



**Social capital and the
health and wellbeing of
children and adolescents**

KEY POINTS

- Social capital is a term used to describe social relationships and networks within families and between individuals/families and the wider community.
- This review explored the role and impact of social capital on the health and wellbeing of children and adolescents.
- An integrative approach was taken, which enabled the synthesis of evidence generated in quantitative and qualitative studies. The majority of the studies included were cross-sectional surveys.
- The results demonstrate that young people can access social capital through other people (e.g. their parents) and networks (e.g. their community) and they can generate their own (e.g. through friendships).
- Social capital generated and used within the context of the family is associated with better health and wellbeing outcomes in children and adolescents. For example, children and adolescents who have a positive relationship with their parent(s) and other family members have better health and wellbeing outcomes.
- Social capital generated and used within the context of the community is associated with better health and wellbeing outcomes in children and adolescents. For example, children and adolescents who have more social support networks, who engage in non-recreational groups/activities (e.g. groups involved in community decision-making, frequent attendance at religious services/activities) and who attend higher quality schools (e.g. high in cohesion, trust and safety) have better health and wellbeing outcomes.
- Combined, the studies offer a strong body of evidence demonstrating a link between family and community social capital and the health and wellbeing of children and adolescents; however, as most studies were cross-sectional surveys the direction of this association cannot be determined with certainty.
- The ways in which social capital is generated and the various mechanisms through which it exerts its influence require further investigation. There is also a need for future studies to be designed in a manner that can more fully explore cause and effect relationships.

INTRODUCTION

This Briefing Paper summarises and discusses the results from a systematic review of the literature on the role and impact of social capital on the health and wellbeing of children and adolescents¹. The full report and the accompanying appendices can be accessed via the GCPH website.

BACKGROUND

Investing in the health and wellbeing of children and adolescents is essential to help them reach their full potential². Health and wellbeing are known to be influenced by a wide range of factors that are social, cultural, political, economic and genetic. Exposure to risk factors in these areas in the early years can create health inequalities, not only in childhood, but in later life. A major challenge for policy-makers and practitioners is to determine how best to influence these wide-ranging determinants of health so that relative inequality can be prevented/addressed. Importantly, solutions are required that span the health, education, social care and voluntary sectors^{3,4}.

Evidence suggests that social approaches to the organisation and delivery of public health have considerable potential for health improvement, particularly for those living in socially deprived circumstances⁵. As a result, initiatives seeking to address the social determinants of health, including social connectedness, have increased dramatically in recent years, with examples including the setting up of community engagement/health initiatives and social prescribing^{6,7}. In Scotland, examples of interventions in the early years include the universal health visiting service, Sure Start, the Family Nurse Partnership and the Triple P Positive Parenting Programme⁸. The importance of the nursery and school environment in “helping develop happy, confident individuals who will do well in life” is acknowledged in the Curriculum for Excellence⁹.

Linked to the above, ‘social capital’ is a concept that allows us to explore the impact/influence of social approaches to public health and health promotion⁵. While differences in the definition of social capital exist, the central idea is that social relationships and networks within families and between individuals/families and the wider community can be a valuable asset¹⁰⁻¹². A sense of belonging and the concrete experience of social networks (and the associated trust and tolerance) can, it is argued, be beneficial to health and wellbeing¹³.

While the family provides the first context for infants and very young children, the wider environment, including friendships and school, takes on a larger role as children mature¹⁴⁻¹⁶. This wider social context, in addition to the influence of family, is therefore crucial to our understanding of the ways in which children and adolescents experience and manage their own health and wellbeing, including how they access and mobilise social capital^{17,18}. The more opportunities children and young people have to experience and accumulate the positive effects of a range of protective factors, the more likely they are to be able to attain and maintain health and wellbeing¹⁸. The protection provided by health assets³, including social capital is thought to offset a range of risk factors including poverty, chronic illness, disability, the death of a parent and parental substance misuse^{20,21}.

