Elevate Series

RESEARCH ARTICLE

Coping during the COVID-19 pandemic: insights from a qualitative study of organizational resilience in an English substance use support service

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ABSTRACT

Introduction: The COVID-19 pandemic posed unprecedented challenges to health and care services, including substance use support, necessitating adaptations to maintain operational continuity. A lack of research exists into the factors that helped substance use services cope and maintain provision. This study aimed to elucidate the organizational resilience factors that assisted a substance use support service in sustaining operations and adapting during the COVID-19 pandemic.

Theory: The study draws on recent conceptual and theoretical developments in the study of organizational resilience, examining findings primarily through the lens of bounce-back and bounce-forward resilience, and Duchek's three-stage framework.

Method: Participants were 36 staff members working for (n=28) or in partnership with (n=8) an organization delivering substance use support services across an area of northern England. A multi-method qualitative approach, including digital timelines (n=19), in-depth interviews (n=18), and five focus groups (n=17), was employed. Timeline text was treated as qualitative text-based data. Interviews and focus groups were recorded and transcribed prior to coding. Data underwent Framework Analysis.

Results: Seven themes were identified: 1) pre-existing relationships and effective multiagency working; 2) prioritization of service delivery; 3) development and implementation of guidance and protocols; 4) autonomy, devolution, and deference to expertise; 5) effective communication, regular meetings, and coordinated decision-making; 6) allowing flexibility and creativity; and 7) development of new and innovative approaches to facilitate the pandemic response.

Discussion: This study identifies resilience factors that substance use and other support organizations should focus on in preparation for potential future crises, to minimise adverse impacts on vulnerable populations.

Introduction

The COVID-19 pandemic resulted in major disruption to the operations of organizations globally, including those delivering essential health and care services (House of Lords Public Services Committee, 2020; World Health Organization, 2022). Organizations adjusted to the adversity caused by the pandemic in a variety of ways. Various studies have described these organizational responses, which include collaborative and joint working; increased use of digital technologies; and adapting systems, routines, and ways of working (Borzaga & Tallarini, 2021; Chui, 2022; Corbaz-Kurth et al., 2022; Fischer et al., 2023; Matysek-Jędrych et al., 2024; Orru et al., 2021; Paeffgen, 2022; Shaw et al., 2022).

Organizational resilience is a key concept used to describe an organization's ability to adjust to, respond to, and ultimately cope with adverse conditions and circumstances (Duchek, 2020; Lengnick-Hall et al., 2011;

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Sutcliffe & Vogus, 2003). The concept is often explored in the context of crises and 'low-chance, high-impact' events (Lloyd-Smith, 2020b) such as terrorist attacks, financial crashes, earthquakes, and other natural disasters, and has recently been applied to the COVID-19 pandemic. Organizational resilience terminology includes multiple definitions, and scholars have been critical about the lack of conceptual clarity (Béné et al., 2012; Duchek, 2020; Hillmann & Guenther, 2021; Vakilzadeh & Haase, 2021).

Despite the conceptual muddiness, a common feature of much organizational resilience literature is a dual conceptualization that comprises the concepts of 'bounce back' and 'bounce forward' resilience (Siambabala et al., 2011). The former refers to an organization's capacity to resist change or return to its original state of equilibrium following an adverse challenge or crisis (Oppong Banahene et al., 2014). The latter defines organizational resilience as the capacity for reorganisation and development, focusing on organisations taking advantage of crises and achieving a new equilibrium derived from structures and practices occurring as part of the crisis response (MacKinnon & Derickson, 2013; Shen et al., 2023).

Another key distinction found in literature on the topic is that of 'precursor' and 'recovery' resilience. This introduces a time component into the understanding of bounce-back resilience, distinguishing between resilience that either acts in a precursory way to achieve bounce-back by preventing escalation into full blown crises or catastrophic failure (precursor resilience), or later to enable recovery and rebuilding of systems (recovery resilience) (Boin & van Eeten, 2013).

Recent definitional work, notably by Duchek (Duchek, 2020), has provided additional clarity about the concept of organizational resilience. Duchek integrates previous conceptualizations and proposes a three-stage framework incorporating 'anticipation' (proactive action before the unanticipated event that enhances the organization's overall ability to cope); 'coping' (development and implementation of solutions during the event); and 'adaptation' (that takes place after the event, characterized by reflection and learning). For this study, we adopt Duchek's definition of organizational resilience as an 'organization's ability to anticipate potential threats, to cope effectively with adverse events, and to adapt to changing conditions' (Duchek, 2020, p. 220). For simplicity, our interpretation of the qualitative findings in terms of organizational resilience focuses on the key distinctions highlighted between bounce-back (including precursor and recovery) and bounce-forward resilience, and Duchek's three-stage conceptualisation (Duchek, 2020) which relates closely (see Figure 1).

Central to the study of organizational resilience is the desire to understand what enables some organizations to cope more successfully than others in the face of adversity (Sutcliffe & Vogus, 2003). Research has identified various factors that support organizational resilience and coping during crises, including organizational leadership, organizational culture, networks, relationships, and social capital; organizational structure; organizational flexibility; informal coordination during crises; creative use of resources; systems and structures; and a shared understanding of the challenges faced (Boin & van Eeten, 2013; Broekema et al., 2017; Cheese, 2016; Lloyd-Smith, 2020; Neal & Phillips, 1995; Shaw et al., 2022; Zahari et al., 2022). However, studies have tended to focus on the private sector and for-profit organizations, and relatively few have explored the operation of public and third-sector organizations to understand what contributes to their ability to be resilient (Bracci & Tallaki, 2021; Liñares-Zegarra & Wilson, 2024). Similarly, to our knowledge, no studies have investigated organizational resilience in an organization delivering substance use support services. Organizational resilience is highly context-specific (Leite & Hodgkinson, 2023) and while learning from other sectors, types of organization, and areas of service delivery, can be a useful
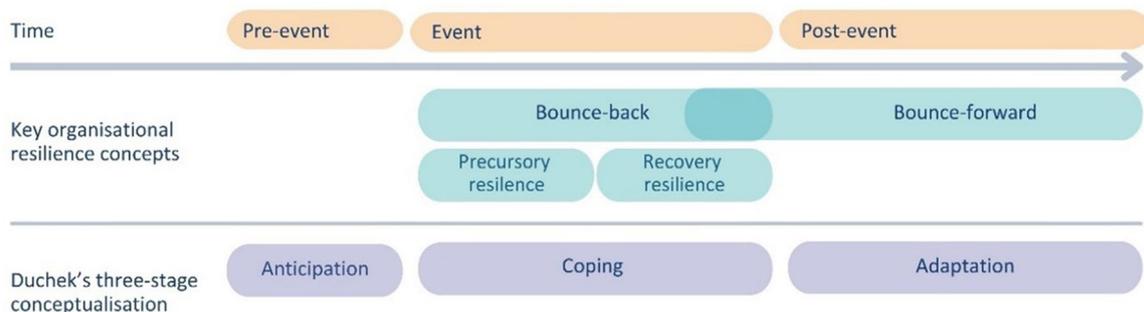

