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## SOCIAL CAPITAL AS A HEALTH ASSET FOR YOUNG PEOPLE'S HEALTH AND WELLBEING

### O CAPITAL SOCIAL ENQUANTO "TRUNFO PARA A SAÚDE" QUE CONTRIBUI PARA A SAÚDE E O BEM-ESTAR DOS JOVENS

Antony Morgan<sup>a</sup>

**Abstract:** Investing in the health and wellbeing of children and young people is essential for the success and sustainability of future generations. We already have much knowledge about the many factors that can impact on their ability to deal with the different pressures that they face from very early years to mid-adolescence. These factors relate to their own genetic susceptibilities to achieving health, to their family, to their environment (particularly school) and life events. Early to mid adolescence marks a particularly difficult period when young people have to deal with considerable change in their lives such as growing academic expectations; changing social relationships with family and peers and physical and emotional changes associated with maturation. The question is therefore how do we provide them with the optimum conditions to be able to understand, make sense and deal with these situations as they arise.

The idea of 'health assets' has emerged recently as one way of focussing the minds of researchers, policy makers and practitioners on the best ways of doing this. Essentially, a health asset can be defined as any factor which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing. The argument then being that the more opportunities young people have in childhood and adolescence to experience and accumulate the positive effects of these assets that outweigh negative risk factors, the more likely they are to achieve and sustain health and mental well-being in later life.

The concept of social capital can be seen as a 'health asset' as it has already been identified as a 'resource for societies, contributing to a range of beneficial economic, social and health outcomes. However there is work to be done to understand how best to apply it to the health and wellbeing of young people. The pros and cons of the concept have been well rehearsed in research regarding its utility for adult health and

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therefore this paper seeks to apply that learning to a young people's wellbeing agenda. In doing so it sets out a building block framework for policy research and practice to refocus their energies into evidence and programmes that help build the skills and competences required by young people so that they can seize the opportunities for healthy and successful lives.

**Resumo:** O investimento na saúde e bem-estar das crianças e dos jovens é essencial para o sucesso e a sustentabilidade das gerações futuras. Temos muito conhecimento sobre os diversos factores que podem ter impacto sobre sua capacidade para lidar com as diferentes pressões que enfrentam na infância e adolescência. Estes factores estão relacionados com as suas próprias susceptibilidades genéticas para ter uma boa saúde, com a sua família, com o seu meio ambiente (especialmente a escola) e com os eventos de vida. A fase inicial e intermédia da adolescência marcam um período particularmente difícil no qual os jovens têm de lidar com mudanças consideráveis nas suas vidas, tais como as expectativas de crescimento académico; mudanças nas relações sociais com família e amigos e mudanças físicas e emocionais associadas à sua maturação. A questão é, portanto, como podemos dar-lhes as condições óptimas, a capacidade de compreensão, a competência de gestão das situações à medida que vão surgindo.

A ideia de um "trunfo" ou um recurso para a saúde surgiu recentemente como uma forma de focar a mente dos investigadores, decisores políticos e profissionais sobre as melhores maneiras de o fazer. Essencialmente, um "trunfo" ou um recurso para a saúde pode ser definido como qualquer outro factor que aumente a capacidade dos indivíduos, comunidades e populações para manter e melhorar a sua saúde e bem-estar. Daqui se conclui que quanto mais oportunidades os jovens tiverem durante a infância e adolescência de experimentar e acumular os efeitos positivos desse capital de saúde, melhor superam, mais tarde, os factores de risco negativos e maior capacidade têm de manter e melhorar a saúde e o bem-estar mental.

O conceito de capital social pode ser visto como um "trunfo para a saúde", visto que já foi identificado como um "recurso para as sociedades, contribuindo para uma série de resultados benéficos a nível de económico, social e de saúde. No entanto, há trabalho a fazer para entender a melhor forma de o aplicar à saúde e ao bem-estar dos jovens. Os prós e contras do conceito têm sido bem analisados na investigação sobre a saúde do adulto e, portanto, este trabalho visa a aplicação dessa aprendizagem ao campo do bem-estar dos jovens. Ao fazê-lo, estabelece uma estrutura para a investigação e prática de políticas que reorientem as suas energias para o conhecimento e para programas que ajudem a construir as competências que os jovens, precisam para que possam aproveitar as oportunidades para uma vida saudável e bem sucedida.

## **Social Capital as a Health Asset for Young People's Health and Wellbeing**

### **Introduction**

Social capital has the potential to be a resource for societies, contributing to a range of beneficial economic, social and health outcomes. The concept of social capital has emerged as an idea which can help us further articulate the relationship between health and its broader determinants. However, its successful practical application to real life situations has been hampered by an over indulgence in the academic literature debating its definition, its value as a concept and its relative importance for health over and above a range of other well established health determinants. Of course, all these things are important and need to be clarified – but this paper argues that it is more important to start with an explicit idea about why social capital might be useful for policy and practice – then the framing of specific research investigations and theoretical debates might be grounded in the real world. Given the importance and emphasis of investing in early child development and life course approaches to health – particularly in the context of addressing the social determinants of health (Irwin, 2007) – this paper focuses on the health and wellbeing of young people as a means of articulating a better framework for social capital research in the future.

