Together through tough times: A qualitative study of community resilience to protect against mental health issues in the UK

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Abstract

Purpose

Living in an area experiencing economic and social disadvantage is a known risk factor to poor mental health and wellbeing. This paper is concerned with how some communities experiencing disadvantage appear to be more resilient to the enduring challenges they face and display better mental health outcomes.

Design/methods/approach

A qualitative case study approach was used. Semi-structured interviews (total=74) were undertaken remotely with residents (n=39) and voluntary, community and social enterprise groups, community leaders and other local stakeholders (n=35) in four case study areas. Data analysis was cross-case, thematic analysis. Community analysis workshops (n=4) and resilience mapping workshops (n=4) in each site corroborated emerging insights.

Findings

Four overlapping and interacting themes support community resilience: (i) Community hubs and local VCSE networks; (ii) Opportunities to participate and make connections within communities; (iii) Open and supportive environments to talk about mental health and wellbeing; and (iv) Community identities and collective narratives. Differences in access to these resources was a cross-cutting theme.

Originality

Community resilience can be understood in terms of the amount of resources – articulated in terms of capital – that communities can draw on in response to challenges, and how well these resources are mobilised. A thriving VCSE sector is important for community resilience in communities experiencing disadvantage as a mechanism for both sustainably building and mobilising community resources in the face of daily and enduring challenges.

Key words

Community resilience; voluntary and community sector; social capital; disadvantage; inequalities

Introduction

A community's resilience is its ability to support the safety of its members and protect them from shocks, adversity, or risks in the face of sudden or more gradual change (Bulbulia et al., 2004, Masson et al., 2019). It also includes the ability to be less vulnerable to future challenges (Nguyen and Akerkar, 2020).

Harnessing the power of community resilience to protect against (or lessens) adverse mental health outcomes (Masson et al., 2019, Mannarini et al., 2022, Flores et al., 2018) has been a recurrent theme in contemporary government policy in the United Kingdom (UK) (Knapp et al., 2013, Parsfield et al., 2015). However, while many of the active ingredients of community resilience have been identified (Nguyen and Akerkar, 2020), interactions between individual-level processes and social conditions are still emerging (Berkes and Ross, 2013, South et al., 2018, Masson et al., 2019)

This paper responds to the need for greater understanding of the mechanisms underpinning community resilience, including identifying, defining, and describing components of community resilience (Nyguyen & Akerkar, 2020). It explores how four communities in the UK appear to be more resilient to poor mental health outcomes than would be expected based on their socio-economic status – a known risk factor for poor mental health and wellbeing (Marmot, 2020). By focusing on resilience at a community level, the paper shifts focus towards a strengths perspective in the study and prevention of mental health and supports prevention of poor mental health outcomes through action on the social determinants of health (World Health Organisation and Calouste Gulbenkian Foundation, 2014, Cresswell-Smith et al., 2021).

Literature review

Existing evidence about the mechanisms underpinning community resilience, particularly in relation to mental health and wellbeing is summarised below. Firstly, there is a cyclical interaction between the resilience of communities and individuals (Frounfelker et al., 2020, Berkes and Ross, 2013); resilient individuals contribute towards building resilient communities, while resilient communities support resilient individuals.

Secondly, there is a link between a community's resilience and its access to various resources, commonly articulated in terms of different 'capitals' – natural, cultural, human, social, political, financial, and built (Paarlberg et al., 2020, Flora and Flora, 2013, Davies et al., 2019). 'Community capital' is sometimes used to refer to the sum of these resources within a community (Knapp et al., 2013, Parsfield et al., 2015). Whilst it is combinations of different resources that contribute to community resilience (McCabe et al., 2022, Masson et al., 2019), social capital appears particularly significant (Frounfelker et al., 2020, Bartley et al., 2010, Parsfield et al., 2015, Long et al., 2022), and different types of social capital each have a different and complementary role (Poortinga, 2012, Aldrich and Meyer, 2015). Bonding social capital is good for 'getting by' but bridging and linking are needed for 'getting ahead' (Gilchrist and Taylor, 2022). However, access to community capital can be uneven among community members (Parsfield et al., 2015), while networks within communities can be exclusive and foster unhealthy behaviours/attitudes (Allan and Phillipson, 2017).

