

PATRICIA HILL COLLINS: We have a wonderful panel planned today for this particular plenary. I have a few introductory remarks about this particular panel and how it relates to the program theme. I will then introduce our illustrious panelists who are looking particularly illustrious. Could you look even more illustrious for us? Thank you. Very good. Let us get started.

The Obama administration has signaled its desire to make science more central to its public policy decision making process. In March, 2009 the nearly \$800 billion American Recovery and Reinvestment Act signed by President Obama infused the National Institutes of Health and the National Science Foundation with a total of \$13 billion over a two year period to fund basic research. Independent of the stimulus investment in science, NSF's Directorate for Social Behavioral and Economic Sciences is enhancing research capacity to examine the effects of the economic stimulus support of science.

Through the Science of Science and Innovation Policy Program, NSF will use its rapid response research five-year funding mechanism to support short proposals that address questions about the impact of this jump-start science investment has on science technology, the economy and the scientific workforce. I don't know, I'm so excited about this conference, I cannot even get a sentence out anymore. So, just bear with me. All right? While I sort of... breathe.

Now, that was to tell you that basically there is some change afoot, perhaps, in Washington around science generally. Now, these and similar developments create new opportunities for sociologists to highlight how our discipline might profitably address macro-policies, for example, social aspects of the economy. They also suggest a willingness to tackle longstanding social issues within health, criminal justice, education, housing and other key areas of public policy. But this one-shot research funding surge, for NIH and NSF for example, will have a time-limited impact even as the agencies attempt to stretch the financial impact. The long term has to remain in our focus as we aim to identify the most suitable social science paradigms to satisfy policy needs.

To develop long term solutions we need to revisit two prevailing paradigms that frame public policy. One paradigm contends that because causes

of social problems, as well as their solutions, reflect an accumulation of individual choices, the individual should be the basic unit of public policy. Yet the recent global financial crisis suggests that market-based solutions that focus on individual decision-making as the foundation for public policy come with serious limitations.

In contrast, an alternative paradigm posits that social structure should be the basic unit of public policy and that changing social institutions eventually changes the behavior of the people within them. Yet this approach has been criticized for its seeming erasure of individual choice and personal responsibility. There are signs among federal agency leadership that the Bush administration's tendency to overemphasize individual factors and underemphasize social structural factors is lessening. Take, for example, the Obama transition team advisors' approach to federal investment in biomedical and health research. Apparently, they listened to the science advocacy community that the effects of the most medical treatments hinge not only on individual factors, such as patient's age, sex and comorbidity, but also on social structural factors.

Clearly, social sciences advocates' chronic drumbeat heralding the role of social structure across the spectrum of macro policies is being heard in Washington. Yet this short term shift to pay more attention to structure may yield more short term fixes if we are not careful. Effective social science paradigms for long term policies must find a way to encompass both prevailing paradigms.

Now because sociologists routinely study social networks and communities, sociology as a discipline may be uniquely positioned to reconcile these seemingly disparate paradigms. Specifically, the construct of community incorporates both individual behavior and social context. This suggests first that peoples' individual beliefs and actions cannot be understood without attending to their communities and diverse social networks, and second that social networks and communities are meaningless without some knowledge of the actual people within them. Bringing multifaceted ideas about community that view individual choice in the context of social structural realities might develop more robust social science paradigms for long term policy needs.

Now, the plenary panel. As many of you have already experienced, the 2009 ASA annual meeting contains many opportunities to investigate renewed possibilities for social science and public policy. Today's plenary session, however, bringing communities back in, setting a new policy agenda, is designed to sharpen our focus on issues of science, community, and public policy. I have invited several prominent sociologists, and you can see how prominent they look because they all look fabulous today, to grapple with the question of how making

ideas about community more central to sociological thinking in their specific areas of expertise might catalyze new avenues of investigation for public policy. All of our panelists are renowned scholars with significant accomplishments within their respective public policy venues and all work with communities and social networks broadly defined.

Our first speaker will be Bernice Pescosolido, a distinguished professor and Chancellor's Professor of Sociology at Indiana University Bloomington. Her research agenda addresses how social networks connect individuals to their communities and to institutional structures, providing the wires through which society's energies influence people's attitudes and actions. The majority of her work has aimed to understand how individuals, their families, and their communities respond to illness. Focusing primarily on the case of mental illness, she has examined how the social networks of both patients and medical providers help determine the fates of illness and occupational careers.

Our second speaker will be Robert J. Sampson, Henry Ford Professor of Social Sciences and Department Chair of Harvard University. Are you that, by the way? Is that accurate? Is that accurate? All right, I just want to make sure. How do you do all this? This is what I'm saying....alright. Sampson's research publications have focused on race, ethnicity and social mechanisms of concentrated inequality, collective efficacy and crime, immigration, the social meanings and stigma of disorder, poverty traps, the spacial dynamics of social life, the comparative network structure of community influence, collective civic engagement and other topics linked to the general idea of community-level social processes. This research stems from The Project on Human Development in Chicago Neighborhoods for which Sampson serves as scientific director.

Our third panelist will be Steve Gortmaker who is Professor of the Practice of Health Sociology, and Director of the Harvard School of Public Health's Prevention Research Center. HPRC's mission is to work with community partners to design, implement and evaluate programs that improve nutrition and physical activity, reduce overweight, and reduce chronic disease risk among children and youth. HPRC projects involve community partners in every phase: conceptualization, design, planning, implementation, and evaluation. Gortmaker's research is focused on the health of children and adolescents, particularly households living in poverty and on minority population. His research is focused on a broad variety of risks that face the young, ranging from sociological concepts such as income poverty, social stress, and social networks, to behaviors such as smoking, inactivity exemplified by television viewing and diet.

After our panelists are finished if there is time available, which I think there will be we will also be taking questions from you. Alright, so we will start with Professor Pescosolido.

BERNICE PESCOSOLIDO: Thank you. Thank you, Pat, for that. I am glad you didn't discuss our shoe fetish in front of the entire audience. Okay. Which is how we met, that's why. Okay, so what I am going to be doing today is talking about health, healthcare and communities. In particular, I really want to talk about why a sociological presence is absolutely essential in changing healthcare policy. So, I think it's... you know, we didn't plan it this way, but I think it's good that I am going first because what I'm going to do is not tell you what I do or what I think we should do with regard to researching community. But I'm going to really... I'm not going to do an explication, I'm really going to do a challenge to us as a discipline to talk about the epistemology of community because, quite frankly, out there in the healthcare community in terms of research and policy, they're just confused about what community is. I think Pat's presidential address yesterday, you know, helped us to begin to understand the depth and meaning of the way we use community.

So, I want to start by pushing this button, okay, let me try this one. There we go. Okay. Do I... it's this button? Who says that sociologists were not technologically sophisticated? Okay, so I want to talk about the three meanings of community that I think are relevant to understanding the potential of sociology to contribute to healthcare policy change. Barbara Reskin once said that sociologists think in threes. Michael Burawoy believes that, you know, all sociological theorizing starts with a 2 x 2 table, so I guess I'm on the gendered side of that discussion today because I think there are three ways that we can use community, and that we have to understand community in order to make our contribution.

The first is the Community One as the community as an object of study. This is where we talk about network and place-based social and cultural meaning that are attached to the kinds of ties we have with others in society. I think if we think about Burawoy's ideas this would be mostly what we would call in the professional sociology realm.

Community Two is when we talk about the community as the target audience that we speak to when we want to share our insights about the role of social forces and social influence in health and health care, so these include public policy makers, and I think that this is what we call public sociology.

Community Three I think is turned internally is turned to ourselves to talk about sociologists or our tribe. I had breakfast with an anthropologist the week I was doing this, and he kept talking about his tribe. I was like, "Well we have a tribe too," so this is where we discuss our internal debates, pecking orders, and politics. I think that this is relevant to understanding the contribution we can make.

So, let me go ahead and clarify community. It is important because each meaning reflects a translational agenda in health and health care research. Those of you who are involved with health and health care know that the translational agenda is predominant in the road map at NIH. The problem is translational means many different things, and so what I wanted to do is clarify them in terms of the concept of community.

So, the first concept of community translational means bringing ideas from the core of our discipline to issues of health and health care. So, from basic to applied, if we want to use those terms, which I am not very happy with, but nonetheless when we bring the core of sociology to the application of health and health care.

The second community, Community Two, when we talk about translational, we're talking about disseminating research ideas to the public, and/or to change medical practice itself, or the medical healthcare treatment system.

