9
Social Capital and Mental Health
An Updated Interdisciplinary Review of Primary Evidence

Astier M. Almedom and Douglas Glandon

Social capital is a compound and complex construct, an umbrella term under which social cohesion, social support, social integration and/or participation are often lumped together. Beyond its growing appeal to policy makers, practitioners and researchers in public health in general and mental health in particular, social capital is now also an integral part of broad-based discussions on social-ecological resilience, ecosystem sustainability, and the collective management of natural resources (see for instance, Adger et al., 2005; Hardin, 1968; Pretty, 2003). This chapter revisits and updates the analysis presented in an earlier interdisciplinary review of primary evidence linking social capital and mental health (Almedom, 2005). The aim is to identify key areas where progress has been made in the quest for understanding both theoretical and empirical associations between social capital and mental health and well-being.

Both social capital and mental health remain difficult to define categorically and measure precisely. Research evidence also suggests that both defy institutional appropriation while remaining open to manipulation by formal and/or informal means of social engineering. Academic researchers continue to contribute to the debate that is fuelled by these inherent characteristics of both constructs. Concerning social capital, Putnam's *communitarian* definition continues to be widely used with reference to the types – *bonding* (horizontal) and *bridging/linking* (vertical or horizontal or diagonal) – of social group interactions evident in civic participation; while Bourdieu's "forms of social capital" (human/economic and cultural) also continues to underlie discussions of individual, family and community access to social capital in relation to health and well-being. The earlier evaluation of the published literature had suggested that the various types and/or forms of social capital may have both *structural* and *cognitive* components operating at micro and/or macro levels. However, questions remained as to how availability and/or access to social capital or lack thereof influenced mental well-being, particularly when only quantitative methods of investigation and analysis were employed (Almedom, 2005). The dozen studies reviewed earlier pointed in the general direction of the need for interdisciplinary, multi-method and multi-level research design. An additional four studies identified since are considered below, three of which turn out to be qualitative. All four investigations focus on the structural and cognitive components of social capital.

9.1. Method of Literature Review

Our literature review used exactly the same methods as the earlier one: main electronic bibliographic databases (including "Global Health") were searched for "social capital and mental health"; "social capital and psychosocial" and "social capital and depression" appearing in the summary/abstract, text and/or list of key words in peer-reviewed journal articles published and indexed between January 2004 and April 2006. Items resulting from the electronic search were hand-sifted in order to follow-up cited references and contact authors when necessary, and the same inclusion/exclusion criteria applied. A final short list of four studies reporting primary data on primary indicators of social capital and mental health were added to the results of the earlier review and incorporated in the thematic discussion of social capital and mental health across the life course and with reference to mental health care services conducted by Almedom (2005).

9.2. Findings and Interpretation

The sixteen studies discussed below reflect the general trend of theoretical and empirical advances made in recent years. As expected, due to the compound and complex nature of both "social capital" and "mental health", multiple definitions and measurement scales/assessment tools have been employed. Indicators of "metal health" range from externalizing and/or internalizing behavior problems in children and young people (Beyers, Bates, & Pettit, 2003; Caughy, O'Campo, & Muntaner, 2003; Drukker et al., 2003; Moffitt et al., 2002; van der Linden et al., 2003); to social withdrawal, anxiety and depression (non-clinical, non-referred) in adolescents and young adults (Harpham, Grant, & Rodriguez, 2004; Stevenson, 1998); coping with "refugee trauma" (Weine et al., 2005) and "maternal depression and symptoms of antisocial personality disorder" (Moffitt et al., 2002; Mulvaney & Kendrick, 2005); "emotional well-being" (Cotterill & Taylor, 2001; Rose, 2000a) and "psychological distress" (Mitchell & La Gory, 2002) in adults and senior citizens. Measurement scales and tools of assessment employed include the Child Behavior Check List (CBCL); Child Health Questionnaire (CHQ-CF87); interviews with children, adolescents, and/or their teachers, and/or parents/primary carers; Revised Rutter Scale; Diagnostic & Statistical Manual of Mental Disorders (DSM-IV); Short form Multiscore Depression Index (SMDI); Teacher Report Form (TRF); Self-report Questionnaire (SRQ-20); Diagnostic Interview Schedule (DIS-IV); Short Michigan Alcoholism Screening Test (SMAST); General Health Questionnaire (GHQ-12); CES-D scale; Mirowsky & Ross' psychological scale; and also semi-structured interviews, focus group discussions and observations. Each study is examined in relation to itself *vis a vis* contemporary social capital and mental health debates and dilemmas, and in relation to other studies under review only with reference to policy and/or practice implications of the findings, if any.

Indicators of social capital used include a Dutch translation and adaptation of Informal Social Control (ISC) and Social Cohesion and Trust (SC&T) scales; Neighborhood Social Capital scale (NSC), Kinship Social Support (KSS) and Fear of Calamity scale (FOC); Adapted Social Cohesion and Trust scale (A-SCAT); interviews with youth, teachers and parents; Psychological Sense of Community (PSOC); and Putnam's Community Social Capital Benchmark Survey. A number of the studies reviewed measure two or more types and components of social capital, namely, the structural and/or cognitive components of bonding and bridging social capital measured in geographically delineated urban areas. However, notions of "the shared social environment" are inconsistent across these studies. For example, "neighborhood" can mean "census block" (Caughy et al., 2003) or "census tract" (Beyers et al., 2003; Mitchell & La Gory, 2002) or "postcode" (Steptoe & Feldman, 2001). Only one study uses the term neighborhood in an "ecologically meaningful" way, and recognizes that "perceived neighborhood" (according to the study participants) differs in meaning from the researchers' use of the term (Drukker et al., 2003).

The significance of access to and use of different types, components and levels of social capital varies across the life course. Geographical area-based social cohesion and informal social control translates into a sense of freedom and safety that is conducive to healthy cognitive and emotional development and socialization of children and adolescents (Davis, 1998; Ross, Reynolds, & Geis, 2000; Sampson, Stephen, & Earls, 1997). This is important for the physical safety, emotional security and well-being of senior citizens as well (Klinenberg, 2002; Lindström, Merlo, & Östergren, 2003). Residential social capital may be more critical to families (specifically women) with young children and to the elderly than to relatively young adults without dependants. Therefore empirical links between social capital and mental health are considered below with reference to specific stages of the lifecourse. The sub-grouping of studies in Tables 9.1–9.4 is however fluid, as some studies belong in more than one sub-group. For example, Harpham et al.'s study includes adolescents and young adults (15–25 year olds), Moffitt et al. report on young mothers and their twin children, and Steptoe and Feldman's sample has a very wide age range: 18–94 years, with a mean of 52 and SD of 18 years). Rather than listing these studies twice in Tables 9.1 and 9.2, their "dual" focus is discussed in the text only.

9.3. Social Capital and Mental Health and/or Social Behavior of Children and Youth

Family and neighborhood social capital are evidently important determinants of children's and adolescents' development, health and well-being. Both individual and ecological factors are at play, warranting plurality of methods and levels of investigation and analysis. Stevenson (1998) defines social capital as "*the sum total of positive relationships including families and neighbors that serve as buffers to the negative influences within one's immediate environment.*" (p. 48)

TABLE 9.1. Studies with primary data linking social capital and mental health of adolescents and young children.

