Progress for People and Places:

Monitoring change in Glasgow's communities

Evidence from the GoWell Surveys 2006 and 2008

GoWell

GLASGOW COMMUNITY HEALTH AND WELLBEING
RESEARCH AND LEARNING PROGRAMME

GoWell is a collaborative partnership between the Glasgow Centre for Population Health, the University of Glasgow and the MRC Social and Public Health Sciences Unit, sponsored by Glasgow Housing Association, the Scottish Government, NHS Health Scotland and NHS Greater Glasgow & Clyde.

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Abbreviations

BTS	Below Tolerable Standard
BMI	Body Mass Index
CAPI	Computer-Assisted Personal Interviewing
CBHA	Community Based Housing Association
CHCP	Community Health and Care Partnership
CHI	Community Health Index
CRF	Community Regeneration Fund
GCC	Glasgow City Council
GCPH	Glasgow Centre for Population Health
GCPP	Glasgow Community Planning Partnership
GHA	Glasgow Housing Association
GP	General Practitioner
HIAs	Housing Improvement Areas
IAT	Intervention Area Type
IPAQ	International Physical Activity Questionnaire
ISPI	Inequalities Sensitive Practice Initiatives
KATS	Kids and Adults Together in Sighthill
LHO	Local Housing Organisation
LHS	Local Housing Strategy
LRAs	Local Regeneration Areas
MSF	Multi-storey Flat
NEET	Not in employment, education or training
PEs	Peripheral Estates
PPR	Persons-per-room
PPF	Public Partnership Forum
ROA	Regeneration Outcome Agreement
RSLs	Registered Social Landlords
SBD	Secured by Design
SEN	Special Educational Needs
SHQS	Scottish Housing Quality Standard
SHS	Scottish Health Survey
SIMD	Scottish Index of Multiple Deprivation
SOA	Single Outcome Agreement
SPV	Special Purpose Vehicle
TRAs	Transformational Regeneration Areas
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
WSAs	Wider Surrounding Areas

Introduction

Background

Urban regeneration features prominently in social policy but surprisingly little is known about the impacts of different approaches because many regeneration programmes have been poorly studied or not studied at all.

Glasgow, Scotland's largest city, is receiving significant investment in regeneration aimed at improving and transforming disadvantaged homes, neighbourhoods and communities. GoWell is a research and learning programme that aims to investigate the impact of investment in Glasgow's regeneration on the health and wellbeing of individuals, families and communities over a ten-year period. GoWell aims to establish the nature and extent of these impacts, to learn about the relative effectiveness of different approaches, and to inform policy and practice in Scotland and beyond.

Glasgow's regeneration activities are funded and delivered by a number of public and private sector organisations. Glasgow Housing Association (GHA), Glasgow City Council (GCC), many other local housing organisations, and stakeholders outside the housing sector are involved. Some activities are co-ordinated, for example, as part of the city's Community Plan or Housing Strategy, and some have emerged independently.

GoWell researchers surveyed just over 6,000 Glasgow householders in 2006 and 4,657 in 2008 to see how the early stages of these regeneration processes have affected people and places in neighbourhoods across the city. This report summarises findings to show how neighbourhoods have changed: focusing on residential outcomes, social and community outcomes, human capital and health outcomes.

Purpose of report

What follows are the key points that summarise the overview of findings, looking at the 2008 results and comparing them with the baseline positions found in 2006. The overview has a number of functions.

1) Providing policy-makers and practitioners involved in Glasgow's regeneration with evidence of community impacts at this relatively early stage in the regeneration process. This is part of GoWell's 'formative evaluation' function: i.e. providing stakeholders with regular feedback to help assess progress and inform continuous improvement and planning processes.

2) Providing GoWell researchers with a greater understanding of the key changes taking place to help guide a number of the programme's 'next steps.' For example, the report will provide a foundation for developing analysis strategies to help identify key findings to be fed back to specific communities, and potential lessons that may be transferable to other regeneration settings.

3) GoWell is a long term study (ten years): overviews such as this are an important means of 'remembering' early developments in the programme that can be referenced at a later stage.

The two years that separate the 2006 and 2008 surveys represent a short period of time over which to find large-scale change. So, major shifts are not expected at this stage. It is also not possible, from only two time points, to draw conclusions about trends over time. However, the report paints a picture of how things seem to be changing in the GoWell areas, and of which factors might be moving in a positive (and which in a negative) direction. The changes found have been related to information about investment and other activities in the areas, as a means of gauging their impacts.

Methods

GoWell is a multi-component, mixed methods study. This report focuses on findings from the GoWell Community Health and Wellbeing Survey of 14 neighbourhoods in Glasgow undergoing different types of regeneration. A random sample of postal addresses from these neighbourhoods was drawn in 2006 (for the baseline survey) and again in 2008, and in the summer months of those years one adult householder per household was approached to participate in the survey. Consenting householders participated in face-to-face interviews lasting around 35 minutes with GoWell fieldworkers contracted from BMG Research. Structured questionnaires were used to ask about people's homes, neighbourhoods, communities, health, wellbeing and personal circumstances. In 2006, 6,008 interviews were achieved (50% response). In 2008, 4,657 interviews were achieved (48% response). Findings from the two surveys were then compared. Appropriate statistical tests were used to identify significant differences at the 5% ($p=0.05$) level. In interpreting the results, however, the substantive importance of the differences was considered.

Settings

The 14 GoWell neighbourhoods were selected and grouped into five categories. GoWell terms these categories **Intervention Area Types (IATs)**: they correspond to five broad types of regeneration activity taking place in the city. The five Intervention Area Types are:

- **Transformational Regeneration Areas (TRAs)**: Large scale, multi-faceted neighbourhood redesign which may include demolitions, new homes, physical renewal, and community initiatives (areas: Red Road, Sighthill, and Shawbridge).
- **Local Regeneration Areas (LRAs)**: Similar to transformational regeneration but targeting smaller pockets of disadvantage (areas: Gorbals Riverside, Scotstoun multi-storey flats and St Andrews Drive).
- **Wider Surrounding Areas (WSAs)**: Neighbourhoods surrounding TRAs and LRAs that may be affected by the transformation of those areas as well as by improvements in their own housing stock (areas: wider Red Road and wider Scotstoun).
- **Housing Improvement Areas (HIAs)**: Neighbourhoods containing many homes that receive housing improvement investment (areas: Townhead multi-storey flats, Riddrie, Govan, and Carntyne).
- **Peripheral Estates (PEs)**: These include many social rented homes managed by other local housing organisations besides GHA. A large number of new builds are planned for these areas, partly to attract home owners (areas: Castlemilk and Drumchapel).

The 14 neighbourhoods selected were due to receive most of their regeneration investment after the 2006 survey.

TRAs and LRAs have many similarities: they are large housing estates with relatively young populations, sharing some common problems and similar regeneration strategies. They are sometimes grouped together as '**Regeneration Areas**.' The other intervention area types are not expected to undergo neighbourhood-level redesign or physical transformation to the same degree as the Regeneration Areas. More details of GoWell's IATs can be found in Chapter 1.

The following section provides an overall summary of the findings followed by the key findings from each chapter.

Summary

Residential outcomes

Residential outcomes have been improving for people in many respects across the study areas. Furthermore, much of this can be related to specific investment programmes such as in housing and in children's play areas, and to programmed attempts to improve the customer service experience of social housing tenants. Overall, housing outcomes are higher than neighbourhood outcomes, reflecting the balance of effort to-date.

Residential outcomes are generally less positive in Regeneration Areas than elsewhere, though even here there have been improvements. Housing specific outcomes (such as satisfaction, and a range of psychosocial benefits) are currently less positive for the occupants of high-rise flats compared with those of people living in other types of building. These contrasting outcomes by area and dwelling are as expected at this stage, since the improvement of high-rise blocks has not yet taken place in the study areas, and regeneration programmes are still in their early stages. It is also noticeable that PEs perform poorly in terms of their neighbourhood environments, with relatively poorer outcomes for environmental aesthetics, cleanliness and for some of the amenities on offer locally, such as shops and social venues (compared to other area types).

Two issues which may be worthy of particular attention in relation to residential outcomes are neighbourhood safety and area reputations.

Perceptions of anti-social behaviour in the neighbourhood have worsened nearly everywhere and feelings of safety outside after dark have similarly declined. Most people feel safe within their homes, in part due to actions taken to improve home security, but this contrasts with more people deciding not to venture outside after dark. More investigation, by GoWell and by service-providers, is required to establish why there should be this decline in neighbourhood safety and whether concerns about anti-social behaviour are the product of actual behaviours, changes in neighbourhood supervision services, or for other reasons.

Trends in area reputations highlight a strong contrast between improving internal reputations (what people feel their neighbours think about an area) and worsening external reputations (what people feel outsiders think about their area). Again this is an issue meriting further attention both to identify its causes and potential solutions. The transformation of areas which currently have a large social housing presence will partly depend upon being able to change the areas' image and reputation. Housing investment and regeneration programmes have yet to substantially change the tenure and physical structures of these areas, and this could make a contribution to shifting area reputations in due course, but we expect that dedicated and specialist efforts to change area reputations will also be required.

Social / community outcomes

There have been some notable improvements in social and community outcomes, in particular in relation to reported social harmony and perceived community influence, though there still remains substantial scope to improve community empowerment in Regeneration Areas.

The picture of social and community outcomes is often a mixed one across the study areas, with improvements on some issues and but not others. Thus, whilst social harmony has improved, perceived informal social control has worsened. There are more people who have daily social contacts, but also more people who have none. Whilst in some areas there has been little change in the availability of social support, in many other areas there have been drops in social support, with more people less inclined to ask anyone for help.

Generally, social outcomes are poorer in Regeneration Areas where there is greater diversity and turnover of residents; and within these areas, such outcomes are lower for families. This is an issue that may require consideration from public agencies, as relatively low levels of sense of community and of neighbourliness among families in Regeneration Areas were found. These are also places with large numbers of families, often headed by adults at the younger end of the age spectrum (in their 20s and 30s) who may benefit from a greater degree of social integration.

Another group whose social integration may require more attention is asylum seekers and refugees, for despite the increase in feelings of social harmony (at least indicating that social tensions between groups have been reduced), a low sense of feeling part of the community was also found among the migrant group within Regeneration Areas, suggesting that efforts so far to assist their integration have been working in one respect (reducing conflict) more-so than in another (promoting inter-group engagement).

There is a positive relationship between many community outcomes and reports of the community's influence over local decisions; thus, efforts to enhance the sense of community within Regeneration Areas may be important not only for their effects upon community activity and social interactions, but also for their potential return in terms of community empowerment.

Human capital / health outcomes

In terms of human capital and health outcomes, there appears to have been progress in respect of employment, with substantially more adult men reporting employment than previously, together with a small reduction in the number of younger adults with no useful activity. However, rates of non-employment remain high across the study areas, and rates of seeking employment are low among those out of work. Mental health outcomes are worsening more than physical health outcomes, although two particular concerns which straddle the physical/mental health divide are very high rates of physical inactivity and a decreasing sense of vitality (feeling energised) among adults in many areas.

Whilst the prevalence of physical ill-health has not worsened over time in the study areas, those people who do have health problems are reporting more of them. On measures of physical health, Regeneration

Areas are generally no worse than other places, due to having younger and migrant resident groups who report better health than others. One exception to this is the higher reporting of psychological and stress-related illnesses by women living in LRAs, which requires more investigation.

Compared to national norms, and particularly for deprived areas across Scotland, many health behaviours are no worse in the GoWell study areas than elsewhere. On the other hand, physical inactivity is very high across the study areas. Several health behaviours are worse in Regeneration Areas than elsewhere, including physical inactivity, poor diet and the amount of alcohol consumed by drinkers (though rates of smoking and drinking are lower in Regeneration Areas due to the presence of migrant groups).

The reporting of long-term mental health problems (lasting over a year) increased across all the types of study area, with GP consultations on these issues also increasing in the LRAs and WSAs. However, many people who saw their GP for a mental health reason did not report a long-term mental health condition, suggesting an increase in shorter-term episodes of anxiety, depression and other emotional problems. Also of concern are the declines in feelings of vitality ('having a lot of energy') in the Regeneration Areas and in the WSAs. The question of how to make more people feel 'energised', and doing things which aid their social integration, physical health and mental health is therefore an issue to be addressed in many areas.

There were substantial increases in reported rates of employment among working age men across the study areas, with more modest improvements for women. Two types of study area (WSAs and HIAs) now had a majority of working-age men in employment. The rate of NEETs (not in employment, education and training) among those aged 16-24 also dropped slightly over time. However, high proportions of adults (both men and women) of working age (in Regeneration Areas more so, but also in other areas) still report that although they are economically active, they do not have a job. Indeed, of those working-age adults not in employment across the study areas, only a minority (one-in-six) had taken any action to seek employment in the past year.

To sum up…A number of areas of progress have been identified across the study areas, but also many remaining challenges, most notably affecting the Regeneration Areas but also particular challenges in other areas too. Overall, physical changes and residential outcomes are progressing better or faster than other outcomes, though reported increases in social harmony, community empowerment and adult employment are notable successes. However, our overall view is that the social regeneration agenda - embracing community level issues (such as social interactions with neighbours, engagement with the wider community, local organisations and facilities) and personal issues (such as the motivation, health behaviours, skills and training of individuals) – needs an increased level of commitment, planning, resourcing and partnership working among a range of agencies at the local level so that social outcomes and health and human capital outcomes might be enabled to keep pace with and improve alongside residential outcomes in future.

The Changing Context in Glasgow

Many regeneration (and related) activities have taken place in Glasgow during the early years of the GoWell programme. These have been delivered by a range of public and private sector providers, often in partnership and often seeking to engage local people in decision-making. The most widespread activity so far has been the delivery of housing improvements, which has occurred in all the study communities to a significant degree. Some key developments are summarised below. It should be noted that targets and timescales are subject to revision. It should also be noted that much of GoWell's information comes from GHA – which means that some of the activities of other Registered Social Landlords (RSLs) and other organisations are under-represented in this summary. In fact there are a range of agencies (e.g. Glasgow City Council, RSLs, police, other Glasgow Community Planning partners, Health Boards, Scottish Government, etc) working in partnership to regenerate Glasgow and so it would be wrong to assume that GHA (or indeed the housing sector) will or should have the prime responsibility for tackling every issue covered in this report. Readers should bear this in mind and GoWell needs to try and address the issue in future summaries of activity.

- **Policy context:** The Scottish Government has taken a broad definition of area regeneration linked to local and national sustainable economic growth. Health and health inequalities feature prominently in government strategies.
- **Local policy:** The advent of community planning brought renewed emphasis on joint working between service providers and community input. Many local outcomes and targets in Glasgow's Single Outcome Agreement are relevant to GoWell's study areas.

- **Economic development:** The upgrading of housing stock in Glasgow forms part of the wider attempt to improve strategic infrastructure in the city region (including water, sewerage, transport and the treatment of derelict land) so that regional economic development is advanced.
- **Recession:** Regeneration is intended to help facilitate economic revival for deprived areas but current macro-economic forces hinder this and obstruct some regeneration activities: e.g. slowing private sector house-building activity in the city (although social sector activity has been maintained to date).
- **Tenure mix:** No GoWell area type experienced substantial changes in tenure mix during the period 2006-2008. There were small overall reductions in the proportion of social rented housing (particularly in areas experiencing demolition), and the PEs experienced a small reduction in the proportion of privately owned homes.
- **Physical improvements:** 75% of Glasgow's social housing stock did not meet the Scottish Housing Quality Standard (SHQS) in the period 2004-2007. RSLs across Glasgow have however improved their stock and by 2008/9 56% of social housing in Glasgow City met the SHQS. Data GoWell has received from GHA shows their improvement programme has included the installation of heating systems to almost all its stock, fitting of new kitchens and bathrooms (to over half its stock), external fabric improvements, and the fitting of new windows to most GHA stock.
- **Demolitions:** The demolition of low demand social housing has been progressing, although some of this activity postdates the two GoWell surveys. By the end of 2009 approximately 30% of the social housing stock in GoWell TRAs had been demolished, with more being cleared for future demolition.
- **House building:** The social housing new build programme of 're-provisioning' will assist the clearance programmes. Plans included the building of 2,800 new GHA homes within the agreed timescales of 2014-2015. None of these homes had been completed by the time of the wave 2 survey (summer 2008), though the first phase of 239 units went on site that year. The second phase (approximately 400 units) has since commenced. GCC has a target of 10,000 new social sector homes through community based housing associations (CBHAs) from 2004-14. The 'reprovisioning' output (for people affected by demolition across the city) for 2008-09 was 278 units. The effects of new build activity around the TRAs should appear by the time of the next (3rd) GoWell survey in 2011.
- **Social regeneration:** Community actions implemented by RSLs, supported by the Scottish Government's Wider Role Fund, have focused on issues such as employability, financial inclusion and community facilities. Various Neighbourhood Renewal / Wider Role programmes funded by GHA partner agencies and other RSLs have been delivered. The most large-scale partnership GHA activities that GoWell is aware of have included youth diversionary programmes, play area improvements and employability programmes such as the Environmental Employability Programme, a training programme active in 45 GHA LHO neighbourhoods. Glasgow Community Planning Partnership also seeks to contribute to the reduction of social inequalities in the city, and to furthering social regeneration by supporting a variety of projects with the Fairer Scotland Fund (which replaced the Community Regeneration Fund).

People and Circumstances

The demographic characteristics of the study areas may play a large part in shaping people's lives, neighbourhoods and communities.

- WSAs and HIAs have large elderly populations with many older people living alone.
- PEs have large numbers of younger adults, and only half of all adults of working age have jobs.
- The residents of TRAs and LRAs are more likely to be male and relatively young. These areas are also characterised by having large numbers of families (and also large families) and large proportions of immigrant groups.

Demographic and housing differences could be associated with the responses given to many of the items investigated and could be at least partially responsible for some of the differences reported. Conversely, they might mask some genuine differences between the study areas. As people move in and out of the areas over time, the demographic characteristics could change. This is likely to influence survey responses as, for example, new people arrive with different perspectives on their home and neighbourhood and potentially different personal circumstances, behaviours and health characteristics.

Of the five types of area, the inner-city housing estates that form the Regeneration Areas have the most atypical demographic characteristics, compared to most of Scotland's neighbourhoods. It is doubtful that the creation of such highly unusual communities was intended as an outcome when the neighbourhoods were designed. They have arisen over time due to the way the housing market operates and due to the

operational practices of a range of agencies. The present profile of these areas raises a question for public agencies involved in renewal as to whether these characteristics (or others) are compatible with the social regeneration of the communities. Does planning regeneration include trying to shape the social composition of places as well as the physical characteristics? Some of the most distinctive demographic characteristics are presented below:

- **Age:** Two of the study area types contain relatively elderly populations: over a fifth of adults are aged over 65 in WSAs and HIAs. By contrast, the adult population is relatively young in the TRAs and LRAs: around three-in-five adults are aged under 40 and less than one-in-ten are aged over 65. In the PEs, one-in-five adults are under 25 years old.
- **Gender:** Adult men outnumber women by at least 10% in the TRAs and LRAs.
- **Ethnicity:** Many immigrants reside in the TRAs (two-in-five being non-British citizens) and LRAs (more than one-in-four). Few live in the other types of areas. GoWell areas do not include sizable British-born black and minority ethnic communities.
- **Crowded homes:** The average number of persons-per-room (ppr) is high (over 1.5 ppr) for two-parent families in TRAs and LRAs and in MSFs, and also quite high (1.3 ppr) for single parent families in TRAs and WSAs.
- **Tenure:** The TRAs and LRAs are dominated by social housing with nine-in-ten dwellings being in the social sector. Home ownership has a significant presence in WSAs (half of all dwellings), HIAs (two-in-five dwellings) and to a lesser extent PEs (one-in-five dwellings).
- **Employment:** One-in-seven working age men say they are economically inactive. Most men of working age in WSAs and HIAs report that they are working, and half do so in PEs. Only a minority of men in the Regeneration Areas report that they are working. Higher reported employment rates were found among men in all the types of study area in 2008 compared with 2006. The same was found for women in two area types: TRAs and HIAs.
- **Other economic activity:** High proportions of adults (both men and women) of working age (40-50% in Regeneration Areas; 20-30% in other areas) report that they are economically active but do not have a job.
- **Looking for work:** Only around 11% of respondents who were of working age, were eligible for work and not in full- or part-time employment or full-time education, had sought work at some point during the year preceding the 2008 survey. These figures were higher (over 14%) in the Regeneration Areas.

Housing

Housing improvement work has been widespread and popular with survey respondents. Significant increases in housing satisfaction were found. Some improvements mentioned by respondents may have been independent of the regeneration investment, but the overall scale of reported improvement suggests an intervention effect. There has been deterioration in the perceived quality of MSFs and a higher rate of intention to move in the Regeneration Areas – where clearances for demolition have often been the dominant housing intervention. One exception to the less positive findings from the Regeneration Areas is that of enhanced feelings of safety inside the home, probably due to the installation of Secure by Design doors, windows and entry systems.

In terms of housing activity, the main challenge now is to improve dwelling quality for residents in the Regeneration Areas - and for some of the residents in the PEs, where there are also many aspects of dwellings rated less than 'good'. Generally, MSFs in Regeneration Areas were found to be less capable of providing high levels of housing satisfaction or of psychosocial benefits than other types of dwelling, thus supporting the idea that they should be replaced wherever possible. Furthermore, most people in Regeneration Areas and a third of people in PEs do not have a garden to use, and the issue of access of private green space is an important one given its potential contribution to health and wellbeing.

- **Type of house:** In the TRAs and LRAs, around eight-in-ten homes are in MSFs and almost no-one has a garden to use, whereas in other locations most people have a garden. Around seven-in-ten homes in WSAs and HIAs are houses or

four-in-a-blocks, whilst PEs are evenly divided between houses and flats.

- **Residential stability:** Regeneration Areas are residentially unstable. Their residents were two to three times more likely to have lived locally for no more than two years (30%) compared to the other area types in 2008.
- **Housing improvement:** Over one-in-three respondents (36%) reported that 'improvement works' had been carried out to their homes in the past two years. This was highest in LRAs (45%) followed by WSAs (39%) and HIAs (38%).
- **Satisfaction with housing improvement:** Resident satisfaction with housing improvement works was very high, with 90% of those who had received improvement works in the past two years being satisfied with the works that had been carried out to their homes. Satisfaction was highest in the WSAs, with 58% 'very satisfied', and lowest in the TRAs where 35% were 'very satisfied' (though overall satisfaction (i.e. 'very' and 'fairly' satisfied) still reached 85%).
- **Satisfaction with the home:** Rates are improving, particularly with regard to those who are 'very' satisfied with their homes. There remain gaps of around 15% in satisfaction rates between the social rented and private sectors in all types of area, except the HIAs, where ratings are much closer ('private sector' in this instance refers mainly to owner occupied homes but also includes some private lets).
- **Condition of the home:** There have been improvements in the reported internal and external quality of homes for most housing types in most areas, but not for MSFs in Regeneration Areas. However, most residents rated specific housing condition features as being less than 'good' on an item-by-item checklist in Regeneration Areas and the PEs.
- **Housing management and local engagement:** In 2006, there was a low level of satisfaction that the landlord or factor took residents' views into account when making decisions. This had increased significantly by 2008 for all area types - especially PEs (+16%) and LRAs (+20%). There were smaller improvements in the levels of residents' satisfaction with being kept informed about decisions. Residents in the private sector are the most satisfied with their homes, but tenants of GHA are the most satisfied with the housing services provided by their landlord or factor, more so than private sector or RSL residents.
- **Psychosocial benefits of the home:** Here we use the term 'psychosocial' to describe potential mechanisms by which people's mental wellbeing might be affected by their social environments. MSFs are shown to provide psychosocial benefits to their occupants to a lesser extent than other types of flats or houses. This is especially true of those benefits which impact upon how people feel about themselves, such as a sense of progress, status, and reflecting their identity and values. It remains to be seen whether this continues to be the case where comprehensive improvement to MSFs takes place. We also need to further explore whether poorer psychosocial outcomes associated with GoWell's MSFs apply generally to MSFs, whether the outcomes vary by different types of MSF, or by their location (e.g. is there a neighbourhood effect?).

Neighbourhoods

There have been widespread, though not universal, actions to improve neighbourhood environments, and also to improve some local amenities such as children's play areas. There have been actions in study areas to enhance community facilities and support community arts / recreation projects. Generally, residents' ratings of their local environments have improved since 2006, with the notable exception of the aesthetics of environments (whether they look attractive). Ratings of environmental aesthetics have worsened in Regeneration Areas – which is not surprising given the impacts of processes of clearance and demolition – and remained modest and unchanged in the PEs. Residents' ratings of local amenities are generally relatively high and in many cases have also improved over time. The outcome measure that appears to have most consistently responded to neighbourhood improvements is that which measures the psychosocial benefit of whether people feel a sense of personal progress in their lives through where they live.

Exceptions to this general improvement include perceptions of anti-social behaviour, youth and leisure services, and declines in feeling safe outside after dark. This is in spite of numerous initiatives to reduce anti-social behaviour and provide young people with more opportunities and facilities. In all area types, except the HIAs, there appears to be an increasing sense among residents that their neighbourhood has a bad reputation amongst other people in Glasgow.

Executive Summary

Key findings relating to GoWell's neighbourhood outcomes are summarised below:

- **Neighbourhood satisfaction:** Neighbourhood satisfaction rates were reasonably high but changed little between surveys. While three-out-of-five people in Regeneration Areas were satisfied with their neighbourhood as a place to live in 2008, this was true of four-out-of-five people in the other three types of area.
- **Anti-social behaviour:** There has been a substantial increase in the mean number of anti-social behaviour problems perceived by residents to be a serious problem in their neighbourhood (percentage change since 2006: +34% for TRAs; +24% for LRAs; +19% for WSAs; +5% for HIAs; +57% for PEs).
- **Safety at night:** Feelings of safety at night time in the local area have declined in all area types, dramatically so in the case of Regeneration Areas where the proportion who reported feeling sufficiently safe in 2008 was roughly half that reported in 2006.
- **Parks and play areas:** The percentage of residents rating parks and play areas as good was higher in 2008 than in 2006 in all area types (percentage change since 2006 ranging from +18% for PEs, to +24% for HIAs). This followed widespread investment in such facilities.
- **Environmental aesthetics:** Resident ratings of the appearance of the local environment and buildings have improved markedly in HIAs (+7% environment, +11% buildings) and WSAs (+12% environment, +10% buildings). However, these outcomes deteriorated by 10% to 25% in the Regeneration Areas and by 1% to 2% in the PEs.
- **Childcare/nurseries and shops:** There have been significant improvements in the quality ratings of these amenities in all area types (childcare/nurseries: increases ranged between +13% and +30%; shops: increases ranged between +4% and +22%).
- **Youth and leisure services:** Considering the increase in perceived anti-social behaviour, it is a cause for concern that youth and leisure services received lower ratings than most other amenities across all GoWell area types in 2008. Moreover, compared to 2006, fewer residents in 2008 felt youth and leisure services in Regeneration Areas were good (-16% for TRAs and -4% for LRAs).
- **Engagement in neighbourhood regeneration:** Regeneration planning has involved numerous consultation exercises. However, only a minority of residents of Regeneration Areas felt well informed about regeneration, or felt that there were enough opportunities for them to have a say about processes of change.

Community

With regard to community outcomes, the picture is fairly static in WSAs and HIAs, with a mixed picture in PEs, and a worsening of many measures of community in the Regeneration Areas. From what we know of the GoWell areas, community activities and/or initiatives to boost people's sense of community are often patchy and small-scale (but there are limits to what we know: we do not have a comprehensive list of all such activities). Sense of community in the Regeneration Areas is often lower for families and for non-British citizens than for other social groups, suggesting a need for additional support to integrate these residents (i.e. in addition to current efforts). In many areas, barely a majority of people have confidence in their community's ability to exercise informal social control to prevent anti-social behaviour, and only a minority believe in the honesty of people in their area. The situation on these issues is worse in the Regeneration Areas than in other IATs.

Community Planning and CHCPs have a role to play in promoting community development and engagement. Individual organisations, including housing providers, also have community engagement structures and support developments in local areas. GHA consultations concerning regeneration and new build housing areas are one example. There have been improvements across all the study areas in the degree to which people feel that they can, with other people, influence decisions affecting their areas. However, only in WSAs and HIAs do a majority of residents feel they can exert influence.

Executive Summary

- **Community spaces:** Only in two of the types of study area did as many as six-out-of-ten people rate their local social and community venues as at least 'good' (WSAs and HIAs). This suggests that there is therefore substantial scope for the improvement of available community spaces, even before the potential introduction of any other resources or personnel to support community development.
- **Inclusion:** Between 52-57% of householders living in Regeneration Areas feel included in their local community, compared to between 81-88% of householders from the other GoWell area types. This is only partly explained by the presence of asylum seekers and refugees, whose sense of community is lower than others. Even British citizens in these areas have a low sense of inclusion compared to other area types.
- **Belonging:** Sense of belonging has also declined in TRAs (-13%) but changed little in other areas. This may reflect the clearances and demolitions in the TRAs but the picture may also be complicated by the presence of asylum seekers and refugees.
- **Harmony:** Respondents in all types of area have reported a higher sense of social harmony between people of different backgrounds than they did in 2006 (range between around +5% and +25%), particularly so in Regeneration Areas.
- **Trust:** Few people in Regeneration Areas see their local social environment as one which maintains high standards of behavioural norms. For example, trust in other people – in terms of reliance on others to exercise social control, and the perceived honesty of fellow residents – has declined dramatically in TRAs and LRAs.
- **Neighbourliness:** Most householders report speaking to neighbours frequently, but this is less common in the Regeneration Areas: (speaking to neighbours: 52% TRAs; 50% LRAs; 80% WSAs; 75% HIAs; 78% PEs in 2008). Often this contact does not seem to convert into more sustained or in-depth knowledge or exchanges, nor does it extend to feelings of trust and reliance in people within the wider locality.
- **Isolation:** Most people report regular social contact, but an increasing minority report having no contact with relatives (between 7% and 11% in 2008), friends (between 6% and 20% in 2008), or neighbours (between 4% and 15% in 2008).
- **Social support:** The availability of different forms of social support has been fairly stable in WSAs and HIAs, but has fallen in other types of area. This is mostly due to an increase in people's reluctance to ask for help. The biggest drop in access to social support has occurred in the PEs.
- **Perceived influence:** There have been improvements in all types of area in residents' perceived influence over decisions affecting their local areas – but from a low base. In Regeneration Areas, around a third of residents in 2008 said they had any influence compared to around a half in the other area types. Community empowerment appears to be underpinned by people's sense of community more broadly. The more people feel a sense of inclusion and belonging, have social connections with neighbours, and trust in the morality and norms of their co-residents, the more likely they are to also feel collectively empowered.

Physical Health

The findings for self-reported physical health problems do not follow the pattern of many of the housing, neighbourhood and community findings. Most of the comparisons of illness prevalence between the two surveys have found no significant changes over the period, and most of the differences that were statistically significant were still relatively small (≤ 5%) in real terms. The health findings tended not to show consistent disadvantages in Regeneration Areas (or PEs) compared to the other GoWell area types. This is despite the fact that the Regeneration Areas have been changing in very different ways to the other areas (i.e. experiencing large scale clearances and demolitions). This suggests that self-reported health does not bear a strong relation to housing and regeneration activity at this relatively early stage of regeneration.

A small decline in self-reported general health and no change in the use of General Practitioner (GP) services have been found. More people reported having no health problems but those people with health problems tended to report having more of them than previously (indicating more co-morbidity). Health behaviours – inactivity, smoking, poor diet, alcohol consumption – were often worse among white Scots, flat dwellers (and particularly occupants of MSFs), the unemployed and long-term sick, and among single adults below retirement age.

- **General health:** Most respondents reported that their current general health is good or excellent: approximately 80% in 2006 and 75% in 2008. Increases in householders reporting not good mental health were significant ($p<0.05$) in the TRAs (+4%) and the PEs (+7%).

- **Long term illness:** Overall reporting of no (zero) long term health problems (lasting at least 12 months) increased by 7% for men and women. The mean number of long term conditions for householders with at least one long term problem also increased for men (from 1.43 to 1.63) and women (from 1.45 to 1.65).
- **Recent illness:** Reporting of no recent health problems (in the previous four weeks) changed little. The mean number of recent conditions for householders with at least one recent problem however increased for men (from 1.91 to 2.06) and, less so, for women (from 1.97 to 1.99).
- **Heart health:** Several measures, sometimes linked to heart-related problems (pain in chest, palpitations/breathlessness, faintness/dizziness), show small but statistically significant findings of reduced prevalence over time, particularly for women. Reductions of between 3% and 5% were found in TRAs, LRAs and PEs.
- **Seeing a doctor:** GP use did not differ markedly between 2006 and 2008.
- **Health behaviours:** The findings on health behaviours support the view that unhealthy behaviours are particularly prevalent in deprived areas. However, levels of population health and healthy behaviours were raised in the Regeneration Areas by the presence of migrants who reported better health and less health damaging behavours.
- **Physical (in)activity:** In terms of health behaviours, the biggest challenge identified was physical inactivity, with two-thirds of respondents across the study areas having not done any moderate or vigorous physical activity in the past week, and one-in-four also reporting that they had not walked for at least ten minutes in the past week.
- **Diet:** In 2008, 55% of GoWell respondents recalled eating at least five portions of fruit or vegetables in the last 24 hours. There was a small overall decrease (from 47% in 2006 to 43% in 2008) in the proportion who ate one or more fast-food main meals in the past seven days. There were considerable variations by area type, ranging from a decrease of 10% in the TRAs (from 50% to 40%) to an increase of 7% in the WSAs (from 42% to 49%).
- **Alcohol:** High levels of self-reported teetotalism (44% across GoWell areas as a whole) are a notable exception to the generally negative picture of health behaviours. This may be a characteristic of populations living in Scotland's deprived areas, particularly when those populations include many residents born outside the UK. However, the results are surprising and their accuracy needs further exploration.
- **Smoking:** Self-reported smoking prevalence was less in 2008 than 2006 (40% and 44% respectively). Nearly half of all smokers said they would never quit. Respondents from the TRAs were the least likely to smoke. Respondents from the HIAs were the most likely to smoke.

Mental Health and Wellbeing

The picture of mental health among GoWell residents is complex. It might have been expected for mental health to have become worse in the Regeneration Areas between 2006 and 2008 relative to the other IATs, because of the higher levels of poverty and deprivation in these areas, as well as the disruption and inconvenience caused by renewal activity. This is largely borne out by respondents' experiences of mental health problems, which were more common in the Regeneration Areas than in the WSAs and HIAs, and were getting worse over time. It was also found that disproportionately many of the people with the lowest scores on the measure of positive mental health were residing in the Regeneration Areas. However the increase in the incidence of respondents seeking help from their GP for a mental health problem was negligible in the TRAs, where regeneration activity might be expected to be most intense, and was more substantial in the LRAs and WSAs. Further analysis, including controlling for potential confounders and demographic characteristics will help to clarify the current findings while future GoWell survey waves will show whether or not a clearer pattern of mental health findings develop in the medium to long term.

- **Mental health problems:** Mental health problems (such as longer-term stress, anxiety and depression) have increased in prevalence over time in all areas, though particularly in the Regeneration Areas.
- **Regeneration areas:** The impact of mental health issues upon quality of life and daily functioning has lessened in the Regeneration Areas while worsening elsewhere. This could be for a number of reasons, such as:
  - o populations in Regeneration Areas are more resilient to the impacts of mental health upon daily functioning;
  - o residents in Regeneration Areas become habituated to difficult and challenging circumstances and so are less likely to feel 'down' about them;
  - o the more deprived circumstances themselves lower the opportunities for mental health problems to have impacts upon daily life;
  - o the prospect of change in the area acts as a buffer or in a protective way against the potentially negative impacts of mental health issues.
- **Quality of life:** Three components of mental health quality of life as measured by the SF-12 health survey (Role Emotional, Mental Health, Social Functioning) showed significant improvements between 2006 and 2008 in the TRAs and LRAs, and small declines or no change in the WSAs and HIAs and the PEs.
- **Vitality:** The fourth aspect of mental health quality of life - Vitality ('having a lot of energy') - decreased substantially in all IATs between 2006 and 2008.
- **Worsening mental health:** More than two-in-five of those people in the TRAs, LRAs and HIAs who reported having a mental health problem over the previous year, said that their condition had worsened since 2006.
- **Seeing a doctor:** In the LRAs and WSAs there were marked increases between 2006 and 2008 in the number of people seeking help from their GP for a mental health problem – with no significant change elsewhere. Substantial proportions of those seeking help from a GP do not report a long-term mental health condition, suggesting an increase in the incidence of acute episodes of anxiety, stress and depression.
- **Mental wellbeing:** Positive mental wellbeing scores as measured by the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) were somewhat lower in the TRAs and LRAs than in the other IATs, and a disproportionately large percentage (57%) of the respondents with the poorest scores lived in Regeneration Areas. Area type differences were also present in respect of measures of vitality and social functioning, with people in Regeneration Areas again scoring lower (after taking age and sex differences between areas into account).
- **Demographics:** Significant amounts of the variation in the measures of components of mental health may be accounted for by the demographic profile of the IATs, rather than, or in addition to, the differences in the regeneration activities taking place. Middle-aged men may be of particular concern as they often report the lowest scores across a range of measures of mental health.

Introduction

This chapter sets out the following:

- **Background:** The origins and purpose of this report.
- **The Changing Context:** What has changed since the first survey in 2006 that could affect the findings.
- **Comparing the Surveys:** How to consider the comparisons made between the findings from the two surveys, in 2006 and 2008.
- **Study Areas and Intervention Area Types:** The identification of the study areas and their grouping into different types of 'intervention' or 'treatment' area.

Background

GoWell is a research and learning programme that aims to investigate the impact of investment in housing, regeneration and neighbourhood renewal on the health and wellbeing of individuals, families and communities over a ten-year period. The programme aims to establish the nature and extent of these impacts, to learn about the relative effectiveness of different approaches, and to inform policy and practice in Scotland and beyond. GoWell is a mixed methods study with different research and learning components. This report focuses on the findings from the community health and wellbeing survey component.

In the summer of 2006, GoWell's fieldworkers interviewed just over 6,000 adult residents in 14 Glasgow neighbourhoods to ask them about their homes, neighbourhoods, communities,

health and wellbeing. The aim was to build a picture of how things were before major changes took place in their areas as a result of housing investment and neighbourhood regeneration.

These improvements, redevelopment and regeneration activities are being funded and delivered by a number of public and private sector organisations, including by Glasgow Housing Association (GHA) and Glasgow City Council (GCC). Consideration also needs to be given to the £435 million Fairer Scotland Fund (FSF)[1] covering 2008/09 – 2010/11, of which just over £150 million was allocated to Glasgow to tackle poverty, regenerate disadvantaged communities and help overcome barriers to employment. There are, however, many other regeneration initiatives taking place in Glasgow that involve different local housing organisations, and stakeholders outside the housing sector. Some activities are co-ordinated and some have emerged independently.

In 2008, GoWell revisited those 14 areas[i] to repeat the survey and consider what had taken place there during the intervening years, and what impacts this may have had on different communities and places.

The Changing Context

The areas being studied are affected by a combination of specific programmes delivered by the housing and regeneration sectors as well as by general public policy developments and wider social and economic developments. Therefore, the survey findings cannot solely be attributed to regeneration. One of the biggest developments in the period 2006-08 was the economic downturn, which could affect how people feel about their own prospects and impact directly on housing construction activity. At the same time, public policy programmes were less affected by the recession. By 2008 the social housing sector investment programme, whose aim is to bring the housing stock up to the Scottish Housing Quality Standard[2] had progressed significantly right across the City of Glasgow, including the GoWell study areas. The redevelopment of the Transformational Regeneration Areas (TRAs) was also progressing with master-planning exercises completed, and clearance and demolition well advanced. Alongside physical renewal, a series of neighbourhood regeneration activities, or 'wider action' programmes had also been instituted by GHA and its partners in many of the study areas by 2008. Finally, across the city, community planning had become well established as a means of better targeting and co-ordinating public service delivery to communities. These developments form the backdrop to the Wave 2 survey and are explored more fully in Chapter 2.

Comparing the 2006 and 2008 Surveys

This report summarises how variables measured in the 2008 survey compare with those from 2006. It represents GoWell's first chance to take a comprehensive look at changes to the study areas over time. The timeframe covers a period during which the most immediate impacts of the early stages of regeneration can manifest themselves, but the medium and long-term impacts cannot be examined until

[i] A fifteenth area was included in the 2008 survey: Birness Drive. As this area lacks comparative data from 2006, findings related to Birness Drive are not presented in this report (see Chapter 3 for more details).

subsequent waves of the survey. Many of the interventions taking place will take years to realise their aims, and some are still being planned. Consequently, the Wave 2 survey should not be viewed simply as a 'post-intervention' survey: some respondents may have experienced completed interventions but others were living in areas for which regeneration plans had yet to be finalised or were in the course of being implemented.

As the two waves of the survey were based on two distinct random samples of householders from the GoWell areas, differences in their findings may have arisen for several reasons, including (a) individuals' experience of changes over time; (b) residential mobility changing the demographic profile (including the health profile) of an area and bringing in new people with a different perspective on their home and neighbourhood; and (c) measurement limitations. These possible explanations are not mutually exclusive and all should be borne in mind when considering the findings reported in subsequent chapters.

Many of the statistics presented include the results of significance testing. These tests are used to identify differences between samples (e.g. between the 2006 and 2008 GoWell surveys) that are unlikely to have arisen as a result of sampling error. For example, a p value of 0.05 indicates a 95% probability that a difference observed in the samples reflects a 'genuine' difference in the 2006 and 2008 populations (with a 5% probability of sampling error). A p value of 0.01 raises that probability of a 'genuine' population difference to 99% (and a 1% probability of sampling error). Statistically significant differences may or may not be large, important or useful, as these are more subjective concepts based on value judgements that extend beyond purely statistical considerations.

The summary presented here aims for breadth more than depth. It groups the GoWell areas into five Intervention Area Types (IATs), defined by the types of regeneration being delivered or planned in each neighbourhood. These IATs are undergoing different types and rates of change and there are also some demographic differences between them. Much of the analysis presented compares the IATs, but in many cases more detailed analysis will be required to tease out the extent to which differences over time may be attributable to regeneration, to spatial demographics and to other contexts associated with particular places. Longitudinal and other data are also currently being collected that will enable the matter of attribution to be considered further.

Study Areas and Intervention Area Types

In the following chapters, the main comparisons will be between the five IATs, although, where appropriate, specific GoWell study areas will also be mentioned. Table 1.1 lists and provides a short description of each of these IATs and the study areas comprising them, along with the abbreviations used for the IATs. It may be helpful to refer to this table when reading this report. The location of the study areas within the City of Glasgow is given in Figure 1.1. Appendix 1 provides study area maps for each of the 14 GoWell study areas.

Table 1:1 GoWell Intervention Area Types (IATs) and study areas

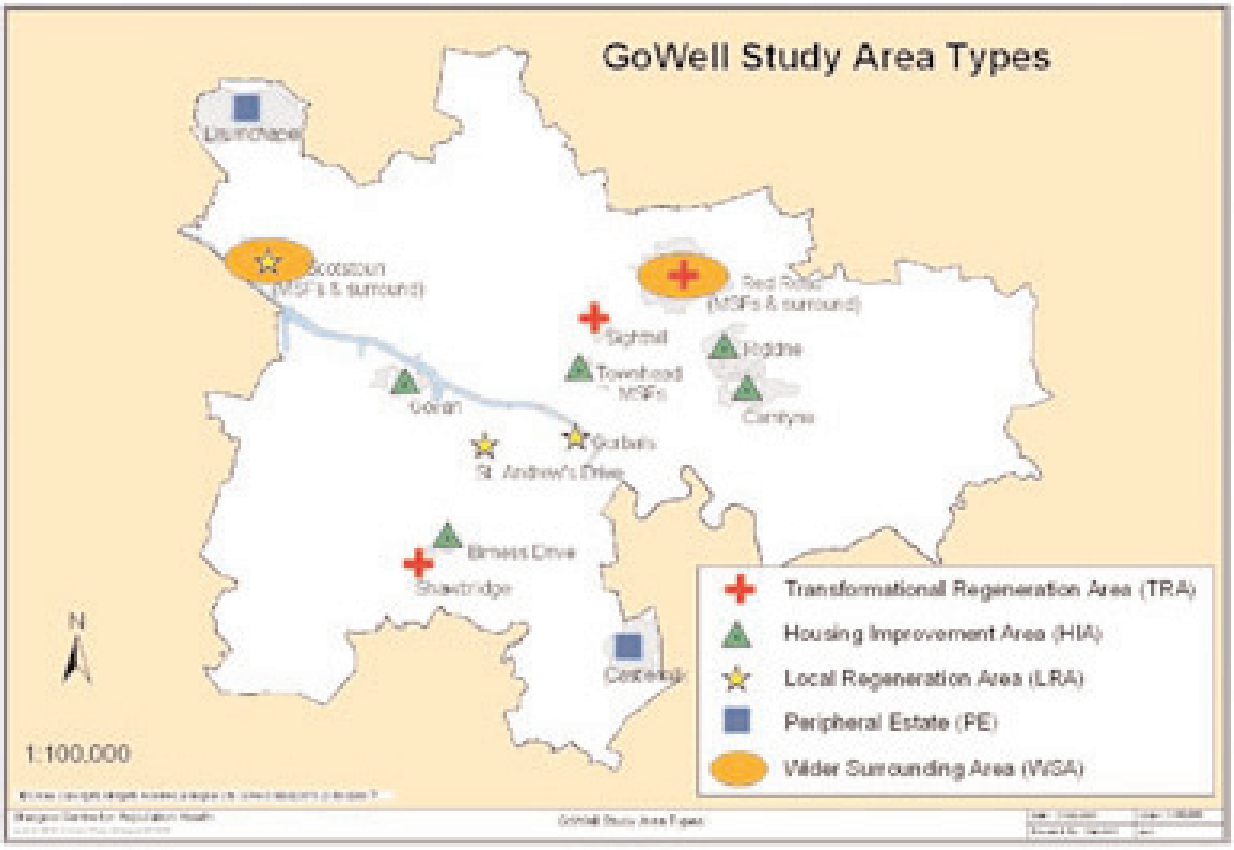
Intervention Area Type (IAT)	Area (number of households at baseline[3]): description
Transformational Regeneration Areas (TRAs) Places where major investment is planned over the next 10-15 years, and where change involves a substantial amount of demolition and rebuilding over a long period, as well as significant disruption for the residents.	**Red Road Multi-Storey Flats (MSFs) and Tenements** (1,500): A large housing estate consisting mostly of MSFs and some tenements built in the 1960s, located in the north of the city. Includes asylum seeker and homeless accommodation. **Shawbridge** (1,100): A large housing estate consisting of high- and low-rise flats built in the 1960s, located on the south side of the city. Includes asylum seeker and homeless accommodation. **Sighthill** (2,500): A post-war large housing estate located north-east of the city centre, consisting of MSFs, tenements and deck access flats. Includes asylum seeker and homeless accommodation.
Local Regeneration Areas (LRAs) Places where a more limited amount and range of restructuring is planned, and on a much smaller scale than in TRAs. GHA has referred to these areas as 'Special Projects'.	**Gorbals Riverside** (400): A small housing estate on the south side of the city located next to the River Clyde on the edge of the Gorbals. It consists of four MSF blocks and some deck access properties. **Scotstoun MSFs** (900): Two clusters of post-war MSFs (Kingsway Court and Plean Street) in the west of the city. Includes asylum seeker and homeless accommodation. **St Andrews Drive** (500): A small estate of modern deck access flats, 'mini-multi' blocks, tenements and terraced houses, located on the south side of the city.
Wider Surrounding Areas (WSAs) Places of mixed housing types surrounding areas of MSFs subject to transformation plans. The surrounding areas are being used for decanting purposes from the core investment sites. These areas also receive substantial amounts of core housing stock investment from GHA.	**Wider Red Road** (4,200): Includes several neighbourhoods surrounding Red Road, including Balornock (old and new), Barmulloch and Petershill. The area consists of 1930s and 1950s cottage flats, semi-detached houses and some late twentieth century housing. **Wider Scotstoun** (2,100): This area, which includes part of Yoker as well as Scotstoun, consists of pre-second world war tenements as well as 1930s and 1950s cottage flats and semi-detached houses. It surrounds the two clusters of MSFs subject to regeneration plans.

Table 1:1 GoWell Intervention Area Types (IATs) and study areas cont'd

Intervention Area Type (IAT)	Area (number of households at baseline[3]): description
Housing Improvement Areas (HIAs) Places which are considered to be popular and functioning successfully, but where significant improvements are required to dwellings, both internally and externally. Extensive property improvement works take place in these areas as part of GHA's core stock improvement programme.	**Riddrie** (2,600): A community to the north-east of the city centre exemplifying inter-war social housing in Glasgow. It consists of 1930s four-in-a-block flats and semi-detached or terraced cottages, many of which have been transferred to private ownership following the right-to-buy policy of the 1980s. **Govan** (600): The study area focuses on two clusters of houses on either side of the shopping centre that provides a focal point for this south side area. One cluster consists of tenements, while the other is made up of concrete houses and apartments. They represent different types of post-war social rented housing. **Carntyne** (1,300): This area borders Riddrie and (with respect to the GoWell area boundaries) has a comparable housing and tenure mix to its neighbour. The GoWell area surrounds, but does not include, some non-traditional housing that is the subject of a separate GHA investment strategy. **Townhead MSFs** (1,000): Two distinct clusters of post-war MSFs on the northern edge of the city centre, located at Drygate and St Mungo.
Peripheral Estates (PEs) Large-scale housing estates on the city boundary where incremental changes are taking place, particularly in terms of housing. These estates were originally entirely social rented but, as a result of the right-to-buy scheme and private developments in recent years, there is now a significant element of owner occupied as well as rented housing. Private housing development and GHA core stock improvement works both take place on these estates.	**Castlemilk** (2,300): The study area includes the eastern half of Castlemilk, which has undergone significant change over the past 10-15 years as part of the earlier New Life for Urban Scotland initiative. Many relatively modern terraced and semi-detached houses now exist amongst the older post-war tenements. The area is situated on Glasgow's south-east periphery. **Drumchapel** (4,600): Drumchapel was planned in the 1950s and was the last of Glasgow's three peripheral estates to be built. It is situated at the north-west corner of the city and amongst its numerous green spaces contains a mixture of post-war tenements, a few MSFs and some late twentieth century semi-detached houses – including some private sector 'new-builds', of which more are planned as part of one of the city's 'New Neighbourhoods' scheme. The study area consists of most of the estate, apart from some neighbourhoods in the south.

TRAs and LRAs have many similarities: they are large housing estates with relatively young populations, sharing some common problems and similar regeneration strategies. Throughout this report they are sometimes grouped together as '**Regeneration Areas**'.

Figure 1.1 Map of GoWell study areas



The Changing Context in Glasgow

This chapter provides an overview of regeneration (and related) activities that have taken place in Glasgow during the early years of the GoWell programme. These activities have been delivered by a range of public and private sector providers, often in partnership and often seeking to engage local people in decision-making. The chapter focuses on housing, and housing-related developments as much of the data has been received from Glasgow Housing Association (GHA), but a summary of relevant high level strategies and initiatives from other stakeholders is also provided.

