Social Connectedness

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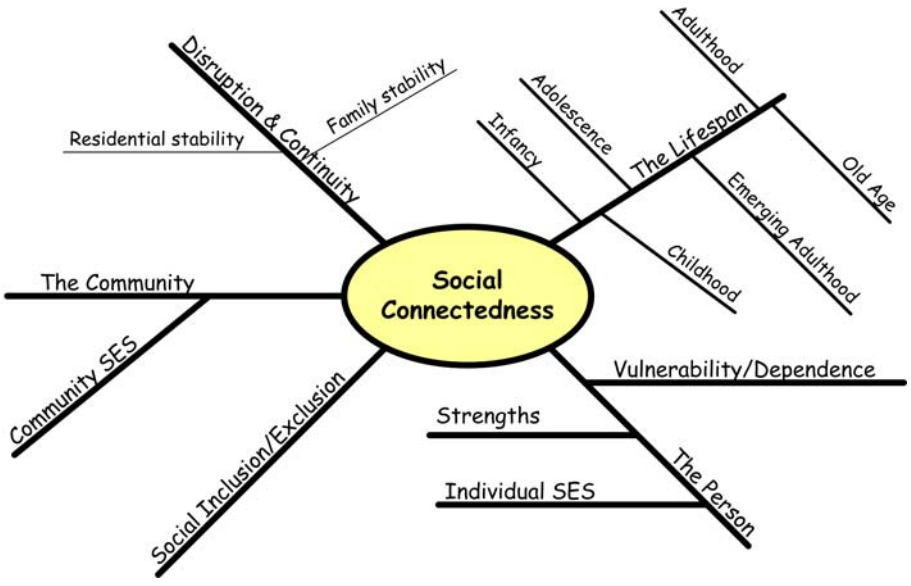
Evaluating the Healthy People 2020 Framework: The Minnesota Project



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Minnesota Department of Health
Community and Family Health Division
Office of Public Health Practice

Social Connectedness

Evaluating the Healthy People 2020 Framework: The Minnesota Project

July 2010

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Prepared by the Minnesota Department of Health
Community and Family Health Division
Office of Public Health Practice
P.O. Box 64882
St. Paul, MN 55164-0882

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If you have questions about this report, please contact:

Dorothy Bliss
Office of Public Health Practice
dorothy.bliss@state.mn.us
651-201-3871

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The Minnesota Project

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Table of Contents

Chapter One: Overview
- Introduction 1
- The Healthy People 2020 Overarching Framework: Recommendations for Social Connectedness 2
- Healthy People 2020 Vision and Goals: Social Connectedness Vision and Goals 4
- Minnesota Project Background 6
- Methodology 7
- Social Connectedness: A Social Determinant of Health 9
- A Mind Map and a Definition 10

Chapter Two: Profiles of Social Connectedness 17
- The East African Women's Center 19
- Light Rail, Rondo, and the ISAIAH Project 25

Chapter Three: Strategies for Social Connectedness 31
- Strategies for Assessing Social Connectedness 32
- Strategies to Strengthen Social Connectedness 35
- Social Connectedness in Action 39
- Measurement Strategies 45
  - Population-Based Indicators of Social Connectedness 46
  - Additional Measurement Tools 49

Chapter Four: Detail and References: Social Connectedness Mind Map 51
- Individual Components 53
- Community Components 61

Appendices 69
- A: Project Participants 71
- B: *A Call to Action*: Executive Summary 73
- C: Measurement Tool Details 79
- D: References 105

Tables and Figures
- Table 1: Healthy People 2020 Overarching Framework/Minnesota's Recommendations 5
- Figure 1: Social Determinants of Health 9
- Figure 2: Simple Mind Map of Social Connectedness 12
- Figure 3: Social Connectedness Mind Map 15

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A special thank-you to the
refugee women of the
East African Women's Center
for so generously sharing with us
their time and life stories

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Chapter One

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Overview

Introduction

According to Dr. Howard Koh, Assistant Secretary for Health, the Healthy People 2020 initiative "aims to unify national dialogue about health, motivate action, and encourage new directions in health promotion, providing a public health roadmap and compass for the country."[1]

A public health agenda for the nation has been periodically identified since the Surgeon General's *Healthy People* report in 1979. *Healthy People 2010* included two overarching goals: to increase years of healthy life and eliminate health disparities. *Healthy People 2020* adds two more overarching goals: promote quality of life, healthy development, and healthy behaviors across life stages; and create social and physical environments that promote good health.

This enhanced framework means that the Healthy People 2020 initiative is placing an even greater emphasis on the social determinants of health. It also recognizes that "the health of the individual is almost inseparable from the health of the larger community"[2] and thus continues an emphasis on engaging non-traditional public health partners in achieving the nation's health goals.

The Minnesota project to evaluate the Healthy People 2020 overarching framework took that social determinants emphasis and focused on the social determinant of social connectedness. Our purpose was to engage more deeply with that issue and advance our understanding and practice. Throughout this project we have worked with people from across the community to learn more about social connectedness and to link those discoveries back to the Healthy People framework.

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[1] Koh, Howard K. (2010). A 2020 Vision for Healthy People. The New England Journal of Medicine, 362:18, May 6, 2010, pp. 1653-1656.
[2] Healthy People 2020. 2nd ed. Washington, D.C.: Department of Health and Human Services, 2000.

The Healthy People 2020 Framework: Recommendations for Social Connectedness

The recommendations that emerged from Minnesota's project on social connectedness closely reflect the mission of Healthy People 2020. Not only will the findings of the Minnesota project help Healthy People 2020 to accomplish its mission, but the recommendations build on and demonstrate the importance of that mission.

Healthy People 2020 Mission: Identify nationwide health improvement priorities.

MN Project Recommendation #1:

Public health entities and their partners must consciously identify how healthy social connectedness can enhance their local, state and national health improvement priorities, as healthy social connectedness is a key factor in protecting, improving, and maintaining health.

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Healthy People 2020 Mission: Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.

MN Project Recommendation #2:

Public health entities and their partners must work to increase both public and professional awareness and understanding of social connectedness as a significant and pervasive determinant of health and well-being, and of the opportunities to harness social connectedness to improve health. This awareness of social connectedness and its impact on health can reap dividends through improvements in the way places, programs, and policies are developed.

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Healthy People 2020 Mission: Provide measurable objectives and goals that are applicable at the national, state, and local levels.

MN Project Recommendation #3:

Physical and social environments, policies, and programs must be assessed for the ways in which they strengthen, promote, neglect or disrupt social connections. While it is

important to use environments, policies and programs to *strengthen* social connectedness, it is just as important to assure that these environments, policies and programs do not *disrupt* or get in the way of opportunities for healthy social connections.

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Healthy People 2020 Mission: Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.

MN Project Recommendation #4:

Multiple sectors must be engaged in the identification and development of strategies, based on the best available knowledge and evidence, to strengthen and protect social connectedness in places, people, programs and policies, in order to develop an adequate range of strategies. Social connectedness is a shared concern and characteristic of all people everywhere. It also can be something very different depending upon your life experience and community context. A full range of strategies will help to assure that all people have the opportunity to form healthy social connections.

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Healthy People 2020 Mission: Identify critical research, evaluation, and data collection needs.

MN Project Recommendation #5:

Public health entities and their partners must continue to explore the potential of multiple measurement strategies for assessing the social connectedness of individuals, families and communities. The social determinants of health are difficult to quantify. Measuring and analyzing factors at the population, community and individual levels will be helpful for a more complete understanding of social connectedness.

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Healthy People 2020 Vision and Goals:
Social Connectedness Vision and Goals

In addition to the mission and recommendations, the Minnesota Project on Social Connectedness also recommends a vision and goals for social connectedness that parallel the vision and goals for Healthy People 2020 (see Table 1):

The Vision for Healthy People 2020:

- *A society in which all people live long, healthy lives.*

A Vision for Social Connectedness:

- A society in which all people are connected to the people, processes and systems they need to live healthy, productive and meaningful lives.

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Healthy People 2020 Overarching Goals:

- *Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.*
- *Achieve health equity, eliminate disparities, and improve the health of all groups.*
- *Create social and physical environments that promote good health for all.*
- *Promote quality of life, healthy development and healthy behaviors across all life stages.*

Social Connectedness Overarching Goals:

- Develop healthy social connections throughout life to prevent disease, disability, injury and premature death and assure a high quality of life.
- Achieve equity in the opportunity to form and maintain healthy individual, family, and community-level social connections.
- Provide opportunities for safe, healthy and productive social interactions in neighborhoods and communities.
- Promote strong, healthy social connections across all life stages to support healthy development and healthy behaviors.

The following table provides a side-by-side comparison of the Healthy People 2020 overarching framework and the vision, goals, and recommendations for social connectedness from the Minnesota Healthy People 2020 project.

Table 1: Healthy People 2020 Overarching Framework and Minnesota's Recommendations

Vision for Healthy People 2020	**A Vision for Social Connectedness**
A society in which all people live long, healthy lives.	A society in which all people are connected to the people, processes and systems they need to live healthy, productive and meaningful lives.
HP2020 Overarching Goals	**Social Connectedness Overarching Goals**
Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.	Develop healthy social connections throughout life to prevent disease, disability, injury and premature death and assure a high quality of life.
Achieve health equity, eliminate disparities, and improve the health of all groups.	Achieve equity in the opportunity to form and maintain healthy individual, family, and community-level social connections.
Create social and physical environments that promote good health for all.	Provide opportunities for safe, healthy and productive social interactions in neighborhoods and communities.
Promote quality of life, healthy development and healthy behaviors across all life stages.	Promote strong, healthy social connections across all life stages to support healthy development and healthy behaviors.
Healthy People 2020 Mission	*Recommendations: Social Connectedness and Health*
Identify nationwide health improvement priorities.	Public health entities and their partners must specifically identify how healthy social connectedness can enhance their local, state and national health improvement priorities.
Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.	Public health entities and their partners must work to increase both public and professional awareness and understanding of social connectedness as a significant and pervasive determinant of health and well-being and identify opportunities to harness social connectedness to improve health.
Provide measurable objectives and goals that are applicable at the national, state, and local levels.	Physical and social environments, policies, and programs must be assessed for the ways in which they strengthen, promote, neglect or disrupt social connections.
Engage multiple sectors to take action to strengthen policies and improve practices that are driven by the best available evidence and knowledge.	Multiple sectors must be engaged in the identification and development of strategies, based on the best available knowledge and evidence, to strengthen and protect social connectedness in places, people, programs and policies.
Identify critical research, evaluation, and data collection needs.	Public health entities and their partners must continue to explore the potential of multiple measurement strategies for assessing the social connectedness of individuals, families and communities.

Minnesota Project Background

In 2001, the Minnesota Department of Health (MDH) conducted a study to deepen understanding of the factors that impact health including social, economic, physical and environmental factors, all of which contribute to increased risk for illness, early death, disease and the health of mothers and infants (see Appendix B: Executive Summary of *A Call to Action: Advancing Health for All Through Social and Economic Change*). Factors such as housing, racism, stress, income and education have all been associated with poor health. With rapid increases in racial/ethnic populations in Minnesota and the persistence of disparities in health status, a focus on multiple contributing factors will be critical in eliminating health disparities. While our understanding of the impact of environment, community, and other social determinants on heath status of Minnesotans has improved in recent years, work still needs to be done to develop and support policies and programs to address these factors and continue to ensure that the elimination of health disparities is a high priority statewide.

In June 2009 MDH received a one-year grant from the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, to evaluate the framework of the upcoming *Healthy People 2020* national public health goals. The purpose of the grant was to have state, territory and tribal governments propose and conduct innovative and participatory strategic planning activities and processes, with an emphasis on multi-sector collaboration, using the *Healthy People 2020* framework and population health improvement concepts.

Minnesota decided that this grant would provide a timely opportunity to continue to deepen our understanding of the social determinants of health, by undertaking an in-depth analysis of a single social determinant. An internal planning committee decided to focus the project on social connectedness. We chose social connectedness because:

- Social connectedness is a powerful social determinant of health with ramifications across all four overarching goals of Healthy People 2020.
- National and international studies have documented that people who have strong social connectedness and healthy relationships have higher quality lives and contribute to better functioning, vibrant communities.
- Healthy social environments promote individual as well as environmental health as communities come together around shared norms and rules, and a healthy physical environment supports the development of strong social connections.
- Persons at all stages of life need social connectedness for optimum health.
- Social connectedness has major implications for and links to a broad spectrum of issues and areas, including the economy and employment, education, neighborhood safety, transportation, environmental protection, faith communities, and technology. The issues related to social connectedness also vary at different life stages.

Minnesota's project on social connectedness addresses several inter-related aspects of the Healthy People 2020 framework, including achieving health equity, eliminating health disparities, creating social environments that promote good health for all, promoting quality of life at all life stages, and increasing public awareness and understanding of the determinants of health, and engaging multiple sectors to take action to strengthen policies and improve practices. Through this project Minnesota has provided:

- An enhanced and more comprehensive understanding of the issue of social connectedness.
- A measurement strategy and a new way of looking at population-based indicators (demographic variables) as a starting point for assessing social connectedness.
- A variety of strategies for assessing and for strengthening social connectedness in places, policies, people and programs.
- A mind map that reveals the scope and complexity of social connectedness and that can serve as a tool to jump-start conversations and lead to further study of social connectedness as a social determinant of health.

Methodology

We began this project with an internal planning group of MDH staff. Through their recommendations we gathered a multi-sectoral group of research partners to help guide our efforts. These partners represent academia, the health care sector, populations of color, community organizations, education, human services, research organizations, and foundations (see Appendix A). In the first meeting we learned of the variety of interests and ideas each partner had related to social connectedness. We also attempted to find a common definition of social connectedness in the literature, and soon realized that these were too many and too diverse to fit our efforts. Our partners agreed to let the definition emerge from our work. The partners also expressed interest in hearing from organizations and groups that already are engaged in "on the ground" efforts to improve social connectedness.

After our second meeting we realized that a few meetings as a group was not going to be effective enough for providing the kind of in-depth information or revealing the nuances of social connectedness that we needed to gain the level of understanding that we sought. We therefore began to conduct a series of key informant interviews, beginning with the research partners themselves and then interviewing others that they recommended, as well as a few more that were suggested to us. We conducted a total of 22 key informant interviews (Appendix A). Each of the individuals we met with gave us at least an hour of their time, and sometimes much more. While time-consuming, this method eventually uncovered the vast range of issues associated with social connectedness, and ultimately helped us develop the mind map (p. 15) and the definition (p. 13).

In addition to the interviews, three groups gave presentations to the Research Partners Group: the Faribault, MN Diversity Coalition and Welcome Center, the St. Cloud, MN Create CommUNITY project, and the Minneapolis area East African Women's Center. The Faribault and St. Cloud projects are grantees of the Blue Cross Blue Shield of Minnesota Foundation's "Healthy Together" grants. The BCBS Foundation is an enthusiastic supporter of the relationship between social connectedness and health, especially for Minnesota's large and growing immigrant community. The East African Women's Center is a program of the Confederation of Somali Community in Minnesota, depending on grants from a variety of sources.

Time and distance did not permit us to visit all these projects in person. We were able, however, to visit the East African Women's Center in Minneapolis several times to hear and see what they are about. An in-depth profile of the Center and how social connectedness is such a critical issue for these women and children is included in this report (p. 19). A special thank-you is due to the women of the Center for the generosity with which they shared their stories and helped us understand social connectedness in the full context of their lived experience.

We also had the opportunity to attend a large community gathering organized by the ISAIAH project, a congregation-based, grass-roots organizing group that has received a Robert Wood Johnson Foundation grant to conduct a health impact assessment (HIA) for the planned light rail transit corridor between the cities of Minneapolis and St. Paul. Social connectednesses is a significant aspect of both the history of the affected community and in the strategies for influencing public policy as the plans for the Central Corridor project develop (p. 25).

At the same time that we were holding meetings and conducting interviews, we were scanning and examining the literature for definitions of social connectedness, measures of social connectedness, information about social connectedness and health, and related issues such as social capital, social networks, and a host of other issues that were suggested to us. We found that, in part because of the overabundance of terminology, finding a cohesive body of literature on social connectedness to review was virtually impossible. We eventually decided to use our key informant interviews as a guide to the issues associated with social connectedness, and assembled a set of references on many of these issues (Appendix C).

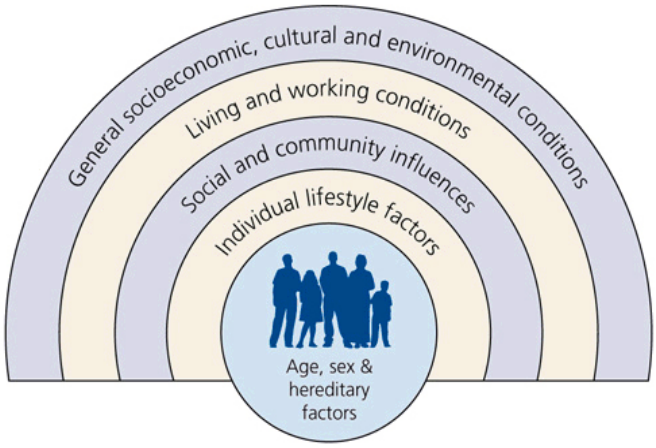
Social Connectedness: A Social Determinant of Health

According to the Commission on Social Determinants of Health (2008), "social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and the risk of premature death." The concern for social justice is and always has been a driving force behind public health, and is now a major factor in the growing body of research, recommendations and actions related to the social determinants of health.

The social determinants of health are the living and working conditions of our lives; the circumstances in which we all grow, live, work and age, the systems we encounter along the way, and the policies that shape those systems. Some of our health status is affected by our physical environment, our individual behaviors, the health care we receive, and our genetic heritage. But far more of our health is a product of our social environment (especially as children), including our education and income. These factors determine whether we live in healthy surroundings, have the opportunity to make healthy choices, have access to health care, and are able to realize our biological potential. They affect our bodies' biochemistry through the chronic stress of living with racism, for example, or being powerless and cut off from participation in the society at large.

The body of research on social determinants of health is large and growing. Social determinants often are characterized as of layers of influence on our individual health (Figure 1).

Figure 1: Social Determinants of Health



Dahlgren G, Whitehead M. *Policies and strategies to promote social equity in health*. Stockholm: Institute of Futures Studies, 1991.

The overarching framework of Healthy People 2020 acknowledges these critical influences on health by stressing social and physical environments, health equity and the elimination of health disparities, stronger policies, and improved public heath practices.

In Minnesota, the social determinants of health were the subject of study and recommendations by the *Social Conditions and Health Action Team* of the *Minnesota Health Improvement Partnership* (2001). This group acknowledged the glaring disparities in health status that exist in Minnesota between whites and American Indians, populations of color, foreign-born populations, and people with low income. One recommendation of this group is to expand the traditional indicators of health to reflect the social and economic determinants of health (see the *Executive Summary*, Appendix B).

The project to evaluate the framework for Healthy People 2020 provided an opportunity to follow up on that recommendation by choosing just one of the social determinants of health, gaining a deeper understanding of that determinant, and identifying measures for assessing it. The social determinant of health that we chose to study for this project was social connectedness.

Studies have been made of many kinds of social factors, including social support, social connectedness, community connectedness, social cohesion, social integration, social networks, and social inclusion (to name a few). While not consistent in the use of terms, this body of research provides considerable evidence of the strong association between these different aspects of human social characteristics and health. Nonetheless, the exact nature of the relationship "remains elusive" (Stansfeld 2006, p. 148). In other words, although the association is strong (people with positive social connections are healthier), the pathways by which social connectedness yields these positive benefits are difficult to evaluate.

We decided, despite the uncertainty over how it works exactly, and because the type of research required to untangle that complex relationship was far beyond the scope of this particular grant, to accept as a given the strong association between the human as a social being and human health. With that as a foundation, we intended to define the concept of social connectedness more clearly and then to identify a few key measures that would lead to a better assessment of this social determinant of health, for the purposes of identifying and framing public health goals at both the local and state levels. We also used our analysis as a way to evaluate the overarching framework of *Healthy People 2020*.

A Mind Map and a Definition

The first difficulty we encountered with this plan was the lack of a common or consistent definition of social connectedness, either in the literature or among our research partners. At its most basic, social connectedness is defined as "the relationships people have with others" (New Zealand, 2003). Yet from our interviews and as we continued to scan the literature we started to recognize that, while individual, interpersonal relationships are the foundation of social connectedness, those relationships do not occur in isolation. Rather, like all the social

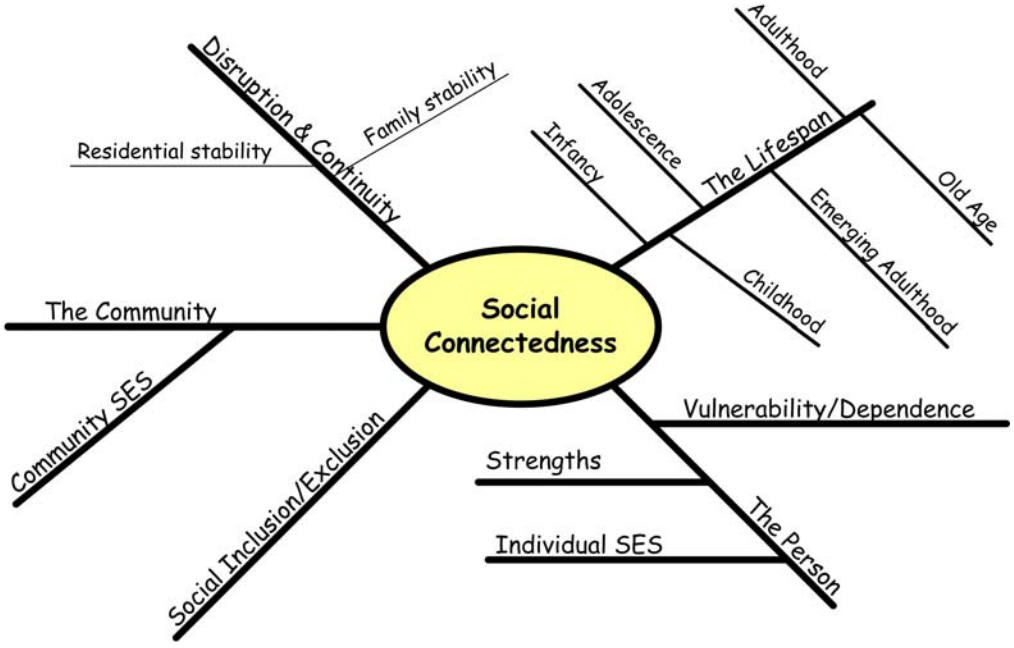
determinants of health, they are embedded within communities and systems and affected by the physical environment as well as the decisions made by those who hold power (including decision-makers in political, economic, and educational systems). Social connectedness (or lack of it) can give you a place at the table, or keep you out of the room altogether. It became apparent, therefore, that to speak of social connectedness only in terms of the individual without considering the layers of social, economic and political factors that affect social connectedness would be to overlook a key set of variables that are critical for understanding and responding to this issue.

We decided, therefore, to not force the issue of a definition until we had sorted out more of the issues related to social connectedness. The number of those issues, however, grew with every meeting we held and every interview we conducted. The issue of social connectedness, in fact, began to seem so amorphous that we were not certain it was possible to define it at all.

