

What is a healthy community?

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Working Paper No. 7 | February 2017

healthequitychicago.org

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Carrillo, A., Nava, M., Rothschild, S., & Saw, A. (2017). What is a healthy community? *Working Paper No. 7*. Center for Community Health Equity. Chicago, IL.

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Foreword

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Center for Community Health Equity

Over the last few years, the Center for Community Health Equity was actively involved in the development of a community health needs assessment and a community health implementation plan for neighborhoods in Chicago and suburban Cook County, especially on the West Side. In many conversations and presentations with multiple stakeholders from the community, public health, and academia, we spent significant time discussing how best to describe the current state of health for communities along with potential metrics for measuring improvement. We spent hours on the details of what to include and not include. Then, one day during a presentation with senior health system leaders, the CEO of Rush University Medical Center asked, “How do we know a community is healthy?” And, there was silence. Another senior executive answered, “We know a healthy community when we see one.” Walking out of that room feeling that we did not have a clear answer to such a simple but key question led to a deeper exploration. Surprisingly, concise and explicit definitions were hard to find. One of the clearest definitions was located on the United States Centers for Disease Control and Prevention Healthy Places webpage (<http://www.cdc.gov/healthyplaces/about.htm>): “A healthy community as described by the U.S. Department of Health and Human Services *Healthy People 2010* report is one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential.” In 2003, the National Network of Public Health Institutes through a cooperative agreement with the U.S. Centers for Disease Control and Prevention funded Health Resources in Action to systematically research the variety of healthy community definitions being used by a breadth of organizations engaging in healthy community efforts. The research revealed that key characteristics and processes for healthy communities could be located; however, very few formal definitions, healthy community principles, or indicators by which to measure community health were provided (see <https://hria.org/resources/defining-healthy-communities/>). In the report, the suggested working definition for healthy community was:

“A healthy community is one in which a diverse group of stakeholders collaborate to use their expertise and local knowledge to create a community that is socially and physically conducive to health. Community members are empowered and civically engaged, assuring that all local policies consider health. The community has the capacity to identify, address, and evaluate their own health concerns on an ongoing basis, using data to guide and benchmark efforts.

As a result, a healthy community is safe, economically secure, and environmentally sound, as all residents have equal access to high quality educational and employment opportunities, transportation and housing options, prevention and healthcare services, and healthy food and physical activity opportunities.”

While somewhat satisfactory to see a working definition provided, a key conclusion of the report was that “each community defines its own notion of a healthy community.” It seems like the search for a universal definition may not be available in the near term.

In this working paper, individuals with different life experiences were requested to share their reflections on what is a healthy community. Their efforts to tackle such a complex question are appreciated. Hopefully, their insights will encourage readers to provide feedback on their working definitions for a healthy community.

What is a healthy community?

Arturo Carrillo, LCSW, PhD ABD

Saint Anthony Hospital

This five-word question is the biggest question we can ask anyone committed to the development of strong communities. It is a question I have wrestled with for the last 11 years, since I began my work in the community of Little Village as a social work intern, and my response to this question has evolved throughout the decade. Today, I can only address this question by reflecting on the knowledge gained and lessons learned by listening to countless community residents, my personal evolution and growth throughout those years, and the many interactions and partnerships I have had with colleagues who have also struggled with this question. In these 11 years, I have been afforded the luxury of developing programs and establishing community partnerships to support in addressing health-related social needs of the community through my position as a clinical social worker at Saint Anthony Hospital's Community Wellness Program. The Community Wellness Program, a fully-funded department of Saint Anthony Hospital, has served throughout its 23-year history in Chicago's southwest side as a community center in the neighborhood of Little Village; offering social services that have evolved throughout the years in response to the various needs of community residents. Building on this success, the Community Wellness Program opened a second community center in 2012, in the neighborhood of North Lawndale. The Community Wellness Program has primarily focused on four issue areas: public benefits enrollment and healthcare navigation, parenting supports with an emphasis on early childhood development, health education and screening through our community nursing program, and mental health services.