Figure 1. Relationship between organisational resilience concepts to be used for interpretation of findings.

starting point, it is important to understand organizational resilience from a sector and service specific standpoint to generate findings of the greatest practical significance and utility. While studies have explored factors important in improving the resilience of national and global health systems (Forsgren et al., 2022; Haldane et al., 2021; Sagan et al., 2023) and broad areas of health care delivery, such as primary care (Mosadeghrad et al., 2024) and public health (Ryan et al., 2023), the context-specific nature of organizational resilience means that a study focused on substance use services is necessary to understand organizational resilience within this distinct area of health service delivery.

The current study draws on the experiences of a not-for-profit organization commissioned by a local government organization to deliver drug and alcohol treatment services on its behalf across a large metropolitan area in northern England. The organization, referred to for the remainder of this paper as the 'lead organization,' delivers services through collaborative work with other public and not-for-profit organizations. The lead organization is part of a larger, not-for-profit organization that delivers substance use services across England (henceforth referred to as the 'parent organization'). Services offered include information and advice; harm reduction initiatives; health screening; one-to-one intervention via a support worker; opioid substitution therapy (OST); psychosocial interventions; detoxification services; and relapse prevention support. Substance use support services were required throughout the COVID-19 pandemic, and to maintain service delivery, the lead organization needed to adapt its practices and significantly reconfigure its operations.

This study explores the lead organization's COVID-19 service delivery experiences through the lens of organizational resilience to help illuminate our understanding of the resilience-promoting factors that helped it cope with the unprecedented and rapidly changing context that defined the pandemic. The aim of the study is to elucidate the organizational resilience factors that assisted the lead organization in sustaining operations and adapting its substance use support services during the COVID-19 pandemic.

The qualitative study described here is part of a wider evaluation that explored the move to remote models of drug and alcohol support during the COVID-19 pandemic (Lloyd et al., 2022) and draws on findings from the analysis of qualitative data collected from service delivery staff. Data focused on the experiences of those receiving substance use support services during the COVID-19 pandemic, the relative advantages and disadvantages of the move to remote service delivery, patterns of service use during the pandemic, and service user outcomes, are considered in forthcoming papers (Brown et al., under review; Lloyd et al., in preparation). In addition, a recent publication has explored the home working experiences of service delivery staff (Lloyd et al., 2025). Findings from our wider evaluation do suggest that the lead organization was able to adapt practice and service delivery to maintain substance use services during the pandemic. Eight per cent more service users engaged with the service in the first year of the pandemic compared with the previous pre-pandemic year and rates of attendance at appointments also increased (Lloyd, et al., in preparation; Smeeton et al., 2022). In addition, although fewer group work sessions were provided for service users during the first year of the pandemic, online group session during the pandemic included a greater number of service users, and service users who engaged in this way were able to attend a greater number of sessions than in the year pre-pandemic (Ibid.). Qualitative findings also indicated that remote delivery of drug and alcohol services during the pandemic was experienced positively by some service users, although various disadvantages were also identified, and it was clear that remote service delivery was not suitable for all service users (Brown et al., under review).

To our knowledge, this is the first study to focus on organizational resilience during the COVID-19 pandemic within an organization delivering substance use support services. We therefore aim to make a novel contribution to the substance use support and public health literatures. Our findings will have relevance for the planning and preparation for future crises of those delivering substance use support services or similar public health provision, by highlighting the resilience factors that assisted the lead organization in coping and maintaining provision during the pandemic, how these factors contributed to service continuity, learning and development, and how resilience and crisis preparedness might be supported in future.

Methods

This article draws on findings from the analysis of qualitative data collected from service delivery staff. The study took a broadly phenomenological approach (Schutz, 1967) to capture the common features of

the phenomenon under study (Starks & Trinidad, 2007) – in this case the experience of service delivery and adaptation during the COVID-19 pandemic. Our qualitative analysis is underpinned by a broad constructivist/interpretivist orientation (Denzin & Lincoln, 2018) acknowledging the role of individuals' experiences and interpretations in the framing of their subjective, constructed realities.

This study used three data collection methods: interactive digital timelines, focus groups, and individual in-depth interviews. The consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007) have been used as a guideline for our reporting.

Registration, ethical approval, and consent

This study adheres to the Declaration of Helsinki. Ethics approval was granted by the University of Hertfordshire Health, Science, Engineering, & Technology Ethics Committee with Delegated Authority (ECDA): aHSK/SF/UH/04423(4).

Staff were consulted during the recruitment planning process to ensure feasibility and acceptability, and the research team attended staff meetings to introduce the study. Managers used emails and internal bulletins to publicise the opportunity to participate, and an information sheet about the study was provided to staff. Staff were then recruited with the assistance of their employing organization, via internal mailing lists, by being provided with an email explaining the nature and purpose of the study that contained a link to the study registration pages on secure REDCap software (Harris et al., 2009). Here, potential participants could read a full participant information sheet, provide informed consent to participate and give basic demographic details. All participants provided written informed consent to participate via REDCap. Participants were assured that whether they registered for or participated in the study would not be shared with their employing organization or anyone outside the research team.