The chapter covers the following issues:

- **Policy context:** a summary of national and local policies and programmes.
- **Physical change:** including investment in housing improvement, the demolition programme, building new homes.
- **Tenure change:** the extent to which plans to create more mixed tenure communities have been realised at this early stage in the regeneration process.
- **Community services and 'wider actions':** Glasgow's regeneration programme includes a suite of initiatives and programmes designed to help residents and strengthen communities. These include community-wide services and facilities, and targeted initiatives for different people in the community: e.g. parents, children, young people, working-aged unemployed, vulnerable groups, ethnic groups, elderly people, etc.

- **Impacts of the recession:** drawing on work from Glasgow City Council (GCC), some early indications of how the recession may have affected regeneration and residents.

Recent National Developments

The 2006 Scottish regeneration policy statement[4] identified regeneration as being about:

- Creating vibrant, safe communities where individuals and families want to live and businesses want to invest and grow;
- Communities which are well planned and well designed;
- Communities with a diverse and attractive environment;
- Communities which provide opportunities for culture and sport;
- Communities with a sense of identity and pride.

At the time of GoWell's baseline (2006) survey, the Scottish Executive was working to achieve its *Closing the Opportunity Gap*[5] policy objectives in areas such as employability, education, health, access to local services, safety and the quality of the local environment in the most deprived neighbourhoods. Other key elements of national regeneration policy included measures to improve the quality of housing (including social rented housing), to tackle fuel poverty and to prevent and alleviate homelessness. The Community Regeneration Fund (CRF)[6] was established to help fund improvements in the 15% most deprived areas in Scotland.

The Scottish Government has more recently restated its commitment to area regeneration in the National Performance Framework that resulted from its 2007 Spending Review. 'We live in well-designed, sustainable places where we are able to access the amenities and services we need' is one of the 15 National Outcomes that describe what the Government wants to achieve over the next ten years[7]. A number of indicators are linked to the outcome, including:

- Increased rate of new house building;
- Increased percentage of adults who rate their neighbourhood as a good place to live;
- Decreased estimated numbers of problem drug users in Scotland by 2011;
- Reduced overall ecological footprint;
- Improved state of Scotland's Historic Buildings, monuments and environment;
- Increased proportion of journeys to work made by public or active transport.

These targets suggest a definition of regeneration that includes both housing interventions and broader areas of improvement such as services, amenities, sustainability, satisfaction and the health and wellbeing of people and communities. The outcome is also intended to contribute to the Government's overarching priority of sustainable economic growth.

From 1 April 2008 the Community Regeneration Fund[6] together with six other regeneration funds was replaced by the £435 million Fairer Scotland Fund[1]. This change followed calls for a single regeneration fund. It reflects the new relationship between the Scottish Government and local government set out in the 2007 Concordat, which

underpins funding to local government during the financial years 2008-2011. A central element of the new relationship was a reduction in the number of ring fenced funds for local government and the creation of Single Outcome Agreements (SOA) between Community Planning Partnerships and the Scottish Government, based on the 15 National Outcomes[7]. The Fairer Scotland Fund (which runs until end-March 2010) is allocated to Community Planning Partnerships to help address both area and individual level poverty. Community Planning Partnerships are given greater flexibility to take decisions on local investment and report on delivery of local outcomes supported by this investment within the SOA reporting process.

In June 2008, the report of the Scottish Government's Ministerial Task Force on Health Inequalities (*Equally Well*)[8] also highlighted the importance of broadly defined regeneration activities (and the role of GoWell in evaluating the effects of such activities) as a means of tackling social inequalities in health. The report includes a chapter on the physical environment, which explores issues such as environmental justice, greenspace, transport, air quality, housing and communities. The chapter concludes that there is disappointingly little evidence for specific effective action on physical environments that would achieve measurable reductions in health inequalities in Scotland. There is, however, an understanding of complex interactions between individual health and physical and social environment characteristics. This should be useful in informing joined up national and local activity.

Regional Investment

Nationally, the Clyde Corridor area, encompassing the Clyde Waterfront and the Clyde Gateway initiatives, has been identified as a regeneration priority. Glasgow is situated at the heart of these regional developments. Plans for the Glasgow and Clyde Valley area were published in a consultation draft in 2005[9,10]. They included a 20-year industrial and business land supply with capacity for 100,000 new jobs; the construction of over 110,000 new houses by 2017; the restructuring of thousands of social rented houses; investment in 53 town centres; a 20-year transport investment programme; a £60 million five-year rolling programme for the treatment of vacant and derelict land; a £50 million programme to improve the environment and the creation of a 'green network' by 2020[10].

Four of Glasgow's main Regeneration Areas lie adjacent to or within the Clyde Gateway and Clyde Waterfront development areas, but all disadvantaged areas of the city might be expected to benefit from the major regional development plans for the city.

Community Planning and City Planning

A major potential contributor to the improvement of the lives of Glasgow's citizens has been the coordinated organisation and delivery of public services. Glasgow Community Planning Partnership (GCPP) was formed in 2004 as a vehicle for achieving this. It brought together five partners: Glasgow City Council, NHS Greater Glasgow and Clyde, Strathclyde Police, Glasgow Housing Association, and Strathclyde Fire and Rescue. GCPP's stated aims are to 'close the gap' in life chances between deprived areas and other parts of the city and to reduce or 'eliminate social inequalities' across the city[11].

There are three main ways in which GCPP is expected to achieve these goals:

- Obtaining the commitment of public service providers to working together, jointly planning services and better co-ordinating services, so that they are 'delivered in the most effective way possible'[11].

- Ensuring that service decisions are based upon the views of communities, with 'effective and genuine community engagement at the heart of [community planning]'.

- Managing the Scottish Government's *Fairer Scotland Fund*[1], which is to be used for projects and programmes that contribute to regenerating disadvantaged communities, tackling poverty and overcoming barriers to employment.

GCPP organises its work under five themes: Working Glasgow; Learning Glasgow; Healthy Glasgow; Safe Glasgow and Vibrant Glasgow. The outcomes and targets it is trying to achieve have been set out first in a Regeneration Outcome Agreement (ROA)[12], and more recently in its first Single Outcome Agreement (SOA)[13], which aligns local priorities with 15 National Outcomes. Each local outcome is supported by a number of local indicators and targets for monitoring progress. Table 2.1 shows the 24 Local Outcomes agreed by GCPP for the city and relates them to the city's five main themes for improvement. Many of the outcomes relate to issues within deprived communities, such as those being studied through GoWell. Therefore, change for the better might be expected if policy interventions within the study areas – physical, social and economic regeneration – are successful. Although each local outcome can be related to others (these linkages are shown in the SOA document), it can be seen that the two areas with the most priority outcomes are the issues of health and crime.

Table 2.1 Glasgow SOA local outcomes

OUTCOME	DEFINITION
HEALTHY GLASGOW	
3	Reduce the public acceptance and incidence of over-consumption of alcohol and its subsequent negative impacts (personal, social, economic).
12	Increase the proportion of the population with a healthy BMI.
13	Increase the proportion of residents involved in physical activity.
14	Improve children's diets.
15	Reduce the difference in life expectancy between the most affluent and most disadvantaged residents.
16	Reduce the harm caused by drug addiction.
17	Reduce the proportion of children in poverty.
18	Increase the proportion of parents who are capable, responsible and supported.
19	Reduce the proportion of residents who smoke.
LEARNING GLASGOW	
20	Improve the literacy and numeracy of the population.
21	Improve educational attainment and achievement of all children and young people.
22	Improve skills for employment.
WORKING GLASGOW	
7	Increase the number of jobs in Glasgow.
8	Increase the proportion of better paid and more productive jobs.
9	Increase the proportion of Glasgow residents in jobs.
10	Increase performance and volume of business carried on in Glasgow.
SAFE GLASGOW	
1	Reduce the level of violent crime, including gender-based and domestic violence.
2	Reduce injuries as a result of road traffic incidents, fires and incidents in the home.
4	Reduce the impact and incidence of anti-social behaviour.
5	Reduce the involvement of young people in crime and as victims of crime and accidents.
6	Reduce the fear of crime.
VIBRANT GLASGOW	
11	Improve the attractiveness of Glasgow as a place to live, invest, work and visit.
23	Improve residents' aspirations, confidence, decision-making capacity and involvement in community life.
24	Improve Glasgow's physical environment and infrastructure.

Source: Glasgow's Single Outcome Agreement, June 2008

Focussing on the use of the physical space in the city, the development strategy of the Glasgow City Plan, published in 2003[14], described specific areas in which it would seek to secure greater industrial and business development. Areas of focus for Glasgow included: Drumchapel, Glasgow North, East End, M8 East, South Central, Greater Govan, Greater Pollok and Castlemilk. The City Plan also identified flagship retail and leisure developments as contributing to Regeneration Areas. The 2005 Regeneration Outcome Agreement for Glasgow (ROA)[12] linked its objectives clearly with those of the community plan for Glasgow, which emphasised increasing the chances of sustained employment for vulnerable and disadvantaged groups in order to lift them permanently out of poverty.

Housing Developments in Glasgow

Housing strategy

Glasgow's Local Housing Strategy (LHS) 2003-2008[15] had six original aims:

- To promote the regeneration of the city
- To raise the city's housing in all tenures to satisfactory standards, with affordable costs
- To meet people's changing housing needs
- To prevent and alleviate homelessness through the delivery of effective services
- To ensure equality of access to housing irrespective of race, gender, disability, age and sexual orientation and to monitor relevant processes effectively
- To promote effective delivery of housing services in the city

An update in 2005[16] specified the need to work jointly with communities and partners, developing a more detailed strategy with reference to specific programmes and city localities and a better analysis of the housing market. The need for a fuel poverty strategy was also stated.

Stock transfer and the creation of GHA

The stock transfer which led to the creation of GHA in 2003 was a key stage in delivering many regeneration objectives in Glasgow. The transfer agreement included grant support to GHA by the then Scottish Executive, Treasury and private finance to fund a range of regeneration activities.

From an initial stock holding after transfer of 80,500 homes, GHA's stock was reported in 2009 to stand at around 66,000 units, reflecting the demolition of over 10,000 units and sales of a further 3-4,000 units. The number of units to be demolished over a 15-year period following stock transfer (to 2018) has increased from an initial total of 11,000 units to 20,000 units, so that half the demolition programme is still to occur. Further, GHA is to build 3,000 new homes as part of a 6,000-unit 're-provisioning' programme to assist with demolition and redevelopment, with the other 3,000 units provided by Registered Social Landlords (RSLs) within the city[17]. By the end of 2008, GHA considered that it had 56,000 core housing stock units[18], all of which had been, or would be, improved through investment.

In 2007, GHA stated that while some £1,714 million of public money was invested in the initial housing stock transfer, £900 million of that was historic debt which was written off. That left GHA with access to £814 million of public money and to £725 million of private borrowing, the first of which could be drawn in the coming year. Of the £814 million, £114 million had been allocated for demolitions, £113 million for new homes, £21 million for central heating and £100 million for capital works for owner occupiers. The balance, £466 million, along with annual rental income of some £200 million, is committed to home and neighbourhood improvements, providing housing services, community regeneration and running the Local Housing Association network and support services[19].

Regeneration in Glasgow

In December 2006, GHA identified eight Transformational Regeneration Areas (TRAs) within the city which would be subject to extensive demolitions and redevelopment, plus a further seven 'special projects' involving redevelopment on a smaller scale (now called Local Regeneration Areas (LRAs)). Together, these 15 areas covered 35,000 people or 6% of the city's population[ii]. Six of these areas (three TRAs and three LRAs) are included in the GoWell study. GHA's aims for regeneration in these areas cover the following themes[20]:

- Vibrant places
- Housing choice
- Growing assets
- Attractive neighbourhoods
- Stronger, safer communities
- Supporting tenants
- Jobs and training

Transformational regeneration was to proceed through partnership working between GHA (as the majority housing stock owner in the areas) and Glasgow City Council (GCC) (a major land owner in the areas and the strategic housing and planning authority). A jointly created Special Purpose Vehicle (SPV) was to be created to deliver regeneration across these eight areas, also involving the private sector as a partner, but progress on this has been slow and arrangements are not yet in place. Once the formal arrangements for a partnership are agreed, three of the TRAs (none of them a GoWell study area) will be used as 'pathfinders' to test the business model and partnership arrangements to be implemented in all eight areas.

Master planning between GHA, consultants and communities was conducted in 2006 for each of the eight areas, but as a result of a number of factors (recession, planning considerations, delivery arrangements, some community opposition) some of the plans for the areas are considered to be in need of revision and the partners' view is that 'further work' is needed on them[17].

Other regeneration priority areas within the city of Glasgow include Clyde Gateway, building the Commonwealth Games Village for 2014, and the completion of four New Neighbourhoods of owner occupied housing, one of which is in Drumchapel, a GoWell study area.

ii A fuller account of the regeneration process in Glasgow is given in our earlier report: *The Regeneration Challenge in Transformation Areas*, GoWell 2007.

Investment in Housing Improvement

In 2004 the then Scottish Executive set a Scottish Housing Quality Standard (SHQS)[21] which set out the standards that all homes in the social rented sector are expected to meet by 2015 (private sector housing is not obliged to meet these standards). Approximately 33% of all dwellings in Scotland passed the SHQS in 2005/6. In tenure terms, this equated to 40% of social housing (up from 23% in 2002) as compared to 31% of private housing (again up from 23%)[22].

On average, between 2004 and 2007, Glasgow City had 75% of its social housing stock fail the SHQS[23]. However, by 2008/9, it was reported that 56% of social housing in Glasgow City met the SHQS[24]. GHA accounted for 25% of the total number of dwellings brought up to Standard (2,686 dwellings) in 2006/07. This proportion doubled to 50% (10,455 dwellings) in 2007/0824. The Scottish Housing Regulator (2009) projects that almost 97% of social rented housing in Glasgow City will meet the Standard by 2015[24].

Table 2.2 summarises the major elements of work that have been undertaken to GHAs core sustainable stock. The heating improvement programme is considered to be complete, thus having a major impact upon the warmth and comfort of people's homes.

Apart from the GHA stock, the other main priorities for investment in housing improvements in the city have been primarily in the private sector. Two-in-five (41%) private sector dwellings had urgent disrepairs at the start of the GoWell survey period, and a quarter (26%) had low energy efficiency[23]. There has thus been a focus in particular on dealing with Below Tolerable Standard (BTS) stock and other major repairs[25]. However, changes to make Private Sector Housing Grants means tested have dramatically reduced the number of pre-1919 properties dealt with under the Comprehensive Tenement Improvement Programme, which assisted housing associations in improving tenements which contained private owners as well as tenants. Private sector action has been proceeding with public resourcing via the City Council at the rate of around 500 private sector properties improved per year across the city. Second, support has been given for adaptations to housing for disabled people in the private sector, proceeding at the rate of around 300 properties per annum.

Table 2.2 GHA improvement programme outturn

Work Element	No. of Units in Core Stock	Completions to March 2009
Gas heating	20,345	18,081
Electric heating	12,616	10,551
Kitchens	44,797	28,144
Bathrooms	41,586	27,800
Roof and overcladding (common property units)	12,614	10,155
MSF overcladding	100	92

Source: Glasgow City Council, Glasgow's Housing Issues. Consultative Draft Local Housing Strategy 2009

There are no significant Glasgow City Council programmes for investing in major repairs and adaptations in the RSL sector beyond GHA (traditional housing associations). Housing associations run their own fabric improvement programmes to achieve the Scottish Housing Quality Standard, but without access to Housing Association Grant via the city council, hence aggregate figures on the scale of these activities are not available to us. The main emerging need is to tackle poor conditions (in particular poor energy efficiency) in ex-Scottish Special Housing Association stock. This stock is of non-traditional construction with solid walls, and is owned primarily by around seven RSLs. The UK government's Community Energy Savings Programme may be one source of funding for these works, but match funding has yet to be identified by the housing associations concerned[25].

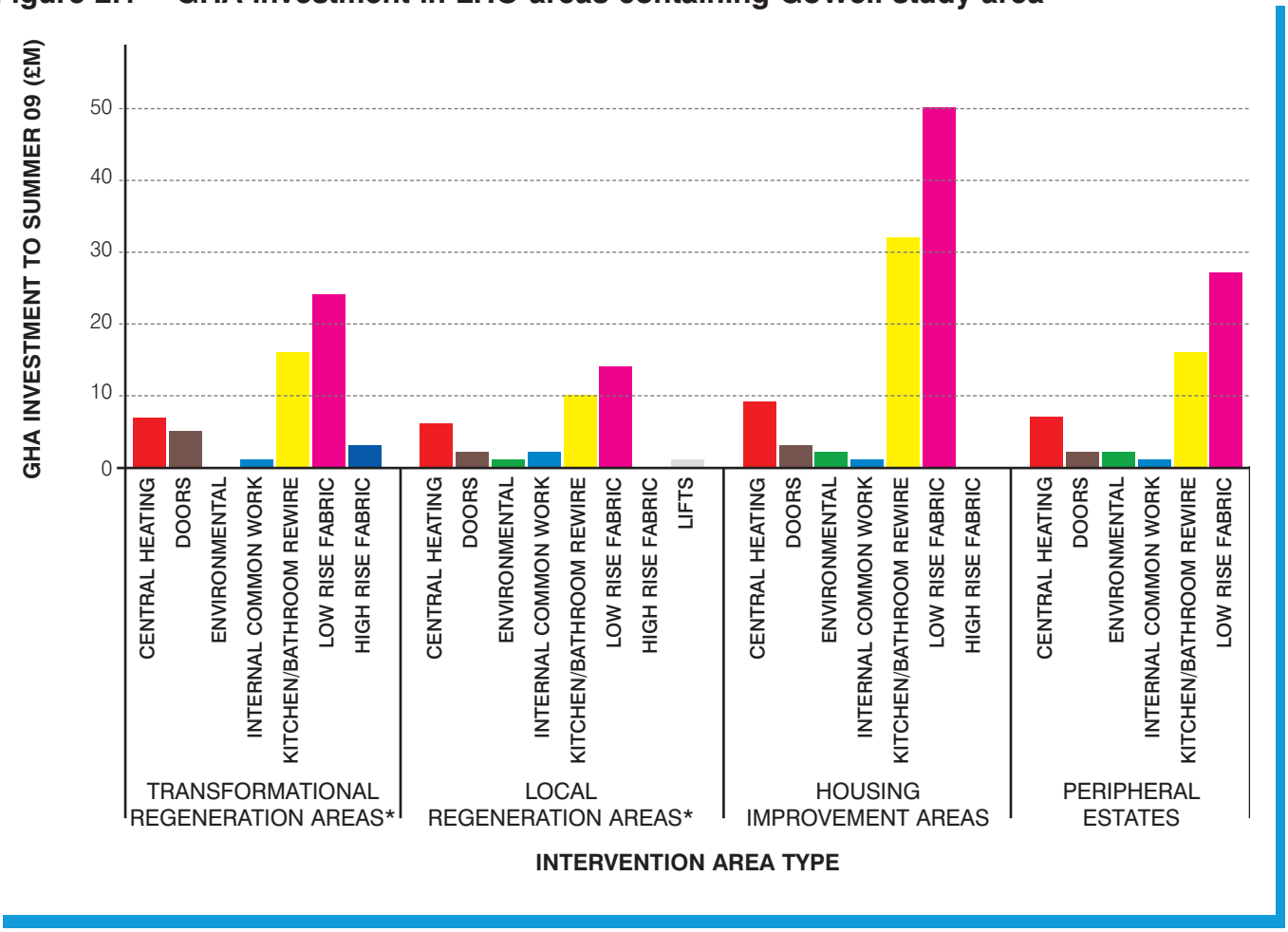
Housing Investment in GoWell Areas

Up until March 2009, GoWell addresses had received a total of nearly £80 million in housing improvement investment. Most of this (nearly 80%) has been spent on improvements to the external fabric of low-rise buildings and internal improvements such as new kitchens, bathrooms, re-wiring and central heating.

GHA has provided the GoWell team with summaries of its investment in Local Housing Organisation (LHO) areas within which the GoWell areas are located (Figure 2.1). Some of the summarised data combine GoWell IATs. For example, the Red Road MSFs and tenements (a TRA) and the Scotstoun MSFs (an LRA) are considered jointly with their respective wider areas in the data provided. The summaries can only provide an approximate breakdown of area investments and do not show the number of housing improvement interventions delivered per GoWell household.

GoWell's HIAs are situated in LHO areas that have received the most intensive investment to date (Figure 2.1). Other types of GoWell IAT are likely to receive more investment over longer periods.

Figure 2.1 GHA investment in LHO areas containing GoWell study area



* *Wider Red Road is included in the figures for TRAs and Wider Scotstoun is included in the LRA figures, as separate data for these areas were not available to GoWell at the time of writing.*
Source: Glasgow Housing Association

Home Security

Since stock transfer in 2003, GHA has installed 46,665 new Secured by Design (SBD) doors and 11,010 homes have been fitted with SBD windows at a cost of almost £56 million across the city. Research by Glasgow Caledonian University[26] (independent of GoWell) found that in areas where SBD standard doors and windows have been installed, the level of total housebreaking fell by 26% and this fall was greater than that experienced by other areas. In postcodes corresponding to GoWell areas, replacement doors constituted around 6% of the total investment in housing improvement.

Clearances for Demolition

As previously noted up to a quarter of GHA's housing stock (as at transfer) is due for demolition over the period 2003–2018, with half of the programme of demolition having already occurred. As a result, a number of MSFs located in GoWell areas are being cleared. The TRAs have been most affected. In those areas, 2,391 homes fall within current clearance plans, three-quarters of which had been cleared by March 2009.

Between the GoWell surveys in 2006 and 2008, 1,754 homes were demolished or handed to contractors for demolition following clearance in GoWell areas (Table 2.3).

Most of the demolitions (1,461 homes; 83%) were of MSFs in TRAs. The other demolished homes were mainly in post-war tenements: 54 (3%) in the TRAs and 226 (13%) in one of the PEs (Drumchapel).

Table 2.3 GHA homes demolished or handed to contractors for demolition in GoWell areas, 2006-08

IAT*	AREA*	HOMES
TRAs	Red Road	366
	Shawbridge	420
	Sighthill	684
HIAs	Govan	12
PEs	Drumchapel	272
TOTAL		1,754

** Includes only those areas and IATs affected.*

The demolition of MSFs is an iconic feature of the current regeneration programme. The events have attracted the traditional mass media and large crowds of observers, some of whom have used video sharing websites such as YouTube to distribute demolition footage. The demolition of the Red Road MSFs in particular has prompted Culture and Sport Glasgow in partnership with GHA to initiate community-based arts projects (2009-2015) to commemorate the high-rise era and its transition. A permanent legacy (museum exhibits and an artwork on the cleared site) is planned.

In July 2008, when GoWell's second survey was underway, two of the MSFs in Sighthill and two in Shawbridge were demolished. Two more MSFs in Shawbridge were demolished in August 2009. The remaining multi-storey tower blocks in the northern half of Sighthill have been emptied and handed over to demolition contractors (clearance of low-rise flats has also taken place on a smaller scale). Six blocks in Red Road are now either empty or close to being empty with further clearances also occurring in neighbouring MSFs and tenements. Preparatory work for the demolitions is progressing.

Clearances have involved 'decanting' of groups of households by the landlord, often to surrounding neighbourhoods and, in the case of Sighthill and Shawbridge, also to holding stock located in the southern half of these TRAs. Many of the properties scheduled for demolition have for some time been characterised by a relatively high turnover of residents, so the clearance figures will include some householders who moved out of their own volition. GoWell has attempted to track many of those who have moved.

Demolition planning has impacted upon local residents and communities. Residents have experienced uncertainty about the future of their homes while decisions are pending – as in the case of some of the Scotstoun MSFs. Resident groups have formed in some cases to challenge specific decisions to demolish (e.g. Sighthill) or not to demolish (e.g. St Andrews Drive) homes. The social dislocation and sense of uncertainty surrounding demolition plans are likely to have short-term impacts, some of which may have influenced the way GoWell participants responded in the surveys.

Social Sector New Builds

Private sector building work may have been disrupted by the recent recession but social rented new builds are under development. Many of these are for residents of housing stock being cleared for demolition. Landlords have consulted with residents over the design of social rented new builds, with residents at times providing input into specifying design features of the homes to which they are earmarked to move.

The social housing new build programme of 're-provisioning' will assist the clearance programmes. Plans included the building of 2,800 new GHA homes within the agreed timescales of 2014-2015. None of these homes had been completed by the time of the wave 2 survey (summer 2008), though the first phase of 239 units went on site that year. The second phase (approximately 400 units) has since commenced. Some GHA new builds will be in or near other GoWell areas (e.g. Drumchapel, Gorbals, Govan, Shawbridge and Townhead). The effects of new build activity (particularly around the TRAs) should appear by the time of the next (3rd) GoWell survey in 2011.

The City Council has a target to complete the construction of 10,000 social sector homes through community-based housing associations from 2004 to 2014. This includes both a 'core programme' and a 'reprovisioning programme' to assist with the rehousing of people from the transformational regeneration areas and other demolition locations around the city (in addition to GHA's reprovisioning programme). In 2008/9 the rate of output from the Community Based Housing Association (CBHA) reprovisioning programme was 278 units for the year[25].

Number of Homes and Tenure Mix

In these early stages of regeneration, clearances and demolitions are outpacing the building of new homes. Comparing the GCC Council Tax registers for 2006 and 2008, the total number of homes in GoWell areas has fallen by around 2,100 and now stands at about 23,500. There is likely to be some delay in clearances and demolitions being updated in Council Tax

Table 2.4 Tenure mix in Gowell areas, 2006 and 2008

	Social rented (n)	Private rented (n)	Owner occupied (n)	Social rented (%)	Private rented (%)	Owner occupied (%)
2006						
TRAs	4,927	27	160	96.3	0.5	3.1
LRAs	1,719	35	122	91.6	1.9	6.5
WSAs	2,840	205	3,185	45.6	3.3	51.1
HIAs	2,973	169	2,381	53.8	3.1	43.1
PEs	5,345	93	1,436	77.8	1.4	20.9
All IATs	17,804	529	7,284	69.5	2.1	28.4
2008						
TRAs	3,457**	14	189	94.5	0.4	5.2
LRAs	1,677	18	146	90.8	1.0	7.9
WSAs	2,739	187	3,254	44.3	3.0	52.7
HIAs	2,924	174	2,321	54.0	3.2	42.8
PEs	5,073**	68	1,287	78.9	1.1	20.0
All IATs	15,870	461	7,197	67.5	2.0	30.6
DIFFERENCE BETWEEN 2006 AND 2008 FIGURES (2008 MINUS 2006)						
TRAs	-1,470	-13	29	-1.8	-0.1	+2.1
LRAs	-42	-17	24	-0.9	-0.9	1.4
WSAs	-101	-18	69	-1.3	-0.3	1.5
HIAs	-49	5	-60	0.1	0.2	-0.3
PEs	-272	-25	-149	+1.1	-0.3	-0.9
All IATs	-1,934	-68	-87	-2.0	-0.1	+2.2

** *Figures derived by subtracting demolition numbers supplied by GHA in Table 2.3, rather than from the Council Tax Register, which lags behind large-scale change in these areas.*
Source: GCC Council Tax Registers, 2006 and 2008

registers, so the figures may underestimate the actual decrease in homes, particularly in those areas where clearances have been most prevalent. For this reason GHA data for social rented housing unit reductions in the TRAs and PEs has been used. The figures also exclude unclassified properties (Table 2.4). The data indicate how the decrease in the number of homes is distributed by area type. Unsurprisingly, the TRAs account for most of this decrease: a loss of 1,470 homes. In terms of tenure, most of the decrease (90%) in the recorded number of homes occurred within the social rented sector.

Clearances and demolitions have had a greater impact than new builds on tenure mix by reducing the number (and consequently the proportion) of social

rented homes in some neighbourhoods, although the changes have been small. Demolitions of homes have served to reduce the social rented sector's share of the housing market in GoWell areas by 2% overall. In contrast, the owner occupied sector's share has risen by 2% as a result, despite a smaller reduction in numbers of units.

The PEs are notable for experiencing a reduction in the number of owner occupied homes over this period. Castlemilk and, especially, Drumchapel are both due to undergo extensive new build programmes, which will result in the construction of many new private sector homes. However, these programmes have not boosted owner occupancy rates in either area during the two-year period considered here.

Tenants' 'right-to-buy' social housing has been an important driver of tenure change in the past. More recently, there has been a reduction in the numbers of social renters who exercise this right because fewer of them are eligible for the more generous former terms which were discontinued for new tenants under the terms of the 2001 Act. The more recent economic downturn may also have contributed to this fall. The Scottish Government announced in October 2009 that the Housing (Scotland) Bill[27] to be introduced in 2010 will reform the Right to Buy. First time tenants and those returning to social housing after a break will no longer be entitled to buy their property.

The economic recession has modestly improved the affordability of owner occupied housing in terms of the ratio of house prices to incomes. Median house price as a multiple of median income was 3.5 in 2002, peaked at 5.4 in 2007 and has since fallen back to 5.0 in 2008. Interest rates have also fallen. However, lenders now require substantial mortgage deposits, which for many customers (and particularly first-time buyers) makes home ownership less rather than more affordable[17].

To help people across Scotland who are on low incomes (particularly first-time buyers) become home-owners, the Scottish Government announced its new Shared Equity Scheme[28] as GoWell's Wave 2 survey drew to a close in September 2008. Shared equity means that the Scottish Government will keep a financial stake in the property so individual buyers do not have to fund all of it. Householders will pay for the majority share in the property (normally between 60% to 80%) and the Scottish Government will hold the remaining share.

Wider Actions: Social and Economic Regeneration

Since 2004, GHA has worked with local partners to support wider action throughout Glasgow aimed at improving the quality of tenants' lives and creating safer and more sustainable neighbourhoods. Programmes have focused on a number of different issues including[29]:

- Attractive environments
- Supporting older and vulnerable tenants
- Financial inclusion
- Jobs and training
- Community safety
- Community learning and development
- Heating and energy efficiency
- Improving health

Table 2.5 shows where and when locally delivered wider actions have been delivered, or are planned for delivery, across the GoWell areas. The Table specifies the types of action and whether the focus is on the whole community or community sub-groups. The most widespread activity is the youth diversionary programme, which has been in operation since before the first GoWell survey in 2006. The most common new activities since 2006 are the play area improvement programme and the Environmental Employability (Community Janitors) programme, which combines environmental actions with employment support.

However, Table 2.5 should not be over-interpreted. It should be noted that people do not only benefit from the services and facilities that are in their neighbourhood – particularly if transport links to other parts of the city are good. Other agencies besides GHA are also responsible for many local services and initiatives.

The Scottish Government has developed the Wider Role Fund in recognition that RSLs have always played an important part in regenerating communities and tackling social exclusion in Scotland. Wider Role funding was first launched as a programme in its own right in 2000. A Wider Role Policy Statement[30] was issued in 2003 which reaffirmed support for RSLs to play a full role in community regeneration. A further three years funding of £12m each year was allocated in the Scottish Spending Review of autumn 2007. This provides funding for Wider Role projects for the financial years 2008-09, 2009-10 and 2010-11. Wider role is not compulsory and it is for each RSL to decide which activities fit with their business development. The Wider Role Fund[30] has supported a wide variety of projects reflecting local priorities and needs. These include:

- employability training and work experience programmes
- help and information services on financial inclusion
- capital funding for community facilities in areas of deprivation.

The largest efforts to tackle social and economic regeneration in the most deprived communities in Glasgow are also led by the Glasgow Community Planning Partnership. There have, however, been a number of changes to the management and funding arrangements for social and community projects within the city, which will have affected the study communities as recipients of these social funds and programmes.

From 2005/6 to 2007/8, social regeneration projects were funded through the Community Regeneration Fund (CRF) of around £40 million per annum. This was used for projects and programmes developed 'in conjunction' with local communities and 'that respond to the needs identified for those communities'[11]. In April 2008, the CRF was replaced by the Fairer Scotland Fund (FSF), though the latter included other pre-existing funding streams as well. In Glasgow , it is reported that this resulted in a more strategic scrutiny of projects funded through the FSF, to better align funded activities with the city's SOA priorities, a so called 'project to programme' shift in funding[31]. The main effects of these changes were, firstly, that around a fifth of local projects supported by the CRF and other sources were no longer in receipt of financial support (though other projects or activities

may have been funded in their place); and second, that a third of the FSF allocation to Glasgow in 2008/9 (£15m) was placed under the management of the ten Local Community Planning Partnerships for use in support of local priorities. In a further change to funding arrangements, for the year 2010/11, the FSF will no longer be ring-fenced but rather included within the total Scottish Government allocation to Glasgow City Council[32].

The GoWell team needs to build a fuller picture of 'actions' taking place in GoWell communities by contacting a range of relevant stakeholders including other RSLs and non-housing sector partners who have been developing a wider role.

Table 2.5 Locally delivered 'Wider Actions' in GoWell Areas: Who are they intended to reach? When did they start?

IATs	Area	Infant / Child (and Parent)				Youth	Working Age Adults				Vulnerable Adults / Adults at Risk of Addiction			Elderly	Community-Wide							
		Play and Learning Activities	Play Parks and Areas	Substance Misuse (Child)	Home Safety	Youth Diversion	Disabled Tenants Employability	Literacy, Maths, Language	Training / Employability	Community Janitors	Home Fire Safety	Homemaking Skills / DIY	Women at Risk	Social Activities and Facilities	Advice - One Stop Shop	Debt Advice	Community Health Outreach	Community Events / Activities	Community Hall / Facilities	Arts Project	Participation in Local Planning	Environmental Improvement
TRAs	Red Road																	*				
	Shawbridge					*																
	Sighthill					*			*													
LRAs	Gorbals Riverside					*																
	Scotstoun MSFs					*																
	St Andrews Drive					*																
WSAs	Wider Red Road																	*				
	Wider Scotstoun					*																
HIAs	Carntyne					*																
	Govan					*																
	Riddrie					*																
	Townhead					*			*													*
PEs	Castlemilk					*																
	Drumchapel					*																

= Started before Wave 1; = Started between Waves 1 and 2; = Started after Wave 2.

* More than one intervention of this kind has been delivered in the area (concurrently or in parallel - shading indicates when the first intervention started)

Source: Glasgow Housing Association

Public Services

This section provides a very brief overview of policies and developments relating to some of the other key public services in Glasgow which will affect resident populations in the GoWell study areas and perhaps influence their responses to some of the questions about their communities and neighbourhoods.

Transport

Public investment in transport infrastructure is seen as one of the ways in which the public sector could encourage economic regeneration. For example, the Clyde Gateway regeneration project has sought to exploit the economic development potential of the new M74 northern extension and East End regeneration road routes. Locally, these have been identified as vital to effective regeneration (although the plans have proved controversial amongst those who are concerned about potential costs to health, the environment and deprived communities, while a public local inquiry into the M74 extension plans rejected claims that the benefits of this extension justified the costs).

Access to public transport has also been seen as an important regeneration issue for Glasgow. The ROA for Glasgow (2005)[12] included an outcome of increasing access to amenities through better transport services. Its indicators for the 15% most deprived Scottish data zones situated in Glasgow were an increasing proportion of residents within specified distances of bus stops, train and underground stations. More recently, Glasgow's SOA (June 2009)[13] has included outcomes linked to improved transport efficiency, safety, and satisfaction and increased walking, cycling and public transport use.

Health improvement was claimed as a wider benefit in the 2006 National Transport Strategy[33] – both as a result of reduced congestion (and thus improved air quality) and by encouraging active travel. However, transport planners are confronted with a series of competing aims: economic growth, congestion easing, improving access and equality of access, and addressing health and environment concerns. Competing does not always mean incompatible (for example, encouraging more people to take up active transport for small journeys may help achieve all of the above aims) but controversy over plans for new roads act as a reminder that in practice, transport policies do appear beset by conflicting demands[34].

Education

Education in Glasgow has been shaped by a National Policy Framework[35] that includes numerous initiatives and programmes, including the National Childcare Strategy, 21st Century School Building Our Future, SureStart Scotland, National Priorities in Education, Determined to Succeed, Active Schools Programme, and A Curriculum for Excellence[35-41]. This list is far from exhaustive and the GoWell Programme will not be able to explore the outcomes of each scheme systematically.

Free school meal uptake has also been a particular feature of Glasgow's schools. The Education Commission Report 2007[35] stated that 41% of Glasgow primary school children and 35% of secondary school pupils received them (compared with the Scotland-wide figures of 21% and 16%, respectively).

Glasgow's per pupil expenditure is reported to have been higher than the national average. In 2005/06 the total gross revenue expenditure per pupil in Glasgow primary schools was £4,428 while the Scotland-wide average was £4,138. The equivalent figures for secondary schools were £6,573 in Glasgow, compared with the Scotland-wide average of £5,771. The Commission stated that Glasgow Education Department delivers its services through 127 pre-five establishments (i.e., nursery schools/classes, Family Learning Centres, mobile crèches), 32 Special Educational Needs (SEN) Schools and 18 SEN units/centres, 171 primary schools and 29 secondary schools; the provision caters for approximately 80,000 children and young people, with services to parents/carers as appropriate.

Since the GoWell Wave 2 survey in 2008, plans to close or merge some of Glasgow's schools and nurseries (including Sighthill Primary and Barmulloch Primary – which are situated in the GoWell areas of Sighthill and Wider Red Road) have been announced and are being implemented.

Health

Glasgow's health service reorganised in April 2006 with the formation of NHS Greater Glasgow and Clyde (NHS GGC). This reorganisation coincided with the establishment of Community Health (and Care) Partnerships (CH(C)Ps), which have a role in bringing partners together to improve wellbeing in communities as well as to provide health and social care services. Five CHCPs fall within Glasgow's city boundaries with a further five CHCPs or CHPs linking to the other local authorities within the health board boundaries (Renfrewshire, East Renfrewshire, East Dunbartonshire, West Dunbartonshire, and Inverclyde).

The activities of NHS GGC and the CH(C)Ps are of obvious relevance to the health and wellbeing of Glasgow's disadvantaged communities, including those surveyed through GoWell. While these activities are too numerous to describe in full, initiatives intended to help tackle health inequalities in the city include the Keep Well / anticipatory care programmes, provision of financial/welfare advice in health care settings, the Glasgow Homelessness and Addictions Partnerships, Inequalities Sensitive Practice Initiatives (ISPI), parenting support, infant feeding strategies and an emphasis on early years. Each CHCP also has a Public Partnership Forum (PPF), which provides a route to developing and maintaining dialogues about health issues with the local community.

The five Glasgow CHCPs are co-terminous with the local community planning area structures within the city: with two of the community planning areas being within each CHCP area. Each community planning area also has a Community Reference Group: a structure through which involvement of the community in decisions about the area is coordinated. These began to operate more fully between the two survey waves, but it may be too soon to see their impact in the 2008 findings. There are also neighbourhood management structures, again co-terminous with the CHCP boundaries, and bring together senior-level officials from the community planning partners to take a strategic overview of each of these five parts of the city. From a health perspective, these approaches enable the determinants of health in these communities to be considered with other partners, thereby moving beyond a focus on health services as the route to better health.

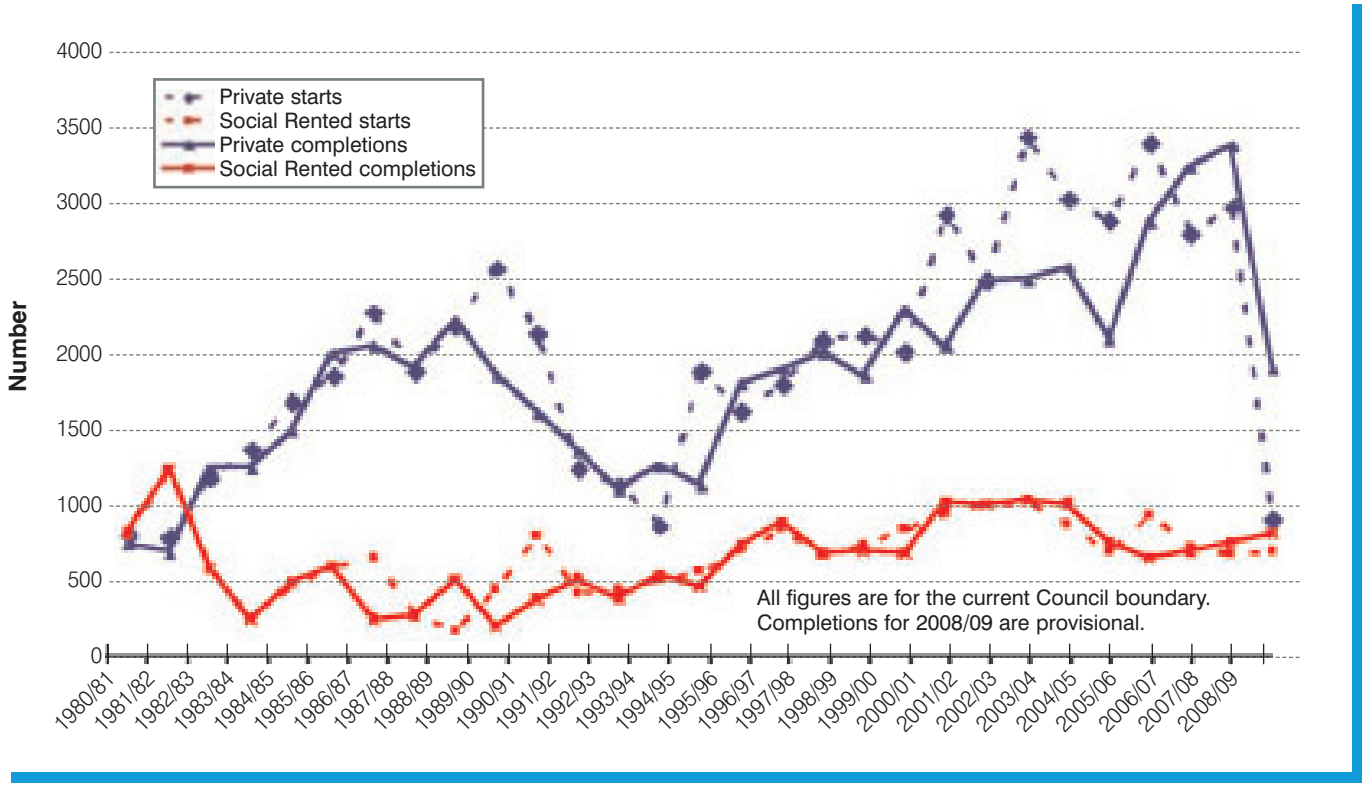
The Economy

Housing investment and area regeneration can impact upon the economic success of Glasgow, and the city's economy can impact upon regeneration. With respect to the relationship from regeneration to the economy, the city's economic development strategy[42] recognises a number of weaknesses within the city including: the effects of having large areas of derelict land; having unattractive locations that may not attract businesses and skilled employees; and what are termed 'residual image issues' not just for the city but Scotland as a whole[42]. On the other hand, successful regeneration is intended to contribute positively to the city's economy in the future by several means. First, this will be achieved by providing an 'effective resource base' of suitable, serviced land for development. Second, the city will become a 'residence of choice' due to high-quality physical development and locally based services. Finally, the city will re-establish 'its position as a leader in strategic area regeneration' through the renewal of its housing stock and neighbourhoods and by the delivery of major projects such as the Clyde Gateway, Clyde Waterfront and Commonwealth Games Village.

At the same time, looking at the relationship between the economy and regeneration in the opposite direction, elements of Glasgow's regeneration programme and some householders' incomes are likely to have been adversely affected by the recent economic downturn. Some effects of this downturn were apparent before and during the 2008 survey, but the recession became more severe with the banking crisis that followed the survey's completion in late 2008. The full effects of the recession are not known, and of course there is no simple way of establishing what the current situation would have been like had the recession not occurred.

According to GCC figures (Figure 2.2), social house-building in Glasgow remained relatively stable in the early stages of the recession compared with previous trends. However, there has been a dramatic fall in private sector new build starts (which had been steadily rising since the mid-1990s), which fell by over two-thirds between 2007/08 and 2008/09. There has also been a fall in private sector new-build completions.

Figure 2.2 Glasgow: new housing starts and completions, 1980/81-2008/09



Source: Glasgow City Council, Glasgow's Housing Issues. Consultative Draft Local Housing Strategy 2009: 18 June 2009

Discussion

Keeping track of Glasgow's complex and constantly evolving regeneration landscape is a key challenge for GoWell. This chapter represents an early stage in the process of assembling a picture of what has taken place both in terms of policy developments at national, city and regional levels, and in terms of progress with housing and neighbourhood improvements and wider actions to address social regeneration. Much of the latter information being based on summaries of GHA's recent investments, delivery and plans. The information gathered to-date is incomplete and often represents local areas that include, but do not exactly match, GoWell area boundaries. However, it will help to start to understand how the findings from the 2008 survey may be the consequence of the changes that have been occurring across the city.

Key Points

- The Scottish Government has over the past few years taken a broad definition of area regeneration so that places contribute to sustainable economic growth for their own towns/cities and the nation as a whole. Health has featured prominently in government strategies, especially the challenge of reducing health inequalities between places. The Fairer Scotland Fund[1] is now in its final year and the Scottish Government is looking to build on its relationship with local government, offering ongoing support to Community Planning Partnerships through its 'Community regeneration and tackling poverty learning network.'

- The upgrading of housing stock in Glasgow forms part of the wider attempt to improve strategic infrastructure in the city region (including water, sewerage, transport and the treatment of derelict land) so that regional economic development is advanced.

- There is a two-way relationship between regeneration and the city economy:

    - Regenerating deprived communities addresses some of the city's image problems, but also increases the contribution that the city's people and place assets can make to productivity.
    - The economic downturn over the past couple of years has slowed private sector house-building activity in the city, although social sector activity has been maintained. For GoWell study areas, this has meant in particular a slowing of progress with the construction of the New Neighbourhood in Drumchapel.

- The advent of Community Planning brought renewed emphasis on efforts to improve the effectiveness of public services by mainstreaming funding and targeting priorities; through joint working between service providers and with community input to service decision-making. Many of the local outcomes and targets in Glasgow's Single Outcome Agreement (2009)[13] pertain to issues that GoWell is examining in its study areas.

- There have been a number of programmes and investments in the city over the past few years that can be expected to contribute to the regeneration of deprived neighbourhoods and communities and which one might expect to see reflected in GoWell survey findings:

    - Large-scale investment in the social housing stock, especially the installation of heating systems (to almost all GHA stock), fitting of new kitchens and bathrooms (to over half the GHA stock), external fabric improvements, and the fitting of secure doors (to most GHA stock) and new windows.
    - A range of 'wider action' programmes funded by GHA and partners; the most widespread of

which are youth diversionary programmes, play park improvements, and an environmental improvement and employability programme ('community janitors').

- A range of community actions implemented by RSLs in deprived areas, supported by the Scottish Government's Wider Role Fund[30], focusing on issues such as employability, financial inclusion and community facilities.
- Glasgow Community Planning Partnership also seeks to contribute to the reduction of social inequalities in the city, and to furthering social regeneration by supporting a variety of projects with the Fairer Scotland Fund (which replaced the Community Regeneration Fund)[1,6].

- The demolition of low demand social housing has been progressing. Within the TRAs within the GoWell study, approximately 30% of the social housing stock has been demolished, and a further proportion is in clearance for future demolition.

- The social housing new build programme of 're-provisioning' will assist the clearance programmes. Plans included the building of 2,800 new GHA homes within the agreed timescales of 2014-2015. None of these homes had been completed by the time of the wave 2 survey (summer 2008), though the first phase of 239 units went on site that year. The second phase (approximately 400 units) has since commenced. GCC has a target of 10,000 new social sector homes through community based housing associations (CBHAs) from 2004-14. The 'reprovisioning' output (for people affected by demolition across the city) for 2008-09 was 278 units[25]. The effects of new build activity around the TRAs should appear by the time of the next (3rd) GoWell survey in 2011.

The Survey

The GoWell community health and wellbeing survey consists of a repeat cross-sectional survey of the study communities, together with longitudinal surveys of cohorts of 'remainers' and 'outmovers' from the Regeneration Areas. This chapter describes the overall design of the second survey conducted in 2008. To enable the most consistent possible comparison of the results from the 2008 survey with those from the first survey in 2006, in planning the second survey as few changes to the methods and the questionnaire as possible were made. The main differences between the two surveys are outlined in this chapter.

The chapter proceeds to explain the following:

- **Sample Design:** the organisation of the sample into different types of study area; and the relationship between the cross-sectional and longitudinal samples.

- **Fieldwork and Interviews Achieved:** the organisation of the interview fieldwork; the achievement of the sample through repeat contacts; survey response rates in different areas; and the distribution of the sample between areas.

- **The Questionnaire:** changes to the survey content, either to capture new information or to improve the collection of information on particular topics.

- **Data Preparation and Analysis:** quality checking of the data; weighting the data to ensure it is representative of the study communities; the approach to the analysis of the data.

Sample Design: Cross-sectional and Longitudinal Samples

The Wave 2 (2008) survey involved interviewing householders or their partners in their homes in 15 study areas (comprised of 33 subareas) across the city.

Wave 2 saw the inclusion of a new study area that had not been investigated at Wave 1 — Birness Drive, which consists of four multi-storey flat (MSF) blocks located near Shawbridge. This was included so that MSFs were more thoroughly represented across the different types of study area, but also so that there was a good sample of tower block residents experiencing building refurbishment.

The 15 areas are classified into five Intervention Area Types (IATs) on the basis of the structural regeneration activity taking place or planned. These are described in detail in Table 1.1, and are listed below with the number of subareas within each study area appearing in square brackets:

1) **Transformational Regeneration Areas (TRAs)**: Red Road MSFs and Tenements [1], Shawbridge [2], Sighthill [2]
2) **Local Regeneration Areas (LRAs)**: Gorbals Riverside [2], Scotstoun MSFs [2], St Andrews Drive [2]
3) **Wider Surrounding Areas (WSAs)**: Wider Red Road [5], Wider Scotstoun [2]
4) **Housing Improvement Areas (HIAs)**: Birness Drive [1], Carntyne [2], Govan [2], Riddrie [2], Townhead MSFs [2]
5) **Peripheral Estates (PEs)**: Castlemilk [3], Drumchapel [3]

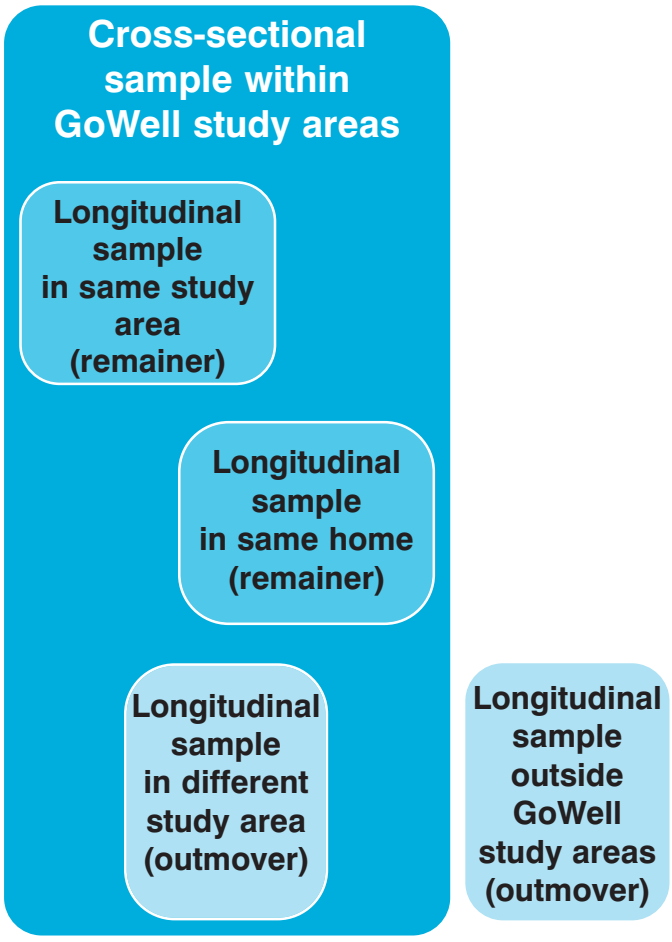
Birness Drive is included here as part of the description of the sample, but in order to ensure the greatest equivalence of the Wave 1 and Wave 2 samples, survey responses from this area are excluded from the analyses of change over time reported in subsequent chapters.