The third type of translation that they talk about at the NIH is when we talk about the melding of insights from many disciplines or fields into a complex holistic realistic view for framing research and policy. So, what I want to focus on today is, my first premise that has to do with Community One is that health and health care research and policy, they've discovered context. Now, context for them means everything from in utero exposure, to lead, to the nation state. So, there is a bit of leverage there in terms of the concepts that we can bring into that discussion. I think that health care researchers who are not trained in the social sciences really face obstacles in pursuing the power of community to shape health and health care.

With regard to community two, my second premise is that sociologists have the theoretical and methodological tools to pioneer new pathways to community-based research and policy. So, we need to bring it if we want to help change the way that health is distributed in our society and the way that health care is distributed and looking at the outcomes of both.

The third meaning of community leads me to premise three. Will that doing so, doing one and two, will require sociologists to push past some real obstacles. Some of those obstacles are structural and real and imposed from the outside. Others are self-imposed and outdated and I think we need to get past those if we're to contribute to the larger social agenda.

So, my goal for today is to explicate and justify each premise to provide illustration of the case from physical health, mental health and healthcare for each of these, and to call for and sometimes suggest sociological approaches that I think have the potential to break through research and policy stalemates. So, with regard to the first community, or premise one, I'm going to deal with the issue of context and how the health and medical sciences understands or doesn't understand context to look at theoretical models that have been proposed to go over that barrier, and the case I'm going to use is obesity. With premise two, or community type two, I'm going to talk about leading and following from research, talking about reinventing the wheel and my case is going to be the stigma of mental illness. For premise three I'm going to talk about the sociological aversion to big science, the aversion to genetics, to biology, and my cases are going to be alcoholism and maybe child health if I get to it. Okay.

So, with regard to the first, the discovery of context, so community premise number one: I have often been known to say that the human genome project is the best thing that ever happened to sociology, and people wonder why I say that. But, from the 1950s on, or actually from probably probably from Watson and Crick, the line at the NIH or in medical science, maybe it was an undertow, but the line was once we crack the genome we won't need anything or anybody else. But what's happened is that the human genome project has showed the limits of the genetic explication of health and healthcare. So, last month, for example, in JAMA there was a debate about whether or not there is in fact a serotonin gene, which is pretty radical for medical science to talk about. They have now decided, as another example, there are 1,000 candidate genes for schizophrenia. We know that it is not a single gene, and we know that there are probably about 1,000 genes that are implicated in some way or another. We see that this embrace of social factors, the environment, context, community, come out in a number of reports from the premier arbiters of American science, and so I have listed some of them here. Not that some of our people from our tribe were not invited. For example, Gary Sandifer was part of the team that put together *From Neurons to Neighborhoods*. But, if we think about obesity as a case with regard to the discovery of context, the focus at the NIH, and if you go to meetings on behavior change and you talk about obesity, they will talk about diet, they will talk about the pyramid, you know the food pyramid. You know, this

reflects the predominant direction since the 1974 Lalonde report in Canada to talk about individual responsibility in health. It's very frustrating because when you go to some of the NIHs and you have lunch they kind of dissect what you're eating and you just feel like walking out of the room and having a cigarette.

So, I want to show you the challenge from the inside, because it's not about us attacking them. It's about the limits that have been hit in taking a clearly narrow focused biomedical model. This is one of my favorite pictures ever, and I really hate rats so that makes it more interesting for me. But, look at this as a challenge from the inside, from medicine itself. These are two rats that are bred exactly the same way and one is obviously what the normal rat looks like. It's brown and it's svelte as they say in the thing under there. Telltale blonde, I know that some of you will know the reference of that to rock and roll. But, on the left, what we've got is a rat that has now turned blonde and is obese. Now, did that rat eat a lot of chocolate fountains at the opening party? You know, the chocolate fountain stuff at the opening party? No. This was a rat that was exposed to BPA. How many of you are holding water bottles? Or other plastic bottles in which the BPA may be leaking into your biological system. That's what this rat was exposed to. If you give somebody an apple, if you give this rat an apple, it's not going to make the rat svelte. Okay, because the exposure is an environmental toxin, which makes the work of John McKinley and others who focus upstream, the work of Phil Brown who looks at social movements, incredibly important to ask about this. Because physicians now are asking, you know they feel like they're lifeguards where they're jumping in and trying to pull people out of the stream, this is a John McKinley story and physicians are asking, who the heck is upstream pushing them all in? That's our purview. We need to bring some understanding of community and community risks to that.

Our answer to that has been complexity theory, well I think social science's answer, everybody's answer has been complexity theory, but where was the first complexity theory, when I think about the sociological imagination and macro/micro link, you know you go back to early sociology. Well, everyone has a model about this now. There are just tons of models that show different levels of context. We've got the levels right. Now, so these are two. One is a very old model which is the Bruff and Brenner model and this is a reprint, so it was much earlier than 1990 where you have the concentric circles that depict the different levels of society. On the right you have one that just came out in science, which looks at different levels of society by Eleanor Ostrum who is a really wonderful political scientist. But, the problem with this is that many of these have been drawn, but few have been chosen. I mean nobody uses these models. I think the reason is, is that James Coleman pointed out a long time ago that they

have no engine of action. They have no way to understand how these levels tie one another. I think this is where sociology comes in.

On the left I have a depiction of my attempt to do this which is the network episode model that talks about how the networks actually serve as the linkage between different levels and allow us to understand that. On the right, you may have seen this, because this was heavily covered in the media, is Nicholas Christakis and James Fowler's depiction of looking at obesity in the context of social network ties in the classic Framingham Heart Study, in which they conclude that in fact what happens to people over time in terms of their BMI or their weight depends very heavily on who they hang out with. So, they either gravitate toward or develop a culture of eating. That means that there are clusters, significant clusters of people of different weights.

So, I think that sociologists have a real contribution to make there because we have studied the link and we can offer information and also points of intervention. Right? So, if you think about one of the things that's been really important for biomedical sciences is that they have adopted some of our measures like social support. But, how do you change somebody's perceived social support? You really can't. Well, I suppose you can change their social psychology in some ways, but in fact networks provide a real point of intervention and I think that's important.

Okay. Community Premise Two: pronouncing social change. This is something else that you see often in the medical and public health literatures. For me, the area that was most interesting was the number of people, and this is just a partial list, including one of the presidents, the recent president of the American Psychiatric Association, that stigma has dissipated in the United States. I think Goffman would be happy we don't have to worry about it anymore. We can substitute there, in terms of neuroscience, you can have specific examples of, people have said the second generation of antipsychotics reduced stigma, other people saying the development of the SSRIs reduce stigma. Other people saying the closing of asylums reduce stigma. But, in fact by 1999 or around 2001 the Surgeon General concluded that not only had stigma not decreased in the United States, but in fact it was the most critical obstacle toward the recovery of people with mental illness.

I want to show you just some examples of how it hasn't dissipated. If you look on the left there is a picture of a recent ad, and I think this is really an important ad in that it says "you can be [from a stigma perspective], you may be like these Olympic athletes because you might have asthma, diabetes, high cholesterol, arthritis, cancer, HIV." What's missing from that list? Any kind of

mental illness, which was Goffman's target. So, getting fed up, curious and exasperated from reading that in medical journals, we mounted the 1996 General Social Survey in which we were able to compare data from 1996 to data from 1976, 1956, and 1955 in which we showed that on the right hand side, just some examples that stigma was alive and well in the United States.

But not only that, our recent replication in 2006 showed that despite the greatest confluence of local, national and international attention and stigma reduction programs, there has been absolutely no reduction in rejection, social desirability rates for social distance from the American population. This is important because some people say, well they're just attitudes, it's not behavior, but community is the place where individuals experience and respond to the onset of mental illness. It's the place where they recognize it, where they name it and frame it or where they ignore it. So, having a sense of what community culture looks like is important. Here's the thing: we're just not into stigma that much right now and other disciplines are far behind us. There was a conference that was held at the NIH in which every speaker who got up, no matter what discipline they came from showed what is on the left here. They all held up, either held up or showed Goffman's book as where they were going with stigma, whether it was epilepsy or cleft palate, HIV.

If you look at, on the right hand side, we have a depiction of sociology's attention to issues of mental illness and particularly issues of stigma since the beginning of our journals. You can see that we are just not very interested at this point. I think it's time for us to really step up and bring some of our ideas from the core of the discipline into refreshing, refurbishing and re-conceptualizing stigma. It's very complicated. We made an attempt to do this in a recent piece in *Social Science and Medicine* that fundamentally sees the engine of action as the interaction between the individual and the community, often, but not always, through social networks. So, I think we have a lot of work to do there.