Participants

A total of 47 staff members registered an interest in study participation and 36 were subsequently involved in one or more data collection methods.[1] All participants were aged 18 years or older and were staff (volunteers or salaried employees) working for the lead organization (n = 28) or one of two partner organizations (n = 8). Seventeen had management responsibilities, 16 engaged solely in front-line delivery work, and three held administrative roles. The median time in post at the time of recruitment was five years and three months. Details of participants' age, gender and ethnicity were not collected as they were not deemed directly relevant to the aims of the study.

To maximise participation, all 32 participants registered at the time when timeline data collection was conducted were invited to complete a timeline. Similarly, all 47 participants who had registered an interest in participating by the time focus group recruitment began were invited to take part in a focus group. Maximum variation sampling (Patton, 2015) was used to select a sample to participate in interviews, with the aim of representing as wide a range of job roles, time in post, seniority, experience of working remotely since the start of the pandemic, and substance use category supported (see NDTMS. net) as practicable.

Data collection

Data collection occurred from March to June 2021, and was sequential, beginning with timeline data collection, followed by focus groups and interviews.

Timelines

In March 2021, participants were asked to complete an online timeline using Lucidspark (https://lucidspark.com). A video guide explaining the method of timeline completion, narrated by one of the research team, was circulated to all participants to ensure they understood what was required of them. This platform presented milestones from the start of the COVID-19 lockdown and restrictions (March 2020) until the date of completion. Participants were asked to annotate the timeline with their

descriptions and experiences of changes to substance use services that occurred during this period due to pandemic restrictions. A total of 19 timelines were completed.

Timelines were deemed an appropriate method because we sought to gather data on changes to service delivery during the COVID-19 pandemic and participants' experiences of these. This was likely to involve detailing numerous events and experiences that had occurred over time, and timelines have demonstrated utility in helping participants recount and reflect on their past experiences in an in-depth and detailed manner (Bremner & Li, 2024; Garcia-Iglesias et al., 2023; Mazzetti & Blenkinsopp, 2012).

Visual timelines may be used in a variety of ways and have often been utilized during face-to-face data collection (Baú, 2024). For this study, participants completed an online timeline autonomously, in their own time, as COVID-19 restrictions prevented in-person data collection. One benefit of the autonomous timeline method was that it allowed participants the flexibility to revisit their timeline after initial completion to add additional information, thereby increasing the potential for detailed completion.

Focus groups and interviews

Five focus groups, involving a total of 17 participants, were conducted between April and May 2021. Between two and eight people participated in each focus group, and they lasted between 60 and 100 minutes. Each was facilitated by two researchers.

Eighteen individual in-depth interviews lasting between 40 and 90 minutes were conducted between May and June 2021 and were conducted by one researcher.

Both interviews and focus groups were included to combine the benefits of each method. While individual interviews allow participants to discuss personal experiences they might be reluctant to disclose in a group setting, focus groups can allow additional depth and perspectives to be captured through participant interaction (Lambert & Loiselle, 2008). Additionally, by including both methods, we aimed to increase participants' choice of available method and opportunity to participate.

One focus group comprised only senior managers (n = 3) as it was felt that their participation alongside other staff might limit discussion. The other focus groups were open to all but aligned to one of the four substance use categories.

Interviews and focus groups considered how service delivery had been reconfigured since the start of the pandemic; implementation of remote modes of delivery; experiences of service changes; effectiveness of service delivery during lockdown and factors influencing this; experiences of working during lockdown; and learning for future service delivery. All interview and focus group data were collected remotely via videoconferencing software, with participants' permission given for audio and/or video recording.

Data analysis

Interview and focus group audio recordings were transcribed using a General Data Protection Regulation (GDPR)-compliant service and fully pseudonymized prior to coding using NVivo 12 software (QSR International). All data were stored on a secure server and all data transfer was conducted securely. The data were analyzed using Framework Analysis following the staged process outlined in Table 1 (Gale et al., 2013; Midgley et al., 2015; Target & Midgley, 2016). To preserve the anonymity of participants, all analysis of focus group and interview data that took place was of pseudonymized transcripts.

Results

Seven themes were identified that illuminate our understanding of the factors that assisted the lead organization in coping with the challenges brought about by the COVID-19 pandemic: 1) pre-existing relationships and effective multiagency working; 2) prioritization of service delivery; 3) development and implementation of guidance and protocols; 4) autonomy, devolution, and deference to expertise; 5) effective communication, regular meetings, and coordinated decision-making; 6) allowing flexibility and creativity; and 7) development of new and innovative approaches to facilitate the pandemic response. Each theme represents a distinct resilience-enabling aspect, although there is some conceptual overlap between themes and some participant responses relate to more than one theme.

Table 1. Staged framework analysis process applied to staff data.

Framework stage	Brief description
1. Familiarisation with data	• NL, KB, WW OF, JG-I, IF and CB read through a subset of interview and focus group transcripts.
2. Coding	• Inductive coding of the transcripts to develop an initial list of codes. • Meetings between NL, KB, WW OF, JG-I, IF and CB to discuss and agree initial codes (involving refinement of codes through merging, splitting and relabelling). • Ongoing, inductive coding of additional transcripts alongside deductive coding using codes derived from interview and focus group schedules and research questions. • Deductive coding integrated into analytical framework.
3. Development of analytical framework	• NL and OF develop an initial codebook. • Initial codebook agreed by other team members. • Refinement of codebook through further meetings between NL, OF and IF and discussions to ensure consensus on code names and related definitions. • Involvement of five members of a Public Involvement in Research Group (PIRg) made up of public contributors, using codebook to code an anonymized transcript and then suggesting further refinements and additions. • NL, OF, and IF incorporate amendments resulting from PIRG coding and continue with further transcript review, reaching consensus (via ongoing discussion) regarding a final codebook.
4. Applying analytical framework	• NL, OF, and IF code all transcripts in NVivo 12 using final codebook, and ensure that the final codebook had been applied to all data. • Regular meetings (at least weekly) and daily communication to ensure consistency of codebook application to transcripts and address any coding discrepancies through discussion and consensus.
5. Charting	• NL, OF and IF conduct charting process, led by NL. • Microsoft Excel spreadsheet used to create a framework matrix for focus group and interview data. • A separate Excel spreadsheet is created with the various framework topics listed. This is used by JG-I to organize timeline data according to the topics.
6. Mapping & interpretation	• NL leads the mapping and interpretation process beginning by examining the framework matrix and timeline spreadsheet to create a preliminary list of potential themes. • List is shared with OF and IF who also systematically explore the matrix, identifying themes within and across framework categories. • OF and IF add to and refine themes. • Regular meetings between the NL, OF, and IF and iterative development to reach consensus around a final list of themes.

