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Book: Wellbeing at Work in a Turbulent Era

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An integrated approach to managing wellbeing in the workplace

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Abstract

Mental health presents a major challenge in the modern workplace and the Covid-19 exacerbated this challenge. In this chapter, we propose the Integrated Organizational Mental Health Resilience Framework, a framework that outlines the steps needed for organizations to develop resilience against turbulence. The development of the framework is based on three case studies conducted during the height of the pandemic. The first case study suggests that primary interventions need to contain flexible work policies and practices need to be in place. The second case study suggests that secondary interventions need to be tailored to the emerging needs of workers during turbulent times and the third case study suggests that there is need to review and adapt policies and practices and provide additional support for the walking wounded of turbulent times, in the case of the pandemic, workers suffering from long COVID, to ensure their sustained employment.

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Mental health is major challenge in the modern workplace. Prior to the Covid-19 pandemic, it was estimated that in the OECD countries, stress, anxiety, and depression affected approximately 15% of employees (OECD, 2014). For approximately half of this group, long-term sickness absence is the consequence (OECD, 2014). Mental health in the workplace is costly. A recent report revealed that in the UK, mental health issues cost UK employers £34.9 billion; the breakdown of these costs were: £10.6 billion were due to sickness absence, £21.2 billion were due to presenteeism (working while ill) and £3.1 billion were due to employees leaving employment due to mental health issues (Parsonage & Saini, 2019). Post-pandemic these figures have only increased, with mental health cost estimates of £53-56 billion (Hampson et al., 2022). Together, these figures call for a comprehensive integrative approach to promoting and protecting mental health in the workplace.

The turbulence created by the recent Covid-19 pandemic highlights even more the importance of organizations having robust policies, practices, and procedures in place that enable quick adaptions to changes in the environment. In the present chapter, we consider these organizational adaptions and develop a research agenda based on three case studies to promote a multi-faceted, integrated approach to manage employee mental health and wellbeing. We propose that resilience is key to managing turbulences in the environment and present the Integrated Organizational Mental Health Framework (IOMHR). We have developed this framework based on three case studies that were conducted at the height of the Covid-19 pandemic. The first case study outlines a preventative approach and demonstrates the importance of developing robust policies and practices on how to prevent poor mental health in the workplace. The second case study presents an approach to addressing emerging mental health issues ensuring mental health provision fits with the needs of employees emerging in turbulent times, and the third case study makes a case for

flexible approaches to novel diseases that require multi-level coordinated approaches to ensure sustainable employment for vulnerable workers.

The first two case studies occurred in the healthcare sector, where employees experienced a dual turbulence, as individuals living through the Covid-19 pandemic, and as workers employed in a sector that was put under extreme pressure during the pandemic. Resources were moved from other departments to the emergency units where Covid-19 patients were treated for multiple issues (Della Monica et al., 2022; Jonsdottir et al., 2021). Healthcare professionals were among the employees at greatest risk of exposure to Covid-19 and their commitment at the forefront of the health emergency exposed them to a growing operational and emotional overload (Della Monica et al., 2022; Gualano et al., 2021), resulting in long-term pressure on healthcare staff, both due to excessive workloads during the pandemic with employees being overworked, but also with long waiting lists in other areas (van Ginneken et al., 2022), resulting in increases in physical, operational, and emotional strain for healthcare employees (Clemente-Suárez et al., 2021).

The third case study focuses on long Covid as an example of an emerging disease that requires a novel approach to workplace support to enable employees to stay at work. According to estimates, one in ten covid patients experience symptoms which last for 12 weeks or longer. This has been termed long Covid (WHO, 2021). It has been suggested that the younger population is more likely to suffer long-term health consequences due to long Covid than to die of Covid-19 (Briggs & Vassall, 2021). Reuschke and Houston (2022) estimated that 0.5% of the working population suffered from long Covid in March 2022 and 3.7% of the workforce suffering from long Covid had left employment. Efforts to manage long Covid focus on the assessment and treatment of the disease rather than on the support

needed to retain long Covid employees in the workplace (Akbarialiabad et al., 2021; NHS England, 2021). Long Covid has significantly impacted the working population and thus requires the development of appropriate strategies for how to effectively manage long Covid and similar viruses in the workplace.

