:

"For me happiness, you're kind of balanced, obviously not everything is going to be good all the time but there's a balance where the good stuff helps you handle all the bad stuff as well…… you don't live in a utopia……. you need that kind of balance where the good stuff outweighs the bad stuff."

Negotiating emotional balancing acts such as this represented one of the key challenges of the pandemic. Introspection brought on by lockdowns, uncontrollable changes to work and family life and other stressors often changed how they participants saw themselves and others:

> *"..for me [positive mental health is] kinda how free your thinking is if that makes sense, if you're in a poor state of mental health your locked into ruminary (sic) thoughts and stuck with ideas and worries and you don't relax, you don't create space for yourself in your head, and I think the pandemic had an effect, it made people more insular and more isolated, I still feel it now going out into groups, what I'm trying to work out now is whether that's still a fear of the virus or have I lost that confidence in social interaction."*

In a final word of cautionary advice offered to support staff in other essential services roles, the following participant emphasises the importance of listening to yourself and self-trust in negotiating mental health issues:

> *"Listen to your body, colleagues and family but listen to yourself. I knew I was going. There's a defence strategy in continuing to go to work because if you take time [off work] the emails are still coming in. Going off sick was going to be detrimental to my health….but in the end it was what I needed to survive."*

Findings – Participants framed resilience as both an individual and social process with self-awareness, the ability to communicate, control and psychological preparation, and self-care impacting their mental health. Positive mental health was discussed as the ability to switch off, balance emotions, and think clearly and freely about oneself and others.

Recommendation 12 – Further research on the concept of resilience in essential services settings with a view to further developing mental health support.

Recommendation 13 – Further research on the relationship between resilience and trauma and the impact of psychological preparation as it relates to work-based stress.

3. Discussion

3.1 Summary of Findings

The pandemic presented a series of challenges to participants' mental health where a perceived loss of social and organisational cohesion, changes in professional and personal circumstances, low controllability and predictability, conspired to undermine self-efficacy and self-esteem. Lack of knowledge about the disease, anger about non-compliance with safety measure, worry about loved ones and increased emotional and physical labour underpinned a complex array of individual, social and organisational challenges.

Working from home created an environment of persistent stress where participants felt they couldn't "switch off" from work, a theme most vividly captured in the idea that COVID-19 had "contaminated" private life. Feelings of isolation created further impacts on relationships with family, friends, and colleagues with participants reporting a reluctance to engage with mental health support and a general mistrust of reporting mechanisms within their organisations. Some participants adopted coping strategies such as increased alcohol use and downward social comparison, the overall efficacy of these strategies was questioned in the analysis.

An enhanced sense of professional identity, inclusive leadership from managers and increased communication with senior colleagues helped raise self-esteem and self-efficacy and contributed to participants' sense of mental health resilience. Self-awareness about mood states and engagement in self-care were important factors in understanding and maintaining personal levels of resilience.

3.2 Mental Health Resilience

From previous research conducted by the National Centre for Resilience we know the vital role emergency responders play in supporting resilience and raising community capacity to cope with natural hazard emergencies (Baxter, 2020). During the COVID-19 pandemic, staff in support and tactical roles, although removed from the frontline, played no less a fundamental role in supporting response while also experiencing negative impacts on their personal, professional, and social lives. The participants in this study demonstrated remarkable mental health resilience and in the face of evolving challenges they relied on a broad range of support systems that go well beyond individual traits or personality types. As Ungar and Theron (2019) state: "resilience depends just as much on the culturally relevant resources available to stressed individuals in their social, built, and natural environments as it does on individual thoughts, feelings, and behaviours." The findings of this study indicate that multi-system models that account for socio-ecological, interpersonal and individual sources of resilience best mirror the lived experiences of our participants. In this study, resilience depended on multiple overlapping systems of support which allowed participants to "regain, sustain or improve their mental health" in line with Ungar's (2019) definition.

Although risk factors identified in the research literature have tended to focus on individual mental health, this research indicates that effective protective measures exceed the scope of individual interventions and require broader social, organisational, occupational health changes. For example, each of our participants discussed work organisation, communication and management styles as impacting their mental health and wellbeing, and these factors have been cited as modulating anxiety in a variety of essential services contexts; Policing (Stogner, Miller and McLean, 2020); Ambulance Service (Heath, Wankhade and Murphy, 2021); Clinical and critical care (Choudhury et al., 2020, Mongomery et al., 2020, Shaukat, Mansoor and Razzak, 2020); Nursing (Philips, 2021); Dental Healthcare (Kar, Bhaumik, Nigma and Rao, 2020); and Social Care (Nyashauna, Pfende and Ekpenyong, 2020). Further research and organisational scrutiny in these areas may be beneficial to the mental health of support staff in similar roles and assist in developing protocols for future events of this kind.

