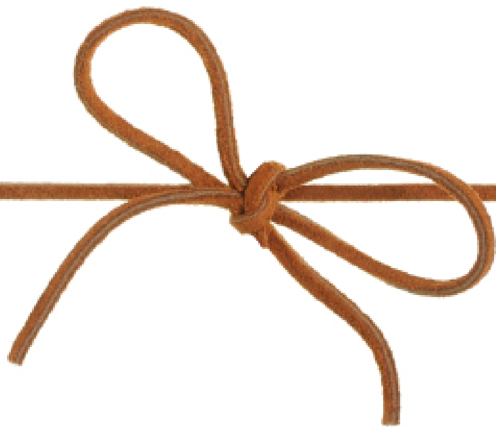
A CLOSER LOOK 2010 SURVEY DATA

CONNECT FOR WHAT?

SOCIAL CAPITAL AND HEALTH



AZ HEALTH SURVEY

CONNECT FOR WHAT?

SOCIAL CAPITAL AND HEALTH

ANALYST
ROGER HUGHES, PHD

AHS DATA ANALYSIS
TARA A. BLANC, PHD, NORTH CENTRAL RESEARCH ASSOCIATES

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St. Luke's Health Initiatives

2929 NORTH CENTRAL AVENUE, SUITE 1550, PHOENIX, AZ 85012

PH 602.385.6500 | FX 602.385.6510 | WWW.SLHI.ORG

Introduction

There is a rich literature documenting the impact of social connectedness on health (Ottman, et. al., 2006). People with strong social relationships are less likely to be depressed, less likely to experience severe cognitive decline as they age, and less susceptible to infectious diseases. The health risks of social isolation are comparable to the health risks of smoking, high blood pressure and obesity. Those who are socially isolated have two to three times the risk of poor health compared to those who are most connected to others (RWJF, 2003).

St. Luke's Health Initiatives (SLHI) has confirmed the impact of social connectedness on health in its own work in Arizona. In our *Mind, Mood and Message* report (Hughes, 2005), we documented the importance state urban residents place on a rich tapestry of social connectedness to help them stay resilient in the face of significant emotional and behavioral health issues. In a SLHI-sponsored analysis of data from the 2008 Arizona Health Survey (AHS), researchers found evidence for the importance of neighborhood social cohesion on self-reported health and well-being (Rios, Zautra, 2009), as well as the protective benefits of volunteering for people with chronic health conditions (Okun, Rios, 2010).

The Central Question

While the health benefits of social connectedness are well established, the evidence that social interventions are effective at improving health is less clear (RWJF, 2003). Social relationships are contextual and complex; and teasing out economic, social, cultural and environmental factors that are causally related to health outcomes is not a straight-forward exercise. There are examples of social intervention programs that have proven effective in addressing health issues at the individual and community levels (GIH, 2007), but questions concerning definition, research design, evaluation, causality, impact and replicability remain.

The question for organizations with limited resources to invest in improving individual and community health is this: If social connectedness can have a positive impact on health, are there social intervention strategies that might be more advantageous than others to explore?

In this AHS report, we draw on the concept of social capital as a way of framing a discussion of the impact of social connectedness on health and suggesting alternative ways to direct investments in individual and community health. Social capital extends the principles and practices of SLHI's work in community building outlined in earlier issue briefs (Hughes, 2008, 2003) by high-lighting the economic and political dimensions of social connectedness as well as its psychosocial dimensions. If one adopts the World Health Organization's (WHO) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2011), there are good reasons for using the concept of social capital to provide a more comprehensive picture of where opportunities to improve health might lie.

The Arizona Healthy Survey

To set the stage for this discussion, we present data from the 2010 Arizona Health Survey that confirm a relationship between social connectedness and health (characteristics and methodology of the AHS are available at www.arizonasurvey.org). That such a relationship exists is not the issue – what it means, and what we might do about it, is. Accordingly, we qualify the AHS data and their significance as follows:

- The AHS includes questions concerning levels of trust and social interaction that can be taken broadly as indicators of social cohesion (Rios, Zautra, 2009). This is part of the story of social capital but not the whole of it, as we discuss below.
- Are questions about levels of trust, social support, social interaction and the like measures of social capital or a consequence of it (Kawachi, 2004)? And what is 'community' these days, anyway? These turn out to be relevant questions for those who invest in community health projects and expect to see a positive difference in outcomes.
- In a similar vein, the AHS asks questions about perceived health status and sense of well-being, which can be correlated with measures of social connectedness. Establishing correlation is one thing, however, and establishing causality is another. It is likely that a multiplicity of factors – and not any single factor alone – combine to produce the perceived effect.
- AHS data collected at the individual response level can be aggregated in various demographic and spatial categories. But does social capital accrue at just the individual level, or is there some collective dimension that is more than the sum of its parts? If so, how should we describe and measure it?

The AHS was never designed to inquire into levels of social connectedness in all of its myriad forms, and certainly not to "measure" a construct as complex – and contested – as social capital. Nevertheless, we can use the survey to provide a window on one aspect of social capital – its *bonding* dimension – and a springboard for a discussion of what we take to be the more interesting and relevant subject of social connectedness for *what*: a critical inquiry into the practices of community development to improve health.

What is Social Capital?

Social capital is a "big umbrella" concept that has been widely used and debated in international policy and scientific circles over the past several decades. Much of the impetus has come from public health circles focused on the socioeconomic determinants of health, researchers interested in the role of networks, collectives and trust in social and political matters; and globally-focused organizations like the Ford Foundation, the WHO and the World Bank that are interested in establishing more effective approaches to community development and capacity building in emerging countries (Ottman, et. al., 2006).

There is an extensive literature on social capital that is beyond the scope of this report (Scheffler and Brown, 2008). Suffice it to say that there are common criticisms of the concept concerning definition ("vague, slippery and poorly constructed"), operationalization and measurement (identifying legitimate proxies, the difficulty in measuring indicators like 'norms' and 'shared values'), and determining exactly where social capital resides (social capital as a social resource, a social product, or an individual response). (Islam, et. al., 2006). These are all valid concerns, but we don't have to rehash them here to apply social capital as a conceptual category to highlight facets of social networks and norms of reciprocity that have descriptive and explanatory power in directing efforts to foster healthy communities.