It is through the mental health services that I walked in on a lively and dynamic conversation around the question of 'what makes a healthy community?' Given the decades-long commitment by Saint Anthony Hospital to the financial stability and growth of the Community Wellness Program, the staff was allowed to focus on answering this challenging yet extremely important question.

I was introduced to the community of Little Village in 2005 as an intern of the mental health services. The services were designed to offer free high-quality, long-term counseling services (the kind afforded to those with the financial means to pay for a therapist in Chicago's Gold Coast) to the low-income, uninsured, Latino immigrant adult population. During this time I was taught an all-important first lesson: that healthy communities begin with healthy individuals, and that health is not limited to only physical

health, but is instead intimately tied to mental health. Although the mental health services supported high-functioning adults (those without severe and persistent mental illness and/or substance abuse) the amount of trauma reported in the lives of the participants was stunning.

However, an even more important discovery was the high demand for services. This was contrary to the professional narrative I was told at the time, that stigma was the biggest barrier keeping Latinos from counseling services. The services had a constant months-long waiting list. What I did not know at the time was that the high demand was as a result of the intentional design to offer services in Spanish that were aligned with the cultural and spiritual elements central to the lives of the participants. Additionally, the services were designed to allow the community residents the necessary time and attention to heal from the traumas that took a constant emotional toll on their lives. These elements created a welcoming and supportive space that allowed for personal transformation in the lives of participants. Our approach led to our mental health services to become a well-known resource for community residents, leading to a steady stream of referrals sourced by word of mouth and community organizations. Throughout the years, the services have remained faithful to this design and the waiting list has never ceased to be a constant, even as we increased the number of clinicians.

As a social worker with an interest in community organizing and as a result of working in such a dynamic and vibrant community, I have always held on to the second lesson: a healthy community requires solid partnerships and robust networks among different community organizations and stakeholders. Despite the constant demand for counseling appointments, a portion of my time in the mental health services has always been dedicated to building community partnerships. My early work with Enlace Chicago taught me the value of community development through partnerships that promote social ties and collective efficacy. Working with Kathryn Bocanegra, at the time the director of Violence Prevention at Enlace, we began the hard work of formalizing a mental health coalition in Little Village, named Roots to Wellness. This initiative was born out of the shared understanding that mental health providers needed to sit at the same table and work together on increasing access to mental health services.

As the community organizing side of the work grew, I found myself engaging with new communities around the issue of mental health. This reinforced the third lesson: every community has existing strengths and resources. Understanding this requires us to take the time to respectfully learn about what those resources are and the ongoing work within a community as you enter it. It involves carefully

finding a space in which you can complement the existing work, join those efforts, and commit to the work necessary of collectively building towards more capacity. This has been true for us as we have built our mental health services from the ground up in the community of North Lawndale and as we have entered the community of Brighton Park.

In Brighton Park, this has meant partnering with the Brighton Park Neighborhood Council (BPNC). Every leader and staff within their organization speak with passion and commitment to the needs of the community, not least of which is mental health. Given the long and successful history of the mental health services within the Community Wellness Program, whose clients also resided in Brighton Park, we realized we were both advocating for the same thing: increased capacity to serve the mental health needs of the community. By this time I was several years into the Social Work Ph.D. program at the University of Illinois at Chicago. In this academic setting, research is the primary language of Social Work, which in a practice-oriented field such as Social Work can actually be quite burdensome. Nevertheless, I learned the fourth lesson: community research is crucial to understanding what is needed for building a healthy community, and this research is done best when it includes the full participation of community residents and partners in developing and collecting organic data to make the case for increased resources.