Discussion of social capital as a resource for the health and wellbeing of children and adolescents first appeared in the literature in the 1990s, with research-based evidence building up over the past ten years^{18,22,23}. However, to date, there have been few attempts to bring the evidence together in such a way as to provide a meaningful framework on which social capital interventions for children and young people can be built²³.

³ Health assets are the resources available to the individual that promote good, and protect against poor, health outcomes. GCPH Briefing Paper Concepts Series 9: Asset based approaches for health improvement¹⁹.

THE AIM OF THE REVIEW

We undertook a systematic review of the literature to find out what is currently known about the role and impact of social capital on the health and wellbeing of children and adolescents. Increasingly used in the health and social care fields, systematic reviews identify, summarise, synthesise and critique evidence from individual studies (primary research) to provide an overview of the strength of evidence in a particular area. As such, they can provide a platform for the development of evidence-based recommendations for policy, practice and/or for future research.

IDENTIFYING AND EVALUATING THE LITERATURE

We undertook a comprehensive search of the international literature using a wide range of health and social science databases and websites. Keywords and phrases were used to identify relevant research papers published in English between January 1990 and March 2012. We sought to identify indicators of social capital at family and/or community levels.

Table 1. Types of family social capital

- Family structure e.g. the number of parents present in the household
- Quality of parent-child relations e.g. relationship conflict or positive communication
- Adult interest in the child e.g. parental involvement in school activities
- Parent's monitoring of the child e.g. perceptions of being monitored by parents
- Extended family support and exchange e.g. participation in activities with extended family

Table 2. Types of community social capital

- Social support networks e.g. friendships with other children/adolescents, social media
- Quality of the pre-school/school environment e.g. relationship with teachers, perceptions of cohesion and safety
- Quality of the local neighbourhood e.g. relationship between neighbours and feeling a sense of belonging to a neighbourhood
- Feelings of trust and safety e.g. trust in other people
- Civic engagement e.g. volunteering
- Religious belief/activity

The outcomes of interest were psychosocial health and wellbeing, with the focus being on pre-school children (0-5 years), school-aged children (5-10 years) and adolescents (10-19 years).

Table 3. Health and wellbeing outcomes
<ul style="list-style-type: none"> • Mental health e.g. anxiety and self-esteem • Behavioural problems e.g. delinquency • Health-promoting behaviours e.g. nutritional intake • Health-risk behaviours e.g. smoking • General health and wellbeing e.g. happiness and quality of life • Developmental issues e.g. language acquisition

On completion of the literature search, the abstracts/papers identified were reviewed for inclusion/exclusion, with data being extracted from the included papers. The quality of the papers was determined using a quality appraisal tool, with papers/studies rated as being of 'high', 'moderate' or 'low' quality.

Further details of the methods used to identify, evaluate and synthesise the literature, and the limitations of these methods, can be found in the full report and the accompanying appendices¹.

FINDINGS

Selecting the evidence

We identified 773 unique papers and, after screening against the inclusion/exclusion criteria, 671 were excluded. This left 102 papers for inclusion in the review.

Contextualising the evidence

The studies

Forty-eight studies explored both family and community social capital, 40 explored only community social capital and 14 explored only family social capital. The studies differed tremendously in the ways that they measured the various elements of social capital.

The majority of the included studies were surveys (85%) but also included were cohort studies, qualitative studies, a randomised controlled trial and a quasi-experiment. It is important to note that the majority of the studies were cross-sectional and are, therefore, limited in providing evidence of cause and effect.

Only 11 of the included studies were conducted in the UK with the majority coming from the USA (n=52) and Canada (n=7). There were also studies from European countries, South American countries and Asia (n=32).

The participants

The majority (n=74) of the studies reported on the health and wellbeing of adolescents. Five studies reported on the health and wellbeing of pre-school children and five on school-aged children. Eighteen studies reported on the health and wellbeing of mixed age group samples. There was a large variation in the number of participants across the 102 studies, with sample sizes ranging from 29 to 98,340.

There was a relatively even mix of male and female children and adolescents in the studies although one had an all-male sample and another had an all-female sample. In 50 of the studies information about the participants' ethnicity, race and/or nationality was either missing or not presented in a meaningful way. The remaining studies reported on a range of different ethnic, racial and/or national groups.

