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# A multilevel cross-lagged structural equation analysis for reciprocal relationship between social capital and health



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## ABSTRACT

We investigated the reciprocal relationship between individual social capital and perceived mental and physical health in the UK. Using data from the British Household Panel Survey from 1991 to 2008, we fitted cross-lagged structural equation models that include three indicators of social capital vis. social participation, social network, and loneliness. Given that multiple measurement points (level 1) are nested within individuals (level 2), we also applied a multilevel model to allow for residual variation in the outcomes at the occasion and individual levels. Controlling for gender, age, employment status, educational attainment, marital status, household wealth, and region, our analyses suggest that social participation predicts subsequent change in perceived mental health, and vice versa. However, whilst loneliness is found to be significantly related to perceived mental and physical health, reciprocal causality is not found for perceived mental health. Furthermore, we find evidence for reverse effects with both perceived mental and physical health appearing to be the dominant causal factor with respect to the prospective level of social network. Our findings thus shed further light on the importance of social participation and social inclusion in health promotion and aid the development of more effective public health policies in the UK.

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## 1. Introduction

A growing recognition of the social determinants of health suggests that social capital contributes to health inequalities both within and between populations (Henderson and Whiteford, 2003). Generally, the research suggests that higher levels of social capital can enhance an individual's sense of self-efficacy and mastery, reduce alienation and stress and ultimately contribute to a sense of well-being, thereby improving health (Morrow, 1999). There is also a consensus that social capital is important in encouraging a physically active lifestyle (Booth et al., 2000; Giles-Corti and Donovan, 2002; Greiner et al., 2004; Leyden, 2003). Social capital might therefore provide a theoretical basis for assessing the impact of community-based health promotion programs on the broader health and life of a community (Baum, 2003). In particular, there is a pressing need in the UK to inform the debate concerning

the veracity of claims that building social capital is an important facet of national health policy. Policy makers have generally accepted the importance of social capital and made changes to health policy accordingly. For instance, the Allen Review, an independent report presented to the UK Government, emphasises the importance of family and community relationships in stimulating the physical, emotional and social development of children and adolescents at key life stages (Allen, 2011). And the UK Department of Health (DoH) has explicitly cited developing social capital as an important feature of health promotion (DoH, 2001, 2006, 2010).

Previous studies highlight a considerable debate over whether social capital is a feature of individuals (Burt, 2009), groups (Bourdieu and Wacquant, 1992) or both (Coleman, 1988; Putnam, 2001). Kawachi (2006) argues that there are two distinct concepts of social capital: social cohesion and social network. The former tends to emphasize social capital as a group attribute and analyses it as a contextual effect on individual health. The later describes social capital in terms of the resources that are embedded within an individual's social networks (Lin, 1999). An additional distinction in research on social capital is between structural and

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cognitive dimensions (Putnam et al., 1994). The structural dimension reflects the ‘quantity’ of social capital and is characterised by behavioural manifestations of associational links between individuals or civic engagement. The cognitive dimension is regarded as the ‘quality’ of social capital as it reflects subjective attitudes such as trust in others and norms of reciprocity (Harpham et al., 2002; Phongsavan et al., 2006). A number of studies have suggested that personal ties, contacts and mutual support enhance an individual’s access to information, resources, opportunities and public welfare policy, making available assistance and emotional support and thus meeting physical and mental health needs (Muntaner, 2004; Nakhaie and Arnold, 2010; Pearce and Davey Smith, 2003).

Folland (2008) indicates that there are three prominent theoretical ideas as to how social capital may improve health: First, both physical and mental health may benefit from sympathetic relationships, a trusting environment, or through the benefits of socializing. Second, social capital provides information on the effectiveness of health care or health behaviours. And third, increased positive social capital enhances an individual’s sense of responsibility, both to one’s self and to one’s key relationships, and would be expected to enhance the benefit of becoming and staying healthy.