Author (year), location of study site(s)	Study design, sample size & unit(s) of analysis	Indicator of social capital & scale(s) used	Indicator of mental health & scale(s) used	Key findings	Policy/practice implications & remarks
Stevenson (1998) Anonymous city, USA	Cross-sectional N=160 African American youth in an unnamed city in the north-east; correlations and multiple regression, mixed models	Neighborhood Social Capital (NSC) scale, Kinship Social Support (KSS) scale and Fear of Calamity (FOC) scale	Emotional adjustment/ mental health (guilt, cognitive difficulty, sad mood, irritability, low self esteem, instrumental helplessness, social introversion, low energy, pessimism, learned helplessness); MDI (short form)	↑fear of potential violent calamity and ↓symptoms of global depression in girls compared to boys. Gender differences in access to neighborhood social capital and use of emotionally adaptive strategies, including social introversion. Supportive and watchful neighborhoods (↑ social capital) can make up for lower levels of family social support.	Author argues in favor of building and strengthening structural components of social capital. His recommendation that families and social networks to which a child belongs need to be connected to larger networks of 'fictive kin' resonates with progressive education, social welfare and health policies.
Beyers *et* al., (2003) Nashville (TN), Knoxville (TN), (IN) USA	Longitudinal, two cohort study of children aged 5 followed into adolescence, age 13 (N=440) evenly distributed among 3 southern cities), multi-level	structural disadvantage, residential instability, concentrated affluence (census-based measures); parental monitoring and involvement (interview with youth and with parents, parental monitoring and activity scores)	Externalizing behavior (e.g. 'gets into fights', 'disobedient at school') as reported by teachers (grades 6–8); TRF (34 items including aggression and delin quency scales)	Neighborhood structure contributed to socialization of adoles cents by moderating the effects of parental monitoring or lack thereof.	Authors point out that their findings may not be generalized to African American families or disadvantaged youth as the majority of the sample consisted of white and middle-class families.

Caughy *et al.* (2003) Baltimore city(MD), USA	Cross-sectional N=200 African American mothers/care givers of 3 – 4.5 year olds in 39 neighborhoods; single-level regression models	Parental sense of community (interview with mothers/care givers; PSOC-G (general) and PSOC-K ('knows neighbors') scales	Child behavior problems; CBCL scores for internalizing (anxiety, depression, withdrawal), externalizing (aggression) and total problem behavior score.	Contradictory evidence:↑ wealth in residential area = ↓ social capital/ levelof attachment with/ sense of community in mothers/carers = ↓ behavioral/mental health problems among 3–4 year olds; and yet ↓ levels of neighborhood impoverishment and ↓ maternal social capital also =↑ child behavior/mental health problems.	Potentially harmful policy and practice implications as children as young as 3 and 4 may be labeled 'aggressive' or 'depressed'. No information on how the African American mothers/care givers' interviewed define their own communities; and whether or not they problematize their young children's behavior.
Drukker *et al.* (2003) Maastricht, The Netherlands	Longitudinal cohort study of 11–12 year old children (N=3401) living in 36 "ecologically meaningful" neighborhoods, to be followed into adulthood; multilevel regression models.	Neighborhood informal social control, social cohesion and trust; translated and adapted ISC and SC&T scales (with 5 site/culture-specific questions added).	General mental health and behavior (aggression, delinquency, hyperactivity, impulsivity and social withdrawal), self esteem; CHQ-CF87	Children's mental health and behavioral problems specifically associated with neighborhood levels of informal social control.	Promising prospects for a sound evidence-base for mental health policy and practice as authors are aware of and responsive to the limitations of epidemiological survey research..
Weine *et al.* (2004), USA	Multi-site ethnographic study, N = 30, refugee Bosnian adolescents & their families in the Bosnian community of Chicago; interviews and participant observation, thematic analysis.	"cultural capital" – 9 identified mechanisms in emic terms: using our language, obliging family, sticking together, returning to religion, going ghetto, building a future, taking pride in tradition, critiquing America, seeking freedom.	Sadness, isolation, confusion, degradation, dissatisfaction, & anomie (interview coding).	No cultural capital mechanism operates in isolation from others. Families are a critical component of converting cultural capital. More research is needed to determine whether these coping strategies are associated with positive mental health outcomes.	Preventive mental health services may be able to assist in "converting" cultural capital to facilitate effective coping to stress and adversity. Such efforts would need to focus on the attitudes, beliefs, and information among and between teens, parents, school, and other community programs.

TABLE 9.2. Studies with primary data linking social capital and mental health of youth, adults (including mothers with young children).

Author (year), location of study site(s)	Study design, sample size & unit(s) of analysis	Indicator of social capital & scale(s) used	Indicator of mental health & scale(s) used	Key findings	Policy/practice implications & remarks
Rose (2000) Russian Federation	Cross-sectional, multi-stage randomly stratified sample, N=1904 adults age 18 and up; Multiple regressions.	Multiple indicators of social integration and individuals' cumulative use of networks including church attendance, trust in people, sense of control over one's life. New Russia Barometer (NRB) surveys.	Emotional wellbeing (12 months recall) 5 point lickert scale: "in the past year, would you say your emotional health has been very good, good, average, poor or very poor?" NRB surveys.	Social capital increases physical and emotional health more than human capital; Human and social capital together can easily raise the individual's self-reported health from just below average on the scale to approaching good health.	Author argues that public policy intervention to increase household incomes coupled with autonomy of social capital networks from government would secure emotional and physical health benefits for Russians across all age groups.
Steptoe & Feldman (2001) London, UK	Cross-sectional N=658 postal questionnaire survey respondents in the London area; Multilevel regression models.	Collective efficacy: social cohesion (SC), informal social control (ISC); Neighborhood problem scale	Feeling unhappy and depressed (GHQ-12, 4-point scale)	Neighbourhood problems (including litter in the streets, air pollution, noise, vandalism and disturbance by neighbors or youngsters) correlated with poor self-rated health, psychological distress and impaired physical function independent of age, sex, neighbourhood SES, individual deprivation, and social capital.	Authors point out that the cross-sectional design and low response rate make it difficult to go beyond recommendations for further research.
Moffitt *et al*. (2002) England & Wales, UK	Longitudinal, N=1116 women who became mothers of twins in	Neighborhood social cohesion and Trust, informal social control.	Mother's mental health history, symptoms of antisocial personality disorder, maternal depression;	'Personality traits' suggestion that younger mothers were less 'conscientious' and with more 'problematic'	Authors make explicit policy recommendations for prevention of teen childbearing, and support for