This report considers the two survey waves as studies of **repeat random stratified cross-sectional samples**. The advantage of this type of sampling is that it is relatively easy to obtain substantial numbers of interviews, which gives a broad and reliable snapshot of people's circumstances and opinions at successive points in time during the course of regeneration. However, this approach has the shortcoming that one can only draw conclusions based on summary measures at an area- or IAT-wide level. In effect, apart from being selected from the same areas, the samples from the two years are considered to be unrelated; and it cannot be assumed that the findings reflect how particular individuals are changing.

In fact, the design of the Wave 2 community health and wellbeing survey is more complicated. As part of its broader aims, it also includes an important longitudinal component (see Figure 3.1). By re-interviewing people, "before and after" information can be gathered about them that shows directly how their responses have altered against the background of their changing conditions and circumstances. This kind of information is very valuable as it can potentially lead to much firmer conclusions. However, it is more difficult to collect since you have to be sure you are interviewing the same respondent or household as before, and know the new addresses of people who have moved. It also requires great effort to minimize the loss of respondents from the sample, since we may lose track of them, they may become ineligible to continue in the study (e.g. if they have moved outside of Glasgow), or they may not wish to participate again.

The longitudinal sample contains several hundred residents from the TRAs and LRAs. These areas were chosen to concentrate on because they are currently experiencing the effects of regeneration and neighbourhood renewal most forcefully and directly. However, those Wave 1 respondents who are still living in any of the other GoWell study areas could also be considered as part of the longitudinal sample (Figure 3.1). In the event, a significant number of respondents in the PEs, HIAs and WSAs were re-interviewed. We shall report the findings from the initial analyses of these longitudinal data in the near future.

Figure 3.1 Schematic structure of the GoWell Wave 2 community health and wellbeing survey



Many of the residents interviewed in the Regeneration Areas (TRAs and LRAs) in 2006 were likely to be living in the same home two years later, simply because they had no cause, desire or opportunity to move. However, a substantial proportion would have moved, either by choice or personal necessity, or because their original home was due for demolition as part of the regeneration programme. Some of these people would have moved to a new home within the same area. In this report, these two groups of residents, whom we refer to as **remainers** (Figure 3.1), are considered as part of the cross-sectional sample.

Other residents interviewed at Wave 1 would have moved from their original study area in the intervening two years (**outmovers**). The analyses presented here include a small number of residents interviewed in a TRA or LRA in 2006 who had moved to another study area by 2008. However, in the analyses presented here, the responses of those outmovers who had moved to any part of the City that we are not specifically addressing for the purposes of this report are not included (Figure 3.1).

Regeneration activity in the TRAs and LRAs since Wave 1 meant that the number of households available to interview in Wave 2 was considerably lower than in 2006. Considerable numbers of residents had moved out of the Red Road MSFs, and the subareas of Fountainwell North (Sighthill) and the Plean Street MSFs (Scotstoun). It was most likely to measure change in the six regeneration study areas because they are the areas most actively undergoing regeneration and neighbourhood renewal. For that reason, combined with the need to interview a

sufficient number of people to be able to identify statistically significant changes, meant that a **census** of every household in these areas (rather than only selecting a random sample of addresses to attempt) was attempted.

Fieldwork and Interviews Achieved

The interview exercise was carried out by staff from BMG Research (Birmingham)[iii]. Potential respondents' addresses were chosen at random from all those available in the Royal Mail's Postal Address File (version April 2008) corresponding to the postcode units comprising the study areas[iv]. The numbers of interviews sought and achieved differed between areas since these places vary greatly in the number of households they contain, and to ensure sufficient numbers of interviews in order to draw statistically sound conclusions from the results.

Letters explaining the purpose and conduct of the survey were sent to potential respondents a week or so before the interviewers first visited each study area.

Efforts were concentrated within a small number of areas at a time, although towards the end of the interview period, interviewer effort was more dispersed among the areas in order to ensure that targets were met.

Pilot versions of the Wave 2 questionnaire were used in April and May 2008. The majority of interviews, with the final version of the questionnaire, were conducted between June and September 2008, at the end of which time 4,657 respondents had been interviewed. On average, interviews took around 35 minutes to complete, using Computer-Assisted Personal Interviewing (CAPI) equipment rather than paper-based questionnaires.

The interviewers initially visited each address up to five times but, particularly in the TRAs, LRAs and HIAs, where targets were difficult to meet, up to eight times. They called at different times of the day and on different days of the week in order to give the best chance of finding somebody at home. Table 3.1 shows how efficient the repeat visits were, by IAT.

Table 3.1 Cumulative percentage of interviews obtained in IATs

IAT	Attempts required to obtain interview					
	1	2	3	4	5	6+
TRAs	51.5	77.3	88.4	94.6	97.2	100.0
LRAs	40.3	70.5	87.6	94.9	98.4	100.0
WSAs	44.3	78.0	92.7	97.9	98.9	100.0
HIAs	44.8	69.1	79.8	89.3	95.0	100.0
PEs	65.3	90.1	97.3	99.8	100.0	100.0
All IATs	49.7	76.7	88.4	94.7	97.6	100.0

iii 53 interviewers were employed at different times, none of whom conducted more than 7% of all interviews.

iv Once recently emptied and void dwellings and 'red-flagged' addresses (those where an interview was considered potentially unsafe) had been discounted.

Overall, around half and three-quarters of the interviews were secured at the first and second attempts, respectively. The variation between IATs was quite marked, with early responses being very high in the PEs but relatively low in the LRAs. Only 2.4% of the interviews were achieved as a result of visiting more than five times. The one exception to this pattern was in the HIAs (specifically, Birness Drive and Townhead St Mungo's), where 3.4% of the interviews were achieved on the sixth attempt.

The distribution of interviews by study area and IAT is shown for both waves in Table 3.2. Overall, the Wave 2 respondent total (4,657) was substantially lower than at Wave 1 (6,008 respondents), the difference being in part an inevitable consequence of the smaller number of households in the TRAs, which were being cleared in advance of demolition, and to accommodate sampling from the new area of Birness Drive. In addition, a lower target number of interviews were set in Wider Red Road, since a disproportionately large number of interviews were obtained from this area at Wave 1. Likewise, the targets for the PEs were set lower than at Wave 1.

Table 3.2 also shows the response rates by area and IAT, calculated as the number of interviews obtained divided by contact addresses issued minus dwellings that were empty, could not be found, were business addresses, duplicated or approached but not used. Overall, there was a greater than 40% response rate from occupied dwellings in the 2008 survey. While this signals an acceptable level of participation, this is generally lower than at Wave 1 (50.3%). Response rates were considerably lower (by around 10% at least) in Sighthill, Gorbals Riverside and all five HIAs. Conversely, rates appear to have increased slightly in the Scotstoun MSFs and its wider area and in the two PEs. Feedback from several of the interviewers indicates that the lower response rate was in large part due to people not answering their door when the interviewers called (there were frequently signs of activity within the home). It is not clear why this behaviour was more prevalent at Wave 2 – interview 'fatigue', whereby respondents have been approached on multiple occasions to participate in similar resident surveys, is one possibility.

Table 3.2 Distribution of achieved interviews and response rates at Wave 1 and Wave 2.

IAT	Wave 1 (2006)			Wave 2 (2008)		
	Frequency	Percentage	Response rate (%)	Frequency	Percentage	Response rate (%)
TRAs	1,435	23.88		1,073	23.04	41.08
Red Road MSFs	330	5.49	44[1]	286	6.39	47.59
Shawbridge	433	7.21	39	309	6.9	34.18
Sighthill	672	11.19	54	478	10.67	43.18
LRAs	726	12.08		818	17.56	46.11
Gorbals Riverside	171	2.85	59	194	4.33	43.30
Scotstoun MSFs	377	6.27	41[2]	349	7.79	51.40
St Andrews Drive	178	2.96	46	275	6.14	42.50
WSAs	1,076	17.91		584	12.54	39.26
Wider Red Road	768	12.78	44[1]	370	8.26	36.39
Wider Scotstoun	308	5.13	41[2]	214	4.78	45.44
HIAs	1,371	22.82		1,222	26.24	41.64[3]
Birness Drive	0	n/a	n/a	178	n/a	40.09
Carntyne	345	5.74	60	266	5.94	50.19
Govan	188	3.13	65	255	5.69	42.71
Riddrie	469	7.81	63	260	5.8	35.04
Townhead MSFs	369	6.14	59	263	5.87	42.28
PEs	1,400	23.30		960	20.61	49.64
Castlemilk	706	11.75	50	484	10.81	53.01
Drumchapel	694	11.55	43	476	10.63	46.62
Grand Total	6,008		50.3	4,657		47.5[4]

Percentages are based on totals exclusive of Birness Drive, which was not a study area in Wave 1.

[1] Combined response rate for Red Road MSFs and Wider Red Road

[2] Combined response rate for Scotstoun MSFs and Wider Scotstoun

[3] Response rate for all five HIAs. When Birness Drive is excluded the response rate for HIAs is 41.91%.

[4] The constituent response rates were 46.1% for the cross-sectional sample and 54.6% for the remainer sample.

The Questionnaire

The questionnaire used at Wave 2 was substantially the same as at Wave 1. In consultation with the survey company, (BMG Research, Birmingham) and Glasgow Housing Association (GHA), some changes were made in order to address matters that had assumed importance since Wave 1 and to improve questions that had yielded responses that tended to be unclear or inaccurate, or that varied little between respondents. Overall, the final version of the questionnaire was longer than that for Wave 1, taking approximately six minutes longer to complete, on average. Nevertheless, although residents were informed of the time it would take, they rarely cited the length of the survey as a reason for declining to participate in the survey.

The main additions to the questionnaire and the questions that were shortened or removed entirely are presented in Appendix 2. Several of these changes are worthy of further comment at this stage.

In particular, there were two health behaviours (consumption of fruit and vegetables, and levels of physical activity), about which the Wave 1 results were less informative than anticipated. In developing the Wave 2 survey, the number of portions of different forms of vegetable- and fruit-containing meals eaten in the previous 24 hours was asked, rather than asking respondents to estimate the average number of fruit and vegetable portions they consumed daily. Two examples of foods considered to be unhealthy (fizzy drinks and crisps) were included in this question. How many times a week people ate two or more slices of brown or wholemeal bread and oily fish (healthy foods) and chips (unhealthy food) was also asked. The reasoning behind this was to prompt respondents to reflect on what they had eaten before stating their estimate, whereas at Wave 1, it seems likely that people were broadly aware of Government advice to eat five or more portions of fresh fruit and vegetables per day and were reluctant to admit to having eaten less than the recommended amount.

With respect to the amount of physical activity undertaken, the number of days per week and the average time per day that respondents did vigorous and moderate physical activity and went walking in their neighbourhood was asked. These values allow the overall level of activity to be quantified more accurately and to convert it to metabolic equivalent minutes in accordance with the widely used International Physical Activity Questionnaire (IPAQ)[43]. This not only provides a more detailed and continuous (rather than categorical) measure of activity, but will also allow comparison of the results with those of other international studies employing the IPAQ protocols.

Finally, particular mention should be made of the inclusion at Wave 2 of the questions comprising the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[44]. This is a new scale, first used in 2005, derived from ordered responses to a suite of 14 questions about hedonic and eudaimonic aspects of positive mental health. This contrasts with the mental health scales of the SF-12[45], which are more appropriate for measuring states of negative mental health. The WEMWBS metric is promoted by the Scottish Government and is being employed in an increasing number of studies[44]. This will allow, in time, comparison of the results from GoWell with those of other studies.

Data Preparation

The use of CAPI technology enables the direct electronic transfer and collation of the data, thereby removing data entry from paper-based questionnaires as a source of error, and shortening the time needed to produce a data file containing all the responses from the entire sample.

Data were range and quality control-checked and back-checked by BMG. This was an extensive exercise by which at least one-in-five respondents were contacted by telephone to verify the manner of conduct of the interview and to double-check a selected number of responses. In total 1,110 of the 4,657 completed interviews were back-checked in this way. This exercise found a high rate of uncertainty or inaccuracy with regard to the question about qualifications (18%) but a low rate of inaccuracy for the other questions checked (2% - 6%). All 'errors' found in the back-checking exercise have been corrected. Data cleaning, however, is a continuous process since small errors come to light in the course of analyses.

To ensure as far as possible that the sample is representative of key features of the population, a set of weights was developed (numerical coefficients) for all of the cases by which the responses of people who possessed characteristics that were under-represented in the sample were given greater importance, while the importance of responses from residents with over-represented characteristics was downplayed. In this way, we can be more confident that the findings for IATs more accurately represent the views held by all adults living there.

Each case in turn was weighted by the following characteristics:

1) Respondent's gender: male / female (by subarea)
2) Respondent's age group: 16-24 / 25-39 / 40-54 / 55-65 / 65+ years (by subarea)
3) Respondent's tenure: owned / social or private rented (by subarea)
4) Adult population size in study area: subareas within study areas
5) Adult population size in IATs: study areas within IATs

The frequencies of the two tenure types for households in each of the subareas were derived from the Glasgow City Council (GCC) Tax Register for March 2008. Populations of adults (16+ years old) in the study areas and IATs (further classified by gender and age group at subarea level) were estimated from the NHS Community Health Index (CHI) records of GP registrations in the corresponding postcode units from August 2008. Weights are the product of the five coefficients whose values correspond to the particular circumstances of each respondent.

In order that highly under-represented cases were not given excessive importance, weights were constrained to have a value of no more than five. Finally, all weights were multiplied by a constant so that the total number of weighted cases was equal to the actual number of interviews achieved (4,657).

To enable the greatest possible consistency in comparisons between the two Waves, a separate set of weights was calculated for the Wave 1 sample by the same method. It should be noted that these weights replace those employed in some previous analyses of the Wave 1 sample.

Data Analysis

At this point, examining changes in the circumstances, opinions and experiences of the respondent samples between Wave 1 and Wave 2 is of primary interest. Change over time across the five IATs (rather than for individual study areas) is compared. The responses to questions that have so far only been asked at Wave 2, are also summarised and compared between the IATs. The following chapters also include a number of short analyses (boxed) in which specific research questions are addressed in more detail.

Statistical and Substantive Significance

Throughout the report values of $p<0.05$ have been taken to indicate statistical significance, meaning that it is at least 95% certain that the observed difference is due to a real difference, rather than arising by chance (of which there is a 5% probability). Since the samples are quite large, however, it is possible for the size of associations to be quite small yet still be statistically significant. Attributing substantive importance to the results entails a value judgement that goes beyond solely statistical considerations.

Key Points

- The GoWell Wave 2 survey covered 15 study areas, divided further into 33 subareas. Comparisons over time are made for 14 of the study areas grouped into five IATs.

- Nested within the GoWell Wave 2 cross-sectional survey is a longitudinal cohort of 'remainers' comprised of people who were interviewed in the six Regeneration Areas in 2006 and who continue to live in those areas in 2008.

- The achieved sample was smaller in 2008 than in 2006: 4,657 interviews compared with 6,008 interviews. This was a result of population decline in the TRAs; a reallocation of some of the sample away from the larger areas with high numbers of interviews in 2006 (WSAs and PEs); and a lower response rate to the survey overall (47% compared with 50%).

- Quality control processes were employed at all stages of the survey from the fieldwork itself (where limits were placed on the number of interviews any one interviewer could conduct), through the post-fieldwork period (when over one-in-five interviews were back-checked by telephone), to the data preparation (with a set of logic and range-checks applied to the data set). The use of a CAPI methodology in 2008 reduced the possibility of data-transfer and coding errors.

- Both the Wave 1 and Wave 2 survey data-sets have been weighted by gender, age, housing tenure and area population size (as at the year in question) to make them more representative of study areas and subareas. In this way, comparisons over time and between area types are more likely to represent the real situation.

People and Circumstances

This chapter describes the demographic profile and personal circumstances of the resident populations and sample respondents in the study areas, and stresses that these personal characteristics may play a large part in shaping the attitudes, opinions and circumstances enquired about in the survey. The following aspects are covered:

- **Gender**
- **Age**
- **Ethnicity and citizenship**
- **Household type and size**
- **Household occupancy**
- **Tenure**
- **Employment and job-seeking**
- **Training and education**
- **Young people and economic activity**

Gender

Data on gender were obtained from the NHS Community Health Index (CHI). The GoWell team was supplied with the total number of people registered with a General Practitioner by combinations of sex and age group in all the postcode units comprising the GoWell study areas, and thereby the Intervention Area Types (IATs). The collated data (Table 4.1) were drawn from the register in August 2008. This allows for a two-month lag time for people new to a GoWell study area to have registered with a local doctor or health centre, thus giving the best estimate of the actual population in the study areas during the period of the survey (May-August 2008). Table 4.1 reveals a slightly higher proportion of women than men in the Wider Surrounding Areas (WSAs), Housing Improvement Areas (HIAs) and Peripheral Estates (PEs), but, strikingly, in the Transformational Regeneration Areas (TRAs) and Local Regeneration Areas (LRAs) there were at least 10% more men than women.

Table 4.1 Gender distribution by IAT, 2008

IAT	Gender (%)		Total (n)
	Male	Female	
TRAs	58.8	41.2	7,159
LRAs	55.0	45.0	2,930
WSAs	47.8	52.2	11,854
HIAs	48.3	51.7	9,286
PEs	48.7	51.3	12,548

Source: Community Health Index, August 2008.

Age

Data concerning the distribution of ages in the study areas were also obtained from the NHS CHI. This information is available for five-year-interval groups, but they are reclassified into five age groups here (Table 4.2).

Regeneration Areas are notable for having higher proportions of younger adults (around 40% are 25-39 years old) than the WSAs, HIAs and PEs (less than 30% in the same age group). These higher proportions are balanced by lower proportions of older adults in the 55+ year age groups in the Regeneration Areas (less than about 16%), compared with 32% and 42% in the WSAs and HIAs, respectively, but only 22% for the PEs. The PEs featured the highest proportion of adults under 25 years of age.

Table 4.2 Age distribution by IAT, 2008

IAT	Age group (%)					Total (n)
	<25 years	25-39 years	40-54 years	55-64 years	65+ years	
TRAs	18.6	40.9	27.2	6.0	7.4	7,159
LRAs	16.8	39.9	27.3	7.3	8.8	2,930
WSAs	14.5	24.6	28.5	11.4	21.0	11,854
HIAs	10.5	20.8	26.5	13.5	28.7	9,286
PEs	20.4	29.4	28.5	10.9	10.8	12,548

Source: Community Health Index, August 2008.

TRAs *Transformational Regeneration Areas*
LRAs *Local Regeneration Areas*
WSAs *Wider Surrounding Areas*
HIAs *Housing Improvement Areas*
PEs *Peripheral Estates*

Ethnicity and Citizenship

Data on ethnicity and citizenship come from the 2008 Wave 2 sample since equivalent estimates are not available for the whole populations in the study areas for the Wave 2 survey period. The distinctive nature of the populations in the Regeneration Areas is revealed simply in Table 4.3 where two-in-five adults (39%) in TRAs are non-British citizens, as are one-in-four adults (28%) in LRAs, compared with a very small fraction elsewhere. Within these groups, there are more asylum seekers than refugees.

Table 4.3 Ethnicity and citizenship status of sample by IAT, 2008

IAT	Ethnicity and citizenship status (%)						Total (n)
	British citizen: white	British citizen: non-white	British citizen: ethnicity n/k*	Refugee	Asylum seeker	Non-British: citizenship n/k*	
TRAs	53.1	7.7	0.2	14.5	19.2	5.3	1,072
LRAs	62.8	9.0	0.3	10.6	12.4	4.9	815
WSAs	97.2	1.6	0.4	0.4	0.4	0.1	581
HIAs	96.7	1.4	0.5	0.9	0.1	0.5	1,220
PEs	96.2	1.0	0.6	0.8	0.6	0.9	960

*Not known i.e. respondent declined to say
Source: GoWell Community Health and Wellbeing Survey, 2008

Household Type and Size

Independent data on the structure and size of households for the GoWell study areas and IATs at the time of the 2008 Wave 2 survey are not available, so the best information available comes from the Wave 2 sample itself. It should be remembered that the sample is unlikely to be exactly representative of the entire population of these areas. Since household type (family, adult and older person) and size are intrinsically somewhat related (e.g. family households must consist of more than one person), the two characteristics are cross-tabulated.

Household type was classified in four ways. Adult households were those consisting of one or more adults not living with any dependent children (this category encompasses families with children of working age). Single- and two-parent family households were those with one and two parents, respectively, and at least one dependent child (the presence of other adults, for example, grandparents, was incidental to the definition of single-parent households). Older person households were those with one or two occupants at least one of whom was of retirement age. Table 4.4 gives the distribution of household types within the sample in each IAT and Table 4.5 shows the range of household sizes within each type of household.

Table 4.4 Household type by IAT, 2008

IAT	Household type (%)					Total (n)
	Adult	Single-parent family	Two-parent family	All families	Older person	
TRAs	44.0	22.4	17.6	40.0	16.0	1,073
LRAs	46.9	21.0	18.9	40.0	13.1	818
WSAs	44.7	13.4	14.9	28.3	27.1	584
HIAs	49.3	11.0	8.0	19.0	31.8	1,222
PEs	48.6	19.1	13.8	32.8	18.5	960
Total	46.9	17.3	14.2	31.5	21.5	4,657

Source: GoWell Community Health and Wellbeing Survey, 2008

Table 4.5 Distribution of household type and size by IAT, 2008

IAT	Household type	Percentage of household type of size (persons; %)						Total (n)
		1	2	3	4	5	6+	
TRAs	Adult	65.3	23.5	6.8	3.4	1.1	0.0	472
	Single-parent family	–	43.8	30.0	17.5	4.2	4.6	240
	Two-parent family	–	–	25.9	33.9	27.0	13.2	189
	Older person	73.8	26.2	–	–	–	–	172
	Total	40.5	24.3	14.3	11.4	6.2	3.4	1,073
LRAs	Adult	68.0	19.3	9.9	2.3	0.5	0.0	384
	Single-parent family	–	39.0	37.2	16.3	2.9	4.7	172
	Two-parent family	–	–	20.0	41.3	26.5	12.3	155
	Older person	57.9	42.1	–	–	–	–	107
	Total	39.5	22.7	16.3	12.3	5.9	3.3	818
WSAs	Adult	37.5	33.0	21.8	5.7	1.5	0.4	261
	Single-parent family	–	30.8	44.9	12.8	10.3	1.3	78
	Two-parent family	–	–	40.2	39.1	14.9	5.7	87
	Older person	57.6	42.4	–	–	–	–	158
	Total	32.4	30.3	21.7	10.1	4.3	1.2	584
HIAs	Adult	62.8	23.9	9.3	3.7	0.2	0.2	602
	Single-parent family	–	47.3	25.6	19.5	4.6	3.0	134
	Two-parent family	–	–	36.7	38.8	20.4	4.1	98
	Older person	68.0	32.0	–	–	–	–	388
	Total	52.6	27.1	10.3	7.0	2.2	0.7	1,222
PEs	Adult	50.1	30.0	13.9	5.1	0.4	0.4	467
	Single-parent family	–	43.7	31.7	18.6	3.8	2.2	183
	Two-parent family	–	–	28.8	43.2	16.7	11.4	132
	Older person	62.9	37.1	–	–	–	–	178
	Total	36.0	29.8	16.8	12.0	3.2	2.2	960
TOTAL	Adult	58.5	25.4	11.3	3.9	0.6	0.2	2,186
	Single-parent family	–	42.1	32.6	17.3	4.5	3.4	807
	Two-parent family	–	–	28.6	38.9	22.2	10.4	661
	Older person	65.4	34.6	–	–	–	–	1,003
	Total	41.6	26.6	15.0	10.4	4.2	2.2	4,657

Source: GoWell Community Health and Wellbeing Survey, 2008

Adult households make up just under half of all households in all types of area. Within this, in the TRAs, LRAs and HIAs, more than half of the adult households in the sample were single persons, and only around 12% of this household type was comprised of three or more occupants. Single-person adult households were least common in the WSAs (around 38%), where more than a quarter of adult households were of three or more persons.

Older person households are least common in the Regeneration Areas (and, to a lesser extent, in PEs) then elsewhere, being most common in WSAs and HIAs, where they account for just over a quarter and around a third of households, respectively. The majority of older person households in the sample were of people living on their own (74% in the TRAs, over 57% in all other IATs).

Family households of both types (single-parent and two-parent) were most common in the Regeneration Areas, comprising around two-in-five households, compared with around 30% in the WSAs and PEs, and one-fifth in HIAs. Larger two-parent families (of five or more persons) were also more common in the Regeneration Areas than elsewhere: around two-in-five two-parent families in TRAs and LRAs had five or more persons. Larger single-parent families were most common in WSAs, where they comprised one-in-eight single-parent families.

Household Occupancy

Household occupancy was calculated from the 2008 Wave 2 survey data as the number of people normally living in the household divided by the number of rooms in the home (excluding bathrooms and toilets, kitchens and halls). The mean values for each of the four household types in the five IATs are presented in Table 4.6. Although the persons-per-room measure has long been used to estimate overcrowding, it is nonetheless a basic calculation that does not take into account sharing arrangements or the age of young children, so in this form it can only be a crude indicator. It does, however, reveal significant differences in the density of people per household between the IATs.

Occupancy was highest among two-parent, followed by one-parent, families and usually highest for these groups in the Regeneration Areas (apart from single-parent occupancy levels in WSAs). Therefore, the highest mean occupancy rates of all were for two-parent families in both TRAs and LRAs, at over 1.5 persons per room; this is often taken as an indicator of overcrowding. People in HIAs tended to live in homes with the lowest density (0.71 persons per room, overall), partly due to the preponderance in the sample of older person households, which, are likely to be smaller than those of younger adults or families.

Table 4.6 Mean household occupancy, estimated as people per room, by household type and IAT, 2008

IAT	Household type	Mean	Standard deviation	Total (n)
TRAs	Adult	0.69	0.347	472
	Single-parent family	1.14	0.467	240
	Two-parent family	1.52	0.488	189
	Older person	0.58	0.234	172
	Total	0.92	0.518	1,073
LRAs	Adult	0.77	0.349	383
	Single-parent family	1.12	0.406	172
	Two-parent family	1.53	0.454	155
	Older person	0.69	0.300	106
	Total	0.98	0.484	816
WSAs	Adult	0.77	0.407	261
	Single-parent family	1.18	0.386	78
	Two-parent family	1.35	0.412	87
	Older person	0.57	0.241	158
	Total	0.86	0.459	584
HIAs	Adult	0.64	0.346	599
	Single-parent family	1.00	0.428	134
	Two-parent family	1.36	0.361	98
	Older person	0.55	0.231	387
	Total	0.71	0.401	1,218
PEs	Adult	0.69	0.344	464
	Single-parent family	1.01	0.370	182
	Two-parent family	1.37	0.426	130
	Older person	0.62	0.283	178
	Total	0.83	0.432	954
TOTAL	Adult	0.70	0.358	2,179
	Single-parent family	1.09	0.424	806
	Two-parent family	1.45	0.446	659
	Older person	0.59	0.254	1,001
	Total	0.85	0.468	4,645

Source: GoWell Community Health and Wellbeing Survey, 2008

Examining occupancy by housing type (Table 4.7), it is apparent that there was a small overall difference in the dwelling densities of the three housing types (multi-storey flats (MSFs), 0.89; houses, 0.82; other flats, 0.81 persons-per-room). Two-parent families in MSFs had the highest density of all, with 1.5 persons-per-room.

Table 4.7 Mean household occupancy estimated as people per room, by household type and building type, 2008

IAT	Household type	Mean	Standard deviation	Total (n)
MSF	Adult	0.69	0.342	1,042
	Single-parent family	1.13	0.448	400
	Two-parent family	1.53	0.473	335
	Older person	0.57	0.226	315
	Total	0.89	0.502	2,092
Other flat	Adult	0.69	0.367	443
	Single-parent family	1.03	0.366	191
	Two-parent family	1.42	0.414	99
	Older person	0.61	0.263	256
	Total	0.81	0.429	989
House	Adult	0.73	0.374	692
	Single-parent family	1.06	0.419	214
	Two-parent family	1.34	0.395	221
	Older person	0.58	0.258	418
	Total	0.82	0.440	1,545
Total	Adult	0.70	0.358	2,177
	Single-parent family	1.09	0.424	805
	Two-parent family	1.45	0.447	655
	Older person	0.58	0.250	989
	Total	0.85	0.468	4,626

Source: GoWell Community Health and Wellbeing Survey, 2008

Tenure

Tenure data for the study areas and IATs were obtained from the Glasgow City Council (GCC) Tax Register database, abstracted in September 2008, and are shown in Table 4.8. Estimates of private-rented dwellings, which in any case make up a very small proportion of the households in the GoWell study areas, are recognised as being prone to some degree of inaccuracy.

The majority of households in the TRAs and LRAs were rented from Glasgow Housing Association (GHA) (around 95% and 89%, respectively), most of the remainder in these areas being owner-occupied (up to about 4% and 8%, respectively). Rental in the PEs was split almost equally between those from GHA and from other Registered Social Landlords (RSLs).

Home ownership was highest in the WSAs (53%) and HIAs (43%) and lowest in the TRAs and LRAs (4% and 8%, respectively). Private-rented households formed a negligible proportion of the occupancies across all the IATs, with a maximum of around only 3% in the WSAs and HIAs.

Table 4.8 Distribution of household tenure by IAT, 2008

IAT	Household tenure (%)				Total (n)
	Rented from GHA	Rented from other housing association	Owner -occupied	Private -rented	
TRAs	94.7	0.9	4.1	0.3	4,598
LRAs	89.4	1.4	8.1	1.1	1,418
WSAs	37.7	6.7	52.7	3.0	6,180
HIAs	51.4	2.6	42.8	3.2	5,419
PEs	38.6	41.1	19.3	1.0	6,671

Source: Glasgow City Council Tax Register, September 2008.

Employment and Job-seeking

The employment status of male and female working-age respondents in the 2006 (Wave 1) and 2008 (Wave 2) samples is presented by IAT in Table 4.9. The categories of employment status are: working (full or part-time), economically active but not working (on a Government training scheme, registered unemployed, temporary sick or in full-time education), and economically inactive (retired, long-term sick, looking after home). Note that these values are based on the weighted dataset, for consistency with other analyses in this report in which change over time is examined.

Table 4.9 Employment status of working-age respondents by gender, wave of survey and IAT

Gender	IAT	Year of survey	Employment status (%)			Total (n)
			Working	Economically active - not working	Economically inactive	
MALE	TRAs	2006	20.1	60.8	19.1	717
		2008	33.7	52.5	13.8	472
	LRAs	2006	27.8	53.2	18.9	370
		2008	40.1	45.2	14.7	387
	WSAs	2006	50.0	27.4	22.6	376
		2008	68.2	18.8	13.0	223
	HIAs	2006	44.8	28.8	26.4	473
		2008	56.4	29.7	13.9	360
	PEs	2006	43.8	29.4	26.9	592
		2008	50.4	31.3	18.3	399
FEMALE	TRAs	2006	14.3	44.5	41.2	553
		2008	20.8	42.9	36.3	366
	LRAs	2006	24.0	44.2	31.8	267
		2008	21.8	47.5	30.7	326
	WSAs	2006	42.1	18.5	39.4	432
		2008	49.1	17.7	33.2	226
	HIAs	2006	42.0	17.2	40.7	464
		2008	50.0	21.8	28.2	348
	PEs	2006	37.9	12.4	49.6	643
		2008	35.5	27.3	37.1	428

Source: GoWell Community Health and Wellbeing Surveys, 2006 (sample base 4,887 working-age respondents, weighted cases) and 2008 (sample base 3,535 working-age respondents, weighted cases)

There were significantly greater proportions of men reporting that they were working in 2008 than in 2006 in all of the IATs ($p<0.007$). These increases ranged from 7.6% in the PEs to 18.2% in the WSAs, with intermediate values for the TRAs (13.6%), LRAs (12.3%) and HIAs (11.6%). These increases were balanced in the main by a decrease in the proportion of economically active but not working males (and to a lesser extent by a reduction in the economically inactive). In the three non-regeneration area types in 2008, a majority of men reported that they were working, compared with a minority doing so in the TRAs and LRAs.

Changes in reported employment rates for women were more modest and more varied. A significant increase in the proportion of working women was only seen in the TRAs (up by 6.5%; $p=0.031$) and HIAs (up by 8.0%; $p=0.001$). There was actually a slight but non-significant decrease of 2.4% in the proportion of women working in the PEs.

There is no full explanation as to why higher employment rates were reported in 2008 than in 2006; the differences for men are particularly stark. Part of the difference could be explained by the different pattern of interview timings in the two surveys. Although in both waves around 30% of the interviews were carried out over the weekend, 40% of those done on weekdays were done during the early evening in 2008, compared with 30% at that time of day in 2006. While one might expect people not in employment to be equally likely to be interviewed at any time of the day, those with work are more likely to be at home on a weekday evening than during the day. In this way, the shift of interviewing effort more to the evenings meant that a bigger sample of working people was available for interview. Nevertheless, the extra 5% of working respondents captured in this way in the 2008 sample compared with that in 2006 does not fully account for the observed increase in employment rate, particularly among the men in the sample.

Considering all British citizen respondents of working age who were not in full- or part-time employment or full-time education, only around 17% had sought work at some point during the year preceding the 2008 survey (Table 4.10; estimates from weighted dataset). There were significant differences among the IATs, the highest rates of jobseeking being seen in the Regeneration Areas (over 20%) and the lowest in the PEs (around 12%). Around one-quarter of those who were unemployed or on training schemes sought work, one-in-seven homemakers, one-in-five of the temporary sick and one-in-25 of the long-term sick or disabled sought work during this period. Although not included in the above analysis, around a quarter of the 77 respondents in full-time education also sought work during this period.

Table 4.10 Job-seeking activity in past year among British citizen respondents of working-age but not in employment or full-time education by IAT, 2008

IAT	Sought work in past year (%)		Total (n)
	Yes	No	
TRAs	21.5	78.5	335
LRAs	20.5	79.5	292
WSAs	17.6	82.4	136
HIAs	16.4	83.6	324
PEs	11.9	88.1	385
Total	17.3	82.7	1,472

Source: GoWell Community Health and Wellbeing Survey, 2008 (sample base 1,472 working-age British citizens not in employment or full-time education, weighted cases)

Training and Education

The levels of participation in training or education in the past year among the British citizens of the 2008 sample are illustrated in Table 4.11 (estimates from weighted dataset). These decrease steeply with age, from seven out of ten in the youngest group (under 25 years) to fewer than 1% amongst the retired group.

Considering this group by their employment status, around 20% of employed respondents also undertook training or education, while only 9% of unemployed respondents did so. Small proportions of the temporary and long-term sick (6% and 4%, respectively) and homemaker (7%) respondents participated in these activities.

Table 4.11 Participation in training or education in past year by British citizen respondents by age group, 2008

Age group	Taken part in training or education in past year		Total (n)
	No	Yes	
<25 years	70.2	29.8	671
25-39 years	81.7	18.3	938
40-54 years	89.1	10.9	1,074
55-64 years	94.8	5.2	442
65+ years	99.3	0.7	694
Total	87.2	12.8	3,662

Source: GoWell Community Health and Wellbeing Survey, 2008 (sample base 3,662 of British citizens, weighted cases)

Young People and Economic Activity

The percentages of young people (16-24 years) who were not in employment, education or training (NEETs) from households where the respondent was a British citizen are shown by IAT in Table 4.12.

Table 4.12 Percentage of NEETs aged 16-24 years in households of British citizen respondents by IAT, 2006 and 2008

IAT	Year of survey	NEETs (%)	Total (n)
TRAs	2006	39.1	192
	2008	34.5	143
LRAs	2006	32.4	136
	2008	32.1	133
WSAs	2006	29.1	333
	2008	21.6	218
HIAs	2006	40.8	375
	2008	33.1	346
PEs	2006	29.3	526
	2008	27.5	360
Total	2006	33.5	1,562
	2008	29.3	1,201

Source: GoWell Community Health and Wellbeing Surveys, 2006 (sample base 1,562, weighted cases) and 2008 (sample base 1,201, weighted cases)

There was a significant drop in the percentage of NEETs across the IATs between 2006 and 2008 ($p<0.001$), ranging from 0.3% and 1.8% in the LRAs and PEs, through 4.4% in the TRAs, to just over 7.5% in the WSAs and HIAs, respectively. This is broadly consistent with the higher employment rates seen in 2008 compared with 2006. There were also significant differences between the percentages of NEETs by IAT in 2008 ($p=0.020$), whereby values in the TRAs (34.5%), LRAs (32.1%) and HIAs (33.1%) were substantially higher than in the WSAs (21.6%) and PEs (27.5%). A similar grouping of the IATs was noted in 2006.

Discussion

The particular nature of the resident populations in the Regeneration Areas (TRAs and LRAs) are revealed in this initial analysis. The resident groups in these areas are male-oriented, relatively young, comprised of large numbers of families (and also large families) and large proportions of immigrant groups. In housing terms the Regeneration Areas are dominated by social housing, and families experiencing high occupancy rates. None of these characteristics was probably intended as an outcome for these communities but they have arisen over time due to the way the housing market operates and due to the operational practices of a range of agencies. The present profile of these areas raises a question for public agencies involved in renewal as to whether these characteristics (or others) are compatible with the social regeneration of the communities. Does planning regeneration include trying to shape the social composition of places as well as the physical characteristics?

Other types of area have different characteristics and possible challenges. WSAs and HIAs have large elderly populations with a lot of older people living alone. PEs have large numbers of younger adults, but only half of all adults of working age have jobs, indicating a possible need for more skills training and employment support in these locations if future long-term unemployment is to be avoided.

The intrinsic demographic and housing difference between IATs could be associated with the responses given to many of the items investigated in the surveys and so could be at least partially responsible for some of the differences reported in later chapters. Conversely, they might mask some genuine differences between the IATs if their effects counterbalance those of the inter-IAT differences. The analyses presented in this report are broad-ranging and, with the exception of the some of the analyses of mental health in Chapter 9, do not currently take into account the influence of these confounding variables (for example by standardising for age). A more detailed statistical modelling of the data is planned.

Key Points

- The Regeneration Areas have male-dominated populations, with adult men outnumbering women by 10%.
- The adult population is also relatively young in the Regeneration Areas: around three-in-five adults are aged under 40, and less than one-in-ten are aged over 65. PEs have an unusually high proportion of very young adults, one-in-five being aged under 25 years old.
- Two of the study area types contain relatively elderly populations with over a fifth of adults being aged over 65 in WSAs and HIAs.
- Immigrant residents are very rare in three of the IATs (WSAs, HIAs and PEs) but form a large part of the resident population in TRAs (two-in-five being non-British citizens) and LRAs (more than one-in-four).
- Families are more common in Regeneration Areas than elsewhere with around a third of households being single- or two-parent families in TRAs and LRAs. Larger families (containing five or more persons) are also more common within TRAs and to a lesser extent in LRAs.
- Occupancy rates (measured as persons-per-room (ppr)) are high (at over 1.5 ppr) for two-parent families in the Regeneration Areas and in MSFs, and also relatively high (at 1.3 ppr) for single parent families in TRAs and WSAs.
- Regeneration Areas are dominated by social housing at present with nine-in-ten dwellings being in the social sector. Home ownership has a significant presence in WSAs (half of all dwellings), HIAs (two-in-five dwellings) and to a lesser extent PEs (one-in-five dwellings).
- Most men of working age in WSAs and HIAs report that they are working, and half do so in PEs. Only a minority of men in the Regeneration Areas report that they are working. Around one-in-seven men of working age across the study areas report that they are economically inactive.
- High proportions of adults (both men and women) of working age (40-50% in Regeneration Areas; 20-30% in other areas) report that they are economically active but do not have a job.
- Around 17% of respondents who were of working age, were eligible for work and not in full- or part-time employment or full-time education, had sought work at some point during the year preceding the 2008 survey. These figures were higher (over 20%) in the Regeneration Areas.
- The percentage of NEETs in all households dropped from 34-29% overall between 2006 and 2008, the biggest falls (over 7%) occurring in the WSAs and HIAs. Broadly maintaining a pattern seen in 2006, percentages of NEETs were significantly higher in the Regeneration Areas and HIAs than in the WSAs and PEs.

Housing

This chapter outlines the housing and residential circumstances in the study areas, covering four issues:

- **Housing Stock:** How do the study areas differ in terms of the types of dwellings within the housing stock, and the housing tenures available? Has there been much new development in the past two years?

- **Patterns of Residency and Moving Home:** Are some areas more residentially (un)stable than others? How many people have moved home over the past two years, or wish to move home in the future and why?

- **Housing Satisfaction and Housing Quality:** How satisfied are people with their homes and their landlords/factors? Have housing conditions, or the quality of homes, improved over time as far as the occupants are concerned?

- **Housing Empowerment:** Do residents (particularly social housing tenants) feel informed and consulted by those responsible for their housing (landlords and factors)? Do occupants derive a range of psychosocial benefits from living in their homes? (here we use the term 'psychosocial' to describe potential mechanisms by which people's mental wellbeing might be associated with their social environments: e.g. the extent to which people's homes give them a sense of empowerment, control, safety, etc).

Housing Stock

In this section the five Intervention Area Types (IATs) are compared according to the tenure and built form of the housing stock they contain, as well as looking at the improvement works carried out to upgrade the housing stock.

Housing Tenure

As Table 5.1 shows, three of the IATs are dominated by social rented housing: Transformational Regeneration Areas (TRAs) and Local Regeneration Areas (LRAs), where almost all dwellings are in the social sector; and Peripheral Estates (PEs) where four-out-of-five dwellings are social rented. The other two types of study area, Wider Surrounding Areas (WSAs) and Housing Improvement Areas (HIAs), are more evenly divided between dwellings in the social rented and private sectors, though only in WSAs does the private sector form a majority of dwellings. The only type of area with a sizeable non-GHA housing association Registered Social Landlord (RSL) sector, is the PEs.

An attempt was made to ascertain whether owned homes were ex-council properties but this proved difficult as the council tax register does not identify ex-council homes, and the responses to the survey questions on this issue are not clear-cut (due to the issue of first and second-hand sales of homes). However, the best estimate is that in TRAs, almost all owned homes are ex-council; in LRAs and WSAs four-out-of five owned homes are ex-council; in HIAs nine-out-of-ten; and in PEs only two-out-of-five. Thus, only in PEs has the private sector been a significant supplier of owner occupied homes.

Table 5.1 Housing tenure by IAT, 2008

	GHA	RSL	Temporary	Total Social rented	Owned	Private rented/ Other	Total Private*
TRAs	89.1	4.1	2.4	95.6	2.8	1.5	4.3
LRAs	88.2	1.1	3.1	92.4	6.3	1.3	7.6
WSAs	38.4	4.6	0.0	43.0	53.5	3.5	57.0
HIAs	48.2	2.8	0.1	51.1	43.6	5.3	48.9
PEs	50.8	29.4	0.1	80.3	18.5	1.1	19.6

'Which of the following best describes your home?'…Rented from….; owned…; temporary accommodation…
These figures are slightly different to those in Table 4.8. There are two main reasons for this: the council tax register (used for Table 4.8) has some uncertainties and missing data, and is subject to a lag effect. Further, respondents in the survey (used here in Table 5.1) may misunderstand their tenure circumstances, especially social renters, and this may lie behind the discrepancy in the balance between GHA and RSL dwellings in PEs between the two tables.

Dwelling Types

The five types of study area fall into three groups when looked at by dwelling types (Table 5.2). Regeneration Areas (TRAs and LRAs) are dominated by multi-storey flats (MSFs). Their surrounding areas (WSAs) and HIAs are predominantly comprised of houses. PEs are divided half-and-half into houses and flats. Both HIAs and PEs also contain some MSFs. Other notable differences between areas include the fact that around a third of properties in WSAs and HIAs are four-in-a-block flats (classified as houses as they have their own garden); most of the other houses in these two types of area are semi-detached houses, whereas in PEs the majority of houses are terraced.

Overall, this means that while most people in WSAs, HIAs and PEs have a garden to use, only a very small number of residents in the Regeneration Areas have this amenity.

Table 5.2 Dwelling types by IAT, 2008

	MSFs*	Other Flats	Houses†	Garden‡
TRAs	86.4	11.7	1.9	3.0
LRAs	76.1	21.7	2.3	3.5
WSAs	0.0	25.4	74.5	81.0
HIAs	17.0	15.6	67.3	73.3
PEs	10.7	37.2	51.9	64.1

*Multi-storey is defined as being in a building of six or more storeys.
†Houses include four-in-a-block properties.
‡Garden includes own-use and shared-use.

Housing Improvement Works

Over one-in-three respondents (36%) reported that 'improvement works'[v] had been carried out to their homes in the past two years. This was highest in LRAs (45%) and in WSAs (39%) and HIAs (38%). Table 5.3 shows that over the two years prior to the survey a little over a third of GHA housing stock had received improvement works of some kind in TRAs, WSAs and PEs, rising to half of the GHA stock in LRAs and HIAs. The lowest incidence of works was in the Red Road MSFs, where only a quarter (26%) of residents reported improvement works – this is the area where clearance and demolition of the MSFs has been most certain to proceed. The most common improvement works reported in areas of MSFs was new doors and locks (this was true for all Regeneration Areas except Gorbals Riverside), whereas in other areas the most common works were new bathrooms, new kitchens and new heating systems.

Significant numbers of private homes had also been improved in some way, 30% or more in WSAs, HIAs and PEs; in the first two of these, private sector[vi] works are likely to have been carried out as a consequence of the GHA investment programme, given the high number of ex-council owned properties in these locations.

Table 5.3 Housing improvement works by tenure within IATs, 2008

	Private Sector*	GHA	RSL
TRAs	24.2	35.1	17.1
LRAs	24.1	52.6	n/a
WSAs	42.7	36.4	n/a
HIAs	30.4	48.9	n/a
PEs	36.6	33.5	22.4

'Have any improvements been carried out to your home in the last 2 years?'
Table and base for calculating percentages omits 'don't know' responses, which totalled 7% of respondents.
*Private sector in this and subsequent tables includes both owner-occupied and private rented homes.

v While respondents were asked about 'improvement works' it is possible that this term could have been interpreted by some people as including repair work.

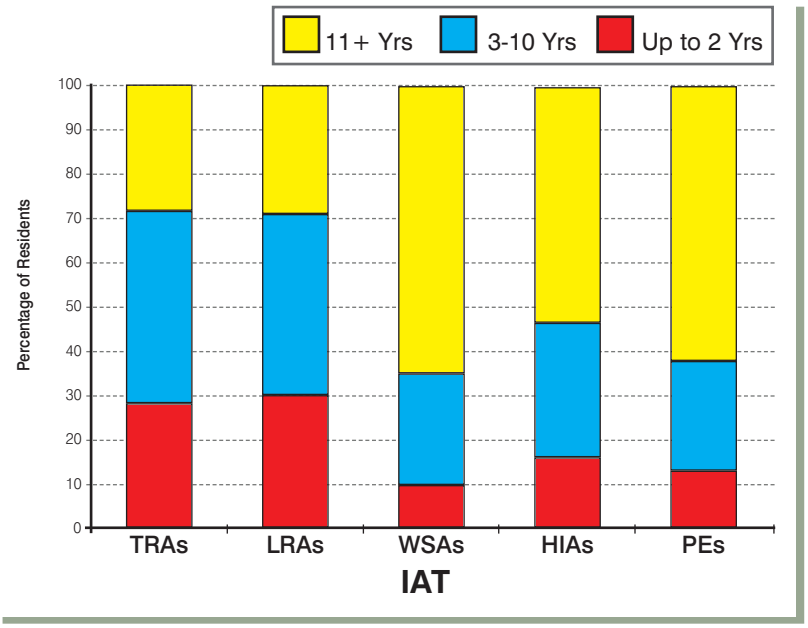
vi The term private sector is used in this report to refer to owner occupied and private rented homes. As Table 5.1 shows, the vast majority are in fact owned rather than rented.

Patterns of Residency and Moving Home

Residential Stability

The five IATs divide into two groups: the two regeneration types, which are relatively unstable in residential terms, and the three other types of area which are relatively stable. As Figure 5.1 shows, in both the TRAs and the LRAs, around three-in-ten people resident in the area have lived there for two years or less, which is two to three times as many as in the other three area types. The areas surrounding high-rise estates (WSAs) are the most residentially stable, with almost two-thirds of residents having lived in the area for over ten years; indeed, in these areas, 27% of residents have lived in the area for over 20 years.

Figure 5.1 Length of residence in the area, 2008



'How long in total have you lived in this area?'

House Moves over the Past Two Years

In the most stable areas, WSAs, 13% of respondents said they had moved home in the past two years (sometime from March 2006 to the interview date in 2008), and in HIAs and PEs the figure was 16% and 17% respectively (see Table 5.4). These all equate to annual rates of house moving of below 10%. However, in TRAs and LRAs the numbers were significantly higher, with 30% and 25% of people respectively having moved into their current home since March 2006.

In TRAs, the three most common reasons given for having moved home were that: the old home was being demolished (12% of movers); wanting a bigger home (10%); and wanting to live in a different area (10%). Around 20 other reasons were also cited for moving home, each by small numbers of respondents. In LRAs, demolition was a relatively uncommon reason for moving (3%), as was affordability (i.e. the old home was too expensive), which was cited by 7%. So, in Regeneration Areas, most house movers who still reside in the areas do not cite the redevelopment programme (demolition), as the main reason why they moved home, even though in many more cases than indicated, redevelopment might well have played a part in generating the move.

As Table 5.4 shows, people living in Regeneration Areas who had moved house report having less choice about where they moved to than people living elsewhere. Approximately twice as many people in WSAs, HIAs and PEs reported having choice about the home and area they now live in than did people living in TRAs and LRAs. This is not unexpected given the reduction in housing stock in Regeneration Areas at this stage in the regeneration process, combined with the need to rehouse larger numbers of people as a result of clearance processes and the use of properties for asylum seekers. The WSAs are shown to be areas of higher demand where large proportions of new occupants had exercised choice about where they live.

When examined in relation to the assessment of positive mental health (see Chapter 9 for a full description), those people who reported that they had 'a lot' of choice over their new home and/or their new area had significantly higher mental wellbeing scores than those who reported having 'none'[vii].