Protecting and promoting mental health and wellbeing in the workplace

Interventions to prevent harm and to protect and promote mental health and wellbeing in the workplace, require attention to the full range of mental health and wellbeing states employees experience and they should ideally address both work-related and other mental health problems (LaMontagne et al., 2014; Petrie et al., 2018). For employees with no history of mental health problems, prevention is the most important. For those with developing mental health problems, early intervention is most beneficial; and for those with diagnosable disorders, access to support and treatment is key. Strategies to address these illustrative scenarios (and more) should be multi-faceted and performed by a range of workplace stakeholders (e.g., employers, unions, occupational health professionals, business service providers; Petrie et al., 2018).

Interventions are often classified as primary, secondary, or tertiary. Primary interventions aim at modifying or eliminating the causes of poor mental health and wellbeing, by reducing the negative impact of the working environment on mental health and wellbeing (Randall & Nielsen, 2010). These types of interventions are also known as organizational interventions, occupational health interventions, job re-design interventions, psychosocial interventions, or work environment interventions (Randall & Nielsen, 2010). They aim to improve employee mental health and wellbeing through making changes to the way work is organized, designed, and managed (Nielsen, 2013). Common examples of such

changes include introducing flexible working practices and work time scheduling or changing job tasks (Fox et al., 2021). Such interventions may also take a participatory approach to changing working conditions whereby employees, managers, and other organizational stakeholders (e.g., Human Resources, HR), jointly decide what changes to make (Fox et al., 2021). Secondary interventions aim to reduce the severity of poor mental health symptoms before they reach a critical stage (Randall & Nielsen, 2010). Such interventions aim to break or weaken the link between the exposure to adverse working conditions and their impact on employee mental health by changing employees' reactions to the environment and enabling them to feel, think and or behave differently in the workplace. The focus of secondary interventions is on providing employees with the skills to manage the adverse conditions they face in the workplace. Secondary interventions often take the form of training (Randall & Nielsen, 2010) and include for example mindfulness training, stress management training, or training on job crafting.

Tertiary interventions are reactive and aim to improve poor mental health for employees who have "fallen off the cliff" and return to work after long-term sickness absence (Randall & Nielsen, 2010). They often take the form of rehabilitation or return to work support (LaMontagne et al., 2014) and include making work adjustments to keep employees at work. Support is provided to enable returned employees to manage their symptoms while working and this avoid taking sick leave (Joyce, 2013).

A framework that combines these three threads, and delivers provision and evaluates the impact across all three threads to ensure employee mental health and wellbeing, is particularly pertinent in times of turbulence and insecurity. We thus suggest that during turbulent times effective strategies to protect and promote mental health and

wellbeing include: (i) protecting mental health by reducing work-related and other risk factors for mental health problems; also known as the *preventative approach*, (ii) promoting mental health and wellbeing by developing the positive aspects of work as well as employee strengths and positive capacities, and (iii) responding to mental health problems as they manifest at work regardless of cause (work-related or otherwise; LaMontagne et al., 2014). An integrated approach to managing mental health and wellbeing is vital in times of instability and uncertainty, when employees with no history of mental health problems are at risk of developing new illnesses, and those with pre-existing mental health issues are at risk of their condition worsening (Neelam, Duddu, Anyim, Neelam & Lewis, 2021).

Recent events such as the Covid-19 pandemic have had a profound influence on the world of work and this calls for a revised research agenda on how we can more effectively prevent harm and promote and protect mental health in the workplace. In this chapter, we draw on three case studies, conducted during the pandemic, to suggest a new framework for managing employee mental health and wellbeing during turbulent times. The case studies focus on primary, secondary and tertiary interventions, respectively. In the following sections, we first discuss the key results of these three case studies and then consider them together in a framework for the improved promotion and protection of mental health and wellbeing in the workplace.

Preventing harm and poor mental health and wellbeing during turbulent times

The first case study was a primary intervention in the Italian healthcare sector aimed at investigating how health care organizations manage psychosocial risk factors assessment to create healthier workplaces. The existing literature on primary interventions has largely focused on employees, as the targets of such interventions. However, such interventions

often employ a participatory approach to ensure the changes to work policies, practices and procedures address the most pertinent psychosocial risks (Nielsen & Randall, 2012). To enable the participatory approach, it is recommended that a steering group is established that oversees the intervention process and the subsequent actions that are developed and implemented. Key members of such steering groups are managers, HR, occupational and health and safety representatives, with the latter representing the interests of employees (Nielsen et al., 2010). It is also recommended that a project champion takes overall responsibility for driving the intervention process; such champions also play a key role in ensuring the steering groups functions well (Nielsen et al., 2010). Despite the important role of these key actors in relation to the effectiveness of the intervention, there is a lack of studies focusing on the experiences of target key stakeholders such as this steering group's members.