The evidence

The studies included in the review explored the role and impact of social capital on children and adolescents' health and wellbeing in five domains: mental health and problem behaviours; health-promoting behaviours; health-risk behaviours; general health, wellbeing and quality of life; and developmental issues. An overview of the key findings in each of these domains is presented below.

Social capital and mental health and problem behaviours

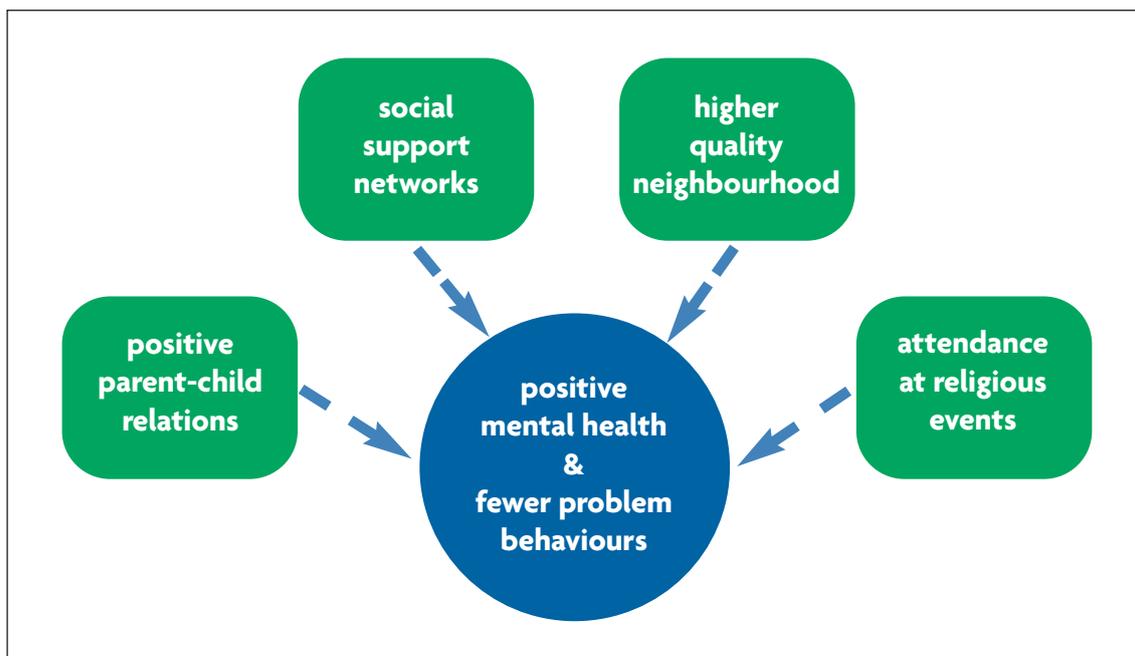
Fifty-five studies explored the association between family and community social capital and children/adolescents' mental health and problem behaviours. The mental health and problem behaviour outcomes included in the studies fell into four categories:

1. Self-esteem and self-worth
2. Internalising behaviours which includes thoughts, feelings, emotions and behaviours that the child/adolescent directs inwards (e.g. depression and anxiety)
3. Externalising behaviours which includes the outward expression of feelings and emotions (e.g. aggression, violence, conduct disorders and disobedience)
4. Composite measures of mental health and problem behaviours, where researchers had measured both internalising and externalising behaviours on a single scale (e.g. the Strengths and Difficulties Questionnaire²⁴).

Family social capital

As illustrated in Figure 1, there was strong evidence across the studies that children and adolescents who have positive relationships with their parents have better mental health and fewer problem behaviours. Positive relationships were characterised as those where communication between the child/adolescent and their parent(s) was good, where the child/adolescent felt that their parent(s) supported and nurtured them and where there were low levels of conflict within the family. Families that spend more time together (e.g. who frequently eat together at mealtimes) seem to foster an environment where children and adolescents are able to develop more positive mental health attributes and are less likely to display behaviours that are generally considered to be problematic (e.g. aggression and disobedience).

