



# Residents' perspectives of health and its social contexts

Qualitative findings from three  
of Glasgow's Transformational  
Regeneration Areas

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## Executive summary

### What did we know already?

There is an expectation that urban regeneration can improve residents' health in disadvantaged areas. However, research evidence suggests that the health benefits of regeneration may sometimes be minor.

### What does this study do?

Using qualitative methods we explored whether residents of disadvantaged neighbourhoods experiencing extensive regeneration believe that their residential environment (including home and neighbourhood) influences their experience of health. Twenty-three households from three inner-city mass housing estates in the city of Glasgow (Scotland) participated in the study. Qualitative studies do not provide evidence of illness prevalence or demonstrate the effectiveness of interventions. They do provide insights into participants' range of experiences and help us understand processes and mechanisms.

### What did we find?

The participants suggested a range of perceived pathways and mechanisms by which their physical and psychological health might be influenced by their environment. Of particular relevance to housing regeneration, homes considered too small, damp and costly to heat were perceived to have adverse health consequences in terms of mental wellbeing, childhood asthma and related illnesses. However, many other factors considered to have important health consequences were not directly linked to the physical condition of people's homes. Social relationships and support structures within and beyond the local neighbourhood were considered to be important for a range of health and wellbeing issues. Participants identified a

number of factors which they considered to be beneficial to their health and wellbeing, including participation within the community; individual or community support from community organisations and professional services (e.g. health, police, housing, etc); and relocation as part of the clearance and new build programme.

### What are the policy and practice implications?

The participants have suggested pathways by which housing improvement and other forms of community support might lead to health benefits. Knowledge of these pathways could help inform regeneration strategies that aim to improve health and wellbeing. A key message from this study is that the social environment is perceived by residents to influence a greater range of health issues than the physical environments of homes and neighbourhoods. Therefore, the potential benefits of urban regeneration would be maximised if strategies include improvements to social as well as physical environments.

## Glasgow's regeneration and GoWell

Attempts to improve the quality of urban dwellings, neighbourhoods and communities have long been a feature of urban development. Terms such as 'urban regeneration', 'renewal' and 'housing led area-based initiatives' are used, sometimes interchangeably, to describe a range of different approaches to achieving better living conditions and opportunities for disadvantaged residents.

This report focuses on neighbourhoods located in Glasgow, a Scottish city that is currently experiencing substantial investment in regeneration. Glasgow is the largest city in Scotland and contains high concentrations of poverty, disadvantage and ill health. Area-based health inequalities are stark: for example life expectancy in the most disadvantaged areas of Glasgow has been estimated to be at least 15 years shorter than in the more prosperous areas<sup>1</sup>.

In 2003, over 80,000 socially rented homes in the city transferred from public ownership to a newly created not-for-profit organisation called Glasgow Housing Association (GHA), following a tenants' referendum. GHA became the largest provider of social housing in the city alongside a number of smaller providers (collectively known as 'Registered Social Landlords' or RSLs). The stock transfer paved the way for a city-wide regeneration investment programme spearheaded by GHA but also involving other RSLs and non-housing partner organisations from other sectors.

Glasgow's regeneration involves a number of different components such as housing improvement, building new homes, demolishing housing stock, tenure diversification (i.e. introducing more private sector housing into predominantly social rented neighbourhoods), as well as delivering improved services and improved mechanisms for community engagement and empowerment. Over a billion pounds has now been invested in communities across the city. The amount and type of investment varies by locality according to circumstances.

GoWell is a research and learning programme that aims to investigate the impact of this investment on the health and wellbeing of individuals, families and communities in Glasgow over a ten-year period<sup>2</sup>. The Programme aims to establish the nature and extent of these impacts and the processes that have brought them about, to learn about the relative effectiveness of different approaches, and to inform policy and practice. It is a multi-component study with a comparative design. Although focused on regeneration in Glasgow, GoWell aims to produce findings that are transferable to other regeneration settings.



## 1 Introduction

### 1.1 Regeneration and health – the expectations and the evidence

There is a commonly stated policy expectation that investment in regenerating disadvantaged neighbourhoods should benefit the health of residents and provide a mechanism for reducing social inequalities in ill health. So, for example, the Scottish Government's policy statement, *Equally Well*<sup>3</sup>, recommends neighbourhood regeneration as a means of tackling health inequalities, while the UK Department of Health has for several decades allocated some of its budget to neighbourhood regeneration initiatives<sup>4</sup>.

The research literature on urban regeneration provides some evidence to substantiate the expectation that regeneration can benefit health, but the evidence is neither conclusive nor comprehensive. For example, a systematic review has found that relatively modest improvements in respiratory, general and mental health have been observed following some improvements to the physical home environment, particularly the provision of more efficient and affordable heating<sup>5</sup>. However, the review concluded that the potential for health benefits may depend on the type of intervention and the degree to which interventions are targeted at populations with the greatest housing needs.

The field of regeneration and health also contains many under-researched areas and 'evidence gaps'. For example, the systematic review referred to above identified a large number of studies that evaluated the health effects of heating improvement interventions, but other types of housing improvement were found to be considerably less (and less robustly) evidenced. Other reviews have also found that the health impacts of more complex interventions, including area-based and multi-intervention regeneration, have a particularly weak evidence base<sup>6-7</sup>.

Therefore, while the research evidence on regeneration and health includes some positive messages, the available evidence base still leaves us with uncertainties and unanswered questions. This suggests a need to be cautious about what we expect regeneration to achieve. Housing-led regeneration initiatives can, it seems, lead to health benefits but we cannot guarantee that they will always do so, or that any effects will be large.

### 1.2 Living with transformational regeneration

This report focuses on three Glasgow neighbourhoods that are undergoing a particularly transformative programme of regeneration (and so are described locally as Transformational Regeneration Areas (TRAs)). This transformational regeneration typically involves a package of different interventions planned at neighbourhood and community level. The three TRAs that GoWell focuses on are all inner-city social housing estates built to accommodate 1000+ households. They are comprised predominantly of post-war high-rise flats but also include some low-rise stock. In each neighbourhood all or most of the existing housing is being demolished so that the neighbourhoods can be redesigned. It is a lengthy process involving community engagement, large scale clearances, and relocation to newly built or improved housing.

GoWell is interested in finding out what it is like for residents who live in neighbourhoods that, over a number of years, are being emptied and demolished around them. There is a longstanding research tradition that alleges and explores the negative social effects of housing clearance programmes: for example, Paris & Blackaby (1979) note that "comprehensive redevelopment has frequently been accused of the 'destruction of communities' and established neighbourhoods"<sup>8</sup>. This 'destruction of communities' narrative has also found a place in some media accounts of regeneration in Glasgow<sup>9</sup>.