Whilst international studies based on longitudinal data have generally supported a causal relationship from social capital to health (Drukker et al., 2003; I. Kawachi et al., 1996; Orthogomer et al., 1993; Welin et al., 1992), a systematic review by Murayama et al. (2012) finds that prospective evidence of the effect of social capital on health in the UK is somewhat limited – only two out of nine articles. This obfuscates the relationship between health outcomes and social capital and seriously impedes any attempt to identify causality. For example, De Silva et al.’s (2005) systematic review of the relationship between social capital and mental health concludes that there is strong evidence that mental illness could result in low social capital as mentally ill individuals are more likely to appraise things negatively and to withdraw socially.

Our aim in what follows is to investigate the temporal and directional character of the relationship between individual-level social capital and perceived mental and physical health using longitudinal data. Such data provide a distinct advantage over cross-sectional data in the variety of sources of variability for understanding causality (Hedström and Ylikoski, 2010). However, the longitudinal analyses in previous studies have been limited to regression or latent growth models in which social capital is served as the criterion measure. Using data from the British Household Panel Survey (BHPS) from 1991 to 2008, we constructed a cross-lagged structural equation model to consider three indicators of social capital and health outcomes together, making it possible to unravel the reciprocal temporal relationships. Since multiple measurement points (level 1) are nested within individuals (level 2), the multilevel model is specified to account for two inherent types of heterogeneity – within-person across time and between-person – thereby identifying the within-person variability over time from the between-person variability found in cross-sectional analyses (Hoffman and Stawski, 2009).

The paper is set out as follows: Section 2 describes our methods in detail whilst Section 3 discusses our estimation and modelling. Our results are presented in Section 4 and final comments are collected in Section 5.

## 2. Methods

### 2.1. Data collection

Our data are derived from the British Household Panel Survey

(BHPS) from September 1991 through September 2008. The BHPS is a nationally representative panel survey of the British population on a micro-social level following a sample of approximately 5500 households and over 10,000 individual respondents aged 16 and over annually since 1991. All original sample members are retained in the panel for as long as possible, even when moving to new households. Those who join the household of a sample member are also included in the survey for as long as they remain in the same household as a sample member. As such, the BHPS includes detailed individual level data in a longitudinal context that satisfy the basic requirement of our substantive analyses.

To ensure comparability over our sample period, we constructed a balanced panel in which information on all the required variables is reported at each wave and in which observations are limited to respondents who answer questions in each wave. The social capital indicators used in our study are not measured at every wave: social participation is recorded in waves 1–5, 7, 9, 11, 13, 15, and 17; social network is recorded in waves 2, 4, 6, 8, 10, 12, 14, 16, and 18; and loneliness is recorded in 1, 3, 5, 7, 9, 11, 13, 15, and 17. We therefore calculated an average of the variables from two adjacent waves every two waves over 18 waves to create values at nine measure points. For example, the value at the first measure point is the average of the first and second waves in the original data. The value at the second measure point is the average of the third and fourth waves, and so on. Information on employment, marital status, and educational attainment was estimated using the values at odd-numbered waves. Because the gap is only one year and most demographic variables are highly persistent, we contend that any bias is likely to be very small. Since estimation of an unbalanced panel is affected by attrition bias over time (Wooldridge, 2005), we focused our analysis on a balanced sample of 3039 individuals, implying 27,351 observations over the nine measure points.