Table 5.4 Choice about house moves over the period 2006-08

	Moved Into Home in Last Two Years (%)	Choice About Area (%)	Choice About Home (%)
TRAs	30.5	36.6	35.5
LRAs	25.0	46.2	44.2
WSAs	12.7	83.2	76.7
HIAs	15.9	66.4	67.0
PEs	17.0	67.1	67.5

'Has this house/flat been your main address since March 2006?'
'How much choice did you have about the area/home you moved into?'
Table shows percentages for those who answered 'A lot' or 'Some' rather than 'None'.
[Statistical significance for differences by IAT on both choice variables $p<0.001$]

When survey participants were asked whether they preferred their new or old home, the pattern of response differed between Regeneration Areas and other types of area. In non-regeneration areas, around 70% of movers liked their new home better, but across the Regeneration Areas (TRAs and LRAs), this figure was only 45%.

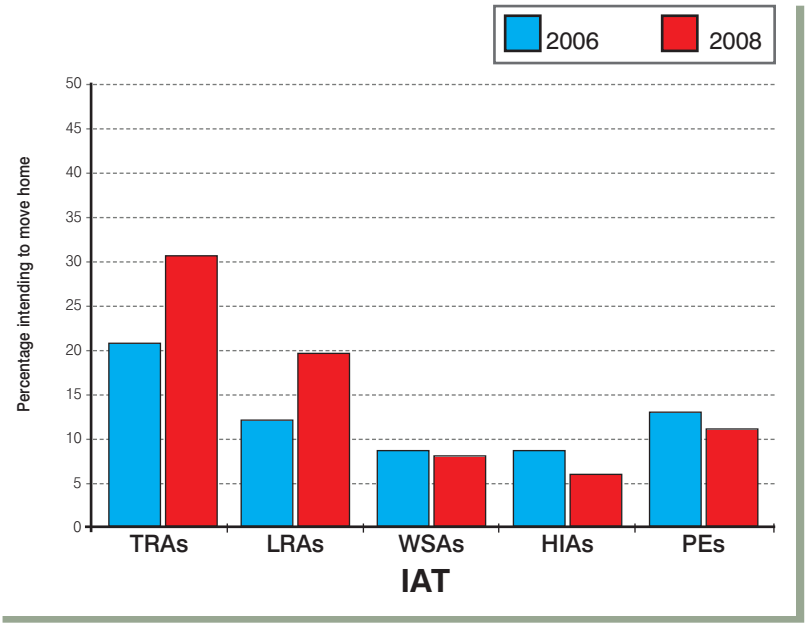
vii This analysis did not control for other demographic characteristics. Nonetheless, those with 'a lot' of choice about their house move, had positive mental health (WEMWBS) scores higher than those reporting no choice, the difference being equivalent to around two-thirds of a standard deviation on the WEMWBS scale.

House Moving Intentions

Figure 5.2 shows that intention to move had risen by nearly half in the Regeneration Areas since 2006, so that by 2008 three-in-ten people in TRAs and two-in-ten in LRAs intended to move home in the next year. Rates of intended mobility were a lot lower in the other types of area and had dropped slightly over time.

Over 20 different reasons for intending to move home were given by respondents. Only 8% of those intending to move cited demolition and clearance as a reason for moving in the near future. Reasons for moving can be classified into three groups: dwelling reasons (e.g. size and type of property wanted); area reasons (e.g. to move to a 'better area' or to move back to one's 'old neighbourhood'); and personal reasons (e.g. for work or health reasons). Table 5.5 shows that people's reasons for intending to move home are similar across all types of area: broadly, 60-70% of people cite dwelling reasons; 30% cite area reasons; and 20% cite personal reasons. Notable exceptions are the greater proportion of dwelling reasons and lower proportion of personal reasons in TRAs.

Figure 5.2 Intention to move home, 2006-08



'Do you intend to move home in the next twelve months?'
[Statistical significance for change over time within each IAT: TRAs $p<0.001$; LRAs $p<0.001$; WSAs $p=0.591$; HIAs $p=0.015$; PEs $p=0.208$]

Table 5.5 Reasons for intending to move home by IAT, 2008

	Dwelling Reasons	Area Reasons	Personal Reasons
TRAs	73.0	27.5	10.1
LRAs	66.3	25.8	17.2
WSAs	62.0	30.0	17.6
HIAs	62.3	26.1	17.4
PEs	60.7	32.7	19.6
All areas total	67.5	28.0	14.6

Table shows percentage of those with a mobility intention who cited one or more of the three types of reason for moving. Respondents could cite as many reasons as they wished.
[Statistical significance for differences between IATs in citation of each type of reason: Dwelling reasons $p=0.090$; Area reasons $p=0.748$; Personal reasons $p=0.069$]

Housing Satisfaction and Housing Quality

This section examines residents' satisfaction with their homes, with the housing services provided by their landlord or factor and with any housing improvement works which had been carried out. How respondents rate the quality of their homes on an item-by-item basis is also examined.

Overall Satisfaction with the Home

In both 2006 and 2008 there was a division between Regeneration Areas and other areas: between 60% and 70% of people were satisfied with their homes in TRAs and LRAs; in WSAs, HIAs and PEs the rates of satisfaction were between 80% and 90%. Table 5.6 compares housing satisfaction rates in the private and social rented sectors over time. It shows that the difference between satisfaction rates in the two sectors has increased over time in most types of area because satisfaction rates have risen slightly more in the private sector than in the social sector. The gap was largest in 2008 in the Regeneration Areas, where overall satisfaction rates in the social sector remained static or fell. The one exception to the general situation is in HIAs, where the gap between the two sectors has reduced. Where there is a substantial sample of both GHA and RSL tenants in 2008, in the PEs, the dwelling satisfaction rates are very similar between the two parts of the social sector, namely 83% (GHA) and 87% (RSL).

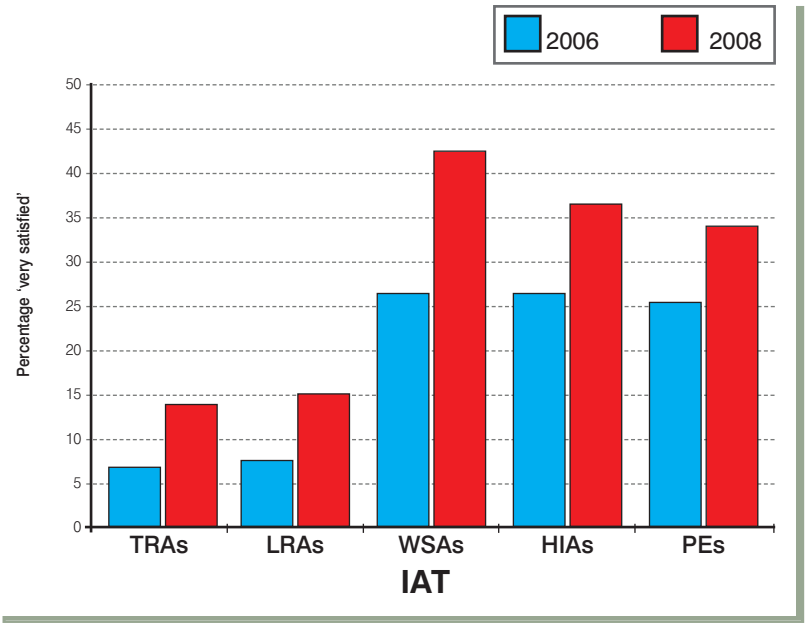
Table 5.6 Housing satisfaction by tenure, 2006-08

	2006			2008		
	Private rented	Social rented	Difference	Private rented	Social rented	Difference
TRAs	65.0	69.9	+4.9	94.1	62.7	-31.4
LRAs	76.5	66.1	-10.4	82.0	65.7	-16.3
WSAs	88.3	77.7	-10.6	95.9	81.2	-14.7
HIAs	92.6	83.1	-9.5	93.4	88.2	-5.2
PEs	90.4	80.3	-10.1	99.0	84.4	-14.6

Table shows percentages of people who were 'very' or 'fairly' satisfied with their homes.

Within this overall picture, the biggest change over time was the increase in the numbers of people who were '*very* satisfied' with their homes, as shown in Figure 5.3. Although still low, the numbers of people '*very* satisfied' with their home doubled in the Regeneration Areas (TRAs and LRAs) and also increased substantially in all other types of area as well. This is probably a reflection of the housing improvement works noted earlier.

Figure 5.3 Change in housing satisfaction (very satisfied with home), 2006-08



'Overall, how satisfied or dissatisfied are you with your current home?'
[Statistical significance for change over time within each IAT: p=<0.001 in each case]

As Table 5.7 shows, satisfaction with the home varies according to the built form of the home. High satisfaction ('very satisfied') is twice as common among house dwellers than the occupants of MSFs, whilst dissatisfaction ('very' or 'fairly dissatisfied') is three to four times as common among flat dwellers (multi-storey or medium rise) than the occupants of houses.

Table 5.7 Housing satisfaction by dwelling type, 2008

	Very Satisfied	Fairly Satisfied or Neither	Dissatisfied
MSF	18.2	58.7	23.1
Other Flat	29.6	54.7	15.7
House	41.1	53.5	5.3

[Statistical significance for differences between dwelling types: p<0.001]
Analysis based on British citizens only.

Satisfaction with Housing Services

Respondents were also asked how satisfied they were with the overall housing service provided by their landlord or factor. The 'overall housing service' would include such issues as repairs, housing allocations, maintaining common areas, and dealing with anti-social behaviour or neighbour complaints. Figure 5.4 compares the responses for homes and housing services for all tenants. This indicates that across all types of area, satisfaction with housing services is typically 15% lower than satisfaction with homes themselves. A comparison with national findings indicates that there may be scope to improve tenant's ratings of housing services. Across the study areas, satisfaction with housing services ranges from 50% to 70%, yet in a recent national survey of social sector tenants, satisfaction with a number of housing services ranged from 60% to 85% for local authority tenants, and from 70% to 90% for RSL tenants[46], both ranges having higher upper ends than found in the GoWell survey.

Figure 5.4 Tenant satisfaction with home and housing services, 2006-2008

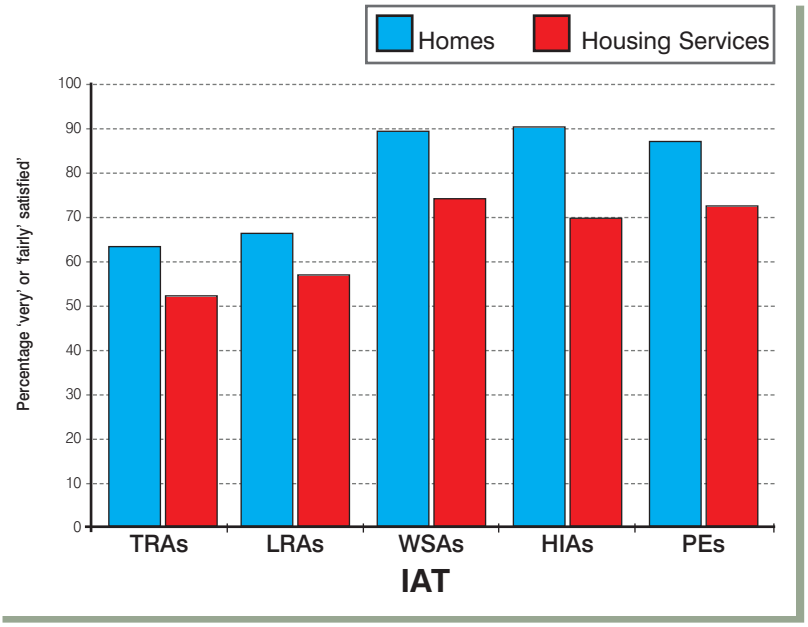


Table includes responses from all tenants, i.e. GHA, RSL and Private Sector tenants.
Figure shows percentage answering 'Very satisfied' or 'fairly satisfied' to statements: 'Overall, how satisfied or dissatisfied are you with your current home?' and 'How satisfied or dissatisfied are you with the overall housing service provided by your landlord or factor?'

Quality of Homes

In 2008, respondents rated their homes for quality across 18 items. As can be seen from Table 5.8, in the Regeneration Areas, all 18 items were on average rated as less than good. The ratings were equally poor in both types of Regeneration Area, though windows were rated worse in TRAs, and internal layout rated worse in LRAs. Over half the items were also rated as less than good in PEs, though they were not rated as badly as in Regeneration Areas. Only one item was rated on average as less than good in WSAs (storage space) and one in HIAs (bathrooms). Therefore, there was a big divide in housing quality terms between Regeneration Areas and other areas, though PEs also provide poorer housing quality than other places.

Table 5.8 Items of poor housing quality, 2008

TRAs	LRAs	WSAs	HIAs	PEs
Overall condition	**Overall condition**			
Damp/condensation	**Damp/condensation**			*Damp/condensation*
Overall space	**Overall space**			*Overall space*
Storage space	**Storage space**	*Storage Space*		
Bathroom / shower	**Bathroom / shower**		*Bathroom/shower*	*Bathroom/shower*
Kitchen	**Kitchen**			*Kitchen*
Heating	**Heating**			
Insulation	**Insulation**			*Insulation*
Internal Repair	**Internal Repair**			*Internal Repair*
Internal Decoration	**Internal Decoration**			*Internal Decoration*
External Repair	**External Repair**			*External Repair*
Ext. Appearance	**Ext. Appearance**			*Ext. Appearance*
Front Door	*Front Door*			
Security of Home	*Security of Home*			
Internal Layout	**Internal Layout**			
Windows	*Windows*			
Electric Wiring	*Electric Wiring*			
Access to Garden or Place to Sit	**Access to Garden or Place to Sit**			*Access to Garden or Place to Sit*

Items in **Bold**: mean rating was <3.50 on a scale of 1 ('very poor') to 5 ('very good'), i.e. mean rating was closest to 'neither good nor poor' (= 3.0). Almost all these items had a mean rating of between 3.0 and 3.5.
Items in *Italics*: mean rating was between 3.5 and 4.0, i.e. still less than 'fairly good' (= 4.0).

These housing items can be combined into three groups: overall condition; external/fabric quality; and internal quality items, and mean ratings can be computed by converting the response categories into scores. Table 5.9 compares the mean ratings across three tenure groupings: private sector housing; RSLs[viii]; and GHA. The rank ordering is the same in each case, with private sector ratings being highest and GHA ratings the lowest. Given that GHA owns most of the post-war and system-built homes in the city, it is perhaps surprising that the gaps in ratings are not larger. Whereas for RSLs, internal quality ratings are higher on average than for external quality, the opposite is the case for GHA stock, and for the private sector the two are the same.

Table 5.9 Mean ratings for housing quality item groupings, by tenure, 2008

	Private Sector	RSL	GHA
Overall Condition (1 item)	4.27	3.95	3.59
External/Fabric Quality (6 items)	4.22	3.84	3.64
Internal Quality (9 items)	4.22	3.91	3.57

Scores for each item range from 1 = very poor; to 5 = very good.
Excluding two items: dampness (not included in 2006 survey); and garden.

viii RSLs include housing associations and co-operatives, i.e. social housing other than GHA.

Table 5.10 shows how the mean ratings for external and internal items have changed over time, by dwelling type within each IAT. This table averages out changes in ratings across all tenures. It can be seen that the biggest improvements overall are to be found in HIAs where mean ratings for each type of dwelling, for both internal and external quality, have risen in 2008 by more than 5% compared to their mean scores in 2006. This is also true for three out of four mean ratings in WSAs. In the TRAs, there have been increases in the quality ratings for 'other flats' (not MSF), with almost a 5% rise in the mean rating for internal quality and an 8% rise in the mean rating for external quality.

Satisfaction with Housing Improvement Works

Resident satisfaction with housing improvement works was very high, with 90% of those who had received improvement works in the past two years being satisfied with the works that had been carried out to their homes. Satisfaction was highest in the WSAs, with 58% 'very satisfied', and lowest in the TRAs where 35% were 'very satisfied' (though overall satisfaction still reached 85%).

Table 5.10 Change in mean quality ratings, by dwelling type by IAT, 2006-08

		External/Fabric Quality			Internal Quality		
		2006	2008	% Change	2006	2008	% Change
TRAs	MSF	3.34	3.33	-0.3	3.30	3.21	-2.7
	Other Flat	3.50	3.77	+7.7	3.40	3.56	+4.7
	House	n/a	n/a	n/a	n/a	n/a	n/a
LRAs	MSF	3.34	3.39	+1.5	3.38	3.33	-1.5
	Other Flat	3.42	3.43	+0.3	3.38	3.39	+0.3
	House	n/a	n/a	n/a	n/a	n/a	n/a
WSAs	MSF	n/a	n/a	n/a	n/a	n/a	n/a
	Other Flat	3.71	3.93	+5.9	3.80	3.90	+2.6
	House	3.96	4.27	+7.8	3.97	4.24	+6.8
HIAs	MSF	3.63	3.92	+8.0	3.56	3.97	+11.5
	Other Flat	3.79	4.04	+6.6	3.75	3.99	+6.4
	House	3.94	4.19	+6.3	3.91	4.13	+5.6
PEs	MSF	3.42	3.60	+5.3	3.40	3.49	+2.6
	Other Flat	3.79	3.90	+2.9	3.70	3.97	+7.3
	House	3.96	4.03	+1.8	3.92	4.01	+2.3

Scores for each item range from 1 = very poor; to 5 = very good.
Change is expressed as a percentage of the 2006 score.
n/a = cell count is <30.

Housing Empowerment

This section looks at the ways in which housing can empower people. First, people's views about their inclusion in housing decision making by their landlord or factor is examined. Second, the various psychosocial benefits people may derive from their home, such as feelings of control and privacy, are considered.

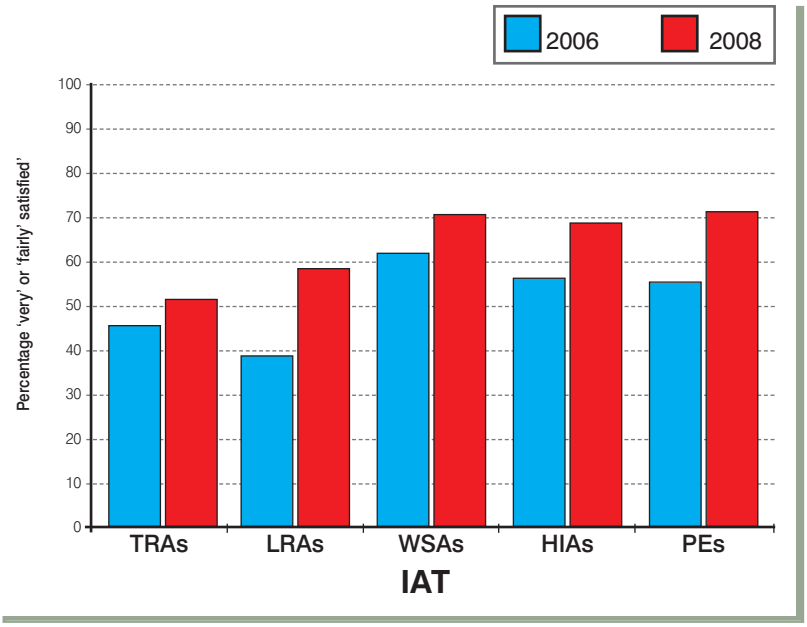
Landlord/Factor Relations

Respondents (both tenants and owners) were asked whether their landlord or factor kept them informed of things that might affect them, and whether they felt that residents' views were taken into account by their landlord or factor in decision-making about housing.

In 2006, around six-out-of-ten people in the Regeneration Areas were satisfied with how they were kept informed about things, compared with seven-out-of-ten people in the other types of area. Satisfaction rates increased by typically 3%-4% in most areas by 2008, but in the PEs, satisfaction rose significantly by 12% to 82% ($p<0.001$), the highest rate of satisfaction with being kept informed in 2008.

In 2006, in all types of area, satisfaction with consultation (i.e. satisfaction that the landlord or factor took residents' views into account when making decisions) was lower than satisfaction with information. Improvements in satisfaction with consultation were, however, greater than in the case of information, and were statistically significant in every type of area, as Figure 5.5 shows. There were large increases over time in satisfaction that residents' views were being taken into account in both PEs (+16%) and in LRAs (+20%).

Figure 5.5 Change in satisfaction with landlord/factor consultation, 2006-08



'How satisfied or dissatisfied are you with…your landlord or factor's willingness to take account of residents' views when making decisions?' Table includes responses from tenants and owners (who had a factor). [Statistical significance for changes over time within each IAT: TRAs $p=0.004$; LRAs $p<0.001$; WSAs $p=0.002$; HIAs $p<0.001$; PEs $p<0.001$]

Psychosocial Benefits of the Home

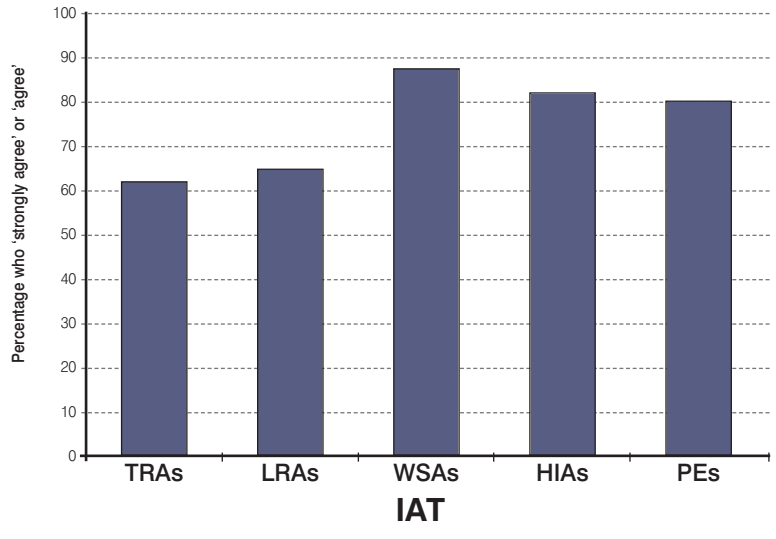
Respondents were asked about eight psychosocial benefits they might derive from their home. The benefits, and the specific questions asked, are defined in Table 5.11.

Table 5.11 Definition of psychosocial benefits from the home

BENEFIT	QUESTION ASKED
Privacy	I feel I have privacy in my home
Control	I feel in control of my home
Progress	My home makes me feel I am doing well in life
Safety	I feel safe in my home
Retreat	I can get away from it all in my home
Freedom	I can do what I want in my home
Status	Most people would like a home like mine
Identity	My home expresses my personality and values

Figure 5.6 shows the average proportion of people who agreed with these eight statements in each of the IATs. The rank ordering was the same for the eight individual items[ix]. The psychosocial benefits were felt by just over 60% of respondents from Regeneration Areas, but by 80%-90% of respondents in the other IATs.

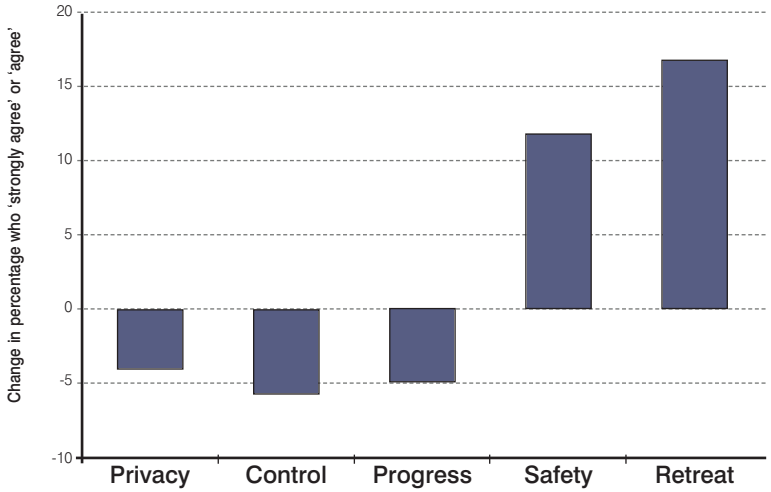
Figure 5.6 Average attainment of psychosocial benefits from the home, 2008



ix The one exception to this was 'freedom', where PEs came second, just ahead of HIAs.

Five of the eight statements were also asked in the 2006 survey. There was a notable improvement in WSAs, where the proportion attaining these psychosocial benefits increased by between 10%-20% across the two year period; in fact the proportion agreeing that their 'home makes them feel they are doing well in life' rose by 23% in two years, perhaps reflecting extensive housing investment activity. In all of the other types of area there was a mixed picture, with some items increasing and some decreasing. Figure 5.7 shows the experience in TRAs, where feelings of safety and retreat at home improved – possibly as a result of home improvements and/or improvements in the management of the neighbourhood whilst other benefits declined, though not so dramatically.

Figure 5.7 Change in psychosocial benefits in TRAs, 2006-08



[Statistical significance for changes over time for each item: Privacy $p=0.027$; Control $p=0.003$; Progress $p=0.022$; Safety $p<0.001$; Retreat $p<0.001$]

Do some types of dwelling offer more psychosocial benefits than others?

It has already been shown that housing satisfaction is lower in flats than in houses, and lowest in MSFs. This will no doubt partly be a function of dwelling and building condition and poorer maintenance of high-rise buildings over time. The 2008 survey responses can also be examined to see whether the different psychosocial benefits that people may derive from their homes systematically vary by dwelling type. In other words, do dwellings such as MSFs uniformly offer less benefit to people?

Table 5.12 shows that there is a consistent gradient across dwelling types with the highest level of psychosocial benefits derived by occupants of houses on all items, and the lowest level of benefits by occupants of MSFs; other types of flats lie somewhere in between, but are generally closer to houses than to MSFs in the benefits they offer.

The gap between MSFs and houses as a built form is greatest in relation to those psychosocial benefits that are more likely to affect how occupants feel about themselves, i.e. status, personal progress and identity (that is how one's home reflects one's personality and values).

But even in relation to some of the other psychosocial benefits that lie closer to issues of security - such as privacy, control and safety – there is a significant gap between MSFs and houses with approximately twice as many occupants of houses 'strongly agreeing' that they derive these benefits as occupants of MSFs. For example, while 15% of the occupants of MSFs strongly agree that 'I feel in control of my home', this is true for 35% of the occupants of houses (the figures for privacy are almost identical).

Table 5.12 Psychosocial benefits of home, by dwelling type, 2008
[percentage 'strongly agree' or 'agree' with statement of psychosocial benefit from the home]

	MSF[1]	OTHER FLAT	HOUSE[2]	DIFFERENCE: MSF TO HOUSE
Privacy	74.2	85.0	87.4	-13.2
Control	73.3	85.1	87.6	-14.3
Progress	54.2	71.3	83.0	-28.8
Safety	75.3	86.4	87.7	-12.4
Retreat	71.6	84.1	86.2	-14.6
Freedom	74.4	84.2	85.0	-10.6
Status	49.8	65.6	80.4	-30.6
Identity	56.3	70.4	79.7	-23.4

Note: Table includes responses from British citizens only, to avoid the confounding effect of asylum seekers and refugees almost exclusively living in MSFs.
1. Dwelling in a building of six or more storeys.
2. Includes four-in-a-block flats.
[Statistical significance for differences between dwelling types on each item: $p<0.001$ in all cases.]

Tenure Differences in Housing Responses

In order to make a comparison between housing tenures, and in particular between GHA and RSL tenants, the non-regeneration areas are examined (as the Regeneration Areas are dominated by MSFs with little housing provision other than that by GHA). Combining responses from all non-regeneration areas, Table 5.13 shows the pattern of responses to the housing satisfaction questions by tenure. Satisfaction with the home itself is notably higher in the private sector than in either part of the social sector. In contrast, satisfaction with the housing service provided by landlords or factors is slightly higher in the social sector than in the private sector, and within this is significantly higher among GHA tenants than among RSL tenants.

Table 5.13 Housing satisfaction by tenure, non-regeneration areas, 2008

	PRIVATE SECTOR	GHA	RSL
Home:			
Very satisfied	42.2	33.6	29.5
Total satisfied	95.2	85.2	85.3
Dissatisfied	2.9	10.6	12.2
Housing Service:			
Very satisfied	15.5	20.5	8.5
Total satisfied	67.2	73.1	70.5
Dissatisfied	6.9	8.6	8.8

Table includes responses from all those living in WSAs, HIAs and PEs.
Housing services in the private sector may be received from landlords or factors.
[Statistical significance for differences between tenures: $p<0.001$ in the case of both variables]

In terms of governance and empowerment, the findings for private sector residents and for GHA tenants are very similar, with around one-in-five people 'very satisfied' with how they are kept informed by their landlord or factor about things that might affect them, and a similar number also 'very satisfied' that residents' views are taken into account (Table 5.14). However, the results for RSLs in these locations are lower on both measures.

Table 5.14 Satisfaction with governance by tenure, non-regeneration areas, 2008

	PRIVATE SECTOR	GHA	RSL
Kept Informed:			
Very satisfied	18.8	20.0	13.7
Total satisfied	77.1	80.6	80.5
Dissatisfied	7.3	7.5	7.3
Take Account of Views:			
Very satisfied	21.7	20.1	8.6
Total satisfied	68.9	73.1	63.4
Dissatisfied	9.0	10.5	12.1

Table includes responses from all those living in WSAs, HIAs and PEs.
Housing services in the private sector may be received from landlords or factors.
[Statistical significance for differences between tenures: $p=0.059$ for 'Informed'; $p<0.001$ for 'Take account of views']

Discussion

The study area types are shown to be very different in housing and residential terms. Regeneration Areas, which are dominated by social housing tenure and by MSFs, are also residentially the most unstable. This is partly of course a function of how the estates are being used in housing terms (e.g. to accommodate short-term, insecure and vulnerable households), but will also be a response to the quality of housing and environments on offer in these locations. Nonetheless, improvement works are taking place across all study area types, including the Regeneration Areas, and it remains to be seen whether such improvements can help generate longer-term stability. A potential constraint on such a trend might be the absence of gardens in Regeneration Areas, in stark contrast to other areas; if access to a private outdoor space were to remain an aspiration for most people, then redevelopment of large parts of Regeneration Areas may be required.

The findings also help shed some light on contrasts within the social rented housing sector. GHA properties lag behind other RSL properties in terms of quality (as assessed by occupants), but this is more the case for internal quality than external quality. On the other hand, where the two sub-sectors are compared (based on sufficient sample sizes), namely in non-regeneration areas, tenants' ratings for landlord services are higher for GHA than for RSLs, with GHA having more 'very satisfied' tenants. This echoes, or rather presages, comments made by the housing regulator that 'GHA has put in place solid building blocks for the delivery of quality landlord services. It is successfully changing the culture of the organisation to focus on customers and continuous improvement'[47]. However, both parts of the social sector may face an equal challenge in seeking to raise customer service satisfaction rates to meet the levels of dwelling satisfaction among their tenants.

Progress is being made, mostly by GHA but also by other landlords, in enabling tenants to feel empowered in housing terms (that their views are taken into account by landlords). However, in Regeneration Areas there is much more progress to be made since in these locations more than two-in-five people still do not hold this view of their level of influence with landlords. But there is room for improvement in all locations on this front.

The findings also act as a reminder that dwelling types are important for outcomes. Occupants of flats derive psychosocial benefits from their homes to a lesser degree than the occupants of houses, and within this, residents of MSFs derive psychosocial benefits the least. This is especially true of those psychosocial benefits that lie closest to how people feel about themselves (e.g. sense of progress, status, and identity); however, even more basic feelings of safety and control are felt less strongly by people in MSFs than in other dwelling types. These things are important for people's sense of wellbeing and so it will be interesting to see in the future, how the mental wellbeing of the occupants of MSFs which are retained and improved rather than demolished compares with that of people who move out to other flats or houses.

Key Points

- Both types of Regeneration Area as well as the PEs are dominated by social rented housing. The two other types of study area are more evenly split between owning and renting. However, in most GoWell study areas, the majority of owners are living in ex-council properties, apart from PEs where most owners live in privately provided dwellings.

- Regeneration Areas remain dominated by MSFs and a minority have a garden to use, whereas in other locations a large majority of people have a garden. The majority of homes in WSAs and HIAs are houses, whilst PEs are evenly divided between houses and flats as a built form.

- Regeneration Areas are residentially unstable, with few long-term residents in the area and a sizeable proportion of people (around 30%) having lived locally for no more than two years. Greater stability should be considered an explicit objective for the management of these areas.

- Significant portions of the housing stock have received improvement works of some sort in the past two years, especially the GHA stock and (largely as a by-product) the private stock as well. Satisfaction with these works was high.

- Housing satisfaction rates are improving, particularly the numbers who are 'very' satisfied with their homes. There remain gaps of around 15% in satisfaction rates between the social rented and private sectors in all types of area, although the ratings are much closer in the HIAs.

- In Regeneration Areas, most aspects of the dwelling were rated less than 'good' on an item-by-item basis. Similarly in PEs over half the items were also rated less than 'good'.

- Tenants' sense of empowerment in relation to their landlords (feeling that their views are taken into account by their landlord when making decisions) has improved in all types of area, but remains lower in Regeneration Areas than elsewhere.

- Residents in the private sector are the most satisfied with their homes, but tenants of GHA are the most satisfied with the housing services provided by their landlord or factor, more so than private sector or RSL residents.

- MSFs are shown to provide less psychosocial benefits to their occupants than other types of flats or houses. This is especially true of those benefits which impact upon how people feel about themselves, such as a sense of progress, status, and reflecting their identity and values. It remains to be seen whether this continues to be the case where comprehensive improvement to MSFs takes place.

Neighbourhoods

In this chapter the local areas in which people live are examined, including:

- **Neighbourhood Satisfaction:** How satisfied or dissatisfied are people with their neighbourhood as a place to live?

- **Neighbourhood Environments and Amenities:** How do people rate the quality of their local physical and natural environment? How attractive, clean and quiet do they find their local environment? Do people consider the local amenities and facilities in the area to be of good quality, and do they use them?

- **Neighbourhood Safety and Anti-social Behaviour:** Do people feel safe in their neighbourhoods? How extensive are problems of anti-social behaviour? How good are policing services in the area?

- **Neighbourhood Change:** Do people perceive their local areas to be changing – for better or worse? In Regeneration Areas, what are local residents' views about change? Do residents support the demolition of tower blocks in some areas, and the retention of blocks of flats in others?

- **Neighbourhood Empowerment:** Do the neighbourhoods in which people live offer them the psychosocial benefit of feeling they are making progress in their lives? Do people think their areas have good or bad reputations? Within Regeneration Areas, do people feel informed and consulted about proposals for change?

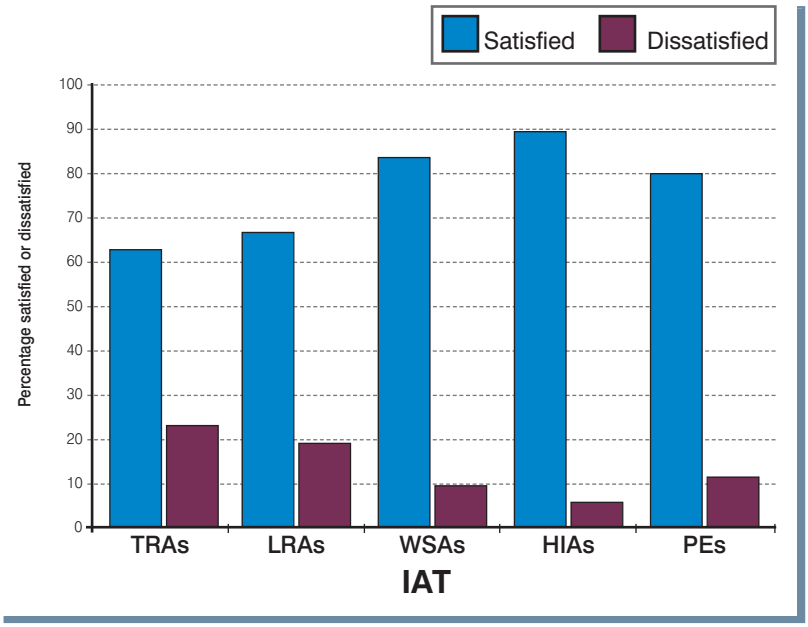
Neighbourhood Satisfaction

Neighbourhood satisfaction rates are reasonably high, though lower in Regeneration Areas than elsewhere. There was no significant change in neighbourhood satisfaction between 2006 and 2008.

While three-out-of-five people in Regeneration Areas were satisfied with their neighbourhood as a place to live in 2008, this was true of four-out-of-five people in the other three types of area (Figure 6.1). In Regeneration Areas, a fifth of residents are dissatisfied with their neighbourhood as a place to live.

For Scotland as a whole, residents' perceptions of their neighbourhood as a good place to live have also shown very little change in recent years. In 2008, 92% said their neighbourhood was either a 'very good' or 'fairly good' place to live. Variations by area level deprivation are clear however: for the 20% most deprived in Scotland, this figure fell to 79%[48]. This figure is comparable to that found in the GoWell 2008 survey for non-regeneration areas.

Figure 6.1 Neighbourhood satisfaction, 2008



'How satisfied or dissatisfied are you with this neighbourhood as a place to live?'
Figure shows those who replied 'very' or 'fairly satisfied' and 'very' or 'fairly dissatisfied'.
[Statistical significance for differences between all area types: p= <0.001]

Neighbourhood Environments and Amenities

This section examines what residents thought of their local environments in terms of their aesthetic qualities, cleanliness and quietness, and how they rated the quality of local amenities for children and for adults.

Neighbourhood Environments

There have been significant improvements in neighbourhood environments in many areas and in several respects, as shown in Table 6.1.

In all area types apart from Transformational Regeneration Areas (TRAs), perceptions of the peacefulness of the local area have significantly improved between 2006 and 2008. However, in TRAs and Local Regeneration Areas (LRAs) only a minority of respondents felt their environment was quiet and peaceful. This is not surprising given that regeneration activity is likely to impact upon how tranquil these areas seem.

Parks and open spaces and children's play areas are rated as being of much higher quality in 2008 than in 2006 – the only exception being no change in the rating of play areas in LRAs. It was noted in Chapter 2 that one of Glasgow Housing Association's (GHA's) wider action programmes has been investing in the improvement of children's play areas in recent years and this could have contributed to these findings.

The aesthetics of the environment (the attractiveness of buildings and the natural environment) are considered by residents to have significantly improved in Wider Surrounding Areas (WSAs) and Housing Improvement Areas (HIAs); this may be linked to the fact that these are areas where substantial amounts of housing fabric investment have taken place through GHA's core-stock improvement programme (particularly in the case of HIAs – see Figure 2.2). In Peripheral Estates (PEs), however, there has been no significant change in residents' ratings of environmental aesthetics and they remain relatively low compared to other non-regeneration areas. In the two Regeneration Area types, the aesthetics of the environment are rated as worse than in 2006, again probably reflecting the clearance and demolition of buildings without the subsequent rebuilding of new housing stock yet. Street cleaning services were also rated much better in WSAs and HIAs than in all other areas.

Table 6.1 Ratings of the neighbourhood environment, 2006-08
[Percentage rating item as 'very good' or 'fairly good']

		2006	2008	CHANGE	p
TRAs	Attractive Buildings	48.70	23.20	-25.50	<0.001
	Attractive Environment	50.80	25.30	-25.50	<0.001
	Quiet & Peaceful Environment	44.80	36.70	-8.10	<0.001
	Parks & Open Spaces	39.30	60.60	21.30	<0.001
	Children's Play Areas	33.40	53.60	20.20	<0.001
	Street Cleaning	n/a	56.10	n/a	
LRAs	Attractive Buildings	51.00	33.90	-17.10	<0.001
	Attractive Environment	51.30	41.60	-9.70	<0.001
	Quiet & Peaceful Environment	40.10	47.70	7.60	0.003
	Parks & Open Spaces	44.90	63.90	19.00	<0.001
	Children's Play Areas	39.20	41.80	2.60	0.387
	Street Cleaning	n/a	56.20	n/a	
WSAs	Attractive Buildings	60.10	70.50	10.40	<0.001
	Attractive Environment	59.10	71.50	12.40	<0.001
	Quiet & Peaceful Environment	56.40	81.50	25.10	<0.001
	Parks & Open Spaces	51.60	74.70	23.10	<0.001
	Children's Play Areas	43.40	58.60	15.20	<0.001
	Street Cleaning	n/a	77.30	n/a	
HIAs	Attractive Buildings	65.20	76.20	11.00	
	Attractive Environment	70.50	77.90	7.40	<0.001
	Quiet & Peaceful Environment	63.50	81.30	17.80	<0.001
	Parks & Open Spaces	50.10	74.50	24.40	<0.001
	Children's Play Areas	44.00	52.80	8.80	<0.001
	Street Cleaning	n/a	69.40	n/a	<0.001
PEs	Attractive Buildings	56.70	54.40	-2.30	
	Attractive Environment	56.00	55.10	-0.90	0.277
	Quiet & Peaceful Environment	47.60	65.50	17.90	0.645
	Parks & Open Spaces	41.20	59.50	18.30	<0.001
	Children's Play Areas	34.70	51.80	17.10	<0.001
	Street Cleaning	n/a	58.30	n/a	<0.001

'How would you rate the quality of your neighbourhood in terms of the following things..?'
Response categories on a five-point scale from 'very good' to 'very poor'.
n/a = not applicable (i.e. question wasn't asked in 2006 survey)

Local Amenities

As sated earlier, children's play areas are considered to be of much better quality in 2008 than in 2006, reflecting investment activity. The survey also asked people about the quality of five other local facilities and amenities: schools; childcare/nurseries; shops; community and social venues (not in 2006); and youth and leisure services. The results are shown in Table 6.2.

Table 6.2 Ratings of local amenities, 2006-08
[Percentage rating item as 'very good' or 'fairly good']

		2006	2008	CHANGE	p
TRAs	Schools	73.10	74.60	1.50	0.590
	Childcare/nurseries	54.70	68.10	13.40	<0.001
	Shops	57.50	65.60	8.10	<0.001
	Youth and leisure services	55.70	39.80	-15.90	<0.001
	Community and social venues	n/a	48.70	n/a	n/a
LRAs	Schools	72.90	76.30	3.40	0.205
	Childcare/nurseries	54.00	65.80	11.80	0.001
	Shops	52.90	66.70	13.80	<0.001
	Youth and leisure services	54.40	50.60	-3.80	0.225
	Community and social venues	n/a	56.40	n/a	n/a
WSAs	Schools	74.60	85.50	10.90	<0.001
	Childcare/nurseries	50.80	81.20	30.40	<0.001
	Shops	60.10	81.80	21.70	<0.001
	Youth and leisure services	44.80	56.70	11.90	<0.001
	Community and social venues	n/a	60.90	n/a	n/a
HIAs	Schools	72.30	78.70	6.40	0.004
	Childcare/nurseries	47.00	71.80	24.80	<0.001
	Shops	63.00	79.10	16.10	<0.001
	Youth and leisure services	47.20	50.10	2.90	0.220
	Community and social venues	n/a	59.90	n/a	n/a
PEs	Schools	78.40	81.40	3.00	0.131
	Childcare/nurseries	50.40	71.80	21.40	<0.001
	Shops	48.10	52.40	4.30	0.038
	Youth and leisure services	43.30	53.70	10.40	<0.001
	Community and social venues	n/a	54.40	n/a	n/a

'How would you rate the quality of the following services in and around your local area…?'
Responses on a five point scale from 'very poor' to 'very good'. n/a = not applicable (i.e. question wasn't asked in 2006 survey).
Base numbers exclude those who responded 'don't know' to particular items.

Schools were the highest rated of the five amenities in 2006, and they maintained that position in 2008; in the WSAs and HIAs the rating of local schools increased over time. Alongside this, there were large increases in residents' ratings of amenities for pre-school children (childcare and nurseries) in all five types of study area. This is consistent with Scottish Household Survey findings – in 2008, 80% reported being 'very' or 'fairly satisfied' with local schools[48].

Residents' ratings of the quality of local shops improved in all types of area apart from PEs, where the position was not significantly different than 2006. The largest improvement in the rating of shops was in the WSAs. In PEs, shops were the lowest rated of the five amenities.

In all types of area other than PEs, youth and leisure services were the lowest rated amenity in 2008. Change over time in the ratings for youth and leisure services was mixed. In some areas their rating improved (WSAs, HIAs and PEs), while it remained unchanged in LRAs and declined in TRAs, where there was a large drop of 16% in the number of respondents who rated local youth and leisure services as being of 'good' quality.

At a national level, in 2008, just over four-in-ten people (44%) living in urban areas reported that they particularly liked the amenities in their local area while a much smaller proportion (one-in-ten, or 10%) reported that they particularly disliked this aspect of their community[48].

Neighbourhood Safety and Anti-social Behaviour

In this section, residents' perceptions of anti-social behaviour, people's sense of safety at night, and the quality of policing services are discussed.

Anti-social Behaviour Problems

Respondents were asked about eleven potential problems in their local neighbourhood. Table 6.3 shows the mean number of problems identified in 2008 and change since 2006. Anti-social behaviour problems were reportedly very low in HIAs compared to other areas, with little change since 2006. Anti-social behaviour problems were highest in the two Regeneration Area types, and a higher proportion of those problems were considered to be 'serious' ones. Whereas problems were most numerous in the TRAs, they had increased the most in PEs, with a very large increase (+57%) in 'serious' problems identified by residents.

Table 6.3 Anti-social behaviour problems, 2006-08

	SLIGHT PROBLEMS		SERIOUS PROBLEMS		TOTAL PROBLEMS	
	2008	% CHANGE SINCE '06	2008	% CHANGE SINCE '06	2008	% CHANGE SINCE '06
TRAs	2.99	-4.2	2.50	+33.7	5.49	+10.0
LRAs	2.79	-26.2	2.73	+24.1	5.53	-7.50
WSAs	2.87	+5.9	1.31	+19.1	4.19	+10.0
HIAs	1.92	+1.6	0.69	+4.5	2.61	+2.0
PEs	3.23	+29.7	1.90	+57.0	5.13	+38.6

'Could you tell me whether you think that each of the following things is a serious problem, a slight problem or not a problem in your local neighbourhood?'
11 items were asked about: vandalism, violence, insults and intimidation in the street, racial harassment, drugs, drunken and rowdy behaviour, gang activity, teenagers hanging around, nuisance neighbours or problem families, rubbish or litter, burglary.

Table 6.4 shows the most commonly cited problems, i.e. those problems identified by half or more of the residents of each type of area and, by at least 20% of residents as a 'serious problem'. This shows that HIAs do not suffer any of the listed problems to such a high degree. In the Regeneration Areas as well as in PEs, a majority of the items are each identified by most residents as problems. PEs, therefore, suffer similar problems to the Regeneration Areas, though less violence and intimidation. The problem of drugs is pervasive, spilling over from the Regeneration Areas into the WSAs, where most people also reported drugs to be a problem.

The Scottish Household Survey, 2008[48] shows that, across all anti-social behaviours, as areas become more deprived, perceptions of anti-social behaviour prevalence increases. Apart from litter, the biggest contrast in perceptions of prevalence between the most and least deprived areas are seen for general anti-social behaviour, in particular rowdy behaviour (41%) and vandalism (39%), compared with 8% and 9% respectively. However, there are no clear trends in any of the problems with the proportions reporting them being broadly similar each year.

Table 6.4 Major anti-social behaviour problems, 2008

TRAs	LRAs	WSAs	HIAs	PEs
Vandalism	Vandalism			Vandalism
Violence				
Intimidation				
Drugs	Drugs	Drugs		Drugs
Drunk/Rowdy	Drunk/Rowdy			Drunk/Rowdy
Gangs	Gangs			Gangs
Teenagers	Teenagers			Teenagers
Litter	Litter			Litter

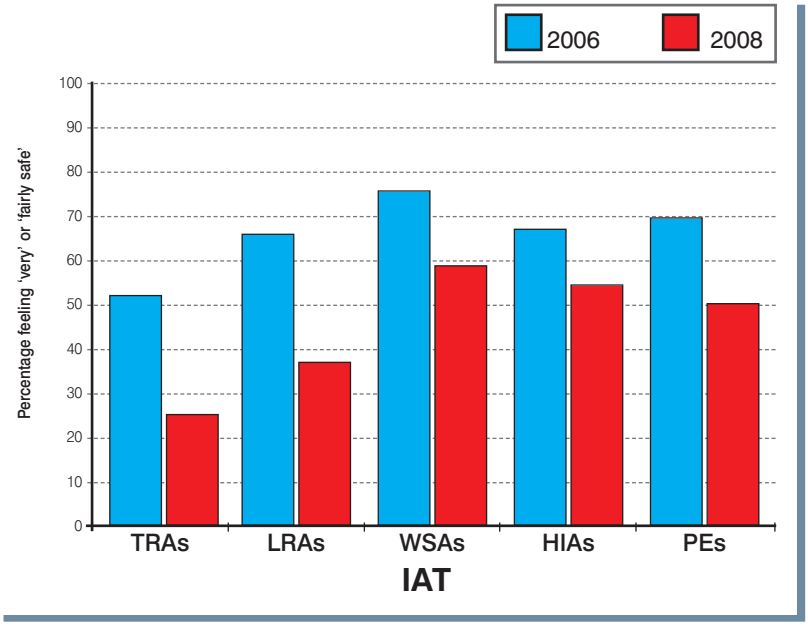
Items were identified by at least 50% of residents as a problem and, within that, by at least 20% of residents as a 'serious' problem.

Feeling Safe in the Neighbourhood

To gauge people's sense of safety, respondents were asked how safe they would feel walking alone in their neighbourhood after dark. This sense of safety declined in all types of area over the two year period, and dramatically in Regeneration Areas (Figure 6.2). In both TRAs and LRAs, only a minority of residents in 2008 said they would feel safe walking alone in the neighbourhood after dark. Indeed, a growing number of people now say they never walk alone after dark, ranging from 19% in WSAs to 29% in the two Regeneration Area types. It is possible that the declining feelings of safety at night in Regeneration Areas may be related to the process of regeneration, due to the combination of a falling population together with the presence of empty buildings awaiting demolition, i.e. fewer people around and unfriendly sites liable to be the focus of anti-social behaviour, as perceived by residents.

Although the Scottish Household Survey (2008)[48] does not provide a direct comparison on the question of neighbourhood safety, it does show that safety is much lower in the most deprived areas, where half as many people (9%) as across Scotland as a whole (20%) identify safety as one of the things they 'particularly like' about their neighbourhood.

Figure 6.2 Feelings of safety after dark, 2006-08



'How safe would you feel walking alone in this neighbourhood after dark?' Figure shows those feeling 'very safe' or 'fairly safe'.
[p=<0.001 for the measure of change over time in the case of all five area types]

Policing Services

Given the concerns expressed about anti-social behaviour and safety after dark, it is interesting to explore whether policing in these areas was considered to be a particularly poor service, or to have got worse recently. Policing was moderately rated by residents for quality; and furthermore, there was no significant change over time in the ratings given to policing. The highest ratings for policing in 2008 were given by residents of Regeneration Areas, where 53% of people in both TRAs and LRAs rated the service as either 'fairly good' or 'very good', compared with 49% in WSAs and HIAs, and 46% in PEs. These figures are much lower than the ratings given in many areas for other services and amenities like schools, childcare and shops (Table 6.2).