However, the relevance of this narrative to modern housing estates – particularly those that contain relatively high proportions of short-term and transient residents (rather than 'established' communities characterised by multiple generations of long-term residents) has received less attention from researchers<sup>10</sup>. Furthermore, the research literature has little to say about the health impacts of clearances, demolitions and relocation. This 'evidence gap' is a cause for concern given that this kind of transformational regeneration is likely to affect potential health determinants related to residents' social and physical environments as neighbours move away, the physical environment deteriorates (e.g. due to derelict buildings and demolition sites) and local amenities close down.

As GoWell is a mixed methods study we can examine the health implications of transformational regeneration from a number of angles<sup>2</sup>. GoWell's quantitative component includes repeated censuses of these three neighbourhoods, through which we can monitor health and wellbeing over time and provide evidence of individual and area level health impacts. Meanwhile, the qualitative component can explore in more depth how a small sample of residents living in these neighbourhoods experience health, wellbeing and illness and how they relate those experiences to their own and their community's changing circumstances.

This report focuses on qualitative findings. It outlines some of the early findings from a particular strand of GoWell's research programme – the GoWell Lived Realities study. The study offers participating residents an opportunity to identify for themselves the kinds of issues that are important to their everyday lives. In doing so, the study also serves as a kind of a reality check for GoWell – i.e. it helps us to explore the degree to which our own research priorities are relevant to residents' own concerns and perspectives. In terms of health, it uses residents' accounts to help us explore a range of perceived pathways by which residential environments might affect health outcomes. Specifically, we will explore the following health issues through the Lived Realities study (see key research questions below).

#### Panel 1: GoWell Lived Realities Study (health component) – key research questions

- 1 Do residents believe that their residential environment (including home and neighbourhood) has important impacts on their health and wellbeing?
- 2 Do residents believe that changes to their residential environment have important health consequences?

For reasons that will be made clearer in the next section, this interim report will focus particularly on presenting findings for the first of these themes, but will also present some early findings relevant to the second theme.

## 2 Methods

The GoWell Lived Realities study is a longitudinal qualitative research study. The first wave of the study took place over the spring/summer of 2011. The second wave will take place during the spring/summer of 2012 when we will attempt to re-interview the wave 1 participants. As this interim report has been produced prior to the second wave, it includes only wave 1 data rather than a longitudinal comparison of wave 1 and wave 2 data. The second key health theme listed in Panel 1 (which explores change over time) is particularly suited to the study's longitudinal component and therefore will be discussed more fully in the post-wave 2 final report.

Wave 1 participants were identified through a combination of local contacts, snowballing\* and by re-contacting residents who had already participated in previous GoWell surveys and consented to follow-up. The original aim was to recruit 24 parents/guardians with dependent children. This was so we could obtain data on the adult participants own experiences, and their perceptions of how other family members have been affected by their home and neighbourhood as these environments changed.\*\* It was hoped that we would recruit eight adult participants from separate households in each of the three TRAs. From previous research experience, and in view of the relatively high numbers of single mother families in these neighbourhoods, we anticipated that recruitment of male participants would be especially problematic but we aimed to have at least some male representation from each of the neighbourhoods.

Following informed consent, participants took part in two wave 1 interviews typically conducted several days apart. The first was an in-depth interview loosely structured around themes such as participants' background, home, neighbourhood, health, aspirations and experience of

\* Using participants' social networks to find further potential participants is referred to as snowballing.

\*\* Some of the younger family members were also interviewed for a separate GoWell study on regeneration and young people. Findings will be presented at a later date as part of Joanne Neary's doctoral thesis, conducted at the MRC/CSO Social and Public Health Sciences Unit and the University of Glasgow.

regeneration. At the end of the interview, participants were loaned a camera and asked to take photographs once the researcher had gone to represent the theme of 'my day.' This instruction was left deliberately open to encourage participants to develop their own sense of what was important to their everyday life (and what was not). In this way, it was hoped that the second interview could be steered to a greater degree by the participants' own priorities rather than those of the researchers. The second wave 1 interview was consequently based around those photographs, as the interviewer returned to ask participants to explain their significance.

The interviews were conducted by Louise Lawson (LL) at the homes of participants, recorded using digital audio equipment and transcribed by a specialist transcription company. The aim was to interview participants without other householders present. However, the interviewer was sensitive to her status as a guest in the participants' homes and respected the wishes of any participants who wanted to allow other householders to sit in for some or all of an interview (this happened in a minority of cases).

After each interview the participants received a £20 voucher to thank them for their time. All data (digital, visual, audio and textual) that could potentially identify participants has been held and transported securely in line with Medical Research Council data handling guidelines, so that the anonymity of participants can be preserved. To help protect participants' confidentiality, this report uses pseudonyms rather than the participants' real names, and does not name the neighbourhoods they live in. The study received ethical approval having been through the University of Glasgow's ethics approval process.

Transcribed interviews were analysed by LL and Matt Egan (ME) using a coding framework they developed jointly. LL and ME categorised data into a series of sub-themes, dividing the themes relatively equally between them. ME led on analysing data relating to the study's health themes, using NVivo 9 (computer software designed to assist with data storage and analysis) to assist with the process. Additional reports are planned focusing on other themes (i.e. besides health) relevant to the study. Further methodological information can be obtained from the authors on request.

## 3 Findings

### 3.1 Who participated?

A total of 23 households participated in the study and 50 interviews were carried out (see Table 1):

**Table 1: Number of households and interviews in each area**

	Households	Total no. interviews
Area 1	11	23
Area 2	9	19
Area 3	3	8
	23	50

- The majority of participants were recruited via the Local Housing Organisations in each area (researcher liaised with housing officers) (n=13).
- Some were recruited through church/community groups (n=3).
- A number were recruited through snowballing (n=6).
- One person was recruited through the GoWell survey and had consented to follow up (n=1).

Detail about the sample - participant pseudonyms, recruitment type, household details, household situation, other relevant information and data collected – is in the appendix.

Of the 23 households, 20 were 'family households' in that there was at least one adult and one child/young person living there either full or part time. Three were single person households. Interviews were usually held with one member of the household but in some instances they were joint interviews (5) or other members of the household joined in at various points. In one case (area 3), interviews were done with each member of the family (2 adults and 2 young people) as this was the first household to be recruited and was considered a pilot.

The participants included a mixture of employed and unemployed residents. Some participants were white Scottish / British, while others belonged to ethnic minority groups – particularly from the substantial asylum seeker and refugee communities that live in each area. In this sense, the sample broadly reflects the socio-demographics and ethnic composition of



family households in these neighbourhoods. However, we do not claim to have samples that are statistically representative of the populations from which they are drawn (nor is it conventional to make such a claim when presenting qualitative research).

### 3.2 Residents' perceptions of health

Focusing on the first research question (Panel 1) we have analysed residents own accounts of their health and explored the importance they attach to residential environments as a health determinant. The accounts tended to suggest that participants found it easier to discuss health in terms of their experiences of illness rather than more positive experiences of health and wellbeing (although there are some examples of more positive accounts that this report will present later). For this reason, most of the health related data we analysed concerned perceptions and experiences of illness.

