Social capital

Headlines

People with strong social networks are healthier and happier.

Most people do not feel lonely or isolated most of the time, though some groups are much more likely to do so with 1 in 4 of those in poor health and those not working due to ill health being most at risk. Deprivation and living alone also increase the risk of loneliness and poor social networks.

Around half of all adults do some voluntary activity, with 1 in 5 volunteering at least monthly. The level of volunteering increases with age; with those nearing retirement being the most likely to say they want to volunteer in the future. People living in households with school-aged children are more likely to volunteer than people living in households without children.

Social capital through informal neighbourhood networks and attachments builds social trust more strongly than other types of social capital such as increased civic engagement.

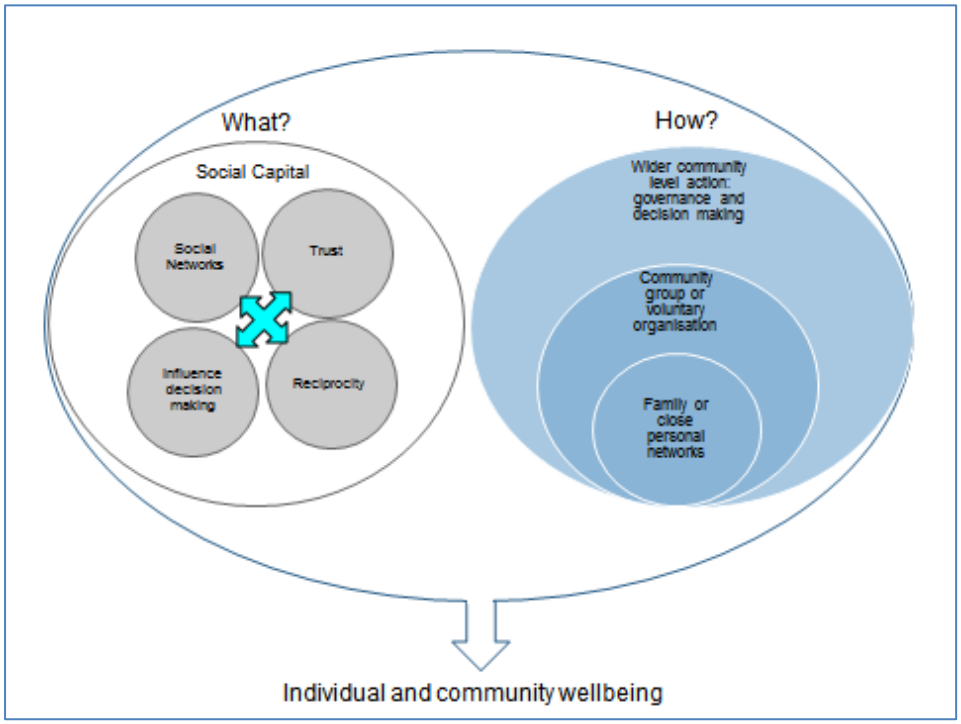
Residents that are affluent, live in areas of low deprivation, own their house, are aged over 30, and have a decent household income are the most likely to volunteer, vote and perceive that their local area is a place where local people pull together and help and support each other. These combinations of socio-economic and demographic factors are likely to explain most of the geographical variation in community capacity across Kirklees.

There is a core of local people that have their say about local issues through voting, consultations and contacting their local councillor. These are often the same people that regularly volunteer or aspire to volunteer more in the future. They are more likely to live in affluent areas and have an above average household income.

Why is this issue important?

People with strong social connections are healthier and happier[1]. Social capital is defined as the resources available through the strength of relationships with family

and friends as well as through participation in wider social groups (with shared values), work and activities in the community – the links that bind and connect people within and between communities[2,3,4]. Social capital and social connectedness are closely linked – strong social connectedness creates strong social capital. Locally we have developed a model to show the key elements of social capital and connectedness and how they relate.



Strong social capital in communities is linked to higher educational achievement, better employment outcomes, lower crime rates and reduced disease and death. Social capital provides a source of resilience and a buffer against particular risks of poor health, through the social support and connections, which are critical to physical and mental wellbeing, to help for people to find work or get through economic and other difficulties. Collective efficacy, the willingness of community members to look out for each other, has also been shown to reduce the risk of obesity[5]. Strong social networks, and the added control over their lives that this brings, are a protective factor that reduces the risk of stress, depression and dementia or cognitive decline over the age of 65 years[6,7].