In this case study, we focused on the experiences of the health and safety representative and the project champion, an internal occupational health consultant, to better understand how they perceived the challenges and opportunities of implementing a primary intervention during times of turbulence and uncertainty. We term this process evaluation of steering group members' reflections of the overall intervention process a 'meta-process evaluation'.

We conducted qualitative interviews with the health and safety representative and the internal consultant on the steering group, exploring their perceptions of each phase of the intervention (Nielsen et al., 2010). Primary interventions comprise of five phases (preparation, screening, action planning, implementation, and evaluation) occurring in a continual process and it is important to understand how each phase influences the

intervention's outcomes. We used a realist evaluation approach (Pawson & Tilley, 1997), which is a theory-driven approach that attempts to answer three main questions: what works, for whom, and in which circumstances (Nielsen & Abildgaard, 2013). This approach allows researchers to gain insight into the complex processes of organizational interventions and may be used to develop supportive activities to ensure successful implementation of the intervention (Nielsen & Randall, 2013).

Two different hospitals in one trust employing 3,656 workers conducted a psychosocial risk management process, a process required by the Italian national safety law. The employees were categorized into 57 homogeneous groups (groups of employees exposed to similar psychosocial work conditions) based on operative units of 30 to 230 employees in each unit. Each interview lasted approximately 100 minutes and were recorded and transcribed ad verbatim. The results of the interviews showed a main overarching influence of the pandemic on all the aspects related to the psychosocial risk management process. Specifically, because of the outbreak of the pandemic, the main and only focus of the organization was related to the physical safety of the employees with less of a focus on mental health and wellbeing. Organizational communication focused entirely on the risks of contracting Covid-19. During turbulent and insecure times, it is important also to consider how organizational changes such as moving staff across departments, allocating them new responsibilities, and exposing them to high risks influence employees' mental health and wellbeing (de Jong et al., 2016).

The interviews focused on two main categories of issues related to the intervention: technical and managerial issues. Technical issues primarily concerned risk assessment. The interviews revealed issues related to the Italian Workers Compensations Authority's (INAIL)

tools to conduct the risk assessment, i.e., the survey and the feedback tools provided by INAIL. Collecting data such as sickness absence rates, injuries, and incidents is time consuming and requires specific and highly proficient data management skills that are not always present in an organization. The Italian approach to psychosocial risk management requires the steering groups to identify homogenous groups. Survey results are then analyzed based on these homogenous groups and the results reported back to the organizations. However, in practice, the homogenous groups were often not easy to identify on the official organizational charts, making it difficult to develop appropriate action. For example, the steering group identified a homogenous group of nurses that rotated between different departments of the hospital (and thus had different managers and work practices and procedures), which meant that it was difficult to understand the results of this group as they had very different work experiences.

The safety representative and the project champion felt that the databases and software used by the organizations should be developed to allow for the consideration of not only the content of the work (e.g., whether an employee is a nurse or a doctor) but also the potential different exposure to psychosocial risks in the workplace (for example, if the person rotates between departments or not). This is extremely important for the success of the organizational intervention process, as it would improve the accurate definition of the homogenous groups at the beginning of the project. These groups were often based on formal organizational structures and not on employees' actual exposure to psychosocial risks. Such flexibility is particularly important during turbulent times where staff may be moved to emergency departments at short notice and be allocated new work responsibilities.

The identified managerial issues related to the intervention focused on communication and management of the interventions. Communication has been identified as an important aspect of many organizational interventions (e.g., Cox et al., 2000; Nielsen, in press). Accordingly, our interviews indicated that communication can directly influence the psychosocial risk management process at many different levels. Communication influenced participants' engagement as many employees were concerned about the anonymity of their responses to the online survey, and thus the survey failed to produce satisfactory response rates. In response to these concerns, the process was adjusted to include the distribution of paper and pencil questionnaires. This result highlights the important role of the members of the steering group in defining a good communication plan that involves managers and supervisors disseminating the relevant information about the process and why employee involvement is relevant.

Another important aspect raised was the management of the initiatives related to the action-planning and implementation phases. Participants reported challenges related to defining initiatives based on the results of the first phases for two main reasons. First, not all the members of the steering group agreed on what should be the initiatives, how they should be implemented, and whom the initiatives should target. This disagreement can easily occur as each member of the steering group members represents the interests of different groups. Second, once the initiatives have been decided, the line managers, if not involved directly, could negatively influence the success of the initiatives jeopardizing the success of the entire process (Christensen et al., 2019).