One of the main challenges for our participants was the effect that isolation had on their daily lives. Feelings of low social cohesion and preference for socio-emotional leadership styles may be indicative of a pattern of deeper emotional insecurity ubiquitous to a pandemic. Further research on the socio-emotional effects of lockdowns and countermeasures such as increased social contact through, for example, informal/optional nightly debriefings, may be useful in ameliorating the negative effects of isolation (see Ozbay, 2007, for analysis

of the effects of social support on stress). Further understanding of effective coping skills for this population may also yield benefits in terms of overall sector resilience and could be delivered remotely during lockdown measures via online workshops and webinars.

One of the most intriguing findings of the analysis was the link between professional identity and self-efficacy, a key component of which was the positive effect of taking an active role in responding to the pandemic. Although attitude and mood were important to the overall discourse, our participants talked about resilience through doing, describing work on testing programmes, enacting emergency plans and the organisation of personal protective equipment as contributing to their wellbeing. Further research focussing on the relationship between professional identity and resilience would aid understanding of the active versus passive distinction and further protective factors arising from defined response and recovery activities. Working to counteract or recover from a hazard event has been shown to support positive mental health in effected communities () and further research on, for example, volunteer roles and identities may help maximise mental health resilience in the wider communities that resilience practitioners serve.

3.3 Limitations and strengths

This pilot detailed the experiences of a small number of participants in support or tactical roles in a narrow range of organisations in Scotland, making generalisability to other emergency response organisations and settings speculative. Differences in context, individual and group variation, cultural and organisational influences, and differences in working conditions mean that further research should focus on a broader range of services across the resilience sector and a broader range of both frontline and support roles. Our participants were self-selecting; therefore, findings represent only those staff who were willing to engage in discussions about mental health with those more reluctant or prone to the effects of social stigma about mental health under-represented. Our participants were drawn from a range of areas across Scotland, with most living in rural settings, staff in urban areas may well have had very different experiences of, for example, lockdowns in more population dense areas with less access to green space. Finally, the data collected in this study represents an opportunistic snapshot, a retrospective of participant experiences of the pandemic, longitudinal qualitative and quantitative data would certainly lend strength to the results and enhance generalisability.

This is not to discount the key strengths of the in-depth qualitative work of this pilot study. Focussing on the experiences of emergency services staff in tactical and support roles provides another means of understanding the ecological web that underpins individual, local, and national forms of resilience (see Ungar, 2019). The pilot has alerted us to specific challenges of the pandemic for these individuals and a number of measures that may be considered in future scenarios to bolster mental health resilience in the organisations from which our participants were drawn. There are also some fascinating insights into the individual, social and organisational pre-conditions for positive mental health, which point the way for further study or consideration from an organisational/procedural perspective. From the perspective of this albeit narrow sample, the pilot indicates a number of protective factors for those in tactical roles in essential and voluntary services (at a secondary level of exposure) which lead to positive mental health outcomes. The themes identified here could also easily lend themselves to the development of a more generalisable quantitative measure of mental health resilience for resilience practitioners.

3.4

Reflection

It may be assumed by many that the stigma surrounding discussion of mental health is a thing of the past, eroded by modern sensitivities. Participants in this study expressed a clear desire to explore their intimate personal experiences with a stranger and yet they were wholly disinclined to conduct these conversations in a professional context with colleagues or seek mental health support. Many were eager to provide clarifications or participate in future research because (I suspect) they felt listened to, had freedom of expression and had time to expand on their ideas in the research context. Such willingness to engage in open, structured discussion

about mental health is not a matter of trust or context alone but of a specific set of cultural values that produce feelings of stigma and that can end discussion before it begins.

3.3 List of recommendations

Recommendation 1 – Clearer definition and planned prioritisation of crisis management roles differentiated from core operations to alleviate stress and confusion.

Recommendation 2 – Managed transition between working environments and awareness training around physical and visual cues for work-based stressors in the home.

Recommendation 3 – further research on professional identity of resilience practitioners with particular concentration on how elements of the role can bolster mental health resilience and engender community empowerment (i.e. understanding how a range of roles impact mental health in both staff in the resilience sector and in the wider community).

