

Community Support Systems and Their Influence on Mental Health Outcomes Among Adults

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Abstract. The level of mental health challenges among adults has not been as high as it is worldwide, and thus, there is a need to have a broad insight into protective factors other than clinical interventions. This research examined the links among dimensions of the community support system and mental health outcomes among adults, with social isolation and loneliness as mediators. Researchers gathered data from 487 adults aged 18–84 living in urban, suburban, and rural settings using validated measures of community support (structural, functional, perceived support, and community engagement), social isolation and loneliness, and mental health outcomes, including psychological distress, depression, anxiety, and well-being. Findings showed a high level of negative correlations between mental health symptoms and all of the dimensions of community support ($r = -.35$ to $-.56$, $p < .001$), and perceived support became the strongest predictor. The regression models used in this study were hierarchical and explained 43.5% of the variance in psychological distress. Community support, along with demographics and physical health, explained 21.4% of the variance in psychological distress. Loneliness mediated 63.8% of the effect of perceived support on psychological distress. Age also had a significant moderating effect, with young adults (18-30 years) showing the greatest effect, reporting the highest levels of symptoms, despite having larger networks. The results indicate the robust links between community support and mental health impacts, which implies that the interventions that can improve community ties can be effective and can assist the population with high rates of loneliness and social isolation.

Keywords: community support systems; mental health; social isolation; loneliness; adult well-being; social determinants of health; community engagement.

INTRODUCTION

Mental health has become a serious issue of public health in all parts of the world, as the current society is facing unprecedented rates of mental distress in adults. Community support networks, which include formal and informal networks of support, are critical safeguards against mental health crises that adults encounter in various life periods. Such systems are not limited to traditional family systems but also encompass neighbourhood networks, religious groups, community centres, and electronic communities [1].

The mental health issue of the adult population in every developmental stage has its own particular challenges. Young adults are trying to es-

tablish their careers and consolidate their identities; middle-aged adults have to balance work and life and care responsibilities; and older adults have to navigate retirement and health decline. The stressors of each stage differ and can be reduced through community support systems [2]. Modern research in mental health has come to acknowledge that the psychological well-being of an individual cannot be separated from the social and community context, and that community support is a key social determinant.

Research Background. Research demonstrates that those adults who have good community networks show decreased rates of depression, anxiety and other mental health disorders. The

community support functions through various processes, including providing emotional validation, practical support, social integration, and assistance with accessing mental health services. Professional interventions are offered by formal community support systems, e.g., community mental health centres and support groups, and informal systems, e.g., neighbourhood relationships and peer networks, each with complementary advantages [3, 4].

Online communities and teletherapy systems offer a new dimension of community support, brought about by the digital revolution. Still, the effectiveness of these tools remains to be questioned compared to offline interactions [5]. Although the importance of community support has increasingly been recognised, there are still considerable gaps in knowledge about the most effective components of such support, particularly for specific mental health conditions, and about how support requirements differ across age groups in adults.

Problem Statement. Adults throughout the lifespan have massive mental health issues that demand all-embracing support. About one out of four adults in the world has a mental health disorder, and depression and anxiety are the most common worldwide [6]. Evidence shows that adults who have high levels of community bondage are reported to have much better mental health outcomes, and those with weak social ties are at a high risk of psychological distress [7, 8]. Nevertheless, although there has been a rise in appreciation of the relevance of community-based support, significant gaps remain in understanding how individual dimensions of community support can impact mental health outcomes throughout adulthood.

But there is a critical knowledge deficiency that limits our knowledge. The majority of studies analyse social support in a general way and do not distinguish between structural support (network properties), functional support (types of assistance), and perceived support (perceptions of availability). Researchers can use knowledge of the most important dimensions to develop targeted interventions [9]. Also, little research examines developmental differences in community support needs among adults, and questions remain about the mechanisms underlying integration between support and mental health [10, 11].

Research Aims and Significance. The study will explore in detail the relationship between com-

munity support systems and mental health outcomes among adults. In particular, the study questions are:

- 1) The correlations between various dimensions of community support and mental health;
- 2) The relationships between the support and mental health outcomes and the adult age groups;
- 3) The mediating variables by which community support is associated with mental health;
- 4) Obstacles to community support access.