	1994–95; 562 of whom were < 20 yrs old at the time of their twins' birth.		SMAST; DIS-IV; Children's cognitive ability and prosocial behavior; TRF; DSM-IV.	mother-child relationships; Mother and teacher reports show ↑ 'inattention-hyperactivity' in children of younger mothers; equal participation in prosocial activity.	teenage mothers to gain access to child care, education, housing, employment and mental health services. They call for comprehensive, 'multimodal' interventions.
Mitchell & LaGory (2002) Birmingham (AL) USA	Cross-sectional N=222 households (30 Census-blocks)	Individual's extent of participation in the community (*bonding*) and strength of trust and *bridging* ties (Social capital community Benchmark survey)	Mental distress (Mirowsky & Ross' psychological scale)	Strong bonding ties within group; weak bridging ties with other groups;↑ participation =↑ mental distress due to increased demands on time & resources; ↑'mastery' more important than social capital in mitigating mental distress.	Findings concerning 'mastery' are potentially useful for designing support interventions to promote individual mastery (and by implication collective resilience) in cohesive inner-city African American communities.
Harpham *et al.* (2004), Colombia	Cross-sectional N=1168 young people in Cali; factor analysis and logistic regression models	Social cohesion and Trust (thick and thin); A-SCAT scale	Global depression and anxiety (non-clinical); SRQ-20	anxiety and depression in females; low levels of education and employment are more significant risk factors for mental ill health than social capital. In the presence of violence (as a variable), social capital has no statistical effect on mental health variables.	Guarded policy and practice recommendations. More research in progress.
Fram (2005), USA	Qualitative, focus groups N=21; parents in a family support program		(n/a)	Most family support center relationships seem to be "bonding." However,	Social support needs to be evaluated in context to determine which relationships are helpful, which

(Continued)

TABLE 9.2. *(Continued)*

Author (year), location of study site(s)	Study design, sample size & unit(s) of analysis	Indicator of social capital & scale(s) used	Indicator of mental health & scale(s) used	Key findings	Policy/practice implications & remarks
	in a suburb of a major West Coast City; analyzed using iterative categorical coding method.	Social relationships (interview coded "core category")		"getting ahead" goals of parents also led to "bridging" social capital.	are harmful, etc. Family support centers need to attract diverse groups of parents to foster bridging social capital.
Mulvaney & Kendrick (2005), UK	Nested case-control N=846 mothers of young children living in deprived areas of Nottingham; random effects logistic regression, likelihood ratio tests.	Neighborhood social capital & stress (questions from 1992 Health & Lifestyles Survey).	Depressive symptoms (CES-D Scale).	Neighborhood-level deprivation, receiving means-tested benefits, lack of social support, and high stress were associated with greater depressive symptoms. Individual-level assessment of neighborhood social capital not associated with depressive symptoms.	Need further research to assess causality between social support, social capital, and maternal mental health. Need both contextual & individual measures of soc. cap. Seems to be a large unmet need for mental health services among mothers of young children in deprived areas.

TABLE 9.3. Study with primary data linking social capital and mental health with reference to senior citizens.

Author (year), location of study site(s)	Study design, sample size & method(s) of analysis	Instrument used to assess social capital & mental health	Key findings	Policy/practice implications & Remarks
Cotterill & Taylor (2001) Plymouth, UK	Cross-sectional, N=95 participants of Plymouth HAZ-funded Age Well Project in six locations; N=10 non-project participants and N= 10 staff from voluntary organizations involved in AW Project.	Study assessed reported "social health": in terms of social participation, social networks and interpersonal interaction.	Housebound elderly people benefited from opportunities for social interaction, but did not want to spoil the atmosphere of social gatherings by "talking about what was wrong with them"; health information generated fear and threatened day-to-day coping strategies. AW project participants engaged in the active management of their sense of well-being by avoiding some topics of information in order to stay happy.	Authors highlight the complex and contradictory consequences of unwelcome health information and the welcome social interactions to combat isolation and loneliness in order to promote older people's sense of well-being and happiness.

He then presents a careful account of mechanisms whereby race, psychological sense of belonging and neighborhood economic deprivation interact to shape mental and emotional health and well-being of adolescents in an anonymous American city located in the North-east. This study addressed three questions: "(a) Do African American youth who live in self-reported unsafe neighborhoods show higher levels of depression? (b) Are there gender differences according to perception of calamity, social capital and depression? and (c) Do adolescents from supportive families and neighborhoods demonstrate healthier psychological outcomes compared to adolescents who have only one of these supports?" (p. 49). Stevenson's insightful analysis highlighted the need for interventions to recognize and bolster existing support systems available to adolescent boys and girls living in racially segregated socio-economically disadvantaged urban quarters. Stevenson observed gender differences in perceptions of potential calamity and expressions of fear. Adolescent girls were more likely to express fear of

TABLE 9.4. Studies with primary data linking social capital and mental health with reference to health care and service provision.

Author (year), location of study site(s)	Study design, sample size & unit(s) of analysis	Indicator of social capital& scale(s) used	Indicator of mental health & scale(s) used	Key findings	Policy/practice implications & remarks
Rosenheck *et al.* (2001) USA	Cross-sectional, one year follow-up observational study of 18 sites participating in the ACCESS (Access to Community Care and Effective Services and Supports) program for homeless seriously mentally ill patients (entered in the study in two cohorts) in the USA (9 States). N=2,668 (mean age 38.5 yrs; 64.4% male; 45.3% African American.	Number of club meetings attended in past 12 months; number of community projects worked on; number of participants in volunteer work; general belief that other people are honest; proportion of adults who voted in the 1994 and 1996 elections.	Clinical diagnoses of mental illness: psychiatric problems and substance abuse problems.	community social capital associated with greater system integration and greater access to assistance from a public housing agency and to a greater probability of exit from homelessness at 12 months. No associations between environmental factors, or systems integration and psychiatric problems.	Collaboration between service providers and service integration may improve outcomes for homeless mentally ill people. More data expected to become available at the end of the ACCESS demonstration period to guide policy and practice more specifically.
Campbell *et al.* (2004) UK	Qualitative study (in-depth interviews, N=30; and two focus groups) with local community "stakeholders" from or working with the African-Caribbean community in an unnamed southern	Participation in local community networks, perception of trust, solidarity, community capacity for forming partnerships, and sense of agency.	Perception of quality of, and access to mental health services	Interviewees had high enthusiasm for participation in local mental health initiatives but were very skeptical of the possibility of effective partnership because of distrust, disillusionment, and disempowerment in the	Local & statutory partnerships are necessary to reduce health inequalities. Such partnerships require trust between voluntary and statutory sectors and require inclusion of the local community in mental health initiatives. It will

	English town analyzed using a grid-coding method.			African-Caribbean community with respect to the statutory mental health service sector.	be important for these groups to have a common understanding of the meaning of a "partnership."
van der Linden *et al.* (2003) Maastricht, The Netherlands	Cross-sectional, case-control (mental health service users versus non-users), N=262 children (56 cases and 206 controls) living in Maastricht neighborhoods; Multi-level logistic regression models.	Neighborhood informal social control, social cohesion and trust; translated and adapted ISC and SC&T scales (with 5 site/culture-specific questions added).	Not specified.	More children from lower SES neighborhoods seen by mental health care services; Neighborhood social capital (social cohesion & trust) mitigate the effects of lower SES and children's coming into contact with mental health services.	This study makes explicit justification for 'early intervention': parenting and family support strategies. Authors argue that prevention/ programs for high-risk children should seek to alleviate neighborhood deprivation by creating safe areas for children to play and for their parents to meet and increase social cohesion.

calamity and benefit from access to neighborhood social capital than their fearless counterparts. Girls were less likely to report depressive ideation including lethargy, instrumental helplessness, and cognitive difficulties even when they lived in high risk locations. Being fearful of violent calamity and articulating this fear is shown to be an emotionally adaptive strategy teen-age girls use to both generate and access social capital. Moreover, social isolation resulting from fear of violent calamity may promote resilience (p. 56). Stevenson couches his crime prevention and mental health promotion policy and practice recommendations in a comprehensive discussion in favor of building neighborhood social capital and healthy communities through adult supervision and care of adolescents (see also Stevenson, 1997).