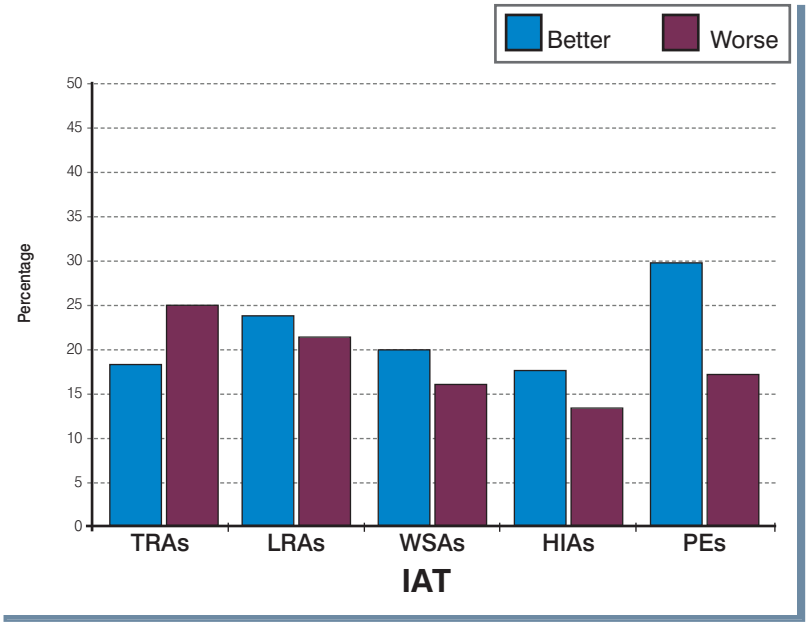
Neighbourhood Change

In Regeneration Areas and PEs, more people see change in their areas (good and bad) over the previous two years than see their area as staying the same. In WSAs and HIAs, the majority of people think their area has remained the same, getting neither better nor worse as a place to live over the last two years.

In all types of area other than TRAs, more people in 2008 thought their area had got better as a place to live than thought it had got worse (Figure 6.3). Moreover, the increases in positive views of change since 2006 were larger than increases in negative views of change. PEs are particularly interesting since the proportion of residents who thought their area had got better as a place to live doubled from 15% in 2006 to 30% in 2008, whereas the proportion who thought their area had got worse only increased from 13% to 17%.

However, in TRAs, the situation was different: the proportion who thought their area had got worse as a place to live increased by 12% from 2006 to stand at 25% in 2008, more than thought their area had got better, standing at 18% (a similar increase of 13% since 2006).

Figure 6.3 Perceptions of neighbourhood change, 2008



'Has this area got better or worse to live in over the last two years?'
Base for percentages excludes those who replied 'Don't know' or who had lived in the area for less than two years; the latter ranged from 6% of respondents in WSAs to 23% of respondents in TRAs and LRAs.

Respondents in the GoWell 2008 survey were more positive about neighbourhood change than people in general. Looking at Scotland as a whole, the prevailing perception (61%) is that things have stayed the same in people's neighbourhoods, while the proportion of people who say things have got worse (19%) outweighs the proportion saying things have improved (13%)[48].

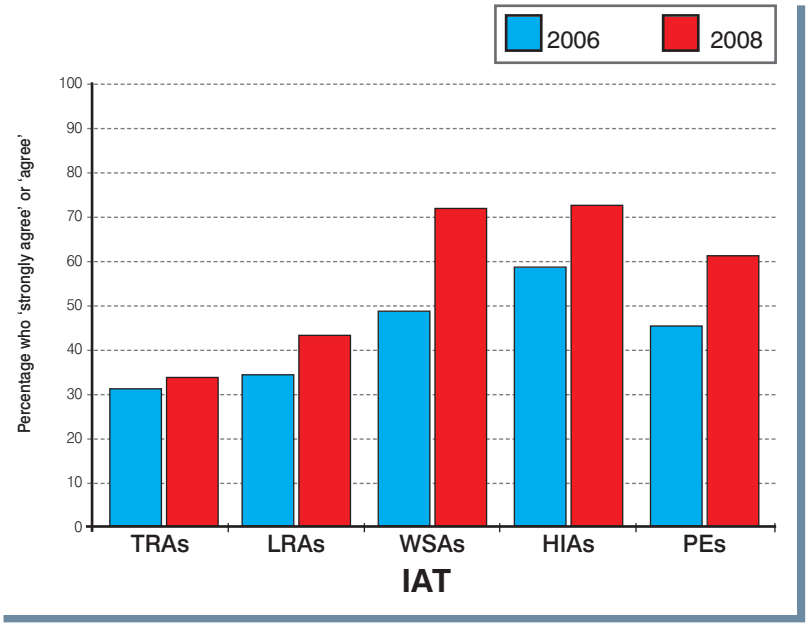
Neighbourhood Empowerment

In this section respondents' views about the sense of progress they derive from living in their neighbourhood; their understandings of the reputation of their areas; and their views about community involvement in regeneration processes are explored.

Sense of Personal Progress

A sense of achievement derived from where one lives can be empowering. Thus, respondents were asked if they agreed with the statement that '*Living in this neighbourhood helps make me feel that I am doing well in life*'. As Figure 6.4 shows, there is a difference between Regeneration Areas and other types of area: in non-regeneration areas, most people derive a sense of personal progress through residence in the area, but only a minority do so in Regeneration Areas. The extent of this sense of progress increased in all types of area between 2006 and 2008, apart from TRAs, where there was no significant change and where only a third of residents felt this way in 2008. In the WSAs, where a lot of physical improvements to the built environment have taken place, there was a large increase (of more than 20%) in the numbers reporting a sense of progress through living in their neighbourhood.

Figure 6.4 Sense of progress through residence, 2006-08



'How much do you agree or disagree with the following statement…? Living in this neighbourhood helps make me feel that I'm doing well in my life'
Figure shows those who 'strongly agree' or 'agree' with the statement.
[TRA, p=0.250; All other area types, p<0.001]

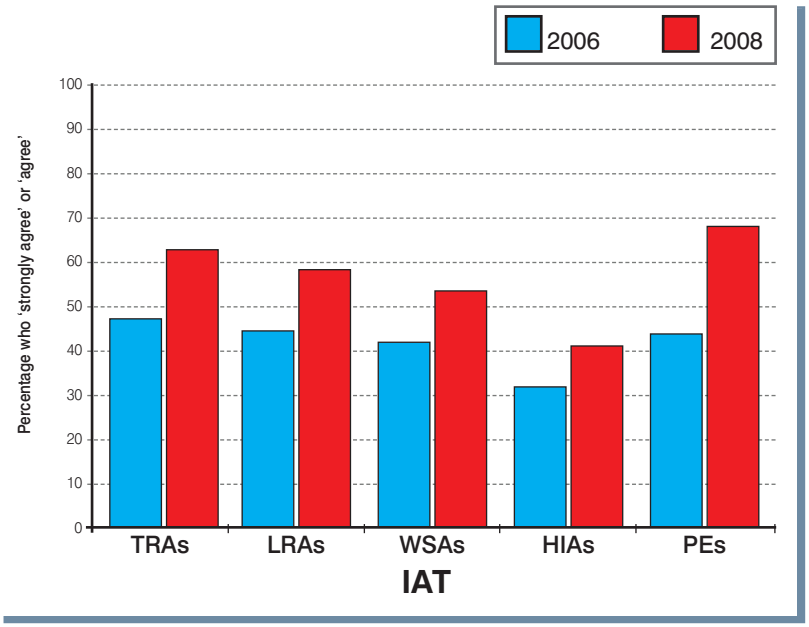
Area Reputations

How people think other people view their place of residence can also impact upon their sense of empowerment. Respondents were asked whether they thought their neighbourhood had a bad external reputation (among the people of Glasgow) and whether it had a good internal reputation (among their co-residents). As Figure 6.5 shows, residents' own views of their neighbourhoods' external reputations have worsened in all types of area. In 2008, only in HIAs do a minority of people think their area has a bad external reputation; in all other types of area, most people think this, showing how extensive negative area reputations are believed to be.

At the same time, across all types of area, more people in 2008 than in 2006 thought that their neighbourhoods had good internal reputations, i.e. that the people who lived in the area thought highly of it (Figure 6.6). However, only a minority of residents in the Regeneration Areas thought their neighbourhoods had good internal reputations, compared with a majority of people thinking this in all other types of area.

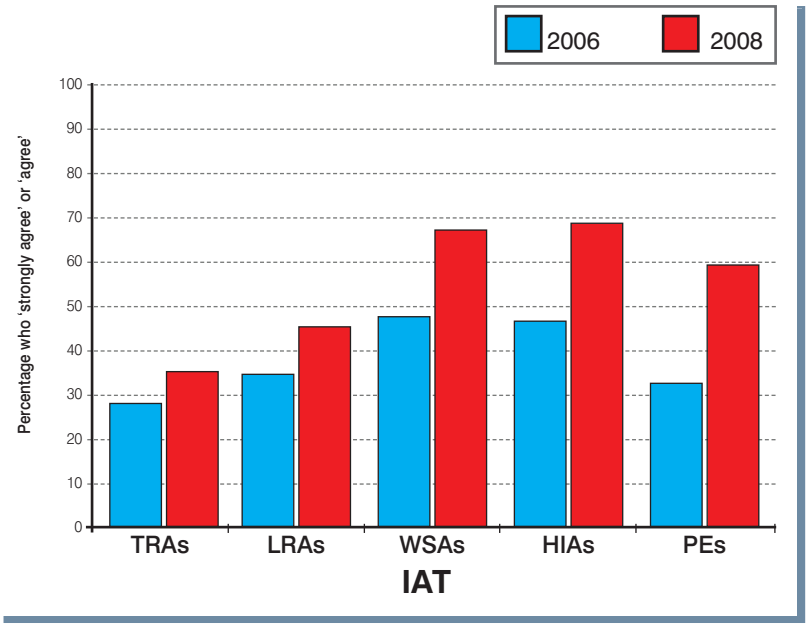
The internal and external reputations are consistent with one another in the case of the Regeneration Areas, where only a minority of people think their

Figure 6.5 Negative external area reputation, 2006-08



Those who 'agree' or 'strongly agree' with the statement 'Many people in Glasgow think this neighbourhood has a bad reputation'
[Statistical significance for change over time: p<0.001 for all area types]

Figure 6.6 Positive internal area reputation, 2006-08



Those who 'agree' or 'strongly agree' with the statement "People who live in this neighbourhood think highly of it"
[Statistical significance for changes over time for each type of area: TRA p=0.001; All other types of area p<0.001]

area has a *good internal* reputation and a majority of people think their area has a *bad external* reputation. In contrast, the two reputations contradict one another in the case of WSAs and PEs, where a majority of people think their area has a *good internal* reputation and at the same time, a majority of people think their area has a *bad external* reputation.

Community Engagement in Regeneration

Within the six Regeneration Areas, residents were asked for their views on the proposals for their areas, as they stood in mid-2008.

In four areas (Red Road, Sighthill, Shawbridge and Plean Street [part of the Scotstoun MSF Study Area]) residents were asked '*What is your view on proposals to demolish tower blocks around here and replace them with a mixture of houses and low-rise flats?*'

In three other areas (Gorbals Riverside, Kingsway Court [part of the Scotstoun MSF study area], and St Andrews Drive) residents were asked '*What is your view on retention of the blocks of flats around here and improving them, rather than knocking them down?*'

The results showed strong support for demolition of tower blocks in the four areas where this was being proposed. Across all four areas, 73% of residents were in favour of demolition with 10% opposed; the level of support was high in each of the four areas, ranging from 70% to 84% in each site.

Support for retention of blocks of flats in the other three areas was less overwhelming: overall 45% were in favour of retention, with 29% opposed and 25% neutral on the matter. Looking at the areas separately, support ranged from 35% to 51%, therefore just reaching a majority in one of the areas.

Respondents in the Regeneration Areas were also asked for their views on how well the community are involved in the process of regeneration.

First, they were asked the following about information:
'*How well are you kept informed about proposals to improve or develop this area?*'

Second, they were asked about consultation as follows:
'*Are there opportunities for you or for the community to have a say in matters relating to the regeneration of this area?*'

The findings from these two questions are given in Table 6.5.

Table 6.5 Community engagement in regeneration, 2008

	TRAs (%)	LRAs (%)
Kept Informed About Proposals:		
Very or fairly well	38.2	35.5
Not very well or not at all well	29.9	33.7
Not aware of proposals or 'don't know'	31.7	30.8
Opportunities to Have a Say on Regeneration:		
Yes, plenty or some opportunities	32.5	27.5
Yes, but not enough opportunities	16.7	20.7
No opportunities	17.9	14.5
Don't know	33.0	37.3

In relation to being 'kept informed', residents fall roughly into thirds: a third feel well informed; a third feel not well informed; and a third either don't know what is going on that they should be informed about, or are not sure whether they are well informed or not. The numbers who felt well informed ranged from 26% in one area to 53% in another, so in none of the areas was there a sizeable majority of residents who felt well informed about the regeneration of their area.

With regard to being consulted, the situation is similar in that just under a third of residents seemed content about the extent to which they (individually or as a community) can have a say about regeneration matters. This figure ranged from 21% in one area to 44% in another; in no area did a majority of people report contentment about their opportunities to have a say. A similar number of residents felt that there were either no, or not enough, opportunities to have a say about regeneration.

Might Community Engagement Reinforce Other Positive Feelings About the Neighbourhood?

By cross-referencing the responses on these issues given by people in TRAs to their responses to a range of other questions, we can see whether there is an association between feeling informed and consulted about regeneration and feeling other positive things about the neighbourhood and its contribution to one's personal and social life.

Table 6.6 shows how positive feelings about the neighbourhood vary according to people's views about community engagement. In all cases, there is a positive association between a person's views about community engagement and the benefits they acquire from the neighbourhood.

The top half of the table shows that people who feel well informed about regeneration and who feel that there are sufficient opportunities for themselves and the community to have a say about regeneration are also more likely to feel a sense of social inclusion, i.e. belonging to the neighbourhood and feeling part of the community.

The second half of the table shows that those people who feel informed and consulted about regeneration are also more likely to be satisfied with their neighbourhood as a place to live, and to derive a sense of personal progress from living in the area.

The weakest relationship seen here is the association with neighbourhood satisfaction. The strongest relationship is that with the psychosocial benefit of personal progress through living in the area, where at least twice as many of those people who feel informed and consulted derive this benefit compared with those people who do not have a positive view of community engagement.

Table 6.6 Community engagement and feelings about the neighbourhood in TRAs, 2008

	KEPT WELL INFORMED (%)			ENOUGH OPPORTUNITIES TO HAVE A SAY (%)		
	YES	NO	p	YES	NO	p
Belong to the neighbourhood	69.7	49.8	*<0.001*	71.8	51.2	*<0.001*
Feel part of the community	66.1	41.6	*<0.001*	69.8	44.8	*<0.001*
Satisfied with neighbourhood	67.1	60.4	*0.031*	71.4	57.9	*<0.001*
Neighbourhood gives sense of progress	47.9	24.2	*<0.001*	50.5	20.2	*<0.001*

Notes:
Table shows percentages for neighbourhood responses, within each category of response to the two community engagement questions. For example, the first row of the table shows that of those people who said they were kept well informed about regeneration proposals ('yes' to 'Kept well informed'), 69.7% also felt a sense of belonging to the neighbourhood; whereas only 49.8% of those who did not feel well informed, felt a sense of belonging to the neighbourhood.
Sample size ranges from 622 to 641 respondents.
Table shows column percentages, e.g. the figure in the top left hand corner shows that of those people who felt well informed about regeneration, 69.7% felt that they belonged to the neighbourhood.
'Kept well informed': is defined as those people who gave one of the first two responses to this question, i.e. 'very well' or 'fairly well'. Not well informed is defined as those who responded 'not very well' or 'not at all well'. Other responses are not included in the analysis ('not aware of proposals', 'don't know' and 'refused').

'Opportunities to have a say' is defined as those people who gave one of the first two responses to this question, i.e. 'yes plenty' or 'yes some'. Not enough opportunities to have a say is defined as those people who responded 'yes, but not enough' and 'no, there are no opportunities'. Those who responded 'don't know' are not included in the analysis.

Belong to the Neighbourhood: those who responded 'A great deal' or 'A fair amount'

Feel part of the Community: those who responded 'A great deal' or 'A fair amount'

Satisfied with Neighbourhood: those who responded 'Very satisfied' or 'Fairly satisfied'

Neighbourhood Gives a Sense of Progress: those who responded 'Strongly agree' or 'Agree'

Discussion

At this early stage of the regeneration process, some of the findings are as one might expect, with ratings of environmental aesthetics and perceptions of neighbourhood change both moving in a negative direction over the period 2006-08 in the Regeneration Areas.

However, on other fronts there are signs that investment activity (by GHA and Glasgow City Council) is having a positive impact on residents' perceptions of their neighbourhoods. Investment in particular items like children's play areas, schools and nurseries is reflected in residents' ratings of these items. Widespread investment in areas is also having an impact as shown in the WSAs and HIAs where large-scale housing improvements are feeding through to more positive ratings of environmental aesthetics.

On issues relating to environmental quality and environmental services, it is noticeable that the PEs perform worse than other non-regeneration areas. In these respects, residents' perceptions in PEs are more similar to the views of people living in the post-war estates in the inner city than they are to the views of people living in other inner or outer suburban areas. The PEs therefore continue to present a challenge for the improvement of residential environments.

The biggest issue raised by these findings is the decline in feelings of safety and increases in perceptions of anti-social behaviour problems. Once again, the experience of PE residents is similar to that of Regeneration Area residents. The large decline in feelings of safety at night in Regeneration Areas may be related to clearances and demolitions, indicating that the agencies responsible should consider what they can do to make people feel safer while these processes are going on.

The importance of youth and leisure services is also indicated: residents' ratings of these services have declined in Regeneration Areas, precisely where feelings of safety have reduced the most. This raises the question of whether more can be done by the partner agencies to assist with youth services during periods of change, in case regeneration has negative impacts upon mainstream services and amenities for young people, while at the same time presenting more opportunities for anti-social behaviour through the process of physical change. More generally, however, youth and leisure services are amongst the lowest rated service or amenity in many areas, whilst 'teenagers hanging around' (a potential consequence of poor youth services) are considered to be a serious problem in at least three of the study area types.

The findings on community engagement in regeneration are modest, at best. Only a minority of residents felt that they were well informed or had opportunities to input to the process over the period. It is conceivable (although unknown) that a lack of declared awareness of, or involvement in, regeneration is partly a function of a lack of sense of influence over the outcomes of the regeneration process, rather than solely a function of a lack of efforts to engage with residents. Community engagement is important for reasons of democracy and accountability, and so that people feel that change is being done with them (or at least with their

knowledge and implied consent), rather than to them. It has been shown that a positive perception of community engagement may have a two-way relationship with people's sense of community and of neighbourhood attachment, therefore holding out the possibility that action on both these fronts (community engagement in relation to regeneration, and wider efforts to support a sense of community) may have mutually reinforcing benefits both for the regeneration process itself and the sustainable communities it seeks to deliver.

Key Points

- Neighbourhood satisfaction rates are high, though there is a clear gap of at least 20% between Regeneration Areas and other areas. This is a gap that processes of change should expect to close in due course.
- There is widespread improvement in the ratings of parks and play areas, which could be the result of recent investment activity.
- In areas where extensive improvements have been made to the fabric of houses, ratings of environmental aesthetics have improved markedly.
- Ratings of childcare/nurseries and shops have improved significantly in most areas.
- Ratings for youth and leisure services and for community and social venues in local areas are much lower than ratings for other amenities. This is the case across all areas.
- Perceptions of anti-social behaviour problems have worsened, and feelings of safety at night time in the local area have declined; dramatically so in the case of Regeneration Areas.
- Social housing areas continue to suffer from poor external reputations, at least in the view of residents, and the situation has worsened over time. In four out of five types of area, most people think their area has a bad reputation across the City.
- Only a minority of residents of Regeneration Areas felt well informed about regeneration, or felt that there were enough opportunities for them to have a say about processes of change.

Communities

This chapter considers residents' views about the communities in which they live. Communities in deprived areas are often thought of as being either 'strong in the face of adversity' or weak and symptomatic of a 'broken society'. Moreover, attempts at urban renewal in the past have been said to lead to the fragmentation of communities. The following aspects of communities are looked at in turn:

- **Sense of Community:** Do people feel a sense of belonging and inclusion with the community in which they live? Are people active within their communities?

- **Community Cohesion:** Do residents perceive that people get along with each other and trust each other within their local area?

- **Neighbourliness:** Do individuals know their neighbours and engage in reciprocal relations with their co-residents, such as visiting each other's homes and exchanging helpful behaviours.

- **Social Networks:** What level of social interaction do people have with family, friends and neighbours? Do people have forms of social support available to help them in times of stress or need?

- **Community Empowerment:** Do residents believe that along with their neighbours they can, as a community, have influence over key decisions and services in their area? Do they feel empowered enough to find solutions to their collective needs or problems?

Sense of Community

In both 2006 and 2008 respondents were asked whether they felt that they belonged to their neighbourhood. The responses will reflect people's views about their history (where they come from) and their future (where they are going to), as well as their sense of whether they 'fit' with the neighbourhood (the correspondence between their view of themselves and their view of their social and physical surroundings). Table 7.1 shows how the responses to this question changed over time.

Sense of belonging remained unchanged in Local Regeneration Areas (LRAs) and Wider Surrounding Areas (WSAs), strengthened in Housing Improvement Areas (HIAs) and Peripheral Estates (PEs), but declined significantly in Transformational Regeneration Areas (TRAs). This is a reflection of the regeneration process which may have impacted upon aggregate sense of belonging in two ways: a sizeable proportion of people with a local sense of belonging may have moved out of the areas in the clearance process; and sense of belonging may have been eroded for some of those who remain due to the unsettling effects of observing a process of change. In contrast, in HIAs there has been a large increase in the proportion of residents who feel a strong sense of belonging – it is higher here than compared to all other areas.

Table 7.1 Sense of belonging, 2006-08

	2006			2008		
	'A GREAT DEAL'	'A FAIR AMOUNT'	TOTAL	'A GREAT DEAL'	'A FAIR AMOUNT'	TOTAL
TRAs	14.7	55.8	70.5	19.9	37.3	57.2
LRAs	16.5	44.4	60.9	18.1	43.8	61.9
WSAs	36.4	54.2	90.6	38.6	50.8	89.4
HIAs	28.2	59.6	87.8	46.7	43.2	89.9
PEs	32.5	53.8	86.3	39.0	46.0	85.0

'To what extent do the following apply to you…I feel I belong to this neighbourhood'
[Statistical significance for changes over time by type of area: TRAs and HIAs $p<0.001$; PEs $p=0.001$; WSAs $p=0.345$; LRAs $p=0.354$]

In 2008 two other questions about people's sense of community were asked: whether they enjoyed living in the area and whether they felt part of the community. Table 7.2 compares the answers to all three questions. This shows that residential 'enjoyment' is not entirely dependent on feeling belonging or inclusion, since the rates of enjoyment exceed the other two feelings across all types of area. In non-regeneration areas, nine-out-of-ten people felt like they belonged, felt enjoyment and inclusion in where they live, the figures being slightly lower in PEs than in the other non-regeneration areas. Sense of community is markedly lower in the Regeneration Areas, on all three items, especially inclusion, where 32% fewer people in TRAs feel part of the community compared with nearby WSAs.

Table 7.2 Belonging, enjoyment and inclusion, 2008

	BELONGING	ENJOYMENT	INCLUSION
TRAs	57.2	70.3	52.2
LRAs	61.9	70.6	57.0
WSAs	89.4	92.7	84.5
HIAs	89.9	93.1	87.7
PEs	85.0	85.4	81.2

Table shows percentages who answered 'A great deal' or 'A fair amount' to each of the three statements: 'I enjoy living here'; 'I feel I belong to this neighbourhood'; and, 'I feel part of the community'.
[Statistical significance for differences between area types for each of the three statements: $p<0.001$]

The lower rates of sense of community within the Regeneration Areas might be expected given the large numbers of asylum seekers and refugees located in these areas. Figure 7.1 compares the responses of British citizens and non-British citizens across the six Regeneration Areas in the study, for 2008. It shows that the pattern of responses is the same for both groups, with enjoyment being highest, followed by belonging and lastly inclusion. Further, non-British citizens feel a sense of community far less than British citizens do, and the gap between the two groups is similar for each of the three items. However, looking just at the responses of British citizens in Regeneration Areas, even they feel these things far less than residents in other types of area (compare the values for British citizens in Figure 7.1 with the values for all respondents in WSAs, HIAs and PEs in Table 7.2).

Figure 7.1 Sense of community for British and non-British citizens in regeneration areas, 2008

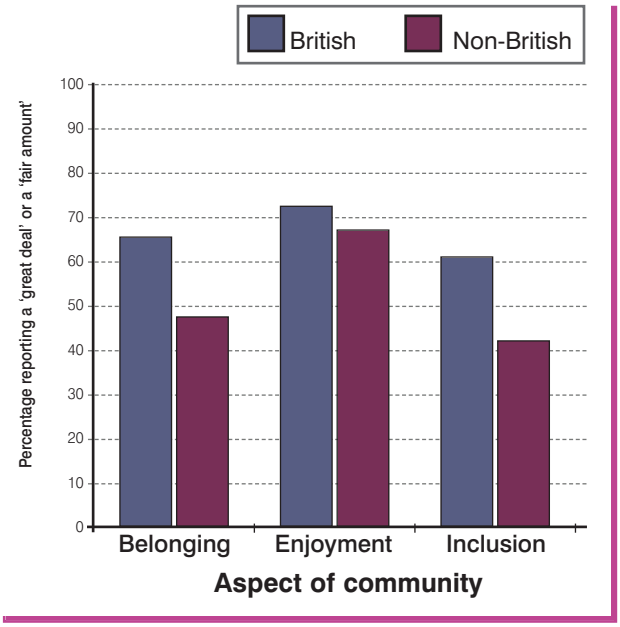


Figure shows percentages of respondents from across all six Regeneration Areas who answered 'A great deal' or 'A fair amount' to each of the three statements: *'I enjoy living here'; 'I feel I belong to this neighbourhood';* and, *'I feel part of the community'.*

All three variables were combined into a score that ranged from 0 to 9, and the results examined for different household types within each IAT – the results are shown in Table 7.3 expressed as an index from 0-100. This analysis explores how different types of household compare, within the same social context. In every type of area, it is older people who feel the strongest sense of community, and in nearly every case (apart from HIAs) it is respondents in family households who have the lowest sense of community. However, the gap between the two varies: not only are sense of community index scores lowest in the two Regeneration Area types for each household type, but the gap between how families feel and how other types of households feel (especially compared with older people, but the same point applies to the gap with adult households as well) is greatest in the TRAs and LRAs.

Table 7.3 Sense of community index by household type, 2008

	OLDER	ADULT	FAMILY
TRAs	71.4	57.1	52.2
LRAs	70.2	62.0	47.0
WSAs	82.4	74.9	73.8
HIAs	83.1	80.0	77.4
PEs	76.7	73.0	70.9

Raw scores range from 0 (answers 'not at all' to all 3 questions) to 9 (answers 'a great deal' to all 3 questions). Scores are then expressed as a proportion of the maximum possible score of 9, to derive an index that ranges from 0 to 100.
Table shows mean index scores for each household type within each IAT

People were also asked whether they had taken part in any groups, clubs or organisations over the past year, either for altruistic or leisure reasons. Although not strictly confined to the local area, this gives some indication of the extent of community involvement. While the numbers engaged in collective activities has risen in relative terms, they are still low: in 2006 the proportion of respondents involved in collective activities was typically 3% or 4% in each type of area, whereas in 2008 the reported rates were typically 8% or 9%, rising to 11% in PEs.

Community Cohesion

In this section respondents' views about community cohesion are explored. This concerns how much one can rely upon co-residents and how much regard you have for them, living in trust, harmony and mutual reliance rather than existing in conflict and without regard for others.

Social Harmony

Residents were asked whether they considered their neighbourhood to be a place where people from different backgrounds got on well together. As Figure 7.2 shows, the responses to this question were much more positive in 2008 than in 2006, most notably in the case of the Regeneration Areas and PEs. At the same time, in all the non-regeneration areas, fewer people in 2008 than in 2006 responded that their area contained people from 'all the same backgrounds', perhaps indicating a greater awareness of social diversity within areas. It may be that efforts at integrating migrant and other groups helps explain the improvement in people's sense of social harmony in the Regeneration Areas, but it is difficult to find a way of explaining the improvement in other areas.

Figure 7.2 Social harmony, 2006-08

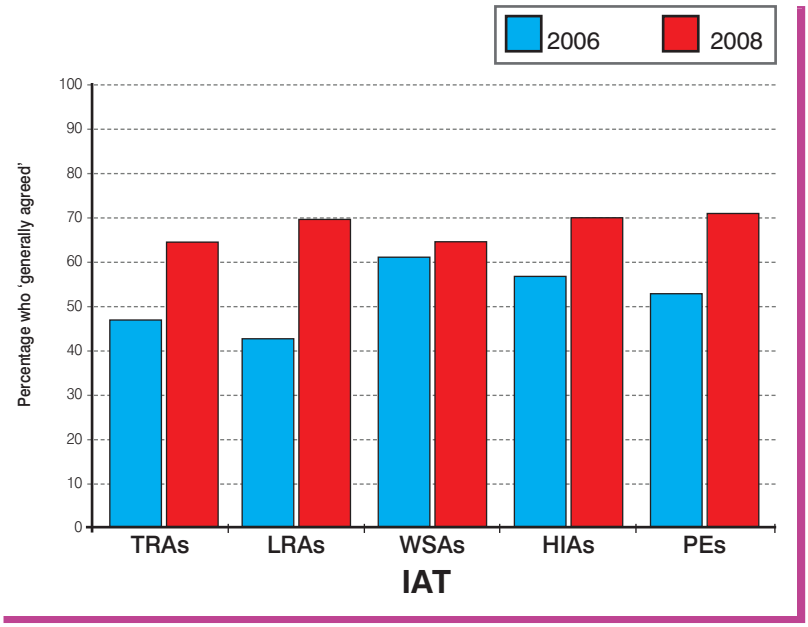


Figure shows percentage who responded 'Generally Agree' to the question *'To what extent do you agree that this neighbourhood is a place where people from different backgrounds get on well together?'*
[In the case of each IAT $p<0.001$ indicating a significant change between 2006 and 2008]

Informal Social Control

Trust in one's neighbours includes feeling that you can rely upon them to contribute to the maintenance of peace and harmony in the area. Residents were asked if they could expect someone in their area to intervene to stop youths harassing someone in the local area. Figure 7.3 shows that people's expectations of informal social control are lower in 2008 than in 2006 in all types of area apart from WSAs. In the Regeneration Areas the numbers of people with confidence in their neighbours in this regard has nearly halved.

Figure 7.3 Informal social control, 2006-08

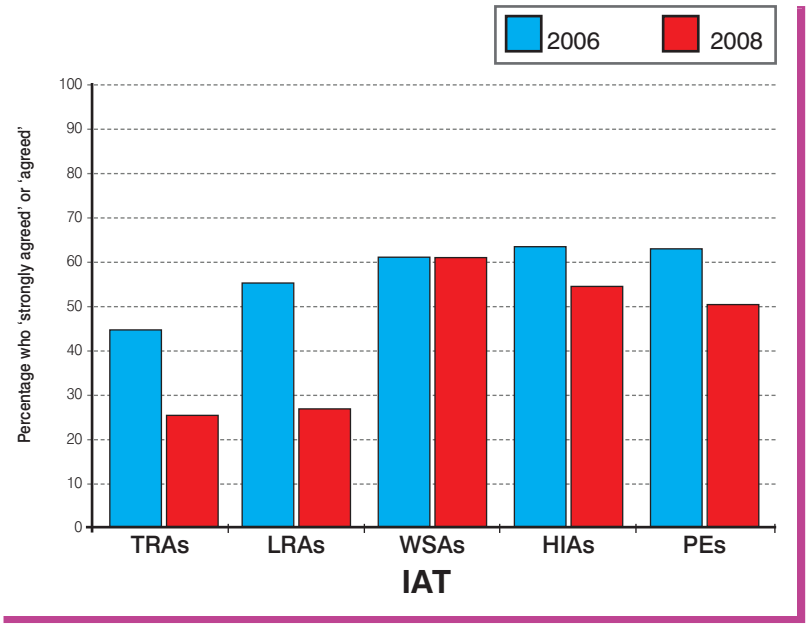


Figure shows percentage who responded 'Agree' or 'Strongly Agree' to the statement *'It is likely that someone would intervene if a group of youths were harassing someone in the local area'*
[In the case of each IAT $p<0.001$, except WSAs where $p=0.074$]

Trust in the Honesty of Co-Residents

Trust involves not only reliance, as discussed above, but also belief in the honesty of others. People were asked whether they thought a purse or wallet lost in the local area would be returned intact. The responses reflect people's perceptions of whether their co-residents are honest and whether they are concerned enough about others in the area to bother handing a lost item of value to the police or back to the owner. People's views about the honesty of others reflect their perception of whether the community matters to other people, since anyone for whom the area mattered would wish to be honest and have regard for the interests of others in the hope that they would be treated likewise, thus improving social circumstances for everyone.

Figure 7.4 shows that trust in the honesty of others is highest, and unchanged over time, in WSAs. Perceptions have improved slightly in HIAs, and stayed the same over time in PEs. In Regeneration Areas, however, perceptions of the honesty of others have declined, with a doubling over time in the numbers in both TRAs and LRAs who disagree that a lost purse would be returned intact. Very few people in Regeneration Areas in 2008 held the belief that a lost item of value would be returned within the local area.

Figure 7.4 Perceived honesty of local people, 2006-08

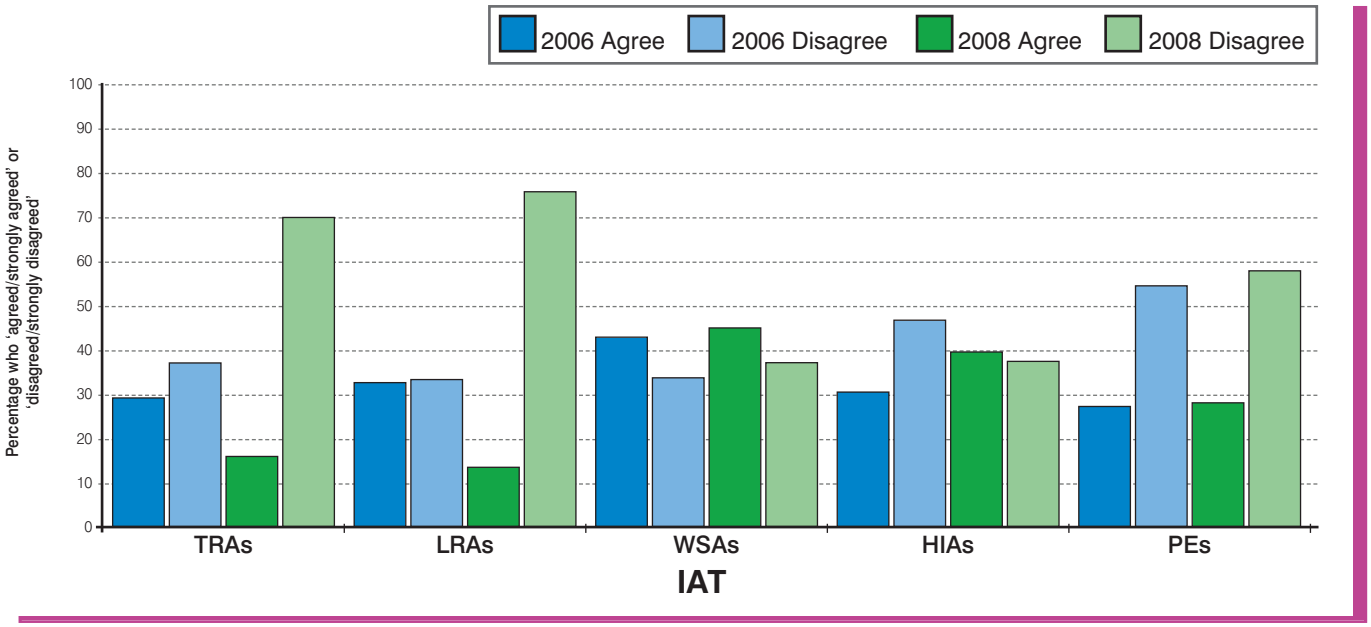


Figure shows percentage who disagreed (strongly or slightly) and agreed (strongly or slightly) that *'Someone who lost a purse or wallet around here would be likely to have it returned without anything missing'.*
[Statistical significance for change over time by area type: WSAs p=0.008; for all other IATs p<0.001]

Community Cohesion Index

The three questions about cohesion can be combined into an index, as shown in Table 7.4. Once again the mean scores are lower in the Regeneration Areas than elsewhere but the differences between types of places are not as great as for the sense of community index. The mean scores for cohesion in non-regeneration areas are lower than the equivalent scores for sense of community. With regard to community cohesion, older people in Regeneration Areas give similar ratings to other household types. Across all types of area, mean scores for families are very similar to those for adults and older people – there are few differences between household types.

Table 7.4 Community cohesion index by household type, 2008

	OLDER	ADULT	FAMILY
TRAs	57.8	57.9	57.3
LRAs	58.8	58.4	54.3
WSAs	66.5	65.5	66.3
HIAs	66.9	68.4	66.3
PEs	65.3	65.9	63.3

Combined score ranges from 0 to 12 (most positive answers to all 3 questions). Scores are then expressed as a proportion of the maximum possible score of 12, to derive an index that ranges from 0 to 100.
Table shows mean index scores for each household type within each IAT

Neighbourliness

In the 2008 survey a set of questions about relations with neighbours was introduced which covered issues of reciprocity, interactions and perceptions of neighbours. Table 7.5 gives a summary of the responses to the five questions.

The least common form of interaction is to borrow and exchange things with neighbours. For every item, the gap between Regeneration Areas and other types of area is large, with a 20-30% difference. In Regeneration Areas, very few people (a quarter or less) know many of their neighbours; in contrast, in PEs, most respondents said that they knew their neighbours.

Table 7.5 Neighbourliness, 2008

	TRAs	LRAs	WSAs	HIAs	PEs
Visit neighbours' homes	36.0	28.8	54.5	53.4	57.7
Exchange things with neighbours	16.8	16.4	45.4	38.0	37.2
Stop and talk in the neighbourhood	51.9	49.7	79.4	75.4	77.7
Neighbours look out for each other	42.4	49.7	80.8	81.5	78.3
Know many or most people in the neighbourhood	25.9	22.6	46.2	45.2	58.5

Table shows percentages answering 'a great deal' or 'a fair amount' to each of the first four questions, rather than responding 'not very much' or 'not at all'.
For the last question, percentage is those who responded 'most' or 'many' to the question rather than responding 'some', 'very few' or 'no-one'.

One might wonder why in non-regeneration areas, four-out-of-five people agree that their neighbours 'look out for each other' yet fewer than half this number agreed that people would act honestly with regard to a lost valuable item (see numbers agreeing in Figure 7.4). This is possibly because the term 'neighbours' is interpreted by respondents as referring to people who live very close to them, in the same close or street, whereas the question about honesty did not refer to neighbours, or indeed to anyone in particular, but rather asked for an opinion about the broader place where people live, termed 'around here'. Therefore, one conclusion is that trust in the goodwill of others does not extend very far beyond the most immediate neighbourhood within a locality of estate.

The five indicators of neighbourliness are combined into an index and examined by household type within each IAT in Table 7.6. Scores on the index are very low for all household types within the Regeneration Areas, but particularly for families and adult households. In contrast, in non-regeneration areas, families often do better than other types of household in terms of their experience of neighbourliness. Across all household types in all areas, the neighbourliness index values are modest, never rising above the mid-50s, indicating that knowing neighbours and interacting with neighbours is not very common or very frequent in the study areas.

Table 7.6 Neighbourliness index by household type, 2008

	OLDER	ADULT	FAMILY
TRAs	41.5	36.3	33.8
LRAs	40.1	35.4	28.9
WSAs	57.1	54.5	56.1
HIAs	55.5	53.3	56.3
PEs	53.5	53.0	58.6

Combined score ranges from 0 to 15 (most positive answers to all 5 questions). Scores are then expressed as a proportion of the maximum possible score of 15, to derive an index that ranges from 0 to 100.
Table shows mean index scores for each household type within each IAT

Social Networks

This section looks at the frequency of people's social contacts (not confined to contacts with local people or within local areas), and the availability of forms of social support – whether people have others near to them who they could ask for different forms of help if need be.

Social Contacts

In both 2006 and 2008, respondents were asked how often they had face to face contact with relatives, neighbours and friends. Table 7.7 shows that the proportion of people having at least weekly contact with each of these three groups has in many instances fallen slightly over time. Within this, however, the number of people who reported contact with others on 'most days' of the week, increased substantially.

In the case of both relatives and neighbours, the number of people reporting contact on 'most days' was 10-20% lower in each of the two Regeneration Area types compared with other areas, but such a gap did not exist in the case of regular contact with friends. In all types of area, the proportion of people reporting no contact with each of the types of people increased between 2006 and 2008. In Regeneration Areas by 2008 around 20% of people reported no contact with relatives, 10% reported no contact with friends, and nearly 15% reported no contact with neighbours. In the case of neighbours, 'contact' means 'speaking to neighbours'.

Table 7.7 Social contacts, 2006-08

		2006			2008		
		MOST DAYS	ONCE A WEEK OR MORE	NEVER	MOST DAYS	ONCE A WEEK OR MORE	NEVER
RELATIVES	TRAs	14.3	42.4	11.6	23.1	31.9	20.2
	LRAs	9.2	50.5	7.1	19.2	29.9	18.3
	WSAs	18.8	53.5	1.7	35.7	30.7	5.6
	HIAs	16.2	50.6	3.7	32.6	37.4	8.4
	PEs	24.3	46.9	2.6	37.8	35.0	9.0
FRIENDS	TRAs	25.2	45.7	4.2	34.9	40.2	8.9
	LRAs	22.2	45.4	4.1	26.4	37.0	10.7
	WSAs	25.7	48.5	1.2	31.1	34.9	9.1
	HIAs	22.3	55.1	1.6	30.1	44.3	7.4
	PEs	32.7	54.3	0.6	39.4	35.6	7.6
NEIGHBOURS	TRAs	18.9	48.0	5.2	33.1	38.6	12.7
	LRAs	24.3	49.4	5.5	23.8	32.6	15.1
	WSAs	35.3	47.1	2.1	43.6	27.2	6.0
	HIAs	26.5	55.3	3.2	41.2	38.2	4.0
	PEs	33.1	57.1	0.9	49.2	33.6	5.8

Percentages of respondents reporting different frequencies of 'meeting up with' relatives and friends and 'speaking to' neighbours. [$p<0.001$ for all area type comparisons over time]

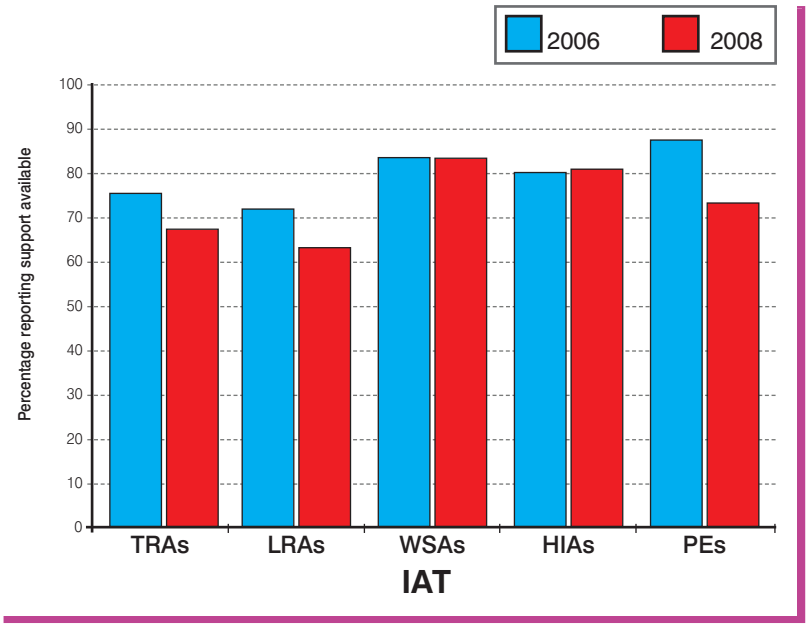
Social Support

People were asked whether they had people outside their home – relatives, friends or neighbours – who they could ask for different kinds of help. Figures 7.5 – 7.7 compare the responses to these questions over time. They show that social support has broadly stayed the same over time in WSAs and HIAs (apart from a drop in financial support in HIAs), but all three forms of social support have declined in the Regeneration Areas and in PEs, where the largest falls have taken place in respect of all forms of social support.

Across all areas, practical support is the most common, followed by emotional support and lastly financial support. In the case of each form of support, the majority of people in each type of area have some support available to them, the two exceptions to this being that only a minority of people in LRAs and in PEs reported having financial support available in 2008. There has been a very large decline in the availability of informal financial support to residents in PEs.

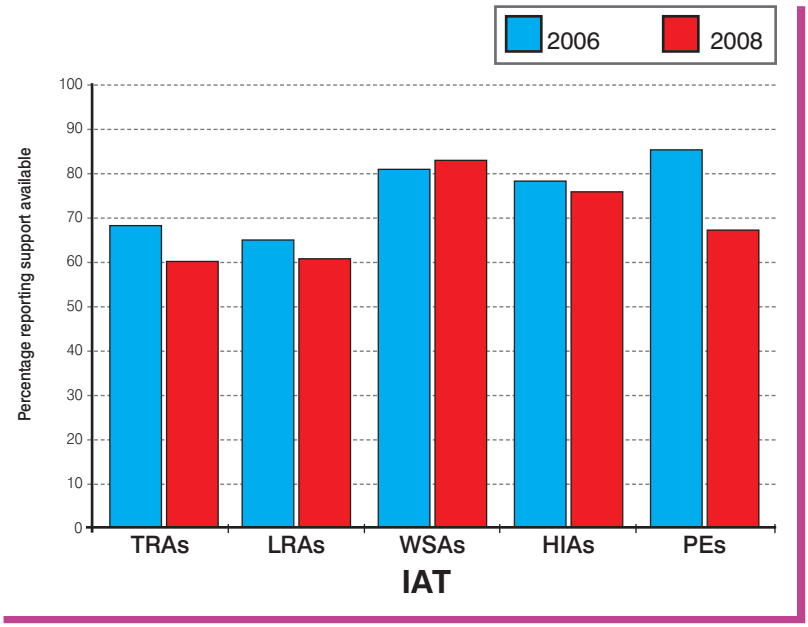
This decline in forms of social support is due more to an increase in the number of people who say they 'would not ask' for help rather than to more people saying they had no-one ('none') available to ask. In 2008, in all types of area around a fifth or more of respondents said they would not ask anyone to lend them money for a few days, reaching a third of people in PEs. In LRAs, a fifth of people also said they would not ask anyone for practical or emotional help either.

Figure 7.5 Practical support, 2006-08



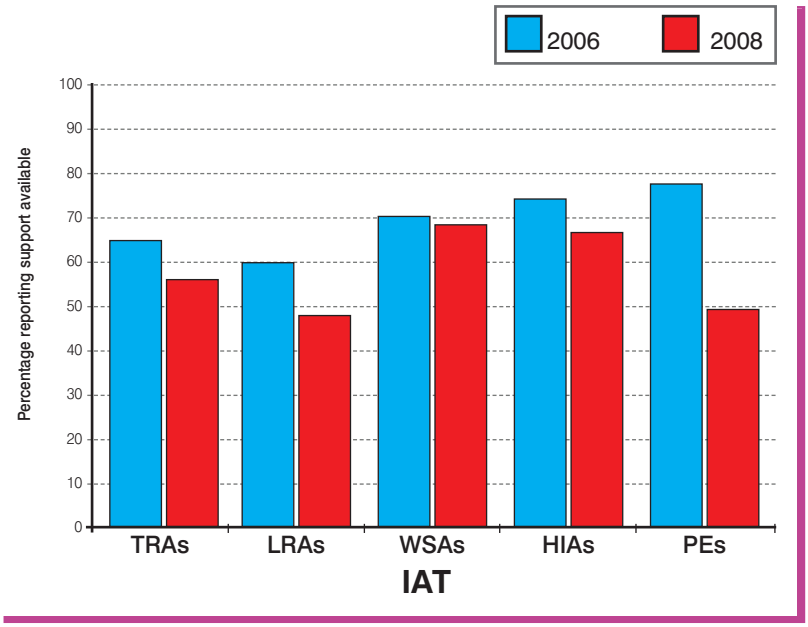
Percentage reporting they had one or more person outside their home they could ask *'To go to the shops for you if you are unwell'.*
[For all area type comparisons over time p<0.001]

Figure 7.6 Emotional support, 2006-08



Percentage reporting they had one or more person outside their home they could ask *'To give you advice and support in a crisis'*
[For all area type comparisons over time p<0.001]

Figure 7.7 Financial support, 2006-08

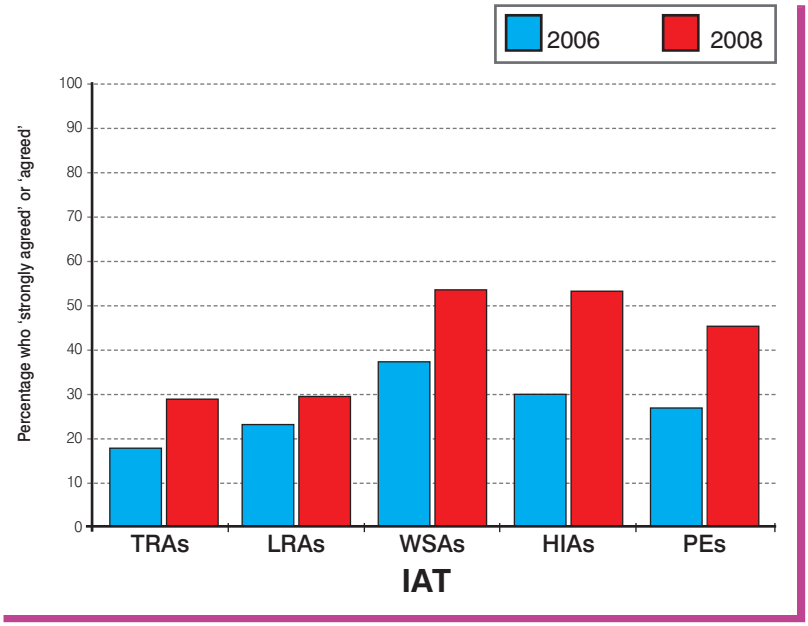


Percentage reporting they had one or more person outside their home they could ask *'To lend you money to see you through the next few days'*
[For all area type comparisons over time p<0.001]

Community Empowerment

Both in relation to regeneration and more generally, Scottish Government policy aims to enable more communities to feel empowered, and able to have a say in public services and other things that affect them. In the GoWell survey, respondents were asked if they felt that they could influence decisions affecting their local area, either individually or collectively. Figure 7.8 shows that people's perception of their influence upon local decisions has increased over time in all types of area. Having said that, within the Regeneration Areas, only a minority of people in 2008 felt they have influence over

Figure 7.8 Perceived influence over local decisions



Percentage answering 'strongly agree' or 'agree' to the statement: *'On your own, or with others, you can influence decisions affecting your local area'.*
[For all area-type comparisons over time p<0.001]

decisions affecting their area; this has to be of concern, since these are the areas undergoing the most significant changes.