This study fills essential gaps in the mental health literature by illuminating how community context relates to individual psychological outcomes. Results will be used to develop community-level mental health interventions and to improve treatment planning in the clinic. In the social context, this study can help highlight the urgent issues of rising mental health challenges and the sustainability of the healthcare system, as community support structures offer scalable, cost-effective approaches to mental health promotion [12, 13].

Literature Review

Mental Health. Mental health is a multidimensional concept comprising emotional, psychological and social well-being. According to the World Health Organisation (2023), it is a state in which people fulfil their potential, manage usual stressors, perform well in the workplace, and serve their communities. Modern understandings of mental health view it as a continuum, and authors [14] construct a mental health continuum that encompasses not only positive traits such as emotional vitality and life satisfaction but also the absence of symptoms of mental illness.

Adult mental health presents itself in various aspects: emotional (positive affect, happiness), psychological (self-acceptance, personal growth, purpose), and social (social integration, contribution) well-being. Major depression, anxiety disorders, and PTSD are common adult mental disorders, and the Global Burden of Disease Study has found mental disorders to be the major causes of disability in the world [15]. They are multifactorial determinants, including biological (genetics, neurochemistry), psychological (personality, coping styles), and social determinants (community characteristics), among others [16].

Community Support Systems. Community support systems are formal and informal networks that provide support and connections within communities. Theoretical views conceptualise support along many dimensions: structural (size of network, frequency of contacts), functional (emotional, instrumental, informational, appraisal assistance), and perceived (subjective beliefs regarding availability) [17].

Formal systems encompass community mental health centres, support groups, and peer specialist programs. Informal systems are the result of networks of the neighbourhood, friendship, and community-based organisations. Digital platforms have revolutionised community support through technology, but people have yet to determine whether they are equivalent to in-person relationships [18, 19].

Community support works through several mechanisms. According to the stress-buffering hypothesis, support buffers the effects of stressors by providing coping resources. The main effects model implies that support has a direct positive effect on well-being by increasing self-esteem and a sense of purpose. The social integration theories emphasise that participation serves the basic need for belonging [1]. New cultural concerns characterise current trends, as values shape expectations for support and effective expression [20].

Social Isolation and Loneliness. Social isolation refers to objective deprivation of social interaction, and loneliness is a subjective, distressing experience of perceived relationship deficit. About one-third of adults report profound loneliness, and rates vary across adults [21]. They both have a severe effect on mental health by triggering stress response mechanisms and inflammatory events [22].

Meta-analyses prove that lonely people are at high risk of depression, and loneliness is among the best predictors. Social isolation also forecasts both the development and maintenance of depression, which correlates with both heightened anxiety and other disorders [23]. There are risk factors at the individual (physical and mental health issues), interpersonal (relationship losses), and community (neighbourhood design, transportation barriers) levels [24].

Community Engagement and Participation. Community engagement includes active participation by organisations, civic participation, and volun-

teering. The social capital theory holds that participation produces resources such as access to information and trust. Role theory holds that participation fosters desired identities and boosts self-esteem [25, 26].

Studies show that engagement is positive and associated with better mental health. The positive effects of volunteering are especially strong, and longitudinal research shows that frequent volunteers experience reduced depression and increased life satisfaction [27]. Mental health inequities are influenced by barriers to engagement, such as socioeconomic constraints, transportation challenges, and social exclusion [28].

Conceptual Framework. This paper is conceptualised based on the available literature, where the dimensions of community support, i.e., structural support, functional support, perceived support, and community engagement, affect mental health outcomes, i.e., psychological distress, depression, anxiety, and well-being. Social isolation and loneliness are considered mediating variables, while demographic factors, especially age, are seen as moderating variables.

The framework presumes that high community support is associated with lower rates of loneliness and social isolation and, consequently, improved mental health outcomes. In this connection, community support systems are likely to affect mental health directly and indirectly by their impact on loneliness and social isolation, the power of which relationships among different age groups. Figure 1 presents the study's conceptual framework.