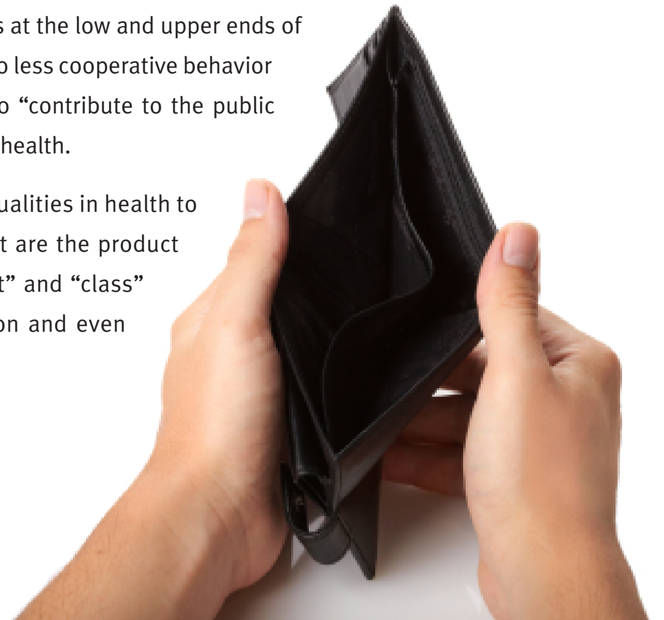
As we shall see, in the future everything singular becomes plural: communities, not community; strategies, not strategy. Social capital, too, is not any single thing but is many things. That is how we use the concept here.

A Working Definition

We follow the sociologist Robert Putnam, who offers a "lean and mean" definition of social capital as "social networks and norms of reciprocity" (Putnam, 2004). The central idea is that social capital has value – privately and publicly – and can generate externalities that have both positive and negative consequences. To this we add the importance of social capital to asset formation and access to resources, as we discuss later.

Researchers (Szreter and Woolcock, 2004) identify three central strands of the efficacy of social capital in the public health literature:

- **THE SOCIAL SUPPORT PERSPECTIVE.** This connects one's social relationships and associated norms of reciprocity to one's objective and subjective welfare. A vast literature documents the effect of social support mechanisms on child development, improved mental health, lower violent crime rates, reduced mortality, etc.
- **THE INEQUALITY PERSPECTIVE.** This connects social capital to widening levels of socioeconomic inequality that are thought to generate increased anxiety and declining access to social support institutions, with very different health outcomes in populations at the low and upper ends of the socioeconomic spectrum. Greater income inequality leads to less cooperative behavior (lower levels of positive social capital) and less willingness to "contribute to the public purse" (Kawachi, 2006). This affects individual and population health.
- **THE POLITICAL ECONOMY PERSPECTIVE.** This connects inequalities in health to fundamental differences in access to material resources that are the product of political and ideological decisions. This is the "materialist" and "class" critique of social arrangements, where networks of exclusion and even oppression figure prominently.



Bonding social capital is how you get by;
bridging social capital is how you get ahead.

Bonding, Bridging and Linking

These are caricatures of complex and shifting perspectives on social capital, surely, but there is enough truth in each to warrant a more comprehensive perspective that reconciles some of their differences. Szreter and Woolcock (2004) offer such a perspective by combining what is by now the familiar elements of bonding, bridging and linking social capital:

- **BONDING SOCIAL CAPITAL.** The strong(er) ties of trust and cooperative behavior that connect family, close friends, neighbors and colleagues who perceive themselves in terms of a shared social identity. Bonding relationships are generally less instrumental and more inwardly-focused, and serve as social protection mechanisms during times of stress and need. Dense bonding can serve to transmit positive values, enhance human capital (education and skill development) and social welfare. Conversely, it can promote exclusion and distrust of dissimilar members and networks, and even prevent potentially productive relationships.

- **BRIDGING SOCIAL CAPITAL.** The weak(er) networks and norms of reciprocity between people who are dissimilar in some sociodemographic or social identity sense (age, ethnic group, occupation, etc.). Bridging social capital is enhanced through networks that join in collaborative action to develop a measure of trust and competency in pursuing shared goals, such as regional economic development, cleaner air and access to integrated health care. Compared to bonding social capital, bridging social capital is more instrumental and is characterized by larger, "loose" networks of both formal and informal social reciprocity. In one sense, bonding social capital is how you get by; bridging social capital is how you get ahead (Woolcock and Narayan, 2000).

- **LINKING SOCIAL CAPITAL.** Networks and norms of reciprocity between people who are interacting across explicit, formal and institutionalized power or authority gradients in society. These are vertical (hierarchical) relationships between unequals in terms of power, resources and status. The importance of developing linking social capital responds to the inequality and political economy perspectives on social capital, where people may systematically be denied access to social support services and material assets necessary to nurture their potential to live full and productive lives. In a country like the U.S., with high levels of socioeconomic inequality, attention to linking social capital becomes paramount.

We will flesh out the dimensions of social capital as we proceed. In our view, what is often missing from discussions of the relationship between social capital and health is closer attention to the shifting concept of community, and especially to the power of media in all of their forms to foster – and manipulate – communities of identity, especially in select advanced industrial nations like the U.S that have growing gaps between groups in economic and cultural power. We may wish to consider new conceptual tools and development techniques that address different dimensions of social consciousness, community and identity if we are to successfully promote healthier individuals and communities well into the future.

Arizona Health Survey: Method and Results

The 2010 AHS is a comprehensive survey of 8,215 adults and 2,000 children. It contains data on over 100 interrelated facets of health, including individual indicators of health status, insurance coverage, access to and patterns of care, mental health, health-related behaviors and lifestyles, and various demographic and social/environmental factors. The AHS provides an important source of state and local health data than can be used to identify and target intervention strategies, plan for the more effective allocation of scarce resources, and inform health policy issues.

In this analysis we are principally interested in taking a broad look at indicators of health status and outcomes, and their relationship to social support, social interaction and, to a lesser extent, social cohesion. The focus is especially relevant to SLHI's various community partnerships, primarily in the Phoenix metro area, where local organizations, governmental agencies, individuals, advocacy groups and others come together to leverage their collective assets to address health issues of common concern (e.g., obesity, chronic diseases, early childhood development, behavioral health).