After more than half our key informant interviews were completed, we learned of an organizing tool called a “mind map.” A mind map is a diagram that is useful for writing, problem solving, decision making, and organizing information. On the mind map, words and ideas are arranged around a central concept. It seemed as if a mind map might be the kind of framework we needed to sort through the myriad of issues and factors associated with social connectedness we were hearing and learning about.

The first hopeful sign of clarification that emerged from the mind-mapping technique was that the factors on our growing list fell fairly clearly into two broad categories: the person and the community (represented in Figure 2 by the right and left sides of the map). Social connectedness factors related to the person include their age, gender, personality, strengths/vulnerabilities, income, and employment. Factors related to the community include the physical environment, political and economic forces, institutional racism, and systems such as schools and public services.

Figure 2: Simple Mind Map of Social Connectedness



Over time, with additional interviews and continued literature search, the map grew and factors were added. Figure 3 (p. 15) shows the mind map with all the associated factors. The two main categories are represented as blue (the person) and green (the community) lines.

The Research Partners Group found the mind map of social connectedness to be useful for "seeing" and understanding the scope and complexity of the issue of social connectedness, and for starting conversations about these factors. Over the final months of our project we shared the drafts of the map with individuals and groups to see if they could "see themselves" on the map. The feedback generated from this process was very positive, and also helped us continue to make adjustments to the map.

The map continues to be a work in progress. It is not an analytical tool, as it does not show relationships among the factors, or hint at their relative strength. It may, however, provide a useful framework for future research and study. Appendix C takes several factors from each major branch of the map and provides some explanation and key references for those factors. We welcome efforts to continue to expand and improve on this work and to contribute to the understanding of social connectedness as a social determinant of health.

Definition

It was in developing the mind map and thinking about the many different factors that contribute to or detract from social connectedness that we ultimately were able to create a definition of social connectedness for this project:

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Minnesota definition of social connectedness:

Social connectedness refers to an *individual's* engagement
in an *interactive web* of key *relationships*,
within *communities* that have particular physical and social *structures*
that are affected by broad economic and political *forces*.

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The "layers" of the definition – individuals and their webs of relationships; the community with its physical and social structures; and economic and political forces – reflect our findings about the context of social connectedness and the personal and community factors discussed above, and is consistent with the depiction of the social determinants of health in Figure 1 (p. 9).

On the one hand, social connectedness is all about the person: how old they are (the lifespan), their personality, their income, occupation, education, and other personal characteristics. Social connectedness, however, is a feature of and influenced by communities: the other people, structures, economy, and social fabric into which individuals are woven. Both the individual and societal aspects of social connectedness must be considered as strategies to improve health are being developed. To address only individual, personal characteristics (i.e., ability to form healthy relationships) without considering the community context (family instability, economic opportunity, community history) would place limits on the effectiveness of the intervention.

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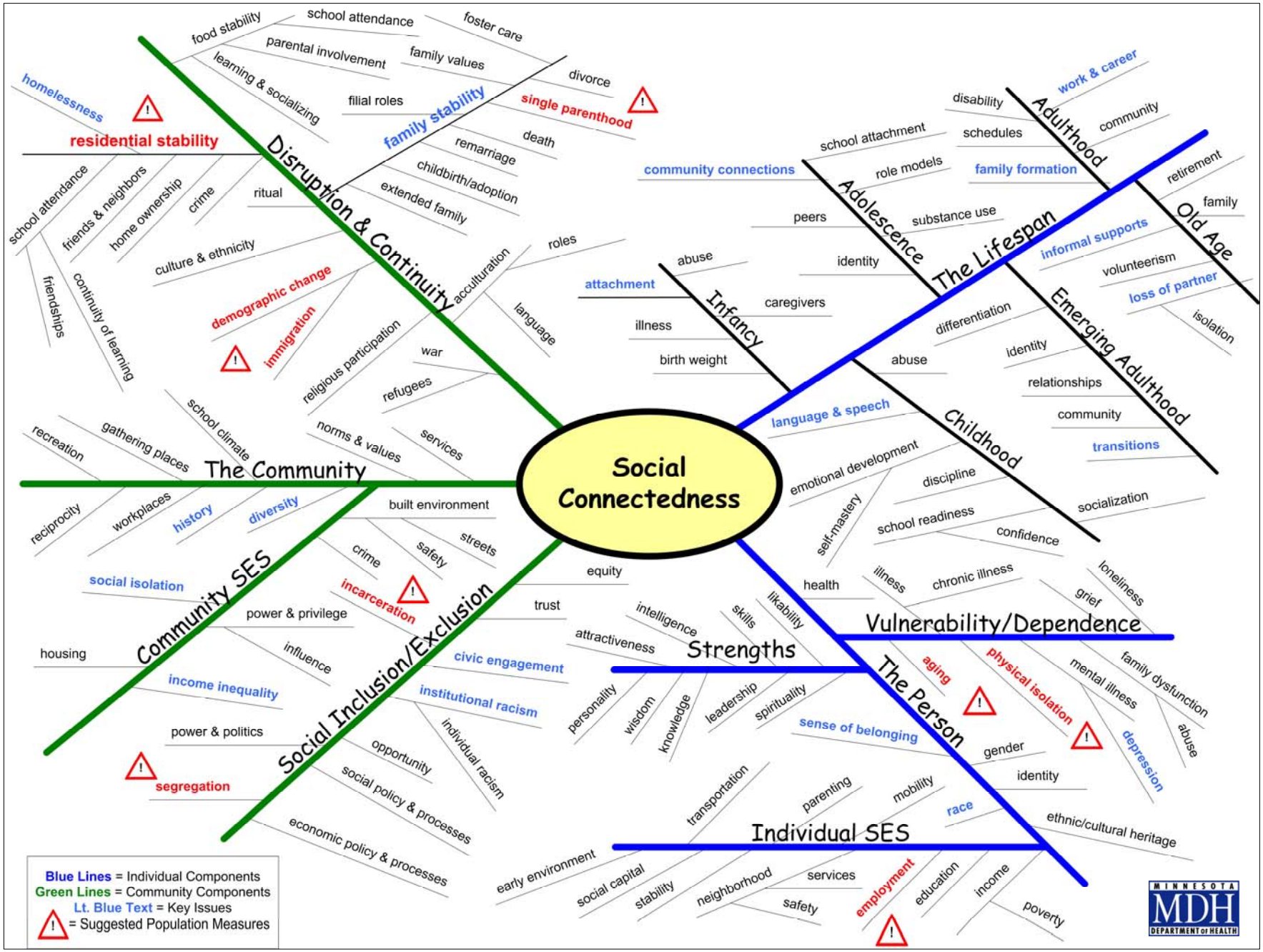

DEFINITION: Social connectedness refers to an *individual's* engagement in an interactive web of key *relationships* within *communities* that have particular physical and social *structures* that are affected by broad economic and political *forces*.

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Chapter Two

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Profiles of Social Connectedness

To more effectively illustrate and explore the concept of social connectedness, we determined that it would be helpful to profile social connectedness across a single person's lifespan. We were looking to understand better the intersection of people, places, policies and programs and the ways in which these encounters can strengthen and/or disrupt social connections.

In the course of our interviews, we also came to recognize that social connectedness is a feature of communities, and that these communities also have a "lifespan." It seemed that it would be instructive, therefore, to profile a community as well, looking again for the signs and influences of social connectedness and the intersections of people with places, policies and programs.

To that end, we completed two profiles, one of an individual and one of a community. The individual profile is a composite, due to sensitive issues that are explained in the profile. The community profile is a compilation of fragments of history, community action, and current events. We hope that both of these stories serve to illustrate the way in which social connectedness is woven throughout our lives and our health.

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Profile 1: The East African Women's Center[1]

Two year-old Saalima[2] made sure she had the visitor's attention. Her eyes sparkled and her face was alive with interest in this new audience. "Watch me!" she said, and she jumped up and down with the other children. "Watch me!" she repeated, as she went over to slide down the tiny children's gym set.

It's hard to believe today that as a one-year old, Saalima was terrified of strangers. At home in the apartment, baby Saalima was very quiet, spending most of her day strapped in a car seat in front of the television. The first time her mother, N., brought her to day care at the East African Women's Center, she screamed non-stop. She continued to cry at the Center for two months. Staff were concerned that Saalima might be displaying early signs of autism.

Today, Saalima switches effortlessly between English and Somali to communicate with her family and her caregivers – and visitors to the Center. She is energetic, sociable, and healthy.

Saalima's mother, N., is a refugee from Somalia. Like most of the woman at the Center, she was uprooted from her homeland by the nearly 20 years of civil war in that country. N. spent her own childhood in a refugee camp in Kenya with her very large nuclear and extended family. She married at the age of 17, in part to relieve her parents of having to care for her, and, since her husband was coming to the U.S., she entertained the hope of being able to eventually help her family. When she came to the U.S. with her husband she already had one daughter and another (Saalima) on the way. N. and her small family settled in a two-bedroom apartment in the Riverside Plaza complex in Minneapolis, Minnesota.

Over 4,000 people in 1,303 housing units call this crowded cluster of high-rise buildings home. It is the most densely populated block between Chicago and Los Angeles. Currently about 85 percent of the occupants are East African, many of whom are Somali. (People from Somalia live throughout the state, not just in Minneapolis. Minnesota, in fact, has the largest population of Somalis in the U.S.)

The Riverside Plaza was built in 1973, near the University of Minnesota, and always has been home to a diverse population, although the make-up of that diversity has constantly changed. Currently, about half the complex is reserved for subsidized housing, far more than the 20 percent originally planned. The Cedar-Riverside neighborhood (so named for the two major streets that intersect there) is very low-income: it has more than twice the percent of people in

[1] A program of the Confederation of Somali Community of Minnesota.
[2] Pseudonym

poverty than Minneapolis as a whole. The median household income of Cedar-Riverside in 1999 was $14,367, compared to $37,974 for the City of Minneapolis.[3]

When N. came, despite being surrounded by other Somalis and East Africans in the complex, she was friendless and alone. N. knew no English and no one besides her husband. The new environment she had landed in was so completely different from everything she had ever known that she was terrified to go outside. She knew of no gathering places for women; her husband had his job and the local coffee shop for gathering with other men. After Saalima was born, N. spent the better part of a year without ever leaving the apartment. Sometimes she would not even eat until her husband came home.

From her apartment window, N. could see a brightly colored children's outdoor play set and other East African women and their children. She often longed to be a part of the group, but still was hesitant to venture out. Eventually, however, love and concern for her daughters gave her courage, as she realized that being shut indoors was not good for her or for them. She finally approached one of the women by the play set and thus found her way to the Women's Center. There she found a group of women that were creating community and becoming "sisters" to one another. She found out about opportunities to learn English and was able to enroll her daughters in the Center's day care so she could take the classes. N. was able to participate in the sewing lessons as well, increasing her opportunities to make a small side income. Her children found playmates and teachers, "aunties" and "grandmas" in the growing bonds among this community of women.

N. recently graduated from the specially-designed English classes, originated by the Women's Center, on child development (a subject of more immediate relevance and much more interest for the women than job-oriented English). Through those classes she has completed the required classroom portion of a child-development associate (CDA) certificate. She now intends to complete the volunteer hours required for the certificate. Eventually she would like to be a teacher. And just as N.'s confidence has grown, her daughters, too, have been able to blossom. "Watch me!"

♦

Saalima is a real little girl at the Women's Center. Her mother's story, however, is a composite based on the lives of several of the women. Many of their individual stories are even more dramatic and contain significant trauma. Because of this, we agreed not to describe any one person.

[3] Minneapolis Community Planning and Economic Development, with data from the U.S. Census of Population and Housing).

We met the women of the Center four times: once when they came to make a presentation to our Research Partners Group (a meeting they braved a snowstorm to attend, so determined are they to share their stories), and three times at the Center – including once to share in their celebration for the six women who have completed the CDA classroom work. The women and the Center's director, Doroth Mayer, expressed a great deal of interest and enthusiasm for our project on social connectedness, as it captures so much of what they are about; thus they were willing to give quite a bit of their time.

On one of our visits to the Center about a dozen of the women sat with us, shared some of their personal journeys and answered our questions. They spoke of their lives before the war, before coming to the U.S., and before and after finding the Women's Center.

All of the women spoke of a rich rural and communal life in Somalia (as well as in Mali, Yemen, Ethiopia, and Kenya) and in the refugee camps. Very large families are common, and include multiple generations and extended family members. Boys and girls alike receive some education. Only one or two of the older children, however, are selected to go to high school. Life in the villages can be hard, and high school costs money, so these educated children are expected eventually to go to work in the city and send money back to the family in the village.

One of the things the women took pains to explain to us is that the idea of deliberate "school readiness" (as we understand it in the U.S.) is very foreign to them. In their homelands, schooling is considered to be the responsibility of the teacher (and the student). Children are not read to at home, nor introduced to books. Once they do get to school, they are expected to do well, and parents do not help with homework. One woman said, "I thought my kids would start learning once they went to school." The world of the family and the school are separate worlds, even in the refugee camps.

On the other hand, from the women's descriptions of their lives, whether in the homeland or the refugee camps, it is clear that children do have informal preparation for school. They are constantly surrounded by many people of all ages and are actively learning all kinds of things – such as how to behave properly, how to act in different settings, and how to play with other children.

The U.S., however, has a very different culture, and for this population of refugees, a drastically different culture for raising children. Alone and isolated in small apartments, children do not learn how to socialize. The East African mothers do not pack up and take their children everywhere, as many American mothers do. The children may never encounter an unfamiliar face – especially not a white face, or people using a different language, or wearing unfamiliar clothing (which explains some of Saalima's terror upon coming to the Center, as it has both African and European staff).

The East African mothers were never read to, and so – even if they had children's books, which they do not – they do not read to their children. To ease the loneliness, the women, and their children, sit in front of the television, understanding nothing. One woman said, "Sometimes you get depressed when you stay at home. You think a lot." Another said, "When you stay home, you feel sick. You don't know how to answer the phone, how to read letters." Some experienced frequent headaches.

The children in these situations, when they first come to school at age six, are anything but ready to learn. They have a vocabulary of about 200 words, instead of 2,000. They do not know how to work independently, play and get along with other children of the same age, or participate in structured situations such as play and story reading. They are at high risk of developing emotional, social and health problems.

At the Women's Center, the women learned about the concept of school readiness and their role as "first teachers" of their children. Through partnerships the Center has with early childhood and nursing experts at the University of Minnesota and Augsburg University, these young mothers learn about teaching their children to put away their toys, showing them how to do simple household chores, and helping them develop language by telling stories, teaching them numbers, colors and letters, and reading to them. When the Center first opened, Ms. Mayer said the women laughed at her when she read books to one of the first infants to be enrolled. She trusted, however, that eventually he would make her case, and indeed he did, becoming a bright, verbal, and friendly child.

The women benefit tremendously as well, as the Center has provided a source of community that they lost as refugees from a war-torn country. One woman said, "We didn't know each other before, just by our face. Now we are like sisters, we eat together, we laugh together, and we fight with each other. We are like a family. When we are here, it's like being back home. I feel like I'm with my family. Everybody is busy, but if you take some time to come here, then you share things with each other and help each other."

Another said, "When you come to the Center, sometimes you are really stressed. But you leave here feeling better. You get more confident and you gain more experience here."

The success of the women and their children are deeply intertwined. Because so many of these women are at home with young children, the Center wanted to meet their expressed need for parenting and child development information. The Center sought and received approval to adapt the CDA certification curriculum to be culturally relevant for the East African/Somali population. The adaptation was done in partnership with the women. English classes were then built around this program, rather than using the traditional English Language Learning (ELL) curriculum centered around "typical" job skills. The women attend the class Monday through

Thursday every week, for nine months. They work hard and help each other to be successful. The director said she thinks they may even care more for each others' success than for their own.

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Social connectedness runs throughout the life stories of these women. They had strong family systems, which were disrupted by war. They reestablished family connections in the refugee camps in Kenya, and in various places in Europe. These connections were disrupted again by moving to the U.S.

Although for refugees the opportunity to come to the U.S. is sought after, resettlement policies (especially the "lottery") can disrupt family connections by focusing on individuals. One of the Somali women was chosen, by lottery, to come to the U.S., but had to leave her husband and small child behind. She eventually went back to Africa until they were all able to come back together.

Once here in the U.S., these refugee women are sorely lacking in social connectedness. Their husbands have their jobs and get to go out and enjoy arguing together at the local coffee shop. No mother, no sisters, no aunties, and no English for navigating the world outside leaves these women isolated and at high risk for mental health and health problems. Several of them mentioned the terrible headaches they used to get. Most of them got very limited physical exercise.[4]

For these women, finding the Center is not about getting social services. It is about finding a community. They receive day care for their children and English classes. But they experience these services in community.

The day care is staffed by Somali women so that children can retain their culture, their language and their religion.[5] The women learn English together, rather than as individual students in a class of strangers, on topics they care about (cooking, child development). They are learning about nutrition together. One week, someone will cook a traditional food for the cooking class; the following week they will all try to adapt it to be healthier. The younger women are learning traditional skills from the older women, skills such as weaving, drumming, and dancing. (These activities were once a natural part of village life in Somalia, but were lost in the refugee camps.) The women share their stories. They laugh and cry together. They help each

[4] This is an issue that remains of concern, as the traditional Somali dress restricts movement and the requirements of modesty limit the places where women can exercise. In addition, neighborhood safety and the way in which the nearby freeways restrict pedestrian traffic also limit where women can simply go for a walk.

[5] Several of the women mentioned that they prefer day care at the Center to the Head Start Program, because even though Head Start helps the children learn, they lose their first language and start speaking only English. One two-year old at the Center switches among three languages: English and Somali, for the Center staff, and Oromo, her family's language.

other solve health problems and navigate the health care system. They are “sisters”, because they have found a way, through the Center, to replace the social connectedness they once had through their biological families.

This social connectedness for the women translates directly into healthy development for their children. Saalima is a bright and articulate two-year-old today, not because she received special services as an individual, but because she and her mother had the opportunity to experience normal child care provided close to home and within a warm and embracing community that is both new (new people, new language, new food, new skills) and familiar (familiar language, familiar customs). Saalima and N. are thriving today because of the social connectedness provided to them as a family within a community that supports them and helps them navigate the economic, political and social environments in Minnesota and the U.S.

This investment in social connectedness for these women will reap benefits for the community and society. At the graduation celebration, one of the young mothers, who is planning to continue on for her CDA certificate and ultimately college, said, “Never give up. We are doing this not just for our children, but for all the children, the poor children, all children, to help them learn.”

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Profile 2: Light Rail, Rondo, and the ISAIAH Project

Part I: Social Connectedness and the Building of a Freeway: the Rondo Experience[6]

The most straightforward version of this story is that in the late 1950s and early 1960s a freeway was constructed right down the middle of a vibrant African-American neighborhood in St. Paul, splitting the area in two and forever changing the nature of the community. The whole history, however, is more complex and quite informative, especially when considering social connectedness.

The area remembered now as "Rondo" was first settled in the 1800s. The area had been bought by Joseph Rondeau, and the main commercial street – Rondo – was named after him. The neighborhood went through a number of demographic changes from the various waves of immigrant populations that settled there: Russians, Germans, Jews, Irish, and eventually African-Americans. By 1910, although less than half the total population of Rondo, the neighborhood contained two-thirds of the African-American population in St. Paul.

The Rondo of the 1920s, 30s and 40s was a tightly-knit, fully integrated, and highly interactive neighborhood. People had access to jobs via the Rondo-Stryker Streetcar and bus routes. Churches were active parts of the community, and the African-American community formed many social clubs, which met in people's homes.

Gradually the neighborhood became more predominately African-American, and, due to a subsequent lack of investment and recognition by city agencies[7], the housing stock, streets, and infrastructure started to decline. Eventually the Rondo area was designated as "blighted", with many tenements and homes with tarpaper siding. The streetcar and bus lines ceased, effectively restricting employment opportunities and also forcing small businesses to close, and adding to the impoverishment of residents. Absentee landlords took advantage of cheap housing prices and contributed further to the decline. Still the people of the community continued in their social connections, living, working, playing and worshipping together, despite the poverty.

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[6] Information for the history of the Rondo neighborhood comes from *Section 3: Western Park Neighborhood History* (undated file). The historical summary was drawn from research papers written by Macalester College Urban Studies students Emily Davidson, Marisol Gomez, Johanna Jones, and Emily Skidmore. Retrieved from: http://www.publicartstpaul.org/downloads/westernhistory-1.pdf. Additional information about the Rondo neighborhood is available from the Minnesota History Society website. Rondo Neighborhood and the Building of I-94: http://www.mnhs.org/library/tips/history_topics/112rondo.html.

[7] The Kirwan Institute at the University of Ohio is working with the ISAIAH project, and has done research on this issue of structural racism, "a method of analysis that is used to examine how historical legacies, individuals, structures, and institutions work interactively to distribute material and symbolic advantages and disadvantages along racial lines." http://kirwaninstitute.org/research/structural-racism.php.

The area was finally targeted for urban renewal and redevelopment – but not for the area residents. The 1952 "Western Redevelopment Project" displaced 608 families, 35 percent of whom were African-American, with no plans for relocating them. In place of the homes that were destroyed, the city built a public school, a park, and designated 24 acres for commercial development but only 11 acres for residences.

On the heels of this redevelopment came the construction of Interstate 94. The decision was made to locate the freeway along – that is, on top of – Rondo Avenue. Area residents did not have a voice in this decision. Another 400 homes were destroyed, 300 of which were occupied by African-Americans. The consequences this time, however, were even more far-reaching. In addition to displacing people, this limited-access road split the community in two, cutting off connections not only to the businesses on either side of the freeway, but also to friends, relatives, churches, and social clubs. The social, economic, and physical effects of that split are still felt, a deep wound that lingers in the collective memory of those who lived there and those who followed.

Yet the spirit of Rondo remains. Since 1982 residents have held a "Rondo Days Festival" every year in mid-July to celebrate "the values and heritage of the Rondo neighborhood" and bring back a sense of community, stability, and neighborhood values. It is the largest African-American celebration in Minnesota. The Festival web site describes Rondo as "a place where you could scold your neighbor's child – and quite frankly, parents expected it, and depended on it, because paramount was the raising of the child which everyone in those days knew took a community. It was a place where people took you in and looked after you – whether you needed a job, a meal, or a place to stay." [8] In other words, the people had very strong social connections, which were disrupted by policies which forever changed the place in which they lived.

Although the community, especially the section that is sandwiched into an isolated, quarter-mile by two-mile strip of land between I-94 and the high-traffic University Avenue, has continued to struggle with lack of recognition and representation on district councils and development commissions, their determination and capacity to influence their own fate has continued to grow.

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Part II: ISAIAH: Connecting a Community for Social and Economic Justice

On an overcast evening in June 2010 over 250 people gathered in the cafeteria of a high school in New Hope, Minnesota, a northwestern suburb of Minneapolis. Just weeks earlier similar sized meetings were held in the east metro (St. Paul) and St Cloud areas. These

[8] http://www.rondodays.com/aboutrondo.html

community meetings were organized by ISAIAH to hold "a new and uncommon conversation [about the] unacceptable gaps between Minnesotans of color and white Minnesotans in housing, education, and health status." Participants heard from speakers about their personal and professional experiences with opportunity and blocked opportunity, with privilege and discrimination, with discouragement and hope. Sitting around lunchroom tables, groups of two to eight engaged in conversations about their own experiences and their hopes for co-creating a more just world.