### 2.2. Measures of perceived mental health

We used the responses to the General Health Questionnaire (GHQ) to measure perceived mental health or psychological well-being. The BHPS uses a 12-item version of the GHQ (GHQ-12) based on answers to questions on concentration, sleep loss due to worry, perception of role, capability in decision making, whether constantly under strain, perception of problems in overcoming difficulties, enjoyment of day-to-day activities, ability to face problems, loss of confidence, self-worth, general happiness and whether suffering depression. The questionnaire is usually self-administered and is based on the respondent’s assessment of their present psychological well-being (Bowling, 2005; Williams and Goldberg, 1988). The respondents are asked to indicate on a four-point ordinal scale how they have felt recently with respect to the item in question. We adopted the standard GHQ dichotomous coding method (i.e. ‘0 0 1 1 coding’) for each of the four possible responses to each item, as advocated by the questionnaire’s author (Williams and Goldberg, 1988). Using this method, the maximum score for any respondent is therefore twelve. The scoring was then reversed such that higher scores reflect an improvement in mental health or a reduction in mental illness. There is no universally used threshold value for GHQ-12 to identify probable self-rated mental health because the populations it is used on vary considerably. We chose a threshold value of eight, as suggested by the author of the questionnaire, to identify ‘cases’ of mental health and to create a dichotomous indicator of positive or negative self-rated mental health (Williams and Goldberg, 1988). The predictive and content validity of the GHQ-12 is good in comparison to other well-known scaling tests of mental health (see, for example, Bowling, 2005). The GHQ-12 also performs well in reliability tests and has been shown to be robust to re-testing, making it a suitable longitudinal

instrument (Pevalin, 2000). For instance, the reliability of the GHQ-12 from 2003 to 2004 BHPS is of 0.89 for the dichotomous coding method (Hankins, 2007).

### 2.3. Measures of perceived physical health

The perceived physical health question in the BHPS is measured following an ordinal scale, with possible responses from 'very poor', 'poor', 'fair', 'good', or 'excellent'. The categories were collapsed into a dichotomous indicator by combining the 'poor' and 'very poor' responses and the 'fair', 'good' and 'excellent' responses such that the respondent was recorded as having either 'negative' or 'positive' self-rated health. Previous studies have shown this measure to be one of the best predictors of healthcare utilisation, costs and mortality (Bierman et al., 1999; Davies and Ware, 1981; Fylkesnes and Forde, 1991; Mossey and Shapiro, 1982). We specified an ordered probability model in the regression analysis of physical health.

### 2.4. Measures of social capital

Previous research has generally maintained that social capital is fundamentally multi-dimensional with disputed and contrary definitions at both theoretical and empirical levels (Cooper et al., 1999). The validity of currently available quantitative measures is keenly disputable (Coulthard et al., 2001). The BHPS does however offer some reasonable individual-level indicators to tackle social capital's multi-dimensionality (see David J. Pevalin and Rose, 2002) – see Table 1 following. There is growing evidence of a lack of correlation between indicators of social capital, in turn hinting at several pathways from social capital to health (Giordano and Lindstrom, 2010; Lindström et al., 2004; Nummela et al., 2008). We, therefore, simultaneously investigated a range of measures for structural and cognitive social capital at the individual level and applied structural equation modelling (SEM) to obtain estimates of several dimensions of social capital. SEM permits measurement error to be isolated and controlled for in a way that is not possible with traditional methods of aggregating data.

We do not consider potential contextual effects for two reasons: First, the most common approach to defining social capital in research on population health to date has been the social cohesion perspective (Murayama et al., 2012); and second, a systematic review of social factors and health (Pickett and Pearl, 2001) and one

recent multilevel study (Giordano et al., 2011) demonstrate that individual-level social capital proxies have the greatest influence on individual health.

#### 2.4.1. Structural social capital

Structural social capital represents individual social participation and networks in the local neighbourhood. Social participation is commonly referred to as a behavioural/activity component of social capital and individual social capital is commonly measured by asking individuals about their participation in social relationships and organisations (Bain and Hicks, 1998). The social participation latent variable in this study is predicted by the observed involvement in the voluntary associations listed in Table 1. The second measure, 'social network', is that of social support from/to friends, since friends can provide an important source of emotional support for adults (Adams, 1985) and the frequency of contact with friends is often considered as bonding social capital (Brisson and Usher, 2007; Derose, 2008; Lowndes, 2004). There is also evidence to suggest that children and adolescents gain some protection against internalising behaviours, such as depression and suicidal ideation, when they enjoy wider networks, either directly with their peers or indirectly through their parents' networks (Rotenberg et al., 2004). Respondents in the BHPS are asked how regularly they are in touch with their three closest friends. Each item uses response options of 'no contact', 'less often', 'at least once month', 'at least once week', and 'most days', and utilises a five point scale. This three-item friendship network latent variable measures overall relationship with the three closest friends in this study. As Bertotti et al. (2013) find that social participation and social network are both significantly associated with mental health, but the sign of correlation is of opposite direction, we used these two measures separately rather than as a single structural component.

