Abstract

Resilience has recently become extremely popular as a means to promote health and well-being for individuals and communities and for health and social care practitioners coping with heavy workloads and stressful environments. Commonly defined as the ability to bounce back while living or working in adverse, challenging or disadvantaged contexts, resilience is seen both as a resource for individuals and communities as well as a way to tackle inequalities. This paper explores these concerns for primary care and community health practitioners. Drawing on a research data set from the South East of England, we show how learning about resilience impacts on practitioners' work, but as importantly, upon their own resilience. Using practice-based theories to understand these effects, this paper discusses these developing resilient practitioners and how their actions or 'resilient moves' might promote change to tackle health and social inequalities.

Key Words

Resilience; resilient practitioner; inequality; practice theory.

DEVELOPING RESILIENT PRACTITIONERS

Introduction

Despite major advances in public health the social inequalities that damage people's health and well-being continue to increase (Equality Trust 2015; Baum & Fisher 2014; Public Health England (PHE) 2014a; Marmot 2011; Wilkinson and Pickett 2009; World Health Organisation 2008). In response to this growing inequality, adversity and disadvantage, public health policy in England has increasingly advocated the building of resilience. Seen as an asset with which to promote well-being, resilience is argued to strengthen individuals and communities, making them more resourceful and connected and is therefore seen as a means to address wider inequalities in health (Public Health England (PHE) 2015; 2014b; Dept. Health 2010; Bartley 2007). For example, with local authorities' renewed public health responsibilities, resilience is again advocated as one of the nine evidenced-based areas where local authorities can act to tackle health inequalities (British Academy 2014; Buck & Gregory 2013). And although resilience is commonly seen in work with children and young people (Ungar 2015), it has become popular as a capacity to promote for marginalized youth (Wexler et al 2009); for people experiencing mental health problems (Cameron et al 2014); for older people in promoting active ageing (Wiles et al 2012); and as a collective asset to recognise and foster for those living in poverty or deprivation (Pearson, Pearce & Kingham 2013).

Similarly within healthcare professions resilience is increasingly being promoted as an individual, managerial and organisational strategy for coping, supporting and retaining staff in the face of challenging workplace or practice contexts (Beddoe et al 2014; Hart et al 2014; Hunter & Warren 2014; McCann et al 2013; Skovholt & Trotter-Mathison 2011; McAllister & McKinon 2009). This workplace adversity is evident in the very nature of the work, such as witnessing the impact of inequality, or from stressful frontline roles in safeguarding (Wallbank and Hutton 2011), to unforgiving environments governing contemporary healthcare evident in mounting workloads in a context of diminishing resources. Moreover, increasing workforce stress is manifest in the growing levels of sickness, fatigue or burn out and attrition of both newly appointed and experienced staff (Adamson et al 2012; Grant and

Kinman 2011). Resilient capacities are therefore argued to be vital for newly qualified staff during their preceptorship period. Having the right competencies and skills, but also a sense of belonging and safety, purpose and meaning, as well as a positive self-image and wider supportive relationships and organisational cultures are qualities and environments considered key to the development of resilient practitioners and staff retention (McInnes 2014). In conclusion, the resilient practitioner literature suggests how crucially important resilience might be, but correspondingly how significant context is in enabling resilience to develop. The importance of managerial systems and processes like regular peer support or supervision are critical (Wright 2014; Beddoe et al 2011, 2012), as is the wider culture of the organisation as this can both constrain but also enable resilience (Adamson et al 2012; McCann et al 2013). Therefore resilience is always more than an individual attribute; it is relational and dynamic; comprised of an ever-changing relationship between practitioner personal and professional lives, those they work with and those who are in their care. A further significant finding is that a strong sense of professional identity and recognition of the emotional work involved is vital to feeling and being resilient (Hunter & Warren 2014).

We have recently written about practitioners developing resilient moves to tackle health inequalities (see Aranda & Hart 2014). In our previous paper we used practice theory approaches because they provide a different way to understand health and actions as well as context and change. These theories understand the world as generated not through conventional explanations of individual behaviours but through sets of social practices. As such, practice theories explore 'what we do', investigating how what people and organisations do is shaped not only by everyday routines, motivations, or tacit shared understandings, skills and knowledge, but also the material world, in using tools or technology or even our bodies, as well as by our conscious choices. As a result these theories are argued to be capable of providing more adequate explanations of both how the world gets reproduced but also how it changes, and are theories that are becoming of increasing interest to those researching inequalities and public health (Maller 2015; Nettleton & Green 2013).

In our previous paper, we showed how one version of practice theory; a 'slim-line' practice theory (Shove et al 2012) can be useful in thinking about how work on resilience can tackle inequalities. In this paper we show how practitioners learning to 'do resilience' produces resilient practitioners and how these actions, both doing and becoming resilient, can be conceived as social practices. First, we briefly discuss how resilience is ordinarily understood and introduce the resilient practice frameworks that we have developed in collaboration with communities of professionals and citizens. We then discuss examples from an empirical research data set to show how practitioners working with one of these frameworks (children and young people), producing resilient moves, become resilient practitioners, but as importantly, how the contexts in which such actions occur are significant for promoting change.