Table 2. Themes mapped against the concepts of bounce-back and bounce-forward resilience, and Duchek's three-stage model.

Key organisational resilience concepts		Bounce-back	Bounce-forward
		Precursor resilience Recovery resilience	
Duchek's three-stage conceptualisation	Anticipation	Coping	Adaptation
Theme	1.	2; 3; 4; 5; 6	7

Table 2 provides a visual representation of how these themes relate to the concepts of bounce-back and bounce-forward resilience and Duchek's three-stage model.

Theme 1: Pre-existing relationships and effective multiagency working

Participants described the importance of the internal and external working relationships that existed prior to the COVID-19 pandemic to the lead organization's response. Strong working relationships within and between organizational teams had been fostered over time and played an important role in enabling the organization to respond to the challenges of reconfiguring service delivery and maintaining support for service users over the course of the pandemic. In some cases, participants described the strengthening of partnership-working relationships during the pandemic period due to an increased reliance on other teams and organizations.

> So I think the relationships that the managers have, the partnership managers, I think that was already very strong, and that helped us get through with quite open communicative, talk things over, used to problem-solving together, used to putting ideas out there and just exploring them. We do that in a lot of our meetings, so I think that was probably a strength…Ultimately, it was a strong partnership, I think, with a good group of managers that were well-embedded and worked well together…So I think it was a really good, solid partnership as well, [Lead organisation], and I think that was one of its big strengths. (Interview 12, lead organization).

And I think the multiagency work's got tighter through, and I think that's what is one of the big things that needs to stay. We haven't relied on, we've relied on services more and done that joint working and that's allowed things to keep as tightknit as possible. (Participant M3, Focus Group 3)

I think we definitely reaped the benefits of having built up relationships in the past…[Prior to the COVID-19 pandemic] Health came to us, and Housing came to us. So we already had those relationships, and we already had relationships with the police, and with [other local organization]. So they became all the more important [during the pandemic] when you were phoning people, and trying to organise things, to already have those relationships in place, I think, paid dividends. It was a real benefit to have them already. So I think we cashed in on them really well. (Interview 13, lead organization).

Participants discussed the importance of effective internal teamwork, positive staff relations, and the ability to work together in a collegiate manner for allowing their organization to plan, coordinate, and deliver services during the pandemic. They described positive, respectful, solution-focused, working relationships, where staff were focused on shared, mutual goals. The benefits of relationships and ways of working that had been nurtured previously were reaped once the COVID-19 pandemic began.

We're quite good at teamwork. Yeah, well, we've had these sort of team building exercises pre-Covid, and suddenly you're asked to pull together. You have an instructor who has asked you to pull together a sketch, getting across some bizarre message, maybe nothing to do with drugs and alcohol. And in a group of colleagues, from all different levels, seniority, from all different types of work, we seem to be able to quickly pull together an action and come out with some quite innovative stuff. Because we're used to listening to each other, and recognising who is good at what, and not being precious about, oh, that person is a director, that person is a secretary, and that person's an administrator, that person is a nurse. (Interview 6, lead organization)

Our analysis also highlighted strong partnerships and multi-agency working as important for the effective maintenance of services. Pre-existing partnership structures and mechanisms were identified as key, as was a broad partnership working commitment and ethos across organizations. This history and the expectations it gave rise to were cited as important.

Theme 2: Prioritisation of service delivery

The pandemic restrictions that began in the United Kingdom in March 2020 necessitated the rapid reorganisation of substance use support services. Prior to the pandemic, face-to-face provision had been central to service delivery and most substance use support was provided in-person within the lead provider's buildings. Service users would undergo a thorough initial assessment leading to the development of an individualised treatment plan and agreement of treatment and recovery goals. The service user would also be allocated a support worker. The assessment process, ongoing liaison with the support worker, and access to other support services (e.g. individual or group-based therapy) would typically take place in person, with very limited remote support provided to service users in treatment.

The lead organization's reliance on in-person support at the onset of the pandemic meant that pandemic restrictions on in-person contact and the need to severely limit access to buildings, necessitated the scaling back of in-person support, while simultaneously aiming to ensure appropriate provision for service users. In March 2020, the lead organization began a process of prioritization to manage its now restricted capacity for service delivery to ensure adequate provision for those who were most vulnerable, in need, or at risk. Service managers collaborated to develop criteria for prioritization and assessment, as well as treatment pathways for service users with differing degrees of assessed vulnerability. In some cases, specific service users were prioritized for provision (e.g. because of a concern from a clinician). In others, particular client groups were prioritized (e.g. those newly released from prison, new referrals, or those for whom there were safeguarding concerns). Service user vulnerability was assessed by considering various factors. For example, all those exiting prison were prioritized for support, but factors such as time out of treatment, substance use category, and substance use and treatment history, informed whether the service user was deemed particularly vulnerable and therefore prioritized for in-person support. Some services were also suspended or scaled back to enable the continued delivery of others.

So [staff details redacted] worked out a system of prioritising. So there are some - there were some clients who were coming out of prison who we'd never met before, who were really vulnerable. We needed to see

them, to support them, to engage with them. So they were offered to come to site, but other people, per-haps, who we had met before, they hadn't been in prison for very long, it was a short break from their treat-ment. We thought we could reassess them remotely over the phone, and start their prescribing without them actually having to come into the service. So we worked out a kind of a pathway that supported everybody… (Interview 4, lead organization).