In 2008 two additional questions were asked about community empowerment: one about whether the community could be proactive in solving problems and the other about the responsiveness of service providers. The findings for the three questions are similar and are shown in Table 7.8. In WSAs and HIAs, a majority of people feel empowered, but this is not the case in the other three area types. On all three indicators, Regeneration Areas lag some way behind other areas. Within Regeneration Areas, the most positive answers are given to the question about service provider responsiveness.

Table 7.8 Community empowerment, 2008

	INFLUENTIAL	PROACTIVE	RESPONSIVE
TRAs	29.0	27.0	31.0
LRAs	30.2	36.2	39.9
WSAs	54.0	59.7	54.6
HIAs	53.9	56.3	52.1
PEs	45.2	48.2	45.2

Percentages responding 'Agree' or 'Strongly Agree' to the following three questions:
'On your own or with others you can influence decisions affecting your local area'.
'People in this area are able to find ways to improve things around here when they want to'.
'The providers of local services, like the council and others, respond to the views of local people'.
[For area differences on all three indicators $p<0.001$]

The three questions can be combined into a Community Empowerment Index and the mean values on this index examined by household type within each type of area, as shown in Table 7.9.

Table 7.9 Community empowerment index by household type, 2008

	OLDER	ADULT	FAMILY
TRAs	52.5	44.9	45.9
LRAs	54.2	51.7	46.5
WSAs	61.5	62.5	60.7
HIAs	61.3	60.9	59.8
PEs	55.2	56.7	58.3

Combined score ranges from 0 to 12 (most positive answers to all 3 questions). Scores are then expressed as a proportion of the maximum possible score of 12, to derive an index that ranges from 0 to 100.
Table shows mean index scores for each household type within each IAT

The mean values on the index are around the middle of the scale or slightly higher, indicating that not many people chose the most positive response categories in answer to the questions on empowerment. Therefore, the community empowerment index values are lower than those for sense of community or community cohesion. The Table also shows that family households feel less empowered than people in other types of household in many areas, but particularly in Regeneration Areas (except for feeling more empowered than those in adult households in TRAs). However, in PEs, families feel more empowered than other types of household.

Is Community Empowerment Supported by Other Aspects of Community?

Providing an opportunity structure that enables communities to have a say in local matters is obviously the main way of seeking to develop a community's sense of empowerment. But communities also need to have the capacity to respond to those opportunities; this obviously relates to the knowledge and skills contained within a community but it is also about the institution of community. A community has to seem real to people if they are to believe in its ability or potential to exercise power.

To explore this issue the values of the three community indices - relating to belonging (sense of community), neighbourliness and cohesion have been related to the responses given to the question about community empowerment: whether the respondent feels that they, as an individual or collectively as a community, can influence decisions affecting their local area. As Figure 7.9 shows, for all three indices there was a positive relationship between each of these three domains of community and perceived empowerment. In each case, the range in mean values of the community indices across the response categories for community empowerment were more than one standard deviation on the relevant community index (the highest being a range of 1.24 standard deviations[x] in the case of belonging).

Similar positive associations were found between the three community indices and the responses to the other two community empowerment questions. The two largest variations in mean scores were found between belonging and proactive empowerment (a range of 1.47 standard deviations on the belonging variable) and between cohesion and responsiveness of service providers (a range of 1.35 standard deviations on the cohesion variable).

This analysis suggests that broader actions to foster and support a sense of community among residents may also contribute to their sense of empowerment in addition to anything that is done with regard to formal arrangements for service delivery or community consultation.

Figure 7.9 Community indices and perceived community influence

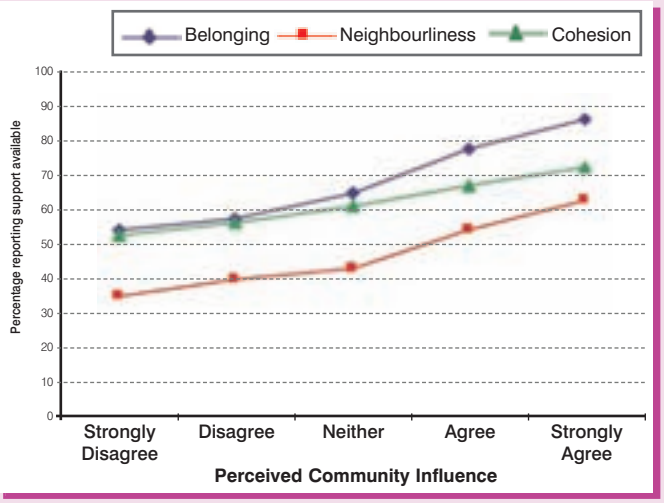


Figure shows mean values of the three community indices for each response category of perceived influence over decisions affecting the local area.
[For each of the three relationships examined here, $p<0.001$.]

x The standard deviation is a measure of the dispersion of values in a population or sample. In a normally distributed variable, one standard deviation from the mean would contain around one third of the cases. A factor which produced a change equivalent to one-third or one-half of a standard deviation on a dependent variable might be considered to be having an important effect.

Discussion

The analysis in this Chapter has highlighted some areas of possible achievement in terms of community development, and also areas where more may need to be done.

There have been two notable advances in the two year period examined here. The first is the reporting of more positive views about social harmony whereby a significant majority of people in all types of area report that people from different backgrounds are able to 'get on well together' in their area. Additionally, the biggest advances were made in the most diverse areas (TRAs and LRAs). This progress could reflect integration efforts in these locations and more general government messages about harmony in a more diverse Scotland. Having said that, social harmony co-exists with low levels of belonging felt by non-British citizens in Regeneration Areas, suggesting a passive rather than active sense of community between ethnic groups.

The other advance is an improvement in perceived community influence over decisions affecting local areas, which was evident in all types of area. Although this cannot be attributed to specific actions, two of the things that have been operational in many of the study areas over the past two years have been consultations relating to GHA investment and regeneration programmes, and communications pertaining to community planning; but there could be other developments of which we are unaware. Having said that, only in two types of area is there a slight majority who feel empowered in relation to local decisions, and at most half of the residents in any type of area feel that public service providers are responsive.

On the other hand, both the regeneration process itself and the continuing instability of Regeneration Areas may be negatively impacting upon communities. Sense of belonging and levels of trust in co-residents have declined in Regeneration Areas, where there is a real lack of sense that the social environment is one which maintains moral or behavioural norms. This is also evident in the very low levels of neighbourliness in the Regeneration Areas, more than in other places. The position of families within such areas deserves further attention since respondents in family households within Regeneration Areas often report lower levels of community (certainly belonging, neighbourliness and to a lesser extent empowerment) than respondents in older or adult households.

More generally, not confined to Regeneration Areas, there is a concern for the increasing numbers of people who display characteristics of social isolation, so that in many areas one-in-ten or more people report never having social contact with others, and between 20% and 40% of people either do not have access to social support from others or, increasingly, would not seek it. This is a concern in communities which are disadvantaged and fragile, and where it is expected for people to have a range of needs for help and contact from others in order to cope well with life's challenges.

Such issues of weak rather than strong communities are important not only in and of themselves, but also because they may have a bearing on community

empowerment, one of the overall aims of Government policies for communities. The findings indicate that perceived empowerment is related to people's sense of community on various dimensions. Therefore the challenge of boosting community empowerment requires not only specific actions and arrangements for community input to decision making, but also the development and support of community capacity more generally, for its own sake. The routes taken to engendering community empowerment need to be both generic (about communities themselves, their vitality, how they operate and feel on a day-to-day basis) and specific (about how communities are involved in decision-making and governance).

Key Points

- Sense of belonging has declined in TRAs, suspected largely as a result of the processes of clearance and demolition, but also complicated by the presence of asylum seekers and refugees. In contrast, sense of belonging appears to have strengthened in HIAs and PEs.

- People's sense of inclusion and feeling part of the community, is a lot lower in Regeneration Areas than elsewhere. This is only partly explained by the presence of asylum seekers and refugees, whose sense of community is lower than others; even British citizens in these areas have a relatively low sense of inclusion compared to other places.

- Respondents in all types of area have reported a higher sense of social harmony between people of different backgrounds than they did in 2006, particularly so in Regeneration Areas. Whether or not people have a sense of community, they are reporting more passive tolerance and civility between people than before.

- Trust in other people – both in terms of reliance on others to exercise social control, and the perceived honesty or regard for the interests of fellow residents of other people – has declined in Regeneration Areas. Few people in Regeneration Areas see their local social environment as one which maintains high behavioural or moral norms.

- Neighbourliness appears to be modest in scale across all types of area, perhaps reflecting broader social patterns where interaction with neighbours these days is not common or very frequent. Speaking to neighbours often does not seem to get converted into more intimate knowledge or exchanges, or to extend to feelings of trust and reliance in people within the wider locality.

- Compared to other people in Regeneration Areas, respondents in family households seem to have lower levels of belonging (sense of community) and of neighbourliness.

- In most areas there has been a slight fall in the number of people reporting at least weekly contact with family, friends and neighbours, but at the same time among those people having regular social contact, more seem to be doing so on 'most days' of the week. The corollary is that slightly more people report 'never' having social contact; in the case of Regeneration Areas, a significant minority of people, 10%-20%, report having no contact with relatives, friends or neighbours.

- The availability of different forms of social support has been fairly stable in WSAs and HIAs, but has fallen in other types of area. This is mostly due to an increase in people's reluctance of ask for help. The biggest drop in access to social support has occurred in the PEs.

- There have been improvements in all types of area in residents' perceived influence over decisions affecting their local areas. Despite this, in Regeneration Areas levels of community empowerment are low at around a third of residents feeling they have any influence. Overall, levels of perceived community empowerment (combining the reactive and the proactive dimensions of this term) are modest across all areas.

- Community empowerment appears to be underpinned by people's sense of community more broadly. The more people feel a sense of inclusion and belonging, have social connections with neighbours, and trust in the morality and norms of their co-residents, the more likely they are to also feel collectively empowered.

Physical Health and Health Behaviours

This Chapter summarises how self-reported physical health measures taken in the 2008 survey compare to those from 2006. The 2008 data provides the first opportunity to look at short term changes in self-reported health during two years of housing investment and neighbourhood regeneration. GoWell's findings on short term health outcomes are expected to be sensitive to both the positive and negative impacts of ongoing housing investment and regeneration processes, and less sensitive to changes resulting from more long term processes.

This chapter looks in turn at changes in the following aspects of physical health:

- **Self-Reported Health:** Overall assessments of current general health, and reports of recent (previous four weeks) and long term (lasting 12 or more months) health problems.
- **Use of GP Services:** How many times do people go to see their doctor in a year?
- **Health Behaviours:** Do people undertake healthy levels of physical activity, and/or do they engage in unhealthy behaviours like having a poor diet, smoking and drinking alcohol?

Self-Reported Health

Respondents reported on current general health, health problems they had experienced in the past four weeks, and also longer-term health problems they had suffered regularly over a period of 12 months or more. They also stated how many times they had seen their doctor in the past year.

Current General Health

Most respondents report that their current general health is excellent, very good or good: approximately 80% in 2006 and 75% in 2008. Hence there was a small overall reduction in self-reported good health over time.

The corollary of this is that in 2006 a fifth of respondents reported that their current general health was fair or poor (i.e. not good), compared to a quarter in 2008. These findings are close to the national figures from the Scottish Health Survey (2008), where 24% of men and 26% of women rated their health as fair, bad or very bad[49]. This is surprising, given the higher concentrations of deprivation in GoWell areas compared to Scotland as a whole, and the links between deprivation and poor general health.

There were differences between area types: particularly concerning female respondents, for whom the change in prevalence in reporting of 'not good' health ranged from just over 0% (women in Housing Improvement Areas (HIAs)) to a 6% 'increase' (women in Peripheral Estates (PEs)).

Health Problems

GoWell respondents at each survey wave were presented with two checklists of health problems and were asked to identify any problems that they had experienced. One listed recent health problems (experienced in the previous four weeks) and included:

(a) sleeplessness,
(b) palpitations/breathlessness,
(c) sinus trouble/catarrh,
(d) persistent cough,
(e) feeling faint/dizzy,
(f) pain in chest,
(g) difficulty walking,
(h) migraines/headaches, and
(i) other pain.

The other listed longer term health problems (problems lasting 12 months or more) and included:

(a) allergies/skin conditions,
(b) asthma/bronchitis/breathing problems,
(c) heart/blood/circulatory problems,
(d) stomach/kidney/digestion problems,
(e) migraine/ frequent headaches,
(f) psychological/emotional,
(g) other long term health.

Multiple Health Problems

Table 8.1 shows that householders in 2008 were less likely to report having a long term health condition compared to 2006. This is obviously an encouraging finding. However, Table 8.1 also shows that the mean number of long term conditions reported in 2008 is greater than that reported in 2006. This suggests that co-morbidity or multiple health problems is more common amongst those respondents who did have health problems in 2008, compared to the earlier survey.

Increased co-morbidity raises the possibility that the prevalence of specific health problems could increase even if more people report that that they do not have any health problems at all. In other words, a greater number of long term health problems could be experienced by a smaller proportion of the population. The proportion of householders reporting no recent health problems changed little between waves but again co-morbidity in relation to recent health conditions was higher in 2008 (especially for men).

Table 8.2 identifies those long term and recent health problems (as well as current general health) that changed significantly in prevalence between 2006 and 2008 ($p<0.05$). These significant results are presented by IAT and gender. The most obvious point to draw from the Table is that most ($n=38$) of the significant changes describe an increased prevalence of reported health problems in 2008 compared to 2006. In contrast there are only five findings that suggest significantly lower prevalence in 2008.

Table 8.1 Householders reporting no specific health problems or one or more health problems (mean average), 2006-08

	GENDER	2006	2008	DIFFERENCE BETWEEN WAVES
Householders reporting no long term health problems (%)	Male	62.90	70.20	+7.30
	Female	58.70	65.60	+6.90
Mean number of long term health conditions*	Male	1.43	1.63	+0.20
	Female	1.49	1.65	+0.16
Householders reporting no recent health problems (%)	Male	69.70	69.00	-0.70
	Female	63.60	63.20	-0.50
Mean number of recent health conditions*	Male	1.91	2.06	+0.15
	Female	1.97	1.99	+0.02

* Amongst householders who report at least one condition excluding 'other health condition.'

Table 8.2 Long term, recent and current health problems that changed significantly in prevalence between 2006 and 2008, by IAT and gender

IAT	2008 PREVALENCE HIGHER OR LOWER THAN 2006?	OUTCOME	Men		Women	
			% DIFFERENCE	p-VALUE	% DIFFERENCE	p-VALUE
TRAs	Higher	Psychological / emotional (long term)	5	0.001	6	0.001
		Other health problems (long term)	4	<0.001	4	0.001
		Allergies / skin condition (long term)	2	0.039	3	0.003
		Not good general health (current)	4	0.047		
		Other pain (recent)	2	0.001		
	Lower	Pain in chest (recent)			-3	0.037
LRAs	Higher	Psychological / emotional (long term)	10	<0.001	14	<0.001
		Other pain (recent)	3	0.007	6	<0.001
		Allergies / skin condition (long term)	3	0.003	4	0.013
		Migraines / headaches (long term)			6	0.001
		Migraine / headaches (recent)			5	0.012
		Persistent cough (recent)			4	0.011
		Sinus / catarrh (recent)			3	0.028
	Lower	Pain in chest (recent)			-4	0.015
WSAs	Higher	Other health problems (long term)	5	0.002	9	<0.001
		Other pain (recent)	5	<0.001	4	<0.001
		Migraines / headaches (long term)			5	0.007
		Migraine / headaches (recent)			5	0.009
		Psychological / emotional (long term)	3	0.026		
		Allergies / skin condition (long term)			3	0.031
	Lower	None				
HIAs	Higher	Other health problems (long term)	10	<0.001	7	<0.001
		Other pain (recent)	3	<0.001	5	<0.001
		Allergies / skin condition (long term)	5	<0.001		
		Sleeplessness (recent)	4	0.045		
		Persistent cough (recent)	4	0.001		
		Psychological / emotional (long term)	3	0.014		
		Sinus / catarrh (recent)	2	0.012		
	Lower	None				
PEs	Higher	Sleeplessness (recent)	7	0.002		
		Not good general health (current)			6	0.009
		Psychological / emotional (long term)			4	0.024
	Lower	Palpitations / breathlessness (recent)	-5	0.006	-4	0.026
		Faint / dizziness (recent)			-5	0.001

In the Appendices of this report a more detailed table and accompanying charts showing all the results from this analysis (i.e. not just the significant findings) are presented. This shows 100 examples of increased reporting of health problems in 2008, compared to 44 findings of lower prevalence (Appendices 3, 4 and 5).

Table 8.3 counts the significant differences identified in Table 8.2. It shows that at the level of IAT, the trend towards more significant increases over time can be observed for Transformational Regeneration Areas (TRAs), Local Regeneration Areas (LRAs), Wider Surrounding Areas (WSAs) and Housing Improvement Areas (HIAs). Only in the Peripheral Estates (PEs) did significant decreases in prevalence occur as frequently as significant increases. The reasons for this are not clear.

From this data it is not easy to make general conclusions about gender differences. Four of the five significant decreases in prevalence affected female populations, whereas the 38 increases were equally split between the sexes (although findings for men and women varied at the level of IAT).

The significant increases in prevalence in 2008 tended to cluster around the non-specific categories of health problems (e.g. 'other pains', 'other health problems' and 'general health'), allergies, breathing problems and categories that can sometimes be associated with stress such as psychological/emotional, sleeplessness and migraines/headaches. Is it plausible that regeneration may have contributed to any of this? One might hypothesise that home improvement work might sometimes release allergens or substances associated with breathing problems but there is no physical evidence to test this. It may also be speculated that some householders may have found disruptions associated with home improvement work, clearances and demolitions stressful. More detailed analysis of the cross-sectional data and data from other components of GoWell (e.g. longitudinal and qualitative) will help explore this.

Table 8.3 Summary count of significant changes in prevalence of long term, recent and current health problems between 2006 and 2008, by IAT and gender

	NUMBER OF SIGNIFICANT FINDINGS REPORTED IN TABLE 8.2					
	2008 PREVALENCE *HIGHER* THAN 2006			2008 PREVALENCE *LOWER* THAN 2006		
IAT	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
TRAs	5	3	8	0	1	1
LRAs	3	7	10	0	1	1
WSAs	3	5	8	0	0	0
HIAs	7	2	9	0	0	0
PEs	1	2	3	1	2	3
Total	19	19	38	1	4	5

One observation that can be made from Table 8.1 is that it does not present noticeably contrasting outcomes between the Regeneration Areas on the one hand and HIAs and WSAs on the other. This sets these health findings apart from many of the housing, neighbourhood and community findings reported in earlier chapters of this report – for which the general trend has been for results that suggest HIAs and WSAs have experienced more positive outcomes over time than the Regeneration Areas. The difference in residential outcomes is perhaps unsurprising given the relative popularity of the different area types and given that the clearances, demolitions and uncertainty that TRAs and LRAs experience in the early stages of transformation may be considered to be more radical and potentially more disruptive than the home improvement programmes taking place in HIAs and WSAs. At this stage, these different residential experiences do not seem to have occurred in parallel with substantially different experiences of recent and long term health problems. However, there is a need to better understand the potential for contextual effects to influence health outcomes (for example, the Regeneration Area populations are generally younger and more ethnically diverse compared to the WSAs and HIAs). In addition, there is a need to further explore possible reasons for the different health outcomes experienced by residents of the PEs.

One might claim that the decrease in chest pain experienced by women in both the LRAs and the TRAs provides an exception to the observation made in the preceding paragraph (because WSAs and HIAs experienced no significant decreases). However, caution is advised when interpreting this isolated example. By analysing a list of outcomes rather than a single primary outcome the likelihood of including findings that are significant simply by chance increases. So the overall trends are arguably more informative than individual findings, particularly where effect sizes are small and p-values are near to the 0.05 threshold. Most of the differences between waves are relatively small (the largest was 14% but most were <5%). The overall trend is that in 2008 reports of health problems have increased, compared to 2006, despite the fact that proportionally more people in the later survey said they had no specific health problems. Increased co-morbidity may explain this apparent paradox.

Use of GP Services

Health service use may reflect illness prevalence but also accessibility of services and the willingness of participants to seek medical help. Its use may therefore be viewed positively or negatively depending on contexts.

GP use across all GoWell areas did not differ markedly between 2006 and 2008. The proportion of respondents reporting zero GP consultations in 12 months remained at around 29% for males and 20% for females at each survey. The proportion of respondents attending a GP three or more times also differed little between survey Waves (men = 37% and 38%, women = 46% and 45%; in 2006 and 2008 respectively). Comparing IATs (Table 8.4) the most notable increase in GP use was among females in LRAs, perhaps reflecting the earlier finding (see Table 8.2) that in LRAs, significant increases in health problems among females outnumbered increases among men.

Table 8.4 Percentage of GoWell householders reporting no GP consultations or three or more GP consultations in 2006 and 2008

		ZERO GP CONSULTATIONS IN PREVIOUS 12 MONTHS (%)			3 OR MORE GP CONSULTATIONS IN PREVIOUS 12 MONTHS (%)			p-VALUE (TOTAL CHANGE IN FREQUENCY OF GP CONSULTATIONS)
IAT	GENDER	2006	2008	DIFFERENCE	2006	2008	DIFFERENCE	
TRAs	Male	32.0	33.2	1.2	39.5	36.5	-3.0	0.315
	Female	23.4	24.0	0.6	48.8	42.7	-6.1	0.007
LRAs	Male	33.8	27.6	-6.2	34.1	41.0	6.9	<0.001
	Female	28.3	15.4	-12.8	40.1	54.2	14.1	<0.001
WSAs	Male	25.5	24.2	-1.3	34.5	38.1	3.6	0.010
	Female	19.8	21.6	1.8	43.8	43.8	0.0	0.231
HIAs	Male	27.1	28.2	1.1	39.9	39.8	-0.1	0.284
	Female	17.1	22.3	5.1	53.5	40.4	-13.1	<0.001
PEs	Male	25.1	30.5	5.4	35.7	33.1	-2.6	0.237
	Female	15.7	17.6	1.9	42.3	43.8	1.5	0.347

Health Behaviours

Health behaviours may be important as mediators of the health impacts of regeneration as well as being important determinants of health in their own right. For example one might hope that improving the quality of local environments might encourage more people to get out and be more active; or that by improving self-esteem, efficacy and optimism in a community fewer people may resort to alcohol and drugs to 'self-medicate' or 'escape' their problems.

Harmful health behaviours often have a reputation for intractability, particularly amongst disadvantaged populations. They can also be difficult to measure reliably using self-reported measures. It was noted that some of the 2006 survey responses for self-reported health behaviours produced surprising findings – particularly in terms of better than expected levels of physical activity, diet, drug and alcohol use. In some cases survey questions were removed (i.e. drug use), the order of questions changed (i.e. alcohol), or the wording changed – usually to ask for more details (i.e. diet and physical activity) in the 2008 survey. The findings between the 2006 and 2008 surveys cannot be compared directly if they are based on responses to survey questions that have been altered.

Physical (In)Activity

The 2008 survey physical activity questions cannot be compared to the 2006 survey. Overall in 2008, one-in-four households reported that at no time in the previous seven days had they walked for more than ten minutes at a time. In two IATs the figure was closer to one-in-three (30% of respondents from HIAs and 31% from PEs). Nationally, the 2008 Scottish Health Survey[49] found that 20% of women and 17% of men (aged 16-74 years) had

not taken any form of physical activity for at least ten minutes at a time in the preceding four week period.

Eight-in-ten residents (81%) reported having done no vigorous physical activity such as heavy lifting, digging, aerobics, fast bicycling or fast swimming for more than ten minutes over the previous week. Two thirds (66%) of all respondents reported having done no moderate or vigorous physical activity for more than ten minutes (moderate activities include carrying light loads, sweeping, or bicycling or swimming at a regular pace). In comparison, the 2008 Scottish Household Survey[48] found that 73% of respondents had participated in at least one form of physical activity (including walking for at least 30 minutes) in the last four weeks. However, 37% of those in the most deprived quintile had not taken any physical activity at all in the same period.

A bivariate logistic regression analysis was conducted to explore reports of physical inactivity by different population subgroups based on GoWell's 2008 findings. How physical activity may be associated with area type, gender, age, tenure, citizen status, household structure, building type and employment structure was explored. A table summarising the analysis findings is provided in Appendix 6. A summary of these findings are presented below:

- While variation between IATs was relatively small, physical inactivity was most prevalent in the TRAs and HIAs and least prevalent in the WSAs.
- There was a small but statistically significant difference between men and women (female householders were slightly more likely to be inactive, as was also found in the Scottish Health Survey, 2008[49]).
- As would be expected, the likelihood of physical inactivity increased with age (also echoed by the Scottish Health Survey, 2008[49]).
- Renters were less likely to be active than home owners.
- People born in the UK were less likely to be physically active than asylum seekers, refugees and UK citizens born outside the UK.
- People who lived alone were more likely to be physically inactive (particularly, but not exclusively, if they were elderly). Householders with young families were less likely to report inactivity.
- Living in a house was associated with a smaller likelihood of reporting physical inactivity compared to living in the various types of flats (i.e. four-in-a-block flats, low rise flats and multi-storey flats).
- Unemployment and sickness were associated with physical inactivity (along with retirement). The Scottish Household Survey, 2008 also found that nearly two thirds (62%) of people who were physically active in the past four weeks reported good health, whereas only a third (36%) of those who had been inactive said their health was good[48].

Many of the differences referred to above were small. The larger differences were associated with householders being of retirement age, or working-age unemployed and long term sick.

A future GoWell publication will explore data on physical activity.

Eating Habits

Respondents in both surveys were asked to report the number of times their main meal came from a fast food outlet over the previous seven days – so the responses to this question represent the most consistent marker of change in population dietary habits between surveys. There was a small overall decrease in the proportion who ate one or more fast-food main meals in the past seven days (from 47% in 2006 to 43% in 2008). There were considerable variations by area type, ranging from a decrease of 10% in the TRAs (from 50% to 40%, $p<0.001$) to an increase of 7% in the WSAs (from 42% to 49%, $p=0.007$).

In 2008 participants were asked to report all the portions of fruit and vegetables they had consumed during the past 24 hours, in response to the following prompts:

- Item of fruit as a snack
- Fruit as part of a meal, either an item of fruit or a heaped tablespoon of fruit
- Bowl of vegetable soup
- Bowl of salad
- Portions of vegetables with a meal (include baked beans and pulses, but not potatoes); think of heaped tablespoons of vegetables.
- Vegetable-based meal
- Glass of fruit juice (unsweetened)

This list is not identical to that used in the Scottish Health Survey[49] therefore comparisons with national figures from that survey should be treated very cautiously. In 2008, 55% of GoWell respondents recalled eating at least five portions of fruit or vegetables in the last 24 hours, whereas the Scottish Health Survey 2008[49] reports a national figure of 20% for men and 24% for women.

8% of respondents reported having consumed none of these during the previous 24 hours (compared to a national figure of 10% for men and 7% for women[49]). The data on respondents who ate no fruit or vegetables have been explored using similar bivariate logistic analysis to that used with the physical inactivity data. Below is a summary of the findings (more details can be found in Appendix 7):

- Again (as with the data on physical activity), householders from the WSAs were the least likely to report eating no fruit or vegetables in the last 24 hours. Householders from the TRAs and LRAs were three to four times more likely not to have eaten fruit or vegetables.
- There was a small but statistically significant difference between men and women (male householders were slightly more likely to say they had eaten no fruit or vegetables).
- Participants of retirement age were more likely to have eaten at least one portion of fruit or vegetables compared to the other age groups although the differences were small.
- Renters were less likely to have eaten any fruit or vegetables than home owners.
- There was little difference comparing householders born in the UK, or outside the UK (including refugees and asylum seekers).
- In terms of household structure, people under retirement age who lived alone were the most likely to report eating no fruit or vegetables (people in family households - with children - were the second most likely). Pensioner households containing two

or more adults were least likely.
- Living in a MSF was associated with a greater likelihood of eating no fruit or vegetables, compared to living in other types of flats (particularly four-in-a-blocks) and houses.
- People who gave their employment status as 'looking after the home/family' (referred to in the table as 'homemakers') were the least likely to report eating no fruit and vegetables. Unemployed householders of working age were the most likely.

The findings on eating no fruit and vegetables identified greater variation between sub-groups than was seen for physical inactivity. Larger sub-group differences were associated with IAT, renting, living alone (<65 years old), living in a MSF and being unemployed.

Smoking

Self-reported smoking prevalence was less in 2008 than 2006 (40% and 44% respectively) which mirrors the trend found by the Scottish Health Survey, 2008. It was higher than the national figures reported by the Scottish Health Survey, 2008[49]; (in which 27% of men and 25% of women aged 16 and over reported that they currently smoked cigarettes), but more closely related to the figures given from that Survey for the most deprived Scottish Index of Multiple Deprivation (SIMD)[50] quintile (40% of men and 39% of women).

Around one-in-seven smokers in 2008 claimed that they had increased the amount they smoked over the last two years whereas one-in-four claimed to have reduced their smoking over the same period. These figures suggest an overall decrease in tobacco consumption amongst smokers over time, but nearly half of the smokers in 2008 stated they would never quit (44%). At a national level, the Scottish Health Survey, 2008[49] also found that there has been a small decrease in tobacco consumption by current smokers in recent years.

Bivariate logistic regression has been used to explore demographic factors that might be associated with being a current smoker using data from the 2008 survey (see Appendix 8). It found that:
- Respondents from the TRAs were the least likely to smoke. Respondents from the HIAs were most likely to smoke.
- There was a statistically significant difference between men and women (men were more likely to be current smokers).
- Older respondents (over 64 years old) were the least likely to be current smokers. Smoking was most prevalent amongst older working age adults (40-64 years old).
- Renters were more likely to smoke than home owners.
- Respondents born outside the UK (especially refugees and asylum seekers) were much less likely to smoke than those born in the UK.
- In terms of household structure, people under retirement age who lived alone were the most likely to smoke, followed by people under retirement age who lived with other adults but no children.
- Living in a low rise flat was associated with a greater likelihood of smoking.
- Respondents who were on sickness benefits were the most likely to smoke, followed by unemployed respondents.

Alcohol Consumption

With regards to drinking, 44% of respondents reported in 2008 that they never drink alcohol. A further 24% said they drank occasionally but not in the last seven days. The Scottish Health Survey, 2008[49], reported that 13% of women and 11% of men across Scotland did not drink at all. An additional 18% of women and 8% of men told the Scottish Health Survey that they had drunk less than one unit's worth of alcohol in the previous week. The GoWell figures are therefore much higher than the national estimate. This could be due to sampling bias or participants' unwillingness to admit to stigmatised or unhealthy behaviours, but if so, this begs the question - why would people under-report alcohol consumption but not smoking? The 2008 Scottish Health Survey[49] also reported that in the most deprived (SIMD) quintile, 55% of women and 39% of men did not drink in the previous week. In other words, abstinence (at least over the course of a week) may be more prevalent in Scotland's deprived areas – and so the relatively large proportion of GoWell abstainers may reflect this wider trend.

Which kinds of people reported recent alcohol consumption and which did not is explored in more detail using bivariate logistic regression (see Appendix 9). The demographic profile of GoWell participants appears to contribute to the high levels of reported abstinence – with nationality being a particularly important factor. Focusing on which kinds of participants are more likely to claim to be teetotal, it was found that:

- Respondents from the WSAs are the least likely to be teetotal. Abstention was most prevalent in the TRAs and LRAs.
- There was a statistically significant difference between men and women (female respondents were more likely to say they never drank alcohol).
- Older working-age respondents (40-64 years old) were the least likely to abstain. Retirement age respondents and respondents aged between 25-39 years were more likely.
- Renters were more likely to abstain than home owners.
- Respondents born outside the UK (especially refugees and asylum seekers) were much more likely to report being teetotal than those born in the UK.
- In terms of household structure, people under retirement age who lived alone were the least likely to report being teetotal, while people living with children were the most likely.
- Living in a MSF was associated with a greater likelihood of reporting abstention from alcohol.
- Employed respondents were the least likely to say they abstained from alcohol. Homemakers and people in education/training were the most likely (in the sample, less than two-in-five participants who said they were in education/training were born within the UK).

The largest differences were associated with being born outside the UK. Refugees and asylum seekers were especially likely to never drink compared to those born inside the UK. Living in TRAs and LRAs (areas that include many residents born outside the UK) and living in a family household were also associated with not drinking alcohol.

How much did people say they drank?

In 2008, participants were asked to recollect their alcohol consumption over the previous seven days, and this was then converted to units. Those who reported no consumption were asked if they drank at all.

- 32% (n=1,483) said they drank in the previous seven days
- 24% (n=1,127) said they drank occasionally but not in the last seven days
- 44% (n=2,029) said they never drank.

Compared to national averages from 2008[49], the mean weekly alcohol consumption reported here is very low: nine units for men and two for women. This compares to a national average of 18 units for men and nine for women, and SIMD most deprived quintile averages of 21 units for men and eight for women. Much (but not all) of this difference can be ascribed to the relatively high proportion of abstainers in the GoWell sample.

To identify where drinking may be a problem, which kind of GoWell respondents said they consumed alcohol, and who drank the most can be examined. Figure 8.1 summaries data on the demographic characteristics associated with mean alcohol consumption amongst survey participants, who reported drinking during the previous seven days. The data suggest that:

- **Overall:** Most drinkers (73% of men and 86% of women) reported alcohol consumption that was within the Government's recommended weekly maximum of 21 units for men and 14 units for women. In comparison, the 2008 Scottish Health Survey[49] reported that 63% of men and 71% of women who consumed at least one unit in the previous week kept within the recommendations (total Scottish Health Survey national figures for non-drinkers and drinkers keeping within the weekly maximum =70% of males and 80% of females).
- **Area Type:** Drinkers from TRAs and LRAs consumed the most alcohol (mean = 19 units per week in each IAT).
- **Gender:** Male drinkers reported consuming more than twice as many units as women during the previous week (males = 20 units, females = 9 units). Corresponding national figures from the 2008 Scottish Health Survey (including only those who drunk at least one unit in the previous week) = 21 units for men and 12 for women[49].
- **Age Band:** Alcohol consumption peaked at the middle age band (40-54 years = 18 units) and fell most sharply at the oldest (>64 years = 10 units).
- **Household**: Working age adults without children living at home tended to drink more (17 units) compared to other types of householder (12-13 units).
- **Tenure:** Unit alcohol consumption was higher amongst renters compared to owner occupiers (renters = 16 units, owner occupiers = 13 units).
- **Employment status:** Householders in full-time education or training, and householders who described themselves as looking after the

home/family reported the most moderate drinking – relative to participants from other employment status categories. The highest mean alcohol consumption was reported by householders who were on sickness benefits (20 units) or unemployed (23 units). Employed householders occupied a mid-range position (13-15 units).

- **Citizenship/Nationality:** High rates of teetotalism amongst respondents born outside the UK meant that virtually all the householders who said they drank in the past week where British citizens born in the UK (n = 1,339). The small number of foreign born residents who did drink (n= 57), reported similar unit consumption to the UK born respondents (13-16 units).
- **House type:** Alcohol consumption was higher amongst householders living in MSFs (19 units) compared to other types of housing (12-14 units).

Analysis of variance = $p<0.001$ for each of these sets of findings except for tenure ($p=0.009$) and citizenship ($p=0.759$). Therefore alcohol consumption varied significantly within each of the demographic characteristics reported except for citizenship.

Conclusions

GoWell's drinkers report consuming on average three units of alcohol per week less than the corresponding national estimates of weekly unit consumption amongst those who drank. Individual characteristics of GoWell respondents which were linked with greater alcohol consumption included being male, middle-aged and unemployed/long term sick.

Drinkers tended to report consuming more alcohol if they lived in Regeneration Areas, MSFs and social rented homes. Householders reporting abstinence from alcohol also tended to have these residential characteristics, which may in part be explained by the location of teetotal asylum seekers and refugees.

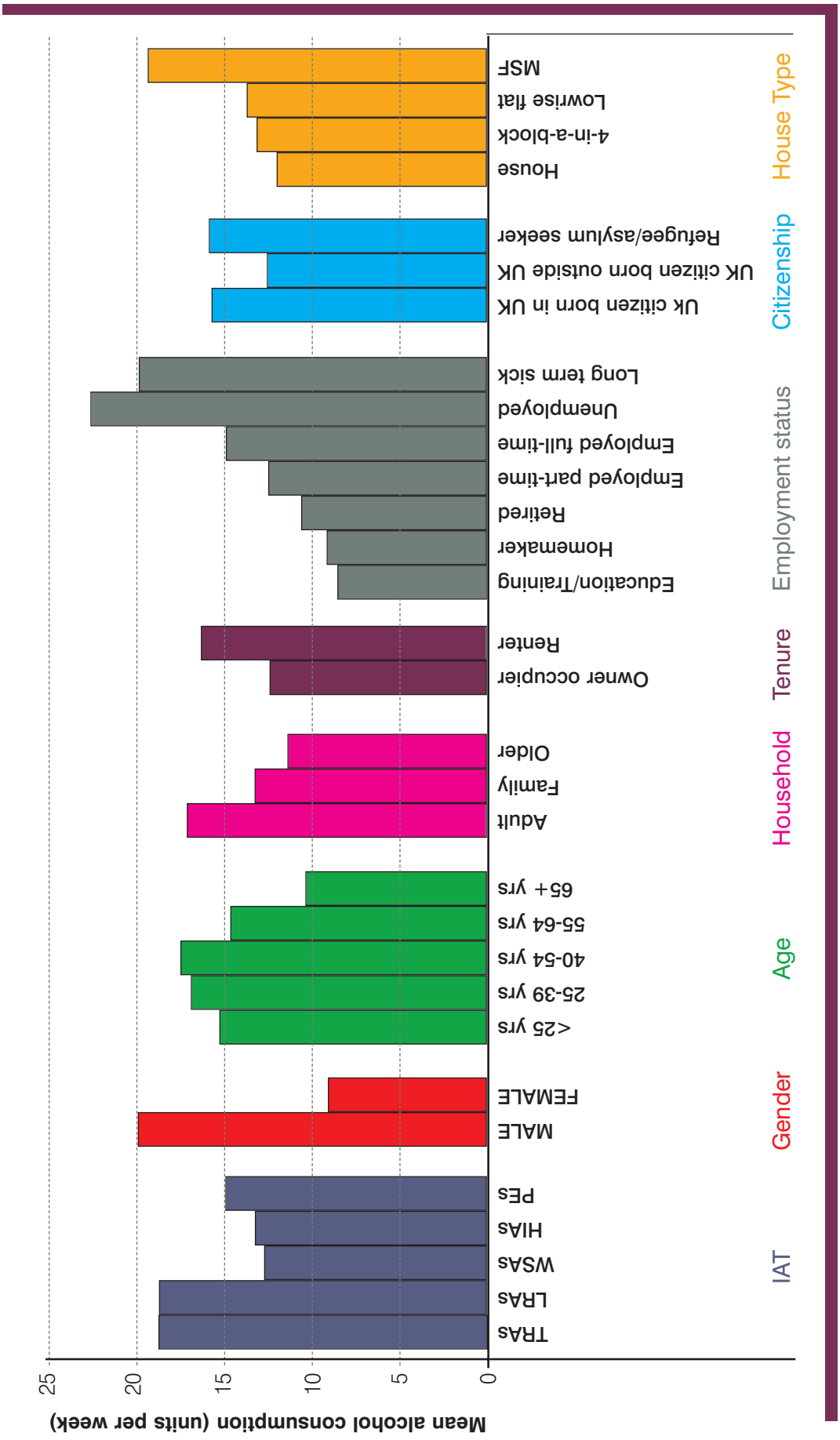


Figure 8.1 Self-reported alcohol consumption, 2008 (mean number of units of alcohol per week)

Discussion

Two years is not a long time over which to examine health changes. Some population health indicators may be sensitive to short term changes. However, many others may take years or even generations for their full effects to be realised. This time lag makes it difficult to attribute causes to effects, particularly as Glasgow's population will doubtless experience a whole range of macro and micro level interventions and changes besides those that fall within the remit of GoWell's study.

The scale and duration of Glasgow's housing investment and regeneration programme also complicates the interpretation of short term health outcomes. Many participants of the 2008 survey were at that time caught up in the process of change, rather than enjoying the benefits of a completed programme of home or neighbourhood improvement. For some, the process of change could mean uncertainty and concern about how future regeneration plans might affect them, especially building clearances and rehousing moves.

Therefore, a longer time span may be required to identify some of the physical health impacts (should they occur) and to explore whether population health trends become more strongly associated with different area types. Nonetheless, the data suggests some changes in the prevalence of health problems between 2006 and 2008.

No obvious explanation for why regeneration might lead to an increase in co-morbidity as found here presents itself.

Of note is that the health outcomes that provided the five significant decreases in ill health prevalence (faintness/dizziness, pains in the chest and palpitations / breathlessness) can all be symptoms of heart-related ill health. It was also found that long term heart, blood and circulatory problems were less prevalent amongst male and female householders in most of the area types at the 2008 survey than at the 2006 survey – although not significantly so. This data could be explored to see if there are any possible explanations for improvements in heart health between 2006 and 2008.

Earlier chapters have reported examples of how the experience of regeneration has differed across IATs – for example some IATs have experienced large scale clearances and demolitions while others have been dominated by housing improvement investment. Considering these different experiences, one might ask whether it would be expected that some health outcomes could worsen in some area types but improve in others. In fact, no examples of a recent or long-term health problem increasing significantly in prevalence in one IAT, while decreasing significantly in another was found. This may suggest that the different interventions taking place in each area type have not led to radically different short term impacts on the health of householders. However, some health behaviour and health service use measures did fluctuate markedly between area types. It will be interesting to see if greater differences between area types are identifiable in subsequent survey waves.

Key points

- Some GoWell health measures are more plausibly sensitive to short term changes than others: for example the psychological / mental health outcomes may be more sensitive than many of the physical health measures.

- At this stage there is little consistent evidence of physical health improvement occurring in GoWell areas over time. Most of the comparisons of illness prevalence between the two surveys have found no significant differences, and most of the differences that are statistically significant are still relatively small (≤ 5%). Reporting of co-morbidity has increased but so has reporting of no recent or long term health conditions.

- Future survey waves will help explore whether more substantial changes in physical health take longer to manifest themselves in the areas, or if they simply do not occur (within the ten year time span of this study).

- Several measures linked to heart-related problems provide some small but statistically significant findings of reduced prevalence over time: this should be explored further.

- Although some specific outcomes varied by area type, the analysis did not identify health impacts that were clearly distinctive to different interventions and area types. This is despite the fact that some of the areas have been changing in very different ways (i.e. some areas experienced large scale clearances and demolition while others experienced housing improvement).

- Overall the findings on health behaviours support the view that unhealthy behaviours are particularly prevalent in deprived areas. However, some of GoWells most disadvantaged areas contain substantial numbers of people born outside the UK – who tend to report healthier behaviours than residents born in the UK.

- High levels of self-reported teetotalism are a notable exception to the above point. Relatively high teetotalism may be a characteristic of populations living in Scotland's deprived areas, particularly when those populations include substantial numbers of residents born outside the UK.

- There was some evidence of small improvements in health behaviours although harmful behaviours may have been under-reported at both waves.

- Some harmful behaviours such as smoking and low physical activity appear to be entrenched for large sections of these populations.

Mental Health and Wellbeing

This Chapter examines mental health and wellbeing among the study populations, looking at how aspects of residents' mental health have changed across the Intervention Area Types (IATs). The chapter covers the following issues:

- **Mental Health and Quality of Life**: Using the SF-12[45] survey instrument, a look at the impact of mental health upon people's quality of life, in terms of doing their job, how they feel, and how they relate to other people.

- **Positive Mental Health and Wellbeing**: For 2008, a new scale the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[44] was introduced to look at positive aspects of mental health, such as confidence, optimism and coping.

- **Demographic Influences on Mental Health**: How the SF-12[45] and WEMWBS[44] measures vary with age and between men and women.

- **Mental Health Problems**: The experience of persistent or regular psychological problems over a period of a year or more.

- **Use of Primary Health Care Services for Mental Health Reasons**: Speaking to your doctor about emotional or psychological problems is another indicator of wellbeing as well as being a direct indicator of the impact of mental health upon health services.

Mental Health and Quality of Life

In both the 2006 and 2008 surveys mental health was examined through questions from the SF-12[45] Health Survey, which address both the hedonic (subjective happiness) and eudaimonic (effective psychological functioning and self-realisation) aspects of wellbeing.

The SF-12 questions require the respondent to estimate *how much time in the previous four weeks* they have experienced certain things or felt a certain way. Responses involved selecting the most applicable of five possible answers: All of the time / Most of the time / Some of the time / A little of the time / None of the time. Four of the six questions are measures of negative mental health states, although the responses to all six questions are subsequently ordered appropriately so that a higher score represents better (or less poor) mental health. The six questions are grouped into four mental health sub-scales as shown in Table 9.1. Each of these scales is then converted to a value between 0 and 100.

Table 9.1 Construction of the SF-12 Mental Health sub-scales

SUB-SCALE	During the past four weeks, how much of the time have you…?
Role Emotional	1) Accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious? 2) Done work or other regular daily activities less carefully than usual as a result of any emotional problems, such as feeling depressed or anxious?
Mental Health	1) Felt calm and peaceful? 2) Felt downhearted and depressed?
Vitality	1) Had a lot of energy?
Social Functioning	1) Has your physical health or emotional problems interfered with your social activities, like visiting friends and relatives?

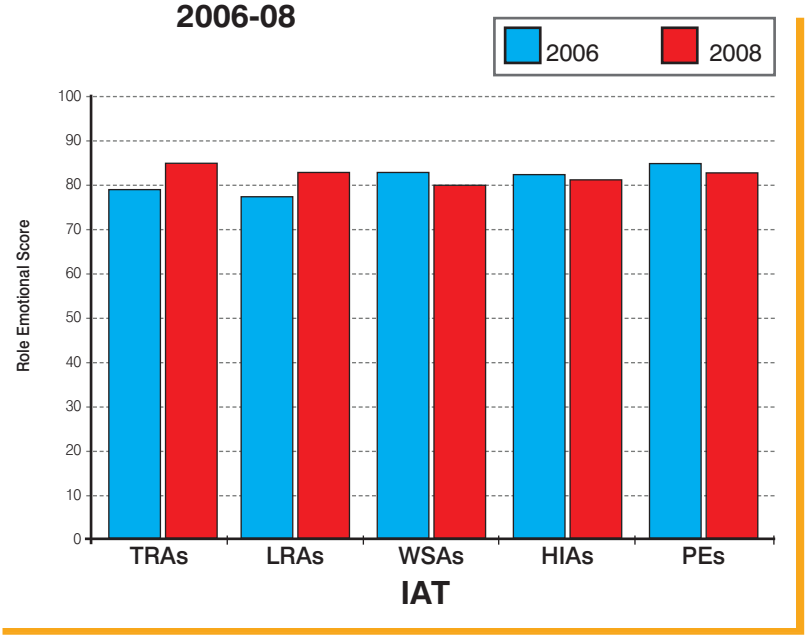
Role Emotional

The Role Emotional scale indicates how well people cope with their daily tasks and activities in the face of possible mental health problems (a eudaimonic aspect of mental health).

In 2008, the scores were generally high (around 83 out of a possible 100, overall), indicating good mental health in this respect (Figure 9.1). The scores ranged from the highest value of 85 in the Transformational Regeneration Areas (TRAs), through the Peripheral Estates (PEs), Local Regeneration Areas (LRAs) and Housing Improvement Areas (HIAs), to the lowest value of 80 in the Wider Surrounding Areas (WSAs). The difference between the TRAs and WSAs was statistically significant ($p=0.021$).

The change in scores between 2006 and 2008 reveals two striking trends. First, there was a significant increase of approximately 5.5 units on average among residents of TRAs and LRAs ($p<0.001$). Conversely, in the other three IATs, there was a small (<2.8 units), though not significant, decrease ($p=0.072$) in this measure. Consequently, in 2008, the Role Emotional scores for the TRAs and LRAs appear to have overtaken those of the WSAs and HIAs.

Figure 9.1 Mean Role Emotional score by IAT, 2006-08



Score based on responses to two questions: *"During the past four weeks, how much of the time have you…"* (1) *"accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?"* and (2) *"done work or other regular daily activities less carefully than usual as a result of any emotional problems, such as feeling depressed or anxious?"*
[Change over time: TRAs and LRAs, $p<0.001$; All other Area Types, $p=0.072$]

Mental Health

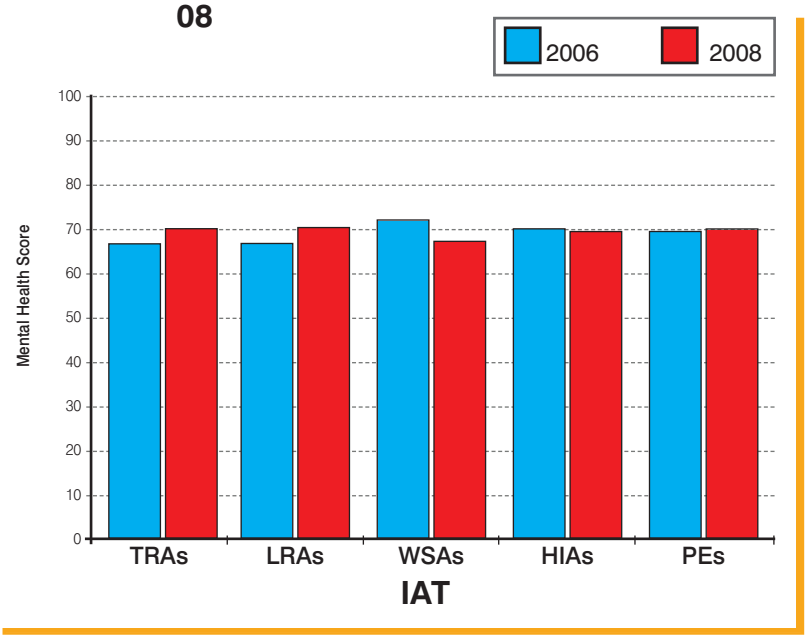
The Mental Health scale measures respondents' perceptions of their own recent state of mind.

Scores were generally quite high (69, overall), indicating fairly good health with respect to this component (Figure 9.2), although the values were consistently lower than for the Role Emotional scale. The highest score was in the LRAs (around 71), with all other IATs scoring almost as highly, except for the WSAs, which, as in the case of the Role Emotional scale, was significantly lower with its score of 67 (p=0.13).

The pattern is also similar to that for the Role Emotional scale with respect to the change in the Mental Health score over time for the separate IATs. The average measure for the TRAs and LRAs increased significantly by about 3.5 units from 2006 to 2008 (p<0.001), whereas in the WSAs it fell significantly by almost 5 units to 67 (p<0.001) and it remained largely unchanged in the HIAs and PEs.

As a result of these relative shifts in the mean measurements over time, in 2008, the Mental Health scores for the TRAs and LRAs had slightly overtaken those of the other three IATs.