Most of the participants stated that either they or another household member had a serious health problem – in most cases these health problems were said to have existed for a number of years. The physical illnesses described in these accounts include asthma, eczema, kidney problems affecting the immune system, kidney stones, pneumonia, AIDS, ulcers, diabetes, brain malformation, back pain, amputations and arthritis. Psychological issues included anxiety, depression, self-harm and violent conduct. Some of these health problems were experienced by more than one participant. Clearly this is a formidable list for such a small sample, and it includes some illnesses that are unlikely to be easily fixed by a change of environment.

The point here is not to make any comment about illness prevalence. The study is not designed for that purpose and we already know from previous research that residents of Glasgow's disadvantaged neighbourhoods experience a disproportionately high burden of ill health compared to more affluent neighbourhoods and national averages<sup>11</sup>. Instead, the point is to learn more about what residents think caused their illnesses or poor health, and whether they perceive their residential environment as having an influence on their experience of (ill) health.

In the sections that follow we explore residents' accounts of their ill health, focusing on

- (a) what are perceived to have been the causes of their health problems,
- (b) what factors are perceived to influence or exacerbate problems of poor health and health behaviours, and
- (c) what factors help to alleviate those problems.

In each case, the intention is to see whether participants believe that their residential environment has a particularly important role to play.

### 3.3 Causes of ill health

Figure 1 (overleaf) summarises participants' perceptions of how they or members of their immediate family came to experience the health problems that impact upon their lives. Usually, the health problems described were those that the participants themselves experienced.

The key issue we want to address is whether or not participants blame ill health on some aspect of their residential environment. Taking the physical illnesses first, there were participants from each neighbourhood who believed that asthmatic or related problems experienced by their children were caused by damp or drafty conditions in their flat (some also provided photographic evidence of the damp and mould problems they referred to).

However, with the exception of childhood asthma, most accounts suggest that participants did not consider their physical environment to be the key cause of their health problems. Instead participants gave accounts of illnesses being caused by other health problems (a number of participants suffered from co-morbidity), or by previous drug misuse. The addiction problems themselves were attributed to the influence of former partners. Other explanations for physical health problems included work related injury, hereditary illness and bad luck.

To an extent, a similar picture can be drawn from participants' accounts of psychological problems. A substantial number of participants said they suffered from anxiety and/or depression with a few also suggesting that this has had a negative impact on their children's mental health. One participant had a history of violent conduct for which she had served time in prison. The physical environment of the home (notably living in a home that was perceived to be too small) was

regarded by one participant as a cause of depression. However, there was a range of alternative explanations (i.e. not the physical environment) that included the difficulties of coping with serious physical illness, and/or previous histories of abusive relationships, family problems and the anxiety involved in making an application for citizen status.

These explanations are, of course, based on participants' perceptions rather than the view of medical professionals – but we point out that medical judgements are themselves often informed by patients' accounts, and the pathways we have described are generally plausible ones. Overall, it appears that participants believe many causes of ill health to be linked to familial and other social relationships, while only a limited set of specific illnesses are seen to have been directly caused by poor physical environments in the home or neighbourhood (see Figure 1 on page opposite).

Based on the participants' perspectives, we might infer that the extent to which regeneration is likely to tackle causes of ill health may in part depend on whether the intervention leads primarily to improvements in the physical environment (in which case their impacts could be quite limited to the causes of a few specific conditions) or to improvements in residents' social/familial relationships as well.

### 3.4 What influences poor health or poor health behaviours?

We do not consider it sufficient, however, to focus simply on the perceived causes of residents' ill health, as residents' environments may potentially exacerbate or help to relieve even those health problems that were not caused by that environment. Furthermore, people's health behaviours might potentially be shaped by the environment they live in. Therefore, the hypothesised potential for homes and neighbourhoods to *influence* (rather than *cause*) residents' experience of health will be explored below with reference to specific illnesses and health behaviours.

Participants provided us with a number of examples of how they perceived existing health problems or poor health behaviours to be exacerbated by poor quality homes and neighbourhoods. Problems with heating homes, cooking, the psychosocial impacts of

poor residential environments, antisocial behaviour and the local drinking culture were among the issues highlighted.

#### 3.4.1 Affordable warmth

With regards to the home environment, affordable warmth was a key issue. In cases where participants had health problems that could be potentially worsened by cold, they needed to choose between spending more money on heating their home or taking their chances with the cold. The problems of affordable warmth were linked by participants to homes that were poorly insulated or damp but it was the pay-as-you-go power card based heating systems that received particular criticism. This is because the card meters were considered to be more expensive than alternative billing systems:

*“Cos I’m diabetic, that’s another problem as well. Trying tae say tae the social security, cos I’m diabetic, baths and heaters, I need that quite constantly. And the way the bill, I pay the power card, I go through it a lot.”*  
(Aisha)

A participant (*Barbara*) with multiple health problems described her situation the previous winter (an unusually cold one) when she was very ill and needed constant heat. According to her calculations, the cost of constant heating would come to around £30 a week, more than half her available weekly income. Another participant told us he had taken his concerns about the health problems related to damp and mould to the local housing organisation:

*“I said you can’t have people living in they flats. The dampness, it’s cost them too much to run, and it’s power cards as well, which is mad, that’s, that’s ludicrous know what I mean?”*  
(Paul)

So, heating was a major concern, but residents also identified other ways in which homes might influence health.

#### 3.4.2 The kitchen

In terms of health behaviours, participants commented that the quality of kitchen equipment could affect their diet. Participants from different households claimed that their main cooker could not be used because of damp around the sockets – limiting their ability to cook.

**Figure 1: Perceived causal pathways to health problems affecting participants or their families**

**INITIAL CAUSE**

(AS DESCRIBED BY PARTICIPANTS)

**SOCIAL RELATIONSHIPS (INCLUDING FAMILY)**

ABUSIVE OR DESTRUCTIVE RELATIONSHIP EARLIER IN LIFE

DRUG ADDICTION (PREVIOUSLY HEROIN, NOW METHADONE)

VIOLENT CONDUCT

ULCER

PNEUMONIA

AIDS/VIRAL ILLNESS

DIABETES

FAMILY PROBLEMS FROM CHILDHOOD / PARENTS WITH MENTAL ILLNESS

SELF HARM

CARING FOR A SICK FAMILY MEMBER

ANXIETY AND/OR DEPRESSION

**CITIZENSHIP APPLICATION**

APPLYING FOR BRITISH CITIZENSHIP

**WORKPLACE**

WORK RELATED INJURY

BACKPAIN

NERVE DAMAGE

TOE AMPUTATION

ABSENTEEISM (UNSPECIFIED)