Clinical staff reviewed with the support from case managers and clinical admin teams using a Covid Plan to identify what changes to make to pick ups, the most vulnerable remained on some level of supervised con-sumption with support from some pharmacies. (Staff Timeline 8, lead organization).

Our analysis suggests that this prioritization of individuals and services was vital for enabling the lead organization to maintain an adequate level of service delivery in a context in which comprehensive in-person provision was no longer possible.

Development and implementation of guidance and protocols

In the weeks and months following the imposition of lockdown restrictions, the lead organization pro-vided a range of guidance and protocols for staff to help manage service delivery. Our analysis indicated that these were essential for guiding service-related decisions made during the pandemic. Guidance and protocols issued included locally focused versions of national and government guidelines, guidance for the lead organization from its larger parent organization, and guidance produced at a team level via consultations with staff. The topics covered included building management, safeguarding, prescribing processes, and clinical safety.

It [pandemic response] was backed up with support from [lead organisation], who were delivering frameworks to support what we were doing. So, for example, there was a really good premises, health and safety frame-work that came out, and it was massive…So it was a really good checklist, and it gave you some new things to do as well. (Interview 4, lead organization).

Early in the pandemic, it was necessary for the lead organization to develop and implement multiple, wide-ranging protocols and guidance concurrently to manage various areas of work and staff and service user requirements. For example, timeline data illustrate how, prior to the initial lockdown, local pharma-cies informed the lead organization of their need to review opiate substitution therapy (OST) consump-tion procedures due to anticipated future restrictions on in-person contact. This necessitated the development of a COVID contingency plan to manage the consumption process and modifications to risk assessment and safeguarding guidance and procedures.

As the pandemic context developed and protocols and guidance were implemented, these were reviewed and modified, and new ones developed where required, for instance in response to changes in national guidance or developing staff or service user need. Participants highlighted the importance of these protocols and guidance for providing operational direction for the organization, reassurance for staff, and promoting the safety, quality, consistency, and continuity of delivery. Protocol and guidance development was an ongoing, iterative process that required forward planning to address expected developments as the pandemic progressed and ensure adequate provision to support the organisation's planned response.

April 2020: Plan[s] were in place to manage self-isolation, and infections to ensure continuation of treatment… In the event we have confirmed case of Covid19 and full isolation period is recommended, to consider a one off 14 days prescription on a green prescription with support from nominated persons to collect the medica-tion and arrange delivery…Risk Assessments to be updated, usual harm reduction advice to be provided and consideration for Naloxone to be provided…Significant amount of new information and guidance to staff and SU to absorb…May 2020: Support plans initiated for staff who needed to self-isolate…infection control guid-ance issued RE: what PPE to wear for clinical interventions, room ventilation etc increased wall hand sanitisers increased cleaning regimes and new guidance for staff, PPE and cleaning regimes for desks and clinical spaces review of clinical rotas again to accommodate F2F with criteria for most vulnerable clients. (Staff Timeline 7, lead organization)

One of the things that happened very quickly and it's astonishing what can be done was a rapid development of a protocol. There were national guidelines and then they were rapidly turned into local ones, how do we

now manage under these conditions? So we weren't trying to make it up individually, there was some very clear, very rapid ways of different working and that was reassuring to have that because it's an element of if you like professional guidance and protection, you can work within those protocols and then you're fine, rather than "thinking this will be okay won't it?" And that came out within a week, which was astonishing. (Participant M3, Focus Group 3)

Autonomy, devolution, and deference to expertise

Importantly, rather than centrally produced guidance simply being imposed on staff, the lead organization demonstrated a commitment to involving those with the most relevant specialist knowledge in decisions about how best to adapt service delivery. Thus, staff at different levels of seniority and with different roles and specialities were directly or indirectly involved in influencing how services were reconfigured and delivered. This included involvement in discussions and decision-making about service modification and prioritization and in the development of guidance and protocols. The lead organization drew on the views and experience of those with the most relevant knowledge and expertise in particular areas of operation or with particular client groups. Various mechanisms facilitated staff involvement in decision-making processes about how best to adapt services. These included multi-agency meetings, meetings between lead organization managers charged with overseeing service delivery across particular localities, team meetings focused on specific areas of delivery (e.g. particular substance use categories or groups of service users, such as those experiencing homelessness), and one-to-one meetings between managers and operational staff. Participants stated that this staff involvement and deference to expertise was important for ensuring that modifications to service delivery were feasible, practical, and effective, and could meet the varied needs of service users.

'Does - do you want to keep telephone interventions at X, Y and Z?'. So I think that's been quite positive, given the kind of staff's opinions on it as well, because they're the ones, at the end of the day, who are doing it, they're on that frontline and that's so important to have their voice. (Interview 14, lead organization).

[Name redacted] said, look, this meeting is full of [management detail redacted]…No disrespect to anybody, but this group is the wrong group to make this decision. We need some [recovery support workers] on this group to tell us what they're seeing, and what they need. At the next meeting, a week later, we had a [recovery support worker], so there's everyone in the group agreed, and nobody was precious about hierarchy. The [recovery support workers] came on the call and told us what was needed. (Interview 17, lead organization).

So feedback, check-ins, they were all on a regular basis of feedback from each manager to discuss what they were noticing, what changes we might need to make…I would say that our meetings increased somewhat over this first few weeks, so there was a lot of input from a lot of staff, in how to manage this, and what we needed to adapt to and so that's really where it [decision-making] came from. (Participant F1, Focus Group 2, lead organization)

Participants described an appreciation by the parent organization that it could not issue guidance covering every eventuality and context, and by the lead organization that its service was made up of different teams and functions with varying needs. The parent organization allowed the lead organization autonomy to adapt its services to local need within the constraints of the guidance it had issued. Similarly, the lead organization provided teams and staff with some autonomy to interpret and apply its guidance.