Much of the evidence accumulated on social capital over the last 10 years and the subsequent deliberations about its usefulness as a health related concept have occurred in the context of adult health (Kawachi, 1996; Gillies, 1997; Kawachi et al., 1997; Cooper, 1999; Lindstrom et al., 2001; Morgan and Swann, 2004). Disciplinary territorial wars and debating points aside, this literature points towards social capital or at least its underlying constructs (for example social relationships, levels of trust, group membership and civic engagement) as being beneficial for health across different ethnic groups, generations and gender. However, the exact relationship between different indicators of social capital and different outcomes vary and some authors suggest that whilst the indicators of social capital have some predictive value for health, when socio-economic status is taken into account this relationship is considerably weakened (Mohan, 2004). There remains a question therefore as to whether the findings from the current evidence base are a function of our inability to properly, conceptualise, define and measure the concept, or at least be consistent as how these things are operationalised in research studies. Social capital research on young people's health was later to develop but in the main has followed a similar pattern to the adult health literature, showing some benefits for health (Morgan and Haglund, 2009; Zambon et al., 2010) but with continuing lack of consistency over definition and measurement issues, thereby making synthesis of the available evidence difficult.

The majority of studies in both the adult and young people's literature have been carried out using either ecological or cross sectional study designs to investigate the associations between the indicators of social capital and a range of mortality, health and behavioural indicators. Unfortunately therefore, despite the vast growth in social capital related studies, there remains little empirical evidence to advance our understanding of the exact mechanisms through which investments in social capital can achieve improved and sustained health status. This seems therefore to be our next task – however a further proliferation of research that does not pay attention to the theoretical basis upon which social capital is based will not achieve this. There is an opportunity for those interested in the health and wellbeing of young people, to seize the moment and take the lessons learned from the research accumulated to date, in order to build a better framework for organising and making more explicit why and how social capital has the potential to secure the healthy development of young people.

This paper sets out a framework for how this can be achieved. It places, social capital as a potential 'health asset' – that is any factor (or resource), which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being (Morgan and Ziglio, 2007, Morgan, Davies & Ziglio, 2010). In doing so, it embraces life course approaches to young people's health (Graham, 2004) and argues that the more we invest in social capital and its related constructs early on in life, the more young people can experience its positive effects within their families, from their friends, at school and in their local neighbourhoods and communities. The notion also fits with the goals of the Commission on the Social Determinants of Health (CDSH, 2008) which highlights that finding the best ways of promoting caring and responsive environments that protect young people and which create opportunities for them to explore their worlds is key to minimising the risks of unequal experiences of health in later life. In this respect it firmly places social capital in the context of the health inequity agenda, as Marmot (2009) argues that reducing inequities require actions that give every child the best start in life and that enable all children and young people to maximise their capabilities and have control over their lives. Recently, Morgan and Ziglio (2007) have argued that asset approaches may provide one means of unlocking some of the barriers to current approaches to tackling inequities in health by focusing on the capabilities and strengths of individuals and communities rather than identifying problems, needs and over reliance on health services. Given that the latest international report of the WHO Health Behaviour in School Aged Children (HBSC) (Currie et al, 2008) summarised that there are strong and consistent associations between family affluence and the health of young people across 39 European countries, USA and Canada, the need to think about asset approaches as an investment for young people's

health is currently an opportunity to contribute to alleviating these unfair differences. Given that social capital has been identified as one means of reducing health inequities, framing it as a health asset for the promotion of young people's health and wellbeing might allow us to overcome some of the conceptual, definitional and measurement issues associated with the concept to date.

### **Social capital as a health asset**

Happy and confident children are most likely to grow into happy and confident adults, who in turn contribute to the health and well-being of nations (*Rao, 2001*). Emotional health and well-being in young people have implications for self esteem, behaviour, attendance at school, educational achievement, social cohesion and future health and life chances (*Olweus, 1991*).

Young people with a good sense of well-being possess problem-solving skills, social competence and a sense of purpose, which can be utilised as health assets that can help them rebound from setbacks, thrive in the face of poor circumstances, avoid risk-taking behaviour and generally continue on to a productive life (*Scales, 1999, Morgan et al, 2008*). So how do young people acquire these skills? At one level, we have a multitude of research that has been gathered over many years about some of the individual aspects, precursors, or determinants of young people's health and wellbeing. But it is the work of the Search Institute ([www.searchinstitute.org](http://www.searchinstitute.org)) that most reflects the idea of identifying the key health protective and promoting factors which provide young people with the best possibility of growing into healthy, caring and productive individuals. They have identified 40 development assets which they see as fundamental to positive youth development. The idea being that the more we can provide young people with opportunities to experience and accumulate the positive effects of a range of health assets, the more likely they are to achieve and sustain health and wellbeing now and in later life. The development assets so far identified by the Search Institute include: family dynamics, support from community adults, school effectiveness, peer influence, values development, and a range of specific skills and competencies required for young people to thrive. These assets grow out of 3 types of applied research – positive youth development, prevention and resiliency (*Resnick, et al., 1997, Lerner et al, 2003, Benson et al, 2006*). The assets identified are derived from well known fields of knowledge about their effects on health, however there is still a job to be done to understand: the precise mechanisms or pathways which operate between these assets and health; whether some assets are more important than others; how the cumulative effects of different assets benefit young people as they grow up; and how different social and cultural contexts impact on the benefits of them. Answering these questions

certainly requires a refocusing of hypotheses to ask what creates health and wellbeing rather than what reduces the risk of disease and may require different methodologies and research techniques to really understand the underlying reasons why some young people thrive and sustain health even when coming from similar social and economic backgrounds.