Social isolation is the flip side of this – those who lack social capital and support can become isolated and as a result, more likely to experience poor physical and mental health, and overall increased mortality.

What significant factors affect this issue?

Social capital is created by:

- Personal and family networks: having people you feel close to, to love and be loved by, people you can count on in a crisis or when you are upset.
- Community activity: people coming together to make things that they care about happen. This depends on and helps create "trust and reciprocity" – people's feelings of trust in each other, getting along together and doing things for each other.
- Influencing decisions: people making the effort to get involved in influencing decisions and feeling that they can make a difference to the communities they are involved with.

The benefits of strong individual social capital are greater for those living in communities with others with similarly high levels[8]. Different "types" or "tiers" of social capital (e.g. personal, community, or societal) are experienced across different groups and social gradients. People in disadvantaged positions are more likely to draw on social capital from informal neighbourhood relations, while people in more advantaged positions are more likely to draw on social capital from personal social networks and formal civic participation. All types of social capital are strongly associated with increased social trust, even when controlling for other effects known to impact on trust such as class and gender. However, social capital through informal neighbourhood networks and attachments builds social trust more strongly than other types of social capital such as increased civic engagement[9].

Personal and family networks

The vast majority of adults in Kirklees do not feel lonely or isolated all or most of the time (94%). However there is a clear social gradient with those living in the most deprived neighbourhoods much more likely to feel lonely or isolated (10%) than those living in the least deprived (2%). The highest rates are amongst those with poor health – 1 in 4 of those with bad or very bad health felt lonely or isolated most or all of the time, the same rate as for those not working due to ill health or

disability[10]. Other groups of concern are those not in work (15%) and living on their own (10%). Perhaps more surprisingly young adults (under 44) are more likely to feel lonely (8%) than those aged 65 and over (4%)[11], though national evidence suggests that 1 in 6 (15%) older people are at risk of social isolation, and this risk increases with advancing age[12].

Similarly most adults have someone that they feel will comfort them when they are upset and that they can turn to in a crisis. This is the case for 9 out of 10 (89%) women, but slightly fewer men (81%). There is the same social gradient, and link to worklessness, living alone and long-term illness/disability. People from minority ethnic groups are less likely to have someone to comfort them – 3 out of 4 (74%) compared to 9 out of 10 (87%) across the white population.

People who reported feeling loved and close to other people often or all of the time were much more likely to report being in good or very good health, have high satisfaction with their life, feel like things are worthwhile and be happy. For example, 1 in 4 (23%) people who said they felt loved or close to people most or all of the time had low life satisfaction compared to 3 out of 4 (75%) who felt loved or close to someone rarely or none of the time.

Again there is a clear social gradient, and those people who are workless, long-term ill or disabled, or living alone are less likely to feel loved or close to people.

Community activity

Volunteering is a vital component of community activity. Overall volunteering levels are the same across men and women with 1 in 5 (22%) volunteering at least monthly and around half having volunteered in the last 12 months. Income and qualification level are heavily associated with volunteering through groups, clubs or organisations and the likelihood of non-volunteers wanting to volunteer. Those on low incomes are as likely to be involved in informal volunteering as those on higher incomes.

Volunteering levels increase up to middle age, dip from ages 45-64 and then rise sharply again at retirement age, before plummeting sharply at old age. As individuals reach retirement age the likelihood of them saying they want to become a volunteer in the future increases[13].

Regular formal volunteering (at least monthly) is most common amongst those working part-time (27%), followed by those who are retired (22%) and then working

full-time (18%). On a positive note 1 in 3 (33%) of those who are unemployed give some form of unpaid help, formally or informally, but this is well below the levels of those working part-time (50%). Those who already volunteer are more likely to be involved in local issues in other ways too – signing petitions, contacting local councillors and completing questionnaires[14]. The extent to which people get on together, trust each other and pull together to improve things is covered in the community cohesion section. There are some key differences between groups[15]:

- Women are more likely to feel people pull together (F = 41%, M = 35%); this increases with age from 18-44 (34%) to 65 and over (47%).
- Perceptions of trust between local people also increases with age from 18-44 (39%) to 65 and over (54%), and increases as deprivation decreases (most deprived quintile = 33%, least deprived = 59%).
- People from a BME background are much more likely to feel people from different ethnic backgrounds get on well together (60%) than people from a white background (40%).
- Similarly people from a BME background are also much more likely to feel people treat each other with respect (61%) than people from a white background (53%). This is also strongly linked to deprivation (most deprived quintile = 46%, least deprived = 70%).