Recommendation 4 – Awareness raising about the benefits of socio-emotional leadership in hazard event management especially when managing remote workers.

Recommendation 5 – Development of further opportunities for open discussion of mental health in the workplace with particular emphasis on an inclusive, stigma reducing approach.

Recommendation 6 – Analysis and possible revision of services and reporting mechanisms with the goal of providing the broadest opportunity to engage in confidential forms of mental health support.

Recommendation 7 – A defined time limit for responses to staff who communicate mental health issues.

Recommendation 8 – Consideration of a strategy for maintaining dynamic communication across departments, vertically within organisations and with partner organisations.

Recommendation 9 – Phased transition from extraordinary events acknowledging that crises can precipitate personal and professional growth.

Recommendation 10 – Awareness raising around increases in alcohol use for staff working from home and signposting for alcohol abuse support.

Recommendation 11 – Further research on the use of social comparison as a coping strategy for essential services staff.

Recommendation 12 – Further research on the concept of resilience in essential services settings with a view to further developing mental health support.

Recommendation 13 – Further research on the relationship between resilience and trauma and the impact of psychological preparation as it relates to work-based stress.

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Appendix 1

Semi structured Interview Schedule (and prompts)

Background

Could you tell me a little about your job role?

length of service – team size- duties and responsibilities – e.g. managing others

Has your work been altered by the pandemic?

PPE- advice and support- resources- relationships- perception of risk

Question strand 1: How is positive mental health defined and conceptualised?

What comes to mind when I use the term mental health?

Has the pandemic had an impact on your mental health?

Mental health- wellbeing- strategies- self-care -practical steps – traits – personality – learning and growth - reaction- response – coping strategies

depression, anxiety, insomnia, and stress

low controllability and predictability

Ongoing nature of the pandemic, covid as slow trauma

perceptions of social support

How does your social circle effect your mental health?

Family – Friends – lockdown – relationships –

Have there been any changes in how you relate to your work during the pandemic?

personal growth- professional growth- competency – self-perception – self-efficacy.

Assigned to or returning from special covid related role? A life left behind

Effects on teams? Has there been more cohesion, sense of purpose, place, togetherness, cohesion, support, compassion, cross-boundary work

Question strand 2: Barriers and aids.

Have you experienced any barriers in terms of mental health during the pandemic?

Perception -traits – community – culture – anything that has affected your wellbeing

social integration, living in a state of existential threat and uncertainty.

Are there changes that stem from working within your specific organisation?

Prompts – public perception/actions – perception of colleagues - Have hierarchies and boundaries changed? - relationships - new norms – culture

Effect of strategic, tactical, and operational decisions? sensitive leadership? Transparency? Policy, practice, procedure that directly affected mental health.

Do you feel listened to?

Community capital and media perception

What are the most effective ways to foster positive mental health in your opinion?

Prompts- strategies – training? – awareness – resources – self-help

What would be your personal definition of mental health resilience?

Outro

Are there any lessons you'd like to share with other essential services staff in terms of mental health resilience?

Memorials, services of remembrance, cultural rituals

Is there anything else import that you feel that we haven't discussed in terms of mental health resilience?

Do you know where to go within your organisation to access mental health support?

Appendix 2

Letter of invitation to NCR contacts list

You are receiving this email because you are on the NCR mailing list. If you would like to be removed from the list please contact nationalcentreforresilience@glasgow.ac.uk.

Dear

I am writing to invite you to participate in a new research project funded by the National Centre for Resilience (NCR) which focusses on mental health during the COVID-19 pandemic.

The aim of the project is to understand wellbeing, resilience, and recovery from the perspective of essential workers in support roles and to use this knowledge to help inform meaningful and relevant training activities in future.

Participation involves a single online interview with a research psychologist discussing the attitudes, strategies, practices, and policies that have affected your mental health during the pandemic. We are particularly interested in understanding the factors that have supported your wellbeing.

We have identified [enter organisation/role with emphasis on support] staff as particularly underserved by research in this area and would like to ensure that your voice contributes to future research findings.

The attached participant information sheet contains further information on the project, details of what participation entails and your rights if you do agree to speak with us.

I understand that you may be extremely busy at present, so I'm offering broad availability to talk at a time that suits you.

To participate please email me at:

lee.shannon@glasgow.ac.uk.

Best wishes,

Lee