**HOME**

SMALL HOME

DAMP/DRAFTY HOME

CHILDHOOD ASTHMA/ ECZEMA

**OTHER CAUSES**

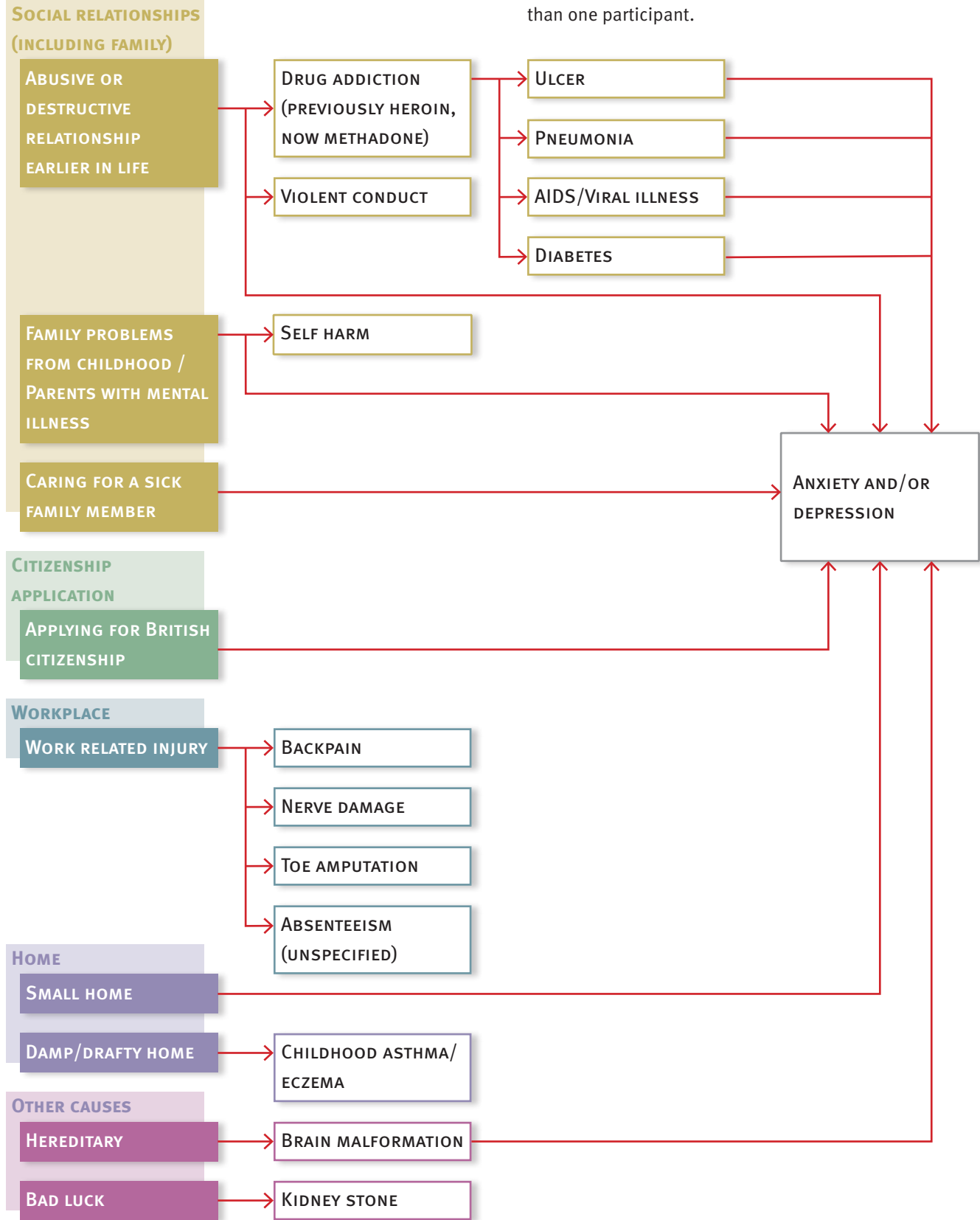
HEREDITARY

BRAIN MALFORMATION

BAD LUCK

KIDNEY STONE

Note: in some instances, participants did not attempt to explain why they experienced health problems. This figure is based on accounts where explanations were provided. Some boxes and pathways apply to more than one participant.



A woman who had recently relocated from Area 3 to a new build house suggested that the family diet had previously been worse because of problems cooking with an 'ancient' oven:

*"Maybe, the quality of the food's better [since moving] because we've got a better cooker. We couldn't afford a nice cooker before."* (Heather)

It should be noted that registered social landlords are generally not responsible for providing their tenants with cookers, except when providing furnished accommodation.

### 3.4.3 The psychosocial environment

The home and neighbourhood can also be considered important psychosocial environments. Here the term 'psychosocial' is used to refer to how people's environments make them feel. Many (but not all) participants suggested they had a low opinion of their flats, at least to the extent that they were looking forward to moving out. On occasion this low opinion was presented as something that could contribute to feelings of low mental wellbeing. For example, one participant said that the following were currently missing from her life:

*"Peace, contentment, feeling safe in your own house, a house that you can live in and that you're not ashamed to bring people into – because this house is a mess."* (Alison)

The problems of loneliness and isolation were recurring themes that were sometimes believed to exacerbate feelings of depression. The relationship between depression and isolation was sometimes portrayed as cyclical – loneliness encouraged depression but depression also discouraged sociability. Some participants' accounts suggested ways in which residential environments could feature within this cycle. Poor quality housing could also be a barrier to social contact if participants were 'embarrassed' to invite people into their home (as suggested in the above and also by participants *Ali* and *Aisha*). Negative external perceptions of the neighbourhood could present a similar barrier if it meant that friends and family were unwilling to visit.\*

\* In an accompanying report, we provide further examples of how fear of antisocial behaviour and embarrassment towards homes and neighbourhoods could sometimes be a barrier to participants' social contact with their friends and family.<sup>12</sup>

*"They always afraid to come here because they think [Area 1's] kind of dangerous for them. They can't leave their vehicle."* (Sami)

### 3.4.4 Antisocial behaviour

Some participants presented antisocial behaviour as a problem that reduced the quality of their (and their family's) life with potential health implications. A number spoke of the stress and anxiety they felt when they heard disturbances taking place outside or somewhere within the high-rise block where they lived (lifts and stairwells were particularly prone to problems)<sup>12</sup>. One complained that the frequent incidents of antisocial behaviour made him *"feel like you're living in a city slum"* (Sami). There were also accounts that highlighted racist intimidation as a particular problem, as in the case of one refugee who told us of the 'stress' her family felt because they were targeted for racial abuse that included verbal harassment and defecation outside their flat.