Understanding of the importance of conducting community mental health needs assessments as we had done in Little Village through Roots to Wellness, I supported BPNC in developing their own needs assessment survey to gain a thorough understanding of mental health needs of Brighton Park residents. The questions were developed to be integrated into BPNC's annual community health survey, where health promoters surveyed parents at all the public schools within Brighton Park, collecting over 550 surveys on a yearly basis. These questions were designed to understand not only the mental health needs but also the barriers to accessing services. In 2014, the findings of the mental health assessment were presented to our hospital administration. The data showed that by far, the biggest barrier out of a list of 10 barriers was cost, followed by lack of health insurance. Stigma was, appropriately enough, in last place. These findings were enough to gain the commitment of the hospital to increase the capacity of our mental health services by adding 2 full-time bilingual therapists to begin to meet the needs in Brighton Park, and at the same time to add a mental health staff to the budding Community Wellness Program in North Lawndale. The survey has been repeated in the subsequent two years and the three-year findings were presented at the [2016 Health Disparities and Social Justice Conference](#), the

presentation was titled, “Structural barriers, not stigma, limit access to mental health services for the low-income Latino community.”

In spite of the challenging times we are living in, I am optimistic that as we have done throughout the history of the Community Wellness Program, we will continue to serve as a resource to community residents and community partners alike and play an integral role in the collective efforts necessary to making healthy communities. The work of Roots to Wellness continues to grow, expanding to now include 10 communities of the southwest side of Chicago. Our mental health services in North Lawndale have developed strong partnerships with various community stakeholders and networks, most recently being accepted to be a part of the North Lawndale Community Restorative Justice Hub after a 2-year partnership that served to integrate mental health into Lawndale Christian Legal Center’s Summer Court Advocacy Apprenticeship Mock Trial Program. Our Community Wellness Program will continue to strengthen partnerships by addressing the social needs that contribute to the health of the community while complementing the incredible work of all of our partners, who are constantly looking to do the same with limited resources. After all, the most important lesson is that we can never stop asking ourselves the question; ‘what makes a healthy community?’

Sense of community as a determinant to sustained community-led health initiatives: Prioritizing sense of community as we work to improve community health

Magdalena Nava, MPH

Greater Humboldt Park Community Diabetes Empowerment Center

A few months ago I was interviewed by a young lady; she was in her early 20's and was a student at Northeastern University who was taking a Community Health class as part of her Community Health and Wellness program. One of the questions she asked me was "can you tell me how you think the Public Health field has changed since you first started doing this type of work?" It took me a while to answer this question considering how many different communities I have worked with. However, as I started thinking about where I began my public health career (in the HIV/AIDS community), it dawned on me that back then the cure was the focus rather than the prevention. The Public Health sector focused on finding a cure for AIDS/HIV, cancer, diabetes, cardiovascular disease and other chronic diseases through studies and research; not to say that today this is not the focus, however, we tend to hear more about how can we prevent such diseases rather than getting to the point of curing it. The attitude back then was to prescribe a regimen of drugs and for the patient to not to ask questions because the public health sector knew better.

I believe this has changed drastically. Today, educating a community on how to prevent a chronic disease is key to every community health program; healthier eating habits and physical activity are being prescribed by doctors regardless of the patients' diagnosis. Today the conversation about prevention starts at a grade school level; children are being sent home with MyPlate and Lets Move! information. Not only is this information translated in the language spoken at home but it also is tailored to that particular culture. Also, the conversation does not start with "this is what you need to do" but rather with "tell me what you need". For the most part I have noticed that the public health sector no longer says "we are here to save you!" but rather asks "tell me how we can save you?" Hospitals are more involved with communities by administering Community Health Needs Assessments in the communities being served. Healthcare insurances are covering more expenses on prevention; dietitian/nutritionist sessions and health educator programs. I say all this to answer the question "what is a healthy community?" Engagement from community members, political figures, community leaders/activist, community based organizations, and stakeholders; all these entities need to work together as a whole to have a self-sustained healthy community. Through advocating and having much needed

uncomfortable conversations more programs are being developed to cater communities of color. Have these conversations led to healthier communities? Maybe not, however, I do believe we are gearing in the right direction.

Just like this young lady who interviewed me I was in my early 20's when I started a career in the public health sector. Twenty years later I continue to advocate for underserved and underrepresented communities; to be more specific the Latino community. I personally think we have come a long way building healthy communities, however, I am hoping that 20 years from now these conversations are continuing with much better lasting results.