Finally, this notion of sociology as a closed clan, or Community Premise Number Three. I know all of us feel that there is no greater frustration when we're on multidisciplinary review panels than to watch one sociologist damage another sociologist and say, "That's not the right kind of sociology." You do not hear that from economists, well sometimes macro/micro, but you know, you don't hear that from economists, you don't hear that from neuroscientists, but you often hear it from other sociologists. I think that diversity is something that is one of our greatest riches and is a welcome diversity in the field. I think the problem is, is that everyone feels... I haven't talked to anyone in the subfield of sociology because we all have a subfield somewhere, that doesn't feel that they're fringe. So, Steve Epstein yesterday, as he received the Distinguished Book

Contribution, told us that it was clear to him that sociology of science was a fringe area of sociology. Is there anyone here that feels that their area isn't fringe, because I certainly know the communities to which I belong, including medical sociology, mental health, but culture, people in the culture section, have told me they feel that they're on the fringe of the discipline. So, I think this is something we have to think about in terms of how we think about our discipline and the example that I want to use where we feel most confrontative, I think, is in the area of biology and this is a quote from Lester Ward, our first president, who went on about how we feel it's necessary to debunk it. I think we now know that issues of nature versus nurture are obsolete. Those kind of arguments don't work. I want to show you some ideas that I think would be useful in terms of how we move ahead because we are seeing, we're the out-group when we go to the NIH. You know, I think it's pretty clear that there are people who are more open and less open, and I'm not talking about staff, because staff actually at NIH, program officers and SRAs, they kind of get it. They kind of get the frustration of hitting the wall and not understanding community.

But, what I want to show you is that we have three really great theories of which there is a lot of evidence that can be used to understand how biology might be swamped or mitigated in its effect on what happens to individuals in terms of health and health care. That's fundamental cost theory, stress, process and social safety net theories. There are very well documented. There's a lot of evidence for them. I think what is important is that *it matters*. So, this is a table, a graph from a piece that we just published in the *American Journal of Sociology* that showed that the genetic predisposition, which is indicated by having this high GABRA-2. Don't ask me about that; if you want to know, ask my co-author Bria Perry, she's the sociologist who really understands genetics. But, if you look at that, if you look at people who don't have any perceived family support, you find that there is a gap. That's the traditional perceived risk of high versus low GABRA in terms of the risk of alcohol dependence. But look what happens as family support increases. We absolutely wipe out the genetic effect. Now, I don't think that that means that sociology wins. I think that's the wrong way to think about it. I think what it means is that they are far behind us because that's one gene of many that might be implicated in the onset of alcohol dependence.

But I think we know two things. One is that what we know about society and communities matter and they can change people's life chances and their lifestyles. I think the second thing that we know that matters is that when we look at these kinds of data we have more work to do as well. So, I'm pretty excited about the fact that I believe people have a body and it took me a while to get there because I was a radical or am, I hope, still a bit of a radical sociologist...

well I'm certainly a sociological imperialist. So, I believe what we have to offer is very powerful.

I think that there are some possibilities for this, for contributing our ideas of community to the scholarship in health and healthcare. The first is that I think we need to see our methodological and theoretical diversity as an advantage and not a bifurcated battlement behind which we stand for our own identity. Second, I think that we need to support multi-method and public goods in sociology. I think that would include support for things like the General Social Survey which people have very strong feelings about, but it's one of the few public goods we have in sociology that we think we can access in a way that no other discipline can. I think that we have to acknowledge that the scholarly monk vision — of only one person hiding away in a library — is the only valuable form of scholarship. I think it's increasingly less viable. I think people work both as individuals and in teams and I think we need to recognize that kind of research scholarship.

And I think we need to sort of get over this notion of public sociology as a problem for the discipline because it strikes me that things like public sociology and the scholarship of teaching and learning really reflect a rich division of labor. I mean, if we can't look at our own discipline with our own tools I think that we have problems. One of the things that I really like about the concept of the division of labor is that we have numbers of people who do very different things very well, and they can slide across different areas within Michael's 2 x 2 table.

So, looking forward, I think this is really a time of opportunity, because I think the community is both something that we conceptualize as in-placed and as a moral or social unit, and it has moved to the fore in terms of the understanding of health and health care. This is going to be a hard battle to win because it doesn't fit easily or normatively with the individualistic notions of American public policy. I think this is challenge to sociologists and sociology as a discipline. If you don't think we have a continuing battle, despite the fact that I think that context is probably the single most uttered word besides, well maybe brain imaging, at the NIHs. But, if you don't think that we have a continuing upward battle I want to show you something that came out just 2 weeks ago in something that I read often, which is called *Science News* which kind of digests and regurgitates for the uninitiated very sophisticated science articles. The reason that this caught my eye is because the person was saying, you know, philosophers are useless. Philosophers tend to think that scientists are useless, but in reality, says the editor of *Science News*, philosophers like August Comte are useless. About the time, he uses this example of how Comte said we'll never be able to understand the chemical composition of stars. And he says well gee, that's wrong, about the time Comte died we were doing spectroscopy. So, we sort of know that.

But, what was most important to me was how much he did not understand about the battle that he is fighting in which he doesn't have the conceptual tools, because this last is also his quote, "Such is often the way science works, by finding ways to acquire knowledge that at first glance seems inaccessible." I think that's to a large extent where parts of health and health care research are. They don't know what to make of context and community, but we do. They've discovered the community, and they're either somewhat flummoxed by it, or some thinks it's as simple as using the advanced search in PubMed or Ovid and cross classifying social support and measurement and then sticking that at the end of their traditional studies. I think that they've found that that is really problematic. I think that community, the concept itself, is intricately tied to health and health care through institutions, through interactions, and through identities in very complex ways that I think requires our complete toolbox of theory and methods. I think we have a lot of work ahead of us and I'm very excited to be part of it. Thank you.

ROBERT J. SAMPSON: Thank you. It's a pleasure to be here today and to follow Bernice. That was a great talk. Let's see, if you could fire up the PowerPoints, we'll see if they work.

Two venerable themes in American society, community and inequality, are in tension with one another, perhaps now more than ever. Community is one of the major themes of this conference, of course. It's also a classic sociological concern that goes back well over a century. By various accounts, community has been lost, found, liberated... but whatever your view on that particular debate, I think it's safe to say that the appeal of community has never gone away, and, if anything, is ascendant. The idea of a shared vision and collective approaches to solving human problems is a deeply sociological one. But pushing against community and pulling the people apart rather than together is inequality, another classic concern of sociologists. Put simply, it is hard to have unity and cohesive communities when there are sharp disparities in resources, especially by ascribed characteristics and when they are concentrated by place. Although in tension, what community and inequality ironically share in common is that they have largely been set aside in recent debates on urban social policy. Despite the talk of context - I think this links with Bernice's point - and even community in many circles, individual reductionism, I believe, rules the day. This dominance is highlighted most visibly and symbolically in the area that I work in: in the move to vouchers as the new policy paradigm. Vouchers for individuals, that is, to move away from whatever bad school or community that inequality has wrought. Escape is the byword, choice is valorized. Consider, for example, how the federal

government has spent billions of dollars in the last 10 or 15 years on housing and urban neighborhood policy. In the Moving to Opportunity and Hope Six programs, policy makers have viewed vouchers, and the more general idea of mixed income housing, as a way to offer public housing residents the means to escape concentrated poverty, improve housing quality, reduce crime and spur investment. Vouchers have quickly become the new policy paradigm. Now these are in some respects noble goals, and I don't mean to undermine vouchers completely, yet I want to problematize them. Early research tracking the outcomes, for example, of residents in some of these programs, such as Hope Six and Moving to Opportunity, show mixed results and sometimes negative results. For example, following the landmark TROG study, which many of you may know about, that helped poor families move out of Chicago's racially segregated ghetto, to the white and presumably better-off suburbs in the 1970s was followed up by programs in the 1990s to give vouchers to poor families to move out of the inner city in Chicago, New York City, Los Angeles, Boston, and Baltimore. Winners receive these vouchers and they have the choice, and if they move they had to move to a lower poverty neighborhood. But despite high expectations, MTO has not had the transformative effects that have been intended. Researchers have reported quite modest gains and sometimes perverse effects. Furthermore, some critics assert that the migration of public housing residents is increasing social problems in destination areas. There was a controversial article in *The Atlantic* by Hannah Rosen a few months ago.