Influencing decisions

Civic engagement is voting and taking action on local and national issues. Voter turnout in local elections has been falling both locally and nationally over recent years. In Kirklees it has fallen from 43% in 2006 to 35% in 2010. Factors associated locally with increased likelihood of voting: increasing age, homeowners, living in social housing rather than private rented accommodation, Asian and non-black background, living in less deprived areas, higher household incomes.

Community capacity

The capacity within communities is a measure of the potential and actual levels of community activity and people's belief in being able to influence decisions and make a difference when they do get involved. Locally, we have developed a set of measures of community capacity based on local data about individual's behaviours

(e.g. volunteering, responses to surveys and voting) and their perceptions of their local area and the behaviours and perceptions of others, i.e. if people feel they can influence decisions, if when people like them get involved in their local community they can really change the way their area is run, if people pull together to improve things, if people help and support each other, if people feel proud to live in an area, and if people want to get involved to help provide local public services and improve the area.

Levels of community capacity in Kirklees are closely associated with **patterns of socioeconomic inequality and disadvantage**. Higher **area deprivation** and lower **household incomes** are associated with weaker community capacity on almost all measures.

Locally, these groups, based on the Mosaic segmentation tool, consistently report lowest levels of community capacity: “young people renting flats in high-density social housing”, “families in low-rise social housing with high levels of benefit need” and “lower income workers in urban terraces in often diverse areas”. The following groups consistently report the highest levels of community capacity: “middle income families living in moderate suburban semis”, “successful professionals living in suburban or semi-rural homes” and “couples with young children in comfortable modern housing”.

Demographic factors are however also important, particularly **age and ethnicity**. Increased age is mostly associated with increased community capacity in terms of volunteering, voting and perceptions of community capacity. However, belief in being able to influence decisions and making a difference when getting involved is highest among young adults. There are few differences across the data in terms of ethnicity, though Asian respondents are the most likely ethnic group to vote. Comparisons with national data on volunteering show that Kirklees bucks national trends in terms of BME volunteering, with Asian residents (particularly Indian residents) locally being more likely to volunteer than Asian and Indian residents nationally.

Housing tenure is also an important local factor: home owners and those with a mortgage report higher levels of community capacity than those living in social or private rented housing.

Having children aged 5-17 years old living in the household is associated with increased levels of volunteering for clubs, groups and organisations, and Mosaic segments with children in their household consistently report among the highest levels of community capacity.

There is evidence from advanced statistical analysis of local survey datasets that a **"civic core"** of local people exists. Residents that have their say about local issues through voting, consultations and contacting their local councillor are often the same people that regularly volunteer or aspire to volunteer more in the future. This **"civic core"** is more likely to live in affluent areas and have an above average household income. National research shows that less than 10% of the UK population contributes towards 25-50% of total civic engagement (depending on how civic engagement is measured), and that this civic core consists predominately of prosperous people who are middle-aged and live in the least deprived parts of the country[16].

Where is this causing greatest concern?

The strength of personal and family networks is more closely linked to an individual's circumstance than where they live.

Levels of community capacity vary across communities and within wards, though the local analysis described above has identified wards, which have:

- strong community capacity: Colne Valley, Denby Dale, Holme Valley South, Kirkburton, Mirfield and Lindley

and those which have:

- limited community capacity (Heckmondwike, Dewsbury East, Dalton, Liversedge and Gomersal, and Golcar).

(Although it is important to note that there is variation within wards.) The Healthy Foundations (HF) model is built on the three core dimensions of motivations, environment (social circumstances) and life stage. The results from CLiK 2012 show clear patterns of association between health and wellbeing issues and HF segments. The model identifies four distinct quadrants that represent the different ways people respond to their environment; namely fighters, thrivers, survivors and disengaged.

Any actions in the areas with limited capacity could work with local “fighters” (who have higher levels of motivation to look after their health) to motivate and support “survivors” (who tend to have low levels of motivation in looking after their health) (see Healthy Foundations section).

What could commissioners and service planners consider?

- How to support individuals and communities to develop and maintain stronger social networks, particularly amongst those most likely to be isolated, i.e. those with a disability, poor health and those who are not working.
- Increase the levels of volunteering by creating opportunities for people to engage in voluntary activity that is appropriate and meaningful to them where they can see the benefits to both themselves and others.
- Develop a clearer and more consistent message about what community activity is available to specific groups and the benefits of participating in community activity.
- How to enable people, particularly in our more disadvantaged communities, to actively participate in decisions about their own lives and their own community.

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