So you got that feed down, but, again, a lot of the decision-making was local, because [parent organisation] have so many different types of project, they couldn't tell you exactly what to do in your project, they had to just give you that safe framework… (Interview 4, lead organization).

Effective communication, regular meetings, and coordinated decision-making

Prior to the COVID-19 pandemic, staff within the lead organization participated in regular management and team meetings. These varied in regularity, with some held weekly, fortnightly or monthly, and others on an ad hoc basis. These meetings continued during the pandemic but were typically held remotely via videoconference rather than in person. In addition to these routine meetings, the pandemic necessitated the introduction of additional meetings related to the pandemic response and the reconfiguration of

services. Participants highlighted the importance of regular meetings for facilitating communication between staff and within and between teams, and for enabling effective, coordinated decision-making regarding initial and ongoing service modification.

> I think we had a check-in from a management team every morning, just to check-in and what's going on, what do we need to do? What are the priorities? Who is doing what? What's going well, and what isn't going well? And then communicating that out to the team. (Interview 15, lead organization).

> We all sat down with a prescriber each, and went through the majority, as much of our caseload as we could, to suggest what supervision we thought, what risks were, and were they using. And we sat and discussed each one as quick as we could, so that communication was really good. And it was quite often that we agreed on what could be done, in terms of how much we can reduce someone going to the pharmacy. (Interview 18, lead organization).

Our analysis suggests that the complex nature of drug and alcohol service delivery, which includes multiple, interdependent services, partners, and functions, meant that regular, effective cross-team communication was essential for allowing the organization to coordinate decisions that might affect different areas of delivery. This enabled services to be reconfigured in a way that aimed to minimize the disruption caused by the pandemic and mitigate any potential negative impact on services users.

> Any adjustments that we've made to the [treatment] pathways have generally been done in conjunction with another team, so say for example it might be [name redacted] might come to me and say, particularly during the COVID period, this is what I'm seeing, so for example we're talking about self-isolation, how we're going to manage that, so then we'd talk about how we'd manage that and work with a plan and communicate it. (Participant F1, focus group 2, lead organization)

Allowing flexibility and creativity

The lead organization allowed staff to be flexible and creative in how they reconfigured services, and our analysis suggests that this facilitated the organization's ability to cope. There was recognition that the pandemic presented a uniquely challenging situation — one that was fluid and unpredictable — and necessitated the ability to be flexible and adapt to changing contexts and requirements.

> I think it was necessary, in the early days, to make some very bold decisions and make them very quickly, and be prepared to steamroller through convention, methods. (Interview 6, lead organization)

> We just had to adapt, but that afforded us the autonomy to think how are we going to do this?… And we've been able to adapt quickly to issues coming up, you know. (Participant M1, Focus Group 3, lead organization)

Different service delivery teams faced different pandemic-related challenges, and the needs of service users differed depending on their individual circumstances. In addition, pandemic-related changes in policy and practice, external to the lead organization, impacted its operations and necessitated a flexible response. These included a government scheme to provide temporary accommodation for individuals who were experiencing street homeless, limitations on contact between service users and key partners such as pharmacists, and cessation of some key services delivered by partner organizations. Examples of flexibility and creativity included: one of the lead organization's outreach teams beginning to conduct needs assessments and harm reduction work within hotels used to house those newly placed in temporary accommodation; those who had previously delivered group-based therapeutic work devising alternative strategies for delivering sessions, including rapidly recording new video content to incorporate within online group sessions; and some teams beginning to use social media platforms as a service user engagement tool for the first time. Allowing teams to respond flexibly and devise creative responses to shifting circumstances was important to the organization's ability to cope with change and maintain operations.

> We adapted quite well in that when we had this homeless cohort in hotels we've got a street support team that would go up and offer assessments and harm reduction would be in them hotels as well, and nip in and training, etc, so it was constantly adapting the way we worked, and changed, and quite innovative at times. (Participant M1, focus group 4, lead organization)

Development of new and innovative approaches to facilitate the pandemic response

Our analysis highlighted that the reconfiguration of service delivery in response to the COVID-19 pandemic resulted in the implementation of innovative ways of working that challenged preconceptions about what was feasible in terms of substance use service delivery. Services were delivered in ways that would not have been considered possible prior to the COVID-19 outbreak, with engagement with support services predominantly in-person, routine remote working by staff generally discouraged, and strict adherence to longstanding, formal prescribing rules the norm. Examples of new and innovative approaches included the widespread implementation of remote modes of support; routine homeworking for staff; adaptations to prescribing procedures; and relaxation of rules regarding the supervised consumption of opioid substitute medications. These new ways of working and delivering support, developed out of the flexibility described above, were essential in enabling service delivery to continue.

> Allowing more remote work and more Zoom or Teams, mixed in with a different way of doing face-to-face, naturally increases capacity within an existing model, without having to fully remodel or hire more staff. So it's just pushed things forward a little bit, to go, actually, there's some lessons learned here that it's really speeded up. (Interview 17, lead organization)

> New guidance from work, stop face to face consultations, change existing supervised scripts to unsupervised with increase take home (TTA) medications and long scripts (12 weeks). Big logistic job to create and send scripts out after contacting patients. (Staff Timeline 19, lead organization)

> I think what it's shown us is that we can adapt to a more flexible working approach, and I think for some of our service users that will work quite well…I think where we might have been too prescriptive before, about people have to come in and we have to do this, and we have to do that, what we have learnt is that we can be more flexible, and I'd like to see that approach remain, and then I think we will be able to reach, I think we will be able to provide a more effective pathways and reach more people, and be more person-centred I think… (Participant F1, focus group 4, lead organization)

Individual, team, organizational, and sectoral assumptions were challenged by such changes to practice, resulting in new understandings about the possibilities for service delivery. However, participants sometimes recognized both the merits and drawbacks of these new approaches. Participants typically favoured the post-pandemic retention of certain innovative practices that had arisen from the organization's pandemic response. One example of this is the integration of remote modes of service delivery where suited to client needs and capabilities, and subject to appropriate risk assessment, and this has indeed been retained by the lead organization because it improved the service experience for many. However, some participants felt that other changes, while necessary for the pandemic response, should only be implemented temporarily, as they were not optimal for service delivery, service user safety, or staff well-being. Examples include the relaxation of supervised consumption rules for service users in opiate substitution therapy (OST) and homeworking by the majority of staff members.