So, the question many are asking is what went wrong? What's going on? We have this voucher program, it's allegedly there to deal with context, poverty, the things that we sociologists are interested in. My answer is that policy makers have been looking in the wrong places for answers. The dominant approach, as I have alluded to, is to study or experiment with individual families in housing units. While important, I begin instead with the neighborhood context within which families live and make choices, and then analytically treating those contexts as important units of analysis in their own right. I think this is an important move. It's one thing to talk about the importance of structure and context; it's another to analytically study those with rigor with which we traditionally study individuals. Neighborhoods in local communities are, ironically, overlooked even in housing policies, which you would think would be primary. The reason is, they're seen as simply settings not active ingredients. I also argue that segregation and inequality by neighborhood reflect durable processes that can transform interventions into continued processes of neighborhood stratification. Another classic sociological theme I want to argue is the law of unintended consequences, which we often overlook.

So, in my brief time today, what I would like to do is make the case for community-level interventions, rather than individual level escape hatches. Now, a disclaimer up front: I am not going to make the case for a specific policy, x rather than y. I'll talk about a few. But I'd rather make the broader point that the job of social scientists, in my view, is not to dictate policy prescriptions, but to provide knowledge and guiding theoretical ideas. As the great social psychologist Kurt Lewin wrote over 50 years ago, and I quote, "There's nothing more practical than a good theory." Sociologists tend to get trapped in the policy game by being forced to try to come up with a specific policy prescription - what do we do? Well that is what policy makers are supposed to decide. We provide knowledge. I'll come back to that.

So, I have a 4-point plan here in my 20 minutes. First, I'd like review a few basic facts about social structure of community within the ecological context. No one here is surprised that racial inequality, for example, is correlated with neighborhood contexts. I take that as a given. But, you might be surprised at the durability of poverty and the durability of inequality. Despite all the frenetic talk of globalization, gentrification, cyberspace, placelessness, social transformation, Twitter (I've heard). Take all of that and we still have a fundamental durable process that we need to come to grips with, which bears directly on policy.

Second, I'll demonstrate the importance of durable inequality in thinking about what the mechanisms are that lead from it, looking at what I've called the process turn in neighborhood effects research. Specifically, looking at factors like cohesion and, in my case, theory of collective efficacy.

Thirdly, I'll briefly discuss not just neighborhood effects but rather the wider social context within which social ecological communities are embedded, thinking of the idea of spacial advantage and disadvantages. Fourth, I'm going to turn to a bit of a review of the MTO data from a new lens. I'll conclude with three implications for policy.

My case study is Chicago. I've spent the last 15 years or so doing work there in the Project in Human Development in Chicago Neighborhoods, which is noted and this is part of bringing together work that is going to part of a forthcoming book from the University of Chicago Press. So, with that let me show you a little data, and I promise you this is just going to be pictures. No heavy stuff here. And the reason is, I can do it that way because the patterns are fundamental.

So, fact one: this is Bill Wilson's era. My colleague Bill was right. There was a social transformation in the inner city in the 1970s to 1990s. Remember,

this is when cities were changing, becoming poorer, minorities, becoming disproportionately black. What this is though, is just a very simple scatterplot. You learn this in research design 101. Poverty in the X-axis in 1970 and 20 years later in 1990 at the neighborhood level in Chicago. Guess what? Poverty was going up, but neighborhoods are not changing their position in the social structure. Poor neighborhoods are getting poorer, good neighborhoods are getting better. I mean this is the classic, the rich get richer, the poor get poorer. We miss this a lot when we talk about transformation. Actually, not a lot transformed. There were some changes, but the correlation here is .87. By social science standards that is quite high. You're going to say, okay that's then. It's a new world, it's gentrification, it's globalization and so forth.

Okay, let's go to 1990 to 2000, the last period we have Census data. You don't get R squared to .92 very easily. This is the community level correlation in Chicago in 1990 to 2000. Basically except for one neighborhood, everything is falling along the same line. Yes, a neighborhood here or there is gentrifying but we can predict which neighborhoods those will be, and again the processes are unbelievably strong in terms of the durability and even where there is change, I'll come back to it at the end, it's predictable. Well, you say racial change. We know about the racial change in the cities. That's true, but I want to emphasize this too is highly structured. It follows a particular structural logic. Namely, this is 30 years now, 30 years, Chicago is the third largest city in the United States, looking at a percent black in the X-axis in 1970 and in 2000 on the Y-axis. What happened? Basically, three things; there are segregated black neighborhoods and they remain segregated. There are segregated white neighborhoods. They remain segregated white, and then there's white flight. Go up the left hand column, what you see are neighborhoods becoming all black that were white. But, that right quadrant, completely empty. Empty cell. Not one neighborhood in the third largest city in the United States went from black to white. Now, that's an interesting phenomenon. Talk about stigma. Stigma exists at a macro level. It exists at a neighborhood level. That's a fundamental pattern I believe. There is racial change, but I call it the asymmetry of change. Again, this is going to bear on policy.

Now, you say is this Chicago? The answer is no. This is every single census tract in the United States, ladies and gentlemen. Sixty-five thousand census tracts on the top. The correlation between concentrated poverty in 1990 and 2000 during the era of gentrification is .89 in Chicago, it's .88. It follows the same pattern, I can do the racial in the book, I have the racial change. The same thing, there's something like 10 census tracts out of 65,000 in the United States

that actually go from black to white. This is a very distinct durable process. This should tell us something about how to think about policy and what's going on.

So, we have this phenomenon. We have concentrated poverty. It's strong, but I think now, to back off a little bit, a lot of the theorizing in the urban literature and policy has focused, not so much in the sense of too much on poverty, but it has only recently really tried to push hard the signs of what are the mechanisms and the mediating processes that help to explain the relationship between the concentration of disadvantage and various outcomes. I'm going to briefly sort of outline a line of inquiry where I've been involved with.

On the left hand side are some of the more traditional structural characteristics of disadvantage, residential tenure, the transiency of neighborhoods. We have begun to understand better how network ties, whether or not there is a high density of let's say friendship or kinship ties in the neighborhood. The density of organizations, we know how these are important. But, when it comes to the sort of right side, what we have been trying to do lately, I and many colleagues around the country, is to try to elucidate what are the social mechanisms? Those active ingredients that are actually potentially causal in orientation. They're not just attributes of the population, but rather processes that are changeable. And how do they relate to the broader, social level, health of a community?

In Chicago we have worked with a notion of collective efficacy which in brief is an attempt to bring together both a cultural and a structural element of community. The cultural being the shared expectations that residents share in a particular space about social life, about public problems, about whether or not their neighbors can be counted on, whether or not there is a shared sense of action. So, one way to think about this then is agency: the activation of social ties or the activation of networks to produce a particular result, hence the notion of efficacy, right? To try to get to an intended result. Now, shared expectations or the cultural aspect of communities doesn't just fall out of the sky. It tends to occur in communities where there is a sense of, what I think of as working trust, a certain kind of cohesion. Not necessarily the old urban village neighborhood where we all deeply know our neighbors, have dinner with our neighbors, because I'll confess right here in public, I don't and I don't want to. But, I do trust them. I know them, and there's a certain kind of working trust. And this, by the way, I believe, it's an aside, works at a societal level. If you can think of a little experiment, if you let a kid loose on a street that doesn't appear to have an adult and you let them loose in the streets of Stockholm versus Chicago or New York. Guess what? An unaccompanied adult who does not know that child will go up quicker in one context to another. They are norms. There are cultural norms

about intervention in public space. That's the idea. So, our research has tried to emphasize the notion of collective efficacy and social health, but also the idea of spacial disadvantage. What I mean by that is that when we think of communities and social ecological communities and neighborhoods, we don't want to simply focus on the indigenous characteristics or what's going on within those locales because they are embedded in larger context. This has been shown ethnographically, for example, Mary Pattillo's fine work *Black Picket Fences*, how the black middle class is disadvantaged.

I'm going to give you a feel of how this actually works going beyond poverty. We approach this in our Chicago data where we did a community survey of about... almost 10,000 residents of the city, in addition to studying children through time, where we asked about their nature of social ties, cohesion, shared expectation and with a highly reliable community level, and I really do believe the collective efficacy is tapping a collective component... We found an interesting phenomenon whereby once you adjust for poverty and once you adjust for the collective efficacy of neighborhoods, it still remains the fact that white and black neighborhoods share a completely different profile. It was stunning even to me and I was expecting a spacial disadvantage. Let me give you just some brief facts.