Figure 1. The elements of family and community social capital demonstrated as having the strongest association with mental health and problem behaviours.



Community social capital

There was evidence of association between social support networks and better mental health and problem behaviour outcomes (see Figure 1). Children and adolescents with wider social support networks that included both peers and non-familial adults reported better outcomes and there was evidence that recreational clubs and groups may be one way in which young people are able to build these networks.

Regular attendance at religious events, such as church services, was associated with better outcomes. Being enrolled in a school assessed as being of a higher quality (i.e. schools high in cohesion, trust and safety) was associated with better outcomes. In addition, children and adolescents living in neighbourhoods with fewer environmental hazards (e.g. graffiti and crime) and one where neighbours knew each other were more likely to report better mental health and fewer problem behaviours.

Social capital and health-promoting behaviours

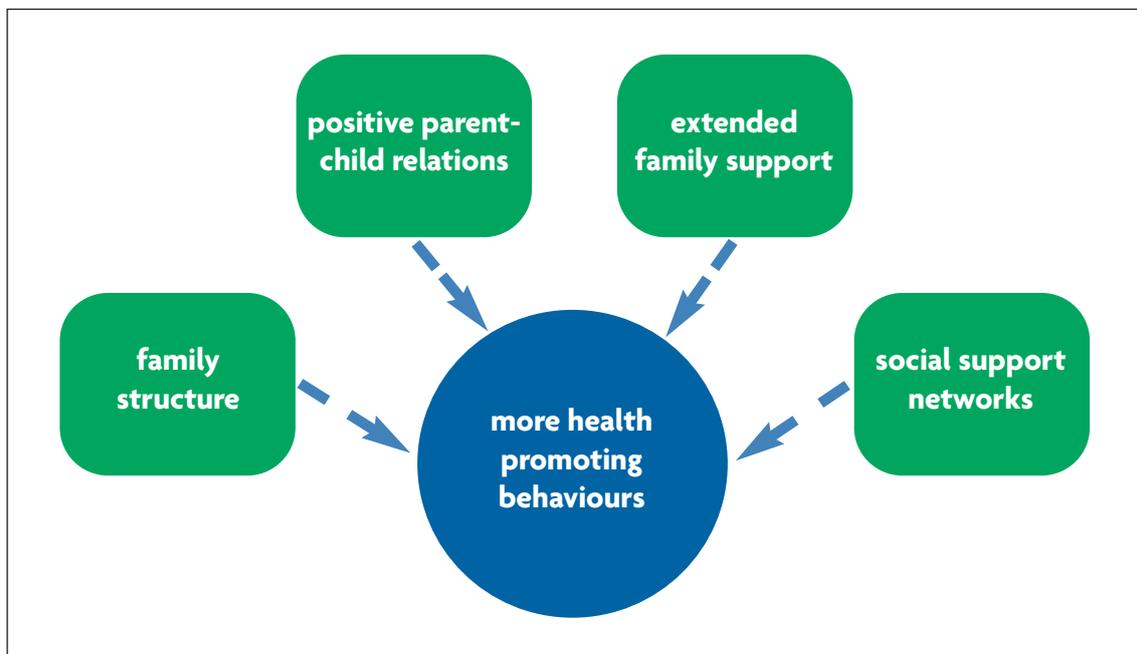
Health-promoting behaviours include actions taken to promote better health outcomes. The health-promoting behaviours described in the 14 studies included in this review were:

1. Nutritional health
2. Physical activity
3. Weight status and body image
4. Dental health.

Family social capital

Like mental health and problem behaviours, there was evidence that family social capital may support better outcomes for children and adolescents (see Figure 2). Children/adolescents who had a father figure present in the home were more likely to have a healthy weight and better body image. Positive parent-child relationships were also associated with children/adolescents displaying health-promoting behaviours. In addition, children/adolescents were more likely to participate in physical activity if they were encouraged and supported by extended family members such as aunts, uncles and grandparents. This encouragement included family members going to watch the activity and/or providing support in the form of transportation or equipment.