These results emphasize how organizational interventions are complex. One solution is the development of meta-process evaluation instruments such as the semi-structured

interviews conducted as part of this study. Meta-process evaluation may assist organizations in achieving the intervention goals. In addition, monitoring, step-by-step actions could also counteract the change of people in specific roles, as career transitions are becoming more and more frequent (De Vos et al., 2021). The use of the meta-process evaluation instruments should be accompanied by a culture of monitoring the process and making suitable adjustments to the process to ensure long-term learning about how to best manage psychosocial risks.

Supporting employees at risk for poor mental health and wellbeing

The second case study was a secondary intervention in the healthcare sector in Italy due to the impact of the pandemic on this sector. Particularly during the first phase of the Covid-19 pandemic, there was a need for providing immediate interventions to provide individualized psychological support for healthcare employees. The adoption of secondary interventions, such as individualized psychological support, is crucial to protect the mental health of healthcare workers. Their mental well-being is at risk due to organizational and contextual factors that cannot be immediately modified through primary prevention measures. Secondary interventions help to cope with stress, maintain the effectiveness of the healthcare professionals, reduce the risk of burnout, and foster resilience in an extremely challenging and uncertain work environment.

In response to this need, INAIL, in collaboration with the Italian Council of the Order of Psychologists, implemented an initiative aimed at providing psychological support to healthcare professionals to enable them to manage stress and prevent burnout. The main strategies employed related to individual employee's coping, adaptation, recovery, and developing interventions appropriate to the situation. Healthcare organizations were

encouraged to establish internal emergency units with a taskforce of psychologists. Units aimed to provide psychological and psychosocial interventions to support and assist the healthcare employees by listening to their needs and responding to their psychological problems.

The target of this secondary intervention were all healthcare employees working on the frontline, who had a high risk of contracting Covid-19. The intervention was promoted with the aim of foreseeing needs and mental problems that may arise in healthcare employees during the Covid-19 pandemic. This intervention aligned with the recommendations of the European Strategy on Health and Safety at work 2021- 2027 (European Commission, 2021) that calls for anticipating emerging risks for employees. Moreover, the purpose of the intervention was to provide psychological support and tools to the employees and to respond to the emergency by taking advantage of resources already present at the local level.

An anonymized psychological triage checklist was developed to collect data about the support delivered to healthcare professionals. The checklist consisted of three main sections: 1) to collect information on the organization and the psychologists involved in the unit; 2) to profile the applicant including personal details, role, and work unit; 3) to register the main psychological problems that the applicants were experiencing due to the direct and/or indirect exposure to the pandemic event. Particularly, the psychologists reported information about previous mental illness and/or psychopharmacological treatments, which type of reaction to the Covid-19 the applicant reported (e.g., anxiety, depression, and psychosomatic disorders), main psychological resources adopted in terms of coping styles (e.g., task-focused, emotion-focused, avoidance-focused; Endler & Parker, 1990). A

summary of the key points, actions provided and indications for eventual follow-up interviews were also reported in each checklist.

Data collected using the checklist were shared with INAIL's researchers for an in-depth analysis about the mental health level of the healthcare employees, their common reactions to the Covid-19 emergency, the personal resources put in place, and the main interventions and actions implemented. Data were collected from February to December 2020 from 556 employees who approached the psychological support unit in their own hospital. Findings highlighted that moderate and severe anxiety symptoms were the most frequent reactions to Covid-19, followed by depression and psychosomatic symptoms. The experience of previous psychological illness was an important predictor of depression, anxiety, and psychosomatic symptoms during the pandemic; thus, the pandemic had a higher impact for individuals with latent mental disorders (Clemente-Suárez et al.2021).

No significant differences were found between those working in Covid-19 and non-Covid-19 units. This result is consistent with other studies reporting that direct contact with patients with Covid-19 was not associated with worse mental health outcomes among healthcare employees, but nurses reported more psychosomatic disorders compared to physicians (Tamrakar et al. 2021; Tiete et al. 2021).

Different reactions in terms of psychological resources also emerged. Emotion-focused and avoidance coping styles were associated with higher levels of anxiety and psychosomatic disorders, while only an emotion-focused coping style was associated with higher levels of depression. Although we were unable to directly assess the effectiveness of the psychological support for the employees' health, this type of secondary intervention demonstrates practical implications in terms of the interventions that may be adopted by

the hospitals. Actions orientated to support employees such as training courses, improved communication, and psychotherapy were implemented. Moreover, evidence from this data help to identify sensitive and at-risk groups and manage mental health in the post-Covid turbulent times.