Among neighborhoods with high collective efficacy, so neighborhoods that are doing well, black neighborhoods were something like over 30 times more likely than white neighborhoods to be spatially vulnerable or be in proximity to those with low levels of collective efficacy. Now that's a high number, but perhaps even more intriguing, if you flip it around, is what I call free rider spatial advantage. I think this defines a lot of what's happening in cities, because we tend to think of communities working together. Well, I think that in many white communities, actually what's happening is that there is a free rider aspect and it goes like this: among neighborhoods with low collective efficacy, white neighborhoods are 10 times more likely than black neighborhoods, and six times more likely than mixed neighborhoods, to be spatially proximate to high collective efficacy. If you think about it, it's not just the local context, you know, your kid's riding off on a bike, you're buying a house, it's a larger context and these are linked into political networks, as well. So, there are policy implications that follow from this. While a black poor neighborhood might be able to be intervened in, or while someone may be given a voucher to move to another neighborhood, we have to be careful to think about these larger contexts, and I will show you exactly why, going right to the policy experiment.

So, let's take the MTO and I'll just quickly run through this, and again, simple pictures. These are the compliers; this is the Chicago site of the Moving to

Opportunity experiment where people are given a voucher to move to low poverty neighborhoods. These are not just the control versus the experimentals. I'll show that in a minute. These are the people that actually took the voucher to move, and interestingly enough only half took the voucher. Dark blue is high disadvantage at the destination after 7 years of the study, medium blue is medium disadvantage, and the white areas are low disadvantage. Those dots are the poor families. Guess what? What do you see? Spreading out they started out here, the inner city and they spread out in a very structured way down the south side even to the suburbs, these are now suburbs, that are low income, predominately black, not one move to a high income neighborhood, that's really kind of surprising. But what about the social consequences that I just talked about? I've followed up, there's a symposium by the way, in the *American Journal of Sociology* on this recently. I followed this up now with the construct I've just talked about, collective efficacy and said, now let's take the entire study, let's look at the control group, which was given nothing. They're just regular poor individuals, and what happens? Well, most of them churn, they're poor, they don't move far, and they move within the same neighborhood, and in this I am now looking at the collective efficacy of the neighborhoods. White is low, this is simple thirds, low, medium, and high. The gray are the medium, and the high are the high efficacy neighborhoods. By the way, this isn't just a simple, yeah they're all near the suburbs, these are high efficacy neighborhoods here. This is a black neighborhood that's high efficacy, so there's diversity here. But, what's happening is that they're moving almost exclusively either to low or some medium. Now, what happens to the control group? Compared to the experimentals now, this is the causal effect of the experiment. There you go. That's social structure. That's social structure. See this part of Chicago? Three million people in the city, about over half live up here. Guess what? No penetration. No context. This is structural social isolation. We can not even talk about cultural social isolation. This is churning and the social reproduction of poverty. Is it just MTO?

Let me go to the Chicago study that I talked about where we followed kids over 7 years. We now looked at the migration patterns. Guess what? They didn't start out in the same neighborhood. The poor live in low income neighborhoods here, the northwest side, and up here. Lots of churning, collective efficacy moving to neighborhoods that are low. So, there is a tremendous reproduction of poverty no matter how you cut it. And it's not unique just to MTO. So, what I'm arguing here is that the hierarchy of places is rendered durable and the MTO... by the way this has been looked at in some of the other cities and research is ongoing, but the basic pattern looks the same in Baltimore. Where it does vary,

where people are moving to better-off neighborhoods, it's conditional on the social structure of the metropolitan area.

Let me discuss one more empirical pattern and then conclude. The last empirical pattern I want to briefly mention, because I think it's really important and often overlooked, and if you think about these findings, and that is that the durability of inequality at the community level should tell us something about developmental effects. Adults that are poor and even children that are poor, for the most part, have grown up in poor neighborhoods. Right? You don't see a lot of this, you know the Horatio Alger myth. There's not a lot of mixing. There's not a lot of upward mobility, so most people are in the same context, even through vouchers, so what's happening then is that if, in fact, the effects of concentrated disadvantage or local lack of efficacy are developmental. What I mean by that are interacting with developmental processes in early childhood. Then if we intervene at a later age we may not get the effects we want. It may actually be too late. Now, I'm not arguing for permanence of effects by any means, what I'm arguing is that there's certain developmental patterns that are important and one of these we've studied, which is verbal ability. Anybody that's trying to learn a language as an adult knows that there is a developmental face of this and actual learning of math skills, as well, and verbal skills at a young age is really important. What we did in my last empirical slide here, well actually I am going to skip over this, this is just another slide showing the moving patterns of whites on the left and blacks on the right, moving basically in separate social worlds, which is just another way of showing the previous point, is the verbal ability effects in our data. Basically what we did is to take the youngest cohorts, and we could only look at African American children. And the reason is, I've already shown you why, the reason is there are no counterfactual comparisons. If you look at those previous slides, there are simply no white children. Interestingly enough, there are no Latino children that have grown up or have lived in the concentrated disadvantages of the extreme. Severe concentration of disadvantage is so intersected with race that you cannot actually define the causal condition. So a lot of the research that we do is actually wrong because it's comparing off the space of what is technically comparable. So, what we did is to take African American children, and what these lines show basically is the comparison of those that lived in disadvantage in the middle of the study and what the lagged or later effect was on their, this is standardized state-of-the-art tests of verbal ability, three or four years later. And what the black and the dash black here, and red lines show, is that if you live in disadvantage, whether or not you moved out or not, this is moving out of disadvantage and staying in disadvantage, there's no difference, you lost about six points, which is the equivalent of over a year of

schooling compared to those that did not live in disadvantage at the previous point. Again, it didn't matter whether they moved in or out.

Now, the reason this is important is that this is the intervention that, I'm not just getting on MTO here - this is the intervention we often think about. Well, if we take kids out after a certain point, move to a better neighborhood at the individual level, it actually turns out that there is no effect because the effect is already part of the developmental process. That, I think, is an important point.

So, let me conclude, because I think I've gone just about to about to where I should conclude. So, with these empirical findings as a backdrop, let me say three things. General implications, I think. The first follows directly from what I've just shown. Public policy must be attune to the life course. If there are developmental effects, then waiting until the teenage years or later may be insufficient to effect change, no matter how profound the intervention. Even if we changed the context itself, cumulative exposures and life experiences remain. I am not saying that these lock-in effects forever doom one. I'm saying we need think about children's contextual disadvantage.

Second, individual level interventions and the presumed purity of experimental approaches need to be rethought. I know that some of you won't like this, but here I go. The classic take on experiments which are supposed to be the gold standard from Cook and Campbell in our early design classes, is that experiments are the gold standard right, because they have high internal validity. They do. But, guess what? Policy makers, as Chuck Mance has argued, are not so much interested in the purity of the experiment from the perspective of internal validity that is the findings within the study population. What policy makers have to do is implement a study in the real world, in a socially structured world, as I have shown. That's external validity. This point is widely misunderstood. In a deeply stratified and socially structured world, experiments take on a new meaning. And social life is not like taking a pill. The assumption of unit independence and static equilibrium that experiments invoke is patently violated in neighborhood effects in most social life. Social human beings, we interact. We talk. There are social interactions. These violate the fundamental assumptions. Moreover, if I move you to a new neighborhood, I am assuming that neighborhood is going to be the same, in order for it to have an effect. But we've shown that people move in response to changing neighborhood conditions which makes that endogenous. So, racial change, perceived neighborhood disorder, and so on, influence who moves. So, the neighborhood is no longer the same. What social scientists need to do, and I think sociologists have a big role to play here, is to evaluate policy implications within the context of a social or a community system. In fact, I'm calling for a paradigm shift in policy evaluation.

We're often called in to evaluate a specific policy, it's important, but perhaps not the most important thing, because it has to be evaluated within this external extrapolation of where we're going in terms of the future, in terms of how neighborhoods change.

And finally, we should think about community level interventions, right? Real community level interventions, not just redefine the individual. We can think about the random assignments of neighborhoods to receive a network-based AIDS intervention, this has been done... community policing, efforts to mobilize collective efficacy. To this day, even though little heralded, are such interventions in public health, the Chicago area project. We have seen, for example, rates of sexually transmitted diseases that have gone down in particular areas through interventions. There are other interventions such as de-concentration of public housing, and I might even argue, and we'll show you one last slide here that if I go back to the durability of poverty and you wanted to know, remember there was a few of those that looked like they changed? Guess what? The neighborhoods that did in fact change in Chicago and the near South Side, Grand Boulevard, are the sites of large scale planned interventions. It's not random. These are the sites of massive infusion of resources in the part of the city, de-concentration, Robert Taylor Homes, were shut down. We can debate whether that was good or bad, but the point is that was a macro-level intervention.