Placing social capital in the context of an asset approach to public health helps to ward off the criticism by some that social capital has its 'dark side' (Portes and Landolt, 1996) – i.e. the notion that strong social networks associated with bonding social capital (Putnam, 2000) are not necessarily conducive to community or individual health. In some cases such as the Mafia or teen gangs – social capital can be used as a resource for social control, effectively excluding certain individuals or parts of the community. In the context of an asset model for health, social capital provides an opportunity for young people to be seen as active social agents, who shape the structures and processes around them (Moore, 1999). This fits with the commitment made by recent policy documents (WHO, 2005; DH 2009) to involve young people in the health development process – social capital in this instance supports the possibilities for encouraging positive citizenship and participation in their formative years.

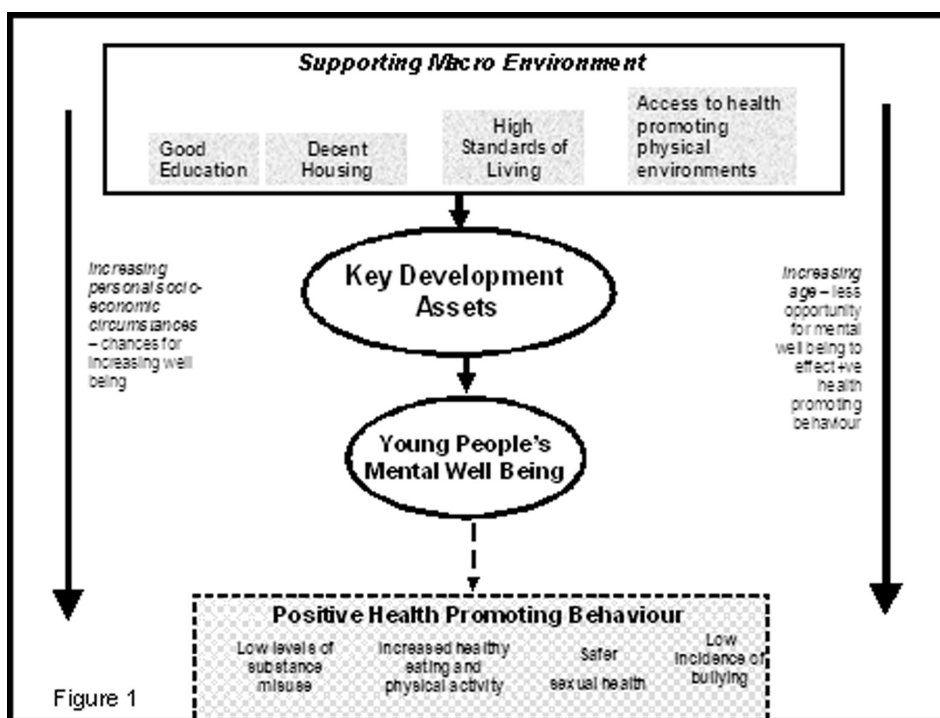
### **Risk and Protective factors for Young People's wellbeing**

It would be naive to think that asset based approaches, could remove all the risks that are associated with young people growing up and indeed some risks are the very things that help to build young people's resilience which helps them cope with the difficulties that they may face in everyday life.

The idea of risk and protective factors can help us understand the likelihood of young people being able to achieve their full health potential. There are many new pressures and challenges for young people particularly in early to mid adolescence. They need to deal with considerable change in their lives at this time: growing academic expectations, changing social relationships with family and peers and physical and emotional changes associated with maturation. Many factors have an impact on children's ability to deal with these changes: factors specific to the child, to their family, to their environment (particularly their school) and to life events (Currie and Todd, 2003). The protection afforded by health assets, can be offset by a range of well known risk factors, including poverty, child abuse, early parental loss and family conflict, parental substance misuse and living in high-crime neighbourhoods. The strength of evidence on risk and protective factors for health and wellbeing varies, but social and economic factors which support warm, affectionate parenting and strong child/carer attachment are particularly significant. Strengthening protective factors in schools,

in the home and in local communities can make an important contribution to reducing risk for those who are vulnerable (Rutter and Smith, 1995, Fonagy and Higgitt, 2000, Heijmens et al, 2000) and in so doing promote their chances of leading healthy and successful lives.

Figure 1 shows how the idea of risk and protection can be articulated to form an analytical framework which allows a more systematic approach to research which identifies the most important assets for the health and wellbeing of young people. It can be used to understand two main strands to the jigsaw. Firstly, it is important to identify in isolation the most important assets for health and wellbeing, defining them precisely and understanding the measurement issues involved in using them to explore health processes. Then we can conduct a range of analyses which make an assessment of their relative importance against the range of risk factors known to influence young people's propensity for health and wellbeing. Secondly, we can start to explore the inter-relationships between the health assets identified and set up studies which are able to detect the point at which the build up of protective factors reduces the likelihood of young people engaging in risk taking behaviours. Social capital as a potential health asset needs to be tested against this framework.