Although the AHS social data questions primarily focus on interactions in neighborhoods between families and friends (bonding social capital), and not on social interactions across horizontal and vertical networks (bridging and linking social capital), we expected to confirm both the importance of these "strong" ties to self-perceptions of health and well-being and their inability to account for all of the dimensions of social connectedness that influence health. In some respects it is what the AHS data don't tell us that is the more generative part of this discussion.

Method

We focused on four variables – self-reported general health status, self-reported quality of life and sense of well-being status, a derived scale for self-reported chronic disease (physical disease)* and a derived scale for self-reported mental disorders.** These were cross tabulated with a variety of demographic variables and several derived scales, including shortened versions of the Kessler Psychological Distress Scale, the Duke Social Support Index (DSSI) Satisfaction Subscale, the DSSI Social Interaction Subscale, and five items from the Collective Efficacy Scale that were collapsed to create a Neighborhood Social Cohesion Scale:

- **KESSLER PSYCHOLOGICAL DISTRESS SCALE.** Six of the 10 items from the Kessler Psychological Distress Scale (K10) were scored on a 4-point scale to indicate psychological stress. Respondents were asked how often in the past 30 days they had felt nervous, hopeless, depressed, restless and so on.

- **SOCIAL SATISFACTION.** Six questions from a shortened version of the DSSI Satisfaction Subscale were used to assess satisfaction with social support. Respondents used a 3-point scale to respond to such questions as "do you feel you have a definite role (place) in your family and among your friends," "do you feel useful to your family and friends" and "can you talk about your deepest problems with at least some of your family and friends."

- **SOCIAL INTERACTION.** Four questions from the DSSI Social Interaction Subscale were used. Respondents used a 3-point scale to reply to such questions as "how many times during the past week did you spend some time with someone who does not live with you" and "about how often did you go to meetings of social clubs, religious meetings, or other groups that you belong to in the past week."

- **SOCIAL COHESION.** Six questions assess the social cohesion dimension of the Collective Efficacy Subscale (Samson, et. al., 1997). Respondents used a 4-point scale to indicate agreement with statements regarding their neighborhood and neighbors, such as "people in this neighborhood can be trusted," "people in this neighborhood do NOT share the same values," and "people in my neighborhood help each other out." These items were collapsed to create a Neighborhood Cohesiveness Scale. (For a more in-depth analysis of neighborhood social cohesion using regression analysis of 2008 AHS data, see Rios and Zautra, 2009.)

* The chronic disease (physical disease) scale asked questions about physician diagnoses of asthma, diabetes, hypertension, arthritis, heart disease and gastrointestinal/digestive disorders.

** The mental disorder scale asked questions about physician diagnoses of bipolar/manic depressive disorder, anxiety disorder, and major or clinical depression.

Statistical significance was measured at the .05 level using chi-square (χ^2). Because of the AHS's large sample size of 8,215 adults, most of the cross tabulations turned out to be statistically significant. Consequently, we measured the strength of association (correlation) between bivariates using Gamma (r_y) for ordinal-by-ordinal cross tabulations and Cramer's V (V) for nominal-by-ordinal cross tabulations. The evaluation of strength of association is based on a generally accepted scale:

>.5 = high association

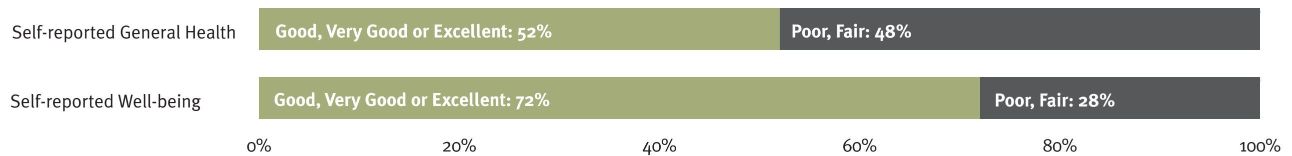
.3 to .5 = moderate association

.1 to .3 = low association

<.1 = little, if any, association

Results

Figure 1. Perceptions of Health and Well-Being Among Arizonans With Three to Six Chronic Diseases



Quality of life and sense of quality of life and sense of well-being comprise more than general health (Fig. 1). According to 2010 AHS data, 13 percent of adults (N=7,983) reported having three to six chronic diseases. Of these, slightly over half reported their general health as good, very good or excellent. By comparison, close to 75 percent – reported their quality of life and sense of well-being as good, very good or excellent.

Even though people with physical conditions may rate their "general health" below optimum, they nevertheless can engage in social activities or other pursuits, such as volunteering or pursuing new learning opportunities, that can buffer physical conditions and give them a greater sense of self-satisfaction, control and well-being. This is, in fact, what many of us do. The self is social. Health and well-being depend on a web of social reciprocity that extends beyond a concern with physical disease alone.

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Table 1. Correlations Between AHS Survey Variables