#### 2.4.2. Cognitive social capital

One of the important aspects of cognitive social capital is the emotional and practical support it offers in times of need. Loneliness is often viewed as a subjective measure of social interaction and the antithesis to social support, highlighting the importance of social perceptions and evaluations of personal relationships (Victor et al., 2000). Since the literature suggests that being socially isolated can negatively affect mental as well as physical health (Holt-Lunstad et al., 2010), we identified loneliness as a perceived lack of

**Table 1**  
Items of social capital.

Question item	Response/scoring
Social Participation	
Member of political party	No = 0
trade union	Yes = 1
environmental group	
parents association	
tenants or residents group	
religious group	
voluntary service group	
other community group	
other organisation	
Social Network	
How often do you see or get in touch with your 1st/2nd/3rd closest friend either by visiting, writing or by telephone	No contact = 0; Less often = 1; At least once a month = 2; At least once a week = 3; Most days = 4
Loneliness	
Is there someone who will listen?	No one = 2; Yes, one person = 1; Yes, more than one person = 0
Is there someone to help in a crisis?	
Is there someone you can relax with?	
Anyone who really appreciates you?	
Anyone you can count on to offer comfort?	

social and emotional support. The BHPS includes variables indicating whether respondents have someone who will listen to them, help them in a crisis, relax with them, appreciates them, or comforts them. In this study these variables were coded as binary outcomes with 1 indicating that they have no-one and 0 otherwise.

2.5. Demographic factors

We used six demographic factors (age, gender, marital status, highest level of education, employment status, and annual household income) in our analyses. These factors are often associated with basic variations in health (Chandola, 2000; Rose and Pevalin, 2000). Current annual household income was constructed from information on the annual labour and non-labour income of each member of the household. To allow for the effects of household size and composition, household income was equalised using the McClements scale (see Taylor et al., 1998), deflated to 2005 prices using the retail price index and transformed to natural logarithms to allow for concavity between health outcomes and income. We used age to remove any within-cohort age effects and also allowed for a flexible relationship between health outcomes and age by specifying a cubic polynomial in age (i.e. AGE, AGE<sup>2</sup> and AGE<sup>3</sup>). We included indicators for region of residence in our models but the parameter estimates are not reported as geographical variation is not the focus of this paper and the categories used in these variables are rather cruder. Our variables are defined in Table 2 following:

3. Models and estimation methods

We conducted autoregressive cross-lagged panel models (ACLPM) (Cole and Maxwell, 2003; Curran, 2000) to simultaneously address reciprocal influences on individual social capital and health outcomes. Since multilevel structural equation model (SEM) allows for the use of latent variables to correct for measurement error, multivariate outcomes, flexible multiple group comparisons, and the calculation of overall fit statistics for model evaluation (Bovaird, 2007; Curran, 2003; Mehta and Neale, 2005), we implemented a two-level SEM approach to partition between- and within-person effects. A simultaneous equation model that allows for autoregressive effects and cross-lagged effects between health outcomes ( $Y_{it}^H$ ) and social capital ( $Y_{it}^{SC}$ ) at each measure point may be written ( $t = 2, \dots, 9$ ) as

$$Y_{it}^H = \alpha_t^H + \beta_1^H Y_{t-1,i}^H + \beta_2^H Y_{t-1,i}^{SC} + \delta^H X_{t-1,i} + \gamma^H Z_i + \mu_i^H + \epsilon_{it}^H \quad (1)$$

$$Y_{it}^{SC} = \alpha_t^{SC} + \beta_1^{SC} Y_{t-1,i}^{SC} + \beta_2^{SC} Y_{t-1,i}^H + \delta^{SC} X_{t-1,i} + \gamma^{SC} Z_i + \mu_i^{SC} + \epsilon_{it}^{SC} \quad (2)$$