TABLE ONE HERE

Resilience

Whilst definitions are complex and varied there is agreement that resilience suggests an ability to bounce back, adapt or cope successfully in response to adversity or adverse contexts which are enduring (Ungar 2015; Masten 2011; Aumann and Hart 2009; Hart et al 2007; Rutter 2007). Resilience is often perceived as an individual or personal capacity unique to and located inside a person. Other definitions focus less on individual abilities and more on how resilience develops between people within their environments, being socially produced and shaped by culture, norms and available socio-economic and political resources (Roisman et al 2002). Hence resilience informed by ecological approaches suggests resilience can only be understood in a broader context of micro, meso and macro levels of support and reliant upon an ability to access, navigate or negotiate support and resources located in broader environments (Unger 2005; 2015).

Arguably asking individuals, communities or practitioners to develop resilience can be seen as justifications for less government or NHS support, or as being complicit with current neoliberal healthcare imperatives of personal rather than social change (Harrison 2012;

Bottrell 2009). However if resilience is understood as dynamic, emerging and entangled with other public health practices and within and across contexts this need not be the case. More recently the focus on resilience is not just about overcoming adversity, but changing or transforming aspects of that adversity (Hart et al 2015; Hart et al 2013a). This approach to resilience politicises the concept; uses a social justice focus in seeking to challenge and change the adversity or disadvantage, through a participatory approach that aims to co-produce knowledge between those experiencing the adversity, poverty, or stigma and their families or communities, and academic researchers or practitioners working alongside them.

RESILIENCE FRAMEWORK AND RESILIENCE BASED APPROACHES

The resilience practice research referred to in this paper is based in the South East of England and is part of a broader set of research and practice developments that continue to work alongside children, young people, parents and practitioners based in health and social care (see www.boingboing.org.uk; Hart et al 2013b). The resilient practice frameworks (see Fig 1), are based on evidence regarding what works in promoting resilience. They were originally developed to enhance practitioners' knowledge and expertise in their work with disadvantaged children and young people. However, these frameworks now continue to be co-produced with groups of parents and carers, academic researchers and public sector practitioners e.g. social workers, nurses, health visitors, charities and third sector organisations as well with groups of LGBT young people, young mothers, older kinship carers, as well as adult citizens who experience mental health difficulties, and with schools, teachers and parents or families (see www.boingboing.org.uk). The frameworks, premised upon foundational principles, seek to build upon people's own capacities and assets, but address both individual experiences of disadvantage and the broader social context of inequalities. The idea of a 'resilient move' is an easy to remember saying derived from the resilient practice evidence-base informing the frameworks which in dialogue with the relevant client group can be adapted to reflect appropriate sayings and are being used as a resource of ideas for actions to support and promote resilience (Hart et al 2007).

FIGURE ONE HERE

From evaluation data from programmes delivered since 2008 to the present day, a process for developing a resilient practice approach in everyday practice was identified and can be used as a step by step guide for using the frameworks (Fig 2).

FIGURE TWO HERE

STUDY DESIGN AND DATA COLLECTION

During the previous eight years, the concept of communities of practice (CoP), Wenger 2010) has been used to organise programmes that create spaces where learning about resilience and practising with the resilient framework brings together parents and carers and service users, with a range of practitioners working in statutory and non-statutory services. Various data collection methods have been utilised, from observations, semi-structured interviews, focus groups and reflective diaries. The data reported on in this paper is drawn from an evaluation of a one year programme jointly commissioned by a local Child and Adolescent Mental Health Service (CAMHS) and a local authority, involving experienced social workers, family nurses, a range of children and youth related voluntary and third sector workers, as well as foster carers (Aranda 2011). The group met once a month for approximately three hours, for a total of fourteen months, to explore and develop a resilience building approach to their work. This original programme evaluation was based on observations of 12 CoP meetings, held between January-November 2010, followed by 13 one to one, semi-structured interviews with participants up to four months on completion of the programme. All Community of Practice (CoP) practitioners received written information and all were required to give written consent, including the two facilitators who ran the group; plus full ethical and governance approval was obtained prior to commencement of the study. A thematic analysis, using computer qualitative data analysis software NVivo 8 was conducted to explore the content of the interview data and

content of the observational notes (Bazeley 2007). In the original evaluation, four key themes captured how participants found learning about and working with the resilience framework for children and young people. They felt more resourceful through developing knowledge of resilience and in using the framework as a guide for thinking differently about practice; they became more responsive and flexible in their approach as a result; and more reflexive of their own practice; and finally, they felt more resilient themselves; practising resilient working had an impact on them personally. In this paper we explore this process of becoming resilient through developing resilient moves, but using slim-line practice theory to focus on their actions, the importance of context and how change occurred.

FINDINGS

In using practice theory, the resilient moves made by practitioners became visible as sets of complex actions involving different elements – that is various *motivations and meanings, skills, knowledge and competencies*, but equally the significance of the material context or conditions shaping current practice.