## **Social capital: an analytical framework for exploring the precursors of young people's health and wellbeing.**

As has already been mentioned, studies exploring the links between social capital and health started to appear in the mid 1990's, and continued to grow in number during the first decade of the 21<sup>st</sup> Century. The vast majority of these studies explored social capital's importance to adult health, although youth studies started to appear in the latter half of this first decade. Whilst the general direction of this research suggests that social capital has a role to play in young people's health development (Ferguson, 2006, Boyce et al., 2008, Morgan and Haglund, 2009, Dallago et al, 2009, Zambon et al., 2010), in the main it has followed the path of adult focussed research with lack of due attention to conceptual and theoretical consideration. A more systematic evidence based approach can only be developed if these issues are resolved or at least made explicit and more attention is paid to a consistency of approach to the definition and measurement of the concept. More importantly, this evidence base needs to be driven by an understanding of the endpoint – the reason why you want to apply social capital to public health practice. Selecting social capital as a potential health asset for young people provides an opportunity to identify the reason 'why' the concept is of interest and helps to build a framework which supports the better empirically testing of possible the mechanisms through which social capital acts to produce health and wellbeing.

There is an opportunity for young people's research on social capital to advance much more quickly if it takes note of the learning accumulated so far from the adult field. This learning permits us to start the development of an organising framework for social capital research. The first four building blocks of this framework are: perspective, type of social capital, context and indicators (see Figure 3). These have all been identified in the literature as important in unravelling the complexity of social capital and in understanding the rationale for its use.

### *Building Block 1 – Perspective*

Firstly, as stated above we must be clear about why we are interested in the possibilities of social capital to help us attain and sustain health and wellbeing so that research can be more easily translated into practical application. Szreter and Woolcock (2004) identify three perspectives: social support, inequalities and political economy. The social support perspective focuses more on the importance of informal networks for facilitating better access to information and services leading to better possibilities for health; the inequalities perspective argues that widening economic disparities have led to a breakdown in social justice and

inclusion; and the political economy perspective sees poor outcomes as the socially and politically mediated exclusion from material resources. Of course, Szreter and Woolcock argue that these are not mutually exclusive but being clear which perspective is of relevance to the context within which researchers are working provides a better chance for us to understand the precise mechanisms with which social capital works to produce health. From the point of view of young people's research into social capital, this paper argues that the 'health asset' approach provides an additional perspective as one of its central principles is to see young people as 'social agents' and to provide opportunities for them to be involved in all aspects of the design, development and implementation of programmes set up to promote health and wellbeing (Moore, 1999, Morgan and Ziglio, 2007).

These perspectives help us make sense of the varying definitions of social capital (Bourdieu, 1986, Coleman, 1988; Putnam, 1995) and help us move beyond academic territorial wars towards finding ways of applying social capital in practice. Those willing to move beyond their disciplinary traditions will then not disagree with the notion that the common thread in all definitions relates to the importance of positive social networks of different types, shapes and sizes in bringing about social, economic and health development between different groups, hierarchies and societies. Adding the first building block of 'perspective' may then allow us to ask better research questions towards better explanations of how the world of social capital works to produce health and wellbeing in different contexts

### *Building Block 2 – Type*

The second building block for social capital research is that of 'social capital type'. So far, these have been identified as bridging and bonding social capital (Putnam, 2000) and more recently linking social capital (Szreter and Woolcock, 2004). Bonding social capital is characterised by the internally focussed strong bonds held by groups of similar ethnic groups, families or communities of interest. As Putnam describes it, 'bonding social capital links you to people just like you, the same gender, or age, or race. These sorts of links are good for some and not for others'. At the community level particularly in diverse multicultural communities, levels of social capital may be high within groups – but less so across groups – which can sometimes lead to tension and adverse outcomes. Bonding social capital in some cases may not be conducive to community health as it is used as a resource for social control – effectively excluding certain individuals or parts of groups or communities. Bridging social capital in contrast to bonding social capital captures a range of less strong bonds, which are more outward looking between and across groups, friends or

businesses. In this instance, individuals may foster ties with people unlike themselves – most likely from different races or generations. It is argued that this type of social capital is more likely to foster diverse democratic societies. The emergence and articulation of bridging and bonding social capital might also be particularly relevant to thinking about young people's health and wellbeing as we can't assume that they occupy the same 'spaces' as adults (Morrow, 2000). The third type of social capital acknowledges that for the development of good community health, there needs to be a range of positive connections between members of local communities and the institutions that govern them. Linking social capital refers to the relations between these groups and the potential to break down the power imbalance that might exist between groups in different social strata. 'High linking social capital' communities build the capacity to involve the local people in decisions which affect their lives, facilitating the leverage resources, ideas and information from formal institutions. This type of social capital is more likely to be relevant to the political economy as it brings state – society relations and power into the social capital equation (Szreter and Woolcock, 2004). The health asset perspective argues that linking social capital is also important for young people's health and wellbeing as it recognises that whilst there maybe limits as to how much they can participate in democratic society, there is a responsibility to find ways of them being involved in formal and informal decision making within the contexts they reside particularly at school but also within their local communities.