where  $t$  represents an occasion,  $i$  represents an individual,  $\alpha_t$  is a time-varying intercept term,  $Y_{t-1,i}^H$  and  $Y_{t-1,i}^{SC}$  are the lags of one time unit for health outcome and social capital,  $\delta$  and  $\gamma$  are row vectors of coefficients of  $X_{ti}$  and  $Z_i$ , which are respectively a vector of control variables that vary over both individuals and time (e.g. marital status, educational attainment, household income) and a vector of control variables that vary over individuals but not over time (e.g. gender). The term  $\mu_i$  denotes fixed effects that vary across individuals whilst  $\epsilon_{it}$  are random disturbances that are assumed to be independent of each other and normally distributed with means of zero and constant variance. We also assume that  $X_{ti}$  is strictly exogenous, meaning that it is independent of  $\epsilon_{it}$ . With respect to  $Y_{it}^H$  and  $Y_{it}^{SC}$ , we cannot assume strict exogeneity because both variables appear as dependent variables. Instead, we assume that they are sequentially exogenous (Wooldridge, 2010).  $\beta_1$  represents the autoregressive effects, or the effects of social capital and health outcomes on themselves measured at a later occasion. A small or zero autoregressive coefficient means that there has been a substantial reshuffling of the individual's standings on the construct over time. In contrast, a sizable autoregressive coefficient means that the individual's relative standings on the construct have been relatively constant over time.  $\beta_2$  describes cross-lagged effects that are the effects of individuals' social capital on their subsequent health outcomes and the effect of health outcomes on subsequent social capital.

The model defined by equations (1) and (2) leads to a two-level cross-lagged analysis for the individual responses with repeated measures (level 1) nested within individuals (level 2), which allows for the control of unmeasured confounders and the presumption that the coefficients are constant over time. The two equations are simultaneously estimated on our balanced panel of data by maximum likelihood methods in generalised SEM procedure of Stata v13.1 (StataCorp, Texas, USA).

ACLPM is specified to examine reciprocal relationships between individual social capital and health outcomes over a total of nine measure points or occasions. In Fig. 1 following, autoregressive effects are represented as single-headed arrows running from a given variable at one occasion to the same variable at the next

Table 2  
Variable definitions.

Mental health	Continuous score, range from 0 to 12 (the higher, the better)
Physical health	Ordinal scale, range from 1 to 5 (the higher, the better)
Age	Age in years at 1st December of current time point
Female	1 if female, 0 otherwise (reference group)
Male	1 if male, 0 otherwise
Married	1 if married or living as a couple, 0 otherwise (reference group)
Separated	1 if divorced or separated, 0 otherwise
Widow	1 if widowed, 0 otherwise
Never married	1 if never married, 0 otherwise
Without qualification	1 if no qualification, 0 otherwise (reference group)
With qualification	1 if qualification, 0 otherwise
With higher qualification	1 if higher degree, 0 otherwise
Paid employment	1 if in paid employed, 0 otherwise (reference group)
Self employment	1 if self-employed, 0 otherwise
Unemployment	1 if unemployed, 0 otherwise
Retired	1 if retired, 0 otherwise
Student	1 if full-time student, 0 otherwise
Other employment	1 if other employment status, 0 otherwise
Log (household income)	Natural log of equalised annual real household income in pounds