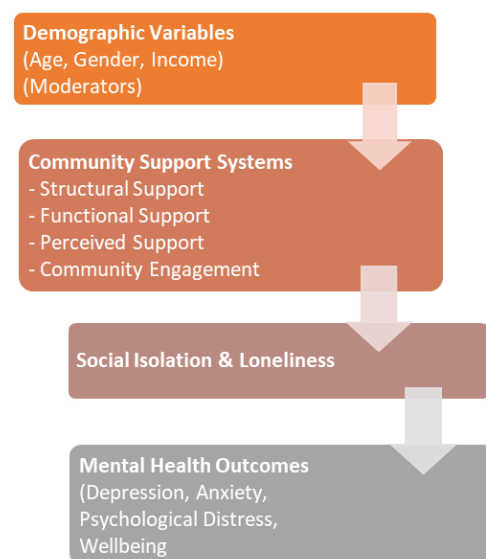


Figure 1 – Conceptual Framework of Community Support Systems and Mental Health Outcomes Relationship

METHODS

Research Design. The research design used was a quantitative cross-sectional survey research to investigate the relationship between community support systems and mental health outcomes among adults. The study used a correlational design to explore relationships between independent variables (structural support, functional support, perceived support, community engagement) and the dependent variable (mental health outcomes), with social isolation and loneliness as mediators and demographic characteristics as moderators.

The target population was adults aged 18 and up in the city, suburbs, and rural areas. Participation was restricted to individuals who met the inclusion criteria of age (18 years and above), competence to read and comprehend English, and willingness to sign an informed consent form. The results of the power analysis showed that the minimum number of participants needed to detect a medium effect ($r = 0.30$) with 0.80 power and 0.05 alpha was 384. The researchers applied a target sample size of 500 to obtain complete responses.

Sampling and Data Collection. Stratified random sampling was used to represent age groups (18-30, 31-45, 46-60, 61+ years), geographic settings (urban, suburban, rural), and gender. Several approaches were used to recruit, including community organisations, digital platforms, and snowball sampling, to cover a wide range of populations [29].

The data collection method was an online survey administered via Qualtrics over three months (January-March 2025), with paper surveys administered to respondents who could not access the internet. Participants provided informed consent before beginning the survey, and the researchers divided the questions into sections that evaluated: a) demographics; b) community support variables; c) social isolation and loneliness; d) mental health outcomes.

The instrument was pilot-tested with 50 participants to refine it, and then implemented in full [30].

Measures

Community Support: The Social Network Index (8 items, $\alpha = 0.76$) was used to measure structural support, the Interpersonal Support Evaluation List-12 (ISEL-12) was used to measure functional

support with subscales of tangible, appraisal, and belonging support ($\alpha = 0.89$), the Multidimensional Scale of Perceived Social Support (MSPSS, 12 items, $\alpha = 0.93$) was used to measure the perceptions, and Community participation Indicators (15 items, $\alpha = 0$).

Social Isolation and Loneliness: The researchers measured social isolation using the Lubben Social Network Scale-6 (LSNS-6; $\alpha = 0.85$), with scores below 12 indicating a high risk of social isolation. They assessed loneliness using the UCLA Loneliness Scale (20 items; $\alpha = 0.94$) [31, 32].

Mental Health Outcomes: Psychological distress was measured with the Kessler-10 (K10, $\alpha = 0.92$); depression as with the CESD-R-10 ($\alpha = 0.88$); anxiety as with the GAD-7 ($\alpha = 0.91$); and positive mental health as with the Mental Health Continuum-Short Form (MHC-SF, $\alpha = 0.91$) [33 – 36].

Demographics and Controls: Standard questions were used to evaluate age, gender, race/ethnicity, education, employment, income, marital status, residential setting and physical health status.

Data Analysis. The researchers used IBM SPSS Statistics Version 29 to analyse the data. Following data cleaning and quality testing, they conducted analyses through:

- 1) Descriptive statistics that involve the characterisation of the sample and variables,
- 2) Reliability analysis that has tested internal consistency,
- 3) Correlation analysis that has tested bivariate relationships,
- 4) Hierarchical regression, which has tested prediction relationships,
- 5) Mediation analysis, which has tested indirect effects through the use of the PROCESS macro, and
- 6) A moderation analysis that has tested demographic variations. The researchers adjusted the significance threshold to 0.05 [37, 38].

Ethical Considerations. The Institutional Review Board approved the study. It was conducted in compliance with the essential principles of the research, such as informed consent, protection of confidentiality by means of the anonymous data collection and protection, the reduction of the risk of the adverse effects of the research by

means of the provision of the mental health resources, and equal opportunity to participate in the study by the members of the population.