Core activities of a healthy community

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Health is often framed as the condition of an individual, influenced by individual lifestyle choices. The World Health Organization's Declaration of Alma Ata, for example, defines health as "a state of complete physical, mental and social well-being" – implying the condition of a single person, not a community (World Health Organization, 1978). Popular culture and medical experts both eagerly offer innumerable recommendations on what behaviors we should engage in to live healthier lives; watch any interview of someone on their hundredth birthday, and they will surely be asked what the secret of their longevity is. As a family physician, I am regularly asked by my patients what steps they should take in order to stay healthy.

While individual behaviors are undoubtedly critical to achieving maximal health, focusing exclusively on those behaviors assumes that everyone has the knowledge, resources, and opportunities to engage in those behaviors. This is clearly not the case. Community factors can be resources for health or barriers. We are therefore asked in this monograph: *What exactly is a healthy community?* Healthy People 2010 describes a healthy community as one that "continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential. Healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders -- where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options." Community and Public health experts have identified various specific components of such a community. Not intending this to be an exhaustive list, I offer nine core activities which I believe must be addressed by healthy communities:

1. Ensuring that every resident has a roof over their head
2. Eliminating hunger and ensuring access to nutritious foods
3. Reducing injury from accidents, trauma
4. Providing accessible public natural spaces
5. Encouraging physical activity through zoning and the built environment

6. Investing in educational opportunity, beginning with early childhood intervention and extending across the lifespan
7. Providing economic opportunity and access to well-paying jobs
8. Supporting the mental health and well-being of residents
9. Monitoring outcomes and working towards health equity

Although these are listed sequentially here, and might suggest a hierarchy of needs, these nine tasks are interdependent. Employment opportunities and the assurance of a living wage can ensure that families can afford decent housing and nutrition. Housing and nutrition are essential for child cognitive and emotional development. Safety requires both physical design to reduce injury-causing accidents, but also education, support for families, and community ties that reduce the likelihood of crime. Green spaces with open commons promote a clean environment and also healthy social interactions. One task does not have priority over the others, and all merit the attention of public health leaders interested in building a healthy community.

Ensuring that every resident has a roof over their head

A community in which large numbers of residents cannot afford housing, and are forced to live on the street, in tent cities, or in overnight shelters cannot be considered healthy. Chronic homelessness in children is associated with malnutrition, psychological problems, developmental delays, and academic underachievement [Rafferty and Shinn, 1991]. The American Psychological Association has called homelessness a public health crisis, associated with increased risks of mental illness, substance abuse, and incarceration [American Psychological Association, 2016]. Policy-makers often rejoin that the homelessness problem is not one of urban planning, but one of poor decisions by those affected by mental illness and substance abuse. This claim is refuted by multiple studies of so-called “Housing First” initiatives which provide stable housing to the homeless without conditions of sobriety, treatment, or employment. A multi-city trial conducted in four Canadian cities from 2009 to 2011 randomized 1,198 homeless adults with mental illness to receive either usual care from social service agencies, or rent supplements for scattered site housing plus intensive case management. With 24 months of follow-up, the Housing First intervention group experienced 33 to 50% more days with stable housing than the usual care control group [Stergiopoulos, 2015]; at one of the sites, provision of housing was also associated with significant improvements in quality of life, community functioning, and the number of arrests [O’Campo, 2016]. In Utah, implementation of housing-first policies reduced the number of

chronically homeless by 72% over a ten year period. Providing housing to the homeless reduced overall costs to the state from about \$19,000 a year to less than \$8,000, through savings in medical care, and costs to the justice system [Deseret News Editorial Board, 2014; Surowiecki, 2014].

Home environmental quality is also of importance, especially for children. Lead remains an environmental problem especially in cities with aging housing stock and water systems, and indoor air quality associated with dust, mold, smoke, and cockroaches can increase acute asthma attacks and school absences in children. Seattle has addressed this issue through its Seattle Healthy Homes Initiative which used community health workers to improve indoor air quality in homes with children or adolescents with asthma [Krieger 2005]. A subsequent study in which children and adolescents with asthma were moved to new homes built with enhanced ventilation, moisture-reduction features, and materials that minimized dust and off-gassing reduced urgent medical visits for asthma, and greatly reduced asthma sick days [Takaro, 2011].