*"Yeah, and they come to use it to make a poo. That's this landing, that's not their landing, but they come exactly on our landing to do that. That I don't like. This also my children doesn't like this building because they told me, we are... we see the people very nice outside. Why to come to this building and we feel that we are not free, not happy to meet this people here? We want to move from this... yeah."* (Layan)

In terms of direct victimisation, the above account is one of the most extreme we heard. *Layan* talked about reporting her problems to her landlord and the police. While she recognised that these organisations were working hard to tackle antisocial behaviour, she also suggested that the antisocial incidents continued regardless. Furthermore, the experience of victimisation left a lasting negative impact on *Layan's* and her family's quality of life. They were fearful and they want to move away.

Other parents also told us of the fears they experienced when their children were outside in environments that were not considered safe. Besides the potential impact such fears might have on psychological wellbeing, participants presented antisocial behaviour as a barrier to physical activity. Young children were unable to play out because play areas were either vandalised (*Nada*) or

they attracted groups of ‘boys’ who would come to the playground to drink (*Maya*).

### 3.4.5 Alcohol consumption

Alcohol consumption in the neighbourhoods was referred to a number of times by participants who described how their quality of life was undermined by local antisocial behaviour. However, alcohol was also portrayed as an instrumental part of residents’ social activities in the area. One participant (*Aisha*) went as far as to say that she was unable to sustain friendships locally because her diabetes excluded her from drinking alcohol with friends – leaving her without opportunities to socialise locally. Given the Scottish Government’s current attempts to reduce Scotland’s relatively high alcohol consumption, *Aisha’s* case suggests a potential barrier to reducing alcohol consumption in disadvantaged neighbourhoods by illustrating how embedded alcohol is within some people’s socialising behaviours.

To summarise, this section has presented participants’ accounts to illustrate how home and neighbourhood environments were perceived to have exacerbated problems of poor health and health behaviours. The physical environments of people’s homes and the social problems associated with neighbourhoods were highlighted.

## 3.5 What helps in terms of health and health behaviours?

The report has so far concentrated on poor health and has yet to consider the range of ways in which residents described how health could be positively affected by homes, neighbourhoods and communities. To some extent, distinguishing between factors that exacerbate health problems (as we did in the previous section) and factors that help improve health and health behaviours (which we consider in this section) necessitates some repetition. If problems with home heating, cookers, loneliness, neighbourhood safety concerns and the local drinking culture have the potential to worsen health, then we may feel it is justifiable to assume that warmer (and more affordably warm) homes, better quality kitchen equipment, social contact and support, safer (or safer-seeming) neighbourhoods and opportunities to socialise without alcohol could all be factors that might potentially confer some health benefits to at least some of the residents.

Another point to keep in mind is that the residents did not all think alike and some clearly liked their homes and neighbourhoods more than others. So, although we have already quoted a refugee from Area 1 whose life was made miserable by racial harassment, we spoke to another refugee who said that she and her family were very happy to live there:

*“I’m involved in [Area 1] community, I, you know, I’m enjoying my life here. Is not stressful. I love [Area 1].”*  
(*Ula*)

Key to this participant’s explanation for why she enjoyed living in Area 1 was her active participation in community groups. Furthermore, there are examples of white Scottish participants and participants from ethnic minority groups expressing the view that, in Area 1 at least, ethnic relations had improved considerably over the past few years – with the police, community organisations and residents themselves being credited for gradually bridging divisions within the community.

*“...year after year and the communities start to work hard to make that bridges or connecting between the asylum seekers and the local people and the communities working hard, church and police and Glasgow refugee make like a connecting between the people to understand each other.”* (*Layan*)

The white Scottish participants included those who presented positive perspectives of their respective neighbourhoods, as well as those who described where they lived in more negative terms. Participants who involved themselves socially in their neighbourhood tended to refer to this as something that benefited their wellbeing. This ‘involvement’ could take different forms – for example, *Maira* fitted the description of a ‘local activist’ and simply laughed off any suggestion that the neighbourhood was a source of serious stress. She was able to express her feelings of empowerment and resilience within a narrative that focused on her involvement in local community organisations and campaigning activities.

On the other hand, social involvement for some participants was less formal and more friendship based, but again participants were clear about the benefits of supportive relationships:



*“This lassie [the participant’s neighbour] saved my life. Literally saved ma life. You know. Such a good friend. She got me through ma, ma mum’s death and everything like that as well.”* (Barbara)

Other participants (particularly some of the residents from Area 1) identified physical features of their home and neighbourhood from which they seemed to derive some psychosocial benefit: e.g. several commented on the view from their high-rise, others commented on the neighbourhood’s proximity to specific places they liked to go to relax (e.g. the town centre and the cemetery). Furthermore, while several participants expressed a preference for houses with gardens, high-rise living also had its advocates. One participant, who had relocated to a house, told us that she had lived all her life in a high-rise: she had felt more secure when she lived high up with a concierge at hand and less secure living in her new house.

*“I like the hoose during the day, at night I just cannae sleep in it’...I’m feart in case the hoose gets broke into.”* (Lesley)

### 3.6 Relocation and health

Of the participants who had recently moved, the woman who had felt more secure when living in high flats was the only one who told us that her move to a new home had a negative impact on her wellbeing (i.e. anxiety and difficulty sleeping because she felt unsafe). Even she admitted that the other members of her household (grandchildren) were happy to have moved.

The other participants who had moved home were very clear that their relocation was a positive experience – citing more spacious and warmer homes, better kitchens, gardens, better schools and neighbourhoods that were perceived to be safer (see Panel 2 on page opposite). The principal health benefits referred to were wellbeing (happiness), physical activity (particularly for children who had a garden and safer streets to play in) and improvements in childhood asthma. Of the participants who referred to their new kitchens, there were mixed reports about the difference improved cooking facilities had made to the family diet: one suggested that a better cooker encouraged a better diet, while another suggested that the household diet remained fairly poor despite the improved kitchen equipment.

Of course, these participants had only been in their home a short time and so although the overall impression is a very positive one, it is worth remembering that a fuller picture of participants’ experiences after rehousing will only be possible after the second wave of this study has been conducted. Those findings will help shed light on the range of potential mechanisms by which participants perceive rehousing to affect health.

#### 3.6.1 The relocation process

Participants who had already relocated therefore tended to be positive about the impacts of their new home on their health, wellbeing and quality of life. However, some participants who were yet to move were worried about how their own imminent rehousing might lead to them being separated from friends and loved ones. For example, one said that if she were to be separated from her closest friend (and neighbour) *“emotionally, I would die inside”* (Barbara). The clearance process also exacerbated anxieties for parents who were worried about whether a move would be disruptive to their children’s social networks and education. In short, if participants expressed anxiety about the relocation process, it tended to be with regards to their own move rather than the clearance process that had already taken place.