This case study illustrates how secondary level interventions aim to improve employees' resources and should be considered essential when potential sources of stress, burnout, and depression cannot be eliminated at the source, or the situation requires employees to work in highly demanding conditions, as is the case of healthcare employees during the pandemic.

Promoting sustainable return to work for employees with long Covid

The third case study focused on the need for a tertiary intervention for employees experiencing long Covid across a range of occupational sectors. Common symptoms of long Covid include fatigue, breathlessness, muscle pain, joint pain, headache and cognitive impairment, memory loss, anxiety, and sleep disorders (Akbarialiabad et al., 2021). As a new condition, with no clearly established pathogenesis and agreed treatment plan, employees with long Covid faced (and many continue to face) periods of great uncertainty as they wait for a diagnosis and a treatment plan to support them in recovering their health and sustaining their work performance. We interviewed a sample of 14 employees with long Covid and conducted round table focus groups with 43 professionals who supported these and other employees with long Covid. These professionals included occupational health and human resource practitioners, employment support and vocational rehabilitation professionals, physiotherapists, occupational therapists, and line managers. The interviews aimed to identify the specific needs for the return to work and the retention of employees

with long Covid. Interviews were transcribed and comprehensive verbatim notes were taken during the focus groups. Thematic analysis was conducted to analyse the data, using the Individual, Group, Leader, Organizational and overarching context (IGLOo) Framework (Nielsen et al., 2018) as a guiding heuristic, followed by inductive analysis to identify discrete sub-themes.

Our findings highlighted the struggle experienced by employees with long Covid. The experiences described by employees, and those providing them with support, echoed the experiences of employees with other long-term health conditions, particularly employees with fluctuating conditions. Thus, it was clear that pathways to diagnosis are slow, access to support is variable, and the disconnect between healthcare and work is not conducive to supporting employees to stay in, or return to, work.

At the individual level, employees and professionals described that recovery accelerated following the formal acceptance of reduced work functioning. Many employees described transitioning through a period of denial and frustration, setting unrealistic and unkind expectations of themselves, noting that pacing and energy management required self-discipline. Those that recovered well were those who were able to put in place clear boundaries between work and home, enabling them to rest and restore and thereby preventing relapse.

At the group level, colleagues played a vital role in restoring employees' confidence through the provision of practical support, such as stepping in to support employees with difficult work tasks, or tasks requiring significant personal energy. Notably, professionals described that where work groups were nuanced in supporting wellbeing more broadly,

routinely discussing mental health and wellbeing needs, these groups were seen to be more proactive in their support of the employee with long Covid.

At the leader level, many of the barriers and facilitators to work sustainability reported by the employees with long Covid, were similar to those identified in relation to work sustainability for employees with mental ill health (Nielsen & Yarker, 2022, 2023a). Too often line managers expected employees to return (prematurely) to full workloads, often including lagged work that had built up in their absence. Professionals reported that many line managers were impatient, frustrated by their employee's slow and fluctuating recovery, and waited for their employees to present a formal diagnosis with a clear specification for work adjustments before fully realizing the employee's needs and adjusting their work. Work sustainability was found to be facilitated where line managers adopted a symptom-led approach, were flexible and responsive to the day-to-day needs of the employee, and where they regularly checked-in with the employee.

At the organizational level, the rigidity of absence management policies and practices was a significant barrier to sustainable work. Many employees and professionals described that absence triggers resulted in them experiencing uncertainty and disciplinary procedures. There was a strong recognition that the changes to the ways of working caused by Covid-19, and the pressures that this placed on HR and health and safety functions within organizations, limited the resources available to support employees' absence management – which is often poorly managed even under normal working circumstances.

External resources were reported to be invaluable for both the employees with long Covid and the professionals supporting them. As a new condition, there was a sense of 'muddling through' and relying on previous experience. Where employees were able to

access support from family and friends, in the form of compassionate understanding or practical support, such as helping with food and travel, they described more positive experiences of sustaining their work requirements. External support groups were utilized to source vital learnings on the impact of long Covid on individual health, functioning, and work ability. The most consistent and pervasive challenge identified by these participants was the pathway to diagnosis and support. None of the participants or professionals, described an effective and straight-forward healthcare pathway. In all instances, employees reported long waiting times to see healthcare professionals, sometimes up to six months, and experienced disconnected care whereby they were transferred from one specialist to another, without a holistic consideration of the myriad of symptoms they were experiencing. This study was conducted in the middle of the pandemic, and it is noted that long Covid clinics have since been established across the UK. However, it is recognised that access to these clinics is variable and limited (Gorna et al., 2021).