Beyers et al.'s longitudinal study (2003) conducted in three southern cities of the USA (Nashville, TN, Knoxsville, TN, and Bloomington, IN) independently reinforces Stevenson's call for concerted efforts to build and strengthen structural and cognitive social capital through prevention/intervention programs. This study addressed two questions: "i) do neighborhood structural disadvantage, concentrated affluence, and residential instability relate to initial levels of and/or growth in adolescence externalizing behavior after controlling for individual and family factors? and ii) do gender and parenting practices differentially affect the development of externalizing behaviors depending on the social structure of neighborhoods in which families reside?" (p. 36) Jennifer Beyers and her team use Coleman's definition of social capital as " . . . physical presence of adults in the family and the quality of relations among family members" (p. 46), and describe family-level collective efficacy as connectedness of social networks among resident adults and youths (after Sampson et al., 1997). They confine their investigation to externalizing behavior problems among youth, and conclude that while neighborhood structure does not directly impact externalizing behavior, it contributes to the socialization of adolescents via the moderating effects of parental monitoring. The authors are careful to point out that their findings are not generalizable to African American youths and/or low SES densely populated urban American neighborhoods, as this category constituted only 17% of their study sample across three southern American cities. However, their findings resonate with "neighborhood-effect" studies of SES in relation to adolescent behavior and mental health, most notably Anneshensel & Sucoff's evidence (1996) from Los Angeles neighborhoods.

Weine, Ware, and Klebic (2004) conducted an ethnographic study among teenage refugees from Bosnia-Herzegovina living in Chicago, Illinois. Participant observations and in-depth interviews were conducted by an American and Bosnian pair of fieldworkers who focused on refugee adolescents and their families said to have been exposed to refugee trauma, defined as "senses of sadness, isolation, confusion, degradation, dissatisfaction, and anomie" (p. 926). The authors use Bourdieu's concept of "cultural capital" to analyze the ways in which Bosnian youth have been adapting to life in Chicago with the support of cohesive family and community structures that affirm and build their ethnic identity, while they are absorbing certain aspects of their new (American) culture at the same time. The authors identify nine

mechanisms whereby cultural capital is "converted" (presumably into social capital of the bonding type): using own language; obliging family; sticking together; returning to religion; going ghetto; building a future; taking pride in tradition; critiquing America; and seeking freedom. This study is ongoing, and may be expected to contribute to the wider discourse on positive psychology and promotion of resilience in the context of international humanitarian policy concerning psychosocial support.

Caughy et al. (2003) focus on African American mothers/carers of young - children in a racially-segregated American city (Baltimore, Maryland) and find that the mother/carer's "lack of attachment to community was a risk factor for behavior problems for children living in wealthy communities but, a protective factor for children living in highly impoverished neighborhoods." (p. 231). This study demonstrates a somewhat muddled view of social capital. Social capital (bonding and not bridging type) is investigated in this study in relation to neighborhood "context" with contradicting results. Margaret Caughy and her team use "census block" as a proxy for neighborhood, and do not attempt to examine the meaning of "community" in the context of their study site and sample of respondents. Their suggestion that weak neighborhood ties may be indicative of weak community ties and that African American mothers and/or pre-school children may be better off without their communities is questionable. "Contextual analysis" without enquiry into the meanings and boundaries of the community in question presents a serious limitation given what is already known about the issues of community, particularly in the context of health research.

It would be reasonable to suggest that social cohesion in the context of poverty and structural disadvantage poses mental health risks to women either because they tend to be giving more than receiving, or because they may be constrained by the norms and expectations of their social ties (Kawachi & Berkman, 2001), but Caughy et al.'s study does not consider such possibilities. Mindy Fullilove (1998), a social psychiatrist, analyzing the insights of insiders has demonstrated that building social cohesion and collective efficacy in four different American inner-city locations was beneficial for women, because "*women have major responsibility for raising children . . . The importance of social connections is not simply a matter of social intercourse, but more profoundly a matter of getting women's work done. Loss of social cohesion in the larger community will make women's work more onerous. Conversely, improvements in social organization create networks that allow women to share responsibilities and aid each other*." (p. 76) Caughy et al.'s suggestion that "being alone might be better" thus runs counter to Fullilove's, Stevenson's, and Beyers et al.'s assertions. The latter highlight positive aspects of social capital with respect to the behavioral development and social adjustment of children and youth; while the former expressly set out to find non-salutary effects of communitarian social capital on individual well-being. Caughy et al.'s study is likely to fuel the ongoing politically-charged debate in epidemiology regarding social capital and public health in general and mental health in particular.

In sharp contrast, Drukker et al. (2003) define neighborhood in an "ecologically meaningful" way, and demonstrate care in fine-tuning their chosen measurement scale for specific components of social capital to suit their study participants.

These authors adopted Sampson et al.'s ISC and SC&T scale (1997) and translated it into Dutch, adding five new questions in order to make it specifically relevant to Maastricht (small city) neighborhoods. This study benefits from and reinforces a related case-control study of children's mental health services in Maastricht (van der Linden et al., 2003) which is discussed in section IV below. Drukker et al.'s longitudinal study was designed to investigate associations between SES and social capital; and how these influence behavior and quality of life of children on the brink of adolescence. The evidence pinpoints children's mental health and social behavior association with one particular aspect of social capital: informal social control. The study design is robustly eco-epidemiological, and the baseline evidence indicates that children living in "better" economic and social capital (low instability) neighborhoods enjoy better quality of life, better general and mental health and exhibit more pro-social behavior as they embark on adolescence. However, a more recent report from this study shows that those living in socio-economically deprived but stable neighborhoods make less use of mental health services (Drukker et al., 2004). The association between socioeconomy, informal social control (social capital) and rates of mental health service use could not be explained by individual differences. It is possible that residentially stable neighborhoods with high levels of informal social control may be more likely to foster and sustain resilience in the face of relative economic deprivation. Mental health care services may well have the effect of undermining resilience, or may be perceived as such. The lack of qualitative data to help interpret the statistical findings is a serious limitation of this study.