Each of these three community meetings was the culmination of months of planning and hundreds of small-group meetings of ISAIAH members around the Twin Cities and St Cloud metro areas. ISAIAH[9] is a multi-ethnic, democratic congregation-based community organization in the Twin Cities and St. Cloud regions of Minnesota. ISAIAH's 100 member congregations represent over 175,000 people from many diverse denominations, including clergy and members of white middle-class suburban churches, low-income African-American congregations and Spanish-speaking churches. ISAIAH's mission is to promote racial and economic justice through intentional, intensive relationship and leadership development and collective, faith-based actions with the goal of effecting systemic change. The organization works to ensure that all people, regardless of class, race, ethnicity or religion, are involved in creating the region's future and benefit from the region's growth.

The social connectedness of ISAIAH is evident in their strategies and structures. For example, every single person who came to the spring meetings was personally invited. As one of the organizers said, "no one comes to a meeting from a brochure." It is not the meetings that effect change, but the relationships that are formed.

Congregation core teams are the heart and soul of ISAIAH. These core teams bring people together in homes and churches, both around their faith and around their desire to create a just society, beginning in their own neighborhoods and extending outward from there. ISAIAH explicitly rejects the language of scarcity and the accompanying pressure to pit people and causes against each other (e.g., health against education, schools against transportation, etc.). They emphasize relationship building as a key strategy to finding creative, innovate solutions that benefit everyone.

These congregation-based core teams were responsible for inviting not only their friends and neighbors to the community meeting, but public officials as well. Over twenty public officials (elected and appointed) showed up, participated in the table conversations, and received public acknowledgement of the key role they play in bringing economic and social justice to the community.

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[9] http://www.gamaliel.org/ISAIAH/default.htm

Part III: Potential Impact of Light Rail Transit on a Connected Community

Just four blocks to the north of I-94 lies University Avenue, a bustling commercial street that is part of what was once the Rondo area. Many small businesses operate on University, with a mix of businesses and residences located in the area squeezed between I-94 and University Avenue. While not replacing Rondo Avenue, this area has become its own kind of community. The neighborhood continues to attract many of Minnesota's immigrants, more recently including people from a number of different Asian, African, and Central American countries.

Now another phase of urban development is ready to take place, and the community is poised this time to ensure that history does *not* repeat itself. While light rail transit (LRT) has been discussed in the Twin Cities area for decades, it was only recently realized with the construction of a line along an industrial corridor in Minneapolis. Now a new (LRT) line is scheduled to be built along University and Washington Avenues, connecting downtown St. Paul and the state capitol with the University of Minnesota and downtown Minneapolis. The Central Corridor LRT, as it is known, is scheduled to begin passenger service in 2014. Just as with the construction of a freeway, the effect of the LRT line will be felt most strongly in the neighborhoods that it runs through.

The City of St. Paul and the Met Council have a vision and strategy for how light rail will contribute to the growth and change of University Avenue and downtown St. Paul over the next twenty years. The resolve of community groups is to make sure that the implementation of that vision (for example, rezoning the land along the Corridor) is racially, socially, and economically just; to make sure that it does not benefit some groups to the detriment of others, particularly populations of color and those of limited means.

One major concern over the LRT project is the potential for displacement once again, as property values rise along the corridor and its accompanying development, squeezing small businesses and lower-income residents out of their neighborhoods unless plans are made for affordable housing. Other issues raised by the community (through a variety of forums) include:

- Well-paying jobs and contracts for vulnerable populations, including women, lower earners and minorities.
- Retention of neighborhoods' diverse cultural identities.
- Maintenance and expansion of bus service along and from University Avenue to other parts of St. Paul and Twin Cities metropolitan area.
- Safe, convenient street crossings for pedestrians and other safety concerns.
- Integration of East Side St. Paul in light rail benefits and opportunities.[10]

[10] *Healthy Corridor for All: Evaluating Health Impacts of New Land Use Development Along the Central Corridor.* Information provided by ISAIAH, Take Action Minnesota, and PolicyLink, July 2010. http://gamaliel.org/ISAIAH/Issues/HealthyCorridorforAll.htm

Civil rights activists, business owners, and residents in the area of Rondo/University filed a lawsuit in federal court to challenge the legality of the planning efforts of the Central Corridor Light Rail Transit Project and provide an opportunity to address community concerns. Another coalition, led and convened by ISAIAH, has received a Robert Wood Johnson Foundation grant to conduct a health impact assessment (HIA) to assure that the project will not have a negative impact on residents' health.

The HIA is an opportunity for community members to partner with policy makers and technical experts[11] to affect the type of systemic change they envisioned at that spring meeting in New Hope. The HIA will consider things such as transportation options that allow people access to health care, healthy foods, and each other; safe and attractive places to walk so that people can get exercise; secure places for children to play and where neighbors can gather together; and the creation of living-wage jobs that provide economic and residential stability.

Social connectedness is a key aspect of all of these issues: transportation to stay connected with one another and with jobs, safety and security to be outdoors and in contact with others, and jobs that create the stability that can lead to long-term relationships. An HIA also examines policies to see how they might differentially affect low versus high income families, or communities of color versus white communities. The findings of this HIA are expected in early 2011, before the St. Paul Planning Commission is due to present their re-zoning recommendations to the St. Paul City Council.

The social connectedness that is part of the Rondo heritage – a thriving, connected community – is now playing a critical role in this new chapter, as ISAIAH, along with many other community leaders and local residents work together to assure that the health and well-being of their neighbors and the whole community is protected and strengthened.

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[11]The Minnesota Department of Health is supporting the HIA in a variety of ways, including providing technical expertise by collaborating with other experts on a Technical Advisory Panel and providing data on community indicators in the area, such as asthma hospitalization rates, full-service grocery store availability and elevated blood lead levels, as well as information on potential environmental contamination sites along the planned Central Corridor Light Rail route. http://www.health.state.mn.us/cclrt.

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Chapter Three

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Strategies for Social Connectedness

It was the consensus of the Research Partners Group and our other key informants that the findings of this project should emphasize *what can be done* to strengthen social connectedness. The ideas for the interventions listed here came primarily from the work in the field being conducted by our partners, key informants and their associates, as well as from the literature we scanned.

The types of public health activities related to social connectedness fall into two broad categories: strategies for the *assessment* of social connectedness; and strategies or *interventions to facilitate, empower, and/or create environments* for social connectedness. It should be noted that the Minnesota definition of social connectedness (p. 13) points toward a broad community approach, whether in measurement of this issue or in improving and enhancing social and civic connections. Because social connectedness reaches into every aspect of the community, those in public health can play an important role by calling attention to social connectedness and its impact on health and well-being, even when the strategies may become the responsibility of other sectors.

In addition, strengthening social connectedness seldom is a stand-alone strategy requiring independent effort (and funding). Rather, it involves a critical awareness: the removal of barriers, the creation of opportunities, and development of strengths to encourage what is, generally speaking, the natural impulse of humans as social creatures.

> "There is growing public interest in the link between the way towns and cities are built and human health….[We should] provide training to planners and elected officials about the connection between health and urban planning, help them collect and distribute data related to the health of local populations, provide them with language and graphics that could be integrated into local plans and ordinances…. The health outcomes of this approach may be more difficult to measure than efforts such as mass vaccinations, providing universal access to health insurance, and anti-smoking campaigns; but this approach can, over many decades, foster health for everyone—from children to seniors."
>
> Slotterback, Carissa Schively, Krizek, Kevein, and Forsyth, Ann
> *The $64 Million Dollar Question: Design Healthier Neighborhoods*
> Minnesota Medicine, February 2009

Strategies for Assessing Social Connectedness

1. Assess places

Place is an important aspect of social connectedness. One important assessment strategy is to assess the community or neighborhood for opportunities for people of all walks of life and at every age to form and maintain positive social connections. Schools also have environments that can encourage or inhibit healthy social connections among students and among students, parents and school personnel. An assessment of places would include an inventory of opportunities as well as barriers:

- Opportunities include environmental assets that encourage people to venture outside and be with their neighbors, such as safe streets, green space, well maintained housing options, well-designed and secure parks, access to sidewalks, protection from traffic, good street lighting, and a range of shops, full-service grocery stores, community centers, and places of worship. In schools the opportunities for healthy connection include safe and pleasant areas for students and adults to gather, and hallways, parking lots, and other spaces that are open, inviting, and safe.

- Barriers include high crime rates or open drug and gang activity that prevent people from leaving their homes; a lack of transportation options, and in schools, places where bullying can be hidden or ignored.

2. Assess people

- Identify the populations at risk of social isolation[1]: people who are physically isolated (live alone, have limited mobility – especially the elderly); non-English speakers; single parent families; persons with disabilities; persons with mental illness; students with social and emotional needs.

- Identify the barriers and/or lack of programs or services that, if in place and accessible, help support these individuals in engaging with the community. These programs might include: home-delivered meals, mental health services, subsidized child care and services designed to support young at-risk families, and special educational services.

- Be alert to life transitions, as these are potential areas of vulnerability for social connectedness (and opportunities to form new connections). Foster children, for example,

[1]This project identified several key demographic variables as a starting point for assessing the population (p.45).

may face difficulty after age 18 when they are no longer eligible for services but still not fully capable of live alone. Systems should be designed and/or redesigned to anticipate and prepare for transitions like these by (for example) helping to assure that social support networks are in place before the need becomes acute. Other transitions include marriage/divorce, death of a life partner, adoption, job change, and moves to a new community and school. Not all transitions can be predicted, but if a disruption is anticipated, attending to social connectedness will help to ease the change or loss and assure continued health.

3. Assess programs

- In addition to the space or place, look around the community and enumerate the kinds of activity opportunities for healthy social interaction and connection. For example, recreational programs for all ages and incomes, structured youth activities, volunteer opportunities for young and old, cultural celebrations, and faith-based activities.

- Examine the assumptions that programs make about social connectedness. For example, any kind of daytime class or program that does not provide or assure child care limits participation to only those with no children or with school-age children. Interventions that require the help of another (such as someone to remind you to take a pill, or drive you to an appointment) will have limited effectiveness for people who live alone and do not have a network of support.

- Determine if those who receive services have had or will have the opportunity to design and implement those services. Engaging participants in the design and implementation of programs assures that the services will fit their particular interests and needs as well as enhance the social connectedness of participants and staff. Additionally, this inclusive approach will increase the level of engagement in and ownership of the programs, thus improving participation, retention and overall success.

- Assess the cultural competence of services and providers. Services that are culturally relevant and sensitive to the unique circumstances of the participants contribute significantly to their sense of value and belonging in the community and/or school environment and yield improved health outcomes.

4. Assess policies

- Assure that health impact assessments (HIA) for new policy development include a component related to social connectedness. For example, consider the impact of a limited access road on neighborhood interactions (see profile on p. 25).

- Analyze current public policies for their impact on social connectedness. For example, reducing county payments for child care may impact the ability of recipients to take advantage of English language classes, which in turn delays their full participation in the economic life of the community, which impacts their whole family as well as the community. Child care programs for children of immigrants that are not multi-lingual may result in a loss of family language for the young ones, affecting family dynamics and social connectedness within the immigrant community. Restrictions on the number of housing units available for families with children affect social connectedness by creating age-based segregation.

- Assess housing and school policies for the ways in which they lead to residential and school segregation. For example, affordable housing programs that concentrate affordable housing units in racially segregated or poor neighborhoods increases both residential and school segregation. When affordable housing is more equitably distributed across a geographic area it also helps to create more integrated neighborhoods, and thus more healthy and successful schools.

- Empower the people who will be most affected in the design and/or revision of public policies to shape those policies. Meaningful participation will motivate and improve civic engagement, which will result in better policy development and further strengthen social connectedness and the health of whole communities.

- Assess school policies for ways in which they support or prevent a sustainable, positive school climate, such as teaching and learning practices that encourage participation and contribute to healthy development, or organizational structures that facilitate healthy interactions among students, parents, and school personnel.

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Strategies to Strengthen Social Connectedness

5. Strengthen places

- Places that support healthy social interactions provide the setting for improving social connectedness among individuals and in the community. The **University of Kansas Community Tool Box** includes a chapter on "Changing the Physical and Social Environment[2]." The section headings include things such as:
    - Ensuring Access for People with Disabilities
    - Improving Lighting and Safety
    - Improving Parks and Community Facilities
    - Encouraging Historic Preservation
    - Creating Good Places for Interaction
    - Establishing Neighborhood Beautification Programs
    - Conducting Neighborhood Cleanup Program
    - Promoting Neighborhood Action

  This resource includes numerous strategies within each of these activities. All these are related to social connectedness and the places that people care about, gather together, work together, and live their lives together.

6. Strengthen people

- Recognize that the social connectedness of parents has profound implications for the healthy development of children. Design interventions at multiple levels (community, family, individual), since social connectedness consists of links among all these elements. Parents who are isolated and out of the mainstream do not have the resources and resiliency to help their children get ready to learn in school, make friends, or participate in the economic life of the community.

- Pay attention to people's moral, spiritual, and religious needs that promote social connectedness and well-being. For example, design programs that will not disrupt or punish religious participation (e.g., Saturday evening or Sunday morning youth activities).

- Pay attention to and seek to build developmental assets in children and youth, as these will lay a strong groundwork for social connectedness throughout life. The Search Institute has identified 40 development assets for children from ages 3 to 18. Many of

[2] http://ctb.ku.edu/en/tablecontents/chapter_1026.aspx

these have a strong social connectedness component (the first section of six assets is on "support"; many of the other assets also have a relationship or connection aspect).

- Provide opportunities for young people to develop their leadership skills and discover their value by connecting them to their communities in constructive and meaningful ways (e.g., coaching or tutoring younger children).

- People who have every advantage still search for meaning and connection in their lives. Use that desire to create (and fund) social connections across different groups in the community: immigrant and non-immigrant, young and old, different races and cultures, different economic classes.

7. Strengthen programs

- Assure that supports are in place that will allow everyone in the community the opportunity to participate in activities which promote social connectedness. For example: access to child care assures that parents can take advantage of opportunities for civic participation, volunteering and more. The provision of child care for refugee/immigrant mothers of young children may well be the determining factor to their participation in English language learning opportunities.

- Approach issues such as children's mental health as a community issue and not an individual child's or family-only issue. For example, how is the family of a child with a special health or mental health need connected to the community? What can be done to improve social supports for these families?

- Design programs and community conversations to reach into and meet the needs of the most "unequal" places or groups; chances are that these strategies will have benefits for the broader community. For example, increase communication and information flow for groups experiencing social exclusion – people who do not have access to social networks outside their communities (Wilson 1987). This may require both special messaging and seeking unorthodox avenues of communication.

- Provide opportunities for recreation. According to studies compiled by the California Department of Recreation (2005), recreation in a community has numerous social benefits. It strengthens communities by reducing crime, encouraging volunteerism, and promoting stewardship. It promotes social bonds by uniting families, building cultural diversity and harmony, and supporting seniors and individuals with disabilities.

Recreation also develops youth, enhances education, deters negative behaviors, decreases drug and alcohol use and early sexual activity, and prevents crime.[3]

- Add a social connectedness component to other programs. For example, identify people (volunteers or paid staff) who can act as "connectors" and help other people to connect (these could be need-based or interest-based connections – see Faith Community Nursing example, p. 43). Develop ways to help the parents of youth involved in a recreation program to have opportunities to get to know one another, such as through shared participation on a project that will benefit their children or post-event gatherings (preferably with food). Help students develop a healthy relationship with at least one caring adult in their school. Use simple and straightforward approaches to get people together (see Carver County example, p. 44).

- "Normalize" activities that bring people together so they can build connectedness. Having a project to do provides people with a reason to come. Working on something together gives them a comfortable way to learn about each other and also creates a common experience to build on. Nutrition classes, activities for children, community gardens are all activities that can be designed to provide opportunities for interaction, especially among people who do not know one another yet. Having a reason to meet and something to do eases the tension of being with strangers, and helps the strangers to become, if not friends, at least familiar.

> "Build informal social ties, engage people in social and civic activities, and cultivate understanding and trust in order to create a sense of belonging and a feeling of community…[to] make Minnesota—and Minnesotans—healthier."
>
> *Sanne Magnan, MD, PhD in: "The $64 Million Dollar Question: Build Social Capital",* Minnesota Medicine, February 2009.

- Encourage and support gatherings and other opportunities that bring together people of different ages, such as foster grandparent programs, multi-generational ethnic celebrations (such as Quinceñera [4]), opportunities for religious participation and youth leadership that create a sense of community and belonging.

8. Strengthen policies

- Change the top-down approach to policy-making to one that begins with the needs and concerns of the populations most likely to be affected by the policy under consideration.

[3] 2005. The Health and Social Benefits of Recreation. California Outdoor Recreation Planning Program. http://www.parks.ca.gov/pages/795/files/benefits%20final%20online%20v6-1-05.pdf

[4] Quinceñera (English: "fifteen years"), is a significant coming of age ceremony held in some Latin American cultures on a girl's fifteenth birthday.

- Strengthen existing policies by empowering communities to change them as needed to be more equitable and inclusive.

- Create communities that are healthy and just across the lifespan (see *Communities for a Lifetime*, p. 42).

- Identify sources of tension and miscommunication around social connectedness in the community (see Social Connectedness in Action, p. 39) and develop strategies to promote greater understanding.

- Support community efforts to address and encourage economic opportunity, supportive work environments and integration and appreciation of the community's diverse cultures, as these have powerful effects on social connectedness.

- Craft school policies that create and support a sustainable, positive and healthy school climate, a community of learning that helps students form attachments to school, reduces high-risk behaviors, and fosters youth development.

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Social Connectedness in Action

During the course of this project we encountered many, many examples of the ways in which people and organizations are working to improve social connectedness at the individual, family, community and systems levels: the social connectedness of places, people, programs, and policies.

♦

Creating connections across cultures

Blue Cross/Blue Shield Foundation of Minnesota: Healthy Together Grants

Healthy Together: Creating Community with New Americans is a grant-making initiative designed to reduce health inequities for immigrants and improve the health and vitality of the entire community. The foundation awards grants to projects that foster exchanges and interactions between newcomers and the receiving community, strengthen the capacity of immigrant-led organizations and their attention to health, and address social adjustment and mental health.
http://www.bcbsmnfoundation.org/pages-programs-program-Healthy_Together_Creating_Community_with_New_Americans?oid=7315&section=grantees

Two of the BCBSMN foundation grantees presented information about their efforts to the Research Partners Group of the Minnesota project on social connectedness: the St. Cloud, Minnesota project called Create CommUNITY; and the Faribault, Minnesota Diversity Coalition/Welcome Center.

St. Cloud: Create CommUNITY

St. Cloud, Minnesota is a centrally-located university town with a rapidly diversifying population. It also has a history of racism. The St. Cloud Create CommUNITY project is a local effort to confront that racism and promote social connectedness and transformational change for both individuals and institutions. One of their methods (among multiple initiatives) is to hold intentional conversations in a safe and supportive environment. The "Learning Circles" project offers members of the community a variety of opportunities to participate in these conversations. For example, the Omeka! gatherings (Omeka is a Swahili word meaning to display, speak out, spread out) are a monthly sharing of journeys, cultures and ideas among African-born and African-American women. The African-born women had heard that the African-American women were "dangerous" and were afraid to be friendly with them. They discover that they have common interests and concerns: education, politics, health care, and how to get their children to stop fighting and play together. Participants in

the Learning Circles have developed new confidence to participate in community affairs, are better able to navigate public systems, and some have stepped into leadership roles. http://www.createcommunity.info/index.html

Faribault Diversity Coalition/Welcome Center

Faribault, Minnesota is about halfway between Minneapolis/St. Paul and the Iowa border. Growing job opportunities have attracted a large immigrant population with all of the accompanying challenges of rapid population change. A survey of immigrant groups in the community (including Latinos, Sudanese, Somali and Cambodian) found that while they had a sense of connectedness with their friends, neighbors and faith communities, they had very little connectedness with the mainstream. The Faribault Welcome Center programs, therefore, were designed to help new immigrants connect with the local community: a community garden provides several dozen families with the opportunity to grow healthy food while also getting to know neighbors of other cultures; "Sharing Circles", diversity education, sidewalk discussions, and other forums brought cultures together to build bridges and understanding (see box); International Market Day celebrates the community's diversity with food, music, and dance; and interpretation services help for many people to connect with the community, with the government, and with services needed for their families.

> A very beneficial dialogue was held April 15 between downtown business owners and members of the Somali community. The Welcome Center and the Faribault Chamber of Commerce worked together to facilitate the gathering. The cultural behavior of Somali men gathering in groups outside the Banadir Restaurant to share news and visit had become a concern to neighboring business owners. The hesitancy of customers to pass through a large group of unknown people had meant that some customers simply chose to stay away--which presented another challenge to already struggling businesses.
>
> Joseph Mbele, a St. Olaf College professor and Diversity Coalition Board Member, started the dialogue with an explanation of the cultural factors at work. He explained that Somalia did not have a written language until just recently, and that they behaved as an oral culture. Those gatherings on the street corner were their newspaper and their books, their way of being community and sharing what was going on. They gather almost as a cultural imperative, being "good people" by socializing with others as they are expected to do.
>
> The shop owners shared very honestly and respectfully how their clients at times reacted to those gatherings, not just because they were African men, but because they were a large group. There is an element of intimidation. The elders present were very apologetic, making it clear that their community had no intention of causing any harm to anyone, and that they would pass the word to their community to be attentive to how their behavior could be perceived. The beauty of the dialogue was the atmosphere of respect and good will that everyone showed.
>
> *Faribault (Minnesota) Diversity Coalition*
> *BCBSF-MN Healthy Together Grantee*
> *http://faribodiversity.blogspot.com/ May 7, 2010*

Creating a place for community

The **East African Women's Center**, a program of the Confederation of Somali Community of Minnesota, has created a safe place where immigrant women can develop and maintain social connectedness for themselves and their families. Women who live in the Riverside Plaza high-rise in the Cedar-Riverside neighborhood of Minneapolis gather at the Center for English, sewing and nutrition classes. But the Center and the program staff do far more than that: they provide the tools and the space where women learn to solve their own problems. They empower the women to develop the kinds of classes and programs that best suit their needs as young immigrant families. And the women get to be together, learn to know and love one another, and develop a sense of family and community. Their children benefit from day care (in multiple languages), the improved parenting skills of their mothers, and the love and attention of a new "extended family." http://eawc.insourcemedia.com/ (See the expanded Profile of Social Connectedness about the Women's Center, p. 19.)

Holding community conversations

- The **ISAIAH** project aims to hold "a new and uncommon conversation [about the] unacceptable gaps between Minnesotans of color and white Minnesotans in housing, education, and health care." The participants in core groups and community meetings come from multiple races and every walk of life, engage in conversations about their own experiences, and discuss what they can do personally and professionally to create a more racially just society. (See the Profile of Social Connectedness, "Light Rail, Rondo, and the ISAIAH Project", p. 25).