Both employees and professionals noted a lack of understanding of the condition and its impact which influenced their ability to access resources. Many employees described having a minimal understanding of their condition and sought resources to accept their situation and focus on recovery. Similarly, their colleagues and line managers also lacked an understanding of long Covid and their behaviour was reported as a significant barrier to employees with long Covid sustaining work. The impact of this lack of understanding varied from overlooking the impact of fatigue on the individual's need for regular breaks, to open cynicism that long Covid was not a 'real' condition, thereby preventing opportunities for pacing and recovery. Our findings suggest that employers were generally slow to mobilise resources to support employees with long Covid, and any action taken was piece-meal and reactive.

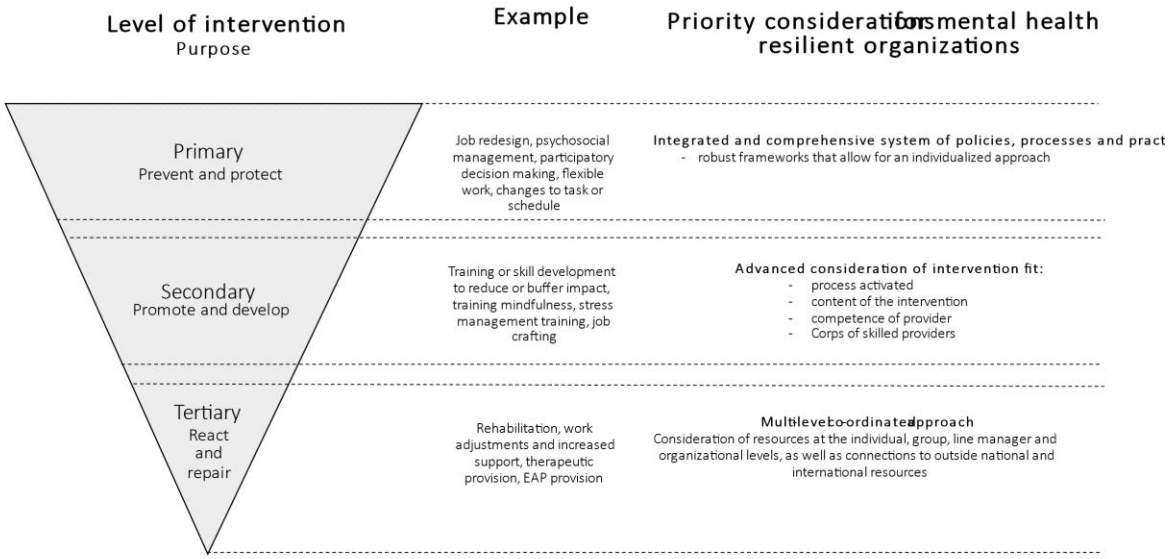
The Integrated Organizational Mental Health Resilience Framework (IOMHRF)

Together, the three case studies call for the development of an integrated approach to organizational resilience in relation to mental health practices. Organizational resilience in relation to managing mental health in the workplace refers to the organization's ability to anticipate unexpecting events and to develop effective monitoring systems. Such systems enhance the organization's ability to identify unexpected events sooner, effectively put processes and practices in place to address the challenges of turbulence and build capabilities for a recovery from unexpected events (Vogus et al., 2007).

In light of the above, we developed the *Integrated Organizational Mental Health Resilience Framework* (IOMHRF). The framework integrates the three types of intervention: primary, secondary, and tertiary. While some larger, well-resourced, organizations may have many interventions at each of these levels in place, our research suggests that gaps remain and limit their resilience to future turbulence.

For each type we discuss the most important factors to consider when aiming to develop organizational resilience. Improving resilience enables organizations to address key challenges and emerge from a situation strengthened and more resourceful (Vogus & Sutcliffe, 2007). It is important to note that there is not one-size fits all formula to achieve organizational resilience, but each organization is best to develop its own systems, processes, and functions to develop the necessary capabilities to most effectively manage turbulence and insecurity (Horne, 1997). Organizational resilience is contingent to policies, practices and procedures that promote competence and efficacy (Vogus & Sutcliffe, 2007). For an overview of the IOMHRF, see figure 1.