9.4. Social Capital and Adult Mental Health and Emotional Well-being

Papers summarized in Table 9.3 include two cross-cultural studies of social capital and emotional/mental health (Harpham et al., 2004; Rose, 2000a). Richard Rose's New Russia Barometer (NRB) study (2000a) sets out to find out whether it is human capital (education, subjective social status, and household income), or social capital (social integration, formal and informal links with others, someone to rely on if ill, etc.), or both human and social capital combined which primarily determine individual health. (p. 1423) Rose's NRB questionnaire was designed to measure "different forms of networking, some familiar in Russia and unfamiliar in the West, and some common to both types of societies" and "administered to a full-scale multi-stage randomly stratified sample covering the whole of the Russian Federation, urban and rural . . . " (p. 1425) This study presents purposely collected data on social capital in the Russian Federation; an improvement on previous studies such as for example, Kennedy et al., 1998 which involved secondary analysis of survey data, "retro-fitting" the concept of social capital on data collected for other purposes. However, it is worth noting that Rose's data on emotional health are subject to significant recall error. In anthropological and related areas of health research, 12-month recall is considered too long to produce

reliable information. Nevertheless, Rose's multiple regression models showed that human capital could explain 12.3% of the variance in emotional health; while social capital explained 15.7%, and a composite model with human capital and social capital variables together explained 19.3% of variance in emotional health. Social capital significantly influenced involvement in or exclusion from formal and informal networks; friends to rely on when ill; control over one's own life; and "trust". Younger Russians (< 40 years of age) had greater sense of control of their lives compared to their middle-aged and older compatriots. Rose argued that social capital, a multifaceted construct, cannot be reduced to a single measure, and cautioned against using aggregate membership statistics as a proxy for social capital in aggregate analysis because, "The fullest understanding of the influence of social factors on health is best achieved by recognizing the independent influence of selective forms of both individual *and* social capital." (p. 1431) Rose concluded that public policy can only intervene in economic terms – to ensure sustained growth in household incomes and to promote resilience. It is worth noting here the prominence of "anti modern" society and culture in contemporary Russia contributes to the complexity of the picture partially presented in this study – see also Rose, 2000b, 2001).

Steptoe and Feldman (2001) investigated neighborhood-level effects of deprivation and deficit of social capital on self-rated health and psychological distress (measured using the GHQ-12). Neighborhood problems, including litter in the streets, air pollution, noise, vandalism and disturbance by neighbors or youngsters correlated with poor self-rated health, psychological distress and impaired physical function independent of age, gender, neighbourhood SES, individual deprivation, and social capital. The study participants represented a "stable residential population" with a very wide age range (18–94 years; M=52, SD, 18), and the authors posit and confirm that higher SES neighborhoods had higher levels of social capital. This could however be an artifact of postal questionnaire response – a response rate of 24% is low. Descriptive epidemiological studies such as this one tend to be limited, as that they confine themselves to quantitative methods of analysis, and do not adequately investigate underlying context and meaning.

Evidence presented by Terrie Moffitt and the "Environmental Risk team" (2002) serves to demonstrate how quantitative data from descriptive epidemiological studies may benefit from existing qualitative data to enhance the quality and applicability of evidence for policy and practice. This study is discussed within the sub-group of reviewed papers on social capital and mental health of adults and young people because the authors expressly focus on and prioritize mother-centered interventions. Moffitt and her team compared younger mothers of twins in England and Wales with older ones in order to examine a wide range of social and behavioral risk factors associated with poor child mental health outcomes. Environmental factors (including younger mothers' mental health history, biological father's mental health history, social support for parenting, neighborhood social cohesion, and twins' cognitive development and behavior at age 5) had negative prognoses for younger mothers and their twins compared to older mothers and their twins. This study's findings and recommendations merit discussion in the wider context of UK health policy and practice reform.

Reducing social exclusion and building social capital have been New Labour's explicit goals of health service modernization; and reducing (unwanted) teenage pregnancy and mental health promotion focusing on children and young people had been prioritized (see Social Exclusion Unit, 1999 a & b). The term "teenage" is not unambiguous, however. It needs careful defining. A qualitative study designed to assess health needs, attitudes and aspirations of young people in South London where teenage pregnancy rated highest in Europe, had revealed that "teenage pregnancy" was a heterogeneous category that embraced cases of under-age (unwanted) pregnancy occurring before girls reached the age of consent (sometimes as young as 12) as well as deliberate (wanted) pregnancy among 16 -19 year olds who often considered themselves "adults" (Health First, 1999). This latter group disapproved of "infantalizing" approaches to their needs on the part of practitioners in health and social services who summarily problematized teenage childbearing. Parenthood in (late) teens was often a function of life aspirations, economic and social needs – a deliberate choice on the part of girls and young women, mainly in working class families following their own mothers'/role models' example concerning early parenting. Considering Moffitt et al.'s findings alongside the qualitative evidence summarized above would strengthen their policy recommendations. Practitioners involved in the allocation of resources to facilitate child care access for "teenage" mothers to enable them to build their human capital through education and employment would gain better understanding of their clients by integrating qualitative research evidence. Lack of communication and coordination between quantitative and qualitative researchers, and between researchers and practitioners has continued to hinder social inclusion and achievement of health improvement policy goals in the UK and other countries such as the USA. The problems are magnified when questions of race and/or immigration status limit the extent to which teenagers (or any other "target groups") may access and benefit from bridging social capital (see for example Almedom & Gosling, 2003; Geronimus, 2003).

Mulvaney and Kendrick (2005) investigated the risk of depression among mothers of young children living in deprived areas of Nottingham using a postal questionnaire survey of depressive symptoms as part of an ongoing randomized controlled trial designed to assess the effectiveness of safety advice given to mothers by health visitors. The results showed that mothers with three or more children under five years of age were at significantly higher risk of depression due to increased stress and/or lack of social support and socioeconomic deprivation as those receiving means-tested benefits reported more depressive symptoms. This study had considerable methodological limitations including response bias and confounding variables for which the analysis could not control.

By contrast, Maryah Fram's qualitative study (2005) assessed the types and levels of social capital developed by parents through participation in a Family Support Center (FSC) in a major city in the West Coast of the USA. Her findings showed that the diverse skills, experiences, and backgrounds of participants in the FSC allowed for helpful social networking. Most FSC relationships generated both bonding and bridging types of social capital. This was facilitated by tree

aspects of the FSC: focus on commonalities in the parent/family developmental stage to bring diverse families together; its location in a diverse community; and activities built on diverse strengths and common concerns of parents and staff. Fram argued that efforts to generate social support in family services should aim to shape, rather than respond to the socioeconomic and demographic characteristics of the communities in which families with small children live. This study's focus on both structural and cognitive components of social capital – emphasis on service provision and promotion of family functioning makes useful for policy makers and planners responsible for resource allocation for family services and further research.

Mitchell and La Gory (2002) employ Putnam's Social Capital and Community Benchmark Survey and Mirowsky and Ross' psychological distress scale to examine how individual level social capital and individual sense of mastery may avert mental distress in an impoverished "ghetto" setting in Birmingham, Alabama. The authors report strong bonding ties within community and weak bridging ties to other groups: 71% of the study participants, pre-dominantly African American, trusted their neighbors, while 32% reported trust in people in general. Women and the unemployed experienced greater numbers of economic and environmental stressors. According to Mitchell and LaGory, bonding social capital significantly increased mental distress, and individual sense of mastery played a more important role than social capital: those with lower levels of mastery experienced more mental distress. It is likely that social cohesion would enhance mastery in individuals and thereby promote collective resilience in the face of socio economic adversity and absence of bridging social capital. However, the authors appear to "blame the victim" by implying that their study participants' cooperation with them could have been transferred to social action on the part of the study participants in order to solve social problems. It is possible that the researchers were viewed (by the respondents) as possible links between the community in distress and external structures of power. Other studies have shown that Birmingham, Alabama is among the cities where impoverished as well as better-off Black neighborhoods demonstrate high levels of political participation (see for example Portney & Berry, 1997).