Thirdly, community resilience does not just depend on the presence of resources within a community – *community capital* – but how well they can be mobilised (McCrea et al., 2016). Thus, community resilience is the process that leads to, or supports, various outcomes and not just a resource in and of itself (Kruse et al., 2017, McCrea et al., 2016). In this instance, good mental health is the outcome of concern. Mechanisms that mobilise community resources/capital include asset-based and empowerment approaches (Berkes and Ross, 2013, South et al., 2018), volunteering and community infrastructure (Frounfelker et al., 2020, Pfefferbaum et al., 2016, Cresswell-Smith et al., 2021), targeting support at people most at risk and providing access to specialist support (Davies et al., 2019), culturally appropriate services (Frounfelker et al., 2020), working at different levels within a local health system (e.g. with individuals, communities, organisation, networks) (Reed et al., 2019, Public Health England, 2019), and relational working (e.g. co-production, co-design, collaboration) (McCabe et al., 2022).

Methodology

The research utilised a qualitative case study approach (Baskarada, 2014). Cases were purposively selected in a two-stage process to identify communities that would provide opportunities to study factors supporting resilience. First, the Community Wellbeing Index (Co-op, 2022) Office for National Statistics (2019a, 2019b), and Public Health England (2018/19) datasets were analysed to identify

communities experiencing lower incidences of mental health issues/high wellbeing relative to their socio-economic status. Second, shortlisted areas were discussed within the research team and with project funders and the cases agreed. Cases were selected to ensure a mix of urban/rural locations and demographic profiles (ethnicity, age etc.), and that each of the four UK nations were represented within the corpus. Over-researched areas and areas with prominent localised issues were discounted. The final selection and a summary of their key characteristics is in Table 1.

******INSERT TABLE 1******

Semi-structured interviews (total=74) were undertaken remotely with up to 10 residents (total=39) and up to 12 representatives of local voluntary, community, and social enterprise sector (VCSE) organisations, local authorities and health service representative, and other community leaders (total=35) in each case. Participants were sampled using a key informant approach (Marshall, 1996) and recruited via the project funders' local networks. Interviews followed an interview schedule and explored resilience narratives, local assets and protective factors, and local challenges to wellbeing. Interviews were audio recorded with participants' consent and detailed notes taken by each interviewer in all instances.

Data analysis involved within- followed by cross-case analysis to preserve the uniqueness of each case but also identify cross-cutting themes (Bryman, 2016). Framework analysis (Srivastava and Thomson, 2009) was carried out on each interview using a coding frame that mapped to the research questions. Cross-case analysis then involved comparing/contrasting the findings from each case to identify commonalities and differences (Bryman, 2016). Two community analysis and resilience mapping workshops were undertaken in each case (total=8) to sense-check and further explore the insights emerging from the interviews.

Ethical review was provided by Leeds Beckett University Research Ethics Committee. The research was commissioned just before the Covid-19 pandemic, which meant the fieldwork was undertaken entirely remotely and in the context of recurring local and national lockdowns. The full research report is available online (Co-op et al., 2021).

Results – what makes communities resilient?

Community hubs and local voluntary sector networks

In all cases, a developed community infrastructure with community assets that could be used to support people was thought to be significant to community resilience. Local VCSE organisations worked together in 'sharing economies' – collaboration over competition – that enabled efficient use of limited resources. Well-known and inspiring community leaders had a facilitating role within networks, often providing an entry point for local people. Networks were commonly supported by umbrella or infrastructure bodies that facilitated cross-sector and cross-community connections.

> *"We work closely with the local authority, with health colleagues, with [the area's] mental health networks – we're very well linked into that work. We support citizens and organisations, bring them together in various forums." – Community network organisation, Case 2*

Within networks, both physical and virtual hubs offered communities a shared space to connect, building both bonding and bridging social capital. Hubs also provide both formal and informal services, like mental health support and signposting. One participant described the value of a local church for bringing people together:

> *"I go to church on Sunday, sing in the choir, help young people, I run on Monday night the basketball, Wednesday morning – run a men's prayer meeting – it's not a holy joe thing. Then we have breakfast [at a local supermarket] and sort the world out, which is [a] real thing." – Male resident, Case 3.*

Actively participating and making connections within communities

People actively participating in their communities, through a range of formal and informal roles, supported community resilience in all cases by strengthening connections between residents, building local capacity to act and support each other, and empowering people. Local participation also formed the bedrock for community-wide organising in response to challenges, such as the closure of a local hospital (Case 2) or nursery (Case 4).