RESULTS AND DISCUSSION

Sample Characteristics. The data collection yielded 523 original responses, of which 487 were retained after quality screening (93.1% usable rate). The sample is mixed-income: 40.7% male, 55.6% female, 3.7% non-binary/other: 61.2% White, 15.6% Black, 11.9% Hispanic, 8.0% Asian, 3.3% other/multiracial: 42.7% urban, 38.8% suburban, 18.5% rural. There was good diversity in education and income levels (Table 1).

Table 1 – Demographic Characteristics (N = 487)

Variable	Category	N	%
Gender	Male	198	40.7
	Female	271	55.6
	Non-binary/Other	18	3.7
Age	18-30 years	126	25.9
	31-45 years	148	30.4
	46-60 years	132	27.1
	61+ years	81	16.6
Education	High school or less	68	14.0
	Some college	112	23.0
	Bachelor's	219	45.0
	Graduate degree	88	18.0
Income	<\$30,000	89	18.3
	\$30,000-\$59,999	143	29.4
	\$60,000-\$99,999	158	32.4
	≥\$100,000	97	19.9
Setting	Urban	208	42.7
	Suburban	189	38.8
	Rural	90	18.5

Reliability and Descriptive Statistics. No measures exhibited unacceptable or poor internal consistency (Table 2).

Table 2 – Reliability Coefficients

Measurement	Items	α	Interpretation
Social Network Index	8	0.76	Acceptable
ISEL-12 Total	12	0.89	Good
MSPSS Total	12	0.93	Excellent

Table 4 – Correlation Matrix

Measurement	Items	α	Interpretation
Community Engagement	15	0.84	Good
LSNS-6	6	0.85	Good
UCLA Loneliness	20	0.94	Excellent
K10 Distress	10	0.92	Excellent
CESD-R Depression	10	0.88	Good
GAD-7 Anxiety	7	0.91	Excellent
MHC-SF Well-being	14	0.91	Excellent

There was medium to high community support (M = 38.42-24.18), medium social isolation and loneliness (M = 16.73, 42.35) descriptive statistics, and mixed mental health results with 38.2% reporting significant psychological distress, 42.5% experiencing clinically significant depression symptoms, and 47.8% experiencing mild-to-severe anxiety (Table 3).

Table 3 – Descriptive Statistics

Variable	M	SD	Range
Structural Support	4.82	1.89	0-8
Functional Support	38.42	8.67	12-60
Perceived Support	5.23	1.28	1.25-7.00
Community Engagement	42.18	11.3	15-75
Social Isolation	16.73	6.24	0-30
Loneliness	42.35	12.9	20-78
Psychological Distress	22.48	8.92	10-48
Depression	9.87	6.34	0-28
Anxiety	7.23	5.41	0-21
Positive Mental Health	3.42	1.08	0.57-5.86

Correlation Analysis. The correlation analyses revealed significant associations between community support dimensions and mental health outcomes (Table 4). The negative relationships were found between community support and distress (r = -.35 to -.56, p < .001), depression (r = -.35 to -.56, p < .001), and anxiety (r = -.35 to -.56, p < .001). In contrast, positive relationships existed between community support and well-being (r = .48 to .61, p < .001). Perceived support showed the best relations. Community support (r = -.51 to -.76) and mental health outcomes (r = .44 to .67) were strongly correlated with social isolation and loneliness.

Variable	1	2	3	4	5	6	7	8	9	10
1. Structural Support	—									
2. Functional Support	.58***	—								
3. Perceived Support	.52***	.71***	—							
4. Community Engagement	.64***	.53***	.48***	—						
5. Social Isolation	-.76***	-.62***	-.58***	-.67***	—					
6. Loneliness	-.54***	-.68***	-.73***	-.51***	.66***	—				
7. Psychological Distress	-.43***	-.52***	-.56***	-.38***	.49***	.62***	—			
8. Depression	-.41***	-.49***	-.53***	-.42***	.47***	.64***	.82***	—		
9. Anxiety	-.38***	-.46***	-.50***	-.35***	.44***	.58***	.79***	.76***	—	
10. Positive Mental Health	.48***	.57***	.61***	.52***	-.53***	-.67***	-.71***	-.68***	-.64***	—

Notes: **p < .001.

Age Group Differences. It was found that there were significant age differences (ANOVA) (Table 5). Older people (61+) reported much higher levels of functional support, perceived support, and community engagement than young people

(18-30). The highest loneliness and mental health symptoms were reported by young adults (psychological distress, depression, anxiety) and the lowest by older adults (symptoms of well-being).