- The **Carver County Health Partnership** (CCHP) started with a commitment between Ridgeview Medical Center and Carver County Community Health to bring key people and organizations together to solve critical county health issues. The initial partnership was formed to gather and analyze health information for better decision making. In September of 2000, key community leaders from various organizations met to formulate a vision, focus on key health issues and develop recommendations. Action teams were formed to work toward improving the health and well-being of county residents. Committees were recruited and began work in early 2002. The work of the initial four action teams was wrapped up in late 2006 as their recommendations were implemented by various community groups and organizations. http://www.cchealthpartnership.org/

- The **League of Minnesota Cities** has developed a guide to dialogue with and about the growing immigrant populations of Minnesota cities. A recent report says that "public officials are learning that one of the most effective ways to address challenging community issues is through citizen and stakeholder dialogue." The report notes that the participants in these dialogues learn more about the issues, connect their personal

experiences to the policy debate, devote time and energy to implementing policy recommendations and action ideas, and forge effective working relationships with others, including elected officials and staff. http://www.lmc.org/page/1/immigration.jsp

- As part of its *Backyard Initiative*, a project for getting to know the residents and improve health in their "backyard", **Allina Hospitals and Clinics** partnered with the **Powderhorn/Phillips Cultural Wellness Center**, with technical assistance from the **Amherst Wilder Foundation**, to host a series of "listening circles". Among their findings were many related to the importance of social connectedness and health, such as: eating healthy, staying active, maintaining relationships and community involvement were often tied together; exercise/staying active, communication and staying connected affects mental health; and that health is communal and reciprocal. Participants talked about the need for personal connection in all things related to health. It also was clear from the conversations that healthy relationships between people and their health care providers is a powerful factor in improving health outcomes. The Listening Circles project recommends (among other things) that all health and wellness activities should be designed with a social/community component. http://www.allina.com/ahs/cmtybenefit.nsf/page/Brief_Backyard_Initiative

Creating healthy communities across the lifespan

Communities for a Lifetime is an idea that began with concern for aging populations and the services which would keep people healthy, active, and connected throughout their lives. Communities that meet this definition will include opportunities for:

- Volunteering and community service
- Socializing, recreation, and wellness activities (both physical and mental stimulation)
- Affordable, accessible housing options
- Access to long-term care in a variety of settings
- Community-wide mobility and access to public transportation
- Services that allow the elderly to remain in their home and which promote independent living
- Access to nutrition (and social eating)
- Caregiver support for family and volunteers
- Adult protection services

The kinds of services and opportunities noted above that create positive social environments for seniors, however, also will benefit youth, young families with children, and ultimately all members of the community. http://www.mnaging.org/admin/cfl.htm

Connecting with history and culture

At the **Division of Indian Work**, all the programs are infused with American Indian culture. The use and teaching of culture in the context of other programs (anger management, youth development, mental health) helps people to become more engaged with and connected to their community and gives them a deep sense of identify and belonging. “To rise above poverty, American Indian families living in Minneapolis need a connection often forgotten by today's society. It is critical that Indian adults and children be linked to their sacred cultural past. It is that link, combined with education, mentoring, and family counseling, that will empower them to proudly claim their place in this world.” http://diw.gmcc.org/

Faith and community connections

Faith Community Nursing (FCN) is recognized as a specialty nursing practice. Faith community nursing is the intentional integration of the practice of faith with the practice of nursing so that people can achieve wholeness in, with, and through the community of faith in which faith community nurses serve. Because of its emphasis on serving people within the context of their faith community, faith community nursing is strongly associated with social connectedness. The rapid growth of the senior population, and the increased need for informal supports to supplement limited resources for institutional care, makes the role of the faith community nurse as “connector” very important. The faith community nurse not only educates, counsels, advocates and refers people to services, but may also coordinate volunteers from within the faith community. In that way they create greater connectedness for both client and the volunteer who share a common faith home. An example from the Journal of Gerontological Nursing noted that one senior was carrying laundry up from the basement less than three weeks after renal surgery. She was at high risk for injury and postoperative bleeding. The faith community nurse coordinated laundry assistance through the volunteer parish network. The senior accepted this help of chore assistance three times a week, for one month. Through this action the isolated older adult reconnected with support from her faith community and significantly reduced her risk after surgery (Rydholm, et al, 2008). http://www.fcnntc.org/

Family connections

- A program called *Eat. Talk. Connect*! was sponsored by the Children's Mental Health Action Team of the **Carver County Health Partnership**. The initiative encouraged families to spend time together by sharing at least three meals a week together for three months. The program is based on research that shows that children who eat at least five meals together with their families are less likely to engage in at-risk behaviors, more likely to do well in school, eat more nutritionally, experience less stress and are significantly less likely to be depressed. Schools, churches and community organizations within Carver County embraced *Eat.Talk.Connect!* More than 1,000 Carver County Families (5,000 people) registered to participate in the challenge and many report continuing the practice of family meals. A highlight of the initiative was a community-wide meal that served more than 700 at one table at the County Fair Grounds. Local businesses, health organizations and individuals all contributed to the remarkable success of this venture. Other communities have adopted their own version of Eat. Talk. Connect!
  http://www.cchealthpartnership.org/
  http://www.co.dakota.mn.us/Departments/PublicHealth/Projects/ETCresults.htm

- "Baby College" is the name for a program originally developed by the **Harlem Children's Zone**[5] in the mid 1990s. The Harlem Children's Zone focuses intensive interventions on a multi-block area of Harlem, with the understanding that it is necessary to reach an entire disadvantaged community to make a measurable difference, rather than reaching out to a few individuals here and there. The Baby College provides the parents from the community who are expecting a child or raising children between the ages of zero to three with information and support so they can bring up happy and healthy children who will enter school ready to learn. Many if not most of the parents targeted for Baby College do not have the kinds of social networks that more advantaged parents have, connections that would provide the role models, information, and resources they need. Sessions occur on eight consecutive Saturday mornings, each lasting approximately four to five hours. Participants receive breakfast, lunch, child care and various incentives at no cost. Nearly 900 people have graduated from the Baby College in the last two years.
  http://www.hcz.org/images/stories/pdfs/ali_summerfall2002.pdf

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[5] http://www.hcz.org/

Measurement Strategies

During this project, as we conducted the interviews and read through the literature on social connectedness (and related terms), we looked for effective ways to measure social connectedness. We found instead a number of challenges:

- Social connectedness is an abstract, complex concept and it does not yield readily to quantification.
- The literature review revealed a lack of consistency in terminology (i.e., what is being measured).
- There is a large array of measures from a diverse pool of studies, with no consistent measurement approach.
- The research includes widely differing levels of analysis (individual, family, community), and varied measurement approaches (indices/scales, interviews, surveys, population-based data).

Nonetheless, there have been many interesting studies and a lot research has gone into the measurement of social connectedness and related concepts. Instruments have been developed to measure the individual, personal subjective sense of belonging and support, and indices have been created that use population-based indicators as very broad-brush measures of this social determinant of health.

Because public health first approaches issues from a population-wide perspective, we decided to begin there, using six key demographic variables that emerged from our work on the mind map of social connectedness. These population-based measures are recommended for an initial assessment of social connectedness, because they are readily available (many at the county level – see indicators, below). From the clues that these indicators provide, and with additional information, public health departments and their community partners can explore more focused means of measuring social connectedness.

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Population-based Indicators of Social Connectedness

- Household size
- Population profile (age)
- Demographic change/diversity
- Residential stability
- Single parent households
- Segregation
- Employment/unemployment rates
- Incarceration rates

Household size

Adults who live by themselves may be more at risk of experiencing social isolation, which can have a negative effect on both physical and mental health (Berkman, 1984; Klinenberg, 2002). A possible measure could be:

- Persons per household *(U.S. Census Bureau, 2000)*

Population profile (age)

Social connectedness may be more salient for youth and older people because of their increased dependency on others (Berkman, 1984; Coleman, 1988; Taylor & Repetti, 1997; Klinenberg, 2002). Possible measures include:

- Persons under 5 years old *(U.S. Census Bureau, 2008)*
- Persons under 18 years old *(U.S. Census Bureau, 2008)*
- Persons 65 years old and over; *(U.S. Census Bureau, 2008)*
- Total Dependency Ratio (Number of people under 15 years old and over 64 per 100 people ages 15-64), U.S. Census Bureau *(Minnesota Vital Statistics State and County Trends, MDH, 2008)*

Demographic change/diversity (e.g., migration; percent foreign-born)

Immigrants/refugees are typically a vulnerable population because of the social disruption that they have experienced either willingly or unwillingly moving from their country of origin to the U.S. In addition, population diversity is negatively associated with community trust (Putnam, 2007). Possible measures include:

- Foreign born persons *(U.S. Census Bureau, 2000)*
- Language other than English spoken at home, age 5 and older *(U.S. Census Bureau, 2000)*

- Primary refugee arrivals to Minnesota by initial county of resettlement and country of origin *(MDH, 2008)*
- Percent of students who have limited English proficiency PreK-12, Minnesota Department of Education *(Minnesota Vital Statistics State and County Trends, MDH, 2008)*

Residential stability (e.g., number of years lived at the same address; number of times moved during a certain period of time, house ownership)

Moving frequently from one location to another typically leads to social disruption and a loss of supportive social relationships, as well as interruptions in school attendance. This can have a negative effect on health, especially among children later on in life, due to increased childhood environmental instability (Bures, 2003). Possible measures include:

- Living in the same house in 1995 and 2000, age 5 and older *(U.S. Census Bureau, 2000)*
- Homeownership rate *(U.S. Census Bureau, 2000)*

Single parent households

Two-parent households may be able to supervise children more, have broader social support systems, and be more willing to participate and invest more in their children's lives than single-parent households (Coleman, 1988). Both parents and children of single-parent households seem to be at risk for adverse health outcomes including mental health problems and unhealthy behaviors, such as drug abuse or risky sexual behavior (County Health Rankings, 2010; Taylor & Repetti, 1997). Possible measures include:

- Births to unmarried women *(Minnesota Vital Statistics State and County Trends, MDH, 2008)*
- Single Parent Households (a measure of the number of households run by a single parent, e.g. male householder with no present or female householder with no male present, with one or more of their own children under 18 years as a percentage of the total number of households), United States Decennial Census, American Community Survey *(2010 County Health Rankings: Metrics, University of Wisconsin Population Health Institute, 2009)*
- Divorce (a measure of the percentage of people aged 15 and over in the population who report being divorced, rather than never married or widowed), United States Decennial Census *(University of Wisconsin Population Health Institute, 2008)*

Segregation

Segregation can occur in many ways: by race/ethnicity, by income, and by geographic location. It can also limit a person's access to jobs, economic prospects, healthcare and schools

(Institute on Race and Poverty, 2009). Along with decreasing opportunities, segregation can also lead to the collapse of social organization and a decline in basic community institutions (e.g. churches, schools) within a neighborhood and a lack of role models regarding education, family values, and positive norms and behaviors (Wilson, 1987). Possible measures include:

- Race/Ethnicity, U.S. Census Bureau *(Minnesota Vital Statistics State and County Trends, MDH, 2008)*
- Percent of all ages in poverty, U.S. Census, Small Area Income and Poverty Estimates *(Minnesota Vital Statistics State and County Trends, MDH, 2008)*
- Food stamp utilization average monthly households, Minnesota Department of Human Services *(Minnesota Vital Statistics State and County Trends, MDH, 2008)*
- Percent of students eligible for free or reduced meals PreK-12, Minnesota Department of Education *(Minnesota Vital Statistics State and County Trends, MDH, 2008)*

Employment/unemployment rates (e.g., length of unemployment; percent of income used for housing; homelessness)

Employment and unemployment rates can be viewed as a corollary to segregation because unemployment can lead to poverty. Other links to social connectedness include that social connections often lead to job possibilities, and employment increases social connectedness through contact with co-workers and others (Wilson, 1987). Possible measures include:

- Proportion of adults who are employed, U.S. Census Bureau: Decennial Census & American Community Survey *(Minnesota Compass, 2009)*
- Share of all households paying 30 percent or more of income for housing, U.S. Census Bureau: Decennial Census & American Community Survey *(Minnesota Compass, 2009)*
- Homelessness rate, U.S. Census Bureau: Decennial Census & American Community Survey; Homelessness Rate per 10,000 Wilder Research, Minnesota Statewide Survey of People Without Shelter *(Minnesota Compass, 2009)*
- Unemployed Annual Average Percent, Minnesota Department of Employment and Education *(Minnesota Vital Statistics State and County Trends, MDH, 2008*)

Incarceration rates

Crime level may be an indicator of collective well-being influenced by the amount of social cohesion available within a neighborhood or community (CDC, 2003; Kawachi and Kennedy and Wilkinson 1999b; Sampson and Raudenbush and Earls 1997). Incarceration rates are the result of crime and decrease the amount of social networks and positive social relationships available to inmates. Possible measures include:

- Average daily population in local jails, Bureau of Justice Statistics Prison and Jail Inmates at Midyear (*Social Determinants of Health Work Group, CDC, 2003)*

- State prison incarceration rates, Bureau of Justice Statistics (*Social Determinants of Health Work Group, CDC, 2003)*
- Confined jail inmates by race, as a percent of total race specific population, Bureau of Justice Statistics, Census (*Social Determinants of Health Work Group, CDC, 2003)*

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Additional Measurement Tools

After identifying potential concerns about social connectedness at the population level, additional analysis may be required to identify specific issues and develop appropriate public health interventions. For this closer look at social connectedness there are several types of measurement tools. Individual community surveys can include questions about social support, neighborhood conditions, and other features that affect social connectedness. Ongoing surveys provide some insight into the social connectedness of certain groups. Screening tools can help to identify factors related to healthy social development. And detailed psychological instruments are designed to measure individual social connectedness. Each of these types of measurement tools may prove useful for public health, depending on the population and the specific health concern.

Sources of data on social connectedness at the community level include the results of local, regional, and national surveys, such as:

- *Roper Center for Public Opinion Research/Social and Political Trends Survey*
- *Minnesota Student Survey*
- *Mental Health America* survey of social connectedness

Other surveys and assessment tools include:

- Local public health surveys (e.g., the Hennepin County SHAPE survey)
- The Search Institute Community Survey tool
- *ASQ* (Ages and Stages Questionnaire) and *ASQ/SE* (Social Emotional) tools
- *NCAST* tool for maternal/child assessment; PCI (Parent Child Interaction) feeding and teaching scales
- EcoMaps (for mapping individual social support networks)
- Duke Social Support Index

See Appendix C for more detailed information about these measurement tools.

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Chapter Four

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Detail and References: Social Connectedness Mind Map

The Minnesota Social Connectedness Mind Map (p. 15) contains 145 components or factors related to social connectedness. This review of literature provides additional detail, descriptors, and references for several factors associated with each of the main branches of the map. The complete list of branches and components is as follows:

Individual Components

The Lifespan

- Infancy
  - Attachment
  - Birth weight
  - Illness
  - Caregivers
  - Abuse
- Childhood
  - Socialization
  - Emotional development
    - Self-mastery
  - Discipline
  - Abuse
  - School readiness
    - Confidence
  - Language and speech
- Adolescence
  - Identity
  - Peers
  - School attachment
  - Substance use
  - Community connections
  - Role models
- Emerging adulthood
  - Differentiation
  - Identity
  - Relationships
  - Community
  - Transitions
- Adulthood
  - Family formation
  - Work & career
  - Community
  - Schedules
  - Disability
- Old Age
  - Retirement
  - Family
  - Informal supports
  - Volunteerism
  - Loss of partner
    - Isolation

The Person

- Health
- Gender
- Race
- Identity
- Ethnic/cultural heritage
- Sense of belonging

Strengths

- Likability
- Skills
- Spirituality
- Leadership
- Knowledge
- Wisdom
- Intelligence
- Attractiveness
- Personality

Vulnerability/Dependence

- Illness
  - Chronic illness
- Mental illness
  - Depression
- Aging
- Physical isolation
- Loneliness
- Grief
- Family dysfunction
  - Abuse

Individual SES

- Income
  - Poverty
- Employment
- Social capital
- Education
- Mobility
- Stability
- Parenting
- Transportation
- Early environment
- Neighborhood environment
  - Safety
  - Services

Community Components

Community SES

- Built environment
  - Streets
  - Safety
- Crime
- Housing
- Power & privilege
- Income inequality
- Social isolation
- Access to systems

Social Inclusion/Exclusion

- Institutional racism
  - Individual racism
- Equity
- Social policy and processes
- Economic policy and processes
- Trust
- Power & politics
- Segregation
- Incarceration
- Civic engagement

The Community

- Recreation
- Reciprocity
- Gathering places
- Workplaces
- School climate
- Norms & values
- Services
- Diversity
- History

Continuity/Disruption

- War
  - Refugees
- Acculturation
  - Language
  - Roles
- Demographic change
  - Immigration
- Family stability
  - Divorce
  - Single parenthood
  - Foster care
  - Family values
  - Death
  - Remarriage
  - Childbirth/adoption
  - Extended family
  - Filial roles
  - Residential stability
  - Home ownership
  - School attendance
    - Friendships
    - Continuity of learning
  - Homelessness
  - Friends & neighbors
  - Crime
- Food stability
  - Learning & socializing
  - Parental involvement
  - School attendance
- Religious participation
- Culture & ethnicity
- Ritual

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Individual Components

Infancy

Attachment

Social connectedness begins at birth. "The quality of early relationships is the most fundamental determinant of healthy social-emotional development in infants and toddlers. A secure attachment to a primary caregiver has an enduring influence on mental health" (Patterson). If the caregiver develops a positive relationship with the infant, then it is more likely that the infant will be able to have positive relationships later on in life as an adult. However, if the caregiver displays ambivalent or avoidant behavior towards the infant, this can eventually lead to difficulty for the child in establishing and nurturing meaningful relationships in the future. The lack of early attachment can also eventually lead to negative health behaviors, as the person attempts to compensate for a deficit in meaningful relationships.

- Hesseltine, S. (2009). *The power of relationships between infants & parents: Supporting healthy social and emotional development* [PowerPoint slides]. Retrieved from file.
- Patterson, Joan M. A Public Health Approach to Early Childhood Mental Health. *Healthy Generations*, Winter 2009-2010.
- Schafer, W. (1991). Planning as an attachment experience. *The Infant Crier*. East Lansing: Michigan Association for Infant Mental Health.
- Sroufe, L.A. (2000). Early relationships and the development of children. *Infant Mental Health Journal, 21*(1-2), 67-74.
- Stansfeld, S.A. (2006). Social support and social cohesion. In M. Marmot & R.G. Wilkinson (Eds.), *Social determinants of health* (pp. 148-171). New York, NY: Oxford University Press.

Childhood

Language and speech

Early childhood development, which occurs before children are of school-age, provides social and cognitive development for young children in order to promote school readiness. Early childhood development programs, such as Head Start, have been shown to be strong independent predictors of positive educational outcomes later on in life. One main component of early childhood development is the development of language and speech skills. Language and speech are typically developed in children through adult-child interactions. Parents play a significant role in developing language and speech in young children through feedback, conversations and educational activities they engage their children in.

- High, P., et al. (1999). Child centered literacy orientation: a form of social capital? *Pediatrics, 104*(4), 1-7.

- Laureau, A. (2003). *Unequal childhoods: Class, race, and family life.* Berkeley and Los Angeles, CA: University of California Press.

- Tough, P. (2008). *Whatever it takes: Geoffrey Canada's quest to change Harlem and America.* New York, NY: First Mariner Books.

Discipline

Mothers who are more socially isolated seem to be more inclined to use harsh physical punishment with their children. This may be because mothers who are socially isolated also have other risk factors that may affect their parenting practices, such as an absent father or early motherhood. Without adequate social support, mothers may experience more stress than mothers who have social support, and may utilize harsh physical punishment. Also, socially isolated mothers may not be exposed to healthy parenting practices because individuals who make up their social network may share similar beliefs about discipline. Harsh parenting practices also have an effect on children and may lead to problems creating and sustaining meaningful relationships for them in the future.

- Lee, Y. (2009). Early motherhood and harsh parenting: the role of human, social and cultural capital. *Child Abuse & Neglect, 33*, 625-637.

- Salzinger, S., Richard, R.S., & Hammer, M. (1993). The effects of physical abuse on children's social relationships. *Child Development, 64*, 169-187.

- Salzinger, S., Kaplan, S., & Artemyeff, C. (1983). Mothers' personal social networks and child maltreatment. *Journal of Abnormal Psychology, 92*(1), 68-76.

- Zolotor, A.J. & Runyan, D.K. (2006). Social capital, family violence, and neglect. *Pediatrics, 117*(6), e1124-e1131.

Adolescence

Community

Research has shown that adolescents benefit when a community views the concept of raising children as a responsibility that everyone shares, as opposed to it being just the responsibility of the parents. The relationship between a community and its teen members can be mutually beneficial: not only can the community benefit adolescents through mentoring programs or other extracurricular activities, but adolescents can also benefit their community through service-learning programs and volunteering. Giving adolescents appropriate-level responsibilities in the community allows them to feel valued and to learn that they can make a meaningful contribution to society.

- Adelman, H.S. & Taylor, L. (2006). Mental health in schools and public health. *Public Health Reports, 121*, 294-298.

- Coleman, J. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 74*, S95-S120. **[1]

- Furstenberg, F. & Hughes, M. (1995). Social capital and successful development among at-risk youth. *Journal of Marriage and Family, 57*, 580-592.

Peers

The normal development of independence in adolescents and their growing exploration of individual identity can create friction with their parents. During this time adolescents may increasingly rely on the attitudes and behaviors of their peers to help guide their own actions. Peers have the potential for both negative and positive impacts on health. Feelings of invincibility and the encouragement by peers to take risks can lead to negative health outcomes through alcohol abuse, drug use, or sexual experimentation. Peers may also have a positive impact on each other, by affirming healthy choices and by providing social support when it does not seem available at home, which can lead to a decreased risk of depression in the future.

- Aseltine, R.H. Jr., Gore, S. & M.E. Colten. (1994). Depression and the social developmental context of adolescence. J*ournal of Personality and Social Psychology, 34*, 237-251.

- Gore, S. & R.H. Jr. Aseltine. (1995). Protective processes in adolescence: matching stressors with social resources. *American Journal of Community Psychology, 23*, 301-327.

- Hirsch, B.J. & D.L. Dubois. (1992). The relation of peer social support and psychological symptomatology during the transition to junior high school: a two-year longitudinal analysis. *American Journal of Community Psychology, 20*, 333-347.

- Sandler, I.N., Miller, P., Short, J. & S.A. Wolchik. (1989). Social support as a protective factor for children in stress. In D. Belle (Ed.), *Children's social networks and social support* (pp. 277-304). New York, NY: Wiley.

Emerging Adulthood

Transitions

Emerging adulthood occurs after adolescence but before being settled into a fully adult life. It is a time characterized by numerous life transitions while these young people, around the ages of 18 to 25, explore a variety of possibilities in relationships, career, values, and living places. This extended developmental period, characteristic only of industrialized nations, is due in part to the increasing levels of education and training needed to enter the workforce, which leads continued dependence on parental economic support, which also delays the commitment to marriage and childbearing. Without adult responsibilities, emerging adults are relatively free to engage in risk-taking behaviors, such as binge drinking. Frequent transitions also mean that emerging adults are

[1] References marked with a double asterisk (**) are listed under more than one of the social connectedness components.

constantly forming, breaking, and reforming social connections as they experiment with who they are and what they want out of life.

- Arnett, Jeffrey (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, Vol. 55(5), May 2000, 469-480.
- McMurry, M. (2010). The *changing lives of Minnesota young adults*. Retrieved from http://www.demography.state.mn.us/documents/ChangingLivesofMinnesotaYoungAdult.pdf
- Smith, Christian, with Patricia Snell (2009). *Souls in transition: the religious and spiritual lives of emerging adults*. Oxford University Press.

