Can urban regeneration programmes assist coping and recovery for people with mental illness? Suggestions from a qualitative case study

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SUMMARY

Researchers and policy-makers are increasingly recognizing that urban socio-environmental conditions can affect the development and course of numerous health problems. The aim of this paper is to investigate the impact an urban regeneration programme can have on everyday functioning, coping and recovery for people with a mental illness. We were also interested in discerning which component parts of the regeneration are the most important in positively affecting people with mental illness. These questions were explored through an in-depth qualitative case study of the Gospel Oak neighbourhood in London, which recently underwent an intensive urban regeneration programme. Interviews and focus groups were conducted with residents living with a mental illness (n = 16). Relevant participant observation was also conducted. Participants reported that interventions that improved community safety were by far the most important in affecting everyday coping and functioning. Interventions that improved the quantity and quality of shared community facilities had a positive, but milder effect on mental health. Component parts that appeared to have little effect included environmental landscaping and greater community involvement in decision-making processes. Most participants reported that their mental illness was a consequence of severe insults over the life-span, for example childhood neglect or family breakdown. Thus, the regeneration was seen as something that could assist coping, but not something that could significantly contribute to complete recovery. Our results thus suggest that urban regeneration can have a mild impact on people with mental illness, but this appears to be outweighed by life-span experience of severe individual-level risk factors. That said, some of our findings converge with other studies indicating that community safety and community facilities can play a role in positively affecting mental health. Further ethnographic and epidemiological research is necessary to explore these two factors.

Key words: mental health; qualitative; urban regeneration

INTRODUCTION

The discipline of public health was founded on research and theory that paid close attention to the impact of inner-city socio-environmental conditions. Figures such as Chadwick, Snow and
Virchow documented how factors particular to urban environments, for example overcrowding and unsanitary conditions, could lead to increased risk and elevated rates of numerous health problems (Eisenberg, 1984). In a similar vein, historical epidemiological analysis has suggested that non-medical interventions that tackled negative socio-environmental conditions were followed by significant improvements in public health (McKeown, 1976; Waitzkin, 1981).

The pre-dominance of an individually orientated risk-factor epidemiology during the latter half of the twentieth century signified a general lull in academic attention to the socio-environmental context in which people lived their lives (Ashton and Seymour, 1998). That said, there is an ongoing paradigm shift in both academia and policy-making circles back to a belief that the fundamental determinants of health status lie beyond individual-level risk factors and are instead to be found in wider social, economic and environmental milieus (Yen and Syme, 1999; Diez-Roux, 2001). Regular international declarations, such as the World Health Organisation Alma-Ata declaration (World Health Organisation, 1978), the World Health Organisation Health for All Ottawa Charter (Ottawa Charter for Health Promotion, 1992) and the WHO Jakarta Declaration (World Health Organisation, 1997) indicate the strength of this paradigm shift, emphasizing a holistic, multi-level and multi-disciplinary approach to public health. The spirit of these declarations are reproduced in policy proclamations of individual nations, for example the British Government’s document ‘Our Healthier Nation’ (Department of Health UK, 1998) notes that socio-environmental conditions surrounding illness and disease must be tackled to improve public health.

The paradigm shift is also leading governments and other agencies to embark on numerous area-based interventions (ABIs), some of which are specifically targeted at improving public health, others having more general aims. All these programmes involve delineation of a geographically bounded area followed by an intense, high profile series of discrete social, economic and environmental interventions. They are therefore in a sense a high-risk intervention, because the neighbourhoods chosen are generally considered deprived and needy. However, they are also a (sub) population intervention in that many of the measures are targeted at the whole population within the area, not just pre-selected high-risk individuals residing therein. The WHO has embarked on a global programme of health-orientated ABIs known as ‘Healthy Cities’ (WHO, 1994). The British Government has mirrored these interventions with its own similar programme known as ‘Health Action Zones’. Both of these programmes involve identifying localities with lower than average population health, then creating tailor-made health-orientated interventions to improve public health. ABIs with wider aims are generally known as ‘urban regeneration programmes’. These are usually multi-faceted with numerous specific objectives, generally including economic development, community safety and public health. The British government is currently ploughing £800 million into urban regeneration programmes through ‘neighbourhood renewal funds’.