Figure 2. The elements of family and community social capital demonstrated as having the strongest association with health-promoting behaviours.



Community social capital

As illustrated in Figure 2, the young person's relationships with people and social support networks outside their immediate family were also important in the context of health-promoting behaviours. Children/adolescents who were members of recreational clubs were more likely to engage in health-promoting behaviours. While it is likely that membership of recreational clubs creates opportunities for engagement in physical activity, it also creates opportunity for children/adolescents to develop social support networks that are wider than, for example, those acquired through school.

Social capital and health-risk behaviours

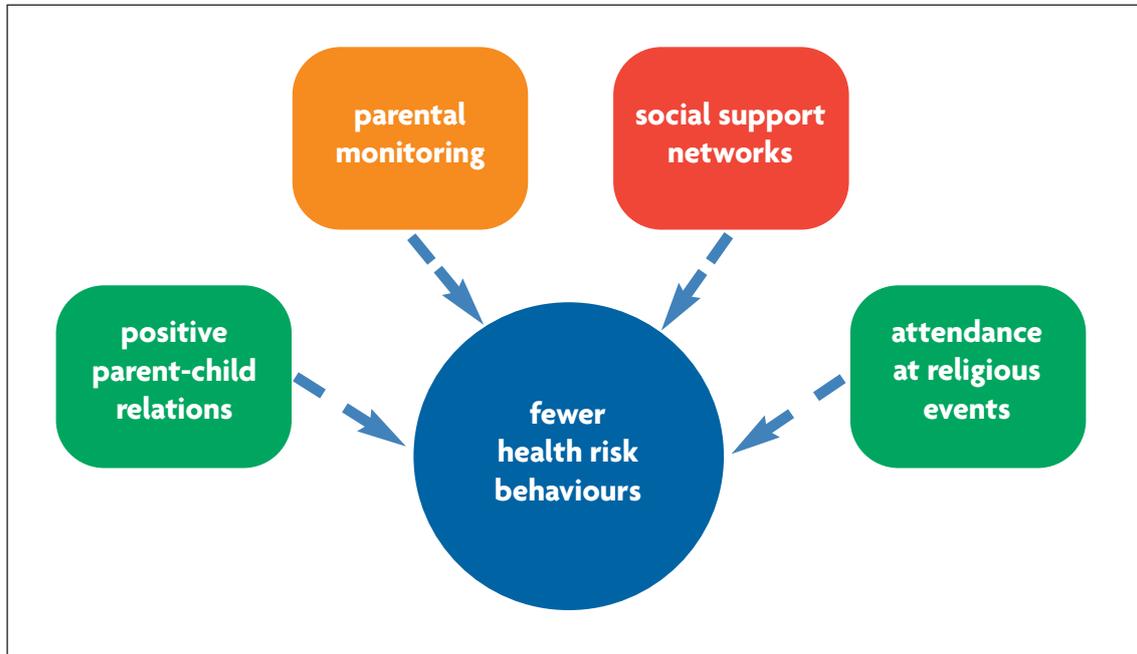
In contrast to health-promoting behaviours, health-risk behaviours are behaviours and actions that increase the likelihood of ill health or decrease the prospect of individuals maintaining optimal health. Thirty-four of the studies included in the review assessed the association between social capital and five categories of health-risk behaviours:

1. Tobacco use
2. Alcohol use
3. Illicit drug use
4. Sexual health risk behaviours
5. General risk behaviours (i.e. where a total health-risk behaviour score was calculated to assess risk across a number of different domains; including, tobacco use and sexual risk behaviours).

Family social capital

Again, there was evidence that children and adolescents who share a strong and positive bond with their parents had better health outcomes in that they were less likely to report using tobacco, alcohol, illicit drugs and they were less likely to engage in risky sexual behaviours (see Figure 3). Given that health-risk behaviours are considered undesirable, it might be anticipated that parents will seek to monitor and control their children to prevent uptake of these behaviours. However, evidence in this review suggests that monitoring and controlling behaviours may only be protective in some circumstances (as illustrated in orange in Figure 3). There was little evidence that parental monitoring prevented tobacco and illicit drug use. On the other hand, parental monitoring was associated with decreased likelihood of adolescents being sexually active, and if they were sexually active they were more likely to engage in positive sexual behaviours (e.g. condom use).