Figure 1: **The Integrated Organizational Mental Health Resilience Framework**



We argue that if the mental health and wellbeing of employees is effectively managed then employees will also be productive (Nielsen et al., 2017). We propose that organizational resilience will occur if organizations develop comprehensive policies, procedures and practices that balance the need for an individualized and targeted approach that fit the needs of the organization to ensure a healthy workforce, together with the needs to enable employees to be productive at work and provide a high-quality service or product.

Primary interventions

As shown in Figure 1, the first level refers to primary interventions. These interventions focus on how work is organized, designed, and managed and are therefore, fundamental to provide better working conditions for employees. Primary interventions can have a preventative function and thus, are especially essential in turbulent times, when

organizations experience sudden external events such as pandemics or wars. In these turbulent situations, an organization's health and resilience is crucial to successfully manage contextual demands. For primary interventions to be effective and foster organizational resilience, we argue that it is important to focus on three different, but intertwined organizational aspects: policies, procedures, and practices.

At the policy level, it is important that organizations prepare emergency plans. As various kind of emergencies occur more frequently, organizations should develop these plans ready to be implemented at the appropriate time for the organization to proactively manage emergencies. This plan requires a clear mapping and definition of all the resources (both human and economic) in the organizations that could be involved in an emergency response. In a qualitative study of the dimensions of effective organizational emergency management using the covid-19 pandemic as a case, Atkinson et al. (2021) identified seven dimension of effective healthcare emergency management: (1) identification of capable leaders; (2) assurance of institutional support; (3) the design of tiered communications systems; (4) initiation of incident command system to delineate roles and responsibilities; (5) promotion of collaboration and team building; (6) initiation of training and exercises; and (7) balance between structure and flexibility. These dimensions could usefully provide a framework for organizations of all sizes and sectors to review the resources required across a range of scenarios (e.g. climate change, civil unrest, pandemic) to aid preparedness.

Moreover, as organizations are increasingly complex, it is important to develop organizational interventions which consider both an overall strategy and a multi-level strategy. Primary intervention needs to be integrated into daily business and work practices

so that employee mental health and wellbeing becomes part of day-to-day discussions, for example as a part of meetings. Von Thiele Schwarz et al (2017) suggested integrating mental health and wellbeing considerations into continuous improvement systems. Effective organizational interventions are also based on an understanding of the complexity of mental health and wellbeing. Organizations should understand that mental health and wellbeing interventions are often related to potential stigmatization processes, thus at the policy level it is important to provide appropriate initiatives to minimize stigmatisation. In many countries, legislation protect against discrimination (e.g., UK The Equality Act, 2010 or the EU Directive 2000/78), however, concrete initiatives are needed to ensure the translation of policy into practice at the organizational level.

At the procedure level, it is important that organizations conduct a needs analysis to inform training initiatives aimed to develop skills and competencies, especially of the members of the steering committee who will manage the organizational interventions and those involved in enacting emergency plans. Procedures should include also a clear and dedicated communication plan. Organizational interventions should also include the implementation of procedures that facilitate the monitoring of the activities of the organizational interventions, in order to guarantee that the organizational intervention is occurring as planned and that all those involved are taking action to successfully deliver the intervention.

Lastly, at the practice level, organizations should provide the involvement of people from different departments of the organizations at the right time and should clearly allocate the needed resources for the interventions to be effective. Organizational interventions are

long-term processes that require a large amount of time and effort from different employees, thus specific resources in terms of people involved, dedicated time, and specific competences required, should be identified, and managed upstream. Moreover, organizational interventions should sustain the commitment to change of the employees and all the stakeholders involved.

Secondary interventions

In turbulent times, secondary interventions for protecting mental health and wellbeing are essential, particularly when the sources of poor mental health cannot be immediately managed, eliminated, or mitigated. To be effective, secondary level interventions should meet their proposed aims. This calls for consideration of four different components of 'intervention fit': 1) the process activated by the intervention; 2) the content of the intervention, 3) the competencies needed for the intervention delivery and 4) and the availability of a corps of resources skilled to deliver the intervention.

First, at the process level, the range of interventions must fit the needs identified to protect employees' mental health and wellbeing. Sometimes secondary interventions are too general and do not target the issues experienced in the organizations, including off-the-shelf components such as general mindfulness training versus tailored bereavement training. Moreover, it is essential to prioritize time for participation to ensure employees have enough time in their daily activity to take part in the assessment.

The second aspect of fit is related to the content. Even if the range of interventions fall into the needs identified, the content of the interventions is often too general. Interventions should be tailored to the specific needs identified. As an example, when some issues concerning management support are identified and a training course for line managers

is considered, then the training must focus on the specific (supportive) leadership skills needed, and not on leadership styles in general.