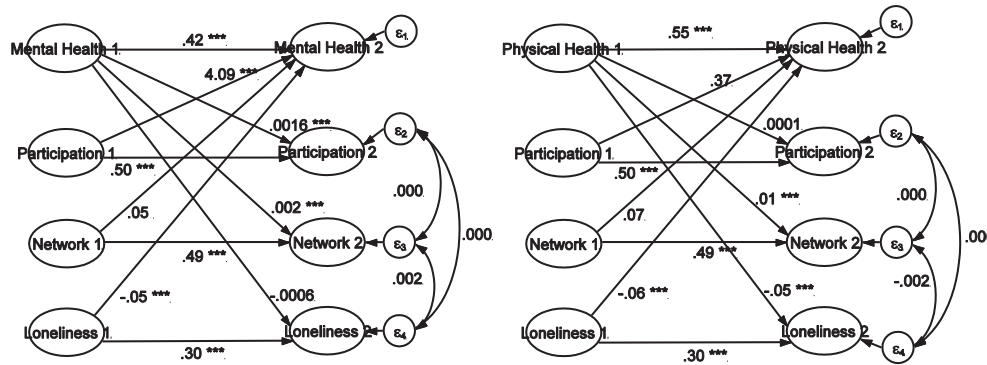


Fig. 1. Lags and cross-lags in multilevel structural equations model for social capital-health reciprocal effects at time  $t-1$  and  $t$  ( $n = 24312$ ).

occasion. The indicators of social capital to prospectively predict health status and for health status to prospectively predict social capital over an interval are illustrated by diagonal single-headed arrows. The error terms associated with the indicators of social capital at follow-up are hypothesised as correlated because we assumed that factors contributing to measurement error in latent variables would be consistent across the two occasions.

4. Results

Table 3 presents descriptive statistics for all of the variables used in our analysis for the analytic sample broken down by mental and physical health status. Stratifying the sample by ‘positive’ and ‘negative’ reveals that individuals who rate their mental health as positive tend to be younger, more likely to be male, married, employed, retired, and to have a higher real household income, and to be less likely to be divorced/separated or unemployed than their counterparts who rate as negative. Similarly, individuals are more likely to rate their physical health as positive if they are younger, male, employed and if they have higher academic qualifications and higher household income.

Our results in Fig. 1 show that the stationary autoregressive effect of self-rated mental (physical) health [0.42 (0.55),  $p < 0.01$ ], is significant, as are the stationary autoregressive effect of social capital, social participation (0.50,  $p < 0.01$ ), social network (0.49,

$p < 0.01$ ), and loneliness (0.30,  $p < 0.01$ ). These coefficients indicate moderate stability of mental (physical) health status and social capital over occasions.

Net of autoregressive effects, the stationary lagged effect of social participation on perceived mental health is significant (4.09,  $p < 0.01$ ). There is also evidence of a lagged effect in the opposite direction, but the magnitude is relatively small (0.016,  $p < 0.01$ ). There is some indication that lagged social network is positively related to perceived mental (physical) health although neither is found to be significant. Lagged mental and physical health do affect individuals’ social network as 0.002 and 0.01 at the 1% level, respectively. Lagged loneliness is significant and negative impacts are found on both mental ( $-0.05$ ,  $p < 0.01$ ) and physical health ( $-0.06$ ,  $p < 0.01$ ). However, only lagged physical health negatively affects loneliness ( $-0.05$ ,  $p < 0.01$ ), a higher physical health score at occasion  $t-1$  is associated with a lower loneliness score at occasion  $t$ .

It is apparent from Table 4 that younger and males generally present better perceived health, both mental and physical. Compared to the baseline category of married/cohabiting, individuals who are widowed or never married exhibit worse perceived mental health, whilst only widowed respondents exhibit worse perceived physical health at the 5% significance level. There is some indication that higher academic qualifications are

Table 3  
Variable means by health indicators.

	Self-rated mental health		Self-rated physical health	
	Positive N = 19648	Negative N = 4664	Positive N = 22462	Negative N = 1850
Age	45.84	47.06	47.11	50.65
Female	0.566	0.671	0.579	0.661
Male	0.434	0.329	0.421	0.339
Married	0.701	0.644	0.690	0.657
Separated	0.094	0.151	0.099	0.165
Widow	0.047	0.048	0.051	0.064
Never married	0.156	0.157	0.160	0.114
Without qualification	0.175	0.182	0.178	0.316
With qualification	0.408	0.393	0.397	0.386
With higher qualification	0.422	0.414	0.421	0.295
Paid employment	0.602	0.553	0.602	0.341
Self employment	0.085	0.072	0.084	0.045
Unemployment	0.019	0.039	0.022	0.030
Retired	0.175	0.143	0.177	0.250
Student	0.011	0.010	0.010	0.012
Other employment	0.013	0.010	0.009	0.010
Log (household income)	10.148	10.085	10.146	9.855

Table 4  
Estimated coefficients for multilevel cross-lagged structural equation model.