Although there is a large literature on the effect of place per se on health, relatively little attention has been paid to whether aspects of urban regeneration programmes can influence public health, particularly mental health (see Macintyre and Ellaway, 2000 for relevant overview). There have been a few quantitative studies suggesting that urban regeneration can have a positive effect on mental health. Halpern noted that an urban regeneration programme in an English town may have contributed to a decrease in rates of anxiety and depression (Halpern, 1995). Dalgard and Tambs found a similar decrease in an Oslo neighbourhood undergoing urban regeneration when compared with similar neighbourhoods receiving no intervention (Dalgard and Tambs, 1998). Although these studies present a clear, overall picture, they are mainly based on epidemiological analysis and the everyday impact of the intervention on people with mental health problems is not explored.

The present paper is novel in that it employs an in-depth, intensive, qualitative approach to specifically study the impact of a comprehensive urban regeneration programme on the everyday lives of people with mental health problems. The regeneration programme took place in Gospel Oak, a London neighbourhood in the Borough of Camden with approximately 6200 residents (Camden Council, 2000). From September 1998 to March 2001 Gospel Oak underwent a period of intense urban regeneration as a result of winning £22 million from the Government’s ‘Capital Challenge’ fund (Camden Council, 1997). Camden Council selected two
key themes for improvement in Gospel Oak—'integration and security'. It was claimed that these priorities arose out of a 1996 Camden Council analysis of the area that concluded the neighbourhood suffered from numerous problems including high fear of crime, inadequate facilities and isolation from the surrounding areas. Camden Council attempted to meet their overall aim through targeted and specific interventions. At the end of the programme in 2001 the following changes had occurred in the neighbourhood:

- External repairs, decorations, roofing, instalment of double-glazing and secure doors for over 1000 properties.
- Refurbishment of sports pitch. Environmental works including street lighting upgrades and improvements to commercial properties.
- The establishment of a partnership board and community forum to input into the process of delivery and assist in new funding applications.
- The building of a new sports activity centre.
- The complete renovation and refurbishment of the community centre and library.
- Security improvements including new electronic doors for communal blocks, a concierge in Bacton (the largest high-rise) and strategic instalment of CCTV.
- Environmental improvements including landscaping and restructuring of the main open space, Lismore Circus.

Although the urban regeneration programme was not designed as a mental health population intervention, we treated it as such, investigating its impact on those living with mental illness, especially its affect on coping, everyday functioning and recovery.

The theoretical framework through which the present paper is formulated originated with Eaton (1951), who posited that all individuals lie somewhere along a continuum with mental illness at one end and mental health at the other. People can move along this continuum in either a positive or negative direction according to salient events and processes. This model has attained ongoing popularity, with eminent epidemiologist Rose (1993) similarly noting that individual mental health/illness is a continuous rather than binary variable that changes incrementally over time. This model is employed in the present study as it provides an adequate conceptual framework with which to examine exposures that may not lead to complete restitution for people with mental illness, but may significantly improve their everyday functioning, moving them along the mental health continuum. Thus, the overall aim of this paper is to examine to what extent aspects of the urban regeneration programme favourably impacts on coping, everyday functioning and recovery of residents living with a mental illness. A secondary aim is to explore the differential impact of the component parts of the regeneration programme, exploring which factors appear to have the greatest impact.