While the relocation process appeared to make some participants feel anxious, there were a range of opinions expressed about how the landlords managed that process. Often, these opinions would centre on the role of local housing officers, who had a crucial role in providing personally tailored advice and assistance to residents. Some participants praised their local housing officer for helping them through the difficult process of moving. *Nadia* described hers as *“...very good... if you want to talk something, he listens to me”*.

On other occasions, participants provided more negative accounts of how they perceived the relocation process to be managed. *Harry*, for example, suspected that local housing officers could be guilty of favouritism when allocating new homes to residents:

*“They pick and choose what tenant they think’s going to be respectable, to move into they blocks. That’s al’ pre-arranged.”* (Harry)

## Panel 2: Improvements following rehousing linked by participants to better health and wellbeing

Perceived improvements	Quote
Bigger home and/or more useable space linked to better familial relationships and wellbeing	<i>“In [previous flat, Area 2] because the living room, our dining area we were sharing the same space...In this room we can all spend time together in this living room, as you can see there’s a lot of space...children would have been fighting for space...we are often sitting here happier and talking to each other. That has changed completely, the bond is more strong than [in the flat] because we all sit together and talk to each other.”</i> (Maya)
Home insulation and warmth linked to improvements in childhood asthma and Single entry home (no lift) linked to mental wellbeing	<i>“Double glazing, yeah, is make warm, and the other, the house is quite big, nice and clean and no more worried about disease and the something else, and there is, your only door you are going to open. There is no lift, anymore, to follow with other people – so is very peaceful... yeah, and the asthma is better, now.”</i> (Basra)
New cooker linked to better diet	<i>“Maybe, the quality of the food’s better because we’ve got a better cooker. We couldn’t afford a nice cooker before.”</i> (Heather)
Garden linked to children’s wellbeing and physical activity (outdoor play)	<i>“And sometimes I’ll say to [her grandchildren] when I’m going to [Area 1] to see...ma pals. And sometimes [name of grandson who lives with participant] say, ‘me no want to go to [Area 1] gran’... [interviewer asks why grandchildren prefer the new house]... I think it’s the garden, they can get out and play with their toys...Mair freedom for them.”</i> (Lesley)  <i>“As soon as my daughter was born...I was thinking you know, boy and girl sharing a room - and it’d be nice to have a garden for them to play in as well. So, we always wanted, like this. This was our dream house.”</i> (Heather)
Safer neighbourhoods linked to parents’ peace of mind and children’s physical exercise	<i>“All the children comes just in the middle of the street and they are all playing and we can also see them yeah so more happier than [Area 2]... Because [in Area 2] most of the time some of the boys would come in and drink, have bottles in their hand and you don’t know what they could do which we don’t see here.”</i> (Maya)
Better school linked to children’s wellbeing	<i>“The life been changed for the children because the happiness. Happiness, in his play, everything, if the school is nice, because the school my children go now is nice.”</i> (Nadia)

Barbara, on the other hand, drew on a tough-but-fair narrative when describing a local housing officer for her neighbourhood:

*“There’s some people that [the local housing officer] rubs up the wrong way...because they can’t pull the wool over her eyes, because she’s a smart cookie.”*

*(Barbara)*

Anxieties and concerns about the moving process tended to accrue among those participants who were not yet sure where they were going to relocate to. Those participants who knew where they were moving to, or had already relocated, tended to present a more positive account of both the relocation process itself, and the way it made them feel.

### **3.7 ‘Dogs that didn’t bark’: hypothesised negative factors that were not mentioned by participants**

Sometimes the things people did not say can be as interesting as the things they did say. In the case of this study, we draw particular attention to the fact that the neighbourhoods we included were all chosen because they were in the middle of a clearance and demolition process.

#### **3.7.1 Demolitions and environmental deterioration?**

Over the past five or six years, each neighbourhood has seen a steady increase in derelict buildings and demolition sites. We assumed that participants would refer to this worsening of the physical environment and potentially describe adverse health consequences. However, the participants made relatively little comment on the environmental impact of the demolition programme and said little to suggest that a declining neighbourhood environment caused by demolition was affecting their health or health behaviours. The nearest we have to an opinion that links the demolition process to a health issue, is an account from a Area 2 resident who described her concerns about violent crime and neighbourhood safety within the context of the recent clearance and demolition in the neighbourhood (particularly the closing down of amenities).

*“They’re meant to be closing [the local shopping precinct] down or knocking it down and rebuilding a new bit. I don’t know when they’re gonna do*

*that – probably once they’ve got the houses up and running, they’ll start on that stuff. One of the primary schools are now closed, that finished up there. The nursery has now finished up, so they’re gonna be away soon. They’re getting demolished wae the next lot. The library, we’re not sure what’s happening wae the library – they’re gonna do that up or move it elsewhere. We used to have a gym in [a nearby area], but that closed down. Next to the library but that’s no even there, now. That’s demolished. Everything, it has totally changed. It’s now, I say, at times, it’s like The Bronx, here. It’s like the Bronx. Every year, there’s at least two murders. In the past year, in the space of a year – not just like this year, but in the space of twelve month, we had [name of victim] murdered on the main road, we had the old man up the stair murdered – and that was somebody local that used to go in and out his house that murdered him.”*

*(Alison)*

#### **3.7.2 Social disruption caused by clearance?**

The research literature also suggests that disruptions to residents’ social networks and support systems caused by friends and neighbours being relocated away could lead to adverse consequences. While some participants living in the three neighbourhoods did tell us that they were worried about how their own imminent move might affect the social networks and support, surprisingly little was said about the clearances that had already occurred. Participants did not suggest that their health, wellbeing or quality of life were being adversely affected by recent clearances in the way we hypothesised. Perhaps this was due to the perception shared by some participants that their current residential environment was in fact already a barrier to their social contact and support networks (as discussed earlier).

Furthermore, even before the regeneration investment, resident turnover was high in each neighbourhood. So, regeneration was not the only source of pressure to relocate and not the only potential disrupter of neighbourhood social networks. For instance, a refugee told us how at one time she *“had a lot of friends”* in the neighbourhood but then one by one they had to move out of the asylum seeker flats once their applications for indefinite leave to remain in the UK were successful (Nada).

## 4 Discussion

We have used qualitative methods to explore residents' accounts of their health within the contexts of their home and neighbourhood environments. We have focused on the perspectives of a small sample of residents from disadvantaged neighbourhoods in the city of Glasgow that are currently undergoing transformational regeneration involving large scale clearances, rehousing and demolitions. The purpose is to explore the range of self-reported pathways by which residents perceive their health to be affected by different aspects of their residential environments. In doing so, we hope to improve our understanding of the potential mechanisms by which transformational regeneration might be expected to affect health.