	Self-rated mental health N = 24312		Self-rated physical health NT = 47856	
	Coef.	S.E.	Coef.	S.E.
Age	-0.052***	0.016	-0.024**	0.012
Age2	0.148***	0.034	0.040*	0.024
Age3	-0.011***	0.002	-0.003**	0.002
Male	0.374***	0.022	0.106**	0.042
Separated	-0.091*	0.049	-0.009	0.039
Widow	-0.273***	0.069	-0.113**	0.056
Never married	-0.173***	0.051	0.006	0.045
With qualification	0.159***	0.047	0.210***	0.059
With higher qualification	0.130***	0.048	0.268***	0.066
Self employment	0.018	0.050	0.053	0.038
Unemployment	0.117	0.079	0.097*	0.055
Retired	0.067	0.050	-0.078**	0.037
Student	0.150*	0.090	-0.078	0.060
Other employment	0.046	0.060	-0.047	0.045
Log (household income)	0.007	0.022	0.054***	0.018

\* $p < 0.1$ , \*\* $p < 0.05$ , \*\*\* $p < 0.01$ .

Notes: Time dummies and geographic covariates have been suppressed from results.

associated with better perceived mental and physical health (as compared to the baseline of respondents with no qualifications). Few of the employment status categories are significant. The retired and disabled are associated with worse perceived physical health, and the disabled report relatively negative perceived mental health. Higher household income is associated with positive perceived physical health.

## 5. Conclusions

Given that social capital plays an important and growing role in UK health policy, it is vital that health enhancing intervention programs are targeted towards those population groups that are in the greatest need. In most studies, these groups have been identified through cross-sectional analyses that cannot exclude the possibility of reverse causality. Moreover, cross-section data provides only a snap-shot of the distribution of health status at a particular point in time and renders population intervention less cost-effective in terms of identifying at-risk groups. Our aim in this study has been to extend prior cross-sectional research and to shed further light on unidirectional and bidirectional causal relations between individual-level social capital and health problems using UK panel data, thereby aiding the development of more effective public health policies in the UK.

Our longitudinal analyses suggest that whilst there is substantial stability in both perceived mental and physical health, the former exhibits lower fluctuation over time than the latter. Our results further indicate that social participation strongly predicts future perceived mental health, whilst simultaneous reciprocal causality occurs between them. Our results are consistent with Bertotti et al. (2013) and Kawachi and Berkman (2001) who argue that social participation contributes to health by providing a sense of meaning to individual's lives as well as increasing access to social support. Social relationships formed by social participation improve mental health by increasing the participants' fulfilment of attachment, their social approval, access to resources and emotional gratification (Moen et al., 1992). Therefore, social participation is important for recovery and improving the health outcomes for individuals with poor mental health. For instance, a meta-analysis of 147 studies involving almost 100,000 individuals finds that religious involvement is also associated with reduced depression, particularly for stressed populations (Smith et al., 2003). Strategies to advantage communities with higher levels of social capital may include individual and community empowerment (Wallerstein, 2006), community arts, and access to safe, green community spaces.