Discussion

This study identified seven themes that illuminate our understanding of the resources, behaviours, processes, and strategies (Duchek, 2020) that assisted the lead organization in coping during the COVID-19 pandemic. The organizational resilience concepts introduced earlier, including Duchek's proposed stages (anticipation, coping, and adaptation), were evident. For example, strong working relationships and effective working practices established prior to COVID-19 were among the factors that played an anticipatory role, enhancing the organization's ability to cope once the pandemic began (Theme 1). 'Anticipation' was also apparent in the lead organization's planning for potential pandemic restrictions, which began just prior to the first lockdown and helped prepare for its response during the 'coping' stage.

Most of the identified themes (2–6) relate to the lead organization's 'coping' during the pandemic. Numerous interrelated 'coping' strategies, actions, and resources were used, including prioritized service delivery, service reconfiguration, and new guidance, protocols, and mechanisms for communication. The presence of multiple resilience-enhancing factors may help explain why the identified coping factors related to 'precursory' rather than 'recovery' bounce back resilience. Our analysis suggests that they, alongside anticipatory factors, helped to prevent a pandemic impact that was catastrophic for the

organization's operations, and thus reduced the need for rebuilding of the type that would have been indicative of 'recovery' resilience.

Importantly, an interplay was apparent between the factors that characterized the lead organization's anticipation, coping, and adaptation. Our analysis suggests that anticipatory factors assisted the lead organization in developing and implementing some of the key actions that helped it cope during the COVID-19 (such as those outlined in Themes 2–6), and these coping factors, in turn, appear to support the aspects of adaptation identified in our study (Theme 7). One example is effective team and multia-gency working, which our findings suggest was beneficial to the lead organization's ability to implement aspects of coping such as prioritization of service delivery and coordinated decision-making, and sup-ported flexibility and creativity in service reconfiguration. Our findings suggest that these, in turn, may have help support the development of new and innovative approaches (adaptation). This aligns with Duchek's model of organizational resilience which conceptualizes anticipation, coping, and adaptation as interrelated, and anticipation as helping to build the foundation for an effective coping response during crises, potentially leading to adaptation (Duchek, 2020).

Bounce forward resilience and Duchek's 'adaptation' are clearly evident in the developments that resulted from the organization's pandemic response, notably the establishment of new and innovative ways of working and delivering services. For example, remote delivery of services, routine homeworking by staff, extensive use of technology to facilitate meetings between delivery partners, relaxation of super-vised consumption rules, and modification of prescribing protocols were innovative aspects of delivery that represented drastic shifts in approach. Their implementation resulted in a renewed understanding of the possibilities for service delivery and changed perceptions of how delivery might be best optimized (e.g. recognition that a hybrid in-person/remote delivery might be possible or even optimal). Our find-ings, particularly around the modification of prescribing practices, relaxation of supervised consumption rules, and widespread adoption of remote support, concur with previous research that has found that modifications to assist coping during the COVID-19 pandemic included changes that would previously have been considered 'taboo' (Loblay et al., 2022). As stated earlier, relaxation of supervised consumption rules for those on OST was an area of adaptation that some staff felt should not be retained after the pandemic. Although at the time of data collection, managers and clinical staff stated that they did not yet have clear data on the impact on service users of this relaxation, recent national data on deaths in treatment indicate that in-treatment deaths increased during the pandemic and have yet to returned to pre-pandemic levels (OHID., 2023a). For people in opioid substitution treatment (OST), this national increase in deaths may be linked to reduced supervised consumption (OHID., 2023b), although in-treatment death data for the area under study indicate that deaths were slightly lower than the expected figures (OHID., 2023a). An important point to make is that service adaptations, although potentially necessary during crises, may not always be optimal for service delivery or beneficial for service users.

The resilience-promoting factors highlighted in this study echo many of those identified in previous resilience studies. These include: effective working relationships within and between organisations (Herbane, 2019; Hollands et al., 2024; Linnenluecke & Griffiths, 2013); networks and social capital (Lengnick-Hall et al., 2011; Stötzer et al., 2022); adaptations to systems, service delivery, and working practices (Hollands et al., 2024b); an organisational culture open to learning and change (Broekema et al., 2017; Cheese, 2016; Linnenluecke, 2017); availability of clear guidance (Faraj & Xiao, 2006; Ignatowicz et al., 2023); diffused power and drawing on individuals' knowledge and expertise (Hollands et al., 2024; Lengnick-Hall et al., 2011); organisational pragmatism, flexibility and improvisation (Boin & van Eeten, 2013; Neal & Phillips, 1995; Rerup, 2001; Witmer & Mellinger, 2016); and formal and informal mechanisms and structures for communicating and coordinating the crisis response (Faraj & Xiao, 2006; Lloyd-Smith, 2020c). All of these factors were apparent in the seven themes we identified and together reflected the continuation of existing practice, enhancement and adaptation, and development of new ways of think-ing and operating.

Building the overall resilience of local and national health systems has been identified as a global priority (WHO, 2024), and recent studies have also identified various resilience-enhancing factors import-ant in achieving this. These factors, some of which operate at the macro level, include adequate resourc-ing and finance, effective leadership and coordination, partnership working, openness to innovation and improvisation, digitization, quality healthcare staffing, and the development of local and national

healthcare policies and plans (Forsgren et al., 2022; Haldane et al., 2021; Mosadeghrad et al., 2024; Sagan et al., 2023; Sari et al., 2023; Witter et al., 2023). The impact of some of these was reflected in the current study, where the lead organization's coping strategy was influenced by external factors, such as national guidance on delivery of substance use support services, leadership and guidance provided by the parent organization, and the parent organization's openness to flexibility and adaptation in response to the challenges of the pandemic.