Relationships

The constantly changing constellation of relationships emerging adults have with family and friends is a significant factor in health. Whether or not peers approve or disapprove of substance use may be a significant predictor of substance use among emerging adults. Substance use, particularly during college, may be used to substitute for a lack of meaningful relationships; it may also act as an integral part of peer interaction. The different activities that emerging adults may participate in can also affect the amount and quality of social relationships that they possess. For example, high Internet use or frequent video game playing may isolate emerging adults and hinder them from making relationships.

- Borsari, B. & Carey, K.B. (2006). How the quality of peer relationships influences college alcohol use. *Drug and Alcohol Review, 25*(4), 361-370.
- Patock-Peckham, J.A. & Morgan-Lopez, A.A. (2008). Mediational links among parenting styles, perceptions of parental confidence, self-esteem, and depression on alcohol-related problems in emerging adulthood. *Journal of Studies on Alcohol and Drugs, 70*(2), 215-256.
- Padilla-Walker, L.M., Nelson, L.J., Carroll, J.S. & Jensen, A.C. (2010). More than just a game: video game and internet use during emerging adulthood. *Journal of Youth and Adolescence, 39*(2), 103-113.
- White, Helene Raskin, and Jackson, Kristina (2004).Social and psychological influences on emerging adult drinking behavior. *Alcohol Research and Health*,Vol. 28, No. 4, 2004/2005, Retrieved from: http://pubs.niaaa.nih.gov/publications/arh284/182-190.pdf

Adulthood

Family formation

One marker of having achieved adulthood is the decision to form a family. The commitment of adults to one another and the arrival of children create strong social bonds with positive effects on health and even on mortality. These bonds are fostered over time through shared activities, such as family dinners or quality time spent with one another. Social bonds are also developed with the broader community as families interact with other families and with systems

in the community, such as schools. The commitment to a family can also create stress, through increased financial concerns or other shared difficulties, such as a serious health problem.

- Franks, P., Campbell, T.L. & Shields, C.G. (1992). Social relationships and health: the relative roles of family functioning and social support. *Social Science & Medicine, 34*(7), 779-788.

- Janisse H.C., Nedd, D., Escamilla, S. & Nies, M.A. (2004). Physical activity, social support, and family structure as determinants of mood among European-American and African-American women. *Women & Health, 39*(1), 101-116.

- Rogers, R.G. (1996). The effects of family composition, health, and social support linkages on mortality. *Journal of Health and Social Behavior, 37*(4), 326-338.

Work and career

The workplace is a significant source of social connectedness, both through relationships with coworkers and by creating an identity and sense of belonging for the employed adult. With most adult Americans spending approximately 40 hours a week at work, work also can play a major role in overall psychological well-being. Positive social support provided by coworkers and supervisors can mitigate work stress, just as contentious relationships can amplify it.

- Ganster, D.C., Fusilier, M.R., & Mayes, B.T. (1986). Role of social support in the experience of stress at work. *Journal of Applied Psychology, 71*(1), 102-110.

- House, J.S. (1981). *Work stress and social support.* Reading, MA: Addison-Wesley.

- Loscocco, K.A. & Spitze, G. (1990). Working conditions, social support, and the well-being of female and male factory workers. *Journal of Health and Social Behavior, 31*(4), 313-327.

- Repetti, R.L. (1993). The effects of workload and the social environment at work on health. In L. Goldenberger & S. Bresnitz (Eds.), *Handbook of stress* (pp. 368-385). New York, NY: Free Press.

Old Age

Informal supports

The population of persons 65 and older in the U.S. is growing rapidly as the "baby boomers" enter retirement age. Many of this generation are not interested in traditional, institutionalized forms of long-term health care (such as nursing homes) should they require assistance. And the systems of formal care would be rapidly overburdened by the size of this population. Instead, informal forms of support, such as family members, friends, neighbors and volunteers from faith communities, will become increasingly important. These informal caregivers not only stand-in for costly institutions, but provide a network of social supports that in themselves have protective health effects.

- Kelman, H.R., Thomas, C. & Tanaka, J.S. (1994). Longitudinal patterns of formal and informal social support in an urban elderly population. *Social Science & Medicine, 38*(7), 905-914.

- Stoller, E.P. & Pugliesi, K.L. (1991). Size and effectiveness of informal helping networks: a panel study of older people in the community. *Journal of Health & Social Behavior, 32*(2), 180-191.

- Wilcox, J.A. & Taber, M.A. (1991). Informal helpers of elderly home care clients. *Health & Social Work, 16*(4), 258-265.

Loss of partner (isolation)

For many couples, long-term partners are a primary source of social support. Losing a partner to death is traumatic and the stress can continue long after the actual event, as the person remaining must adjust to the loss. The grief and suffering that result from a partner's death may have harmful effects on physical and mental health. Many studies have also shown that losing a spouse leads to increased rates of mortality for the remaining spouse.

- Berkman, L.F. (1984). Assessing the physical health effects of social networks and social support. *Annual Review of Public Health, 5,* 413-432.**

- Kobrin, F.E. & Hendershot, G.E. (1977). Do family ties reduce mortality? Evidence from the United States, 1966-1968. *Journal of Marriage and the Family, 39*(4), 737-756.

- Lillard, L.A. & Waite, L.J. (1995). 'Til death do us part: marital disruption and mortality. *American Journal of Sociology, 100,* 1131-1156.

- Martikainen, P. & Valkonen, T. (1996). Mortality after the death of a spouse: rates and causes in death in a large Finnish cohort. *American Journal of Public Health, 86,* 1087-1093.

The Person

Sense of belonging

Social support can lead to a sense of belonging through relationships with individuals who share similar interests or similar objectives. For adolescents, a sense of belonging can lead to increased engagement in school and increased academic motivation. Among college students, a sense of belonging results in better health perceptions for women and fewer physical symptoms for men, lending credence to the idea that a sense of belonging that results from social support is a key component of physical health. Belongingness also seems to be associated with mental health outcomes, with a lowered sense of belonging as a significant predictor of depression.

- Choenarom, C., Williams, R.A. & Hagerty, B.M. (2005). The role of sense of belonging and social support on stress and depression in individuals with depression. *Archives of Psychiatric Nursing, 19*(1), 18-29.

- Hale, C.J., Hannum, J.W. & Espelage, D.L. (2005). Social support and physical health: the importance of belonging. *Journal of American College Health, 53*(6), 276-284.

- McNeely, C. & Falci, C. (2004). School connectedness and the transition into and out of health-risk behavior among adolescents: a comparison of social belonging and teacher support. *The Journal of School Health, 74*(7), 284-292.

Ethnic/cultural heritage

Cultural heritage provides a framework in which people develop their normative beliefs, knowledge and behaviors. This cultural framework can influence the values placed on social relationships, which can eventually influence health. For example, Latino immigrants typically have better health outcomes than expected for a disadvantaged population. This could be because Latinos also place a high emphasis on family and therefore seem to experience higher levels of familial social support. Since family ties among Latinos may be of higher quality than other social connections, family social support may have a beneficial impact on overall health.

- Abel, T. (2007). Cultural capital and social inequality in health. *Journal of Epidemiology and Community Health, 62*(13), 1-5.
- Almeida, J., Molnar, B.E., Kawachi, I. & Subramanian, S.V. (2009). Ethnicity and nativity status as determinants of perceived social support: testing the concept of familism. *Social Science & Medicine, 68*(10), 1852-1858.
- Carpiano, R.M. (2006). Toward a neighborhood resource-based theory of social capital for health: can Bourdieu and sociology help?

Vulnerability/Dependency

Aging

As aging occurs, older adults become more vulnerable due their increased physical and occasionally mental dependency on others. Growing limitations on mobility may hinder their ability to form and maintain social connectedness. At the same time, changing levels of responsibility, e.g., through retirement, may create opportunities for older people to become volunteers and connect with their communities in new ways, with positive health outcomes.

- Antonucci, T.C. (1990). Social support and social relationships. In R.H. Binstock & L.K. George (Eds.), *Handbook of aging and the social sciences* (3rd ed., pp. 205-266). San Diego, CA: Academic Press.
- Klinenberg, E. (2002). *Heat wave: A social autopsy of disaster in Chicago.* Chicago, IL: The University of Chicago Press.
- Pillemer, K. & Glasgow, N. (2000). Social integration and aging: background and trends. In K. Pillemer, P. Moen, E. Wethington & N. Glasgow (Eds.), *Social integration in the second half of life* (pp. 19-47). Baltimore, MD: John Hopkins University Press.
- Seeman, T.E., Lusignolo, T.M., Albert, M., & Berkman, L. (2001). Social relationships, social support, and patterns of cognitive aging in healthy, high-functioning older adults: MacArthur studies of successful aging. *Health Psychology, 20*(4), 243-255.

Physical isolation

Physical isolation refers not only to people who live alone, but who are unable to go out to places where they might connect with others. This situation can occur, for example, among the elderly, either through physical limitations or fear of crime that keeps them home, among

refugees or immigrants who do not have languge or cultural skills and are afraid to go out into the community, and among people with physical or developmental disabilities who are unable to leave their dwellings. Isolation can have negative effects on psychological well-being, leading to feelings of loneliness and depression. Physical isolation can also put individuals at higher risk for mortality in potentially dangerous situations. For example, during the heat wave in Chicago that occurred in 1995, a large majority of heat-related illnesses and deaths occurred among people who were isolated within their homes and had little to no contact with family or friends.

- Klinenberg, E. (2002). *Heat wave: A social autopsy of disaster in Chicago.* Chicago, IL: The University of Chicago Press.
- Russell, D. (2009). Living arrangements, social integration, and loneliness in later life: the case of physical disability. *Journal of Health and Social Behavior, 50*(4), 460-475.
- Stancliffe, R.J., Lakin, K.C., Doljanac, R., Byun, S.Y., Taub, S. & Chiri, G. (2007). Loneliness and living arrangements. *Intellectual and Developmental Disabilities, 45*(6), 380-390.

Individual Socio-Economic Status (SES)

Social capital

The concept of social capital became popularized by Robert Putnam in his seminal work, *Bowling Alone: The Collapse and Revival of American Community*, which is explored in further detail later on in this report. Social capital consists of the social networks that foster norms of reciprocity and trustworthiness between community members. This allows community members to be able to work together towards collective goals. Social capital has also been theorized to be one of three components that make up socioeconomic status, with the other two components being human capital and material capital.

- Oakes, J.M. & Rossi, P.H. (2003). The measurement of SES in health research: current practice and steps toward a new approach. *Social Sciences & Medicine, 56*(4), 769-784.
- Portes, A. (1998). Social capital: its origins and applications in modern sociology. *Annual Review of Sociology, 24*, 1-24.
- Putnam, R.D. (2000). *Bowling alone: The collapse and revival of American community.* New York: Simon & Schuster Paperbacks.**

Employment

Whether or not an individual is employed has a significant impact on his/her socioeconomic status. Broad social factors, such as racial and economic segregation, may determine whether or not an individual is able to be employed, or to be employed at an adequate level of income. For example, if an individual lives in a segregated neighborhood that mainly consists of poor, underemployed or unemployed people, and his or her connections are only with people who are unemployed, then the chance of finding a job is greatly reduced. Conversely, if an individual has many connections with people who are employed, there is a greater chance that he/she will hear

about a job opening and be able to pursue it. Employment also provides the opportunity to increase the size of social networks with either beneficial relationships or harmful relationships.

- House, J.S., Landis, K.R. & Umberson, D. (1988). Social relationships and health. *Science, 241*, 541-545.
- Wilson, W.J. (1987). *The truly disadvantaged: The inner city, the underclass, and public policy.* Chicago, IL: The University of Chicago Press.**

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Community Components

Disruption/Continuity

Demographic change

Demographic change can occur in several ways: declining populations due to aging, death, low birth rates, and out-migration; growing populations due to high birth rates and/or in-migration, and a change in the racial, ethnic, or economic diversity of the population due at least in part to immigration. Demographic change may be gradual or sudden. The impact of demographic change on social connectedness can be positive or negative: as a community becomes smaller the remaining members may become more dependent on and closely connected with one another; they may also become more wary of outsiders and more physically isolated (such as the rural elderly). Rapid demographic change can change a community from a population of friends to one of strangers, and increased diversity has been shown to be associated with lower levels of trust among everyone in the community.

- Putnam, Robert (2007). *E Pluribus Unum:* Diversity and Community in the Twenty-first Century -- The 2006 Johan Skytte Prize. *Scandinavian Political Studies* 30 (2), 137-174.

Immigration (war, refugees)

Immigrants and refugees are typically a vulnerable population because of the social disruption that they have experienced, by either willingly or unwillingly moving from their country of origin to the U.S. Many immigrants follow family to the U.S.; some come as students and remain; others are forced to flee political conflict in their countries of origin. Some immigrants and many refugees are ill-prepared to navigate daily life in the U.S. because of language barriers and cultural differences. They may remain isolated through fear of the strange surroundings, unless they can form a connection with someone who will help them navigate their new landscape.

- Barnes, D.M. & Aguilar, R. (2007). Community social support for Cuban refugees in Texas. *Qualitative Health Research, 17*(2), 225-237.

- Schweitzer, R., Melville, F., Steel, Z. & Lacharez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *The Australian and New Zealand Journal of Psychiatry, 40*(2), 179-187.

- Simich, L., Beiser, M., Stewart, M. & Mwakarimba, E. (2005). Providing social support for immigrants and refugees in Canada: challenges and directions. *Journal of Immigrant Health, 7*(4), 259-268.

- Shisana, O. & Celentano, D.D. (1987). Relationship of chronic stress, social support, and coping style to health among Namibian refugees. *Social Science & Medicine, 24*(2), 145-157.

Acculturation (roles, language)

Acculturation plays a poignant role in the lives of immigrants and subsequent generations. While acculturation eases the interaction of immigrants with the receiving community, it may also lead to a loss of culture and the sense of history and belonging that goes with it. The children of immigrants typically acculturate to the culture of their receiving country at a quicker pace than their parents. This difference in intra-family acculturation rates can cause problems due to misunderstandings and conflicting values. Some families experience role reversal, with second-generation children interpreting and performing tasks for their parents. On the other hand, increased language and non-verbal communication skills accompany acculturation, providing opportunities to build social connections with people of the receiving community.

- Atri,A., Sharma, M. & Cottrell, R. (2006-2007). Roles of social support, hardiness, and acculturation as predictors of mental health among international students of Asian Indian origin. *International Quarterly of Community Health, 27*(1), 59-73.

- Finch, B.K. & Vega, W.A. (2003). Acculturation stress, social support, and self-rated health among Latinos in California. *Journal of Immigrant Health, 5*(3), 109-117.

- Yeh, C.J., Okubo, Y., Ma, P.W., Shea, M., Ou, D. & Pituc, S.T. (2008). Chinese immigrant high school students' cultural interactions, acculturation, family obligations, language use, and social support. *Adolescence, 43*(172), 775-790.

Family Stability

Single parenthood

Single parent households face multiple challenges to social connectedness, compared to two-parent families. Two-parent households may be able to supervise children more, may have access to broader social support systems, and be more willing to participate and able to invest more in their children's lives than single-parent households. And both the parents and children of single-parent households seem to be at risk for adverse health outcomes, including mental health problems and unhealthy behaviors, such as drug abuse or risky sexual behavior.

- Coleman, J. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 74*, S95-S120. **

- County Health Rankings. (2010). *Family and social support.* Retrieved from http://www.countyhealthrankings.org/health-factors/family-and-social-support.

- Furstenberg, F. & Hughes, M. (1995). Social capital and successful development among at-risk youth. *Journal of Marriage and Family, 57*, 580-592.

- High, P., et al. (1999). Child centered literacy orientation: a form of social capital? *Pediatrics, 104*(4), 1-7.

Residential Stability

Residential stability allows for the development of supportive social relationships over time. Moving frequently from one location to the next typically leads to social disruption, which seems to specifically affect children. If children are able to live within the same neighborhood throughout their childhood, they are able to develop strong and supportive social and institutional networks through their school and their surrounding community.

- Bures, R. (2003). Childhood residential stability and health at midlife. *American Journal of Public Health, 93*(7), 1133-1148.

- Gilman, S.E., Kawachi, I., Fitzmaurice, G.M. & Buka, L. (2003). Socio-economic status, family disruption and residential stability in childhood: relation to onset, recurrence and remission of major depression. *Psychological Medicine, 33*(8), 1341-1355.

Homelessness

Inherent to homelessness is residential instability, due to the lack of consistent housing. Homelessness is a chronically stressful experience, especially for families. Social support networks may buffer that stress and have positive effects on psychological and possibly physical health. Social networks may also provide a way for homeless individuals to connect with social services that can provide them with housing opportunities and access to healthcare, employment and education.

- Meadows-Oliver, M. (2005). Social support among homeless and housed mothers: an integrative review. *Journal of Psychosocial Nursing and Mental Health Services, 43*(2), 40-47.

- Rosenheck, R., et al. (2001). Service delivery and community: social capital, service systems integration, and outcomes among homeless persons with severe mental illness. *Health Services Research, 36*(4), 691-710.

- Shinn, M., Gottlieb, J., Wett, J.L., Bahl, A., Cohen, A. & Baron Ellis, D. (2007). Predictors of homelessness among older adults in New York city: disability, economic, human and social capital and stressful events. *Journal of Health Psychology, 12*(5), 696-708.

The Community

Diversity

Although population diversity is initially negatively associated with community trust, this mistrust can be transformed through the creation of social relationships between different groups of people. The development of meaningful 'bridging' opportunities among groups of people

from different backgrounds will help to foster tolerance of diversity and increase the amount of trust and social cohesion in a community.

- Berkman, L.F. (1984). Assessing the physical health effects of social networks and social support. *Annual Review of Public Health, 5,* 413-432.**

- Putnam, R.D. (2007). E pluribus unum: diversity and community in the twenty-first century – the 2006 Johan Skytte prize lecture. *Scandinavian Political Studies, 30*(2), 137-174.

- Sampson, R.J., Raudenbush, S.W. & Earls, F. (1997). Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science, 277*, 918-924.**

Reciprocity

Social connectedness fosters norms of trustworthiness and reciprocity, which stems from the sense of mutual obligation that individuals within a social network have for one another. Reciprocity can either be specific ("I'll do this for you if you do that for me") or generalized ("I'll do this for you without expecting anything specific back from you in the expectation that someone else will do something for me eventually down the road"). Therefore, reciprocity not only has direct benefits to the individuals involved within the specific transaction, but also benefits those who are not directly involved. Reciprocity has been known to be measured by responses to the question whether "most of the time people try to be helpful—or are they mostly looking out for themselvess" (Kawachi, 1999, p. 122).

- Kawachi, I. (1999). Social capital and community effects on population and individual health. *Annals of the New York Academy of Sciences, 896,* 120-130.

- Lochner, K.A., Kawachi, I., Brennan, R.T. & Buka, S.L. (2003). Social capital and neighborhood mortality rates in Chicago. *Social Science & Medicine, 56*(8), 1797-1805.

- Putnam, R.D. (2000). *Bowling alone: The collapse and revival of American community.* New York: Simon & Schuster Paperbacks.**

- Sampson, R.J. & C. Graif. (2009). Neighborhood social capital as differential social organization: Resident and leadership dimensions. *American Behavioral Scientist, 52*(11), 1579-1605.

Community Socio-Economic Status (SES)

Income inequality

Income inequality refers to the unequal distribution of income within a geographic area, whether a neighborhood, city, state or country. Studies have found that income inequality leads to higher rates of mortality, with social capital a possible component of the pathway between the two. Income inequality can lead to higher levels of mistrust and reduce social cohesion, resulting in lower social capital. Differences in the amount of social capital among different groups of people is associated with deleterious effects on the health of the more disadvantaged groups leading, for example, to premature death and increased mortality rates.

- Kaplan, G.A., Pamuk, E., Lynch, J.W., Cohen, R.D. & Balfour, J.L. (1996). Income inequality and mortality in the United States. *British Medical Journal, 312*, 1004-1007.

- Kawachi, I., Kennedy, B.P., Lochner, K., & Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health, 87*(9), 1491-1498.**

- Mansyur, C., Amick, B.C., Harrist, R.B. & Franzini, L. (2008). Social capital, income inequality, and self-rated health in 45 countries. *Social Science & Medicine, 66*(1), 43-56.

Neighborhood (crime)

Neighborhood characteristics have a significant impact on social connectedness and health in a variety of ways. High-crime neighborhoods keep people isolated from one another by keeping them indoors, limiting opportunities for interactions as well as for physical activity. Neighborhoods without places, such as parks or playgrounds, or opportunities for informal as well as organized forms of recreation (such as walking clubs) also reduce social interactions and exercise. Community norms can also influence social connectedness and health, by influencing the care that neighbors extend to each other. An elderly widow living alone will benefit from being part of a community where people feel an obligation to look out for one another, such as having someone to drive her to medical appointments, or making sure her sidewalks are shoveled after it snows.

- Institute on Race & Poverty. (2009). *Access to opportunity in the Twin Cities metropolitan area.* Retrieved from http://www.irpumn.org/website/projects/index.php?strWebAction=project_detail&intProjectID=64

- Kawachi, I., Kennedy, B.P., Lochner, K., & Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health, 87*(9), 1491-1498.**

- Lochner, K.A., Kawachi, I., Brennan, R.T. & Bukam S.L. (2003). Social capital and neighborhood mortality rates in Chicago. *Social Science & Medicine, 56*(8), 1797-1805.

- Sampson , R.J., Raudenbush, S.W. & Earls, F. (1997). Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science, 277*, 918-924.**

- California State Parks (2005). The health and social benefits of recreation: An element of the California outdoor recreation planning program. Sacramento, CA.

Social Inclusion

Trust

Trust is a necessary feature of social connectedness. Trust occurs at both individual and community levels: people trust or distrust other people, as well as the systems that they encounter. Many people do not trust government, based on experiences of social exclusion and disappointment with the established order of business, what they see as a failure of these systems to deliver what they promise in an equitable way. This distrust discourages civic engagement and participation in those same systems. Trust is also associated with neighborhood organization and social order within the neighborhood. If a neighborhood is perceived by an individual to be

disorderly, that individual may be fearful of others; if a neighborhood is perceived to have social order, then community members are more likely to trust each other and initiate and maintain positive and healthy social relationships.

- Ross, C. E., & Jang, S. J. (2000). Neighborhood disorder, fear, and mistrust: The buffering role of social ties with neighbors. American *Journal of Community Psychology, 28*, 401–420.
- Putnam, R.D. (2000). *Bowling alone: The collapse and revival of American community.* New York: Simon & Schuster Paperbacks.**
- Ross, C.E., Mirowsky, J & Piresh, S. (2001). Powerlessness and the amplification threat: Neighborhood disadvantage, disorder and mistrust. *American Sociological Review, 66*, 568-591.

Segregation

Segregation still occurs in many ways: by race/ethnicity, gender, income, and geographic location. Segregation can limit an individual's access to jobs, economic prospects, healthcare and education. Along with decreasing opportunities, segregation can also lead to the collapse of social organization, to a decline in basic community institutions (such as churches and schools) within a neighborhood, and to a lack of role models regarding education, family values and positive norms and behaviors.