So, I'll end then on some good news which I think links to President Collins' initial remark. I think the Obama administration is poised to take community level interventions seriously. Not pseudo community level interventions that smuggle in through the individual on their back. For example, the Harlem Children's Zone, which I am not advocating for or against, but it has attracted national attention. There is, I think a sense that the administration wants to invest in disadvantaged neighborhoods in multiple cities. I just want to say that the logic of the Harlem Children's Zone is that it did not start with the assumption that the poor Harlem neighborhood was bad in the beginning. It's bad, we got to get people out. I couldn't resist thinking of Kenneth Clark's classic in 1965, very blunt. He talked about the tangle of pathology. We don't talk about that anymore, but if we think about disadvantage. What did he say? He said, "why then would members of the cities' ghettos seek to embrace the pathology of the suburb in exchange for their own?" You know, that's a good question. Harlem was improved and now people want to move into Harlem. The structural logic of community level intervention is profoundly different than the individual level logic of vouchers and other individual interventions that have heretofore dominated policy thinking. Other examples are available as I've said. I don't think

going into specific ones is really the issue here. I'm trying to make a broader thematic point. Remember, there's nothing so practical as a good idea, and hopefully this is one. So, I just conclude by saying, to more macro community-based framework policy might profitably turn. Thank you.

STEVE GORTMAKER: Good afternoon. And everybody's recovered from lunch, right? I'm going to talk about really a lot of public health work, but from, really, a sociological perspective. I'm going to be talking a lot about obesity, working with communities to improve nutrition, physical activity, to stop the obesity epidemic. It may be too applied for some of you, I'm sorry about that, but maybe not. What I want to do is first give you a little background on the epidemic. Yes, it's a big one. I want to talk about the fundamental causes. It's not rocket science. It's pretty simple and yet most discussion kind of misses it I think. So, there might be some surprises there. And then I'll talk about strategies for action and the importance of theory. I think this is where sociology really has a lot to add. The importance of evidence, solid science and the mechanisms, and the importance of partnerships and I think that this is where sociology has a lot to add also, working with communities to create change, really much in the same line that both Bernice and Rob were talking about, thinking about how you do that.

So, let me begin with the big picture and this is no news to anybody, obesity has been increasing rapidly in the United States among children, adolescents and adults. Increases are found in all regions of the country, urban, rural, both sexes, all ethnic groups, rich and poor. You know, we're almost number one in the world. Oh, that was a joke? Okay. How many have you seen these slides from the CDC? Wow, this is like, you really haven't seen these slides? Oh, okay, boy. When I do this in front of a public health audience it's like everybody raises their hands, "Oh God we've got to look at these slides again?" These slides show a graphical map of the prevalence of obesity among adults by state. We begin in 1988 and I'll go year by year through 20 years. You can start by looking at the places here that are kind of very light colored or light blue. 1988. Light blue is a prevalence of obesity of 10% to 14%. That is starting to increase in just a couple of years, you know, 1990, 1991. Now, we're starting to get some little darker blues in there, the 15% to 19%, '91, '92, '93, '94, '95, '96. Obesity is growing rapidly, you know, we're being successful at something here. Oh, now it's starting to turn kind of tan, that's a prevalence of 20%, '98, '99, 2000, 2001. Now we have a red state, oh that's a prevalence of 25%, greater than 25%. Let's see, 2002, 2003, 2004, 2005, 2006, 2007, 2008. We have some states there with a prevalence greater than 30%. So, we've been growing in obesity rapidly in this

country. You may be wondering about this state out here. The great state of Colorado, that stayed blue there? Yeah, there's someone from Colorado and you go, well, why have they stayed? Well, it's actually well known that if you get a population at 5,000 feet they don't gain as much weight. That's a real expensive intervention though.

We see the same trends among children. These slides show increasing rates of obesity in the childhood population and we also show, these are slides we produced pretty recently, really widely growing disparities, racial ethnic disparities in obesity. I have the same chart for low income versus higher income. See, widely growing disparities, increase in obesity and growing disparities. So, lots of stuff is happening in this county and it's happening throughout the world.

What are the causes of the overweight and obesity epidemic? Well, the fundamentals are pretty simple. You know, obesity is caused by more energy intake in excess of energy expenditure. The bottom line is we don't move very much and as we get older, meaning we move from childhood to adulthood, we move not much at all. I mean remarkably little. Like, look at what we're doing here, right? The daily energy imbalance driving the epidemic for kids is pretty small. It's just about an extra 100 to 150 calories per day. An extra sugar sweetened beverage per day. That's the average weight gain among kids. To become obese, it's much more, it's an extra 600 to 1000 calories per day. Of course, the social context is really important. If we make it really simple for people to be drinking sugar sweetened beverages all day long, well it will happen. So, here's our little picture of, that guy on the right, you when I was growing up around Chicago, I was actually born in Englewood, and grew up in Maywood, I never saw anybody walking along this street, and now you see it all the time, right? How'd we get here? Okay, here's where it's not really rocket science, okay. What are the important forces driving the epidemic? I'm kind of showing you some cartoons and telling jokes, but this is serious stuff and there is good science behind all this stuff I'm talking about. I could go into it if I had more time.

Food producers in the fast food industry, if they're all successful we all eat more. They make money, we spend more and more of our day consuming. You know, you can eat all times of day now, right? You can eat in your car, you can eat walking along the street. They've been good at this. It just makes it real easy. I kind of like this cartoon. These are a couple of Chinese citizens going, like "Let me get this straight, the U.S. is claiming our food exports are unhealthy?" I don't know if you have been to a lot of foreign countries, like I was in Beijing, where there are 110 McDonalds, in Beijing, you see exactly the same ads on TV from McDonald there. KFC is big. It's all over the world. We have exported this, as

well as all of our beverages, you know the Pepsi-Cola and Coke, all over the world and believe me this stuff really helps drive this obesity epidemic. It's not made up. It's not that simple, but sugar sweetened beverages are actually a really big, a really big component of this. Actually, most people are really confused about it. You know, I mean one of the things that really strikes me is that I talk to so many parents and they think their kids need a sports drink to play a sport. You know, sports drinks are sugar, water, and a little salt. Kids don't need the salt, they don't need the sugar, but they need the water. But, parents think they need a sports drink because of the advertising. It's one of these remarkable things. This is a chart here just showing, it's a recent publication of ours... you can't make out a lot of the details. But, the average high school kid is consuming like 300, 340 calories a day of sugar water. How did we get here? This consists of number one down here are the sodas and these are the fruit drinks. Sports drinks are kind of small in here, but the fastest growing category. A lot of sugar water. It is directly linked to obesity in adults and kids and we believe all this stuff, you know that, "Oh yeah, the major league baseball players drink Gatorade, maybe I should drink that too." They are paid millions of dollars. Major League Baseball actually forces major league baseball players to drink water out of Gatorade containers. It's true. The other important force is television, video film production and distribution industry. Their goal is to get us spending a lot of time in front of screens watching the ads for this kind of food and beverage that we then consume. We've calculated that for each additional hour of TV viewed kids consume an extra 100 calories. It's not rocket science. Why do you think they spend billions and billions and billions on advertising? Because it works. How can TV cause this?

Well, we can think about it could be the inactivity, spending a lot of time watching TV or doing other screen things. We've studied internet use, gaming and everything, and TV is actually the worst. But, actually the biggest component is dietary intake. It's the advertising. It really does work. It's true for adults. It's true for kids. We tend to think of it as a kid problem. There are hundreds of studies now throughout the world actually showing the same relationships. But, it's an issue for adults too. I kind of like this one, the caption says, "Every few years Gordon and the TV get a couple of inches wider." It's funny, but it's true. I mean it really affects us. Don't raise your hand, but do you have a TV set in the bedroom where you sleep? Don't do that. Seventy percent of kids in the United States have a TV set in the room where they sleep. Twenty-five percent of 2 year olds have a TV set in the room where they sleep. Why do we do this? How'd we get there?