The seven identified themes encompass both service- and system-level elements of the type also identified in Loblay et al.'s (2022) recent study on adaptive practices in community-based public health services. They also support Corbaz-Kurth et al.'s (2022) assertion that resilience and coping during a pandemic can necessitate both top-down and bottom-up processes, with organizational components playing their part alongside team and individual staff adaptability and creativity (Corbaz-Kurth et al., 2022). In our study, a confluence of service, system, organizational, team, and individual factors influenced the lead organization's ability to cope during the pandemic. Our findings, therefore, suggest that enhancing public health service providers' abilities to cope during crises may require due regard to these multiple factors. While singular strategies such as a greater use of technology and telehealth may play a role in enhancing resilience (Kleykamp et al., 2020), a focus on these multiple factors and the interplay between them is likely to be important for optimizing resilience.

Although various interrelated elements influenced the lead organization's ability to cope, it is important to note that not all of these reflect changes implemented to cope with the challenges of the pandemic. Instead, some reflect mechanisms and practices established prior to the pandemic. For example, the anticipatory role played by pre-COVID aspects of practice such as effective partnership working suggests that such ways of working, which are held to represent good practice in substance use and wider public health service delivery during 'normal' non-crisis circumstances (HM Government, 2021), may also act to support an organization's ability to cope when crises occur. Effective routine public health service delivery may involve some of the same skills, processes, and practices that are valuable for coping with adverse events. Leveraging these may provide a firm starting point for better preparedness for, or coping with, crises.

Future crises will inevitably occur, and although building the resilience of health systems has been the focus of recent studies, these have tended to focus on hospitals or health systems in general, rather than community and public health services (Copeland et al., 2023). The current study makes a novel contribution to the literature on crisis resilience in substance use support and broader public health services, outlining factors that promoted and supported organizational coping and the maintenance of services during the COVID-19 pandemic. It provides valuable insights for substance use and other support services wishing to enhance their resilience to future adverse events through pre-crisis preparedness, coping during the event to enable service continuation, and generating learning that benefits both the organization and service users. For example, the study highlights the importance of multiple, interrelated factors in enhancing the lead organization's ability to cope during the pandemic. In addition, at a time when public sector finances and resources are under pressure, and costly adaptations in preparation for future crises might not be possible, our findings suggest that routine good practice (for example, in terms of effective communication and team and multiagency working) may positively contribute to crisis preparedness. For some service providers, developing and leveraging such good practice may provide a more feasible and sustainable route to crisis preparedness than large scale adaptation.

There are various ways that public health service providers may wish to practically implement the findings of this study. For example, the importance of effective communication, pre-existing relationships and multiagency working, expressed in themes 1 and 5, suggests that, when reviewing practice and planning services, service providers should consider whether they have well enough established links and lines of communication with all partners whose work is relevant to their service users. The relevant organizations will vary, but might include, welfare and financial support organizations, food banks/pantries, lifestyle support services, and those delivering mental health services and crisis support. Strategic planning might involve routinely reviewing existing linkages and identifying where new ones need to be developed, in preparation for future crises. Similarly, the importance of allowing flexibility, creativity, autonomy, and the active input of those with most expertise, reflected in themes 4 and 6, suggests that fostering these attributes would benefit the public health service providers' crisis preparedness. Research

suggests that open-minded organizations fare better during crises and that an enabling, creative culture is important in fostering organizational resilience (Hollands et al., 2024; Koronis & Ponis, 2018; Weick & Suttcliffe, 2007). Strategies to foster open, collaborative, creative, learning environments within service delivery organizations are therefore likely to be of benefit.

Limitations

Staff members were voluntarily registered to participate rather than being chosen randomly, so there is a possibility of selection bias. However, the fact that the majority (80%) of those registered subsequently participated in the study, and the use of maximum variation sampling to select interview participants, increased the likelihood that our sample includes those with a variety of roles, views and experiences, and may have helped mitigate the effects of any selection bias present. The use of multiple data collection methods also provided varied methods for participants to engage with the research based on preference or availability, individually, via group discussion, or through the autonomous timeline method. The study also focused on one organization operating across a single geographical location and some findings may be specific to this context. In addition, our data collection took place during the pandemic; some post-pandemic data collection would have allowed greater exploration of the bounce-forward and adaptation aspects of resilience and the impact of learning on post-pandemic practice.

Conclusions

To our knowledge, this is the first study to focus on organizational resilience within substance use support services during the COVID-19 pandemic. The analysis provides insight into the resilience-promoting factors that helped the organization cope and maintain provision. By highlighting these factors, some of which reflect aspects of organizational practice that may be current within organizations, this study provides important learning for organizations wishing to develop practice or enhance resilience in preparation for future crises. Importantly, for substance use services and others where established practices are embedded, this study also illustrates the capacity for the integration of new, innovative ways of working and delivery, and the potential benefits of thinking creatively, in collaboration with staff, about service design and delivery.

We conclude that the use of multiple interrelated resilience-enhancing factors of the type described in this study, incorporating anticipatory and coping aspects, can assist substance use support services in preparing optimally and preventing unnecessary harm in future crises. Furthermore, some of these factors may already exist within routine practice, potentially limiting the need for large-scale reconfiguration in the pursuit of resilience-building. As we move forward from the COVID-19 pandemic, it is important that resilience remains a priority for public health services. Substance use and other support organizations are likely to benefit from actively incorporating, in their own contexts, resilience factors of the type identified in this study. Our findings offer an opportunity for such organizations, in planning for service delivery and preparing for future crises, to consider how the resilience factors identified might be best integrated into their specific contexts and areas of work.

Note

1. Thirty-two participants were registered as willing to participate at the point at which timeline data collection was conducted. An additional 15 participants subsequently registered prior to participant selection for focus groups and interviews beginning.

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Author contributions

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Data availability statement

The participants of this study did not provide written consent for their data to be shared publicly, and the data contain some information that could compromise the privacy of research participants; therefore, supporting data are not publicly available. However, data supporting the findings of this study are available from the corresponding author, NL, upon reasonable request.

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