> *"People are neighbourly – we know each other and help out. I know everyone who lives on my street. At Christmas we all do Christmas cards… our neighbours do our bins – we all help. Acts of neighbourliness." – Community centre, Case 1*

Participation was enabled by well-maintained community spaces that allowed local people to come together, as well as to feel pride in the local area and, in the case of green spaces, a place to reflect and relax. However, poorly maintained public spaces were very often reminders of the challenges facing communities, which could impact negatively on wellbeing.

Open and supportive environments to talk about mental health and wellbeing

An openness to talking about mental health and wellbeing was linked to supporting community resilience. Close contacts like family members and long-established friends were often the starting point for talking about mental health and wellbeing, although the benefits of outside perspectives were also recognised.

> *"With your family you're connected, with friends you're connected in a different way... you're just you, you can be yourself, you don't have a label… different groups of friends… some I would say all things to, others I would be a bit more filtered." – Female resident, Case 3*

Community hubs provided informal opportunities to talk without being labelled or stigmatised. Social media could be a place to speak more openly about wellbeing and connect with people, especially for young people.

Openness to talking about mental health and wellbeing was often stimulated by a high-profile event (e.g. a suicide in the community, a community event) and developed over time in all cases.

> *"In our school one of the younger kids committed [suicide]… our school came together when that happened, people talked about their mental health more, they didn't want it to happen again." – Female resident, Case 2*

However, stigma around mental health still existed in all cases. In particular, hegemonic masculine norms – humour, 'toughness' – often persisted among men to deflect or avoid talking openly about their mental health.

> "It's a stereotypical thing…tough men who didn't do anything and just got on with it… that kind of toxic masculinity teaches boys that they can't be emotional." – Community organisation, Case 4.

Identities and belonging

In all cases, resilience was strengthened by collective narratives and identities that brought people together to build a sense of belonging and solidarity. Narratives around friendliness gave residents confidence that help would be available, if needed. Narratives around overcoming past struggles, such as deindustrialisation (Cases 1 & 4) and sectarian violence (Case 3), whilst being a potential cause of ongoing mental health problems, inspired a sense of togetherness, a history of overcoming adversity, and built collective efficacy. In some cases, emerging collective understandings of mental health were shifting local narratives into acknowledging pain and vulnerability as well as toughness.

> *"A sense of belonging, this is where they are from a sense of place, a shared history." – Community centre, Case 1*

Potentially excluded groups

A cross cutting theme was that access to resources for building resilience was unequally distributed among community members and between the sub-groups within communities. In all cases, there were community members outside of social networks built around strong social bonds and collective narratives. This included people new to an area and also people that may have lived in an area for many years but had an obviously different identity (e.g. religious, cultural, sexuality, gender). While identity-specific and culturally sensitive groups/services supported the resilience of these groups, weak social ties and a lack of culturally sensitive assets limited access to, and participation in, local activities.

> *"It's difficult as an outsider. The community is close-knit… I think people know each other and it's hard to break in and get to know them." – Female resident, Case 3*

Other people at risk of exclusion from communal resources were people 'time poor' due to work and caring responsibilities, older people at risk of social isolation, people with physical and intellectual impairments, people on low incomes, and those experiencing 'digital exclusion'.

> *"People who struggle to get out of the door – they could be struggling with their mental health, or don't like going to big places like supermarkets or town centres, which can be quite intimidating for them." – Female resident, Case 4*

Discussion

This paper has explored how four communities in the UK appear to be more resilient to poor mental health outcomes than would be expected based on their socio-economic status. The paper contributes further understanding of the components of community resilience (Nguyen and Akerkar, 2020) and the mechanisms that protect against (or lessen) adverse mental health outcomes for communities experiencing disadvantage (Masson et al., 2019, Mannarini et al., 2022, Flores et al., 2018).

Four themes have been identified. These are the presence of community hubs and local voluntary sector networks, opportunities for local people to actively participate and make connections in communal spaces, the existence of open and supportive environments to talk about mental health, and community identities and collective narratives that give people a sense of belonging and identity. Unequal access to these resources among community members was an additional cross-cutting theme.

The findings support existing theories that community resilience stems from the resources available to communities to respond to challenges, which can be articulated as different forms of capital (McCrea et al., 2016, Davies et al., 2019). While other conceptual and theoretical frameworks could

be used to interpret this data (e.g. collective efficacy, community resourcefulness), the analysis here illustrates the multiple ways that different forms of capital overlap and interact, suggesting that it is not one type of resource alone that communities need to be resilient to economic disadvantage and protect their mental health (McCabe et al., 2022, Masson et al., 2019). Community resilience appears to comprise a number of aspects of local life that enable people individually and collectively to resist, adapt and recover by working together, mobilising shared resources and providing support to one another.