Trudy Harpham and her team (2004) developed, tested and validated an adapted form of Sampson et al.'s social capital measurement scale (1997) prior to its application in a South American city. They conclude that in the presence of violence, social capital, namely, trust, is not as closely associated with mental health as is socioeconomic status, specifically, poverty and unemployment. The distinction between thin and thick trust helps to dissociate personal from structural stressors; however, it is not surprising that in a setting where crime and political violence are widespread, bonding social capital may accrue negative effect on mental health, and may even serve to perpetuate conflict in the absence of, or due to breakdown in bridging social capital. Nevertheless, Harpham et al. found that only 24 % of their study participants were "probable cases of mental ill health" and only "13% of the youth admitted considering suicide in the last month" (p. 2272). This may not be as "disturbing" as Harpham et al. suspect,

given that a large majority (84%) did not report suicidal ideation, the exact meaning and significance of which is unknown for this sample. In Harpham, Snoxell, Grant, and Rodriguez's more recent report (2005), being mentally ill is referred to as "caseness" and although the prevalence of common mental disorders remains the same, in the absence of statistical associations between mental health and social capital, the authors recommend "more qualitative research to inform potential intervention" (p. 166). Their approach does not take into account their study populations' own views on the matter – only social capital was talked about in the focus group discussions, and mental health left unmentioned for "reasons of sensitivity" (p. 162). It is a matter of concern that this approach may inadvertently reinforce undue pathologization of youth behavior and undermine resilience. It is well accepted in mental health policy circles that the mentally ill resent interventions that (metaphorically) lock them up in the "case management" paradigm of health care provision – "I am not a case, and I can manage" is often the sentiment expressed (see Sayce, 2000).

Taken together, the evidence from Russia (Rose, 2000a) and London, England (Mulvaney & Kendrick, 2005; Steptoe & Feldman, 2001), England and Wales (Moffit et al., 2002), respectively West Coast and Alabama, USA (Fram, 2005; Mitchell & La Gory, 2002), Cali, Colombia (Harpham et al., 2004), confirm earlier research reports showing more reports of depression in women compared to men; implicating social support (giving and receiving differentials) and gender specific economic and social inequalities (see Aneshensel, Frerichs, & Clark, 1981; Aneshensel, Estrada, Hansell, & Clark, 1987;; Antonucci & Akiyama, 1987; Brown & Harris, 1978; Dohrenwend, Levav, & Shrout, 1992; Pevalin & Goldberg, 2003). Randomized controlled trials have also confirmed that social intervention aimed at treatment of depression may be more effective than medical intervention (Harris, Brown, & Robinson, 1999 a & b). Building and/or strengthening bonding as well as bridging social capital is therefore salutary for mental health; but it is worth noting that top-down models that inhibit bottom-up efforts may not be successful at preventing mental ill-health or promoting health and well-being.

9.5. Social Capital and Senior Citizens' Mental and Emotional Well-being

Cotterill and Taylor's evaluation of Plymouth Health Action Zone's "Ageing Well (AW)" project (2001) comprises a qualitative study of a portion of a complex inter-sectoral, multi-agency government supported initiative to build social capital. Health Action Zones (HAZ) are area-based British government-initiated interventions to tackle health inequalities and social exclusion, with explicit mandate to build social capital. Policy analysts and practitioners have expressed both support for and concern over the prospects of evaluating such complex initiatives with compound structural and functional opportunities and challenges (Higgins, 1998; Jacobson & Yen, 1998; Powell & Moon, 2001). In response, a national

HAZ evaluation commissioned to examine successes and failures of all 26 HAZ in England (plus one in northern Ireland) had proposed combined "Theories of Change" and "Realistic Evaluation" models of evaluation (see Judge, 2000). These did not incorporate specific measures of social capital. Moreover, one of the challenges to local evaluation design has been the absence of baseline data on pre-HAZ levels of social capital against which the success of targeted interventions can be measured. However, the health service modernization programme is said to be progressing steadily, and HAZs are currently in the process of relocating from local Health Authority to Primary Care Trust (PCT) settings in order to accomplish institutional "Whole Systems" change. It is worth noting here that HAZ funding timeframe of seven years may be too short to effect real change. As Putnam, Leonardi, and Nanetti (1993) observed from the Italian experiment, the development of effective democracy and meaningful civic engagement involves lengthy processes of public discussion, reasoning and decision-making for which government-led, time limited time and funding-bound initiatives hardly allow.

Cotterill and Taylor's qualitative assessment of effectiveness of a social capital building intervention (2001) exposes the contradictory effects of dissemination of health information intended to empower senior citizens (which threatens their emotional well-being by introducing fear about their health) and building bonding social capital to reduce isolation and thereby promote mental health. Enabling senior citizens to generate bonding and bridging social capital in order to "manage health information" thrown at them by health professionals with whom they have unequal power relationships may indicate positive overall outcome. This study brings to the fore inherent problems in social engineering, namely, the contradictions of "empowerment" and target-driven health promotion activities aimed at the production of statistically significant measurable results in time for local and/or general election campaigns. It is well known that social capital in terms of reciprocity, availability of social networks and access to social support involves delicate negotiations, time-intensive processes of social interaction and individually-crafted balances between dependence and autonomy (see Antonucci, Fuhrer, & Jackson, 1990; Krause, 1997; Liang et al., 2001). External agency interventions may thwart more rather than enhance these salutary processes. The UK social and health modernization policy has set in train processes of decentralization and devolution of public health (Evans, 2003) which may serve to empower health workers at the expense of excluded groups for whom prospects of social inclusion and civic participation may be a long way away (see for instance Almedom & Gosling, 2003). While advances in operational research (OR) herald promise of real integration of participatory and cross-cultural multimethod (Taket & White, 1994, 1998, 2000; White & Taket, 1994), translation of research into action may be pie in the sky. Real improvements in health and social development are likely to progress at a slow and arduous pace as and when the poor and marginalized gain control over their own health and social welfare.

9.6. Social Capital and Mental Health Service and Care Provision

The former WHO Mental Health Division head Norman Sartorius' valedictory appeal for social capital highlights a two-way process whereby efficient and effective mental health services help to build and/or strengthen social capital in the communities they serve, and are in turn built and strengthened by the social capital of service users (2002, 2003). Rosenheck et al. (2001) and van der Linden et al. (2003) independently reinforce Sartorius' views.