The current report presents interim findings following the first wave of a two wave study. It focuses on the question: *do residents believe that their residential environment (including home and neighbourhood) has important impacts on their health and wellbeing?*

We have asked this question because we know that the residents are undergoing considerable changes to their residential environments, and we are aware of a general policy expectation that regeneration of this kind could be a potential means to improve health in disadvantaged areas – thereby helping to reduce social inequalities in health. Yet we are also aware that the research evidence suggests a need to be cautious with our expectations about what regeneration can really achieve in terms of health benefits.

Research exploring how physical and social environments may affect health can help to explain why the expectations are not always fully realised and how they might be better realised in future. Furthermore, we think that part of that explanation should be informed by the residents themselves: they are the people who have the most experience of living with disadvantage and with the changes that result from regeneration. From this perspective, their insights into how their experiences of health are related to their homes and the local environment are well informed (although, of course, they are subjective and represent a different kind of perspective to that offered by a medically trained researcher, housing practitioner or health professional).

Residents' perspectives are particularly important given plans to promote and encourage greater community empowerment and engagement, both in local decision making and through the regeneration process itself<sup>13,14</sup>.

Among the accounts we obtained from participants, we have identified a range of ways in which home and neighbourhood environments were considered to have potential impacts on health – either as initial causes of health problems or as factors that influenced (positively or negatively) residents experience of health and wellbeing. These perceived pathways to health problems, health behaviours and wellbeing were particularly diverse on account of the large proportion of participants who reported that either they or a close family member had a serious health problem.

Looking at the causes of ill health first, we found that many participants had developed explanations for why they (or a family member) developed illnesses. Some of these perceived 'causes' of ill health had little or no direct linkage with home and neighbourhood environments. Hereditary illnesses, workplace injuries and the anxieties some residents experienced over their applications to obtain British citizenship can be classed as perceived causes of ill health that have little direct linkage with the residential environment. Therefore, one might hypothesise that it is not within the 'gift' of home and neighbourhood regeneration programmes to prevent illnesses occurring from these kinds of causes (e.g. there is no compelling reason for expecting better quality homes to improve population health by preventing accidents at work or hereditary diseases).

In contrast, some of the other causes and mediators of ill health described by the residents do directly involve the physical home environment. Small homes and damp homes were perceived to be causes of depression and asthma (and related illnesses) respectively. Furthermore, homes that were difficult or expensive to heat were considered to exacerbate health problems. Household energy providers and their regulators clearly have a role to play in protecting residents from fuel poverty. Recent increases in the cost of household energy were not referred to but are clearly relevant to the problem of fuel poverty in disadvantaged neighbourhoods. Power card meters were identified by participants as a particular barrier to achieving affordable warmth.

There is research evidence to suggest that house size, dampness and heating issues are all potential mediators linking home environments to health<sup>5,7</sup>, and therefore we suggest that this study has identified some health problems that could potentially be improved by regeneration interventions that focus on improving specific characteristics of the home environment: i.e. size/usable space, damp and affordable warmth.

The causal pathways for some of the other illnesses referred to by participants suggest that the quality of social relations are particularly important in residents' accounts of ill health: family problems experienced in childhood, and problems with sexual/romantic partners were highlighted as causes of serious (and at times multiple) health problems. Antisocial behaviour and the alcohol culture were considered to exert a negative influence on health behaviours and wellbeing in these neighbourhoods. Poor quality homes and neighbourhoods, and areas with poor reputations were also reported to have direct and indirect negative effects on social relations and mental wellbeing. Tackling these kinds of social causes of ill health goes beyond the confines of housing-led regeneration.

Unlike home improvement, transforming social behaviours and relations in disadvantaged areas is not a problem that has a direct technical fix. Our interviews with participants who have already relocated suggest that moving participants to neighbourhoods of better quality and with a better reputation might be one solution to the adverse effects of social problems. However, some potential flaws in this strategy are apparent – notably, the question of what happens when people who have actively contributed to the social problems of one neighbourhood are then relocated to another? At this point, we hypothesise that even if housing-led regeneration strategies were capable of influencing social relationships, the nature of that influence is likely to be indirect and therefore the health impacts may be difficult to either predict or rely upon.

On the other hand, participants' accounts highlight the importance of what we might term 'social regeneration'. While this report has focused on perceived environmental influences on health, the interviews provided a number of examples of participants praising the work of community services for residents in difficult

or vulnerable positions (e.g. residents with mental or physical illnesses, young carers, people applying for British citizenship, ex-heroin addicts). Some participants praised the police for helping to improve community relations (including relations between ethnic groups) and perceived neighbourhood safety. Support from sympathetic concierges and the helpful role of local housing officers in assisting participants through the relocation process were recurring themes in our interviews (although not all the accounts were positive). We have also found that residents who actively involve themselves with community groups, or even with informal local networks of friends, say this can have a positive impact on their health and wellbeing.

The interviews provide some specific examples of community organisations that participants rely on and praise, but identifying those organisations in this report could potentially compromise neighbourhood and, in some cases, individual anonymity. Nonetheless, we think there is a need to make a more general point about the importance of social improvement and community development services (professional and voluntary) within the context of regeneration. The message from our participants is that these kinds of activities can be extremely important to their health and wellbeing. Furthermore, some people in the community require support, assistance or surveillance that goes beyond what can be offered through housing services alone. These kinds of activities are clearly a necessary part of transformational regeneration, but are not always identifiable as a key component of regeneration strategies.

#### 4.1 Strengths and limitations

Qualitative studies seek to obtain detailed and complex data from relatively small samples of participants. They provide insights into participants' range of experiences and help us understand processes and mechanisms. This type of study, which focuses on individuals' perceptions and situations, does not provide generalisable evidence of prevalence or causation. It should be recognised that complex factors influence outcomes for the individuals, households and communities that this study focuses on. In terms of generalisability, it should be noted that the participants' accounts are based on experiences of



living in disadvantaged inner-city mass housing estates currently undergoing transformational regeneration. The extent to which the findings are applicable to other neighbourhoods depends on the extent to which those other neighbourhoods resemble the places that provide the setting for this study. This, we would suggest, is an issue that all studies of health and place need to contend with – however, we note that many of the issues identified in our study were common to all three of the neighbourhoods we recruited from. This suggests a potential for generalisability beyond the most immediate local context.

Different ways of recruiting participants have varying strengths and limitations, so there are advantages to using more than one method of recruiting participants. In this study we used a mixture of recruitment methods.<sup>7</sup> ‘Snowballing’ relies on participants’ social networks and therefore risks recruiting associates with similar views and experiences. Risks of selection bias are also involved in recruitment through housing officers and community organisations: for example, these approaches may potentially lead to the sampling of particular kind of participants characterised by high levels of involvement in local housing committees and community initiatives. We think it is fair to say that a minority of the study’s participants could indeed be described as being particularly motivated and connected with local organisations. However, we have also interviewed residents who have told us how isolated and disconnected they feel, and residents with a range of backgrounds – including white and Black and BME Scottish citizens, residents seeking British citizenship, residents who have served prison sentences and residents who have survived abusive relationships and/or addiction. We therefore believe our recruitment has been successful in including, but also extending far beyond, the ‘usual suspects’ of well connected, motivated and articulate local activists.