Eliminating hunger and ensuring access to nutritious foods

Rising rates of obesity, diabetes, and heart disease have raised public health alarms across the US. The 2006 publication of Examining the Impact of Food Deserts on Public Health in Chicago raised public awareness of the marked variation in access to high quality food across Chicago neighborhoods, and the health impact of that variability. Gallagher and her associates found that over half a million Chicagoans, mostly African American, lived in one of three food deserts on the South and West sides of the city. For these Chicagoans, getting to a full service grocery store would take twice as long as getting to a fast food outlet. In response, the city and neighborhood groups have encouraged the development of local farmers markets and grocery stores in the past decade; retail pharmacy chains have also tested the introduction of produce sections into their stores. The Neighbor Carts initiative created a network of produce carts through the city, with vendors trained to run their own business while improving access to healthy foods in their communities. Across the city, urban farming initiatives have taken root, giving families the opportunity to learn about fruits and vegetables to inspire better nutrition. Examples include a student run rooftop greenhouse in Humboldt Park's Pedro Albizu Campos alternative high school, a partnership between a community church and Rush Medical College students to teach children to grow herbs and vegetables in Little Village, and the Eden Place Nature Center, built on what was once an illegal dumpsite in the Fuller Park neighborhood. These initiatives, coming from grassroots

community groups, the business sector, and the Chicago Department of Public Health illustrate the need for multiple social sectors to collaborate in building a healthy community.

Reducing injury from accidents, trauma

Unintentional injury and homicide are among the top killers of Americans before the age of 44.

Accidents and unintentional injury are consistently the most frequent cause of death in this age group, with homicide ranking between the 3rd to 5th most frequent, depending on age group. While these have very different root causes, and have different solutions, healthy communities take actions to prevent these sources of premature morbidity and mortality. With regards to accident prevention, street engineering that separates foot and bicycle traffic from automobiles is a major step. Chicago currently provides 225 miles of dedicated protected bicycle lanes, with plans to increase to 645 miles by 2020 [Chicago Complete Streets, 2017]. Protections include barriers and buffers separating bikes from cars as well as conventionally marked bicycle lanes. In heavily trafficked areas downtown, separate bike lane lights protect both bicyclists and pedestrians from cars turning left. Individuals and community based organizations can influence this development to build healthier neighborhoods by helping identify particularly dangerous intersections or advocating for bicycle- and pedestrian-friendly intersections in their communities.

No community in the country appears immune from shootings or homicides, but Chicago has been particularly impacted by violence. Across the city though, grassroots organizations are taking active steps to protect their neighborhoods. Since 2000, CeaseFire has deployed violence interrupters across the city, using local residents to identify potentially violent conflicts and use mediation and other techniques to prevent the escalation of gang violence. In Englewood, a more recently formed group, Mothers Against Senseless Killing, has put themselves on streets during the summer to observe, counsel, mentor, and change community norms. To prevent the destructive consequences of imprisoning young adults for non-violent offenses, the North Lawndale neighborhood has just begun restorative justice Community Court that will hear non-violent felonies and misdemeanors committed by adults younger than 26 [Datcher ML, 2016]. Even in the face of violence, community health can be observed as residents come together to identify and implement solutions.

Providing accessible public natural spaces

In the heavily built urban environment, so-called green spaces may impact multiple domains of community health. Robust evidence is still pending for most hypothesized impacts; for example while green space is associated with increased levels of physical activity, it is not clear if this is the direct result of the green space on residents, or the selection by physically active individuals to live close to parks and natural environments. Still, there is some evidence to suggest that green spaces may buffer extremes of high temperature during the summer months, improve air quality, and enhance the social environment within a community. More robust and consistent evidence shows that exposure to natural environments acts as a stress reducer, reducing both physiologic stress and psychological distress [Nieuwenhuijsen, 2017; Pope, 2015]. A recent California study using satellite imaging and survey data provided additional evidence of health benefits in urban areas, finding that tree cover was related to better overall health, primarily mediated by lower overweight/obesity and better social cohesion, as well as other health effects [Ulmer, 2016].