Figure 3. The elements of family and community social capital demonstrated as having the strongest association with health-risk behaviours.



Community social capital

In the context of community social capital, there was some evidence of, what has been called, the 'downside' of social capital (see Figure 3). That is, children and adolescents with wider peer-based social support networks were more likely to report tobacco use and some, but not all, studies showed this to be the case across the other risk behaviours (as illustrated in red in Figure 3). Thus, while some social networks may support young people in some circumstances (e.g. in the development of positive mental health) they may also create opportunity and encouragement to experiment with behaviours that are considered undesirable (e.g. smoking). On the other hand, having a peer or an adult mentor and regularly attending religious events were associated with better outcomes across the various health-risk domains. However, it is important to note that while attendance at religious events was associated with better outcomes, personal faith or belief was not.

Social capital and general health, wellbeing and quality of life

Twenty-two studies explored the association between social capital and general health and wellbeing, which included quality of life^b.

Family social capital

As illustrated in Figure 4, children and adolescents reported better health, wellbeing and higher quality of life when they lived in families that engaged in activities together (e.g. play) and where communication between family members was positive and levels of conflict were low.

Figure 4. The elements of family and community social capital demonstrated as having the strongest association with general health, wellbeing and quality of life.



Community social capital

Children and adolescents appeared to be further supported by positive relationships that extended beyond the family boundaries to include their peers. Living in a higher quality neighbourhood (i.e. those where cohesion was high and hazards were low) and attending a school with a high quality environment (i.e. high cohesion and safety) were also associated with better outcomes (see Figure 4).

Social capital and developmental issues

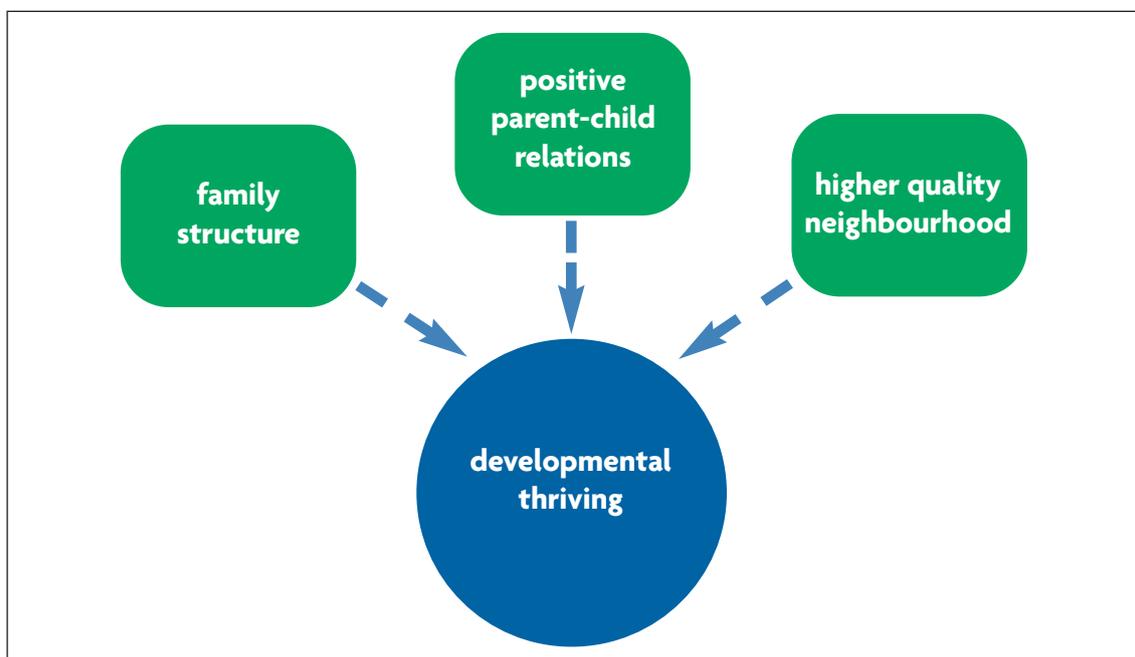
There was very limited evidence available about the association between social capital and developmental issues, such as language development, cognitive development and social development, with only four studies exploring this. All four of these studies were conducted with children under the age of seven years.