### *Building block 3 – Context*

So if we are clear on the perspective and the type of social capital we are interested in – then we can proceed to the third level of the framework – that is the recognition of context and the idea that young people may access stocks of social capital within the family, at school, amongst peers and in the neighbourhood. Again, each of these are not mutually exclusive and all are important – some may be more or less important at different stages in young people's development and a lack in one context might offset the benefits from another. From a health assets point of view the earlier young people experience and accumulate social capital (seen in this context as a protective factor for health) – the more likely they are to be able attain and sustain health and wellbeing throughout their life. The emergent research on social capital and health is clearly helping us to further understand these contexts. However, there are 2 issues that need to be addressed if we are to move forward towards a more systematic evidence base for social capital and its links to health and wellbeing. Firstly, there needs to be more recognition that social capital is a dynamic concept and levels of social capital for individual or community health may

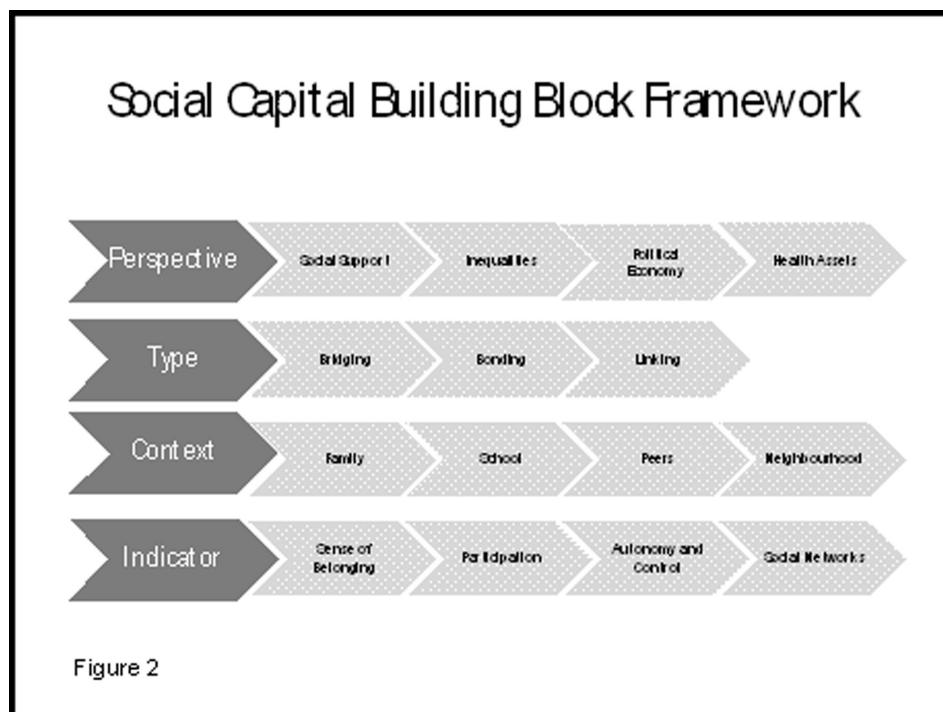
change and vary over time. With respect to our third building block of context, research is required to ascertain the relative importance of family, school, peers and neighbourhoods and the relationship between them. The second issue relates to our fourth building block – indicators – this has been specified in the framework as it is one of the most fundamental pre-requisites of our ability to produce a good evidence base – precise and valid measurement of the concept is crucial to making social capital a practical reality.

#### *Building Block 4 -Indicators*

Our ability to build an evidence base that establishes the importance of social capital as a health asset for the promotion of health and wellbeing relies on good measurement of the concept and its associated constructs. Measurement of social capital to date has relied on the use of social surveys, measuring individual perceptions of the quantity and quality of social networks, feelings of safety and trust in neighbourhoods and the willingness to engage in a range of informal and formal activities. There are now numerous guides which support researchers and practitioners carry out surveys with reliable measures of social capital (Coulthard et, 1999, Inkles, 2000, Harpham, et al, 2002). They describe a series of principles which help to guide the measurement of social capital through surveys and show that it is possible a to develop meaningful set of standard indicators of social capital through surveys. Most studies on young people's social capital have used and adapted these guides – all but all few (Morgan and Haglund, 2009) have made any attempts to provide any theoretical background to the rationale for the selection of various social capital indicators. A lack of theoretical underpinning is the main reason for the lack of progress in the better development of valid measurement and importantly a framework for our further understanding of how social capital works to produce health outcomes. That said, there is enough literature around to establish a detailed taxonomy and framework, that seeks to categorise a series of indicators which when mapped together can be recognised as predetermining factors associated with social capital – proxy indicators of social capital or events which occur as a result or consequence of social capital development. This will allow us to avoid confusion in future research as to the most appropriate measures to be used in testing different hypotheses

Building block four encourages us to deal with both the development of valid measures to isolate the underlying constructs of social capital (including the different types – building block 2); and to understand how they operate together in different contexts (building block 3), depending on the particular perspective (building block 1) that is being taken to achieve young people's health and wellbeing. Indicators of social capital that relate to young people may

or may not be the same as those already identified for adults but a better categorisation of them before any research is undertaken to examine their links to health and wellbeing will go some way towards producing a more consistent and comparable evidence base as researchers investigate the idea in different country and population contexts.