METHODS

Participants from the present study were recruited from within an ongoing longitudinal mental health survey in the same neighbourhood that used random probability sampling methods to recruit almost 1000 participants (see Weich et al., 2002 for details). Mental health status was discerned by respondents’ scores on the Centre for Epidemiologic Studies-Depression (CES-D) scale; a validated screening instrument for elucidating likely cases of depression and/or anxiety (Roberts and Vernon, 1983). For the present study, we stratified the quantitative survey into two groups, those scoring 16 or over on the CES-D and those scoring 15 or under, 16 being an accepted cut-off score indicating likely mental illness. Participants in the present study were randomly selected from the CES-D 16+ sub-group. Of the 23 people contacted who were still living in Gospel Oak, 16 agreed to participate, giving an overall response rate of 70%. Nine of the participants were men and seven were women. We did not sample for age or ethnicity, however our final participant list tended to reflect the officially described distribution of these variables in Gospel Oak (Whitley et al., 2005).

Of the 16 participants, 14 took part in in-depth interview and two in one focus group. The aim of utilizing both methods of data collection was to assist triangulation of research findings. We initially planned a number of focus groups however these were discontinued after only two people turned up at the first group, despite having many more ‘confirmed’ participants. Non-attenders told us afterwards that they preferred one-to-one interviews than group encounters. Interviews and focus groups took part towards the end of the regeneration programme. These were directed by a topic guide, which began by exploring
general factors with regards to the Gospel Oak neighbourhood (e.g. views of the neighbourhood, neighbours, community activities, statutory services, transport, etc.). The interaction then became progressively more focused to concentrate on specific factors regarding the urban regeneration (e.g. household repairs, new community facilities, environmental improvements, etc.). Most of the interviews took place in residents’ homes, the focus group occurred in the local community centre. All were facilitated by the first author, who also engaged in regular and systematic participant observation over a 24-month period. Specifically the researcher would spend time in places earmarked for urban regeneration intervention before, during and after the change to discern impact on everyday behaviour. These included locations such as the community centre, the library, crime hot spots that were receiving CCTV and open-spaces that were being re-designed.

Analysis of data took place both during and after the research. All interviews and focus groups were tape-recorded, transcribed and collated together with the field-notes from participant observation. The data was initially analysed by the first author who examined participant responses to the various component parts making up the whole intervention programme, assessing commonality of response and differential impact on functioning, coping and recovery. For purposes of analysis, five sub-categories were created, into which data was coded and allocated, which summarized all aspects of the intervention, these being:

- New measures intending to increase community safety.
- Improvements in quality and quantity of shared community facilities.
- Environmental improvements.
- Household repairs.
- Greater community involvement in local decision-making processes.

To ensure validity, the second author independently examined the data before critically examining the first author’s provisional conclusions. After discussion, both authors agreed on the findings listed below in the results. For reasons of space, we only present a limited number of quotations to support our arguments. However, these are emblematic of the wider data and have been deliberately selected because of their representative nature. Discussion is ongoing with the results. Ethical approval was received from the local committee. All names and some key variables have been changed to protect anonymity.

**RESULTS**

As stated in the method, we systematically analysed the data to examine the differential impact of the five principal component parts that account for the whole urban regeneration programme. These are treated separately in the results, the most significant coming first. It became apparent during coding that measures that increased community safety were by far the most important in impact for people with mental illness. The increase in quality and quantity of shared community facilities had a more mild positive impact. Household repairs and improvements also had a mild impact, appearing most important when they affected feelings of safety. Environmental improvements (except community safety improvements) and greater involvement in community processes did not emerge as significant themes from participants’ narratives.

**New community safety measures**

As mentioned in the Introduction, one of the main themes of the urban regeneration programme was ‘security’. Thus, specific measures were taken to increase actual community safety and feelings of security. As mentioned these principally consisted of strategically located CCTV cameras, new security entry systems in blocks of flats (including a concierge at the biggest tower block) and re-design of open spaces. Many of the participants remarked that these interventions had the most important impact on everyday functioning and coping. By increasing feelings of security, residents felt more secure in leaving the house and thus accessing services, facilities and social support networks. Fernando is a middle-aged resident currently being treated for depression. Throughout his interview, he mentions that increased security measures have helped him cope better with his mental illness. Below are some unprompted remarks:

This place is getting a lot better . . . now they have got the control with the porter and security and cameras . . . they are building more things, for the children, they are
now doing the park. I have been in other areas and seen more trouble there ... since they have did the job and the work it is much better.