^b These studies tended to assess health, wellbeing and quality of life using a single item that asked participants to rate their health, wellbeing and/or quality of life or they calculated a total health, wellbeing or quality of life score from a larger questionnaire.

Family and community social capital

As illustrated in Figure 5, the evidence that was available pointed to positive parent-child relationships supporting better developmental outcomes. There was also some, albeit limited, evidence to suggest that family structure may be associated with better developmental outcomes for some children. In addition, children who lived in higher quality neighbourhood environments had better developmental outcomes than their counterparts from lower quality neighbourhoods.

Figure 5. The elements of family and community social capital demonstrated as having the strongest association with developmental issues.



EVIDENCE STATEMENTS

The aim of the review was to synthesise what is currently known about the role and impact of social capital on the health and wellbeing of children and adolescents. It is clear that both family and community social capital have an important role to play in determining a wide range of health and wellbeing outcomes for children and adolescents.

The evidence from the 102 papers, synthesised across the various health and wellbeing outcomes is summarised in the following six evidence statements, which could inform future policy and practice. The evidence used to generate these statements is presented in full in the final report and accompanying appendices¹. It is important to note here that the strength of evidence underpinning the statements varies and this is reflected in the wording of each.

Table 4. Evidence statements: family social capital.

1. Children and adolescents living in a two-parent household have better health and wellbeing outcomes.
2. Children and adolescents who have a positive relationship with their parent(s), and other family members, have better health and wellbeing outcomes.
3. Parental monitoring may offer some protection in the context of health-risk behaviours.

Table 5. Evidence statements: community social capital.

4. Social support networks are associated with better mental health outcomes, fewer problem behaviours and more health-promoting behaviours. However, in some circumstances they are associated with increased participation in health-risk behaviours.
5. Engagement in non-recreational groups/activities (e.g. civic and religious groups) is associated with better health and wellbeing outcomes.
6. The structural support of higher quality schools and neighbourhoods (e.g. schools/neighbourhoods high in cohesion, trust and safety) is associated with better health and wellbeing outcomes.

IMPLICATIONS OF THE FINDINGS

The findings of this review are among the first to demonstrate that both family and community social capital have an important role to play in supporting positive health and wellbeing outcomes for children and adolescents. Young people can access and use social capital that is generated by their families, by the communities and neighbourhoods they are part of, and they have a capacity to generate their own. This means a wide range of professional groups and agencies can support children and adolescents in accessing and using social capital in ways that promote and support positive health and wellbeing outcomes, and reduce health inequalities.

The evidence statements generated following our comprehensive review of the literature transgress professional and disciplinary boundaries and should be used to guide policy and practice in health, education, social care and the voluntary sector. In what follows we illustrate how these evidence statements might be mobilised by different sectors and incorporated into policy and practice in such a way as to support better outcomes for young people. We offer examples of how policy and practice might directly influence young people themselves as well as how they can be supported through action taken at the level of the family and/or the community (see Tables 6 and 7).

When considering the evidence statements and the implications of the findings, it must be acknowledged that, as a result of the current economic climate, in the UK and internationally, measures have been put in place to reduce budget deficits. Austerity measures include cuts to public spending, services and benefits which will impact on what services and resources are available/feasible to support families²⁵. Interventions that build on the strengths/assets of families and communities and which encourage families, communities and outside agencies to work together to 'co-produce' solutions would appear timely, given the current economic constraints²⁶.

Table 6. Building family social capital through policy and practice.