- House, J.S. (1987). Social support and social structure. *Sociological Forum*, *2*(1), 135-146.
- Institute on Race & Poverty. (2009). *Access to opportunity in the Twin Cities metropolitan area.* Retrieved from http://www.irpumn.org/website/projects/index.php?strWebAction=project_detail&intProjectID=64
- Wilson, W.J. (1987). *The truly disadvantaged: The inner city, the underclass, and public policy.* Chicago, IL: The University of Chicago Press.**
- Wilson, W.J. (2009). Toward a framework for understanding forces that contribute to or reinforce racial inequality. *Race and Social Problems, 1*: 3-11.**

Incarceration

Crime level may be an indicator of collective well-being influenced by the amount of social cohesion, or collective efficacy combined with the willingness to intervene and practice informal mechanisms to maintain social order for the common good, available within a neighborhood or community. Incarceration rates are the result of criminal activity within a certain neighborhood or community. Incarceration also limits the social networks and positive social relationships available to inmates.

- Centers for Disease Control and Prevention. (2003). *Data set directory of social determinants of health at the local level.* Retrieved from http://www.cdc.gov/dhdsp/library/data_set_directory/index.htm
- Kawachi, I., Kennedy, B.P., & Wilkinson, R.G. (1999). Crime: social disorganization and relative deprivation. *Social Science & Medicine, 48*, 719-731.

- Sampson, R.J., Raudenbush, S.W. & Earls, F. (1997). Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science, 277*, 918-924.**

Civic engagement

Civic engagement is typically considered to be a key indicator of social capital. Community members may participate in civic engagement by being involved within their community, usually through various groups and associations. Through their involvement in groups and associations, community members can build social capital by meeting together, agreeing on common values, and pursuing a common goal as a collective unit. This can eventually result in changes on a community level, and even on a policy level.

- Barnes, K. (2003). Community Pride. *Harlem Children's zone: A Look Inside, 2*(1). Retrieved from http://www.hcz.org/images/stories/pdfs/ali_spring2003.pdf

- Kawachi, I. (1999). Social capital and community effects on population and individual health. *Annals New York Academy of Sciences, 896*, 120-130.

- Putnam, R.D. (2000). *Bowling alone: The collapse and revival of American community*. New York: Simon & Schuster Paperbacks.**

Institutional racism

Because of institutional racism (also called structural racism[2]) the U.S. continues to maintain a clear association between socioeconomic status and race. National, state, and local policies, systems, resources, information, employment, medical care, and a healthy environment (to name a few) are not equally accessed by nor do they equally serve whites and persons of color. Housing and community investment policies set in place decades ago to benefit white populations continue to wreak their havoc on subsequent generations of African Americans and the immigrant populations of color that have joined them (see profile of social connectedness on p. 25). People of color are now often segregated in poor and violent inner-city neighborhoods. However, there may be little opportunity to move to a better neighborhood because subsidized housing policies often locate affordable housing options only within low-income neighborhoods. Institutionalized racism affects social connectedness by limiting opportunities to connect with employment and educational opportunities and thereby developing a sense of belonging in the broader society, and by poisoning the atmosphere of human relationships.

- Jones, Camara Phyllis, (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*, 90:1212–1215. Retrieved from: http://ajph.aphapublications.org/cgi/reprint/90/8/1212.pdf

[2] "A method of analysis that is used to examine how historical legacies, individuals, structures, and institutions work interactively to distribute material and symbolic advantages and disadvantages along racial lines." Kirwan Institute, University of Ohio, http://kirwaninstitute.org/research/structural-racism.php.

- Lukehart, J., Luce, T. & Reece, J. (2005). *The segregation of opportunities: the structure of advantage and disadvantage in the Chicago region.* Retrieved from http://www.irpumn.org/uls/resources/projects/Full%20Report%20-%20May%202005.pdf

- Wilson, W.J. (1987). *The truly disadvantaged: The inner city, the underclass, and public policy.* Chicago, IL: The University of Chicago Press.**

- Wilson, W.J. (2009). Toward a framework for understanding forces that contribute to or reinforce racial inequality. *Race and Social Problems, 1*: 3-11.**

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Appendices

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Appendix A: Project Participants

Appendix B: *A Call to Action*: Executive Summary

Appendix C: Measurement Tool Details

Appendix D: References

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Appendix A

Project Participants

Research Partners Group

Patricia Adams, Co-chair
Assistant Commissioner
Minnesota Department of Health

Kathy Brothen
Coordinated School Health Program Coordinator
Minnesota Department of Education

Bonnie Brueshoff
Public Health Director
Dakota County Public Health

Janny Dwyer Brust
Director, Medical Policy and Community Health
Minnesota Council of Health Plans

Joan Cleary
Vice President
Blue Cross/Blue Shield of Minnesota Foundation

Melanie Ferris
Research Associate,
Wilder Research;
representing the Minnesota Public Health Association

Hal Freshley
Planning and Policy Coordinator
Minnesota Board on Aging

Jose Gonzalez, Co-chair
Director, Office of Minority and Multicultural Health
Minnesota Department of Health

Baris Gumus-Dawes
Research Fellow, Institute on Race & Poverty
University of Minnesota Law School

Laura LaCroix-Dalluhn
Executive Director
Youth Community Connections: Minnesota's Statewide Afterschool Alliance

Jonathan Larson
Medical Consultant for Carver County Public Health
Lakeview Clinic Ltd.

Richard Lee
Associate Professor
Department of Psychology
University of Minnesota

Karen Nordstrom
Bloomington City Council Member, representing the State Community Health Services Advisory Committee

Debra Rodgers
Executive Director
Center for Cross-Cultural Health

Minnesota Department of Health:

Dorothy Bliss (Project Lead), Office of Public Health Practice

Emily Wang (Graduate Student Assistant), Office of Public Health Practice

Don Bishop, Center for Health Promotion

Debra Burns, Office of Public Health Practice

Gail Gentling, Office of Public Health Practice

Brenda Menier, Office of Public Health Practice

David Stroud, Center for Health Statistics

Dan Symonik,
Environmental Impact Analysis Unit

Key Informant Interviews

10/26/09
Michael Oakes
Associate Professor
University of Minnesota, Department of Epidemiology

11/04/09
Rich Lee
Associate Professor
University of Minnesota, Department of Psychology

11/18/09
Cathy Jordan, Director
University of Minnesota, Children, Youth and Family Consortium

11/23/09
Joan Cleary
Vice President
Blue Cross Blue Shield Foundation of Minnesota

12/2/09
Mark Snyder, Professor
University of Minnesota, Department of Psychology

12/2/09
Scott McConnell
Professor
University of Minnesota, Department of Education Psychology

1/6/10
Wanda Alexander
Secretary-Treasurer
Faith Community Nurse Network of the Greater Twin Cities

1/20/10
Kathy Brothen
Program Coordinator
Minnesota Department of Education, Coordinated School Health

1/20/10
Hal Freshley, Planning and Policy Coordinator
Minnesota Department of Human Services;
Minnesota Board on Aging

1/21/10
David Scheie, President
Touchstone Center for Collaborative Inquiry

2/3/10
Laura LaCroix-Dalluhn, Executive Director
Youth Community Connections

2/3/10
Doroth Mayer, Director
East African Women's Center

2/4/10
Debra Rodgers
Executive Director
Center for Cross Cultural Health

2/11/10
Bonnie Brueshoff, Director
Dakota County Public Health Department

2/17/10
Jose Gonzalez, Director
Minnesota Department of Health, Office of Minority and Multicultural Health

3/3/10
Jon Larson
Medical Consultant
Carver County Health Partnership

3/4/10
Janny Brust, Director of Medical Policy and Community Health
Minnesota Council of Health Plans

3/10/10
Baris Gumus-Dawes
Associate Fellow
University of Minnesota Law School, Institute on Race and Poverty

3/23/10
Melanie Ferris
Research Associate
Wilder Research Institute

5/13/10
Refugee Women of the East African Women's Center

5/27/10
Noya Woodrich, Director
Division of Indian Work, Greater Minneapolis Council of Churches

6/17/10
Jeanne Ayers
Director of Nursing
University of Minnesota, Boynton Health Service

Appendix B

A CALL TO ACTION: Advancing Health for All Through Social and Economic Change[1] Executive Summary

The Minnesota Health Improvement Partnership
Association for MN Counties
Business for Social Responsibility, Upper Midwest Network
Center for Population Health
Consumer Member
Health Care Education and Research Foundation
League of MN Cities
Local Public Health Association
Maternal and Child Health Advisory Task Force
MN Business Partnership
MN Chamber of Commerce
MN Council on Disabilities
MN Council of Foundations
MN Council of Health Plans
MN Council of Non-Profits
MN Department of Children, Families and Learning
MN Department of Employee Relations
MN Department of Health
MN Department of Human Services
MN Environmental Health Association
MN Hospital and Healthcare Partnership
MN Medical Association
MN Nurses Association
MN Planning
MN Public Health Association
Neighborhood HealthCare Network
Population Health Assessment Work Group
Prairie Regional Health Alliance
Rural Health Advisory Committee
State Community Health Services Advisory Committee
University of Minnesota
• Center for Spirituality and Healing
• School of Public Health, Division of Epidemiology
• School of Public Health, Division of Health Services Research and Policy

Background

This report is a multi-disciplinary, inter-sector Call to Action produced by the Social Conditions and Health Action Team of the Minnesota Health Improvement Partnership (MHIP).

The purpose of this report is to deepen understanding of the impact that social and economic conditions have on health, and identify recommendations with potential to help create more health-enhancing social and economic environments in Minnesota.

A unique contribution of this report is its focus on social and economic change as a strategy for health improvement and as a remedy to health disparity. This report examines the importance of social interactions and policies within settings (e.g., places where we live, work, learn, worship and play) and systems (e.g., education, criminal justice, human services) outside of the health sector that have a profound impact on health.

VISION: *All people in Minnesota have an equal opportunity to enjoy good health.*

Minnesota ranks as one of the healthiest states in the nation, but mounting evidence shows that this great state of health is not shared by all – particularly American Indians, populations of color, foreign-born populations, and people with low income.

We are one Minnesota. Health disparities affect us all. Minnesota should commit to leading the nation in the health of *all* of its citizens, not only because this is the right thing to do, but because this will contribute to the overall health and prosperity of Minnesota.

Health is more than not being sick. Health is a resource for everyday life – the ability to realize hopes, satisfy needs, change or cope with life experiences, and participate fully in society. Health has physical, mental, social and spiritual dimensions. Achieving this vision is bigger than our systems of public health and health care.

[1] **A Call To Action: Advancing Health for All Through Social and Economic Change**, 2001. Prepared by the Minnesota Health Improvement Partnership Social Conditions and Health Action Team. Funded in part by a Turning Point grant from the Robert Wood Johnson Foundation; Pp. 1-8. http://www.health.state.mn.us/divs/cfh/ophp/resources/docs/calltoaction.pdf

All individuals, systems and institutions in the community share responsibility for – and reap the rewards of – improved health.

> ***America's strength is rooted in its diversity. Our history bears witness to that statement E Pluribus Unum was a good motto in the early days of our country and it is a good motto today. From the many, one. It still identifies us – because we are Americans.***
>
> *Barbara Jordan, former U.S., Senator*

Summary Of Key Findings

Health is a product of individual factors (such as genes, beliefs, coping skills, and personal behaviors) combined with collective conditions (factors in the physical, social and economic environment). The social and economic environment is a major determinant of population health that has not been a focus of most health improvement efforts in Minnesota.

Key aspects of the social and economic environment that affect health include income, education, and income distribution; social norms; social support and community cohesion; living conditions such as availability of affordable housing, transportation and nutritious foods; employment and working conditions; and culture, religion and ethnicity. For example:

- People with a higher income generally enjoy better health and longer lives than people with a lower income. The rich are healthier than the middle class, who are in turn healthier than the poor. This is true for people of all racial and ethnic backgrounds.

- Disease and death rates are higher in populations that have a greater gap in income between the rich and poor. The effect of income inequality on health is not limited to people in poor and low income groups. The health of people in middle (and in some studies upper) income groups is worse in communities with a high degree of inequality when compared to communities with less inequality. The health of a population depends not just on the size of the economic pie, but on how the pie is shared.

- People are healthiest when they feel safe, supported and connected to others in their families, neighborhoods, workplaces and communities. More cohesive communities (those characterized by greater civic participation, volunteerism, trust, respect and concern for others) have lower rates of violence and death.

- Workers are healthiest when they believe their job is secure, the work they do is important and valued, the workplace is safe and there are ample opportunities for control, decision-making, advancement and personal growth.

- Culture, religion and ethnicity have an overarching influence on beliefs and practices related to health, illness and healing. This includes perceptions of health and illness, beliefs about the causes of health and illness, decisions about whether to seek a health care provider, and decisions about the type of provider or healer that should be sought.

More research is needed to understand precisely how these factors affect health and health disparities, and how to translate these findings into the most promising policies and programs. Studies conducted to date point to conclusions such as:

- Social and economic factors influence a broad array of opportunities, exposures, decisions and behaviors that promote or threaten health (e.g., availability of safe and convenient parks and trails encourage recreation and neighborhood connections; oppression and marginalization contribute to violence and apathy; high housing costs leave fewer resources for other necessities; transportation eases isolation; farmer's markets encourage eating fresh produce; family leave and quality childcare promote attachment and positive development; cultural insensitivity alienates community members; the concentration of liquor outlets in low income neighborhoods encourages alcohol use and abuse).

- Discrimination and racism play a crucial role in explaining health status and health disparities, through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, residential segregation (which can limit access to social goods and services), and chronic stress.

- People of color and American Indians do not experience worse health simply because they are more likely to have a lower income (although this is an important factor). *At every level of income,* their health is worse than that of their white peers.

- People with low income do not experience worse health simply because of high risk personal behavior (although this is an important factor). In one recent study, health behaviors such as cigarette smoking, alcohol use, and physical inactivity explained less than 20 percent of the difference in death rates across income groups.

Conclusions

Good health enables Minnesotans to lead productive and fulfilling lives, and contributes to the competitiveness, prosperity and social stability of the state.

Good health results from good systems of public health and medical care, from sound public policies that create social and economic conditions that support health, and from individual decisions and behaviors that value health. A comprehensive health improvement agenda addresses each of these determinants and recognizes the inter-relationships between them.

More supportive social and economic conditions are needed to eliminate disparities and achieve Minnesota's overall health improvement goals.

The links between health and factors such as income, education, living and working conditions, culture, social support and community connectedness are clear. But more research is needed to

understand more precisely how these factors affect health, and how to translate these findings into the most promising policies and programs.

Recommendations

Identify and Advocate for Healthy Public Policy

Policies and programs have health consequences though they may not have explicit health objectives. Since investments outside the health sector have consequences for community health, the potential impact of social and economic policies on the health of Minnesotans should be an integral part of policymaking processes.

- Develop and pilot tools for Health Impact Assessment in Minnesota.
- Produce briefs that summarize emerging research on the health impacts of social and economic policies.

The Minnesota Department of Health (MDH) and the MHIP should focus united advocacy and action behind social and economic policies and programs with significant potential to improve or diminish health and quality of life in Minnesota.

Findings of Health Impact Assessment and other avenues of evaluation and research are needed to identify the most promising policies and programs. As this research moves forward, Minnesotans should capitalize on current evidence and experience to discuss and debate the potential health affects of current and proposed policies and programs to:

- Help people move out of poverty and meet their basic needs.
- Promote optimal early childhood development and attachment.
- Assure opportunities for quality education and lifelong learning.
- Link economic development, community development and health improvement.
- Elevate the standard of living and prospects for future generations.

Build and Fully Use a Representative and Culturally Competent Workforce

The MDH and the MHIP member organizations should establish and adhere to practices to recruit, retain, and promote personnel who reflect the cultural and ethnic diversity of the communities served. The following strategies will increase diversity, promote cultural competence, and enhance organizational credibility and effectiveness.

- Create diverse applicant pools of qualified people.
- Create an environment where all employees feel welcome, accepted and valued.
- Increase the future pool of qualified applicants.
- Retain people of color in the workforce.
- Measure and report progress.

Increase Civic Engagement and Social Capital

Health improvement programs often focus narrowly on a pre-determined disease, age group, or risk factor, for a one or two year time span. Yet research supports – and communities seem to want—programs that are more comprehensive, flexible, responsive, and enduring. Models of community development, civic engagement, and participatory evaluation and research have been developed to help communities draw on the resources and strengths of community members and

organizations as the foundation for prioritizing, designing, implementing, and evaluating community health improvement initiatives.

- Identify tools, policies and approaches that more actively engage community members and community groups in health improvement.
- Identify and act on obstacles to their broad implementation.
- Develop culturally sensitive and linguistically appropriate health education materials.
- Build mutually beneficial relationships between community-based organizations and larger systems and institutions.
- Recognize communities and organizations with rewards and incentives for their efforts in building on the ideas in this report.

Re-orient Funding

The social and economic changes described in this report will not happen by chance. Stable funding and leadership are needed within a critical mass of organizations to support innovative, long-term collaborative efforts with potential to achieve and sustain change. Change is needed with regard to the amount of funding available to community-based organizations, as well as the terms on which it is available.

New mechanisms to deliver funding must be developed that balance accountability with maximum flexibility, community autonomy and efficiency. Because MDH operates numerous grant programs, the department is in a position to take immediate steps that will begin a long-term process of reorienting funding:

- Involve a greater variety of people in evaluating grant proposals.
- Notify more community-based organizations from around the state of the availability of grant proposals.
- Streamline administrative requirements.
- Determine barriers to funding initiatives designed to eliminate disparities.
- Require that grant applicants involve community-based organizations and/or representatives from the populations to be served in the preparation of the grant proposal, and in the implementation of the grant.

Strengthen Assessment, Evaluation and Research

More rigorous use of population health data, and more sophisticated measures and indicators of health are needed to provide a comprehensive picture of the factors that affect health. MDH, MHIP member organizations, Community Health Service (CHS) agencies, the MDH Minority Health Advisory Committee, and the MDH Population Health Assessment Work Group, should work with other interested organizations to:

- Act on the future data initiatives recommended within the 1997 Populations of Color Health Status Report and the 1998 Report to the Legislature of the MDH Minority Health Advisory Committee.
- Build on lessons learned through minority health assessment grants awarded during 2000; leverage additional resources to support similar assessment and planning initiatives across the state.
- Expand traditional indicators of health to reflect the social and economic determinants of health; collect and communicate baseline data on social and economic factors that contribute to health and health disparities.

- Incorporate social and economic factors into planning and assessment processes at the state and local levels.
- Link health indicators with measures of socioeconomic status and race/ethnicity. For example: incorporate measures of income, education and race/ethnicity into health information systems; take steps to overcome limitations of information systems that currently include some health, socioeconomic and race/ethnicity data; assure uniform and accurate collection of socioeconomic and racial/ethnic data; expand analysis and reporting of hospital discharge data, health plan enrollment and claims encounter data, and surveys of health plan member/patient satisfaction.

Communicate and Champion the Findings and Recommendations

- Distribute this report to key leaders and organizations.
- Champion the findings and recommendations throughout MDH and the organizations, systems and networks represented on MHIP.
- Create opportunities for dialogue and action.

Focus Coordinated Commitment on Priority Strategies

Many groups and individuals in Minnesota are dedicated to improving the social and economic climate in Minnesota, though they may not have fully realized the health implications of their actions and advocacy. MHIP members should work jointly to mobilize action and leverage the strength of these organizations.

Take This Work to the Next Stage

MHIP and MDH should bring overall leadership and direction to this work during the next year by expanding and re-convening partners, promoting accountability, issuing "calls to action," producing issue briefs, and positioning Minnesota to capitalize on research and related activities occurring nationally.

Appendix C

Measurement Tool Details

POPULATION DATA				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	City/townships jobs per 100,000 residents (an indicator of proximity of transportation and jobs)	*Institute on Race and Poverty, Humphrey Institute, University of Minnesota, 2006*	*Opportunity Index (U.S. Census Transportation Planning Package; Metro GIS; MN Dept of Education; MN Dept of Health; MN Pollution Control Agency; MN Secretary of State; MN State Demographic Center; MN Dept of Public Safety; U.S. Census Bureau)*
	X	City/township low-skill jobs per 100,000 residents (an indicator of proximity of transportation and jobs)		
	X	Jobs within 10 miles of the city/township (an indicator of proximity of transportation and jobs)		
	X	% change in jobs within 10 miles of the city/township (an indicator of growth of transportation and jobs		
	X	Average commute times (an indicator of access to transportation and jobs)		
	X	% of population within ¼ mile of transit (an indicator of access to transportation and jobs)		
	X	Violent crime rate per 100,000 residents (an indicator of safety)		
	X	Non-violent crime rate per 100,000 president (an indicator of safety)		
	X	Housing value appreciation (an indicator of housing market health)		
	X	Voter participation rate		
	X	MN Comprehensive Assessment (MCA) reading scores (an indicator of education quality/outcomes)		
	X	MCA Math scores (an indicator of education quality/outcomes)		
	X	High school graduation rate (an indicator of education quality/outcomes)		

POPULATION DATA				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	Attendance rate (an indicator of education quality/outcomes)		
	X	Limited English proficiency rate (an indicator of education costs/poverty)		
	X	Mobility rate (an indicator of education costs/poverty)		
	X	% of elementary students eligible for free or reduced cost lunch (an indicator of education costs/poverty)		
	X	Divorce Rate	*Kansas Health Institute, 2009*	*Vital Statistics, Office of Health Assessment, Kansas Department of Health & Environment*
	X	Single Parent Households		*U.S. Census Bureau*
	X	Voting: Votes cast for president, by party	*Social Determinants of Health Work Group, CDC*	*USA Counties & Census Bureau*
	X	Voting: Percent of persons registered to vote and voting by race/ethnicity		
	X	Political Party Membership		
	X	Donations to parties and candidates: Donations to Republican and Democratic candidates, parties, and political action committees		*Center for Responsive Politics*
	X	Community organizations: Number and size of organizations: religious, political, civic and social, social advocacy, human rights, environmental and wildlife, business, labor, grant making and giving		*County Business Patterns (Census)*
	X	Unions		*Union Membership and Earnings Data Book*
	X	Segregation: Racial Ethnic (Indices of Dissimilarity, Isolation, Delta, Absolute Centralization, and Spatial Proximity)		*Census 2000 Special Report*

POPULATION DATA				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	Segregation: Economic		*Jargowsky, 2003*
	X	Volunteer Organizations: Number of churches, total and by denomination		*Religious Congregations and Membership in the United states: 2000*
	X	Volunteer Organizations: Number of church members and church adherents, total and by denomination		
	X	Charitable Giving: Average charitable contribution per itemized income tax return; number of public charitable organizations by type of charity; monetary public support for public charitable organizations by type of charity		*National Center for Charitable Statistics*
	X	Jails (Expenditures): State and local justice expenditures		*Sourcebook of Criminal Justice Statistics*
	X	Jails (Expenditures): Corrections expenditures		*Census of Governments*
	X	Jails (Incarceration rates): Average daily population in local jails; state prison incarceration rates		*Bureau of Justice Statistics, Prison and Jail Inmates at Midyear*
	X	Jails (Incarceration rates): Confined jail inmates by race, as a percent of total race specific population		*Bureau of Justice Statistics, Census*
	X	Jails (Crime): Number of serious crimes known to police		*U.S. Counties (Census)*
	X	Lawsuits (Civil Lawsuits): Number of tort trials		*Bureau of Justice Statistics: Tort Trials and Verdicts in Large Counties*
	X	Protective Services (Government services) : Police protection expenditures		*Census of Governments*
	X	Protective Services (Government services): Percent of households reporting poor levels of police protection in their neighborhood		*American Housing Survey*