As stated these views were commonly shared. Other participants heavily praised community safety interventions. Luke is a participant in his late twenties with a long-term mental health problem. He has spent most of his life in the neighbourhood and believes that the area has improved considerably since the regeneration. As Fernando notes the regeneration is making things ‘much better’, Luke notes the regeneration is ‘heartening’ and throughout his interview there is a theme of optimism in the programme:

It used to be quite a rough area ... it used to be certain kids stomping ground ... if they don’t like you they let you know ... actually lately it has not been too bad ... it is quite interesting watching all the work go on ... it is heartening.

It should be noted that data gathered through participant observation triangulated well with data gathered through in-depth interview and focus group. At the beginning of the research certain overhead walkways and derelict buildings often acted as magnets for youth gangs and many residents reported having eggs thrown at them from these walkways. These walkways and derelict buildings were demolished during the research, with many participants alluding to a decrease in anti-social activities as a consequence. In fact, there was a very strong degree of consensus across participants that community safety measures were by far the most important component of the regeneration. This emerged as the single most important theme, and may be related to the fact that fear of crime appeared to be a large problem in Gospel Oak, especially amongst the mentally ill (Whitley and Prince, 2005).

Improvements in shared community facilities

A significant component of the intervention was concerned with improving the quality and quantity of shared community facilities, most notably the local library, the local community centre and local sports facilities. Evidence gathered from participant observation illustrated that these renovated facilities were very highly valued and utilized by local residents. They provided a variety of new services, which gave both concrete help to people in need as well as facilitating the development of social support networks amongst residents. Some residents also remarked that these services had a more intangible and indirect knock on effect for everyone in the community in that they gave certain individuals places to go and do things whereas in the past they may have been lonely or engaged in anti-social facilities. Sean, a pensioner with a long-term mental illness, indicates throughout his interview that he often utilizes these newly rejuvenated facilities, reflecting that they have also had a positive communal effect:

There was one time when they didn’t have the Community Centre and they have got one now, you know. They have got a football pitch, they spent a lot of money on it and they are building another one down there, children have got somewhere to go and play, before that they had nowhere ... its good, yeah.

Other residents made more focused comments about these facilities indicating how they can specifically help to promote social and economic involvement in everyday life. Doug is middle-aged with a long-term mental health problem who uses the revamped facilities for social and educational purposes, especially the new computer suite in the library:

I am doing an IT course at the Library, I started a week ago. I am learning how to use computers, I bought one two years ago it is still sitting in its box. I am a bit technology shy, but I need to be competent at it because I write poetry, and I want to type up my poems, get them on computer, maybe start a website and share what I write. The course is very good, the library is not bad ... There was a degree of unanimity across participants that the increase in quality and quantity of shared community facilities was a positive outcome of the urban regeneration programme. This appeared to have a mild effect on functioning and coping; however, this theme was weaker than community safety.

Environmental improvements

Numerous environmental improvements occurred as part of the urban regeneration programme. These included landscaping, planting trees, better waste management and greater street lighting. Participant observation and data gathered from interviews suggest that these measures impacted most positively on people with mental illness when they addressed issues
of community safety. Elderly resident Sean, who has a long-term mental health problem, makes this point well:

Camden job train people came in and ran a course, yeah planting flowers, cutting hedges and everything. They are doing a great job, before that the hedges were not always cut, it was poor, no-one did anything, you were scared out of your life passing them, but now they have cut them all down, yeah.