Morrow's (1999, 2000) early conceptualisation of social capital as it relates to young people remains a valid starting point for this categorisation – although a more thorough review of the research on young people and social capital would help us develop this further. In the meantime she suggested the following areas for further investigation:

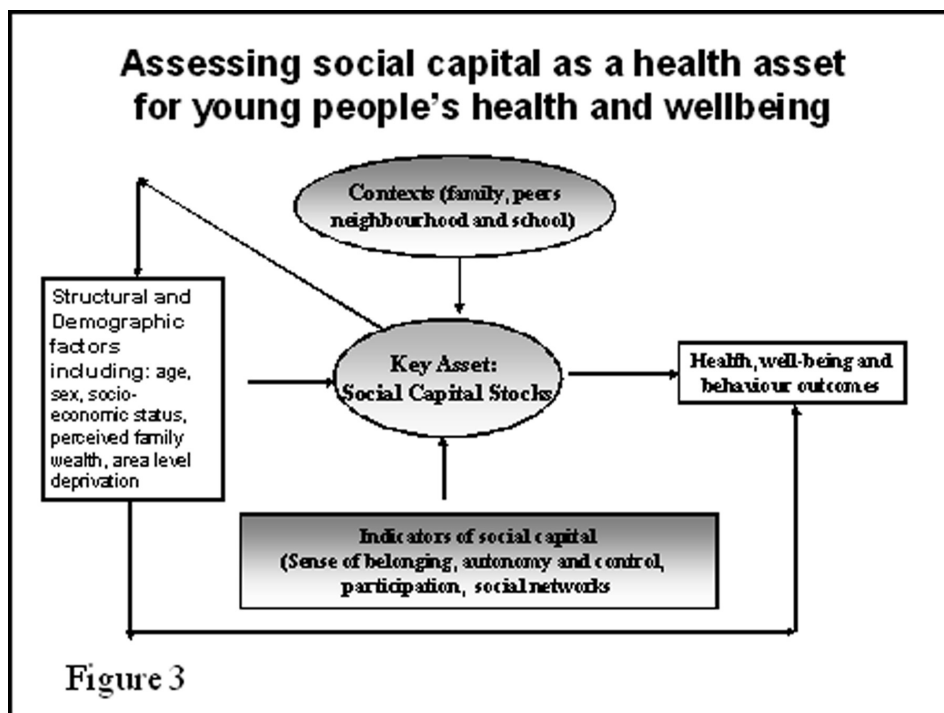
- Social networks: what is the composition, durability, ease of access to and frequency of use of young people's social networks? How are these networks defined and what do these networks provide, and how does this differ according to age and gender? What does friendship mean to this age group?
- Local identity: Do young people have a sense of belonging and identity with their neighbourhoods / communities / schools and do they feel safe in neighbourhoods?

- Attitudes to institutions and facilities in the communities: what physical spaces, such as parks, streets, leisure centres, clubs used for social interactions, are available to use and used by young people?
- Community and civic engagement: to what extent do young people engage in local community activities? To what extent do they feel they have a say in community and institutional decision making?

Essentially, these questions are useful in testing our assumptions about the context of young people's lives and importantly the relevance and interpretation of the definitions of social capital put forward by various authors. For example, she found that young people put great importance on their interpersonal networks based on friendship and family to secure their sense of belonging and well-being. In contrast membership of formal community networks and associations appeared to be very limited and therefore immediately less important. Similarly, experiences of their neighbourhoods differed according to gender, in that girls did not feel safe in their neighbourhoods; ethnic background (e.g. unpleasant episodes of racial harassment were reported by boys and girls from minority ethnic groups), and age (e.g. younger children reported a lack of suitable places to 'play', older children reported a lack of satisfactory places to socialise). Morrow also found that from the perspective of young people, school is an important 'community' in its own right, although there seemed to be a feeling of limited efficacy and participation in decision-making in their schools and even more so in their communities.

Developing appropriate indicators to examine the influence of social capital on young people's health and wellbeing does not require us to start from a blank sheet of paper. We need only in the first instance to re-examine and review the literature that has already been accumulated and to reassemble into a more systematic framework using the building blocks suggested in this paper. If we can do this then we have more chance of being certain about the true relationship between social capital, health and wellbeing and how it can operate as a protective factor mitigating the harms associated with well know risks (see figure 3).

Two major sources of knowledge to help with the identification and measurement of indicators of social capital are worthy of note. Firstly, the work of the Search Institute ([www.searchinstitute.org.uk](http://www.searchinstitute.org.uk)) and the development of their 40 development assets illustrate the types of indicators that need to be considered in thinking about the health and wellbeing of young people. The external assets they identify relate to the family and community factors that are protective of young people's health and wellbeing and are closely related to the concept of social capital. The internal assets including such phenomenon as social competence, adaptability and problem solving skills may help to understand



some of the intermediate outcomes that link social capital to health. The work completed by the Search Institute helps us to start the process of building the taxonomy of indicators required for investigating social capital from a positive perspective – closely related to the health assets perspectives in the building block framework.

The second major source of knowledge is the WHO collaborative cross-national Health Behaviour in School-aged Children (HBSC) study which over the last 25 years has accumulated evidence that provides insights into how to promote the health and well-being of young people, particularly by looking at the social contexts in which they live, learn and play. The study has put forward a set of indicators (not necessarily labelled as social capital) that can help us assemble a set of valid measures that can be used to test the links between social capital and health and the refinement required if future studies are to adhere to the building block framework highlighted in Figure 2.

Here we provide a few examples, of how these measures have been articulated and the evidence of their links to health.