POPULATION DATA				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X	X	Divorce Rate (rate of divorce cases per 1,000 population) – although this was not directly linked to social support	*Tennessee Institute of Public Health*	*Tennessee Department of Health*
X	X	Single Parent Households (% of own children in single-parent households) – although this was not directly linked to social support		*Kids Count (www.kidscount.org)*
X	X	Divorce (a measure of the percentage of people aged 15 and over in the population who report being divorced, rather than never married or widowed) – social disruption	*University of Wisconsin Population Health Institute, 2008*	*United States Decennial Census*
X	X	Single Parent Households (a measure of the number of households run by a single parent, e.g., male householder with no present or female householder with no male present, with one or more of their own children under 18 years as a percentage of the total number of households)	*University of Wisconsin Population Health Institute, 2008 & 2009 (2010 County Health Rankings: Metrics)*	*United States Decennial Census, American Community Survey*
X	X	Percent of adults without social/emotional support (family and social support)		*Behavioral Risk Factor Surveillance System*

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X	X	This is a good community to raise children in. Would you say you … • Strongly agree • Somewhat agree • Somewhat disagree • Strongly disagree	*Hennepin County Human Services and Public Health Department*	*Shape 2006: A Survey of Residents of Hennepin County*
X	X	How often are you involved in school, community or neighborhood activities? • Weekly • Monthly • Several times a year • About once a year • Less often than that • Never		
X	X	How often do you go to a church, temple, synagogue, mosque or other place for worship or other activities? • Daily • Weekly • Monthly • Less often than that • Never		
X		How often do you get together or talk with friends or neighbors? • Daily • Weekly • Monthly • Less often than hat • Never		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	Questions about where you live and your neighborhood (on a 4-point scale from "strongly agree: to "strongly disagree") • People in this neighborhood know each other • People in this neighborhood are willing to help one another • People in this neighborhood can be trusted • People in this neighborhood are afraid to go out at night due to violence • Gangs are a serious issue in this neighborhood • Children are safe in this neighborhood • People in this neighborhood generally get along with each other		
X	X	How many times during the past year did you: • Attend church or other place of worship • Bowl • Do exercises at home • Do volunteer work • Entertain at home • Give or attend a dinner party • Make a long distance call • Send a greeting card • Use the Internet • Go to a club meeting • Work on a community project • Write a letter to an editor	*DDB Worldwide*	*DDB Needham Lifestyle Survey, 1999*

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X	X	Which, if any, of these things have you done in the past year? • Served as an officer of some club or organization • Worked for a political party • Served on a committee for some local organization • Attended a public meeting on town or school affairs • Attended a political rally or speech • Made a speech • Wrote a congressman or senator • Signed a petition • Was a member of some "better government" group • Held or ran for political office • Wrote a letter to the paper • Wrote an article for a magazine or newspaper	*Roper Center for Public Opinion Research, University of Connecticut*	*Roper Social and Political Trends, 1997*
X		Which, if any, of these things have you done in the past week? • Discussed politics • Had friends in for the evening • Went to a home of friends • Made a personal long distance call • Went to church • Went out to watch a sports event • Wrote a personal letter • Received a personal letter		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X	X	How many times, if any, did you do any of these activities in the past month? • Made a contribution to charity • Did volunteer work • Donated blood • Went to a friends' house for dinner or evening • Had friends in for dinner or evening • Went to a church social function • Went to a meeting of a club or civic organization		
X	X	How often do you do the following things together as a family unit? (asked of respondents with children under 18 living at home) • Having the main meal together • Sit and talk together • Watch TV together • Go out to eat together • Take a vacation together • Attend religious services together • Exercise/play sports together		
X		Number of relationships with people who can be trusted and turned to when in need of support • More than 5 people • Up to 5 people • No people	*Mental Health America, 2008*	*Their own "Social Connectedness and Health" Survey*

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X		Types of relationships turned to for emotional support during stressful times • Family Members • Significant Other • Friends • Religious Community • Doctor		
X		Relationship characteristics (on a 6-point scale from "total agree" to "strongly disagree") • I often meet or talk with family or friends • I have someone to talk to about decisions in my life • When I feel lonely there are several people I can talk to • I have close relationships that make me feel good • There are people I know will help me if I really need it • I have close relationships that help me cope with stress • There are people who appreciate me for who I am • I feel a strong emotional tie with at least one other person		
	X	Rating of the region's ability to work together • Outstanding or Good	*Minnesota Compass, 2009*	*2007 Twin Cities Compass Survey conducted by Wilder Research*
X		Perceived ability of individuals to make community better • Outstanding or Good		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	Percentage of residents (16+) that volunteered in the past year		*Current Population Survey, Volunteer Supplement, U.S. Census Bureau for the Bureau of Labor Statistics*
	X	Voting-age turnout		*Minnesota Secretary of State for number of voters & U.S. Census Bureau, intercensal estimates for population to calculate turnout percentages*
	X	Proportion of adults who are employed		*U.S. Census Bureau: Decennial Census & American Community Survey*
	X	Percent meeting or exceeding proficiency in 3rd grade reading		*MN Dept. of Education*
	X	9th grade average attendance		
	X	Percent meeting or exceeding proficiency in 11th grade math		
	X	Graduation rate (on-time)		
	X	Share of all households paying 30% or more of income for housing		*U.S. Census Bureau: Decennial Census & American Community Survey*
	X	Homeownership gap		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	Homelessness rate		*U.S. Census Bureau: Decennial Census & American Community Survey; Homelessness Rate per 10,000 Wilder Research, Minnesota Statewide Survey of People Without Shelter*
	X	Proportion of adults indicating crime victimization in past year (property and violent crime)		*2007 Twin Cities Compass Survey conducted by Wilder Research*
	X	Serious crime rates per 100,000		*MN Dept. of Public Safety; Bureau of Criminal Apprehension, Uniform Crime Reports*
	X	Proportion feeling unsafe walking on their street after dark		*2007 Twin Cities Compass Survey conducted by Wilder Research*
	X	How many students in your school: • Are friendly? • Behave well in the hallways and lunchroom? • Have made fun of our threatened students of different races or backgrounds Answers include: None, A few, Some, Most, All	*MN Dept of Education, MN Dept of Health, MN Dept of Human Services, MN Dept of Public Safety*	*Minnesota Student Survey 2010*
X	X	How many of your teachers: • Are interested in you as a person? • Show respect for the students?		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X	X	How much do you agree or disagree with the following statements? • I feel safe going to and from school • I feel safe at school • I feel safe in my neighborhood • Bathrooms in this school are a safe place to be • Illegal gang activity is a problem at this school • Student use of alcohol or drugs is a problem at this school Answers include: Strongly disagree, Disagree, Agree, Strongly agree		
X	X	In general, during the last 12 months, how often have you participated in the following activities? • Fine arts activities (lessons, band, choir, dance, drama, etc.) • Club or community sports teams • School sports teams • Community club and programs (4-H, Park and Rec, Community Ed, etc) • Mentoring programs (as a mentor or being mentored) • Religious activities (religious services, education, youth group, etc.) • Service learning programs • Tutoring, Homework Help or other academic programs Answers include: Every day, 3-4 times per week, 1-2 times per week, Monthly, Less than monthly, Never, Not available in my community		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	In general, why do you participate in school-based or community-based activities and clubs? • I don't participate in any activities • To have fun • To learn new skills • My parents (or guardians) want me to • My friends participate • To help me get into college • It is a safe place to be after school • Other		
	X	In general, why don't you participate in any school-based or community-based activities and clubs? • I do participate in at least one activity • Activities are not available in my community • Activities cost too much • My parents (or guardians) won't let me • My friends don't participate • I'm not interested • I am too busy with other things • I don't have a way to get there or home • I have to take care of other family members • It's not a safe place to be after school • Other		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X	X	During the school year, how many hours in a typical week do you spend doing the following? • Homework/study • Reading for pleasure • Watching TV/DVDs or videos • Playing video games • Talking on the phone or texting • Online activities (email, instant messaging, etc.) • Volunteer work • Work for pay (including babysitting for others) • Hanging out Answers include: 21 hours or more, 11-20 hours, 6-10 hours, 3-5 hours, 1-2 hours, 0 hours		
X		How much do you feel … • Friends care about you? • Teachers/other adults at school care about you? • Religious or spiritual leaders care about you? • Other adults in your community care about you? • Your parents care about you? • Other adult relatives care about you? Answers include: Very much, Quite a bit, Some, A little, Not at all		
X	X	Donated blood during the past 12 months	*National Opinion Research Center, University of Chicago*	*General Social Survey, 2004, Altruism*
X	X	Has given food or money to a homeless person		
X	X	Done volunteer work for a charity		
X	X	Has given money to a charity		
X	X	Membership in church-related groups		*General Social Survey, 2004, Voluntary*

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X	X	Are there any activities that you do with the same group of people on a regular basis even if the group doesn't have a name such as a bridge group, exercise group, or a group that meets to discuss individual or community problems?		*Associations/Social Networks*
X	X	Do you belong to more than one/Do you belong to more than one/how many years have you been a member of a: • Fraternal group • Service club • Veteran group • Political club • Labor union • Sports group • Youth group • School service group • Hobby club • School Fraternity • Nationality group • Farm organization • Literary group • Professional societies • Church affiliate group • Other group • Informal group		
		Volunteer rates (the percentage of individuals who responded that they performed unpaid volunteer activities at any point during the 12-month period that preceded the survey for or through an organization	*Volunteering in America*	*Current Population Survey's Volunteer Supplement, U.S. Census Bureau*
		Volunteer hours per resident (volunteer hours per residents calculated as the total volunteer hours served divided by the population aged 16 and over)		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
		Volunteer retention rates (the proportion of volunteers who also perform volunteer service in the following year)		
		Older adult (aged 65 years old and older) volunteer rates		
		Baby boomer (individuals born between 1946 and 1964) volunteer rates		
		Young adult (individuals aged 16 to 24 years old) volunteer rates		
		College student (individuals aged 16-24 years old who are enrolled in college) volunteer rates		
		Millennial (individuals born in 1982 and after who are at least 16 years old) volunteer rate		
		Teenage Volunteer Rates		
	X	Social trust (cognitive social capital indicator): People in my neighborhood trust each other… • Likert-scale ranging from "not at all", "a little", "some", and "a lot". • During analysis, "not at all" and "a little" were collapsed together in order to create three categories of "high trust", "middle trust" and "low trust".	*Fujiwara & Kawachi, 2008*	*Self-administered mail questionnaire to twin pairs*

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X		Sense of belonging (cognitive social capital indicator): a three-item scale derived from the weighted average of responses to the following statements: 1. I don't feel I belong to anything I'd call a community, 2. I feel close to other people in my community, and 3. My community is a source of comfort. • Responses to each question were recorded on a 7-point Likert scale with higher scores denoting a higher sense of belonging. Answers were analyzed as tertiles (high, medium and low).		
	X	Amount of volunteer work (structural social capital): calculated as the sum of reported hours per month in volunteer work at a hospital, nursing home, or other health-related settings; school or other youth-related activities; political organizations or causes; and/or any other local organizations or charity. Volunteer was categorized into three groups: • No volunteer work • 1-9 hours per month • ≥10 hours per month		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	Community participation (structural social capital): calculated as the sum of reported frequency of participation per month in religious services, meetings of religious groups, meetings of unions or other professional groups, meetings of sports or social groups, or meeting of any other groups (not including those required by the respondent's job). Community participation was categorized into four groups: • No participation • 1-3 times per month • 4-7 times per month • ≥8 times per month		

SURVEYS				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
	X	Examples of profiles of student life: 1. Getting to know people of a different race or ethnic group than I am. (Rate importance) 2. I get a lot of encouragement at my school. (Rate agreement) 3. In my neighborhood, there a lot of people who care about me. (Rate agreement) Examples of Adult-Youth Engagement: 1. How often do you yourself actually show kids the importance of volunteering or giving money to change law or policies so that life is more fair or equal for everyone? (Rate frequency) 2. How many kids in your neighborhood do you actually know by name? 3. When some neighbors actually see children or youth doing something wrong, they tell the parents of those children or youth. How important is this for neighbors to do?	*Search Institute*	*Community Surveys that identify risk youth behavior and attitudes and community problems and/ or assets that may impact positive youth development. There are seven different types of surveys that range from:* ***Profiles of student life: attitudes and behaviors*** *(looking at the 40 developmental assets,* ***Me and my world*** *(middle childhood), to* ***Adult-Youth Engagement*** *(assessing intergenerational relationships).*

INDICES AND SCALES				
Person	**Community**	**Measure** *(Answers to questions/notes on the measure)*	**Source**	**Methodology**
X		**Social Network Subscale**: Number of parents and grandparents who live within 1 hour's travel	*Duke Social Support Index*	*Measures four major dimensions: social network, social interaction, subjective support and instrumental support*
X		Number of brothers and sisters who live within 1 hour's travel		
X		Number of children who live within 1 hour's travel		
X		Amount of time spent talking with other people at work or school		
X		Household size		
X		**Social Interaction Subscale:** Number of family members within 1 hour that subject can depend on or feel close to		
X		Number of times past week spent time with someone not living with		
X		Number of times past week talked with friends/relatives on telephone		
X		Number of times past week attended meetings of clubs, religious groups, or other groups that you belong to (other than at work)		
X		**Subjective Support Subscale:** How often do you feel lonely?		
X		Do friends and family understand you?		
X		Do you feel useful to family and friends?		
X		Do you know what's happening with family and friends?		
X		Do you feel listened to by family and friends?		
X		Do you feel you have a definite role in family and among friends?		
X		Can you count on family and friends in times of trouble?		

INDICES AND SCALES				
X		Can you talk about your deepest problem?		
X		How satisfied are you with relationships with family and friends?		
X		Do you need additional help?		
X		**Instrumental Support Subscale:** Does family or friends ever help in any of the following ways: Help you out when you are sick?		
X		Shop or run errands for you?		
X		Give you gifts (presents)?		
X		Help you out with money?		
X		Fix things around your house?		
X		Keep house for you or do household chores?		
X		Give you advice on business or financial matters?		
X		Provide companionship to you?		
X		Listen to your problems?		
X		Give you advice on dealing with life's problems?		
X		Provide transportation for you?		
X		Prepare or provide meals for you?		
X		Help take care of small children?		
X		**Other items:** Are you satisfied with how often you see your friends and relatives?		
X		Is there at least one person with whom you have a close, lasting relationship?		
X		Are you presently married or currently living with someone as though married?		

INDICES AND SCALES				
X		Is there someone available to you whom you can count on to listen to you when you need to talk? • None of the time • A little of the time • Some of the time • Most of the time • All of the time	*ENRICHD Social Support Instrument*	*7-item self-report measure with more emphasis on general feelings about being loved and valued rather than instrumental types of support*
X		Is there someone available to you to give you good advice about a problem?		
X		Is there someone available to you who shows you love and affection?		
X		Is there someone available to help with daily chores?		
X		Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?		
X		Do you have as much contact as you would like with someone you feel close to, someone in whom you can trust and confide in?		
X		Are you currently married or living with a partner?		
X		30 Month examples: Does your child look at you when you talk to him? • Most of the time • Sometimes • Rarely or never • Check if this is a concern	*Follow Along Program: ASQ (Ages and Stages Questionnaire) and ASQ/SE (Social Emotional)* .	*Child screening and monitoring system. The questionnaires are designed to identify infants and young children who show potential developmental problems.*

INDICES AND SCALES				
X		Does your child like to be hugged or cuddled? • Most of the time • Sometimes • Rarely or never • Check if this is a concern	*The Follow-Along questionnaires are used widely by Local Public Health Departments and most Minnesota Counties that participate in the Follow Along Program.*	*Social emotional screening is a component of developmental screening of young children that focuses on the early identification of possible delays in the expected development of a child's ability to express and regulate emotions; form close and secure relationships, and explore his/her environment and learn.* *ASQ/SE questionnaires are sent out to parents at 6, 12, 18, 24, 30, 48 and 60 months of age for completion. The results are screened by professionals.*
X		Does your child cling to you more than you expect? • Most of the time • Sometimes • Rarely or never • Check if this is a concern		
X		Does your child like to hear stories and sing songs? • Most of the time • Sometimes • Rarely or never • Check if this is a concern		

INDICES AND SCALES				
X		Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____. (You may write in something else.) • Most of the time • Sometimes • Rarely or Never Check if this is a concern		
X		Topics addressed include: entering motherhood, connecting with the baby, attachment, relaxation and well being, self-esteem and sense of personal control, making space for baby and understanding fetal development.	*NCAST Assessment Tools and Interventions Promoting Maternal and Infant Mental Health – PCI Scales, Network Survey, and Community Life Skills Scale (see below)* (Materials are copyrighted but may be purchased through www.ncast.org.)	*During pregnancy; a set of assessment tools and interventions that inform home visitors and others working with pregnant women on how the emotional and psychological needs and changes to women during pregnancy affects the development of the mother-child relationship.*

INDICES AND SCALES				
X		Some of the topics addressed include: caregiver sensitivity to child cues; caregiver response to child's distress, fostering child social-emotional and cognitive growth, clarity of child cues and child response to caregiver.	*NCAST: PCI Scales* (Materials are copyrighted but may be purchased through www.ncast.org.)	*Parent Child Interaction (PCI) Feeding and Teaching Scales are tools to assess the quality of the parent-child relationship and communication behaviors of both the parent and the infant/child.*
X		This clinical tool is a method of assessing who the important sources of support (personal and professional) are for the individual and the family and how satisfactory the help has been. It can also be used as a teaching tool, helping individuals become aware of the importance of social support and ways to access helpful personal and community resources.	*NCAST: Network Survey* (Materials are copyrighted but may be purchased through www.ncast.org.)	*The Network Survey assesses a parent's source of social support, both personal and professional, within a network framework.*
X		The six major content areas for this 33 item binary scale include: Transportation, Budgeting, Support Services, Support-Involvement, Interests/Hobbies and Regularity-Organization Routine in daily life and in health care.	*NCAST: Community Life Skills Scale* (Materials are copyrighted but may be purchased through www.ncast.org.)	*Community Life Skills Scale measures aspects of a parent's ability to negotiate herself and her family within a community and what the parent's role is within a community to advocate for their child.*

INDICES AND SCALES				
Individual or Family		The *Ecomap* measures a person/family's involvement and support (strength) in a number of spheres: Neighborhood, Community Services, Social Groups, Education, Significant Personal Relationships and Employment. The questions are open ended. Below are several examples of questions used to guide the sphere or domain being addressed: **Neighborhood :** **1.** How well do you know your neighbors? **2.** What neighborhood activities do you attend? **3.** Do your children play with other neighborhood children? **4.** How long have you lived there? **5.** What do you get from your neighborhood? **Social Groups** **1.** With which social groups are you involved? Examples include Church, Civic, YMCA, Bowling League, etc. **2.** How long have you been involved? What frequency? **3.** With whom do you have a relationship? Who gives you support? **4.** What services work best for you? **5.** How do you feel about your involvement?	*Ecomap*	*An Ecomap is a pictorial representation of a family's connections to persons and/or systems in their environment. These ecological maps, or ecomaps, were developed by Hartman in 1975 as a means of depicting the ecological system that encompasses a family or individual (Hartman, 1995). They are primarily used in counseling or therapy sessions.* *The Ecomap as used in the state of Ohio, can illustrate 3 separate dimensions for each connection: 1. The **STRENGTH** of the connection (Weak; tenuous/uncertain; strong) 2. The **IMPACT** of the connection (none; draining resources or energy; providing resources or energy) 3. The **QUALITY** of the connection (stressful; not stressful)*

Appendix D

References*

Abel, T. (2007). Cultural capital and social inequality in health. *Journal of Epidemiology and Community Health, 62*(13), 1-5.

Achebe, Chinua (1958). *Things Fall Apart*. William Heinemann, Ltd.

Adelman, H.S. & Taylor, L. (2006). Mental health in schools and public health. *Public Health Reports, 121*, 294-298.

Allina Hospitals and Clinics and Powderhorn/Phillips Cultural Wellness Center (2010). *Backyard Initiative: 2009 Listening Circles Report*. With assistance from the Amherst H. Wilder Foundation.

Almeida, J., Molnar, B.E., Kawachi, I. & Subramanian, S.V. (2009). Ethnicity and nativity status as determinants of perceived social support: testing the concept of familism. *Social Science & Medicine, 68*(10), 1852-1858.

Antonucci, T.C. (1990). Social support and social relationships. In R.H. Binstock & L.K. George (Eds.), *Handbook of aging and the social sciences* (3rd ed., pp. 205-266). San Diego, CA: Academic Press.

Arnett, Jeffrey (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, Vol. 55(5), May 2000, 469-480.

Aseltine, R.H. Jr., Gore, S. & M.E. Colten. (1994). Depression and the social developmental context of adolescence. J*ournal of Personality and Social Psychology, 34*, 237-251.

Ashida, S. & Heaney, C.A. (2008). Differential associations of social support and social connectedness with structural features of social networks and the health status of older adults. *Journal of Aging and Health, 20*(7), 872-893.

Atri,A., Sharma, M. & Cottrell, R. (2006-2007). Roles of social support, hardiness, and acculturation as predictors of mental health among international students of Asian Indian origin. *International Quarterly of Community Health, 27*(1), 59-73.

Barnes, D.M. & Aguilar, R. (2007). Community social support for Cuban refugees in Texas. *Qualitative Health Research, 17*(2), 225-237.

Barnes, K. (2003). Community Pride. Harlem Children's zone: A Look Inside, 2(1). Retrieved from: http://www.hcz.org/images/stories/pdfs/ali_spring2003.pdf

* Includes references from the Mind Map.

Berkman, L.F. (1984). Assessing the physical health effects of social networks and social support. *Annual Review of Public Health, 5*, 413-432.

Berkman, L.F. & Syme, L. (1979). Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents. *American Journal of Epidemiology, 109*(2), 186-204.

Berkman, L.F. (2000). Social support, social networks, social cohesion and health. *Social Work in Health Care*, 31:2, 3-14. DOI: 10.1300/J010v31n02_02. Retrieved from: http://dx.doi.org/10.1300/J010v31n02_02.

Borsari, B. & Carey, K.B. (2006). How the quality of peer relationships influences college alcohol use. *Drug and Alcohol Review, 25*(4), 361-370.

Brooks, D. (2010). The limits of policy. *The New York Times*, May 4, 2010.

Bures, R. (2003). Childhood residential stability and health at midlife. *American Journal of Public Health, 93*(7), 1133-1148.

California State Parks (2005). The health and social benefits of recreation: An element of the California outdoor recreation planning program. Sacramento, CA.

Centers for Disease Control and Prevention. (2003). *Data set directory of social determinants of health at the local level.* Retrieved from: http://www.cdc.gov/dhdsp/library/data_set_directory/index.htm

Center for Social and Emotional Education (2010). What is school climate and why is it important? Retrieved from: http://schoolclimate.org/climate.

Choenarom, C., Williams, R.A. & Hagerty, B.M. (2005). The role of sense of belonging and social support on stress and depression in individuals with depression. *Archives of Psychiatric Nursing, 19*(1), 18-29.

Christakis, N.A. & Fowler, J.H. (2008). The collective dynamics of smoking in a large social network. *The New England Journal of Medicine, 358*(21), 2249-2258.

Christakis, N.A. & Fowler, J.H. (2007). The spread of obesity in a large social network over 32 years. *The New England Journal of Medicine, 357*(4), 370-379.