The GoWell programme as a whole includes both quantitative and qualitative research so that we can benefit from the advantages that both approaches offer.

## 5 Conclusion

Using qualitative methods we explored whether residents of disadvantaged neighbourhoods experiencing ‘transformational’ regeneration believe that their residential environment influences their experience of health. Many of the residents’ accounts included descriptions of long running and complex problems with their homes and neighbourhoods – problems that predate the regeneration programme and which lend further weight to the view that urgent action has been necessary to transform the residential environments for these communities.

The participants suggested a range of perceived pathways and mechanisms by which their physical and psychological health might be influenced by their environment. Of particular relevance to housing regeneration, homes considered too small, damp and costly to heat were perceived to have adverse health consequences in terms of mental wellbeing, childhood asthma and related illnesses. As the residents’ perceptions are plausible and fit with other research literature on this subject<sup>5,7</sup>, we suggest that findings from this study help support, from a health perspective, decisions to target these particular neighbourhoods for Transformational Regeneration. They also help support the case for new build, housing improvement and fuel poverty strategies (current and future), since those strategies, appropriately designed, can help to address some of the problems that negatively affect residents.

However, many of the factors considered to have important health consequences were not directly linked to the physical condition of people’s homes. Social relationships and support structures

within and beyond the local neighbourhood were considered to be important for a range of health and wellbeing issues. Antisocial behaviour and the alcohol culture were particularly noted for their negative effects upon people. On the other hand, participants also identified a number of factors which they considered to be beneficial to their health and wellbeing, including: participation within the community; individual or community support from community organisations and professional services (e.g. health, police, housing, etc); and relocation as part of the clearance and new build programme.

The participants have therefore suggested a range of pathways by which residential environments may affect their health. A key message from this study is that the social environment is perceived by residents to influence a greater range of health issues compared to the physical environments of homes and neighbourhoods. Therefore, we would expect the potential benefits of urban regeneration to be maximised when strategies include improvements to social as well as physical environments.

In an earlier GoWell publication, we reported that key personnel involved in regeneration policy and practice similarly identified a need for action to improve not only physical housing and neighbourhood characteristics, but also services, education, employment, community participation and a range of broader social issues health<sup>15</sup>. Improved health was identified in this earlier study as an emergent property of this holistic approach to regeneration. It is therefore notable that key messages from residents who participated in the Lived Realities study align well with the views of policymakers and practitioners. This alignment of opinion within the public, practitioner and policy spheres is a positive finding, even if it does

reinforce the view that there are no quick fixes to tackling the complex problems of neighbourhood disadvantage and health inequalities. However, these findings raise the question of whether regeneration policy and practice can sufficiently extend beyond the housing-led approach to achieve holistic transformation in social, cultural and economic terms, and what changes are required to bring this about.

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## Appendix: Lived Realities – sample characteristics (July 2011)

Participant				
Recruitment	Household details	Housing situation	Ethnicity and country of birth	Working / not working
<b>Lesley</b>				
Local Housing organisation (LHO)	Female, lives with grandchildren	Recently relocated from Area 1 to new build	White Scottish, born in UK	Not working
<b>Ali</b>				
LHO	Male, lives with partner and baby	Lives in Area 1, in process of moving	Middle Eastern, born outside UK	Working (on sick leave)
<b>Jon</b>				
LHO	Male, lives alone	Recently moved within Area 1	African, born outside UK	Not working
<b>Sue</b>				
LHO	Female, lives with 2 adult sons	Lives in Area 1, future relocation unconfirmed	White Scottish, born in UK	Not working
<b>Rachel and Keith</b>				
LHO	Female & Male, 3 children	Live in Area 1, in process of moving	White Scottish / British, born in UK	Neither working
<b>Sami</b>				
LHO	Male, lives with partner and baby	Lives in Area 1, future relocation unconfirmed	Asian, born outside UK	Working
<b>Ula</b>				
Church	Female, lives with partner and 3 children	Lives in Area 1, in process of moving	African, born outside UK	Not working (high level of voluntary work)
<b>Layan</b>				
Church	Female, lives with partner and 3 children	Lives in Area 1, in process of moving	Middle Eastern, born outside UK	Not working (high level of voluntary work)
<b>Jackie</b>				
LHO	Female, lives with 3 children	Lives in Area 1, in process of moving	White Scottish, born in UK	Working
<b>Nada</b>				
Snowballing	Female, lives with partner and 5 children	Lives in Area 1, future relocation unconfirmed	Middle Eastern, born outside UK	Not working
<b>Moira</b>				
LHO	Female, looks after grandchild at weekends	Lives in Area 1, future relocation unconfirmed	White Scottish, born in UK	Not working (high level of voluntary work)





Participant				
Recruitment	Household details	Housing situation	Ethnicity and country of birth	Working / not working
<b>Aisha</b>				
LHO	Female, lives with child	Lives in Area 2, future relocation unconfirmed	Asian Scottish, born in UK	Not working
<b>Harry</b>				
LHO	Male, lives with child	Lives in Area 2, future relocation unconfirmed	White Scottish, born in UK	Not working
<b>May and Dave</b>				
Snowballing	Female and male, live with child	Live in Area 2, in process of moving	White Scottish, born in UK	Neither working
<b>Morag</b>				
Snowballing	Female, lives alone	Lives in Area 2, future relocation unconfirmed	White Scottish, born in UK	Not working
<b>Carol</b>				
Snowballing	Female, lives with 2 children	Lives in Area 2, in process of moving	White Scottish, born in UK	Working
<b>Nadia</b>				
LHO	Female, lives with partner and 2 children	Recently relocated from Area 2 to new build	African, born outside UK	Working
<b>Maya</b>				
LHO	Female, lives with partner and 3 children	Recently relocated from Area 2 to new build	African, born outside UK	Working
<b>Alison and Nicola</b>				
LHO	Females, live with 3 children	Live in Area 2, in process of moving	White Scottish, born in UK	Working
<b>Barbara</b>				
Snowballing	Female, lives alone	Lives in Area 2, future relocation unconfirmed	White Scottish, born in UK	Not working
<b>Heather and Paul</b>				
GoWell survey	Female and male, live with 2 children	Recently relocated from Area 3 to new build	White Scottish / British, born in UK	Both working
<b>Lynda</b>				
Snowballing	Female, lives with son	Recently relocated from Area 3 to new build	White Scottish, born in UK	Working
<b>Basra</b>				
Community organisation	Female, lives with partner and 4 children	Recently relocated from Area 3 to new build	African, born outside UK	Not working

Note: Participants born outside of the UK included people on various types of visa and different stages of the British Citizenship application process for asylum seekers/refugees.