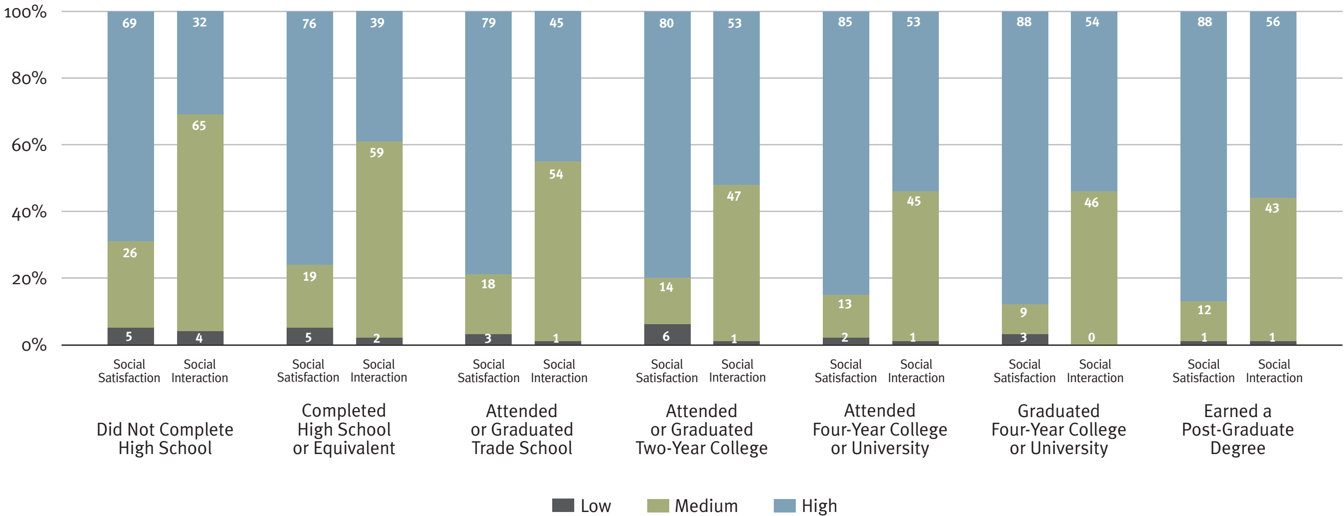
	AGE	GENDER	RACE	EDUCATION	INCOME	DUKE SATISFACTION SCORE	DUKE SOCIAL INTERACTION SCORE	KESSLER SCORE	NBRHOOD COHESION SCORE	PHYSICAL DISEASE	MENTAL DISEASE	SELF-RATED HEALTH
AGE	1											
GENDER	.05***~	1										
RACE	.13***~	.04*~	1									
EDUCATION	.06***	.08***~	.20***~	1								
INCOME	.01***	.10***~	.16***~	.50***	1							
DUKE SATISFACTION SCORE	.04***	.05***~	.13***~	.26***	.35***	1						
DUKE SOCIAL INTERACTION SCORE	.01***	.11***~	.06***~	.24***	.22***	.53***	1					
KESSLER SCORE	.12+	.02+~	.02+~	.39***	.40***	-.66***	.51***	1				
NEIGHBORHOOD COHESION SCORE	.19***	.00+~	.19***~	.33***	.32***	.51***	.40***	.47***	1			
PHYSICAL DISEASE	.50***	.04**~	.08***~	.05***	.13***	.05***	.08***	.34***	.00+	1		
MENTAL DISEASE	.04***	.09***~	.07***~	.10***	.20***	.35***	.22***	.87***	.21***	.38***	1	
SELF-RATED HEALTH	.13***	.05**~	.10***~	.32***	.35***	.36***	.242***	.74***	.28***	.44***	.45***	1
SELF-RATED WELL-BEING	.04***	.03+~	.12***~	.33***	.36***	.51***	.35***	.81***	.39***	.22***	.49***	.63***

Notes: ***pc<.001, **pc<.01, *pc<.05. +pc>.05, ~correlation coefficient = V (all others = r_y).

Table 1 presents bivariate correlations among the variables selected for this study. Some general observations follow:

- As expected, self-rated health and well-being are highly correlated (.63). People who rate their health high on the 5-point scale tend to rate their quality of life and sense of well-being high as well, and vice-versa.
- There is less correlation between self-rated well-being and physical health (.22 – see Fig. 1). This is contrasted to the high correlation between well-being and the Kessler score on psychological distress (.81). There are many factors that impact one's psychological state. Physical conditions are only one of them.
- The relationship between social satisfaction/interaction (the Duke scales) and self-reported health and well-being are roughly the same as the effects of education and income, although there are some differences. We will return to this.

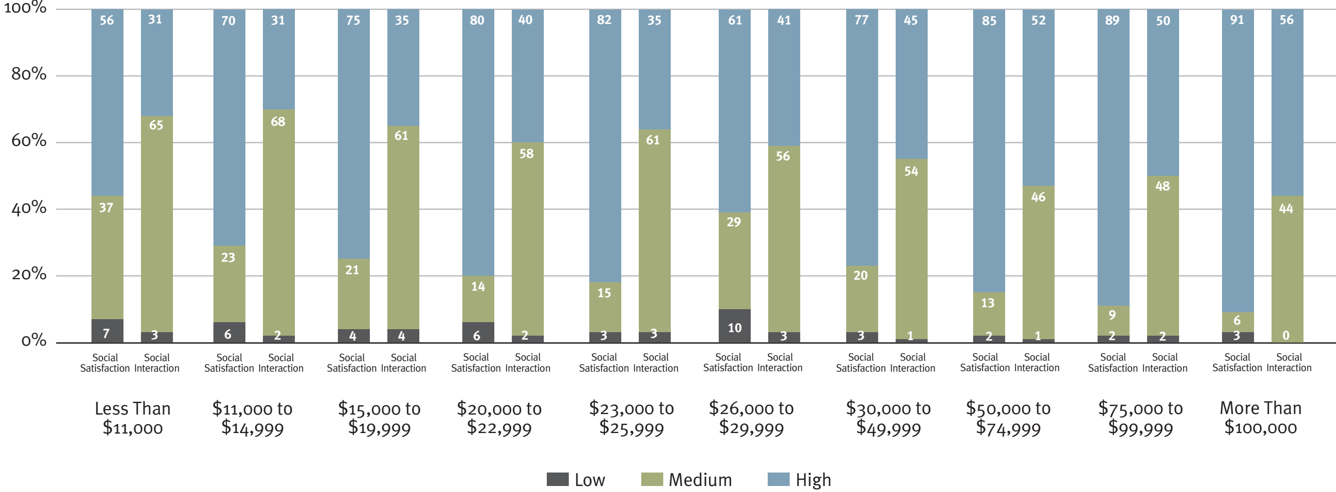
Figure 2. Social Satisfaction and Social Interaction by Education



Note: Numbers may not add due to rounding.

- Education is correlated with social satisfaction (.26), and social interaction (.24). Persons with higher levels of education score higher on these scales than persons with lower levels of education, as Figure 2 demonstrates. Education is also positively correlated with neighborhood cohesion (.33).

Figure 3: Social Satisfaction and Social Interaction by Income



Note: Numbers may not add due to rounding.

- Similar to education, income is positively correlated with social satisfaction (.35) and social interaction (.22), as seen in Figure 3. As we discuss later, investing in human capital (education, skills) is the surest way to increase both social and material assets, which in turn improve health and well-being.

- The Duke Social Satisfaction Score, Social Interaction Score and Neighborhood Cohesion Score have a positive correlation with perceived health (.36, .24, .28) and well-being (.51, . 35, .39). The more socially connected people are, the better they generally feel about themselves, even when their health is compromised (Fig. 1).

- The prevalence of chronic diseases (physical conditions) has little or no correlation with social satisfaction (.05), social interaction (.08) and neighborhood cohesion (0). How one copes with chronic disease is another matter. For example, engaging in social activities such as volunteering can play a protective role in adults with chronic diseases (Okun, Rios, 2010).