Christakis, N.A. & Fowler, J.H. (2009). Connected: The surprising power of our social networks and how they shape our lives. New York: Little, Brown and Company.

Coleman, J. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 74*, S95-S120.

The Commission on Children at Risk (2003). Hardwired to connect: The new scientific case for authoritative communities. New York: YMCA of the USA, Dartmouth Medical School, Institute for American Values. Retrieved from: http://www.americanvalues.org/html/hardwired.html.

County Health Rankings. (2010). *Family and social support.* Retrieved from: http://www.countyhealthrankings.org/health-factors/family-and-social-support

Crane, R. and Manville, M. (2008). People or place? Revisiting the who versus the where of urban development. *Land Lines*, a publication of the Lincoln Institute of Land Policy, July 2008.

Crosby, R.A. & Holtgrave, D.R. (2006). The protective value of social capital against teen pregnancy: a state-level analysis. *Journal of Adolescent Health, 38,* 556-559.

(2010). Upper bound: social mobility and inequality. *The Economist*. April 15, 2010. Retrieved from: http://www.economist.com/node/15908469?story_id=15908469&CFID=143331125&CFTOKEN=81877200

Egolf, B., Lasker, J., Wolf, S. & Potvin, L. (1992). The Roseto effect: a 50-year comparison of mortality rates. *American Journal of Public Health, 82*(8), 1089-1092.

Fairbanks, E. (1990). *The Days of Rondo*. St. Paul, MN: Minnesota Historical Society Press.

Finch, B.K. & Vega, W.A. (2003). Acculturation stress, social support, and self-rated health among Latinos in California. *Journal of Immigrant Health, 5*(3), 109-117.

Fowler, J.H. & Christakis, N.A. (2008). Dynamic spread of happiness in a large social network: longitudinal analysis over 20 years in the Framingham heart study. *British Medical Journal, 337,* a2338.

Franks, P., Campbell, T.L. & Shields, C.G. (1992). Social relationships and health: the relative roles of family functioning and social support. *Social Science & Medicine, 34*(7), 779-788.

Fujiwara, T. & Kawachi, I. (2008). Social capital and health: a study of adult twins in the U.S. *American Journal of Preventive Medicine, 35*(2), 139-144.

Furstenberg Jr., F.F. & Hughes, M.E. (1995). Social capital and successful development among at-risk youth. *Journal of Marriage and the Family, 57,* 580-592.

Ganster, D.C., Fusilier, M.R., & Mayes, B.T. (1986). Role of social support in the experience of stress at work. *Journal of Applied Psychology, 71*(1), 102-110.

Gilman, S.E., Kawachi, I., Fitzmaurice, G.M. & Buka, L. (2003). Socio-economic status, family disruption and residential stability in childhood: relation to onset, recurrence and remission of major depression. *Psychological Medicine, 33*(8), 1341-1355.

Gold, R., Kennedy, B., Connell, F., & Kawachi, I. (2002). Teen births, income inequality, and social capital: developing an understanding of the causal pathway. *Health & Place, 8*, 77-83.

Gore, S. & R.H. Jr. Aseltine. (1995). Protective processes in adolescence: matching stressors with social resources. *American Journal of Community Psychology, 23*, 301-327.

Hale, C.J., Hannum, J.W. & Espelage, D.L. (2005). Social support and physical health: the importance of belonging. *Journal of American College Health, 53*(6), 276-284.

Hendryx, M.S., Ahern, M.M., Lovrich, N.P., & McCurdy, A.H. (2002). Access to health care and community social capital. *Health Services Research, 37*(1), 85-101.

Hesseltine, S. (2009). *The power of relationships between infants & parents: Supporting healthy social and emotional development* [PowerPoint slides]. Retrieved from file.

High, P., et al. (1999). Child centered literacy orientation: a form of social capital? *Pediatrics, 104*(4), 1-7.

Hirsch, B.J. & D.L. Dubois. (1992). The relation of peer social support and psychological symptomatology during the transition to junior high school: a two-year longitudinal analysis. *American Journal of Community Psychology, 20*, 333-347.

Hortwitz, S.M., Morgenstern, H., & Berkman, L.F. (1985). The impact of social stressors and social networks on pediatric medical care use. *Medical Care, 23*(8), 946-959.

House, J.S. (1981). *Work stress and social support.* Reading, MA: Addison-Wesley.

House, J.S. (1987). Social support and social structure. *Sociological Forum, 2*(1), 135-146.

House, J.S., Landis, K. R, & Umberson, D. (1988). Social Relationships and Health. *Science,* Vol. 241, 540-545.

House, J.S., Robbins, C. & Metzner, H.L. (1982). The association of social relationships and activities with mortality: prospective evidence from the Tecumseh Community Health Study. *American Journal of Epidemiology, 116*(1), 123-140.

Institute on Race & Poverty (2009). Access to opportunity in the Twin Cities metropolitan area. Retrieved from: http://www.irpumn.org/website/projects/index.php?strWebAction=project_detail&intProjectID=64

Institute on Race and Poverty (2009). A comprehensive strategy to integrate Twin Cities schools and neighborhoods. Retrieved from: http://www.irpumn.org/uls/resources/projects/3_Regional_Integration_-_Schools_and_Housing.pdf

ISAIAH and the Kirwan Institute for the Study of Race and Ethnicity (2010). *Shining the Light: Revealing Our Choice.* Report on structural racism/inequities prepared for the spring, 2010 community meeting in the Twin Cities Metropolitan area. Handout.

ISAIAH, Take Action Minnesota, and PolicyLink (2010). Healthy Corridor for All: Evaluating Health Impacts of New Land Use Development Along the Central Corridor. July 2010. Available at: http://gamaliel.org/ISAIAH/Issues/HealthyCorridorforAll.htm

Janisse H.C., Nedd, D., Escamilla, S. & Nies, M.A. (2004). Physical activity, social support, and family structure as determinants of mood among European-American and African-American women. *Women & Health, 39*(1), 101-116.

Jones, Camara Phyllis, (2000). Levels of racism: A theoretic framework and a gardener's tale. American Journal of Public Health, 90:1212–1215. Retrieved from: http://ajph.aphapublications.org/cgi/reprint/90/8/1212.pdf

Kaplan, G.A., Pamuk, E., Lynch, J.W., Cohen, R.D. & Balfour, J.L. (1996). Income inequality and mortality in the United States. *British Medical Journal, 312*, 1004-1007.

Kawachi, I. (1999). Social capital and community effects on population and individual health. *Annals of the New York Academy of Sciences, 896*, 120-130.

Kawachi, I. (2006). Commentary: social capital and health; making the connections one step at a time. *International Journal of Epidemiology, 35*, 989-993.

Kawachi, I. & Berkman, L.F. (2001). Social ties and mental health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 78*(3), 458-467.

Kawachi, I., Kennedy, B.P. & Glass, R. (1999). Social capital and self-rated health: a contextual analysis. *American Journal of Public Health, 89*(8), 1187-1193.

Kawachi, I., Kennedy, B.P., Lochner, K., & Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health,87*(9), 1491-1498.

Kawachi, I., Kennedy, B.P., & Wilkinson, R.G. (1999). Crime: social disorganization and relative deprivation. *Social Science & Medicine, 48*, 719-731.

Kawachi, I., Kim, D., Coutts, A., & Subramanian S.V. (2004). Commentary: reconciling the three accounts of social capital. *Journal of Epidemiology, 33*, 682-690.

Kelman, H.R., Thomas, C. & Tanaka, J.S. (1994). Longitudinal patterns of formal and informal social support in an urban elderly population. *Social Science & Medicine, 38*(7), 905-914.

Kessler, R.C. & McLead, J.D. (1985). Social support and mental health in community samples. In S. Cohen & S.L. Syme (Eds.), *Social support and health* (pp. 219-240). New York, NY: Academic Press.

Klinenberg, E. (2002). *Heat wave: A social autopsy of disaster in Chicago.* Chicago, IL: The University of Chicago Press.

Kobrin, F.E. & Hendershot, G.E. (1977). Do family ties reduce mortality? Evidence from the United States, 1966-1968. *Journal of Marriage and the Family, 39*(4), 737-756.

Koenig, H.G. (1993). Abbreviating the Duke Social Support Index for use in chronically ill elderly individuals. *Psychosomatics, 34(1),* 61-69.

Laureau, A. (2003). *Unequal childhoods: Class, race, and family life.* Berkeley and Los Angeles, CA: University of California Press.

Lee, R.M, Dean, B.L., & Jung, K. (2008). Social connectedness, extraversion and subjective well-being: testing a mediation model. *Personality and Individual Differences, 45*, 414-419.

Lee, R.M., Draper, M., & Lee, S. (2001). Social connectedness, dysfunctional interpersonal behaviors, and psychological distress: testing a mediator model. *Journal of Counseling Psychology, 48*(3), 310-318.

Lee, R.M. & Robbins, S.B. (1995). Measuring belongingness: the social connectedness and the social assurance scales. *Journal of Counseling Psychology, 42*(2), 232-241.

Lee, R.M. & Robbins, S.B. (1998). The relationship between social connectedness and anxiety, self-esteem, and social identity. *Journal of Counseling Psychology, 45*(3), 338-345.

Lee, R.M. & Robbins, S.B. (2000). Understanding social connectedness in college women and men. *Journal of Counseling & Development, 78*(4), 484-491.

Lee, Y. (2009). Early motherhood and harsh parenting: the role of human, social, and cultural capital. *Child Abuse & Neglect, 33*, 625-637.

Lewis, K. and Burd-Sharps, S. (2009). A century apart: new measures of well-being for U.S. racial and ethnic groups. American Human Development Project of the Social Science Research Council. Retreived from: www.measureofamerica.org.

Lillard, L.A. & Waite, L.J. (1995). 'Til death do us part: marital disruption and mortality. *American Journal of Sociology, 100*, 1131-1156.

Lochner, K.A., Kawachi, I., Brennan, R.T. & Buka, S.L. (2003). Social capital and neighborhood mortality rates in Chicago. *Social Science & Medicine, 56*(8), 1797-1805.

Lochner, K., Kawachi, I. & Kennedy, B.P. (1999). Social capital: a guide to its measurement. *Health & Place, 5*, 259-270.

Lomas, J. (1998). Social capital and health: implications for public health and epidemiology. *Social Science & Medicine, 47*(9), 1181-1188.

Loscocco, K.A. & Spitze, G. (1990). Working conditions, social support, and the well-being of female and male factory workers. *Journal of Health and Social Behavior, 31*(4), 313-327.

Lukehart, J., Luce, T. & Reece, J. (2005). The segregation of opportunities: the structure of advantage and disadvantage in the Chicago region. Retrieved from: http://www.irpumn.org/uls/resources/projects/Full%20Report%20-%20May%202005.pdf

Marmot, M., and Wilkinson, R.G., eds. (2006). *Social determinants of health*. Second edition. Oxford University Press.

Marmot, M. (2007). Achieving health equity: from root causes to fair outcomes. On behalf of the Commission on Social Determinants of Health. www.thelancet.com. Published online September 6, 2007. DOI: 10.1016/S0140-6736(07)61385-3.

Mansyur, C., Amick, B.C., Harrist, R.B. & Franzini, L. (2008). Social capital, income inequality, and self-rated health in 45 countries. *Social Science & Medicine, 66*(1), 43-56.

Martikainen, P. & Valkonen, T. (1996). Mortality after the death of a spouse: rates and causes in death in a large Finnish cohort. *American Journal of Public Health, 86*, 1087-1093.

McMurry, M. (2010). The changing lives of Minnesota young adults. Retrieved from: http://www.demography.state.mn.us/documents/ChangingLivesofMinnesotaYoungAdult.pdf.

McNeely, C. & Falci, C. (2004). School connectedness and the transition into and out of health-risk behavior among adolescents: a comparison of social belonging and teacher support. *The Journal of School Health, 74*(7), 284-292.

Meadows-Oliver, M. (2005). Social support among homeless and housed mothers: an integrative review. *Journal of Psychosocial Nursing and Mental Health Services, 43*(2), 40-47.

Mendes de Leon, C.F., Glass, T.A. & Berkman, L.F. (2003). Social engagement and disability in a community population of older adults: The New Haven EPSE. *American Journal of Epidemiology, 157*(7), 633-642.

Minnesota Board on Aging (2010). Building communities for a lifetime in Minnesota: A report to the 2010 Minnesota Legislature. February 28, 2010.

Minnesota Health Improvement Partnership (2001). A call to action: Advancing health for all through social and economic change. Report prepared by the Social Conditions and Health Action Team, July 2001. Retrieved from: http://www.health.state.mn.us/divs/cfh/ophp/resources/docs/calltoaction.pdf

National Institutes of Health. (2004). *Demographic and social factors: social connectedness* (Cognitive and Emotional Health Project: The Healthy Brain). Retrieved from: http://trans.nih.gov/cehp/HBPsocialconnectmeasures.htm

National Public Radio (2010). Report: Foster kids face tough times after age 18. Transcript retrieved from: http://www.npr.org/templates/transcript/transcript.php?storyId=125594259.

New Zealand Ministry of Social Development (2007). Loneliness. *New Zealand Social Report 2009*. Retrieved from: http://socialreport.msd.govt.nz/social-connectedness/loneliness.html

New Zealand Ministry of Social Development. (2003). *The social report 2003: social connectedness.* Retrieved from: http://www.socialreport.msd.govt.nz/2003/social-connectedness/social-connectedness.shtml

Oakes, J.M. & Rossi, P.H. (2003). The measurement of SES in health research: current practice and steps toward a new approach. *Social Sciences & Medicine, 56*(4), 769-784.

Padilla-Walker, L.M., Nelson, L.J., Carroll, J.S. & Jensen, A.C. (2010). More than just a game: video game and internet use during emerging adulthood. *Journal of Youth and Adolescence, 39*(2), 103-113.

Patock-Peckham, J.A. & Morgan-Lopez, A.A. (2008). Mediational links among parenting styles, perceptions of parental confidence, self-esteem, and depression on alcohol-related problems in emerging adulthood. *Journal of Studies on Alcohol and Drugs, 70*(2), 215-256.

Patterson, Joan M. A Public Health Approach to Early Childhood Mental Health. *Healthy Generations*, Winter 2009-2010.

Pillemer, K., Moen, E. & Wethington & N. Glasgow. (2000). *Social integration in the second half of life*. Baltimore, MD: John Hopkins University Press.

Pillemer, K. & Glasgow, N. (2000). Social integration and aging: background and trends. In K. Pillemer, P. Moen, E. Wethington & N. Glasgow (Eds.), *Social integration in the second half of life* (pp. 19-47). Baltimore, MD: John Hopkins University Press.

Portes, A. (1998). Social capital: its origins and applications in modern sociology. *Annual Review of Sociology, 24*, 1-24.

Putnam, R.D. (2000). *Bowling alone: The collapse and revival of American community*. New York: Simon & Schuster Paperbacks.

Putnam, Robert (2007). *E Pluribus Unum:* Diversity and Community in the Twenty-first Century – The 2006 Johan Skytte Prize. *Scandinavian Political Studies* 30 (2), 137-174.

Repetti, R.L. (1993). The effects of workload and the social environment at work on health. In L. Goldenberger & S. Bresnitz (Eds.), *Handbook of stress* (pp. 368-385). New York, NY: Free Press.

Robison, J., 2010. Disengagement can be really depressing. Gallup, Inc., 2010. Retrieved from: http://gmj.gallup.com/content/127100/disengagement-really-depressing.aspx?utm_sour

Rogers, R.G. (1996). The effects of family composition, health, and social support linkages on mortality. *Journal of Health and Social Behavior, 37*(4), 326-338.

Rosenheck, R., et al. (2001). Service delivery and community: social capital, service systems integration, and outcomes among homeless persons with severe mental illness. *Health Services Research, 36*(4), 691-710.

Ross, C. E., & Jang, S. J. (2000). Neighborhood disorder, fear, and mistrust: The buffering role of social ties with neighbors. American *Journal of Community Psychology, 28*, 401–420.

Ross, C.E., Mirowsky, J & Piresh, S. (2001). Powerlessness and the amplification threat: Neighborhood disadvantage, disorder and mistrust. *American Sociological Review. 66,* 568-591.

Russell, D. (2009). Living arrangements, social integration, and loneliness in later life: the case of physical disability. *Journal of Health and Social Behavior, 50*(4), 460-475.

Rydholm, Laura, MSN; Moone, Rajean, PhD; Thornquist, Lisa, PhD; Alexander, Wanda, MPH,BSN; Gustafson, Vicki, MSN; Speece, Bethany, BSN (2008). **Care of Community-Dwelling Older Adults by Faith Community Nurses**. *Journal of Gerontological Nursing,* Vol. 34, No. 4.

Salzinger, S., Feldman, R.S., & Hammer, M. (1993). The effects of physical abuse on children's social relationships. *Child Development, 64*, 169-187.

Salzinger, S., Kaplan, S., & Artemyeff, C. (1983). Mothers' personal social networks and child maltreatment. *Journal of Abnormal Psychology, 92*(1), 68-76.

Sampson , R.J., Raudenbush, S.W. & Earls, F. (1997). Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science, 277*, 918-924.

Sampson, R.J. & C. Graif. (2009). Neighborhood social capital as differential social organization: Resident and leadership dimensions. *American Behavioral Scientist, 52*(11), 1579-1605.

Sandler, I.N., Miller, P., Short, J. & S.A. Wolchik. (1989). Social support as a protective factor for children in stress. In D. Belle (Ed.), *Children's social networks and social support* (pp. 277-304). New York, NY: Wiley.

Schafer, W. (1991). Planning as an attachment experience. *The Infant Crier*. East Lansing: Michigan Association for Infant Mental Health.

Schweitzer, R., Melville, F., Steel, Z. & Lacharez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *The Australian and New Zealand Journal of Psychiatry, 40*(2), 179-187.

Search Institute (2003). Unique strengths, shared strengths: Developmental assets among youth of color. *Insights & Evidence: Promoting Healthy Children, Youth and Communities*. Vol. 1, No. 2, November 2003.

Search Institute (2005). 40 Developmental assets for early childhood (ages 3 to 5); children grades K-3 (ages 5-9); middle childhood (ages 8-12); adolescents (ages 12-18). Retrieved from: http://www.search-institute.org/developmental-assets/lists

Seeman, T.E., Lusignolo, T.M., Albert, M., & Berkman, L. (2001). Social relationships, social support, and patterns of cognitive aging in healthy, high-functioning older adults: MacArthur studies of successful aging. *Health Psychology, 20*(4), 243-255.

Shinn, M., Gottlieb, J., Wett, J.L., Bahl, A., Cohen, A. & Baron Ellis, D. (2007). Predictors of homelessness among older adults in New York city: disability, economic, human and social capital and stressful events. *Journal of Health Psychology, 12*(5), 696-708.

Shisana, O. & Celentano, D.D. (1987). Relationship of chronic stress, social support, and coping style to health among Namibian refugees. *Social Science & Medicine, 24*(2), 145-157.

Simich, L., Beiser, M., Stewart, M. & Mwakarimba, E. (2005). Providing social support for immigrants and refugees in Canada: challenges and directions. *Journal of Immigrant Health, 7*(4), 259-268.

Smith, Christian, with Patricia Snell (2009). *Souls in transition: the religious and spiritual lives of emerging adults*. Oxford University Press.

Sroufe, L.A. (2000). Early relationships and the development of children. *Infant Mental Health Journal, 21*(1-2), 67-74.

Stancliffe, R.J., Lakin, K.C., Doljanac, R., Byun, S.Y., Taub, S. & Chiri, G. (2007). Loneliness and living arrangements. *Intellectual and Developmental Disabilities, 45*(6), 380-390.

Stansfeld, S.A. (2006). Social support and social cohesion. In M. Marmot & R.G. Wilkison (Eds.), *Social determinants of health* (pp. 148-171). New York, NY: Oxford University Press.

Stoller, E.P. & Pugliesi, K.L. (1991). Size and effectiveness of informal helping networks: a panel study of older people in the community. *Journal of Health & Social Behavior, 32*(2), 180-191.

Szreter, S. & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology, 33*, 650-667.

Taylor, S.E. & Repetti, R.L. (1997). Health psychology: what is an unhealthy environment and how does it get under the skin? *Annual Review of Psychology, 48*, 411-447.

Tough, P. (2008). *Whatever it takes: Geoffrey Canada's quest to change Harlem and America.* New York, NY: First Mariner Books.

Unger, J.B., McAvay, G., Bruce, M.L., Berkman, L., & Seeman, T. (1999). Variation in the impact of social network characteristics on physical functioning in elderly persons: MacArther studies of successful aging. *Journal of Gerontology, 54B*(5), S245-S251.

Vaglio, J. et al. (2004). Testing the performance of the ENRICHD Social Support Instrument in cardiac patients. *Health and Quality of life Outcomes, 13(2),* 24.

Van Kemanade, S. (2002). *Social capital as a health determinant: how is it defined?* Canada: Health Canada Policy Research.

Western Park Neighborhood History (undated file). Part of the *Western Park Neighborhood Assessment*. This historical summary is drawn from research papers written by Macalester College Urban Studies students Emily Davidson, Marisol Gomez, Johanna

Jones, and Emily Skidmore. Retrieved from: http://www.publicartstpaul.org/downloads/westernhistory-1.pdf.

White, Helene Raskin, and Jackson, Kristina (2004).Social and psychological influences on emerging adult drinking behavior. Alcohol Research and Health,Vol. 28, No. 4, 2004/2005, Retrieved from: http://pubs.niaaa.nih.gov/publications/arh284/182-190.pdf

Whitehead, Margaret (2007). A typology of actions to tackle social inequalities in health. *Journal of Epidemiology and Community Health*, 2007; 61:473-48. Retrieved from: http://www.chronicdisease.org/files/public/HDIG_healthdisparities_actions.pdf.

Wilcox, J.A. & Taber, M.A. (1991). Informal helpers of elderly home care clients. *Health & Social Work, 16*(4), 258-265.

Williamson, I.., Sandage, S.J. & Lee, R.M. (2007). How social connectedness affects guilty and shame: mediation by hope and differentiation of self. *Personality and Individual Differences, 43*, 2159-2170.

Wilson, W.J. (1987). *The truly disadvantaged: The inner city, the underclass, and public policy.* Chicago, IL: The University of Chicago Press.

Wilson, W.J. (2009). Toward a framework for understanding forces that contribute to or reinforce racial inequality. *Race and Social Problems,* 1: 3-11.

Work Group for Community Health and Development (1994-ongoing). Chapter 26: Changing the Physical and Social Environment. *The Community Tool Box*, University of Kansas. Retrieved from: http://ctb.ku.edu/en/tablecontents/chapter_1026.htm.

World Health Organization (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Commission on Social Determinants of Health.

Yeh, C.J., Okubo, Y., Ma, P.W., Shea, M., Ou, D. & Pituc, S.T. (2008). Chinese immigrant high school students' cultural interactions, acculturation, family obligations, language use, and social support. *Adolescence, 43*(172), 775-790.

Yoon, E., Lee, R.M., & Goh, M. (2008). Acculturation, social connectedness, and subjective well-being. *Cultural Diversity and Ethnic Minority Psychology, 14*(3), 246-255.

Zolotor, A.J. & Runyan, D.K. (2006). Social capital, family violence, and neglect. *Pediatrics, 117*(6), e1124-e1131.