Encouraging physical activity through zoning and the built environment

As a physician, I encourage patients on a daily basis to engage in regular physical activity, and I am by no means alone. Physical activity is often described as the “real fountain of youth”, with benefits including increased life expectancy, reduced incidence of heart disease, cancer, stroke and other illnesses, and improved mental well-being. In his book *The Blue Zones: 9 Lessons for Living Longer From the People Who've Lived the Longest*, Dan Buettner describes seven regions characterized by outstanding longevity – and in all of them, the built environment and social structures of the community promote constant moderate physical activity among residents [Buettner, 2012].

These are not communities marked by more gyms and health clubs than others. They are communities in which human powered transportation – walking and bicycling – are the norms. As part of its well-publicized effort with AARP and Blue Cross, the town of Albert Lea, Minnesota initiated walking clubs, “walking school buses” to bring kids to and from school, and enhanced the walkability of the town through the addition of walking paths [Painter, 2009]. Zoning also plays a key role. In suburban environments, planners typically separate residential areas from shopping and commercial districts. The result is communities in which cars are essential to everyday life, and sidewalks are rarely used. By contrast, zoning that supports mixed use development, allows people to live, work, play, and meet their

everyday needs within a single, walkable neighborhood. The CDC offers guidance and strategies to enhance daily physical activities in communities at <https://www.cdc.gov/healthyplaces/healthtopics/physactivity.htm>. Physical activity illustrates the interconnectedness of the healthy community, and how communities must consider “health in all policies”. Public health initiatives to encourage physical activity among citizens will fail if those citizens are afraid of falling victim to crime, or simply falling due to cracked uneven sidewalks.

Investing in educational opportunity, beginning with early childhood intervention and extending across the lifespan

Education is strongly associated with health, even when controlled for income and other related factors: the more education, but better the health outcomes an individual is likely to have. Negative impacts of poor educational attainment include increased smoking rates, decreased physical activity, higher stress levels, worse self-rated health, and decreased life expectancy. Further, the impact of poor education is multigenerational: children born to those with low educational attainment are more likely to have low birth weight, higher infant mortality, and worse health. Children born into families with low levels of education are themselves more likely to have low educational attainment, extending and even accelerating the problem.

Healthy communities create educational opportunities for all children, with intensive outreach and intervention for children most at risk. One illustration of a strategy that connects health and education is the “Reach out and Read” program established at Boston City Hospital in the late 1980’s. This program which has been endorsed by the American Academy of Pediatrics gives books to children during well child visits from infancy until they start school, and encourages parents to read aloud with their children every day. Early childhood education is critical to the health of a community, but not sufficient; resources are needed through high school and beyond to help develop a healthy community. Pedro Albizu Campos High School, mentioned previously in the discussion of nutrition, was founded when community members recognized that many bright young people were dropping out of the local public high school; family and neighbors refused to give up on these children, and created an alternative high school, drawing on Puerto Rican culture, and promoting education and high school graduation.

Providing economic opportunity and access to well-paying jobs

Employment and economic opportunity are critical to the health of a community, and the effects of neighborhood poverty extend over multiple generations. Robert Sampson, in *Great American City: Chicago and the Enduring Neighborhood Effect* examined Chicago community areas over a 40 year span and found that poverty in the year 2000 was concentrated in most of the same neighborhoods that it had been concentrated in in 1960 [Sampson, 2012]. This led Sampson to explore the persistence of these so-called “poverty traps” over a period of dramatic social change, with neighborhood populations impacted both by “white flight” and gentrification. Race and racial segregation play key roles, but a bigger predictive role was found for unemployment. As rates of unemployment rose, especially in highly segregated neighborhoods, incarceration rates also climbed. This incarceration of potential wage earners led in turn to declines in neighborhood businesses: stores and businesses close, leading to fewer opportunities for employment, increasing the risk of poverty. As neighborhood poverty and unemployment climb, students become more likely to drop out of high school, further concentrating poverty [Chapman, 2011].