In line with previous research (Frounfelker et al., 2020, Bartley et al., 2010), the findings highlight the particular significance of social capital. In all case study areas, the strength of social networks, norms of reciprocity within communities, and trust in people and institutions were evident. To varying degrees, the functions of different types of social capital were also evident (Aldrich and Meyer, 2015, Poortinga, 2012). Whilst bonding capital reflected a sense of common identity, built trust and familiarity, provided practical support networks between residents, and formed links with trusted people to talk to for mental health support, it was communities' bridging that enabled them to 'get ahead' (Gilchrist and Taylor, 2022), connecting people through acts of neighbourliness, providing access to formal and informal support, opportunities to take part in community activities. Linking capital was generally the resource of key individuals and community leaders that brought people together and influenced decisions.

However, the findings also illustrate the 'dark side' of social capital (Parsfield et al., 2015, Allan and Phillipson, 2017). Within the tightly bonded case study areas, harmful norms about masculinity and 'toughness' were fostered, and some community members were excluded from community resources. Further research is needed to unpick the role of social capital in building community resilience, particularly the apparent duality of bonding capital as both a strength and a challenge.

Across the four case study sites, other types of capital thought to be important to community resilience were also evident but in varying degrees (Davies et al., 2019, McCrea et al., 2016). Natural capital/built capital, human capital, and cultural capital featured strongly. For example, good quality living and socialising spaces, people's skills, confidence and self-esteem, and collective narratives and shared identities. Distinctions between different types of public and communal spaces did not emerge in the data but might be usefully explored in future research. Perhaps unsurprisingly, political and economic capital did not feature strongly in the findings. Case study areas were selected because of their socio-economic deprivation and so an abundance of economic capital was unlikely to be highlighted as a resource.

The research also supports previous theories that resilience results from the effective mobilisation of resources (Kruse et al., 2017, McCrea et al., 2016). Based on the findings, a significant mobiliser of resources to support resilience to poor mental health and wellbeing in communities experiencing socio-economic disadvantage is a vibrant and active VCSE sector. These organisations very often provided formal and informal services in communities, spaces for people to connect, opportunities for volunteering and other forms of community participation, instances to talk about mental health, and maximising the impact of scarce local resources through collaboration and asset-based approaches. Whilst VCSE organisations frequently struggled with representation and diversity (like other organisations in communities), they were also very often organisations most prominently championing those at risk of exclusion through both culturally sensitive and inclusive and cross-cultural networking. This supports previous research on the value of local infrastructure (Bagnall et al., 2018) and the contribution of the VCSE in facilitating community resilience through programs and initiatives that enhance social capital and resource acquisition and mobilization (Frounfelker et

al., 2020, Pfefferbaum et al., 2016, South et al., 2019). This also reinforces calls for the sector to be adequately resourced to support public health goals (Bibby et al., 2020).

Finally, while the research was ostensibly focused on resilience at a community level, some of the results move between individual and community level mechanisms. For example, social connections provided support to individuals, while at a community level whole networks facilitated the flow of resources between groups. This reinforces the cyclical relationship between the resilience of communities and individuals (Frounfelker et al., 2020, Berkes and Ross, 2013).

The findings of the research are not without limitations. Qualitative case studies enabled an in-depth but not generalisable understanding of factors underpinning community resilience. Further research across more sites, including comparative case studies with apparently less resilient communities, or using methodologies to produce more generalisable findings are necessary. Whilst effort was made in sampling and analysis to account for community characteristics other than socio-economic status (e.g. ethnicity, urban/rural), further research taking greater account of these features is necessary. Additional research with different stakeholders is needed to counter a bias towards VCSE actors in the sample – twenty participants (~30% of total sample) were VCSE representatives. Finally, the research was undertaken in summer 2020 whilst communities were still responding to the Covid-19 pandemic. While communities' response to the pandemic was not a specific focus of the research, it inevitably influenced people's thinking and also prohibited in-person data collection. Further research is needed when Covid-19 is less of an immediate concern.

Conclusion

Community resilience to the enduring challenge of socio-economic disadvantage that can lead to poor mental health outcomes comes from the resources (capital) they have available and how well these resources can be mobilised in response to challenges. In the face of daily and enduring challenges, a thriving VCSE sector underpins resilience in communities experiencing disadvantage as both a mechanism for sustainably building and mobilising community resources and a means of facilitating other mechanisms.

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