- Race has limited correlation with social satisfaction (.13) and social interaction (.06), although it has slightly higher correlation with neighborhood cohesion (.19). Native Americans report lower levels of social interaction and social satisfaction than other groups.

- As expected, the Kessler score on psychological distress is highly correlated with social satisfaction (.66), social interaction (.51) and neighborhood cohesion (.47). People with high levels of psychological distress report lower levels of social interaction and support. But this begs a central question: Is good health a result of social capital, or is social capital the result of good health? If policy makers are to be persuaded to invest in developing higher levels of social capital, they will probably require more convincing demonstrations of causality (Kawachi, 2006).

Forces of Dislocation and Transformation

To no great surprise, the AHS data confirm the importance of social reciprocity and trust to self-reported general health and well-being. All other things being equal, Arizonans who report higher levels of social satisfaction, social interaction and neighborhood cohesiveness report higher levels of general health and well-being. In other studies, researchers have found that this "bonding" social capital collectively contributes to people's self-rated health over and above the beneficial effects of personal social networks and support (Poortinga, 2006). This gives credence to the view that social capital accrues to communities, and not just to individuals alone.

But this is hardly the end of it. The data say nothing about the direction of causality between social connectedness and health, nor about the role of bridging and linking dimensions of social capital. The data are also defined by a place-based definition of community (neighborhoods), which is now under assault by large-scale economic, social and cultural forces. Before we consider the question of whether efforts to increase bonding social capital in place-based communities are preferred to other alternatives to improve individual and community health, we need to take a short side tour through American history to note the genesis of selected forces of social and economic dislocation and transformation that face us today. Much of this builds on the author's related work on community building and fostering community resilience through philanthropy (Hughes, 2008, 2010).

The Formalization of Human Capital

Social capital is a necessary condition for asset formation, whether considered as resources that people use to create a life for themselves and others, or as the capabilities people have to act on those resources (education, skills, training, etc.), sometimes referred to as human agency, or *human capital.* In the early years of community building in America, market and government forces were limited, and people came together through voluntary association and contributed their time, money and talents to develop their own assets in local contexts. As the business and government sectors began to grow in reach and power, however, especially in the period of rapid industrialization following the Civil War, the ability of people to adapt to rapidly changing economic and social conditions required ever more formalized programs of education, social amelioration and control.

Today, as humans continue to adapt to social and economic dislocation and transformation on a global scale, we can legitimately ask whether the view of social capital as constructed primarily in shared norms of reciprocity in voluntary civil society –a "Tocquevillian" view of democratic life after the French aristocrat Alexis de Tocqueville, who visited America in the early 1830s – must now factor in a growing technical and "managed" corporate-governmental apparatus that increasingly shapes and regulates our individual and collective capacity to adapt successfully to change.

From Diversity to Pluralism

Resilience in social-ecological systems is characterized by diverse functions, structures, roles, relationships, responses and activities, as well as a measure of redundancy. Stress in one part of the system can spread out and be absorbed by other parts. This is not the same thing as diversity in the sense of pluralism, a state in which members of diverse ethnic, racial, religious and social groups are able to maintain their particular cultures and identities within the confines of a larger society. Such a society could, in fact, be remarkably uniform in its central economic and political functions and thus be more, rather than less, susceptible to system shock. The recent U.S. credit and housing crisis is a case in point.

Without presenting the evidence here, we suggest that economic, social and cultural forces over the past 60 years, rather than promoting diversity in the first sense, have promoted diversity in the second sense, in the form of a rainbow of racial, ethnic, gender, sexual orientation, sociopolitical ideologies, disability- and interest-specific causes and groups that comprise a new politics of *identity* – of separateness and difference. This in turn has engendered a preoccupation with self-actualization through one's group(s) rather than through participation in, and service to, some broader community. Robert Putnam's (2007) research on linking immigration and ethnic diversity to lower levels of social solidarity and social capital can be interpreted in this light.

The Assault on Place

For all of the rhetoric and nostalgia about the importance of community and place in American life, there is ample evidence that the forces of economic globalism are testing its vitality and survival. The imperatives of increasing productive capacity and efficiency have rent asunder entire industries and the communities that have come to depend on them – a textbook example of what can happen when communities lack economic diversity in the face of social and economic dislocation. In this new economic order, physical place is increasingly contingent on economic criteria as local input and control take a backseat to system decisions made elsewhere. Whether it is loss of well-paying jobs to outsourcing, displacement of diverse local businesses and social capital by the dominance of "big box" stores like Walmart™, or the loss of civic engagement and local leadership in the face of corporate dislocation, communities are increasingly at the mercy of larger forces over which they seemingly have little control.

In this type of emerging environment, *place* – physical space – becomes potentially fungible. Communities may experience the effects of *spatial remoteness*, where CEOs of companies headquartered elsewhere make decisions affecting communities in which they themselves do not live. Communities may also experience *consequential remoteness*, e.g., legislators may decide to cut funding for mental health services in low-income communities without having the inconvenience of experiencing the effects of the cuts themselves. Further, each of us may experience *virtual remoteness*, where we psychologically "disappear" into a virtual, online world of connections and services that supersedes social connectivity and reciprocity in physical settings: the teenager who feels more connected to her online community of friends than to her friends at school, or the person who prefers to shop online instead of socializing in the local marketplace.

The Eclipse of Public Space

Over 80 years ago, the philosopher John Dewey (1927) foresaw the eclipse of the public in the rise of a mass-mediated culture of rapid, continuous information and a growing dependence on experts and a technocratic elite for "solving" problems instead of people's active participation in a common political life. For Dewey, it was distractions of "the movie, cheap reading matter and the motor car" that drew people's attention away from participation in civic life. Today, it is cell phones, computers, the Internet and a mind-boggling, 24/7 industrial "infotainment" complex that comprise the very infrastructure in which public policy is defined, marketed and "sold" to individual consumers and various "publics" of identifiable interests. Ironically, the promise of technology to enhance a common public life has instead appropriated public space into a breathtaking pluralism of private spaces occupied by these publics.