Healthy communities must therefore also implement policies and investment that support neighborhood economic development. While large impactful businesses, such as the Whole Foods Grocery that opened in Englewood in 2016, often get extensive attention from the public and local media, numerous smaller scale initiatives can also help build economic opportunity. These include support for local chambers of commerce, training and mentorship for new entrepreneurs, attracting new and innovative businesses (such as urban farms, microbrewers, small scale manufacturing), and urban planning that creates accessible business districts. Because non-profit hospitals and universities are often among the largest employers in many communities, the health of the community especially depends on the stewardship of these institutions in hiring and training local residents.

Supporting the mental health and well-being of residents

The link between neighborhood vitality and mental health has been explored by several investigators, most notably Dr. Mindy Fullilove, at Columbia University in New York. She has described the displacement that resulted first from redlining and subsequently from urban renewal policies as “root shock”; community dispossession traumatizes residents much as a plant that has been uprooted is traumatized (Fullilove MT, 2001). Fortunately, community level interventions have been shown to enhance mental well-being. Fullilove has described the phenomenon of urban “hospitality”, the degree

to which the physical structure of main streets invite social interactions characterized by conviviality and connectedness among residents and promote community health [Izenberg JM, 2016]. Observations of 50 New Jersey communities found that features such as narrow roads with clearly marked street crossings, building fronts with large windows and sidewalk displays, and adjoining neighborhoods with sidewalks enhanced hospitality and built community. Because communities don't exist in isolation, neighborhoods with high hospitality were connected to others via public transportation and a network of roads, and wayfinding signs facilitated movement among visitors. Unsurprisingly, many of the qualities which Fullilove describes as supporting the mental health of the community such as inviting residential neighborhoods, walkability, green spaces, accessible mixed use commercial areas, have been previously touched on in this review.

Given the prevalence of depression and other mental illness, healthy communities must have resources to address these challenges beyond a supportive built environment. The CDC's [Community Guide](#) provides evidence-based community level interventions. These interventions include active screening for depression by clinicians, collaborative care of depressive disorders by primary care providers working with mental health specialists, and the use of case management and depression care managers in home and clinic settings for depressed older adults. Although individual and group exercise programs have demonstrated improved scores on depression scales for older adults, the Community Guide found insufficient evidence to support this intervention for depressed subjects. In so far as group exercise programs improve mobility, reduce isolation, and promote social interaction, affordable accessible programs would seem to be an essential element of promoting community mental health.

Monitoring outcomes and working towards health equity

The eight activities listed above offer a core set of infrastructure needs for healthy communities. Processes don't of themselves guarantee outcomes. Those who care about ensuring that our communities are healthy must consistently collect and analyze public health surveillance data. Such analysis must assess whether all residents benefit from the health infrastructure, including equity of outcomes. A healthy community has a diverse population, made up of individuals with widely varied strengths, as well as vulnerabilities rooted in socioeconomic status, racism and sexism, educational opportunities, physical disability, developmental delay, or other barriers to health. These vulnerabilities are not distributed randomly through society but are rooted in longstanding historical injustices and

policies that actively favored one group over another. Therefore, efforts to ensure equity of outcomes are of critical ethical concern.

Principles of distributive justice are by no means the sole reason for focus on health equity. Equity is also critical to the sustainability of a healthy community. The term “the tragedy of the commons” had its origin in the early 19th century to describe the problem of ensuring that individual decisions aimed to maximize personal gain do not result in the destruction of a common good (originally, grazing land for cattle) [Hardin, 1968]. Ignoring equity of outcomes may maximize health benefits for a few members of a community, but result in worse outcomes for all. Contemporary examples include privatization of education to ensure better outcomes for those who can afford it, or the prioritizing of industrial development over environmental protections. Healthy communities must be evaluated not by the health of its best off citizens, but by the health outcomes of those who are its most vulnerable. In using this metric, and working towards equity, we can implement the activities described here to develop truly healthy, sustainable communities.