So, here are the important forces driving the epidemic and advertisers of course make this just all seem a lot of fun. I don't think we talk about the role of these industries in really creating these corporate entities, in spreading a lot of poor information, bad information, wrong information, and creating unhealthy lives for our kids and for adults. The consequences here with obesity are that there is clear evidence for cardiovascular disease, risk, diabetes, adult obesity, and cancer if we think of childhood obesity. We don't really know the magnitude of these effects as we grow childhood obesity and then adult obesity because we've never been here before. The studies that talk about the mortality effects related to obesity are generally based on people that became obese in adulthood, not in childhood, because it's been so recent. We don't really know the consequences, but it's not good. So, what can we do about it?

Actually, we have pretty limited evidence for effective treatment of overweight and obesity. I'm glad Bernice brought up the fact that don't be afraid of DNA and the human genome project because there's actually some really important stuff to learn there. You know, like once you grow fat cells they're really hard to get rid of. They kind of stay with you the rest of your life, and it really makes sense to try and prevent obesity by not having kids become obese in the first place. We've got to realize this. There's pretty good science on this now and do something about it. Talk about prevention. It's not about treatment. Prevention. I mean there's some preventive actions that can make a difference, but what we really want is primary prevention. Far upstream. The causes of the epidemic are rooted in the success of the food and beverage, television, video games and advertising industry and our low levels of physical activity.

Okay, what's the good news? We have some scientific evidence that you can make some differences. I really think we have to think about how to make policy an environmental change in all the kind of settings where kids really spend their time. I'm focusing on kids here but you can apply it also to adults. You know, neighborhoods, schools, work sites, healthcare settings. But then if you think about it, if you want to make these kind of changes and help policy changes, regulatory changes, you've really got to work with community partners. I think that's the main theme I wanted to have today is to encourage you, and I know a lot of sociologists do this, you know, start working with more community partners. Don't spend all your time doing this. You got to do some good theory. Do some good quantitative work where you step back and try and really get the science right, but you've got to spend a lot of time working with community partners too. What we do at our prevention research center is we've had to look for the inner section of effective strategies or evidence for effective action. Like, I think it was in 2001 we did a paper in *The Lancet* that really identified sugar

sweetened beverages as really important for childhood obesity. We've been working with community partners since then and one focus is the schools, you know, where you can make a little difference there. You can actually get sugar sweetened beverages out of schools. It's a big political fight. Only about 10% of kids' consumption of sugar sweetened beverages occurs in schools, but it's a good place to start.

And there's just the most bizarre examples... we were just in Wisconsin recently, in Madison, in fact where I graduated, and I was talking to a couple public health people there. They told me that they could identify a number of high schools in the state where the principals of these high schools had shut off all the drinking fountains in the school. Why would that be? Because they could make more money from the soda machines. Really bizarre stuff.

Okay, so how do we think about strategies here? Well, one theory is really important. And, here's where sociologists can really help. A big thing in public health now is to think about broad social ecological models in thinking about multilevel policy of environmental strategies. Some of this stuff is really simple, like regulatory stuff and some is big policy. In the state of Maine there were just a few meetings with folks at the state level, and they decided just to do a statewide regulation. They pretty much eliminated most sugar sweetened beverages in schools. You know, pretty quick change can be made and at other times it's much more complicated and takes a long period of time. Clearly, evidence is really important. We've talked about, I think Rob was talking about really getting an efficacy in effectiveness studies. The other issue that's really important, and he pointed that out, is — what's sustainable? You could have lots of studies come out of NIH where you have evidence of efficacy but whether or not they're sustainable, they're too expensive, whether or not really realistic. They weren't really developed with community partners to show that they can really be sustained and make a difference. And then there's the issue of cost. They can just be too expensive. So, cost effectiveness is really important too. More than anything else, I think community partners are really important. You can't really understand communities unless you work with community members. Community-based participatory research, Barbara Israel has written about this, is one approach that's really useful. If you're not familiar with it, there was a nice ASA session this morning that the ASA office put together. It's really useful. All the prevention research centers actually funded by the CDC, like we are, engage in some form of participatory research with their community partners. The CPPR model is one model, but there are lots of others. You can develop your own. A lot of people are doing work like this already. It's really valuable. You learn a lot from your community partners. They're the experts on their communities. You can give

them a lot of your science and there's a great interchange. It can take a long time. I'll tell you a story or two as we head forward.

The broad vision around our work as prevention research center and I think I've heard a few people say this, it's not just individual choice. We focus on social, behavioral, transdisciplinary approaches to improving nutrition, physical activity and reducing chronic disease and overweight. It can be really simple stuff, like right now we're trying to figure our ways to get water in the Boston Public Schools. One-hundred thirty schools do not have a working drinking fountain. There were issues of lead in the water. It seems kind of practical stuff, but it's really important. We work with our community partners in all of these processes in many different settings.

Here is a preschool setting. I just love that picture. We worked with the Baltimore Public Schools for about 5 years and developed *Eat Well and Keep Moving*. It's now actually being used in all states of the United States and about 20 different countries now. It's a curriculum for primary grades. We developed *Planet Health* as a middle school interdisciplinary curriculum, and we were effective at reducing obesity, reducing TV time, it's actually not that hard. The cool thing about *Planet Health* is that actually some economists did a cost effectiveness study. Because it's something that can be taught in a lot of classrooms, math, science, language arts, social studies, P.E. and you can use existing teachers, it is pretty inexpensive. We learn that by talking with the teachers and principals and superintendents, and they said don't make us hire somebody or don't just give us someone to teach it for a year, but rather make it work within our system. So, it was inexpensive and that makes it cost effective. It can be disseminated and sustained. Actually, one of our community partners actually spent a few million dollars to spread it to most middle schools in the state of Massachusetts. It's now being used in 20 countries.

We did some really interesting work with Play Across Boston, a big community initiative with a bunch of our partners there, where as part of that we documented how parts of the city in these communities here had much poorer facilities for physical activity for kids, poor quality playgrounds. It took about two years to really get the study going. We had to negotiate with the mayor's office for about a year and a half to get him to present the results, but then he took ownership of it. So, it was about a five-year process, but I really think it helped make a difference within the city because everybody now realizes that these disparities exist. He took ownership, and said "We've got to make some changes" and they actually did improve the quality of the parks in these areas over here, but it was a long process. The community partners were really critical. Actually, they demanded that we rate the quality of all the playgrounds because

they knew that there were big disparities and so we changed our whole design to take that into account. We've worked with Boston Steps, the Boston Public Health Commission, and actually on evaluating a policy change in the Boston Public Schools, in the high schools they eliminated all sugar sweetened beverages, it was actually all the schools but we have data from the high schools and we actually saw a nice drop over time in kids' sugar sweetened beverage consumption. At the same point in time we had no evidence that there was any change happening nationally. And that's just about the change you'd expect. As I said, about 10% of the kids, sugar sweetened beverage consumption occurs in school.

Finally, we've worked with the state of Maine and the pediatricians up there in creating and evaluating a program called Keep Maine Healthy, which takes place in primary care practices and it is now being used in about half of the state. The American Academy of Pediatrics is now distributing these materials world wide, and again we have some very simple guidelines there and one of these is avoiding sugar sweetened drinks and the other is really reducing TV time.

So, these are the kind of things we've been engaged in with our community partners. It always engages or involves large social structural issues, walking with lots of community partners. Our vision here for the obesity epidemic or any obesity epidemic, in eliminating disparities which have been growing, is the sense that we can work with community partners and base it on the best science we have to really provide supportive environments for healthy eating and physical activity for kids and adults. But you know, unless this science is translated into action, into the diverse lives of households and children and youth, via all the channels I've talked about here - preschools, elementary schools, middle schools, high schools, afterschool programs, community programs, neighborhoods. It really has to be throughout the life course and sustained through community partnerships. You know, then the impact is just going to be trivial, and you really have to work with partners if you're going to see some big change. The coolest thing actually for me has been working with the CDC folks for the last 10 years and to see the excitement that's taking place now as a new administration has come in. It's just been amazing to see the excitement happening in DC and I think we'll see a lot more of this working with communities to make these kinds of large changes and I think there's a lot of opportunity for sociologists here to get involved and to help evaluate these kinds of changes. A lot of this stuff happens really at the large scale community level, and people need assistance. So, I do hope you can really get involved and

figure out ways to connect in this process. This is just one part of public health, but I think it's an interesting example. Thank you.

PATRICIA HILL COLLINS: I believe we have time for one or two questions. So if anyone has a question or a comment there are two mics, one over here and one over here.