Actions

Many practitioners recognised how learning about resilience changed they felt about their current working practices (Table 2) to becoming more confident, organised, coherent and effective. These actions had similar impacts upon themselves:

I think developing ourselves as resilient practitioners, being able to pull on some of this stuff when the going gets tough, and to be able to think creatively about situations, and to know that you know, tomorrow is another day and you know there are things that you can do. (Participant L).

Obviously the current climate we are facing sorts of huge changes, so I find myself drawing on a lot of this stuff, you know, at times, you know it becomes part of you personally. I would say you would use a lot of this stuff on a daily basis, personally I do (Participant S).

Analysing how practitioners developed their resilience meant witnessing again how important the material world is to health, well being and resilience, basics like housing, a sense of belonging, feeling safe and having money matter:

It calmed me down (learning about resilience). And things don't get me so wound up in my personal life. I am better able to get things in perspective. Which I always thought I was good at, but this has made me think, and next time I feel really under it from all sorts of things going on, I just take this thing out [framework] and I look at it and – 'basics' – yes I have got that. Enough money to live on and it is quite nice to give myself a little mental tick list like that (Participant B).

In developing resilient practices or moves in their everyday work, these practices then 'travelled' and became inseparable from practitioners becoming resilient themselves:

Having a child with a disability and sometimes, just feeling, really this is so hard. And it was about trying to help him to be more resilient and me to be more resilient in the face of the adversity that he experiences on a daily basis. *Yes so part of it was also about applying it personally when things are feeling a bit tough, and thinking about 'how are we going to get through this day? And how can I manage work and this situation? And it is about thinking that there are other people that can help us out, actually thinking about what would be a resilient move? So there are things that ring – they stay with you – some of the phrases from the framework) and how I hear myself saying them [Participant N).*

Context

The context in which resilient moves are potentially made remains difficult. Many found incorporating the framework into everyday practice challenging because of dominant policy or organisational objectives, targets or priorities. Increased workloads and continuous reorganisations meant the very infrastructure of work was changing daily, producing enormous uncertainty. In our previous paper we noted how using practice theory allowed us to pay more attention to this context and the material conditions of practitioners' work

(Aranda & Hart 2014). These theories made visible that invisible context of 'old ' or pre-existing practices and routine work that any 'new' practice would inevitably meet.

TABLE TWO HERE

Change

The potential of resilient moves to tackle inequalities can be found in the ways practices changed. All practices need to be enacted or repeated and in the performance, they subtly change. However, intervening more deliberately to reconfigure combinations of elements as with a resilient move – so changing the combination of meanings, competencies and materials – produces change. This reconfiguration may seem modest but can transform current working cultures or challenge fragmented service delivery by joining up knowledge, things and people differently:

[Resilient based practice] It connects up that whole team of people, so you have got me as a practitioner, you have got young people, you have got carers, you have got parents – and it connects up with the academic bit as well…..whereas before maybe your focus was completely with the young person and not with any of the others in that network (Participant D).

Together, these findings suggest the importance of continually configuring different combinations of elements or attuning actions to make resilient moves in becoming resilient. Such interventions are, according to Mol et al (2010), a way of 'tinkering' with people, with their bodies, and with our knowledge, selves and relevant technologies. Tinkering practices like this are vital to producing good care or good outcomes for both practitioners and those more disadvantaged in their care.

DISCUSSION

Public health inequalities work and slim-line practice theory suggests a new model for understanding change both for practitioners and those in their care (Shove et al 2012). The elements that comprise a social practice, how this is configured, then enacted or performed in any given context varies. So resilient moves will always be composed of differing combinations of meanings, competencies and materials, which can be deliberately altered, or will change as they are repeated, but as social practices they will also converge, transform or even compete or conflict with other practices tackling health inequalities.

Moreover from this perspective practitioners are neither completely free to act, but nor are they completely determined or prevented by systems, organisations or contemporary cultures of healthcare. Practitioners can take on a variety of roles to deliberately intervene but these theories suggest a more modest approach is taken; that change is subtle and contingent on contexts. Practitioners' small or serial adjustments or tinkering are importantly anchored in, but never detached from other specific public health or care practices and therefore outcomes from practices can be far reaching, but are to some extent unknowable (Shove et al 2012).

In conclusion, practice theories suggest that promoting resilience for both practitioners and those they care for is complex work. However the evidence reveals the significant value of small everyday actions – in other words ordinary familiar endeavours count. Perhaps more significantly, in working to tackle inequalities through resilient moves, context really matters; it becomes more than a background to individual action, it is the source or location for understanding action and how that action or resilient move can tackle health inequalities. This approach therefore suggests that a context driven or whole systems approach is ever more relevant for managers and organisations struggling to transform health and social care in a context of continuing austerity. As part of this, supporting individual practitioners to become aware how their individual resilient moves 'travel' and potentially effect wider change may help embed a greater sense of hope regarding what can be achieved to build resilience, both for practitioners and service users.

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