Figure 9.2 Mean Mental Health score by IAT, 2006-08



Score based on responses to two questions: *"During the past four weeks, how much of the time have you…"* (1) *felt calm and peaceful?"* and (2) *"felt downhearted and depressed?"*
[Change over time: TRAs, LRAs and WSAs, p<0.001; HIAs and PEs, p>0.500]

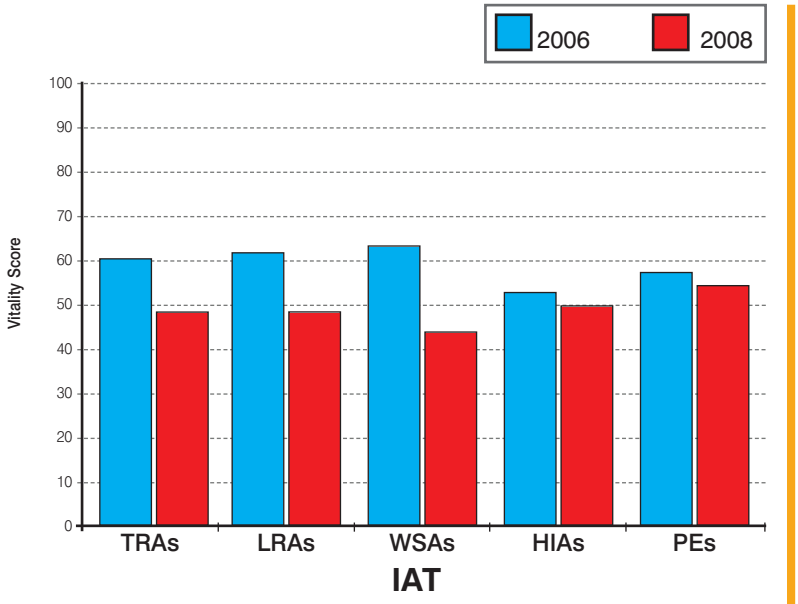
Vitality

Vitality can be considered as another hedonic component of mental wellbeing. People who are in good mental health will feel more energised than people in poor mental health.

Average values for vitality were quite low in 2008, indicating relatively poor health with respect to this component (Figure 9.3). Only the PEs reached the upper half of the scale, at 54 units, followed by the HIAs, LRAs, TRAs and WSAs (where the average score was only 44). These were the lowest values of all the four mental health scales in the SF-12 questionnaire. The differences between the IATs are significant in 2008 ($p<0.001$), with the PEs, LRAs and WSAs being distinct from one another.

The pattern of change in vitality is very different from the other three mental health scales of the SF-12[45] Health Survey. All IATs exhibited significant deteriorations in average vitality between 2006 and 2008 ($p<0.001$). The decreases were amongst the largest seen of all the four component mental health measures. In the case of the WSAs there was a drop of almost 20 units. LRAs and TRAs had falls of 14 and 12 units, respectively, while even in the HIAs and PEs there was a decrease of around three units.

Figure 9.3 Mean Vitality score by IAT, 2006-08



Score based on question *"During the past four weeks, how much of the time have you had a lot of energy?"*
[Change over time: All area Types, $p<0.001$]

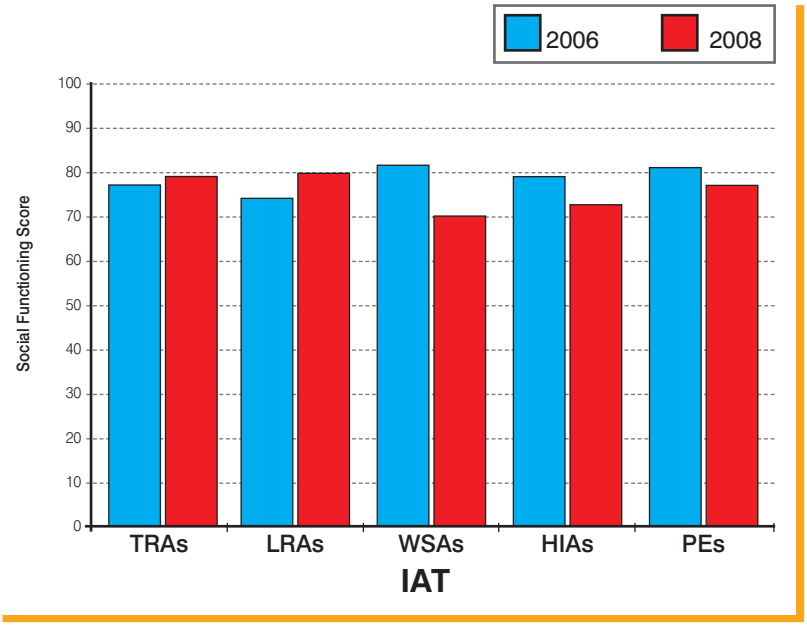
Social Functioning

The final SF-12[45] scale pertaining to mental health indicates the extent to which people's habitual social activity is affected by their physical or emotional health. While there may be a connection between the two, it should be remembered that the changes measured by this scale may be partly attributable to the state of people's physical rather than, or as well as, mental health.

Average values were high in 2008, between 71 (WSAs) and around 80 (TRAs and LRAs), indicating good health with respect to this component (Figure 9.4). Scores in the TRAs and LRAs were significantly higher than the other three IATs ($p<0.001$). These values lie between those of the Role Emotional and Mental Health scales.

The pattern of change over time is similar to that seen in the Role Emotional and Mental Health measures. The TRAs and LRAs showed an increase in the average score (2.3 and 5.5 units, respectively; significant only for LRAs ($p<0.001$)), while the other IATs experienced substantial drops in their scores ($p<0.001$ in all cases). Once again, the greatest decline was seen in the WSAs. As a result of these relative changes in the mean scores over time, the Social Functioning scores for the TRAs and LRAs were higher than those of the other three IATs in 2008.

Figure 9.4 Mean Social Functioning score by IAT, 2006-08



Score based on question *"During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities, like visiting friends and relatives?"*
[Change over time: LRAs, WSAs, HIAs and PEs, $p<0.00$; TRAs, $p=0.063$]

Positive Mental Health and Wellbeing

There is increasing interest in positive mental health, that is, in how a positive psychological perspective can contribute to wellbeing, not merely the absence of negative mental health (or mental illness).

In 2008, new questions on positive mental health: the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[44] were included in the survey. This new scale is derived from ordered responses to a set of 14 positively phrased statements about hedonic (subjective happiness) and eudaimonic (effective psychological functioning) aspects of mental health. Its construction is given in Table 9.2.

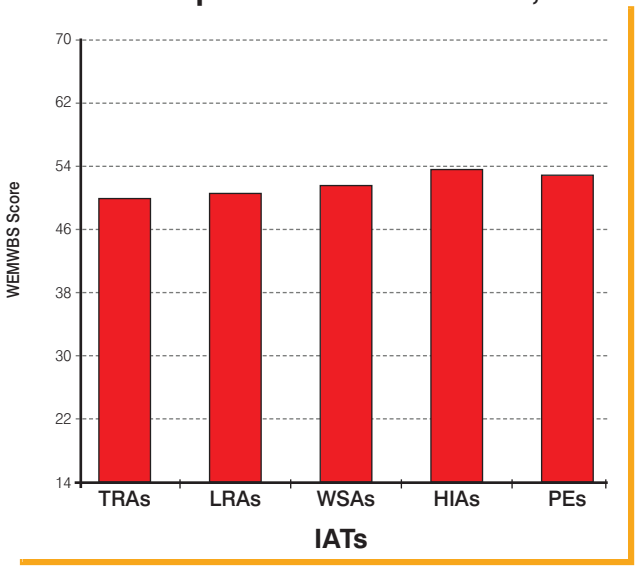
Table 9.2 WEMWBS positive mental health scale

ASPECT	Item (Over the past two weeks…)
Optimism	1) I've been feeling optimistic about the future
Utility	2) I've been feeling useful
Relaxation	3) I've been feeling relaxed
Interest in others	4) I've been feeling interested in other people
Vitality	5) I've had energy to spare
Coping	6) I've been dealing with problems well
Clarity	7) I've been thinking clearly
Self Esteem	8) I've been feeling good about myself
Closeness	9) I've been feeling close to other people
Confidence	10) I've been feeling confident
Decision-making	11) I've been able to make up my own mind about things
Love	12) I've been feeling loved
Interest in things	13) I've been interested in new things
Cheer	14) I've been feeling cheerful

Responses are on a 5-point scale, from "none of the time" (1) to "all of the time" (5), which are summed to give an aggregate score between 14 and 70.

Looking at how the WEMWBS scale varies among the IATs in 2008 (Figure 9.5); it was found that all IATs have mean scores in the middle-upper part of the scale, indicating reasonably good positive mental health in the overall population. The mean scores all fall within a fairly narrow range (3.7 points), but the differences are statistically significant ($p<0.001$). Average scores were lowest in the TRAs (49.9) and LRAs (50.7) and highest in the HIAs (53.5). This mirrors the higher prevalence and seriousness of long-term mental health conditions noted in the Regeneration Areas. Considering the range of values around the means, the poorest scores tended to be found amongst respondents in the Regeneration Areas: 32% and 25% of all the respondents in the lowest decile (with scores of ≤ 38) were in the TRAs and LRAs, respectively. Conversely, 29% and 24% of the scores in the top decile (>66) were recorded by residents of the HIAs and PEs, respectively.

Figure 9.5 Mean WEMWBS scores of positive mental health, 2008



Aggregate score based on 14 questions (see Table 9.2), and can range between 14 and 70.
[Differences between area types, $p<0.001$]

The WEMWBS scale is a valuable addition to the outcome measures of health and wellbeing and how these scores change against the background of regeneration activity will be followed through subsequent survey waves. Furthermore, WEMWBS is promoted by the Scottish Government and is being employed in an increasing number of studies[44]. This means that, in time, the results from GoWell will be able to be compared with those of other studies.

Demographic Influences on Mental Health

As seen in Chapter 4, the populations of the IATs are comprised of different distributions of age-groups and gender. It is therefore conceivable that some of the differences in the mental health measures noted between the IATs may be due in part to demographic features of the areas rather than the nature of the IATs themselves (for example, proportionally more older people live in HIAs than in TRAs). By examining each of the five mental health scores with respect to age, gender and IAT simultaneously, which of these variables is responsible for the observed associations can be explored. The average (mean) scores for six combinations of gender and age group (18-39, 40-59 and 60+ years) by IAT in 2008 only are shown in Table 9.3.

Analyses of variance reveal some different relationships between the distinct mental health measures and the age, sex and location of respondents.

In the case of the SF-12 Role Emotional score, the differences in the means can be ascribed to the effect of age, with 18-39 year olds generally scoring more highly than the other two older groups ($p<0.001$), although this trend was not consistent across all IATs. There was no significant difference between the means of men and women.

It can also be argued that the IAT is not significantly associated with the SF-12 Mental Health score, since the observed differences in the means are better explained by the significant differences between, firstly age groups and secondly gender: typically, the oldest age group had the highest scores, while those aged between 40 and 59 years had the lowest ($p<0.001$). Men had higher scores than women ($p=0.023$).

Table 9.3 Mean Mental Health scores by gender and age for each IAT

IAT	GENDER	AGE GROUP (YEARS)	SF-12 ROLE EMOTIONAL	SF-12 MENTAL HEALTH	SF-12 VITALITY	SF-12 SOCIAL FUNCTIONING	WEMWBS SCORE
TRAs	Male	18-39	86.5	69.0	52.0	80.4	51.2
		40-59	79.9	70.1	46.8	77.0	49.0
		60+	81.5	71.8	40.0	76.5	49.3
	Female	18-39	85.5	66.4	48.4	78.8	49.9
		40-59	79.5	64.7	44.0	74.3	47.9
		60+	86.2	73.5	30.8	83.0	48.5
LRAs	Male	18-39	85.1	71.8	54.1	78.9	52.5
		40-59	77.7	68.7	49.4	73.0	50.0
		60+	88.3	75.0	36.3	77.3	50.4
	Female	18-39	81.8	69.3	48.9	81.3	50.5
		40-59	76.3	63.7	40.7	72.1	47.4
		60+	80.7	73.5	34.3	78.4	49.0
WSAs	Male	18-39	83.7	69.4	52.8	69.8	54.8
		40-59	75.3	66.3	47.2	68.3	51.7
		60+	78.8	66.8	38.1	70.2	50.5
	Female	18-39	80.9	62.0	50.0	66.0	51.9
		40-59	79.3	69.4	44.8	73.3	51.5
		60+	81.8	70.1	32.4	77.2	49.9
HIAs	Male	18-39	86.5	69.6	53.0	74.3	55.9
		40-59	78.5	67.6	45.3	72.8	52.0
		60+	77.0	69.3	40.0	73.4	50.0
	Female	18-39	88.8	68.3	50.8	78.4	55.2
		40-59	80.3	67.1	47.1	73.8	52.1
		60+	79.7	71.4	43.0	76.0	50.8
PEs	Male	18-39	89.0	73.6	64.0	79.0	55.1
		40-59	78.2	66.2	49.4	75.4	50.7
		60+	73.4	72.3	39.5	77.8	51.2
	Female	18-39	86.4	69.1	55.5	77.2	52.3
		40-59	74.9	66.4	44.3	72.3	50.2
		60+	79.9	69.9	41.6	78.8	49.8

There were significant differences in the SF-12 Vitality scores that can be attributed to the IAT, whereby average scores in the TRAs, LRAs and WSAs were lower than those in the HIAs and PEs ($p<0.001$); this is after taking into account the fact that people in the 18-39 and 40-59 age groups had higher scores that the 60+ age group ($p<0.001$), and men had higher scores than women ($p<0.001$).

The pattern of variation of the SF-12 Social Functioning scores is similar to that of the Vitality scores, whereby average scores in the TRAs, LRAs and WSAs were lower than those in the HIAs and PEs ($p<0.001$), even after taking into account the higher scores for people aged 18-39 compared to others ($p<0.001$), and for men compared with women ($p<0.001$).

The variation in the WEMWBS scores can be ascribed to highly significant associations with IAT ($p<0.001$), such that most age-sex groups in the TRAs and LRAs scored lower than their equivalents elsewhere. Within the Regeneration Areas, the 40-59 year olds had lower scores than younger or older people.

The group of middle-aged men (aged 40-59) are of more general interest or concern since they are often the lowest scoring male age group: this is true in all five area types for the SF-12 score; in four area types for SF-12 Social Functioning; and in three area types for the SF-12 Role Emotional and WEMWBS measures. (The oldest men and women, 60+ always score lowest for vitality).

These findings hint at the complexity of the relationships involving just a few of the many possible personal characteristics of the residents of the GoWell areas that might impinge on aspects of their mental wellbeing. The patterns are not consistent among the measures of the various components of mental health, and furthermore, despite the strong statistical significance of many of the relationships, the variables that have so far been chosen to examine together explain a very small fraction (<4.5%) of the total variation in each score. Further analyses will attempt to explore and account for the patterns of variation in these scores.

Mental Health Problems

The survey also asked some direct questions about people's experience of mental health problems and the professional help they sought for them.

As part of the investigation into longer-term health conditions (those lasting for 12 months or more), respondents were asked about the following in 2006 and 2008:

2006: Whether they had 'a psychological or emotional condition' lasting 12 months or more.
2008: Whether they had 'stress, anxiety or depression' lasting 12 months or more.

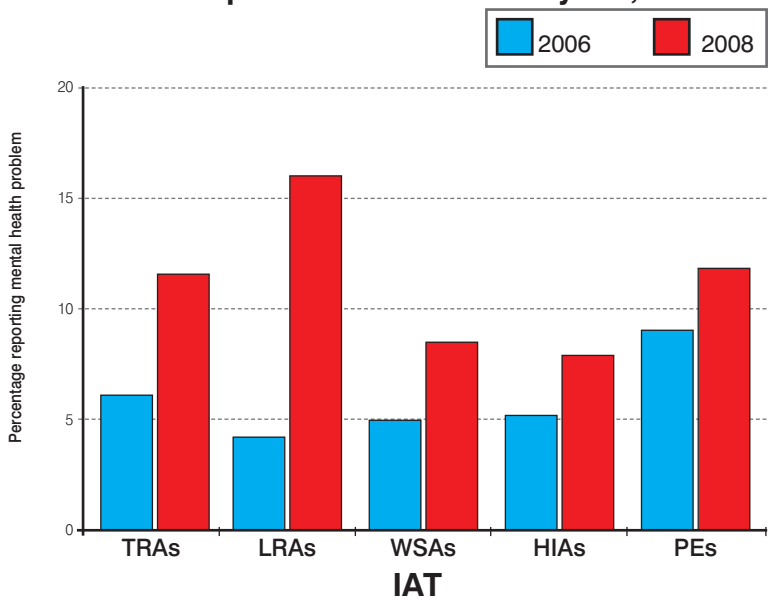
In 2008, between 8% (in HIAs) and 16% (in LRAs) of respondents reported some mental health problem in the previous 12 months (Figure 9.6), with significant differences between IATs (TRAs and PEs vs. LRAs vs. WSAs and HIAs ($p<0.001$)). The rates of problem were consistently higher than had been reported in 2006 ($p<0.001$) and the proportional increases were greatest for the two Regeneration Areas: in TRAs, nearly twice as many people reported a mental health problem in 2008 as in 2006, and nearly four times

as many people did so in LRAs as in 2006. Although the questions in 2006 and 2008 are considered as equivalent, it is possible that some of the difference is accounted for by the wording changes, i.e. more people prepared to say they suffer stress or anxiety, than to have a psychological 'condition'.

In order to examine not only the prevalence of mental health conditions in the study area populations, but also the severity of the conditions experienced, in 2008, those participants who had reported a mental health problem in the previous 12 months were asked: 'Has this condition improved, stayed the same or got worse in the last two years?'

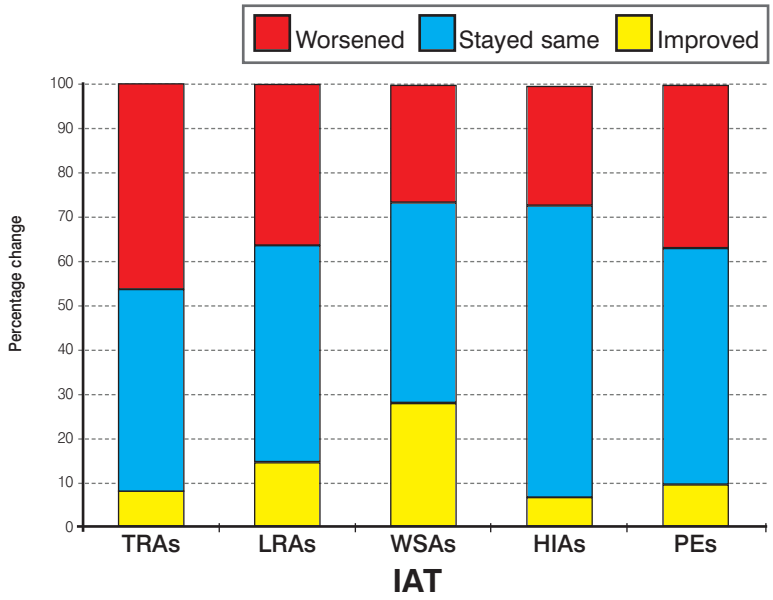
The responses indicate a general worsening of respondents' conditions between 2006 and 2008 (Figure 9.7). Almost half of those in the TRAs who were suffering a mental health problem in 2008 reported a worsening of their condition. In fact, in four of the five IATs (WSAs being the exception), more of the mental health problem sufferers reported a worsening rather than an improvement in their condition.

Figure 9.6 Reporting of mental health problems in the previous 12 months by IAT, 2006-08



Question: (2006) *"Have you had a psychological or emotional condition over the past 12 months"* (2008) *"Have you had stress, anxiety or depression regularly over the past 12 months"* (for a condition that has lasted for 12 months or more)
[Change over time: All area types, $p<0.001$]

Figure 9.7 Change in mental health condition, 2006-08



Question:*"Has this condition improved, stayed the same or got worse in the last two years?"*

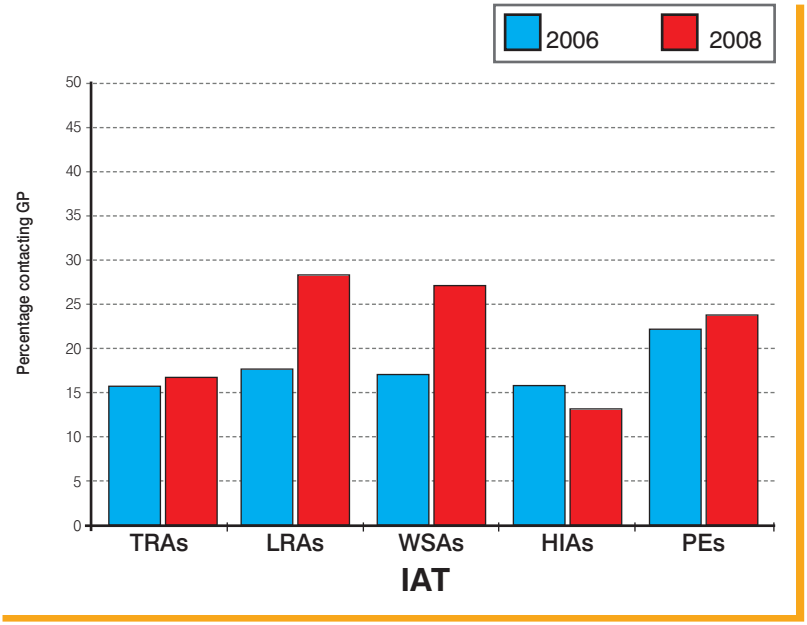
Use of GP for Mental Health Reasons

Not all mental health conditions may be long-term in nature; they may be short-term responses to temporary difficulties or changes of circumstance to which people may adapt in time. To ensure that information about mental health problems of any duration was gathered respondents were also asked:

> *'In the past 12 months, have you spoken to a GP or family doctor on your own behalf, either in person or by telephone about being anxious or depressed or about a mental, nervous or emotional problem (including stress)?'*

Once again, there was a general pattern of worsening mental health (Figure 9.8). Overall, in 2008, one-in-six residents had visited their GP in the previous year because of a mental health-related matter. There was considerable variation between IATs, however ($p<0.001$). Over a quarter of residents in the LRAs, WSAs and slightly fewer in the PEs had sought this type of help, whereas only 13% of those in the HIAs and 17% of those in the TRAs had done so. The figures for 2008 are higher than those of 2006 for all IATs except for the HIAs, which registered a small, and statistically non-significant fall of 2.5%. The increases of just over 10% in the LRAs and WSAs were significant ($p<0.001$).

Figure 9.8 Contact with GP over a mental health related issue, 2006-08



Question: *In the past 12 months, have you spoken to a GP or family doctor on your own behalf, either in person or by telephone about being anxious or depressed or about a mental, nervous or emotional problem (including stress)?*
[Change over time: LRAs and WSAs, $p<0.001$; TRAs, $p=0.532$; HIAs, $p=0.080$; PEs, $p=0.392$]

Thus, more people visit their GP about mental health-related issues at some point in the year than report that they have a longer-term or an ongoing mental health-related condition. This suggests that significant numbers of people experience temporary mental health problems each year, i.e. stress, anxiety or other emotional problems which may last a few weeks or a few months but not longer. In 2008, for example, 44.9% and 51.7% of respondents in the TRAs and LRAs, respectively, who visited their GP about a mental health-related matter, did not claim to have a longer-term mental health-related condition, while these values were even higher for the WSAs (71.4%), HIAs (61.8%) and PEs (67.7%).

It is also possible that the slightly different manner in which these psychological problems were enquired about in 2006 and 2008 may have contributed to the different responses.

Discussion

A complex picture of mental health among GoWell residents has been presented. It might generally have been expected for mental health to have become worse in the Regeneration Areas between 2006 and 2008 relative to the other IATs, because of the worse poverty and deprivation in these areas as well as the disruption and inconvenience caused by renewal activity. This is largely borne out by the results about respondents' experiences of mental health problems, which were more common in the Regeneration Areas than in the WSAs and HIAs and were getting worse over time. This is not to say that mental health problems are a function of regeneration activity. Indeed, the increase in the incidence of respondents seeking help from their GP for a mental health problem was negligible in the TRAs, where regeneration activity might be expected to be most intense, but more substantial in the LRAs and WSAs. The large number of aspects of personal circumstances, the home, neighbourhood and community that may influence residents' mental health and wellbeing are likely to prevent a straightforward explanation. At the other end of the spectrum, one might expect to see the mental health consequences of the 2008-9 recession reflected in the findings of future surveys compared with the measurements made at Wave 2, before the recession properly began.

However, in assessments of the impact of mental health issues upon people's quality of life (how they performed daily functions and how they felt on a daily basis) the situation in Regeneration Areas appears to have improved over time, so that mental health quality of life was at least as good, if not better, in Regeneration Areas than elsewhere. This suggests that despite a worsening of mental health problems over time, people in Regeneration Areas may be more resilient to the potential effects upon their functioning. Two potential explanations for this are: firstly, that the younger and non-British-born population in Regeneration Areas is indeed more able to cope with mental health issues; and, secondly, that as a consequence of the former, mental health issues are not so detrimental to those with less active lifestyles in these areas.

The downside to this pattern, though, is perhaps revealed by the findings on the question of vitality, namely whether residents have energy and inclination to do things on a daily basis. Here, it was found that capability and performance were deteriorating, so that people reported 'having a lot of energy' less of the time in 2008 than in 2006. Indeed, generally, vitality is worse than other aspects of mental health quality of life, as well as itself getting worse over time. Reversing this position, so that people are in fact 'energised' is a big transformational challenge across all the study areas, not just Regeneration Areas.

Key points

- Mental health problems (such as longer-term stress, anxiety and depression) have increased in prevalence over time in all areas, though particularly in the Regeneration Areas.

- However, the impact of mental health issues upon quality of life and daily functioning has lessened in the Regeneration Areas while worsening elsewhere. This could be for a number of reasons, such as:
  - o populations in Regeneration Areas are more resilient to the impacts of mental health upon daily functioning;
  - o residents in Regeneration Areas become habituated to difficult and challenging circumstances and so are less likely to feel 'down' about them;
  - o the more deprived circumstances themselves lower the opportunities for mental health problems to have impacts upon daily life;
  - o the prospect of change in the area acts as a buffer or in a protective way against the potentially negative impacts of mental health issues.

- Three components of mental health quality of life as measured by the SF-12[45] health survey (Role Emotional, Mental Health, Social Functioning) showed significant improvements between 2006 and 2008 in the TRAs and LRAs, and smaller declines or no change in the WSAs and HIAs and the PEs.

- The fourth aspect of mental health quality of life - Vitality ('having a lot of energy'), decreased substantially in all IATs between 2006 and 2008.

- Significant amounts of the variation in the measures of components of mental health may be accounted for by the demographic profile of the IATs, rather than, or in addition to the differences between IATs.

- The percentages of respondents reporting some type of mental health problem in the previous 12 months increased substantially in all IATs, especially in the LRAs and to a lesser extent in the TRAs.

- More than two-in-five of those people in the TRAs, LRAs and HIAs who reported having a mental health problem over the previous year, said that their condition had worsened since 2006.

- There were marked increases in the percentages of people seeking help from their GP for a mental health problem from 2006 to 2008 in the LRAs and WSAs. Substantial proportions of those seeking help from a GP do not report a long-term mental health condition, suggesting an increase in the incidence of acute episodes of anxiety, stress and depression.

- WEMWBS[44] scores of positive mental wellbeing were somewhat lower in the TRAs and LRAs than in the other IATs, and a disproportionately large

percentage (57%) of the respondents with the poorest scores were living in Regeneration Areas. Area type differences were also present in respect of measures of vitality and social functioning, with people in Regeneration Areas again scoring lower (after taking age and sex differences between areas into account).

- Further analysis is required to draw sound conclusions about the likely drivers of positive and negative states of mental health.

- Middle-aged men may be of particular concern as they often report the lowest scores across a range of measures of mental health.

Are positive and negative mental health inversely associated?

It is increasingly appreciated that positive mental health is not the same thing as the absence of negative mental health states and that people's overall mental health can be comprised of good (healthy) and poor (unhealthy) components. GoWell's measures of mental health are the four SF-12[45] scores (Role Emotional, Mental Health, Vitality and Social Functioning), which tend to assess negative states of mental health – although the scales are ordered so that higher scores indicate better, or more exactly, less poor, mental health – and the WEMWBS[44] score, which measures positive mental health (in which higher scores correspond to better positive mental health). The simplest expectation would be that individuals with high levels of positive mental health would have low levels of negative mental health, and vice versa. The GoWell 2008 survey data can be used to examine how consistently respondents' positive and negative mental health measures are negatively correlated.

In a simple but illustrative analysis, the four continuous SF-12[45] scales are each converted into a two-category variable with, as far as possible, equal numbers of low and high scoring respondents, and the WEMWBS[44] score is converted into a three-category variable corresponding to values 1 standard deviation (8.79) or more from the national population

norm mean of 50.7 (below and above average), and those of 1 standard deviation or less of the mean (average):

- Role Emotional: <100 *vs.* 100 (reflecting the large number of people whose Role Emotional score was the maximum possible)
- Mental Health: = 75 *vs.* >75
- Vitality: = 50 *vs.* >50
- Social Functioning: = 95 *vs.* >95
- WEMWBS score: = below average (≤41.91) *vs.* average vs. above average (≥59.49)

Table 9.4 shows the cross-tabulated percentages of respondents in the entire 2008 sample with low and high scores for the four SF-12[45] scales in combination below average, average and above average WEMWBS[44] scores. If positive and negative aspects of mental health are indeed negatively correlated one would expect a substantial proportion of respondents to be distributed respectively in the low-below average and high-above average combinations (figures shown in bold in the table). Although this general trend is observed (Role Emotional, 28.9%; Mental Health, 25.9%, Vitality, 30.9%, Social Functioning, 25.2%), substantial numbers of respondents therefore have an apparently paradoxical combination of a low and a high score (Role Emotional, 9.6%; Mental Health, 12.6%, Vitality, 7.7%, Social Functioning, 13.4%).

Table 9.4 Cross-tabulated percentages of respondents scoring low or high in measures of positive (WEMWBS) and negative (SF-12) mental health

SF-12 SCORE		WEMWBS SCORE		
		BELOW AVERAGE	AVERAGE	ABOVE AVERAGE
Role Emotional	low	**9.7**	22.0	3.5
	high	6.1	39.4	**19.2**
Mental Health	low	**12.6**	39.7	9.4
	high	3.2	21.7	**13.3**
Vitality	low	**14.8**	41.1	6.7
	high	1.0	20.3	**16.1**
Social Functioning	low	**9.0**	25.8	6.6
	high	6.8	35.6	**16.2**

Even this straightforward presentation of the relationship between positive and negative components of mental health is sufficient to highlight the complexity of this aspect of personal wellbeing. Future analyses will examine these connections in greater depth as well as investigating the characteristics of personal circumstances, the home, neighbourhood and community that are associated with good and poor mental health.

Conclusion

In this chapter the nature and scale of policy interventions in the study communities is reviewed, what the impact of those policy actions have been to date, and some of the main challenges remaining to be tackled across Glasgow's poorer communities identified.

Housing

The most widespread activity so far has been the delivery of housing improvements, which has occurred in all the study communities to a significant degree. Most commonly, these works consisted of new kitchens, bathrooms and heating systems, though in multi-storey blocks the most common additions were new secure by design doors and entry systems. These housing investments have resulted in increases in housing satisfaction and in the attainment of many psychosocial benefits from the home. Improvements in these housing outcomes for residents were greatest in the Wider Surrounding Areas (WSAs), where owner occupation is highest, and the delivery of improvements to owner-occupied dwellings was most common. One might speculate that these residents could not only experience direct benefits from specific types of improvement, but may also feel that the investment may increase their property value.

The situation in Regeneration Areas has worsened in housing and residential terms, with deterioration in the perceived quality of multi-storey flats (MSFs) and a higher rate of intention to move. The one exception to this story of decline in Regeneration Areas is that of enhanced feelings of safety inside the home, probably due to the installation of secure locks and doors.

Generally, MSFs have been found to be less capable of providing high levels of housing satisfaction or of psychosocial benefits than other types of dwelling, thus supporting the idea that they should be replaced wherever possible. Whether the retention and improvement of high-rise blocks can provide equally high levels of returns for residents as other buildings is a question we hope to be able to address in futures waves of the GoWell survey.

In terms of housing activity, the main challenge now is to improve dwelling quality for residents in the Regeneration Areas and, to a lesser extent, for some of the residents in the Peripheral Estates (PEs), where there are also many aspects of dwellings rated less than 'good'. Most people in Regeneration Areas and a third of people in PEs also do not have a garden to use, and the issue of access to private green space is an important one given its potential contribution to health and wellbeing. In residential terms, Regeneration Areas continue to be subject to higher levels of turnover, with many more incomers than other areas. A decision and a strategy to reduce population turnover in these areas may be helpful to them – although we accept that this may be a difficult goal to achieve.

There have been efforts by Glasgow Housing Association (GHA) to improve its customer services (noted also by the Scottish Housing Regulator[47]) and the possible results of this can be seen in increases in feelings of housing empowerment by tenants in all the study communities, with more people than in 2006 thinking that their landlord or factor takes account of residents' views in making decisions. Indeed, in non-regeneration areas GHA as a landlord was found to be performing better than other Registered Social Landlords (RSLs) and comparable to private sector factoring, in terms of customer services and governance. Nonetheless, there is scope to further improve tenants' satisfaction with housing services (given what is known about national norms on this issue) and there is clearly room to further enhance tenants perceptions of their influence over landlords in Regeneration Areas.

Neighbourhoods

There have been widespread, though not universal, actions to improve neighbourhood environments (including extensive housing fabric improvements in some areas), and also to improve some local amenities such as children's play areas. There have also been actions in some areas relating to community facilities and community arts projects. Generally, residents' ratings of their local environments have improved since 2006, with the notable exception of the aesthetics of environments (whether they look attractive). Ratings of environmental aesthetics have worsened in Regeneration Areas – which is not surprising given the impacts of processes of clearance and demolition – and remained modest and unchanged in the PEs. Residents' ratings of local amenities are generally relatively high and in many cases have also improved over time. The outcome measure that appears to have most consistently responded to these neighbourhood improvements is that which measures the psychosocial benefit of whether people feel a sense of personal progress in their lives through where they live.

The one notable exception to improved ratings of local amenities is youth and leisure services which are perceived to have declined in the Regeneration Areas, whilst also often being given the lowest rating of all amenities and services in many other areas. This perception of youth and leisure services is pertinent given that perceptions of safety at night, and of anti-social behaviour, have worsened in all areas, despite widespread actions to provide youth diversionary activities and support community safety. It may be significant that the study areas with the highest incidence of serious anti-social behaviour problems – the Regeneration Areas and PEs – are also those areas with high numbers of family households, many more than found in urban areas in Scotland generally. These areas also have high proportions of younger adults (aged under 25), and of single parent families. This amalgam of issues raises the question as to whether support services are adequate in many poorer areas, given the high numbers of young people and young parents concentrated together in certain communities.

All areas apart from HIAs are considered by their residents to have poor external reputations, even more so than in 2006. Furthermore, in Regeneration Areas, only a minority of residents think their area has a good reputation even among local people. The transformation of many areas, therefore, requires specific actions to enhance area status and reputation (and to counter negative reputations), rather than merely hoping that area reputations will automatically change as areas are physically improved.

Communities

Actions designed to support or stimulate community activities and/or to boost people's sense of community are delivered by a range of organisations in the public, voluntary and community sectors. The question of whether the structures and projects that have been put in place reflect the different needs and priorities of the community needs to be explored further. As well as supporting community activities, individual organisations also undertake engagement in relation to their own plans and proposals. GHA's consultations concerning regeneration and new build housing are examples.

The advent of community planning brought the potential to put in place a more strategic approach to community-led activities. Engagement network coordinators have been recruited to ensure that mechanisms are in place to promote community engagement in each part of Glasgow. In addition, 13 Community Reference Groups (panels of local residents) have been formed – the aim being to have community dialogue in deciding the key things that matter to communities and how community planning partners might respond to these. These were put in place in the period between the two GoWell surveys.

With regard to community outcomes, the picture is fairly static in WSAs and Housing Improvement Areas (HIAs), with a mixed picture in the PEs, and a worsening of many measures of community in the Regeneration Areas. Despite most people reporting that they talk to, or have contact with their neighbours at least weekly, most people across the study areas do not

know many of their neighbours or exchange things with them, and many people do not visit their neighbours' homes. Hence there are limits to which these neighbourhoods can be considered to contain 'close' communities. Levels of available social support have fallen slightly over time in the Regeneration Areas and in the PEs. In many areas, barely a majority of people have confidence in their community's ability to exercise informal social control, and only a minority believe in the honesty of people in their area. The situation on these issues is worse in the Regeneration Areas than in other Intervention Area Types (IATs).

Therefore, whilst respondents do provide some positive reports of their communities, many of the study areas cannot be said to be characterised by a strong sense of community or by the more active forms of neighbourhood contact (e.g. social support, reciprocity, etc). In the Regeneration Areas, sense of community is often lower for families than for other household types, echoing the earlier concerns about support for young families in some areas. This may be important for regeneration's ultimate outcomes, since a positive association between the measures of community and people's sense of collective empowerment have been found.

Although there have been improvements across all the study areas in the degree to which people feel that they can, with other people, influence decisions affecting their areas, only in WSAs and HIAs does this reach a bare majority of residents. Indeed, in the areas subject to the most significant decisions – the Regeneration Areas – only three-in-ten people feel so empowered or influential.

Improvements in the number of people in many areas who report the existence of social harmony (that people from different backgrounds get along well together) sit alongside the fact that in Regeneration Areas only two-in-five non-British citizens say they feel part of the community. This may indicate that programmes to support the integration of migrants in many areas have had some success both in enabling migrant groups to support each other, and in reducing some of the tensions between migrant groups and local people which existed a few years ago. They seem, however, to have been less successful at interweaving migrants into the life of communities which themselves are quite dormant.

Boosting communities will require a mixture of community development activities and the greater provision of opportunities and facilities for people who share the same residential space to engage with each other. Only in two of the types of study area did as many as six-in-ten people rate their local social and community venues as at least 'good', thus indicating substantial scope for the improvement of available community spaces, even before the introduction of any personnel to support community development.

Employment and activity

Higher reported employment rates were found among men in all the types of study area compared with 2006, and in two-in-five types of study area also for women. It is not currently possible to firmly attribute these improvements to policy interventions, though there are a wide range of employment and employability

programmes in the city, provided by Glasgow Works, the City Council, Local Economic Development Agencies, the Wise Group and others. Actions by GHA and RSLs are varied and some did not commence until after the 2008 survey. Nonetheless, despite the reported improvements in employment rates, it is still the case that between one-third and two-thirds of adult respondents of working age are not in employment across the study areas.

The employment challenge is emphasised by the fact that of those working age adults who are not in employment or education, very few have done anything about their employment situation in the past year: the number who have sought work ranges from just over one-in-ten in the PEs to just over one-in-five in the Transformational Regeneration Areas (TRAs). Even among the younger adults out of work (those under 25), only a third had taken part in education or training in the past year, and very few of those over age 39 had done so. With less than a fifth of out-of-work adults seeking work or training across all the study areas, and with only 9% of all respondents taking part in any group, club or organisation in the past year, it is clear that many of the study communities contain large proportions of adults with no means of making a positive contribution to society or their communities beyond their own family lives.

Health

The findings for self-reported physical health problems and also several mental health measures do not follow the pattern of many of the other findings, suggesting that self-reported health does not bear a strong relation to housing and regeneration activity at this point in time. A small decline in self-reported general health and no change in the use of GP services have been found. More people reported having no health problems but those people with health problems tended to report having more of them than previously (indicating more co-morbidity).

In terms of health behaviours, the biggest challenge identified was physical inactivity, with two-thirds of respondents across the study areas having not done any moderate or vigorous physical activity in the past week, and one-in-four reporting that they had not walked for at least ten minutes in the past week. Health behaviours – inactivity, smoking, eating no fruit or vegetables, alcohol consumption – were often worse among flat dwellers (and within that among occupants of high-rise flats), people who were unemployed or long-term sick, and among single adults below retirement age. Overall, population health and health behaviours in the Regeneration Areas were improved by the presence of migrants who reported better health and less health damaging behaviours.

In terms of mental health, the main findings were declines in reported vitality in Regeneration Areas and WSAs, increases in the reporting of long-term mental health problems in all areas (but especially Local Regeneration Areas (LRAs)) and increased use of GPs for mental health reasons in LRAs and WSAs. In accord with many of the earlier results, a disproportionate number of those people with the lowest scores on the measure of positive mental health were found residing in the Regeneration Areas.

Summary: People and Place

In summary, more progress in terms of physical than social regeneration has been found thus far in the study areas. It is probably too early to see many connections between physical changes and health outcomes, but we might expect these to become clearer in future surveys. The continued improvement of Glasgow's predominantly social housing areas requires a clear strategy and commitment which will support and enable individuals to make changes to improve their own health and wellbeing, and to contribute to the enhancement of their communities, so that both people and places are transformed. Such a strategy should contain interventions focused on the infrastructure, organisation and functioning of communities as well as people-based interventions targeted at individuals in need of support to make personal changes to their behaviours and aspirations. Consideration of the demographic composition of these communities, now and in the future, is also required, given the consequences of current allocation policies. This depends upon the provision of leadership, commitment and resources from the main responsible agencies in order to assemble the necessary partnerships to deliver such a comprehensive programme. None of these things yet exist on a similar scale for social regeneration as they do for physical regeneration. That is a past mistake in danger of being repeated yet again unless steps are soon taken to avert it.

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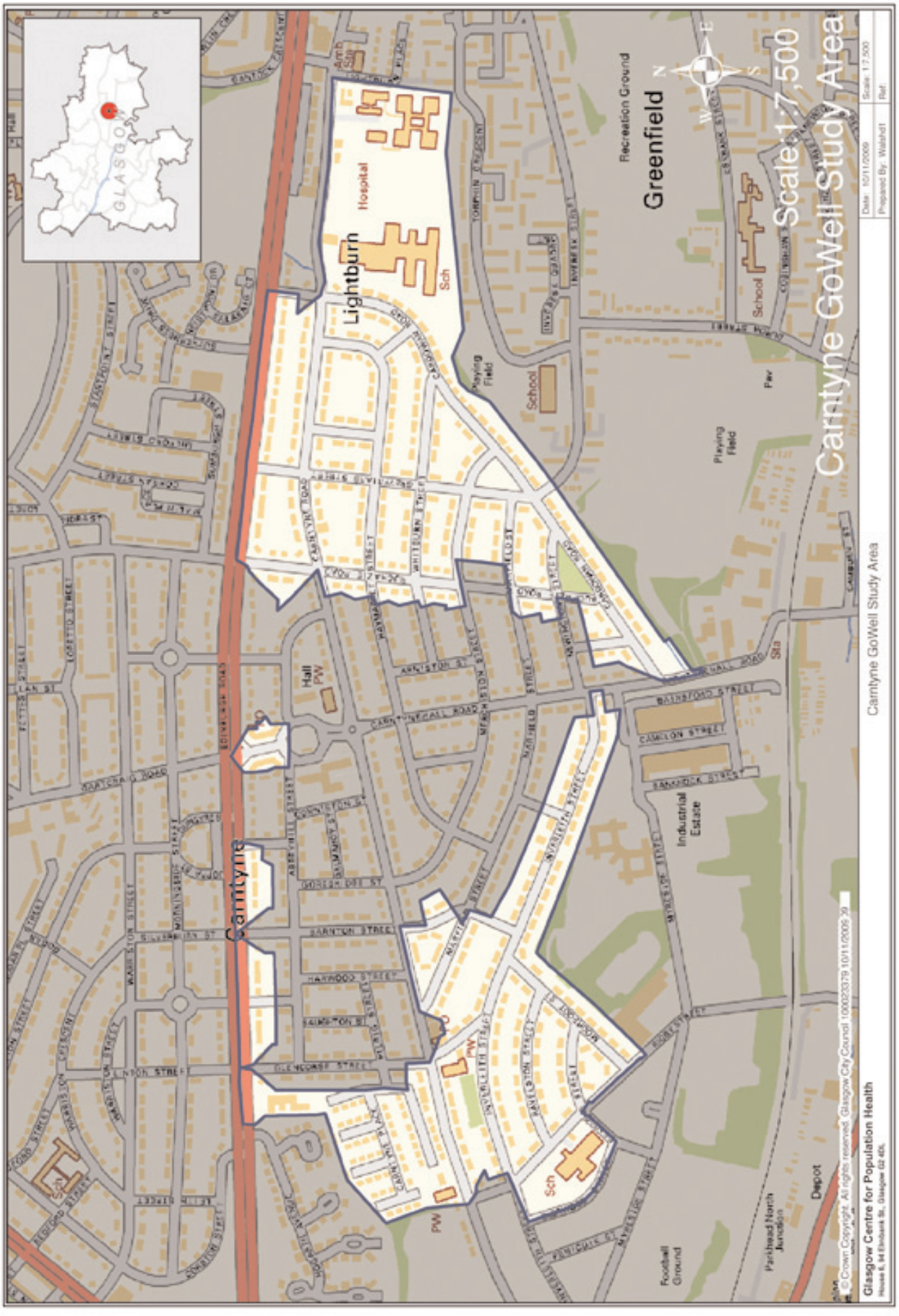
Appendix 1



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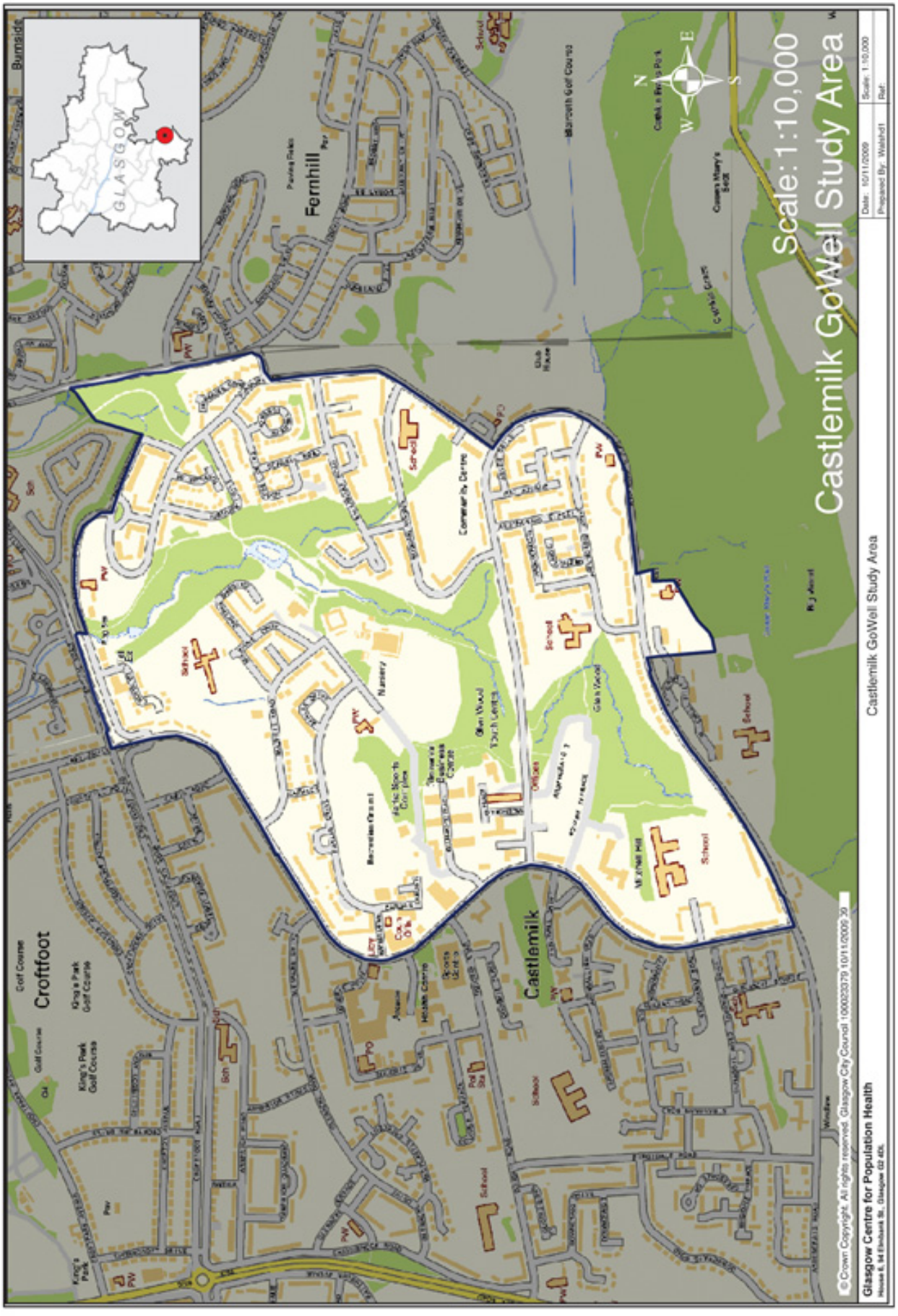