AUDIENCE MEMBER: Good afternoon. I'd like to thank the panel and thank the president for convening the panel. I have a comment. I think the advice that the panel, you put together the three presentations, they're very powerful. It's very easy being in the audience to see how to integrate the advice through each of the three presentations. The comment is that clearly there is a need both, and we see this in the schools of public health, we see this among the social epidemiology community, Dr. Sampson, your work with neighborhoods and neighborhood effects and so on. There is, I think, a powerful opportunity for professional sociology, and I mean specifically the ASA, to promote a conceptual and methodological apparatus. One of the ways that the first presentation, Bernice, if I can be so colloquial, you pointed at the issue that we're in our own way. We're tangled up in our own underwear in some respects, because in our desire to be as scientific as we possibly can and given some of our biases, our disciplinary biases, we're not quick to just look at applied work. What I'm specifically referring to is the idea of social indicators. If we were to promote at a disciplinary level some measure of social indicators, notwithstanding that we'll have issues - conceptual issues, theoretical issues and so on, but put them aside to actually get behind having a sort of social indicator approach to measuring community characteristics in a sophisticated methodological way, so that we create a research infrastructure so that the individual researchers that are interested in following up... You know, we need that kind of research infrastructure to look at, to provide our scientific establishment, and I mean the policy establishment. We need that infrastructure so that we can facilitate policy evaluation and policy experiments. We need a form of big science for social science in a certain sense and this is going to take a lot of money but it's going to take professionals in this association deciding that they want to move forward with some kind of a theoretical and methodological approach to doing community level, this social, ecological kind of analysis, and to do it in a rigorous way, so we have an infrastructure of individual researchers in different parts of the country come together and do these kinds of intervention, the kind of work that really precedes the kind of interventions that we all would like to see. Thank you.

ROBERT J. SAMPSON: I fully agree. I think that that would be something that the ASA could lead in. In some of my own work I thought exactly the same thing, and I've tried and produce models for how to develop these sort of

indicators at least in our Chicago project called “ecometrics”, it’s a little jargon, but makes sense right? Sort of a metric for ecology that can lead to sort of a standardized way to think about how to measure some of these important processes that could then be used by cities, government, national, whatever. It’s sort of like a report card on context. We do this all the time for individuals. That’s the whole point, in my mind, of ecometrics or psychometrics. We’ve done it for individuals for 100 years, it’s time for context to have an equal say.

AUDIENCE MEMBER: Just to follow up Rob, what would be the governmental agency that would have a responsibility for that? I know for a lot of the indicators like that in public health, it’s the CDC’s responsibility, or HHS.

ROBERT J. SAMPSON: That’s a good question, I think that’s where organizations like the ASA can come in to help mediate that. I don’t know exactly what the appropriate... might be NSF, might be NICHD, I don’t know.

PATRICIA HILL COLLINS: It’s the big idea here that matters. I mean that’s what’s really interesting to me, because I would think there are multiple agencies; it isn’t just one. Alright. But, the point is I think it was a really important point that was made, so I want to reiterate that. I’m just gonna go from side to side until we run out of time. Yes?

AUDIENCE MEMBER: So, I thought it was a very convincing presentation about the importance of having community partners for implementation. I guess my question to the panel is, and I’m afraid I missed the first presentation, maybe it was addressed there. My question would be, how do you see the collaboration - so I have two questions. How do you see the collaboration with communities advancing the science? I don’t think I heard that so clearly. You know, can you point to some of the ways in which we as sociologists can learn from the people we work with? My gut instinct is that you’re right, they know more about what we’re studying that we do, but it’s not a commonly held view in sociology, and I would be interested in your take on that, and then secondly Rob, you talked about the neighborhoods in Chicago that changed were really ones where there had been a large level of interventions. I thought that most of your focus was really on the failure of the individual-level interventions. I’d like to hear you say some more about what kind of structural interventions you think we should be promoting, testing, thinking about. I understand you’re saying we don’t write policy, but if we are going to sort of move the policy in this direction, how do we get started?

STEVE GORTMAKER: I’ll answer the first question. Thanks. Or at least try, I think. My experience has been that working with our community

partners has been probably most valuable when we are talking about designing interventions or designing policy changes, because you really need the insights from individuals who have been in those communities for a long time to figure out what's going to work and what's going to be sustainable, what's not going to work. I think that's probably the most important level. But the measurement side, you always gain a lot insights I think, but at the kind of higher sociological science, sometimes maybe, sometimes not. I think probably at the intervention policy and regulatory change, that's where you get the most insight.

ROBERT SAMPSON: Great question on you know where do we go in terms of the structural interventions and something I'm currently thinking about a lot. For one thing in the housing area, I think there's some progress. The most recent Hope Six interventions are at a more structural level, either the housing development level, not completely the neighborhood level, but still it's not just about individuals. We can argue about the housing policies in terms of de-concentration of the high-rise public housing in Chicago as an aberrant case. I think New York City housing, for example, was never in disrepair to the extent that Chicago was, but nonetheless, there was a sense at a high- level of policy that deliberate policies of segregation and concentration were wrong and failed and there was a move made to change that. It's had a huge change and we're still figuring out what the effects are. I mean, I talked about spatial effects and we know there's probably some spillover, but my read of the data is that while there may be some residual spillover, the net effect of that has been to significantly reduce the concentration of poverty. So, I think HUD is now in business of doing research again. Right? They weren't under the Bush administration. They're now serious people, Xavier Briggs, and others there. They're listening to sociological research on how to think about community-level housing level interventions, mixed income housing is a very hot area right now, so I think there is, I'm actually very optimistic. Sociologists should be on this because HUD is listening. I think community policing is something that has been going on for awhile. There's various variants of it. Some, I think, are quite reasonable and are working, especially those that take into account local organizations, and this relates to some of the points that were made earlier. We know that in neighborhoods, for example, that are stably integrated, they usually have strong institutions behind them that are involved in institutional mechanisms to promote the durability, in this case, of integration. I think we need more of that. We need to recognize that and help sustain and perhaps promote local organizations.

Finally, I mentioned the Harlem Children's Zone, not so much for the specific policy, but the idea of infusion of resources at a multiple level from, starting with young children, education, housing, safety - these things are all

necessary for successful child development. I like that idea of an infusion of resources, so there's the positive sign there. Lastly, we can use our analysis and knowledge of how neighborhoods work to select particular neighborhoods for intervention, right? I mean in the sense that networks can be used... and this goes to Bernice's work, some of the AIDS intervention work. I mean, if you select the key actors, the brokers, the central players as information dispersers, that makes a lot of sense from a scientific perspective, and it takes into account sociological knowledge. The same thing, analogy applies to neighborhoods that have let's say brokers in a certain sense, or where there is migration flows through them, or if you want to intervene you can use the knowledge that sociologists have. So, I'm actually fairly optimistic, it's just that it's been such a drought for awhile because the administration was not interested in science, number one. Number two, it was so heavily individualistic in its approach when they were interested. So, now there's an opening and it's up to sociologists to grab what they can.

BERNICE PESCOSOLIDO: I want to follow up on that. I'm optimistic as well, but I want to make sure, I want to issue a caution because the last time that there was big interest in macro level change, say with regard to mental illness, there were two big projects mounted. One was called the Robert Wood Johnson Program on Chronic Mental Illness. The idea behind that was something that made a whole lot of sense, which is we know that there are cracks in the system and people fall through the cracks. So, the idea behind it was: if we can integrate the mental health system so the organizations that work together, not just the treatment places, but the missions and the food pantries and the social welfare agencies that work together, then that should produce good outcomes for people with chronic mental illness. The problem is that, well this wasn't a problem, this was great, they used a network perspective at the macro level and they showed that over the course of the intervention where they put in a central mental health authority, they *could* better integrate the mental health system. But in terms of looking at outcomes for individuals, they monitored a panel of individuals. But, where sociology comes in, and why I've moved to such a strong network perspective is there was no research that looked at the black box in the middle. What they found, they found no change for people with chronic mental illness, even though they spent all this money and had a successful reintegration of the mental health system. We don't know who in that panel actually had contacts into the changed organizations, whether or not they used them, and this is why I think at this point we need to have sociological perspective on a multilevel contextual approach that looks at where points of intervention can be studied and followed through in the community. The other one that did the same thing was the Access Program for the homeless persons

with mental illness. So, I think, you know the last time there was some interest in this, we took our best shot, it was a good shot, but I think we know better now in terms of understanding, looking at the social processes and structures that connect macro level change to micro level outcomes.

PATRICIA HILL COLLINS; It is with deep regret that I am going to have to announce that we have run out of time. I would like us to stop and thank our panelist one more time and continue with your questions individually. Thank you.