Table 5 – Age Group Comparisons

Variable	18-30	31-45	46-60	61+	F	Post-hoc
	M (SD)	M (SD)	M (SD)	M (SD)		
Functional Support	36.84 (9.12)	38.23 (8.45)	39.18 (8.21)	40.67 (8.35)	4.32**	61+>18-30
Perceived Support	4.98 (1.38)	5.21 (1.26)	5.32 (1.21)	5.52 (1.19)	3.87**	61+>18-30
Community Engagement	38.42 (11.76)	40.89 (10.98)	43.67 (10.84)	47.23 (11.12)	12.34***	61+>46-60>18-30
Loneliness	45.18 (13.21)	42.67 (12.54)	41.23 (12.68)	38.92 (12.34)	5.43**	18-30>61+
Psychological Distress	24.67 (9.34)	23.12 (8.76)	21.45 (8.52)	19.23 (8.12)	8.92***	18-30>61+
Depression	11.23 (6.78)	10.45 (6.34)	9.12 (6.01)	7.89 (5.67)	6.45***	18-30>61+
Positive Mental Health	3.21 (1.15)	3.38 (1.08)	3.52 (1.04)	3.78 (0.98)	6.23***	61+>18-30

Notes: ***p < .001, *p < .01.

Regression Analysis. Hierarchical regression predicting psychological distress (Table 6) revealed that demographics explained 8.9 per cent of the variance (Model 1), physical health 6.5 per cent (Model 2), community support 21.4 per cent (Model 3), and social isolation/loneliness 6.7 per cent (Model 4).

Table 6 – Hierarchical Regression Predicting Psychological Distress

Predictor	Model 1 β	Model 2 β	Model 3 β	Model 4 β
Age	-.18***	-.14**	-.09*	-.08*

Predictor	Model 1 β	Model 2 β	Model 3 β	Model 4 β
Gender (Female)	.16***	.14**	.11**	.10*
Education	-.12**	-.09*	-0.05	-0.04
Income	-.14**	-.10*	-0.06	-0.05
Physical Health		-.26***	-.18***	-.16***
Structural Support			-0.08	-0.07
Functional Support			-.18***	-.16***
Perceived Support			-.25***	-.23***
Community Engagement			-.12**	-.11**
Social Isolation				.14**

Predictor	Model 1 β	Model 2 β	Model 3 β	Model 4 β
Loneliness				.31***
R ²	.089***	.154***	.368***	.435***
ΔR^2	.089***	.065***	.214***	.067***

Notes: *** $p < .001$, ** $p < .01$, $p < .05$.

The final model accounted for 43.5% of the variance, and perceived support ($b = -.23$) and loneliness ($b = .31$) were the best predictors. The same tendencies were observed in the case of depression ($R^2 = .41$) and anxiety ($R^2 = .39$).

Mediation Analysis. Comparative mediation analyses of the perceived support and psychological distress showed that loneliness played a significant role in mediating the relationship between perceived support and psychological distress. The overall impact was strong ($B = -3.92$, $p < .001$). The researchers found that perceived support predicted lower levels of loneliness ($B = -7.34$, $p < .001$), and loneliness predicted higher levels of distress ($B = 0.34$, $p < .001$). The indirect effect was considerable ($B = -2.50$, 95% CI $-3.21, -1.83$), and loneliness mediated 63.8% of the total effect. The direct effect was also meaningful ($B = -1.42$, $p < .001$) and partially mediated (Table 7).

Table 7 – Mediation Analysis Results

Path	B	SE	95% CI	p
Total effect (c)	-3.92	0.32	[-4.55, -3.29]	<.001
Perceived Support → Loneliness (a)	-7.34	0.43	[-8.18, -6.50]	<.001
Loneliness → Distress (b)	0.34	0.04	[0.26, 0.42]	<.001
Direct effect (c')	-1.42	0.35	[-2.11, -0.73]	<.001
Indirect effect (ab)	-2.5	0.35	[-3.21, -1.83]	—
Proportion Mediated	63.80%	—	—	—

Summary of Key Findings. This is a thorough study of the interactions between community support systems and mental health outcomes in a sample of 487 adults, which found significant associations that enhance understanding of the social factors that determine mental health. The mental health outcomes were strongly predicted by all dimensions of community support, with perceived support emerging as the strongest. The percentage of variance in psychological distress

explained by community support was 21.4% of the total variance not explained by demographics and physical health, indicating substantial predictive capability.