Family structure	Quality of parent-child relations	Extended family support/exchange	Parental monitoring
Evidence statement 1	Evidence statement 2	Evidence statement 2	Evidence statement 3
<ul style="list-style-type: none"> • Encourage early intervention to support the couple relationship (where appropriate) 	<ul style="list-style-type: none"> • Consider mainstreaming parenting support for parents (mothers and fathers) of children of all ages 	<ul style="list-style-type: none"> • Encourage extended families to engage in joint activities that foster positive interaction (e.g. recreational activities) 	<ul style="list-style-type: none"> • Encourage authoritative parenting (i.e. nurturing with clear and consistent rules)
<ul style="list-style-type: none"> • Consider the provision of conciliation/ support so both parents maintain contact with their child(ren) following separation/ divorce 	<ul style="list-style-type: none"> • Encourage families to engage in joint activities that foster positive interaction (e.g. recreational activities and whole-family school events) 	<ul style="list-style-type: none"> • Support for intergenerational child care (e.g. Triple P for Grandparents) 	<ul style="list-style-type: none"> • Provide access to age-appropriate safe places for young people to go without parental supervision
	<ul style="list-style-type: none"> • Promote family mealtimes 		<ul style="list-style-type: none"> • Help parents to have age-appropriate expectations when considering their child/ adolescent's behaviour

Table 7. Building community social capital through policy and practice.

Social support networks	Quality of pre-/school	Quality of neighbourhood
Evidence statements 4 and 5	Evidence statement 6	Evidence statement 6
<ul style="list-style-type: none"> Recognise the importance of child/adolescent-centred recreational clubs for young people of all ages (e.g. play centres, sport clubs and youth clubs) 	<ul style="list-style-type: none"> Encourage whole family pre-/school engagement (e.g. representative councils) 	<ul style="list-style-type: none"> Encourage neighbourhood cohesion (e.g. community councils and centres)
<ul style="list-style-type: none"> Involve local communities in developing peer and adult mentoring initiatives 	<ul style="list-style-type: none"> Jointly develop initiatives designed to foster feelings of cohesion, unity and common purpose among staff, pupils and families 	<ul style="list-style-type: none"> Involve the local community in the prevention/removal of environmental hazards (e.g. litter, graffiti and crime)
<ul style="list-style-type: none"> Support community cohesion and neighbour support (e.g. community groups) 	<ul style="list-style-type: none"> Foster high levels of trust, safety and respect among staff, pupils, families and the local community 	<ul style="list-style-type: none"> Involve the local community in initiatives to increase neighbourhood safety (e.g. ensuring green space is welcoming for all)

THE NEED FOR FURTHER RESEARCH

While the evidence presented demonstrates that family and community social capital have an impact on the health and wellbeing of children and adolescents, the ways in which social capital might be acquired and the various mechanisms through which it exerts its influence require further investigation. It is particularly important that future research is designed to more fully explore the cause and effect relationships that might exist between social capital and children/adolescents' health and wellbeing outcomes. Also of note is the fact that only 11 of the 102 studies included in the review were conducted in the UK. While aspects of the results from studies undertaken in North America, and elsewhere, may be generalisable to other cultural contexts, including the UK, others may not be and there is a need for a UK-specific evidence base to be built. An additional point is that the majority of the studies focused on the role and impact of social capital on the health and wellbeing of adolescents. There is, therefore, a need to further explore the development and impact of social capital in the pre-school and primary/elementary school years.

 CONCLUSIONS

To the best of our knowledge, our review is the first to systematically collate, analyse and synthesise the international, empirical, peer-reviewed literature on the role and impact of social capital on the health and wellbeing of children and adolescents. In conducting such a large-scale review, we are able to provide solid evidence to demonstrate that family and community social capital are associated with differences in the health and wellbeing of children and adolescents. Families that are nurturing and cohesive provide an environment in which children and adolescents are able to thrive. Moreover, children and adolescents who are able to acquire social capital in and through their local communities have the potential for much better health and wellbeing. While limitations in the current evidence base have been highlighted, we consider that the results have significant and wide-reaching implications for policy-makers, practitioners and educators.

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FULL REPORT

The full report and accompanying appendices can be accessed via the GCPH website: http://www.gcph.co.uk/publications/398_social_capital_and_the_health_and_wellbeing_of_children_and_adolescents

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