A lack of fit of the content is closely related to the third level of fit, namely the level of competencies of those delivering secondary interventions. Mapping of the competencies of intervention providers would help in case of emergency to identify and activate immediately the correct trainer, as in the case reported above in this chapter. It is important to have an overview of the cross-organizational resource persons that can be activated at short notice. Mapping the competencies present in an organization is a useful exercise to identify who might be best suited to provide tailored emergency training. Co-operative groups could be created by selecting one emergency reference person in each department who in times of emergency will engage in a coordinated response. Existing roles such as health and safety or union representatives could be expanded. An intra-departmental group could help in collecting competencies, identifying specific needs, and facilitating communication into the organization and this could increase the level of awareness of employees of secondary interventions put in place.

Tertiary interventions

The final level of interventions are the tertiary interventions, addressing the identified health problems of employees. Effective tertiary interventions adopt a multi-level coordinated approach, moving beyond the siloed and reactive provision currently experienced by many employees. In line with the results of our qualitative study, we propose that actions need to be taken at the IGLOo levels.

At the individual level, organizations need to offer improved support for employees to stay at work or return to work after long-term sickness absence. This support can take the form of training to build employees' resources. First, interventions should aim to build

employees' ability to identify which work adjustments are needed to enable them to manage their symptoms successfully while working, and communicate the needs to occupational health, HR, and to their managers. Second, employees should be offered interventions that help them to develop awareness about self-care strategies to identify when they risk becoming overwhelmed and be at increased risk for relapse. This for example, includes setting boundaries, time management, energy management and pacing, building awareness of and confidence in requesting work adjustments and job crafting strategies. At the group level, organizations are recommended to develop the group's ability to make rapid adjustments to the working conditions, accounting for the potential reduced work functioning of returned employees.

At the leader level, line managers should be trained in understanding the needs of struggling or returned employees, but also which work adjustments are needed to address these needs post return to work to ensure that employees are supported in the weeks and months following their return. Line managers should develop the competencies to facilitate the discussion about working conditions and how to make ongoing adjustments that meet the needs of the employee at a given point in time, engaging in a dialogue about what changes are required for long-term effective work performance.

At the organizational level, policies, practices, and procedures need to be in place for the lower levels of the IGLOo model to fully support returned employees. This includes providing raising awareness about the dangers of stigmatizing employees and allocating resources to enable groups and line managers to make the necessary adjustments to support struggling or returned employees on a flexible and ongoing basis to in order to respond to changing needs. Procedures should be in place that enable groups and line

managers to report when issues arise, and tailored, ongoing support should be in place once issues are reported. Furthermore, flexible work policies should be in place that enables struggling or returned employees and their managers to make adjustments as and when they are needed in recognition of the fluctuations of the health and wellbeing or employees. Existing policies tend to focus on linear recovery and the pre-return and re-entry periods (Nielsen & Yarker, 2023b).

Organizations should also work with the healthcare system in the overarching context outside the organization, specifically with long Covid clinics. While there is an impetus for employers to better integrate recommendations from healthcare professionals, an effective coordinated approach will not be realized without healthcare professionals placing a greater emphasis on work as a health outcome, this means upskilling healthcare employees to recognise and discuss the impact of symptoms and treatment on cognitive, emotional, and physical functioning as long Covid affects all bodily functions (Davis et al., 2021). Employees should also be provided with direct and anonymous access to qualified providers to ensure they obtain the necessary support via EAPs. Finally, organizations should liaise with community and charity support groups to provide assurances that employees are not alone, and to identify early emerging trends in the experience and solutions of similar unusual occurrences.

Conclusion

It could be argued that the Covid-19 pandemic is a once in a century phenomenon, yet predictions suggest we will see a range of emergencies in the future due to climate changes, wars, and other major viruses. It is, therefore, vital that organizations develop resilience in their approach to mental health. Resilient organizations can meet the

challenges by seeking and analysing relevant information, loosening control to enable rapid adjustments to meet emerging demands and reconfiguring resources. We propose that an integrated and multi-level approach to address employee mental health and wellbeing is required to provide organizations with a robust foundation, integrating primary, secondary and tertiary interventions, upon which they can quickly adapt to emergencies. The Integrated Organizational Mental Health Resilience Framework outlines the priority considerations required to enable organizations to prevent harm and promote and protect employee mental and wellbeing both in times of stability and turbulence.

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