Our study also supports previous findings that poor mental health has a detrimental impact on a person's ability to participate economically and socially in social and civil activities (Psychiatrists, 2009). Although the impact may be small in magnitude, it is worth noting that exclusion from key areas of social life, such as social interaction and political engagement, as well as from health service engagement results in inequality, which is also a major determinant of negative mental health and a marker of other risk factors (Parsonage, 2007). Interventions that use social contact or a combination of social contact and education are effective at increasing awareness of poor mental health in selected group and changing negative attitude in ways that will improve relationships, job performance and health (Corrigan et al., 2001). Despite the paucity of evidence that individual social network in preceding time periods is linked to increase perceived mental/physical health at subsequent time points, our results suggest that positive perceived mental and physical wellbeing helps individuals to develop a good support network. The mutuality and reciprocity that occurs through social network, builds social capital, which in turn is

associated with well-being and resilience (McKenzie and Harpham, 2006). For example, the UK Department of Health (2012) in the related Implementation Framework recommends the development of peer support as one of the roles of mental health organisations in implementing the strategy.

Our findings also support the view that loneliness has a significant negative impact upon perceived mental and physical health. Cacioppo and Patrick (2008) find that loneliness causes higher rises in morning levels of the stress hormone cortisol, altered gene expression in immune cells, and higher blood pressure. Loneliness is also associated with an increased risk of depression, sleep problems and a faster progression of Alzheimer's disease. Tackling social isolation formed the logic for much of the 'Third Way' policy agenda of the UK Blair Labour governments (Giddens, 2013). The non-significant influence of mental health on loneliness may provide evidence that loneliness is sometimes due to the unwillingness of others to befriend the mentally ill with the stigma associated with poor mental health creating a substantial barrier to socialisation (Harvey and Brophy, 2011). Whilst some of the mental ill withdraw from others as a way of managing symptoms, many desire more connection. For example, nearly 45% of participants in the Australian National Survey of Mental Health and Wellbeing with psychosis felt they are in need of good friends (Jablensky et al., 2000). It is therefore necessary to confront biased social attitudes in order to reduce the discrimination and stigma of individuals who are living with poor mental health.

There are also systematic differences in health outcomes across socio-economic groups. In general, age, gender, marital status, employment status and household income are significantly related to changes in both perceived mental and physical health. The analyses suggest that older individuals rate their health as more negative compared to younger individuals (Zack et al., 2004). Rates of positive perceived health are higher among high school graduates with further education (Mikolajczyk et al., 2008; Mirowsky and Ross, 1998) and among males compared to females (Benyamini et al., 2003). Our study also provides evidence that marriage is associated with enhanced perceived mental health (Simon, 2002) and adjusted household income is associated with perceived physical health (Subramanian et al., 2003).

This study has distinguished three indicators of social capital and their relative impacts on both perceived mental and physical health. Our statistical model clearly establishes the temporal relation between the two constructs and protects against the potential biasing effects of reverse causation. It further allows for the differentiation of individual-specific influences as well as the differentiation between time-varying and time-invariant unmeasured influences on health outcomes using panel data. The estimation of these individual-level and occasion-level effects renders it possible to draw valid and reliable conclusions regarding the relative magnitudes of reciprocal effects of social capital and health outcomes.

There are, however, several limitations in our data. The self-reported retrospective measures for health outcomes almost certainly lead to some degree of self-reported bias. In particular, self-reported bias may inflate the size of the correlation of construct across time and reduce the unexplained variance available for other latent variables (Marsh, 1993). A second limitation is that, similar to most panel data, the BHPS is not based on sensitive designs that can provide powerful methodological possibilities to understand genetic influences on personality traits leading to consistent behaviour, thoughts, and emotions across situation and context (see, for example, Hahn et al., 2012; Kenrick and Funder, 1988). The third limitation is that there may be potential dilution bias from regression to the average values from two waves in dynamic models (Liker et al., 1985). And finally, a number of commentators argue that there is more than one type of social capital.

This study mainly focuses on ‘individual’ (i.e. bonding) social capital – that is, horizontal tight-knit ties between individuals sharing similar demographic characteristics – rather than ‘linking’ social capital – that is, vertical connections that span differences in power. Szezter (2002) argues that the decline in linking social capital is likely to lead to an increase in health inequities. Recent studies suggest that social capital can be influenced by contextual, relational, and psychological attributes such as neighbourhood capacity and norms (Yu et al., 2011). It is therefore important to more closely examine the contextual and individual elements of social capital separately in future research.

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