Rosenheck et al. (2001) demonstrate effectively that structural bonding and bridging social capital in mental health and housing service integration "reflect the state of civic culture in the community at large." (p. 701). This supports Sartorius' argument (2002) and is borne out by the findings of other studies (see Ahern & Hendryx, 2003; Hendryx & Ahern, 2001; Hendryx, Ahern, Loverich, & McCurdy, 2002). Similarly, van der Linden et al.'s report of children's use of mental health services substantiates the view that deficit in social capital in the shared social environment contributes to increased exposure of children to mental health services. The Rosenheck team's interest in studying the links between communitarian social capital and mental health care services has extended to investigating the quality of mental health care service in department of Veterans Affairs (VA) hospitals across the United States. According to Desai, Dausey, and Rosenheck (2005) who conducted a prospective mortality study of psychiatric inpatients of 128 VA hospitals around the country (a total sample of 121,933 patients discharged with a diagnosis of major affective disorder, bipolar affective disorder, posttraumatic stress disorder (PTSD), or schizophrenia between 1994 and 1998), only 2.9 per cent died within a year of discharge; and of those only 481 (0.4 per cent of the sample) committed suicide, mostly during the first 6 months following discharge from hospital. Desai et al.'s presentation appears to be overkill (no pun intended!) as the proportion of suicides is so small. Moreover, given the levels of variation in individual diagnosis, length of hospitalization, and (unknown) post-discharge circumstances, it seems that this study started out with an overstretched hypothesis in trying to test whether or not suicide risk could be an indicator of quality of care in mental health hospitals. The study may have benefited from investigating individual level access to social capital, but as it stands, it is an example of the way in which "social capital and mental health" research can sometimes fail to see the wood for the trees.

In contrast, Campbell, Cornish, and McLean (2004) shed light on both the structural and cognitive obstacles to mental health care improvement in England. Using robust qualitative methods of investigation and analysis, Catherine Campbell and her team unveil the depth of distrust between African-Caribbean community and statutory sectors that inhibit meaningful partnerships. Three factors, social capital (considered to have complementary explanatory power to income and health inequalities), social identity ((based on content of social representations of group membership), and social representation (systems of shared social knowledge that help people make sense of their world and communicate it to others) comprise the

"social psychology of participation" applied in their analysis of the processes involved in the functioning of community participation. As would be expected, Campbell and her team's data revealed multiple meanings of "community participation" among those represented in their sample often hampered by the lack of resources and capacity to engage in meaningful partnerships with the statutory sector, over and above the deeply entrenched perceptions of institutional racism.

In summary, this evaluative review serves to derive from the findings a set of guidelines for interdisciplinary research aimed at unraveling the complex associations between social capital and mental health. What is known so far about the associations between social capital and mental health is outlined herewith. Neighborhood safety is a function of informal social control, social cohesion and trust whereby prevention of vandalism and violent crime, parental active involvement in children's and adolescents' activity generates collective efficacy. Residents' sense of physical and mental or emotional well-being cannot be disaggregated into separate categories or promoted by means of social in the absence of economic and capacity building interventions. Furthermore, the value of qualitative studies in illuminating the areas that are often overshadowed by quantitative data that are, on their own, difficult to interpret and use has been demonstrated. The challenge remains to combine both qualitative and quantitative analyses in the quest for a better understanding of the ways in which social capital and mental health are inter-connected.

References

Adger, W. N, Hughes, T. P., Folke, C., Carpenter, S. R., Rockstiön, J., (2005). Social-ecological resilience to coastal disasters. *Science, 309*, 1036–1039.

Ahern, M., & Hendryx, M. S. (2003). Social capital and trust in providers. *Social Science & Medicine,* 57, 1195–1203.

Almedom, A. M. (2005). Social capital and mental health: An interdisciplinary review of primary evidence. *Social Science & Medicine, 61*, 943–964.

Almedom, A. M., & Gosling, R. (2003). The health of young asylum seekers and refugees in The United Kingdom: Reflection from research. In Allotey, P. (Ed.), *The health of refugees: Public health perspectives from crisis to settlement* (pp. 169–184). Melbourne: Oxford University Press.

Aneshensel, C. S., Estrada, A. L., Hansell, M. J., & Clark, V. A. (1987). Social psychological aspects of reporting behavior: Lifetime depressive episode reports. *Journal of Health and Social Behavior, 28*, 232–246.

Aneshensel, C. S., Frerichs, R. R., & Clark, V. A. (1981). Family roles and sex differences in depression. *Journal of Health and Social Behavior, 22*, 379–393.

Aneshensel, C. S., & Sucoff, C. A. (1996). Jue neighborhood context of adolesceut meutal health. *Journal of Health and Social Behavior, 37*(4), 293–310.

Antonucci, T. C., & Akiyama, H. (1987). An examination of sex differences in social support among older men and women. *Sex Roles, 17*, 737–749.

Antonucci, T. C., Fuhrer, R., & Jackson, J. S. (1990). Social support and reciprocity: A cross-ethnic and cross-national perspective. *Journal of Social and Personal Relationships, 7*, 519–530.

Beyers, J. M., Bates, J. E., & Pettit, G. S. & Dodge, K. A. (2003). Neighborhood structure, parenting processes, and the development of youths' externalizing behaviors: A multilevel analysis. *American Journal of Community Psychology, 31*, 35–53.

Brown, G. W., & Harris, T. (1978). *Social origins of depression: A study of psychiatric disorder in women*. New York: Free Press.

Caughy, M. O., O'Campo, P. J., & Muntaner, C. (2003). When being alone might be better: neighborhood poverty, social capital, and child mental health. *Social Science & Medicine, 57*, 227–237.

Campbell, C., Cornish, F., & McLean, C. (2004). Social capital, participation and the perpetuation of health inequalities: Obstacles to African-Caribbean participation in 'Patrtnerships' to improve mental health. *Ethnicity & Health, 9,* 313–335.

Cotterill, L., & Taylor, D. (2001). Promoting mental health and wellbeing amongst housebound older people. *Quality in Ageing, 2*, 32–46.

Davis, M. (1998). *Ecology of fear*. New York: Vintage.

Desai, R. A., Dausey, D. J., & Rosenheck, R. A., (2005). Mental health delivery and suicide risk: The role of individual patient and facility factors. *American Journal of Psychiatry, 162*, 311–318.

Dohrenwend, B. P., Levav, I., Shrout, P. E. Schwartz, S., Naveh, G., Link, B. G., Skodol, A. E., & Stueve, A. (1992). Socioeconomic status and psychiatric disorders: The causation-selection issue. *Science, 255*, 946–952.

Drukker, M., Driessen, G., Krabbendam, L., & van Os J.(2004). The wider social environment and mental health service use. *Acta Psychiatrica Scandinavica, 110*, 119–129.

Drukker, M., Kaplan, C., & Feron, F. & van Os J. (2003). Children's health-related quality of life, neighbourhood socio-economic deprivation and social capital: A contextual analysis. *Social Science & Medicine, 57*, 825–841.

Evans, D. (2003). 'Taking public health out of the ghetto': The policy and practice of multi-disciplinary public health in the United Kingdom. *Social Science & Medicine, 57*, 959–967.

Fram, M. S. (2005). "It's just not all teenage moms": Diversity, support, and relationship family services. *American Journal of Orthopsychiatry, 75*, 507–517.

Fullilove, M. T. (1998). Promoting social cohesion to improve health. *Journal of American Medical Women's Association, 52*, 72–76.

Geronimus, A. T. (2003). Damned if you do: culture, identity, privilege, and teenage childbearing in the United States. *Social Science & Medicine, 57*, 881–893.

Hardin, G. (1968). The tragedy of the commons. *Science, 162*, 1243–1248.

Harpham, T., Snoxell, S., Grant, E., & Rodriguez, C. (2005). Common mental disorders in a young urban population in Colombia. *British Journal of Psychiatry, 187*, 161–167.