## At home

It is well known that positive parenting can act as a buffer against adversity, such as poverty or peer pressure, and as a mediator of damage in child abuse (Stewart-Brown, 2002). Parents have a key role and an opportunity to do this at a very early age to provide young people with the social support they need to develop the confidence and self-esteem to manage the world they live in. So what does the HBSC study tell us about the most important family factors to the health and wellbeing of young people?

Firstly, HBSC consistently confirms that good communication at home is an important predictor of young people's health and wellbeing. Better communication with both mothers and fathers is associated with higher self-rated health for both boys and girls, and this pattern is consistent across many countries (Pederson *et al.*, 2004). In Italy, Zamboni *et al.* (2006) found this association declines with age as young people begin to rely more on friends for social support. They also found some evidence to suggest that young people from wealthier families are more likely to find it easy to talk to their fathers, although there was no difference in relation to mothers. In all age groups and across all countries, young people find it easier to talk to their mothers rather than to their fathers.

Good communication in the home is likely to foster a sense of family belonging, a key facet of social capital and shown by Morgan (2006) to be an important in securing health and wellbeing of young people.

Data from Ireland confirm the associations with good parental communication and high levels of life satisfaction, happiness and infrequent subjective complaints. Molcho *et al.* (2007) found that the accumulation of support from parents, siblings and peers leads to an even stronger predictor of positive health: the higher the number of sources of support, the more likely it is that the children experience positive health.

Pederson *et al.* (2004) found that young people who live with both parents are more likely to perceive their health as good or excellent than those who live with a single parent or step family. There is, however, wide variation in family structures among countries and regions participating in HBSC. Less than 70% of young people live with both parents in the United Kingdom and some Scandinavian countries, but in countries such as Italy, Greece and Malta, the figure is over 90%. Different cultural and societal norms and economic factors account for many of these differences.

Maggi *et al.* (2005) argues that the definition of family is less critical than defining the characteristics of optimal early childhood environments that support child development and transcend any particular definition of the family.



## **At school**

There is evidence from HBSC to demonstrate that young people who have a positive experience at school (in terms of how they get on with their classmates, whether they feel pressured by school work and their perceptions of performing well in relation to others) are more likely to report good health and life satisfaction and suffer fewer health complaints. More positive experiences of school related to fewer subjective health complaints and self-rated health and life satisfaction for all, with especially strong gradients for girls (Ravens-Sieberer et al, 2004).

In a study of Italian adolescents, Vieno et al. (2004) found that social support from teachers, parents and peers within the school setting were important factors in improving student motivation and school satisfaction, which in turn led to positive health and well-being outcomes, although there were some gender differences.

Due et al. (2003) found in a sample of Danish adolescents that poorer relations with parents, peers and teachers in the context of school were all associated with more subjective health complaints. Patterns of parent-child relations with the school were the greatest contributors to socioeconomic differences in physical and psychological symptoms.

Results from the United Kingdom (England) 2001/2002 HBSC study lend further evidence to the theory that levels of support from parents and teachers at school and a sense of belonging at school have an important impact on young people's well-being. School factors such as being involved in decision making, getting help from other classmates and feeling safe were all significantly related to being bullied in the English study. Young people with a low sense of "belonging" in school were over 2.5 times more likely to have been bullied than classmates with high perceptions of belonging, independent of age, sex and socioeconomic circumstances (Morgan et al, 2006).

## **Peer and friendship networks**

Being liked and accepted by peers is crucial to young people's health development and those who are not socially integrated are far more likely to exhibit difficulties with their emotional health (Settortobulte et al., 2004). Interactions with friends tend to improve social skills and strengthen the ability to cope with stressful events. Gaspar et al. (2003), for example, used HBSC data from Portugal to study the effects of peer social support on levels of anxiety and depression. They found that levels increased with increasing ages, but those with better-quality peer relationships were less likely to suffer from anxiety and depression across all ages.

Having a number of close friends marks the ability to engage in close relations with others. Although peer contact is strongly associated with a number of risk-taking behaviours, it also has the potential to improve interpersonal communication, problem solving and emotional awareness and can be important for the development of protective factors.

### **Neighbourhood safety and belonging**

Runyan et al. (1998) found that the presence of neighbourhood social capital acted as a buffer against the negative effects of unfavourable (abusive and/or neglectful) environments. Their longitudinal analysis of deprived children found that those with support from their neighbourhoods were more likely to "do well" and thrive developmentally.

Some data from HBSC allow us to investigate the links between supportive and inclusive neighbourhoods and young people's mental well-being. Specifically, data explore young people's sense of local identity, belonging and safety and how much they are allowed to participate in local decision making. Most of the evidence to date comes from national analyses. For example, an analysis of the United Kingdom (England) 2001/2002 HBSC study (Morgan et al, 2006) found factors associated with neighbourhood social capital to be highly predictive of health and well-being, even after controlling for age, sex and family affluence. For example, young people who had no involvement in the local community were twice as likely to report poorer health; those who rarely felt safe in the neighbourhood were almost four times as likely to report being unhappy and twice as likely to feel low at least once a week.

Maes et al. (2005) found that perceived neighbourhood social capital had a significant effect on self-rated health independent of the socioeconomic status of parents, family affluence and health-related behaviours.