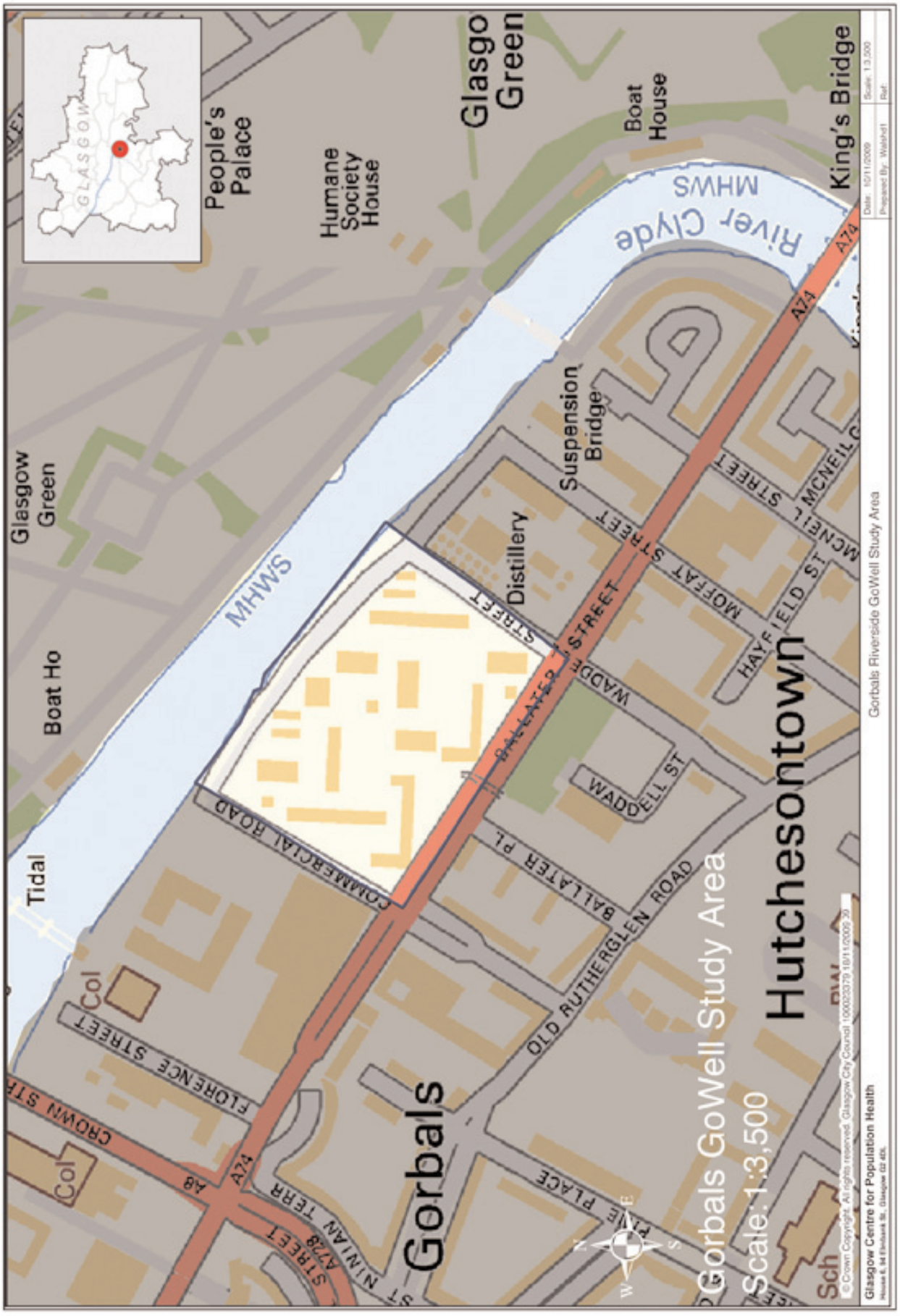

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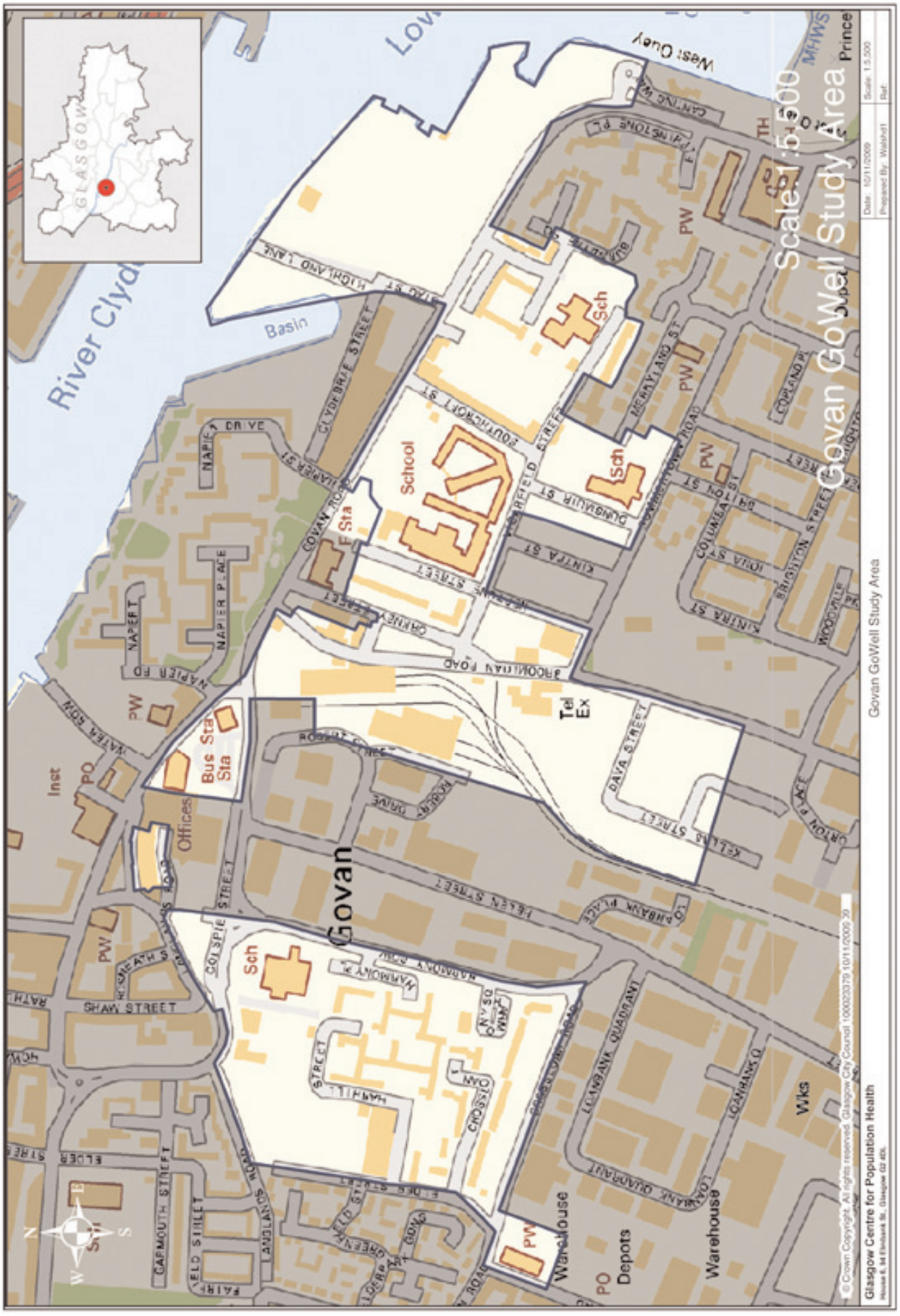

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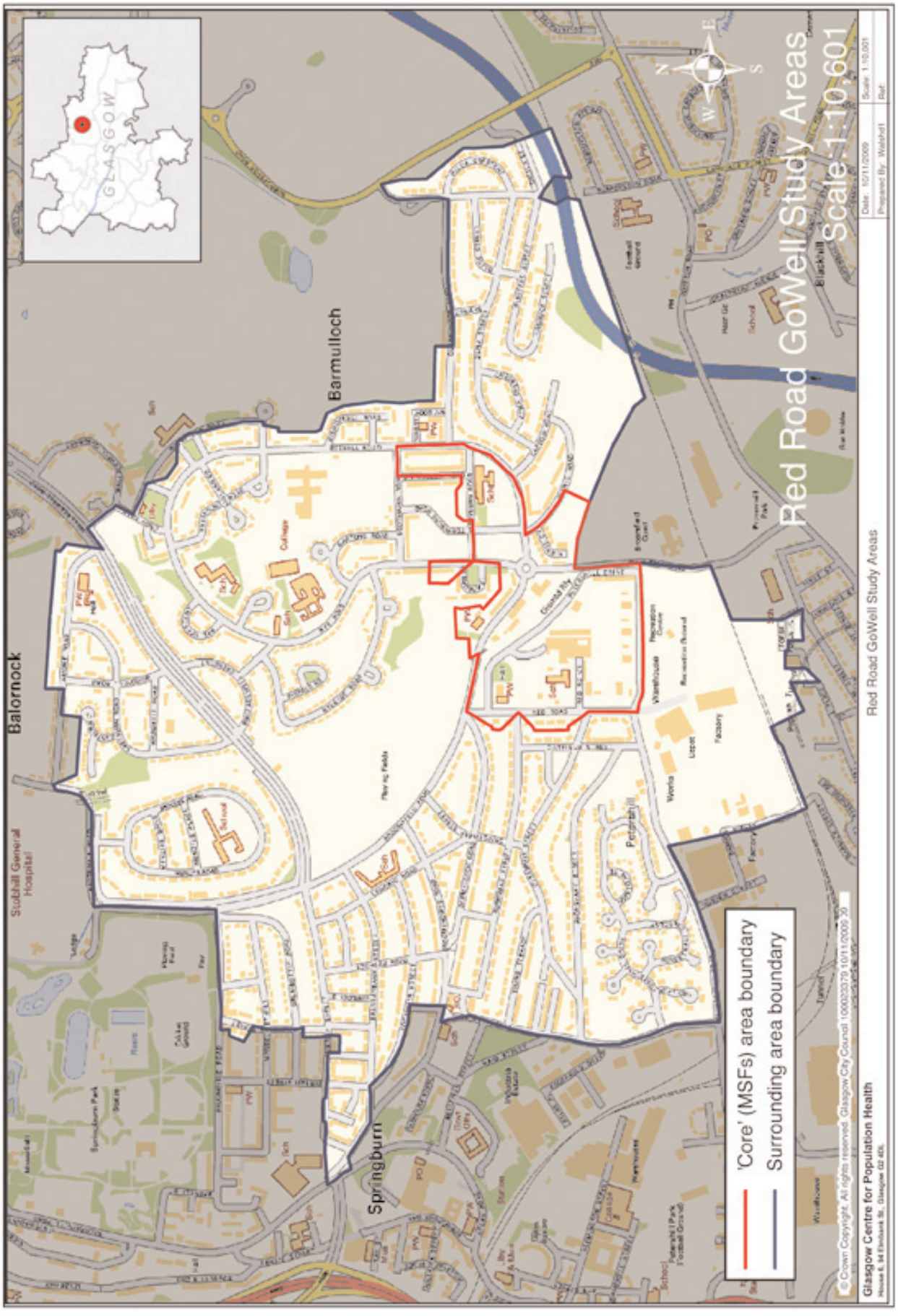

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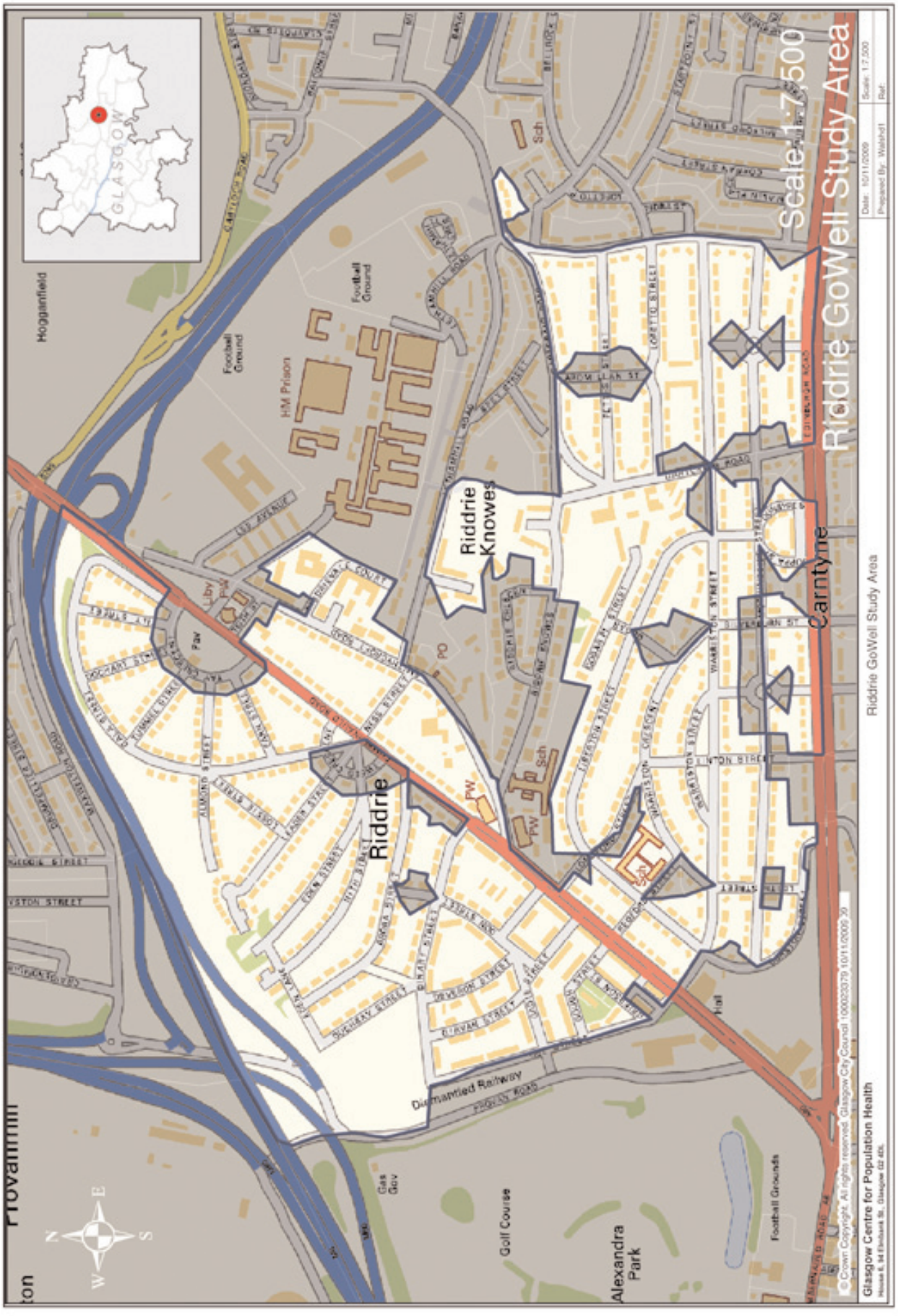

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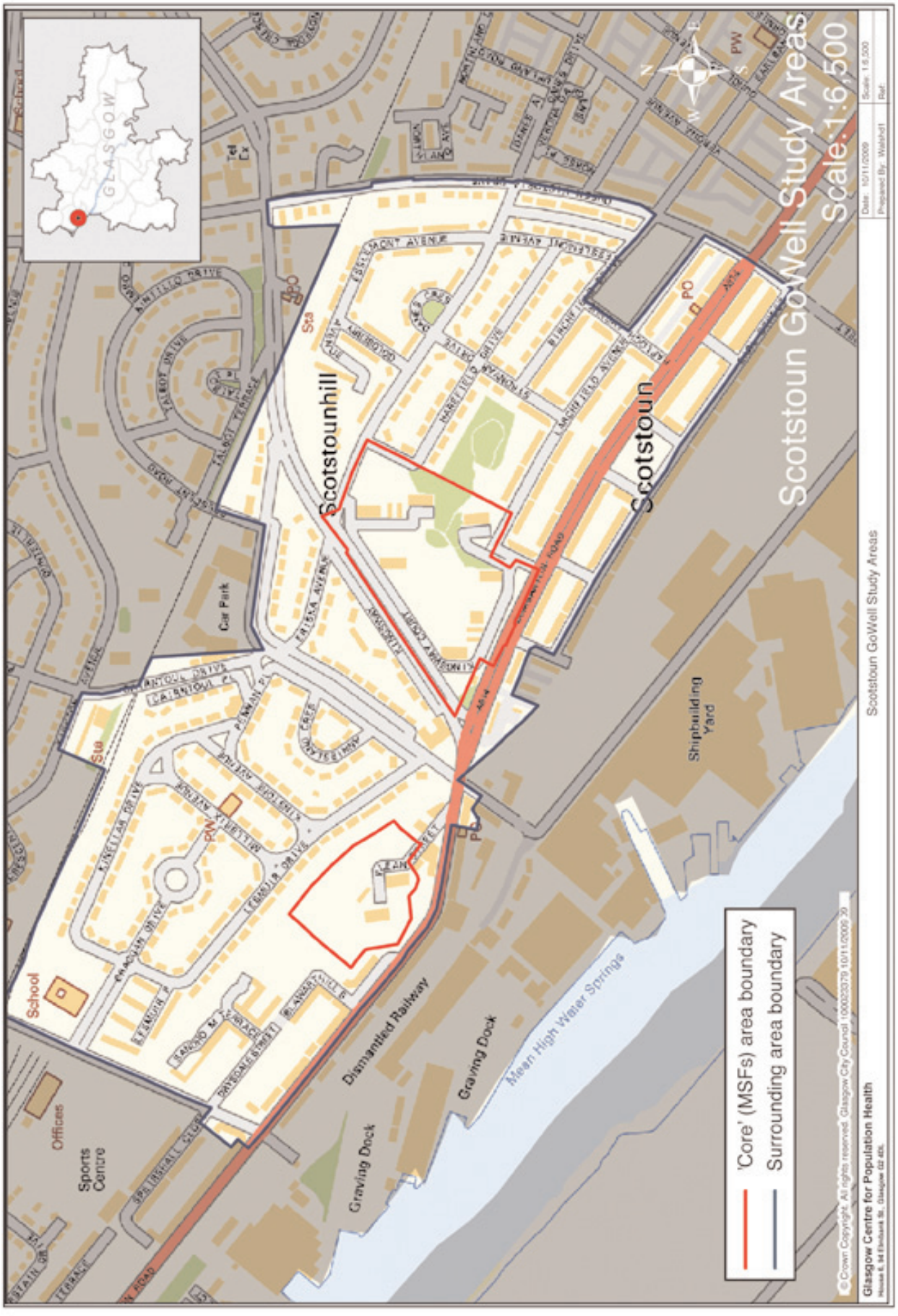
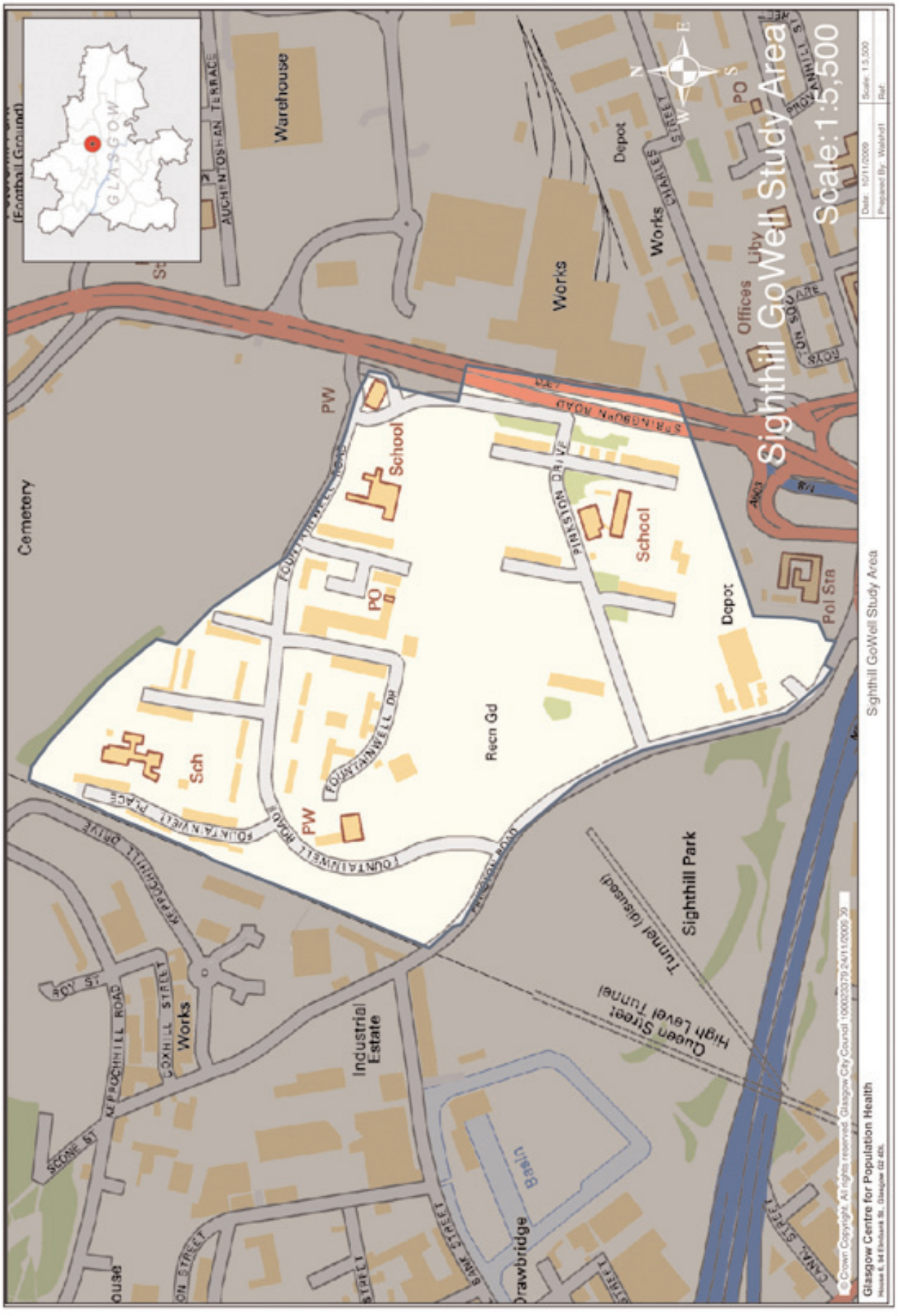
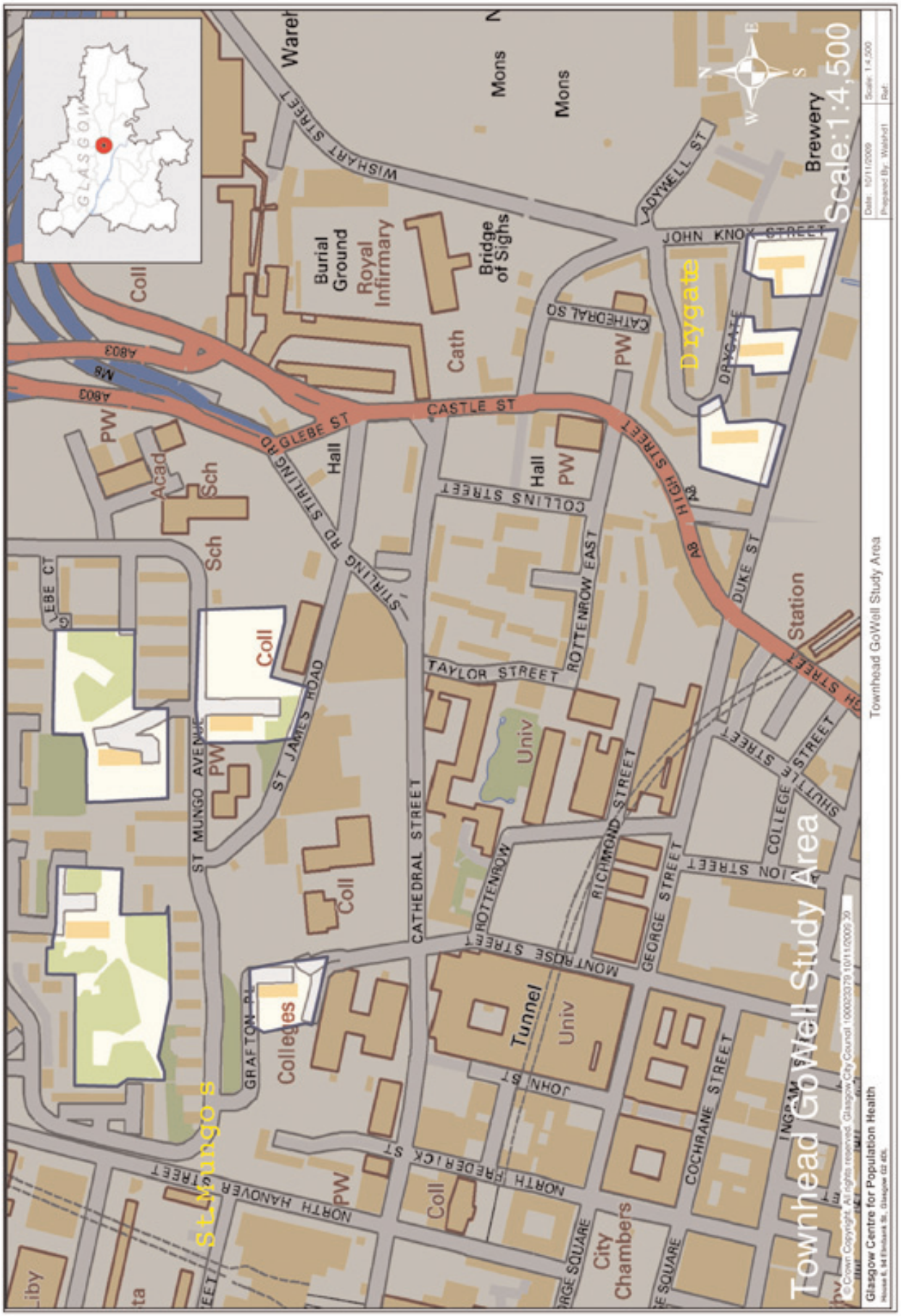


Appendix 1





Appendix 1

Appendix 2: Differences between the 2006 and 2008 survey questionnaires

The questionnaire used for the second survey in 2008 was substantially the same as at the first survey in 2006. Changes were made to address matters that had assumed importance since the first survey and to improve questions that had yielded responses that tended to be unclear or inaccurate, or that varied little between respondents.

The main additions to the questionnaire concerned:

1) Whether respondent or household participated at Wave 1, confirmation of previous address (new question)
2) Whether the building is managed by a factor or property management service, and, if so, degree of satisfaction with this service (new questions)
3) Whether an ex-council home or bought from the council or a private seller (new questions)
4) Moving: reasons for moving, amount of choice offered in moving, relative satisfaction with new and previous home (new questions)
5) Psychosocial benefits of the home (extra aspects)
6) Neighbourhood empowerment (extra aspects)
7) Neighbourhood services and amenities (extra aspects, others removed)
8) Neighbourhood cohesion and belonging, acquaintance with neighbours (new questions)
9) Degree to which respondents feel they are kept informed about proposals to improve or develop their area, and extent of agreement with regeneration plans and proposals (TRAs and LRAs only) (new questions)
10) Change in external reputation of area over previous two years (new question)
11) Participation in or support of groups, clubs or organisations in previous month (new question)
12) Relative quality of home, incomes in local area, quality of life and standard of living (new questions)
13) WEMWBS positive mental health scale (new questions; see Chapter 3 for further explanation)
14) Change in smoking and alcohol drinking behaviours over previous two years (new questions)
15) Frequency of positive and negative dietary habits (extra aspects)
16) The neighbourhood as a place to bring up children (new question)
17) Job-seeking, education or training undertaken in past month and year (new questions)
18) Single or mixed ethnicity household (new question)
19) Date of arrival in UK (except British citizens born in UK) and date leave to remain granted (refugees only) (new questions)
20) Educational/vocational qualifications from non-UK country (except British citizens born in UK) (new question)

To compensate for the additional questions, others were shortened or removed entirely:

1) Rating aspects of home (fewer items)
2) Neighbourhood services, quality and problems/incivilities (fewer items)
3) Description of neighbourhood improvement and deterioration (removed)
4) Social contact (fewer items)
5) Attitudes towards community (fewer items)
6) General health over previous year (removed)
7) Long-term illnesses (fewer items)
8) Amount smoked (removed)
9) Amount of alcohol drunk (fewer items)
10) Recreational drug use (removed)
11) Self-reported height and weight (removed)
12) Nature of job (removed)
13) Receipt of housing benefit (removed)
14) Income categories (removed)
15) Methods of borrowing money (fewer items)
16) Marital status (removed)
17) Religious affiliation (removed)

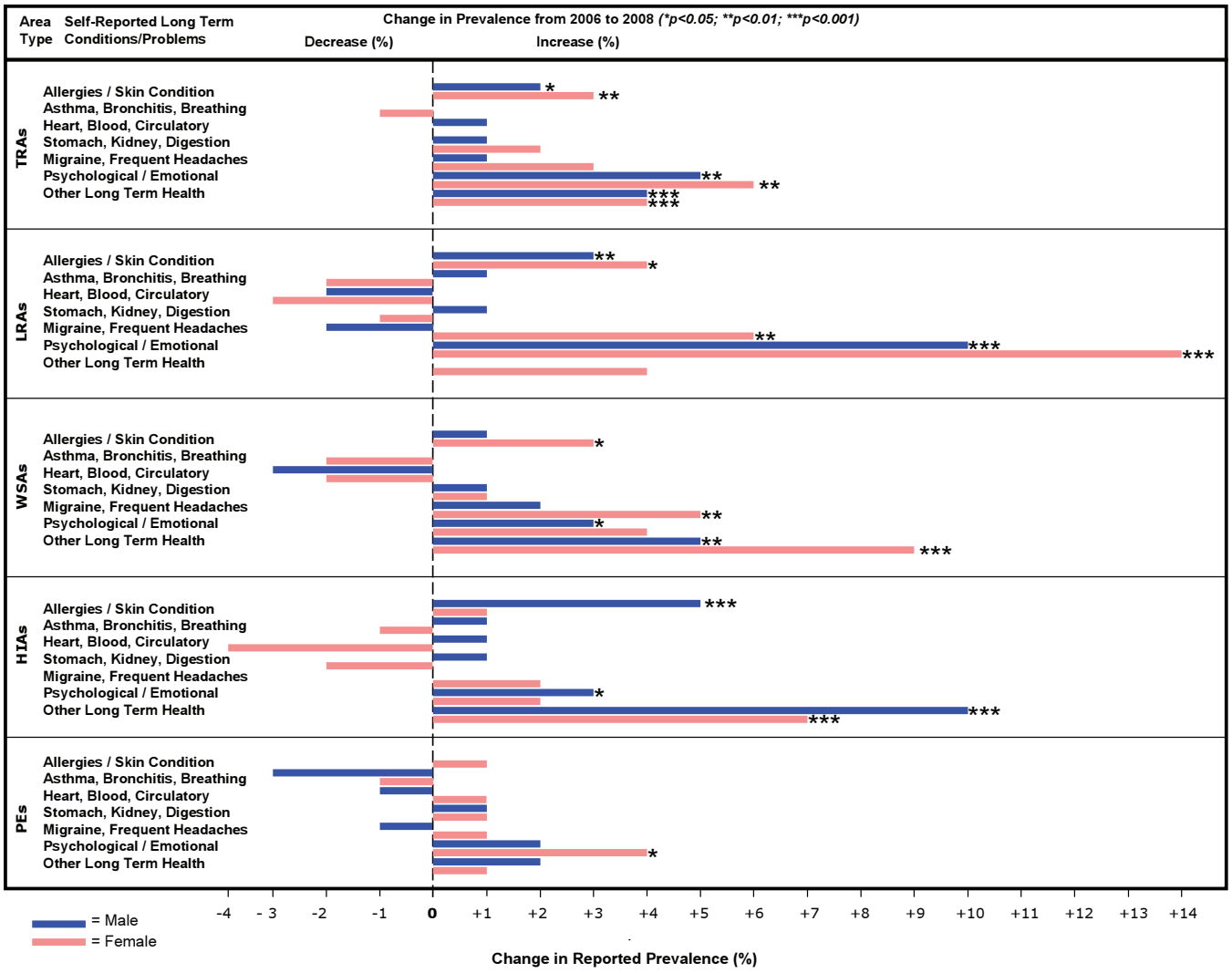
Appendix 3: Differences in prevalence of specific health problems, 2006-08, by IAT and sex, 2006-08

HEALTH PROBLEM	SEX	% DIFFERENCE (p-VALUE*)									
		TRAs		LRAs		WSAs		HIAs		PEs	
Psychological / emotional	M	**5**	**(0.001)**	**10**	**(<0.001)**	**3**	**(0.026)**	**3**	**(0.014)**	2	(0.370)
(long term)	F	**6**	**(0.001)**	**14**	**(<0.001)**	4	(0.056)	2	(0.127)	**4**	**(0.024)**
Other health problems	M	**4**	**(<0.001)**	0	(0.801)	**5**	**(0.002)**	**10**	**(<0.001)**	2	(0.174)
(long term)	F	**4**	**(0.001)**	4	(0.051)	**9**	**(<0.001)**	**7**	**(<0.001)**	1	(0.237)
Not good health	M	**4**	**(0.047)**	5	(0.080)	4	(0.221)	5	(0.061)	4	(0.147)
(current)	F	3	(0.223)	4	(0.177)	4	(0.198)	0	(0.992)	**6**	**(0.009)**
Other pain	M	**2**	**(0.001)**	**3**	**(0.007)**	**5**	**(<0.001)**	**3**	**(<0.001)**	1	(0.079)
(recent)	F	1	(0.103)	**6**	**(<0.001)**	**4**	**(<0.001)**	**5**	**(<0.001)**	1	(0.207)
Allergies / skin condition	M	**2**	**(0.039)**	**3**	**(0.003)**	1	(0.375)	**5**	**(<0.001)**	0	(0.836)
(long term)	F	**3**	**(0.003)**	**4**	**(0.013)**	**3**	**(0.031)**	1	(0.237)	1	(0.160)
Migraines / headaches	M	1	(0.596)	-2	(0.204)	2	(0.140)	0	(0.760)	-1	(0.556)
(long term)	F	3	(0.123)	**6**	**(0.001)**	**5**	**(0.007)**	2	(0.090)	1	(0.671)
Migraine / headaches	M	1	(0.522)	0	(0.970)	0	(0.775)	0	(0.978)	-1	(0.699)
(recent)	F	2	(0.252)	**5**	**(0.012)**	**5**	**(0.009)**	2	(0.287)	3	(0.091)
Sleeplessness	M	1	(0.533)	4	(0.161)	0	(0.941)	**4**	**(0.045)**	**7**	**(0.002)**
(recent)	F	0	(0.923)	4	(0.156)	-3	(0.299)	-4	(0.058)	3	(0.230)
Persistent cough	M	0	(0.871)	-2	(0.233)	2	(0.164)	**4**	**(0.001)**	2	(0.094)
(recent)	F	0	(0.769)	**4**	**(0.011)**	1	(0.392)	1	(0.383)	-1	(0.382)
Sinus / catarrh	M	0	(0.997)	0	(0.554)	2	(0.097)	**2**	**(0.012)**	0	(0.812)
(recent)	F	-1	(0.280)	**3**	**(0.028)**	-1	(0.572)	1	(0.461)	1	(0.357)
Stomach, kidney, digestion	M	1	(0.480)	1	(0.359)	1	(0.345)	1	(0.221)	1	(0.546)
(long term)	F	2	(0.129)	-1	(0.397)	1	(0.392)	-2	(0.102)	1	(0.498)
Difficulty walking	M	2	(0.192)	0	(0.825)	0	(0.979)	-2	(0.442)	-2	(0.395)
(recent)	F	0	(0.967)	3	(0.265)	2	(0.413)	-4	(0.058)	-1	(0.605)
Asthma, bronchitis, breathing	M	0	(0.756)	1	(0.715)	0	(0.944)	1	(0.484)	-3	(0.154)
(long term)	F	-1	(0.494)	-2	(0.364)	-2	(0.407)	-1	(0.823)	-1	(0.517)
Faint / dizziness	M	-1	(0.282)	1	(0.307)	-1	(0.449)	2	(0.125)	-2	(0.237)
(recent)	F	-1	(0.503)	0	(0.916)	0	(0.760)	0	(0.820)	**-5**	**(0.001)**
Heart, blood, circulatory	M	1	(0.629)	-2	(0.388)	-3	(0.251)	1	(0.653)	-1	(0.632)
(long term)	F	0	(0.862)	-3	(0.132)	-2	(0.417)	-4	(0.053)	1	(0.483)
Pain in chest	M	-2	(0.178)	-1	(0.646)	0	(0.953)	1	(0.538)	-1	(0.774)
(recent)	F	-3	**(0.037)**	**-4**	**(0.015)**	0	(0.908)	1	(0.576)	-2	(0.161)
Palpitations / breathlessness	M	-1	(0.394)	1	(0.598)	-2	(0.316)	0	(0.906)	**-5**	**(0.006)**
(recent)	F	-1	(0.610)	1	(0.621)	0	(0.893)	-3	(0.138)	**-4**	**(0.026)**

* Pearson Chi-Square Asymp. Sig. (2-sided). Statistically significant findings ($p<0.05$) are in bold.

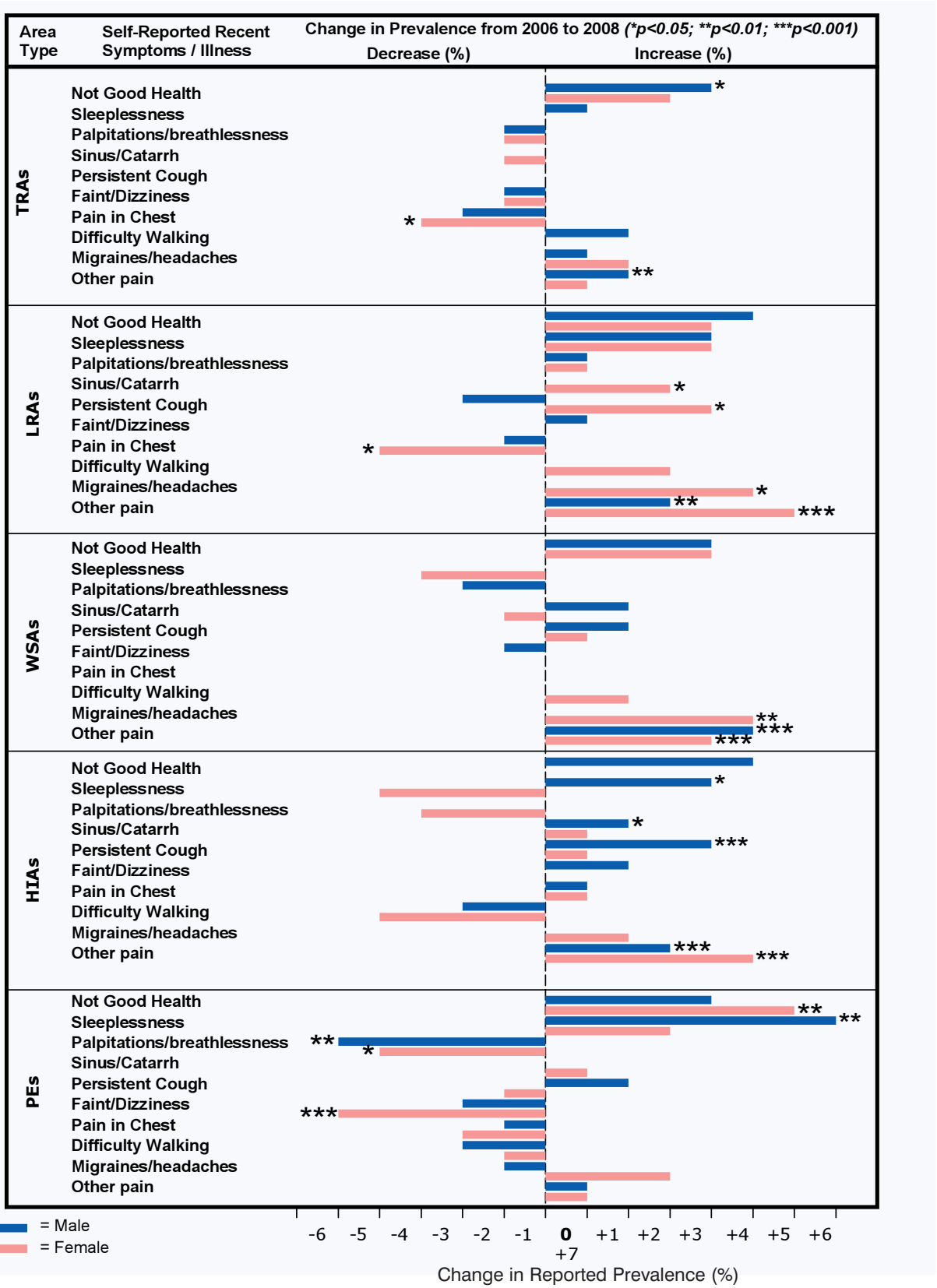
Appendices 4 and 5 summarise findings from questions about respondents' long-term and recent health. Bars to the right of the zero line represent a higher prevalence of specific health problems in 2008 compared to 2006, whereas bars to the left of zero represent a lower prevalence in 2008.

Appendix 4: Changes in the prevalence of longer-term (lasting 12 months or more) health conditions, by IAT, 2006-08



Statistically significant differences are indicated as follows: *p<0.05; **p<0.01; ***p<0.001.

Appendix 5: Changes in the prevalence of recent health problems (last four weeks), by IAT, 2006-2008



Statistically significant differences are indicated as follows: *p<0.05; **p<0.01; ***p<0.001.

Appendix 6: Bivariate logistic regression for householders reporting no moderate or vigorous physical activity, 2008

VARIABLES (LOWEST VALUE = BASE)	NO PHYSICAL ACTIVITY LASTING > 10MIN IN PREVIOUS 7 DAYS				CONFIDENCE INTERVAL (95%)	
	n	(%)	ODDS RATIO	p-VALUE	LOWER	HIGHER
AREA TYPE						
TRAs	740	68.97	1.52	<0.001	(1.23 -	1.87)
LRAs	526	64.30	1.23	0.063	(0.99 -	1.53)
WSAs	347	59.42	1.00			
HIAs	857	70.13	1.60	<0.001	(1.31 -	1.97)
PEs	612	63.75	1.20	0.089	(0.97 -	1.48)
GENDER						
Male	1,277	64.30	1.00			
Female	1,805	67.58	1.16	0.019	(1.02 -	1.31)
AGE						
<25	175	49.86	1.00			
25-39	780	57.82	1.38	0.008	(1.09 -	1.74)
40-54	826	65.35	1.90	<0.001	(1.49 -	2.41)
55-64	458	71.90	2.57	<0.001	(1.96 -	3.38)
65+	843	79.83	3.98	<0.001	(3.08 -	5.15)
TENURE						
Owner occupiers	463	58.46	1.00			
Renters	2,619	67.76	1.49	<0.001	(1.28 -	1.75)
CITIZEN STATUS						
UK citizen born in UK	2,488	67.65	1.81	<0.001	(1.38 -	2.36)
UK citizen born outside UK	125	53.65	1.00			
Asylum seeker / refugee	222	58.89	1.24	0.205	(0.89 -	1.72)
Other	74	55.22	1.07	0.771	(0.70 -	1.63)
HOUSEHOLD STRUCTURE						
Family	682	59.15	1.00			
Single adult <64yrs	540	82.32	3.21	<0.001	(2.55 -	4.06)
Single adult >64yrs	794	67.46	1.43	<0.001	(1.21 -	1.70)
2+ adults <65yrs	495	61.26	1.09	0.347	(0.91 -	1.31)
2+ adults >65yrs	404	66.67	1.38	0.002	(1.12 -	1.70)
BUILDING TYPE						
House	490	57.18	1.00			
4-in-a-block	473	68.35	1.62	<0.001	(1.31 -	2.00)
Low rise flat	667	67.10	1.53	<0.001	(1.26 -	1.85)
High rise flat	1,437	68.59	1.64	<0.001	(1.39 -	1.93)
EMPLOYMENT STATUS						
Employed	652	51.79	1.10	0.562	(0.80 -	1.52)
Education/training	83	49.40	1.00			
Unemployed	671	68.82	2.26	<0.001	(1.62 -	3.15)
Retired	1,016	79.31	3.93	<0.001	(2.82 -	5.47)
Sick	385	76.69	3.37	<0.001	(2.34 -	4.86)
Homemaker	234	58.21	1.43	0.054	(0.99 -	2.05)

Appendix 7: Bivariate logistic regression for householders reporting eating no portions of fruit or vegetables in the previous 24 hours, 2008

VARIABLES (LOWEST VALUE = BASE*)	NO PORTIONS OF FRUIT OR VEG. IN LAST 24 HOURS				CONFIDENCE INTERVAL (95%)	
	n	(%)	ODDS RATIO	p-VALUE	LOWER	HIGHER
AREA TYPE						
TRAs	102	9.51	3.12	<0.001	(1.89 -	5.15)
LRAs	103	12.59	4.28	<0.001	(2.59 -	7.07)
WSAs	19	3.25	1.00			
HIAs	92	7.53	2.42	0.001	(1.46 -	4.01)
PEs	50	5.21	1.63	0.074	(0.95 -	2.80)
GENDER						
Male	179	9.01	1.32	0.012	(1.06 -	1.63)
Female	187	7.00	1.00			
AGE						
<25	29	8.26	1.52	0.075	(0.96 -	2.42)
25-39	112	8.30	1.53	0.011	(1.10 -	2.12)
40-54	113	8.94	1.66	0.002	(1.20 -	2.30)
55-64	53	8.32	1.53	0.029	(1.04 -	2.25)
65+	59	5.59	1.00			
TENURE						
Owner occupiers	24	3.03	1.00			
Renters	342	8.85	3.11	<0.001	(2.04 -	4.73)
CITIZEN STATUS						
UK citizen born in UK	280	7.61	1.29	0.369	(0.74 -	2.24)
UK citizen born outside UK	14	6.01	1.00			
Asylum seeker / refugee	24	6.37	1.06	0.859	(0.54 -	2.10)
Other	7	5.22	0.86	0.756	(0.34 -	2.19)
HOUSEHOLD STRUCTURE						
Family	94	8.15	1.70	0.014	(1.12 -	2.60)
Single adult <64yrs	122	10.37	2.22	<0.001	(1.47 -	3.35)
Single adult >64yrs	39	5.95	1.21	0.438	(0.74 -	1.98)
2+ adults <65yrs	52	6.44	1.32	0.238	(0.83 -	2.10)
2+ adults >65yrs	30	4.95	1.00			
BUILDING TYPE						
House	43	5.02	1.21	0.443	(0.75 -	1.96)
4-in-a-block	29	4.19	1.00			
Low rise flat	60	6.04	1.47	0.097	(0.93 -	2.31)
High rise flat	233	11.12	2.86	<0.001	(1.93 -	4.25)
EMPLOYMENT STATUS						
Employed	74	5.88	1.26	0.383	(0.75 -	2.11)
Education/training	10	5.95	1.28	0.545	(0.58 -	2.81)
Unemployed	136	13.95	3.27	<0.001	(1.99 -	5.36)
Retired	79	6.17	1.32	0.283	(0.79 -	2.21)
Sick	43	8.57	1.89	0.025	(1.08 -	3.30)
Homemaker	19	4.73	1.00			

* Except where the category is 'other' (i.e. citizen status).

Appendix 8: Bivariate logistic regression for householders reporting being a current smoker, 2008

VARIABLES (LOWEST VALUE = BASE)	CURRENT SMOKERS IN 2008				CONFIDENCE INTERVAL (95%)	
	n	(%)	ODDS RATIO	p-VALUE	LOWER	HIGHER
AREA TYPE						
TRAs	368	34.30	1.00			
LRAs	342	41.81	1.38	0.001	(1.14 -	1.66)
WSAs	505	41.33	1.35	0.001	(1.14 -	1.60)
HIAs	462	48.13	1.78	<0.001	(1.49 -	2.12)
PEs	223	38.18	1.18	0.115	(0.96 -	1.46)
GENDER						
Male	905	45.57	1.41	<0.001	(1.25 -	1.59)
Female	995	37.25	1.00			
AGE						
<25	122	34.76	1.34	0.027	(1.03 -	1.73)
25-39	535	39.66	1.65	<0.001	(1.39 -	1.96)
40-54	633	50.08	2.52	<0.001	(2.12 -	2.99)
55-64	309	48.51	2.36	<0.001	(1.93 -	2.90)
65+	301	28.50	1.00			
TENURE						
Owner occupiers	239	30.18	1.00			
Renters	1,661	42.98	1.74	<0.001	(1.48 -	2.06)
CITIZEN STATUS						
UK citizen born in UK	1,744	47.42	7.39	<0.001	(5.31 -	10.29)
UK citizen born outside UK	51	21.89	2.30	<0.001	(1.47 -	3.60)
Asylum seeker / refugee	41	10.88	1.00			
Other	24	17.91	1.79	0.038	(1.03 -	3.09)
HOUSEHOLD STRUCTURE						
Family	409	35.47	1.27	0.022	(1.04 -	1.56)
Single adult <64yrs	654	55.56	2.89	<0.001	(2.36 -	3.54)
Single adult >64yrs	198	30.18	1.00			
2+ adults <65yrs	348	43.07	1.75	<0.001	(1.41 -	2.17)
2+ adults >65yrs	209	34.49	1.22	0.102	(0.96 -	1.54)
BUILDING TYPE						
House	324	37.81	1.00			
4-in-a-block	295	42.63	1.22	0.054	(1.00 -	1.50)
Low rise flat	476	47.89	1.51	<0.001	(1.26 -	1.82)
High rise flat	800	38.19	1.02	0.847	(0.86 -	1.20)
EMPLOYMENT STATUS						
Employed	484	38.44	3.12	<0.001	(2.05 -	4.76)
Education/training	28	16.67	1.00			
Unemployed	492	50.46	5.09	<0.001	(3.33 -	7.79)
Retired	424	33.10	2.47	<0.001	(1.62 -	3.77)
Sick	296	58.96	7.18	<0.001	(4.61 -	11.19)
Homemaker	144	35.82	2.79	<0.001	(1.77 -	4.39)

Appendix 9: Bivariate logistic regression for householders reporting abstinence from alcohol consumption, 2008

VARIABLES (LOWEST VALUE = BASE)	NEVER DRINK ALCOHOL				CONFIDENCE INTERVAL (95%)	
	n	(%)	ODDS RATIO	p-VALUE	LOWER	HIGHER
AREA TYPE						
TRAs	599	55.82	2.54	<0.001	(2.06 -	3.13)
LRAs	420	51.34	2.12	<0.001	(1.70 -	2.64)
WSAs	194	33.22	1.00			
HIAs	474	38.79	1.27	0.022	(1.04 -	1.57)
PEs	342	35.63	1.11	0.336	(0.90 -	1.38)
GENDER						
Male	691	34.79	1.00			
Female	1,338	50.09	1.88	<0.001	(1.67 -	2.12)
AGE						
<25	147	41.88	1.16	0.233	(0.91 -	1.47)
25-39	651	48.26	1.50	<0.001	(1.28 -	1.75)
40-54	485	38.37	1.00			
55-64	245	38.46	1.00	0.969	(0.83 -	1.22)
65+	501	47.44	1.45	<0.001	(1.23 -	1.71)
TENURE						
Owner occupiers	275	34.72	1.00			
Renters	1,754	45.38	1.56	<0.001	(1.33 -	1.83)
CITIZEN STATUS						
UK citizen born in UK	1,297	35.26	1.00			
UK citizen born outside UK	172	73.82	5.18	<0.001	(3.84 -	6.99)
Refugee: indefinite leave to remain	129	76.79	6.07	<0.001	(4.22 -	8.74)
Refugee: exceptional leave to remain	72	86.75	12.02	<0.001	(6.35 -	22.74)
Asylum seeker / refugee	103	82.40	8.59	<0.001	(5.40 -	13.69)
Other	86	63.70	3.22	<0.001	(2.25 -	4.61)
HOUSEHOLD STRUCTURE						
Single adult <64yrs	419	35.60	1.00			
Single adult >64yrs	316	48.17	1.68	<0.001	(1.38 -	2.04)
2+ adults <65yrs	313	38.74	1.14	0.155	(0.95 -	1.38)
2+ adults >65yrs	251	41.42	1.28	0.016	(1.05 -	1.56)
Family	629	54.55	2.17	<0.001	(1.84 -	2.56)
BUILDING TYPE						
House	320	37.34	1.12	0.279	(0.91 -	1.38)
4-in-a-block	240	34.68	1.00			
Low rise flat	396	39.84	1.25	0.032	(1.02 -	1.53)
High rise flat	1,070	51.07	1.97	<0.001	(1.64 -	2.35)
EMPLOYMENT STATUS						
Employed	402	31.93	1.00			
Education/training	106	63.10	3.64	<0.001	(2.61 -	5.10)
Unemployed	449	46.05	1.82	<0.001	(1.53 -	2.16)
Retired	579	45.20	1.76	<0.001	(1.50 -	2.07)
Sick	208	41.43	1.51	<0.001	(1.22 -	1.87)
Homemaker	252	62.69	3.58	<0.001	(2.83 -	4.53)

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