Whether there is traction in technologies such as the Internet to create broad-based social networks, public journalism and a rebirth of active participation in civil discourse remains to be seen. What seems beyond dispute is that those who seek to create social capital through "shared norms of social reciprocity in voluntary civil society" are going to have to learn how to adapt and even shape this new communications arena, the contours of which we do not yet fully comprehend.

The Search for Community

All of these larger forces of social dislocation and transformation call into question both the definition and experience of community, a common definition of which is "a group of people with diverse characteristics who are linked by social ties, shared common perspectives and engage in joint action in geographical locations or settings." (MacQueen, et. al., 2001) This definition certainly applies in many instances, but it doesn't account for the fact that the experience of community in the geographical sense can be fragmented into the experience of *communities*, organized both in real-time and virtual settings by interests, ethnicity, religion, work, age and other dimensions. The experience of community in more homogeneous, rural settings may be very different than in large, pluralistic urban settings with myriad physical, economic and sociocultural localities. For example, the resilience of New Orleans in the wake of Hurricane Katrina broke down into the attributes and joint action capabilities of quite different sub-communities defined by economics, race, physical location and function, including the "community" of federal workers and volunteers who assisted with rescue and rebuilding.

The experience of community – the sense of identity and belonging within a network of shared norms and social support – can have both positive and negative consequences. The young adult who develops strong bonds within the insular culture of a drug trafficking gang and lacks the bridging and linking social capital that might connect him to more positive opportunities, faces a dismal future. One of the challenges facing organizations that seek to foster healthy communities is defining the boundaries of community in the first place. Residents of a geographically defined and bound community may participate in a multiplicity of "communities," each with its own structure of identity and support. Interventions that are designed to increase bonding social capital and a sense of solidarity in pursuing a common goal may find tough sledding if residents in the same *place* are in quite different *spaces* of social identity as defined by race, religion, education and other factors.

Connect for What?

Communities and Networks

The formalization of human capital, a pluralistic and individualistic society, the assault on place, the eclipse of public space and the search for community are powerful socioeconomic and cultural trends. But they are not destiny. The story of human progress is written not in grand theories or statistical snapshots of abstractions like populations, but in the remarkable stories of specific individuals and communities that adapt and even thrive in the face of adversity, while others do not. To paraphrase the Danish philosopher Soren Kierkegaard, we explain life backwards, but we live it forward. Those who would intervene in time- and place-bound communities to improve health are well advised to begin with what people have, not what they lack, and to encourage local involvement and leadership from the grassroots-up instead of starting from the top-down alone with grand plans derived from theories of social change, no matter how "logical" and compelling.

With that in mind, we outline a working framework for thinking about social capital and community change in the future. It is offered as a hypothesis, subject to revision based on experimentation. In short, it is meant to be *adaptable*.

From Growth to Adaptation

The challenge we face is to move from a fixation on increasing productive capacity alone to one of increasing adaptive capacity. Clearly, productive capacity is critical to growth and development; but if we are to improve the sustainability of our natural and social environment, we need to turn our attention to encouraging adaptation and learning through a broad diversity of functions, economic and social supports, knowledge, institutions and human opportunities.

Communities as Adaptive Markets

One way to think of core adaptive capacities that seed the ground for improved health and well-being is to characterize communities as potential markets of relationships and opportunities for value, choice and access (Traynor, 2008). Both public and private organizations, as well as individual enterprise, can help to extend these opportunities through networks characterized by a high degree of civic engagement; diversity in economic base, environmental resources, skills, roles, relationships, perspectives and beliefs; redundancy in the sense of overlapping functions and institutions; and robust and stable feedback loops of information, communication and social connectivity.

Communities as adaptive markets encompass communities of place (geographically bounded), but they also include communities of identity and shared space. For example, SLHI supports resource development and social connectivity in place-bound communities in the Phoenix metro area, but we also support learning networks (communities of practice) consisting of various consultants, health care practitioners, public health officials and others who may or may not live in these geographically defined communities but who interact with local citizens in various skill and resource development initiatives.

In other words, we extend *place* through *networked space*, both real-time and virtual.

Social Capital

In this framework, social capital is best understood as access (networks) plus resources, as distinct from focusing on shared norms of social reciprocity alone (Foley, Edwards and Diani, 2001). Access to networks of social support, strong organizational linkages and cooperation, diverse sources of capital and a high degree of civic participation and formal leadership roles are predictors of economic activity, a significant portion of which today is embedded within a vast communications, financial and regulatory infrastructure.

Attachment to place and a sense of community, as important as they are, are increasingly provisional and temporary in the face of the forces of dislocation outlined earlier. One can legitimately question either the ability or suitability of traditional civil society configurations (unions, community organizations, traditional nonprofits) both to critique the ideology of relying on consumer market forces alone to supply public goods like education and health care, and to present a viable alternative to it.

Bridging Networks

But what alternatives are there? In SLHI's experience, the growing prevalence of *bridging networks* based on identity politics, advocacy, professional services/interests and faith-based activities is a fruitful area to explore. Here, the role of organizations such as SLHI as independent conveners and providers of information and technical assistance is as important as supplying funds for organizational and network support. This amounts to investing in *human agency* – building individual and organizational capacity and competence to reach shared goals – as well as both the material structure and social-psychological structure of shared norms and values that can only be developed by establishing relationships of trust between separate but complementary individuals and organizations over time.

This comes down to "re-creating" social capital at the cellular level. Today, people move in and out of these bridging networks quickly, and their level of commitment to, and interest in, a specific community of place or community of practice is influenced by their personal situation (education, income, mobility). In an unstable economic and sociocultural environment, bridging networks – real-time, place-based or virtual – have to be as fluid and adaptable as individuals themselves, and provide substantive and timely access to social and economic resources. Further, these networks must exhibit a high measure of redundancy and strong feedback loops of shared information and collaboration.

For example, an SLHI study (Hughes, 2005) in the greater Phoenix metro area on the pathways people use to cope with a variety of behavioral health issues documented an impressive web of interconnected self-help groups, institutions, businesses, churches, government agencies, and informal circles of family and friends. It was not necessarily efficient, but it was *effective*. It was not necessarily stable or permanent, but it was *adaptable*. It did not arise whole cloth as the result of some top-down strategic planning exercise with techniques of formal intervention and control, but it grew organically from the bottom-up through networks of social reciprocity. In short, it was literally *self-organizing*.