Harpham, T., Grant, E., & Rodriguez, C. (2004). Mental health and social capital in Cali, Colombia. *Social Science & Medicine, 58*, 2267–2277.

Harris, T., Brown, G. W., & Robinson, R. (1999a). Befriending as an intervention for chronic depression among women in an inner city. 1: Randomized controlled trial. *British Journal of Psychiatry, 174*, 219–224.

Harris, T., Brown, G. W., & Robinson, R. (1999b). Befriending as an intervention for chronic depression among women in an inner city. 2: Role of fresh-start experiences and baseline psychosocial factors in remission from depression. *British Journal of Psychiatry, 174*, 225–232.

Health First (Community Health South London). (1999). *Health needs and perceptions of young people in Lambeth*. Report prepared by Carrick James market Research, June 1999, London.

Hendryx, M. S., & Ahern, M. M. (2001). Access to mental health services and health sector social capital. *Administration and Policy in Mental Health, 28*, 205–218.

Hendryx, M. S., Ahern, M. M., Loverich, N. P., & McCurdy, A. R. (2002). Access to health care and community social capital. *Health Services Research, 31*, 85–101.

Higgins, J. (1998). HAZs warning. *Health Service Journal,* 24–25.

Jacobson, B., & Yen, L. (1998). Health action zones offer the possibility of radical ideas which need rigorous evaluation. *British Medical Journal, 316,* 164.

Judge, K. (2000). Testing evaluation to the limits: the case of English Health Action Zones. *Journal of Health Service Research Policy, 5*, 3–5.

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health-Bulletin of the New York Academy of Medicine, 78*, 458–467.

Kennedy, B., Kawachi, I., & Brainerd, E. (1998). The role of social capital in the Russian morality crisis. *World Development, 26*(11), 2029-2043.

Klinenberg, E. (2002). *Heat wave: A social autopsy of disaster in Chicago*. Chicago: University of Chicago Press.

Krause, N. (1997). Anticipated support, received support, and economic stress among older adults. *Journal of Gerontology: Psychological Sciences, 52B*, 284–293.

Liang, J., Krause, N. M., & Bennett, J. M. (2001). Social exchange and well-being: Is giving better than receiving? *Psychology & Aging, 16*, 511–523.

Lindström, M., Merlo, J., & Östergren, P-O. (2003). Social capital and sense of insecurity in the neighborhood: a population-based multilevel analysis in Malmö, Sweden. *Social Science & Medicine, 56*, 1111–1120.

Mitchell, C. U., & LaGory, M. (2002). Social capital and mental distress in an impoverished community. *City & Community, 1*, 195–215.

Moffitt, T. E., the E-Risk Study Team. (2002). Teen-aged mothers in contemporary Britain. *Journal of Child Psychology and Psychiatry, 43*, 727–742.

Mulvaney, C., & Kendrick, D. (2005). Depressive symptoms in mothers of pre-school children: Effects of deprivation, social support, stress and neighbourhood social capital. *Social Psychiatry and Psychiatric Epidemiology, 40*, 2002–2008.

Pevalin, D. J., & Goldberg, D. P. (2003). Social precursors to onset and recovery from episodes of common mental illness. *Psychological Medicine, 33*, 299–306.

Portney, K. E., & Berry, J. M. (1997). Mobilizing minority communities: Social capital and participation in urban neighborhoods. *American Behavioral Scientist, 40*, 632–644.

Powell, M., & Moon, G. (2001). Health action zones: the 'third way' of a new area-based policy? *Health and Social care in the Community, 9*, 43–50.

Pretty, J. (2003). Social capital and the collective management of resources. *Science, 302*, 1912–1914.

Putnam, R. D., Leonardi, R., & Nanetti, R. Y. (1993). *Making democracy work, civic traditions in modern Italy*. New Jersey: Princeton University Press.

Rose, R. (2001). When government fails: Social capital in an antimodern Russia. In B. Edwards, M. W. Foley, M. Diani (Eds.), *Beyond tocqueville* (pp. 56–69)., Hanover and London: Tufts University, University Press of New England..

Rose, R. (2000a). How much does social capital add to individual health? A survey study of Russians. *Social Science & Medicine, 51*, 1421–1435.

Rose, R. (2000b). Uses of social capital in Russia: Modern, pre-modern, and anti-modern. *Post-Soviet Affairs, 16*, 33–57.

Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Stolar, M., Johnsen, M., Randolph, F., Blasinsky, M., & Goldman, H. (2001). Service delivery and community: Social capital, service systems integration, and outcomes among homeless persons with severe mental illness. *Health Services Research, 36*, 691–710.

Ross, C. E., Reynolds, J. R., & Geis, K. J. (2000). The contingent meaning of neighborhood stability for residents' psychological well-being. *American Journal of Social Review, 65*, 581–597.

Sampson, R. J., Stephen, W. R., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science, 277*, 918–924.

Sartorius, N. (2003). Social capital and mental health. *Current Opinion in Psychiatry, 16*, S101–S105.

Sartorius, N. (2002). *Fighting for mental health*. Cambridge: Cambridge University Press.

Sayce, L. (2000). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. London and New York: Macmillan and St. Martin's Press.

Social Exclusion Unit, 1999a. *Teenage Pregnancy* Report presented to Parliament by the Prime Minister by Command of Her majesty (June 1999), London.

Social Exclusion Unit, 1999b. Bridging the Gap: *New opportunities for 16–18 year olds not in education, employment or training* London.

Steptoe, A., & Feldman, P. J. (2001). Neighborhood problems as sources of chronic stress: Development of a measure of neighborhood problems, and associations with socioeconomic status and health. *Annals of Behavioral Medicine*, *23*, 177–185.

Stevenson, H. C. (1998). Raising safe villages: Cultural-ecological factors that influence the emotional adjustment of adolescents. *Journal of Black Psychology*, *24*, 44–59.

Stevenson, H. C. Jr. (1997). "Missed, dissed, and pissed": Making meaning of neighborhood risk, fear and anger management in urban black youth. *Cultural Diversity and Mental Health, 3*, 37–52.

Taket, A., White, L. (2000). *Partnership & participation.* Chichester: John Wiley & Sons.

Taket, A., & White, L. (1998). Experience in the practice of one tradition of multimethodology. *Systemic Practice and Action Research, 11*, 153–168.

Taket, A., & White, L. (1994). Doing community operational research with multicultural groups. *Omega, International Journal of Management Science, 22*, 579–588.

van der Linden, J., Drukker, M., Gunther, N., Feron, F., & van Os, J. (2003). Children's mental health service use, neighbourhood socioeconomic deprivation, and social capital. *Social Psychiatry & Pshychiatric Epidemiology, 38*. 507–514.

Weine, S. M., Ware, N., & Klebic, A. (2004). Converting cultural capital among teen refugees and their families from Bosnia-Herzegovina. *Psychiatric Services, 55*, 923–927.

Weine, S. M., Ware, N., & Klebic, A. (2004). A family approach to severe mental illness in post-war Kosoro. *Psychiatry, 68*(1), 17–27

White, L., & Taket, A. (1994). The death of the expert. *Journal of Operational Research Society, 45*, 733–748.