The analyses of mediation provided valuable mechanistic insights, and loneliness explained 63.8 per cent of the effect of perceived support on distress. The partial mediation pattern implies that various routes work in parallel: community support decreases loneliness and, at the same time, has a direct impact on increased self-esteem, behavioural modelling, and access to resources [1]. Age also became an important moderator, with the greatest effects observed in community support among young adults who ironically reported the poorest mental health, even with larger networks.

Theoretical and Practical Implications. Such results contribute to theoretical knowledge by empirically confirming the multidimensional nature of community support and by explaining that loneliness is a key channel through which the lack of support can be translated into mental health issues [39, 40]. Moderation results contradict universal frameworks, showing that community support plays different roles across life stages and thus requires developmental frameworks [41].

In practice, the quality of community support and its enhancement should be systematically assessed by mental health professionals and incorporated as a therapeutic element, especially when working with clients who feel lonely. The interventions may include behavioural activation focused on social life, interpersonal therapy focused on relationship patterns, and support for community activities [42, 43].

Preventing loneliness among high-risk populations, especially young adults undergoing transitions, should be a focus of public health initiatives. There are promising programs that build meaningful connection opportunities, social skills, and cognitive patterns that lead to loneliness [24]. Social determinants via environmental adjustment are supported through policy that provides community structures that promote social connection, such as walkable neighbourhoods, community spaces, and accessible programmes [44].

Comparison with Previous Research. The results are in line with meta-analyses on social support-mental health relationships, and the magnitude

of the correlations ($r = -.35$ to $-.56$) is within the reported ranges [1, 45]. Trends among heterogeneous groups of people support the prevailing implications of perceived over structural support [20]. The loneliness mediation is based on recent studies that define loneliness as an important mechanism [23, 40].

Nevertheless, the present study builds on the previous literature by considering a range of support dimensions simultaneously and tests mediation through loneliness and isolation, suggesting that subjective disconnection is more important than objective isolation. The age-moderation results add colour to studies that treat adults as a bloc and show that community support is especially effective against young adults [21].

Limitations. There are several limitations to consider. First, the cross-sectional design does not allow causal conclusions, even though theoretical and temporal reasoning suggest that community support affects mental health. Reverse causation is a possibility of negative mental health issues undermining relationships. Both constructs require longitudinal research in tracking.

Second, self-report measures are susceptible to biases such as social desirability and common method variance. Depressed people might feel less supported based on negative cognitive biases as opposed to actual weaknesses. Researchers would validate the findings through a multi-method assessment, including informant reports and objective network analysis [9].

Third, the sample was restricted to English-speaking adults with internet access, potentially leaving vulnerable groups most at risk of support deficits. Recruitment through community organisations could have oversampled people who were already fairly connected. Future studies must oversample the marginalised groups in culturally sensitive ways [46].

Fourth, the researchers did not investigate specific mental conditions beyond symptom dimensions, nor did they compare online and face-to-

face assistance. Future researchers could expand current knowledge by studying clinical samples with diagnoses and comparing traditional and digital support methods [5, 11].

Future Research Directions. Serial longitudinal studies of community support and mental health would help to understand causality and critical timeframes. Randomised controlled trials to test interventions supporting enhancement programs would provide vocational advice and conduct cause-and-effect research [13]. Researchers would test generalizability through cross-cultural studies and identify other culturally specific mechanisms. In contrast, researchers conducting qualitative studies would examine lived experiences to provide depth to the quantitative findings [12].

Studies that bridge the gap between social and biological analyses at the level of neurobiological processes examine how support experiences relate to brain structure and functioning. The needs of underrepresented groups, such as older adults in long-term care, homeless individuals, and refugee populations, would be identified in studies.

CONCLUSIONS

This research offers strong arguments that community support systems are important in determining adult mental health outcomes. The researchers found that perceived support and community engagement were especially powerful tools, primarily because they reduce loneliness. The results reveal the necessity of mental health practices that should be beyond clinical treatment to involve community-based and socially integrating interventions. Enhancing community engagement is a viable and economical solution to attaining mental health among populations, and more so young adults who seem to be most susceptible to social detachment. Future studies must adopt longitudinal designs to develop causal pathways and guide the formulation of specific interventions.

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