Linking Networks

Similarly, investing in linking networks is also necessary to provide access to the resources and capital communities need to leverage bonding and bridging social capital at the local level. These are networks that cross gradients of power and access to entice outside investment and collaboration. To cite one of many examples among SLHI partnerships, a community on Phoenix's west side, after establishing a healthy level of trust and cooperation among churches, a local community development corporation, city government, neighborhood associations and several nonprofits, was able to secure a grant from the federal government to construct low-income housing units, which are designed to serve as the hub around community activities such as job training, health education and community gardens. The salient point is that the access to significant outside investment – linking social capital – requires both a strong base of bonding social capital within closely knit groups and the weaker but more diverse ties of bridging social capital between the various groups that have a stake in the goal being pursued, such as better housing, economic development, a health safety net and the like. In effect, the three types of social capital complement each other. All can coexist in a community in various degrees, but frequently one may be more prominent. Before one "intervenes" in a specific place-based community to address an issue, it is important to have a good understanding both of the balance of the types of social capital already in place and those points along the social continuum where leverage can be applied for maximum effect.

Community Competence

Health as a state of complete physical, mental and social well-being is ultimately rooted in individual and community agency, or the capabilities for meaningful, intentional action. Unless communities have the capacity to acquire information, reflect critically on it and address emerging problems, planned interventions to improve health are of limited practical benefit.

How should we approach community competence? It is tempting to wax nostalgic about a return to smaller communities, local control and people coming together to "take care of their own" through community-based (and financed) activities. The fact of the matter, however, is that local communities are increasingly dependent on, and interdependent with, large scale economic forces and a

financial/regulatory infrastructure that is relentlessly extending its reach into communities all across the world. If this structure itself is to prove adaptable and resilient, we will need to look for ways to invest in open, transparent, intelligent and responsive government structures at all jurisdictional levels, and not reject government involvement for ideological reasons alone. Paradoxically, we will create vital, healthy communities with a high degree of civic engagement, bridging and linking social capital to develop a diversity of opportunities, and a strong web of social reciprocity and support through the intelligent investment of resources in a public and regulatory infrastructure – and vice versa. Interdependence and integration, not separateness and fragmentation, comprise the operable state of all sustainable social-ecological systems.

The Signal in the Noise

The other salient point about increasing community competence in today's social and political environment is to note the sheer amount of "noise" arising from adversarial conflict and dissension. The ability of communities to find the signal of purposeful action in this noise is enhanced by constructive engagement in group processes, being able to collect and analyze relevant information, to resist undesirable influences and to participate in a constructive political process that involves all citizens, and not just special interest groups. This community empowerment process is enhanced by investing both in the skills people need to collaborate with others –- bridging social capital – and creating the public space in which such collaboration can occur.

This translates into increased attention to the activities of civic engagement, advocacy, grassroots organizing and leadership development. This can generate "noise" as well, but it is only through active and ongoing citizen engagement – not through uncritical and passive acceptance of the manipulated images of mass culture – that we will increase adaptive capacity and community competence.

Information and Communication

In the face of system stress and shock, having access to trusted sources of information and a robust communications infrastructure is necessary for both individuals and communities to respond and adapt quickly. This is true not only for responding to disasters and emergencies, but also for creating and disseminating narratives of shared meaning and purpose in community life. Today, these narratives are increasingly the province of mass media that shape the terms, set the agenda and referee the debate on the disposition of conflicting values and the allocation of scarce resources to address common social and economic issues through public policy. Like it or not, mass media dominate our collective perceptual space. If organizations wish to intervene in communities to advance their goals, they have to participate in this "mediated" and "staged" environment themselves if they are going to be effective.

Consider, for example, that the fast food industry spent more than $4.2 billion on marketing and advertising in 2009, focusing extensively on television, the internet, social media sites and mobile applications (Yale Rudd Center, 2010). The effects of this messaging on obesity and related chronic conditions dwarf the impact, important as it is, of local and even national efforts to change eating habits and improve health. Social capital is a product of social consciousness, which in turn is reflexively formed in the heady cauldron of a shared language and mediated culture. If we are to reinvigorate social capital through greater participation in public life, we must move away from what is increasingly becoming a passive spectator role of "consuming" orchestrated news and cultural amusements and "reclaim" that mediated space through more artful and effective education and communication activities targeted at advocacy and public policy.

Narratives of shared purpose support the bonding, bridging and linking networks of constructive action. Over the past several years SLHI has invested in communications and message frame training for advocacy agencies and service providers that work with persons with serious mental illness and other disabilities. In addition to building organizational communications capacity, some of this work "places" human interest stories in the local media of people with disabilities who are vulnerable and often isolated in the face of economic and social dislocation. These stories, along with survey data and other relevant information, serve as a back drop for visits with key legislators, health officials and other policy leaders who are in a position to respond. In our experience, this type of media work plays an important role in fostering social capital.

Strategies for the Future

The multidimensional view of social capital described here provides a useful lens through which to view activities to improve individual and community health. The following development strategies are embedded in this more comprehensive framework. We offer them as provisional points of departure to stimulate further discussion and effective practice.

1. **THINK OF 'COMMUNITY' AS A PLURALITY.** Even when we limit our activity to a specific geographical place, we will in fact be working with multiple communities of space, identity, experience and markets. We will not fully leverage social connectedness in physically bound communities without also leveraging connections and experiences people have in these other dimensions of community.

2. **THINK OF COMMUNITIES AS NETWORKS.** Old world definitions and the experience of community are likely to be augmented and even replaced by the new world development of permeable networks that foster experimentation, innovation and discovery. Building networks shifts the attention outward to creating social connectedness characterized by quick learning, evaluation and adaptability.

3. **CONDUCT A SOCIAL CAPITAL SCAN.** Communities vary on quantity, quality and types of social connectedness. One community may exhibit a high degree of bonding social capital but lack bridging and linking capital to leverage significant change. Another may have access to sources of economic and political capital but be unable to take full advantage of them due to a lack of sufficient social trust between communities of identity existing uneasily in the same physical place. What we find in a particular community determines the course of action. One size, one approach do not serve all equally well.

4. **INVEST IN HUMAN CAPITAL.** It is a mistake to think of human agency as distinct and separate from social capital. Education and income are highly correlated with social interaction, social satisfaction and neighborhood cohesion for a reason: social capital is enhanced through human development. One of the best ways we can improve community health is to invest in education, training, skills and leadership development.