These illustrations from the WHO HBSC study highlight that much work has already been done to develop indicators of social capital that are valid across a range of country contexts, however further work is required how in develop a consistency of approach to how these measurements are used against the social capital framework outlined in figure 2.

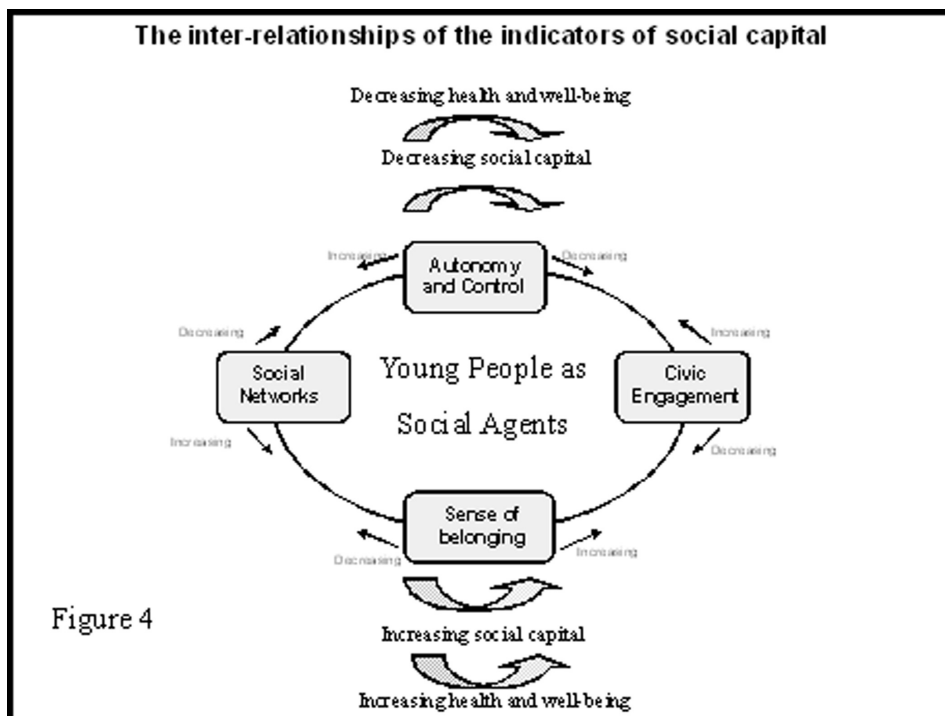
## Conclusions

Given the strong and complex inequalities that exist in adolescent health at both the national and international levels (Currie et al, 2008), a range of solutions are required to help alleviate them. Social capital has a key role to play in this endeavour. Taking the health assets perspective provides an opportunity for overcoming some of the barriers in translating the concept for practical use. If the building block framework described above is followed by future research on young people's health and wellbeing, it stands a better chance of (than has been done in the adult literature) responding to social capital critics (for example, Lynch et al., 2000) that it is more than just an old idea with a new name; that its multi-faceted nature is a strength and not a weakness; and that it has a unique contribution to make to health development and the reduction of health inequalities over and above the need to improve the material and living circumstances of those worst off in society

Most importantly, there is an urgent need to unravel the concept so that we can remove some of the tautological issues related to the evidence base on the links between the concept and health. For example, what comes first – the need for people to trust neighbours, politicians and society at large before they engage in civic or altruistic activity – or does the participation in these activities lead people to be more trusting than they would without it?; Also are those with existing low health status less able to form the relationships which lead to high levels of social capital. Further investments in longitudinal studies capable of determining the causal direction of the associations already established in the literature are required to develop the evidence base on in this important topic. However a better understanding of the links between the indicators of social capital itself would serve a useful purpose in identifying the inputs and outputs of the complex concept (see figure 4 for an example).

In this way, a taxonomy can be built that categorises a series of indicators which when mapped together can be recognised as predetermining factors associated with social capital – proxy indicators of social capital or events which occur as a result or consequence of social capital development. This will avoid confusion in future research as to the most appropriate measures to be used in testing various hypotheses.

Moving social capital from a concept with potential to a useful practical tool for action on the social determinants of health requires the development of theory or theories which make explicit the linkages between its different indicators and importantly distinguishing between those indicators that reflect the antecedents and consequences of social capital. Theory development and measurement should be inextricably linked, the one informing the other in an iterative process that balances pragmatism against the need for theoretically justifiable and useful questions.



The multi-faceted nature of social capital has proven to be a weakness so far. In the main most of the studies which have tried to investigate the links between social capital and health, have tended to utilise and focus on a particular aspect of these underlying constructs. For example, some of the earliest studies used a single measure of trust to examine its relationship to a range of health related outcomes. In this instance, the construct of trust was used as a proxy measure for social capital. Whilst this type of research is useful in providing a snapshot of the levels of social capital in our societies, it has the potential to undermine the power of the multi-faceted concept. It is the complexity of social capital that gives its strength over other concepts. However, its potential will only ever be reached if we (through empirical research) find ways of understanding the relationships between the individual constructs.

The building block framework presented here, presents a way of more clearly outlining the links and explaining the relationships between the dimensions that underpin social capital. The health assets perspective of this framework secures young people's health and wellbeing within the context of positive capabilities and resources for health and maximises their opportunities for attaining and sustaining health in all stages of their life.

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