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What is a healthy community? Considering the importance of sense of community

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Oftentimes, healthy communities are measured by the health statuses of its members. As a clinical/community psychologist, I consider a healthy community to be one that contributes to the health and well-being of its members in empowering and sustaining ways. One aspect of community health that is often overlooked is the psychological and social experience of community. This is referred to by community psychologists as “sense of community.” This construct was originally developed by Seymour Sarason (1974) and further refined by David McMillan and David Chavis (1986). It is described as “a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members’ needs will be met through their commitment to be together” (McMillan & Chavis, 1986, p. 9).

Sense of community has been studied across a wide range of population groups (e.g., racial/ethnic minorities, sexual/gender minorities, urban dwellers, individuals with mental illness) and environments (e.g., neighborhoods, religious groups, online groups, workplaces, schools) in the United States and globally. It overlaps with other concepts related to community health, including social capital and social cohesion (Kawachi & Berkman, 2000). Research has linked sense of community with positive psychological, social, and civic outcomes. Sense of community is related to psychological factors such as subjective well-being and self-efficacy, and social factors such as social support and collective efficacy (Davidson & Cotter, 1991; Ohmer, 2008; Prezza & Costantini, 1998). Sense of community is also related to community engagement, including in religious and neighborhood organizations (Brodsky, O'Campo, & Aronson, 1999).

Sense of community is related to better health. Results from several waves of the Canadian Community Health Survey found that sense of community is correlated with self-reported health and health behavior change (Hystad & Carpiano, 2012; Ross, 2002). The belonging aspect of sense of community has a particularly strong dose-response relationship to exercise, weight loss, and improved diet (Hystad & Carpiano, 2012). Hystad and Carpiano (2012) suggest that community belonging may impact health through (1) individual exposure to community norms and attitudes about health and health behaviors, (2) psychosocial factors, and (3) access to material and other resources within the community (p. 277).

Sense of community has also been implicated as a key characteristic in theories of community capacity (a community's ability to work to tackle systemic problems affecting social and public health) (Chaskin, 2001; Goodman et al., 1998). Goodman and colleagues (1998) suggest that sense of community is crucial for building and sustaining community initiatives because it: (1) influences how satisfied community members are with initiatives, (2) facilitates conflict resolution among community members, (3) enhances social resources such as social capital, trust, and caring, and (4) enhances networks within the community through cooperation. The authors argue that sense of community can be strengthened through a strong, shared sense of community history, and in turn, sense of community can drive collective action.

I consider sense of community to be both process and outcome. That is, strong sense of community is an indicator of community health, but it's also a predictor of community health at the individual-level through activating other psychosocial factors such as self-efficacy that push us to pursue healthy behaviors, and at the community-level through facilitating community organizing and action. As someone passionate about community health equity, I am most interested in the idea that fostering sense of community can help to empower communities and strengthen their capacity to enact change. This can be challenging for a number of reasons. Factors implicated in health disparities, such as social conditions (e.g, poverty, group-based discrimination), public policies, the physical environment, and access to institutional resources like appropriate health and mental health care (Warnecke et al., 2008), can also impact the development of sense of community, and in fact, some studies have shown that in under-resourced communities having a negative sense of community contributes to individual resilience (Brodsky, 1996; Brodsky, Loomis, & Marx, 2002). Moreover, some community psychologists have noted that sense of community and diversity are often negatively related (Townley, Kloos, Green, & Franco, 2011). These challenges notwithstanding, I believe it is necessary to think of ways to enhance sense of community to better achieve health and social justice goals.

As practitioners, organizers, and researchers working with communities, we may consider how we can attend to, respect, and facilitate community members' psychological, social, historical, and sometimes spiritual relationships to their community and its members. In doing so, we may become better partners in helping to tackle social and resource inequities that degrade health in communities.

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