5. **CONNECT CIVIC AND POLITICAL INSTITUTIONS.** This is hardly a novel strategy in the history of American democracy, but many organizations remain uncomfortable in the messy world of advocacy, grassroots organizing and politics. Nevertheless, the protective benefits of bonding social capital and social cohesiveness are no substitute for confronting political power concerning social justice, access to services like health care and education, discrimination and other issues that have a significant impact on all dimensions of health.

6. **INVEST IN COMMUNITY "WELLS."** At the local level, space- and time-bound communities are enhanced by the presence of accessible and trusted "wells" of information, services and social connections. This is especially true in communities characterized by diverse populations and high rates of transience. If a specific community of identity "owns" such a well (e.g., an African-American church), it has to be networked with other groups and wells in order to decrease social separateness and foster identity with the larger community. Here, bridging social capital ameliorates some of the potentially negative impact of bonding social capital.

7. **RECLAIM AND RECREATE PUBLIC SPACE.** Hypermedia and communications technology are fueling the reconfiguration of public space as a riot of private spaces occupied by communities of identity and interests (race, ideology, lifestyle, religion, etc.) that have limited connection and a measure of trust and understanding with each other. Foundations with an appetite for intelligent risk are well positioned to serve as conveners and connectors of these groups in both physical and virtual settings. The caveat is that developing bonds of trust takes time. Foundations have to be prepared to stay with it for the long haul.

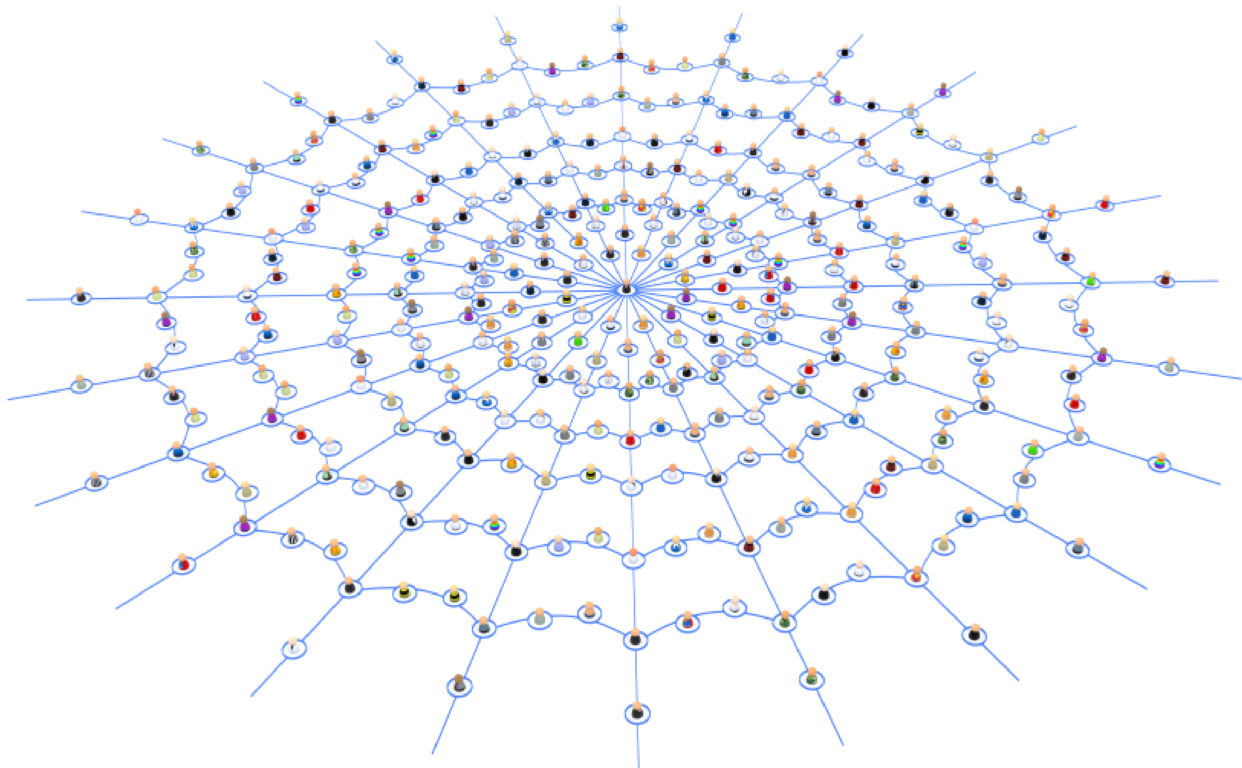
8. **LEVERAGE LOCAL CULTURE.** Start where people are rather than where you think they ought to be. Development organizations need to balance their own perceptions of time and measures of performance (project "periods," funding "cycles," "benchmarks" of success," etc.) with perceptions of time and social cohesiveness among quite distinct communities, such as recently arrived immigrants and Native Americans. In today's hyperworld of virtual encounters, short attention spans and a preoccupation with immediate results, people from all walks of life crave meaningful human contact. An environment where people meet, break bread together and engage in celebratory rituals enhances trust, communications and social reciprocity – all of which are necessary to build social capital.

9. **CREATURE AND NURTURE STRONG FEEDBACK LOOPS.** Robust and stable connectivity, both in a biological and social sense, allows individuals and communities to monitor and adapt to change. Feedback loops between all of the community participants and stakeholders must be developed, managed and maintained in order to promote an active community of learners, and not a passive community of consumers. Monitoring these feedback loops (social, environment, economic) to ensure that everyone is fully informed and engaged is critical to the development of bridging and linking social capital.

10. **PRACTICE ASSET-BASED PLANNING.** Resilient communities start their planning with a focus on their strengths and assets, not their deficits and limitations. It is impossible to mobilize and energize communities without asset-based plans that set priorities and goals; merge social, environmental, political and economic resources; and build local capacity. This process should arise organically out of the community, and not be "presented" for approval by a panel of experts.

A Profound Moral Imperative

All of us who seek to make a positive difference in the health and well-being of others can employ these and other strategies to weave the web of social connectedness and reciprocity that extends and sustains our common work. So it was in the beginning of the founding of this country, and so it is today: It is a profound moral imperative to connect with and to help others, so that we all ultimately may help ourselves. Bound thus together, we will learn to adapt successfully and thrive in the face of ceaseless change.



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