Other participants suggested that environmental improvements had a generic effect of making them ‘feel good’. Both participants of the focus group quickly reached consensus that improvements in the area have had a positive impact:

Jane: Camden have cleaned themselves up, the place is cleaner, the children are playing, you see trees coming up and you think ‘oh how wonderful’. I think the area is getting much better. It’s on the up! When I come out now you look and think ‘God isn’t this nice!’ You think they are looking after that and you feel a bit lighter in your heart.

Patrick: The money poured in has engendered a sense of regeneration which is, as we expressed earlier, we felt good about.

That said, consensus across this theme was not nearly as strong as that concerning community safety and community facilities. A number of participants openly stated that these kind of environmental factors could have little impact on mental health problems. These problems were ascribed as rising from serious long-term individual-level factors. Steven is a case in point, a participant with a severe obsessive-compulsive disorder that began after years of child abuse. He had tried to kill himself on various occasions. Although he speaks highly of community safety interventions, he feels environmental interventions such as new parks and greenery can have little effect on mental health, almost ridiculing the thesis that these things can effect mental health:

God! If I thought the environment affected me I would just go and sit in some beautiful gardens all day! You know literally.

Another participant echoed these remarks, talking about her son who suffered from a long-term mental health problem and had been on the receiving end of a variety of individual-level interventions, which did little to lessen his condition. She stated:

For someone like Paul it wouldn’t matter if you put gold on the streets he would still have a compulsive disorder!

Household repairs and renovation

Part of the urban regeneration programme involved household-level physical interventions, most notably the instalment of new double-glazing and stronger, more secure doors. We have noted in detail elsewhere that these interventions appeared to have a positive effect on people with mental health problems, mostly by protecting individuals from ambient noise exposure as well as diminishing fear of break-in (Whitley et al., 2005). Again these findings fit in with the rest of the results, suggesting that urban regeneration measures that increase feelings of community safety appeared to have the greatest impact on people living with mental illness.

Greater community involvement in local decision-making processes

One of the aims of the urban regeneration programme was to encourage community participation in local decision-making processes. This was done through the setting-up of various partnership boards and other community-statutory bodies. Many of the participants had heard of these organisations, however very few of them reported ever attending any meetings, or any desire to attend. This lack of participation diminishes our ability to comment on the potential role involvement in these kind of activities could have for people with mental illness. It could be that they feel inhibited from these kind of activities (as they felt inhibited from coming to our focus group). If so, regeneration programmes may need to make greater efforts to create more imaginative opportunities by which people with mental illness can make their contribution.

CONCLUSION

From the point of view of study participants, urban regeneration measures that deal with community safety have by far the greatest impact on coping and everyday functioning. The increase in quality and quantity of shared community facilities was the next important aspect of the
regeneration, but the strength of this theme was mild when compared with community safety. Considering the model of mental health used in this study is the ‘continuum’ model proposed by Eaton (Eaton, 1951), these two measures combined could be considered to slightly shift participants towards better mental health, or at least stabilise their current position on the continuum. Thus, when considered as a population intervention, urban regeneration programmes such as ‘Capital Challenge’ in Gospel Oak do appear to play some role helping people with mental health problems live with their illness. That said, study participants generally remarked that when considered in light of other risk and protective factors (e.g. adverse childhood experience, family breakdown, unemployment, etc.) overall impact of the regeneration programme was mild. Whilst it appeared to contribute to everyday functioning and coping, participants did not feel it could significantly contribute towards complete recovery or restitution. Thus, our data suggests that when considered as a population intervention, urban regeneration programmes only appear to have a mild impact on people with a mental health problem.

Having said that, our findings do raise issues that demand further epidemiological and ethnographic exploration, as they triangulate well with existing work on urban mental health, most notably regarding the nexus between community safety, community facilities and mental health. Halpern (1995) found that widespread community safety measures (and an associated reduction in fear of crime) correlated with a reduction in common mental disorders amongst residents of an English town. Similarly, Baum and Palmer found that certain neighbourhood characteristics such as safety and nature of community facilities were related to resident assessment of general community health in Adelaide (Baum and Palmer, 2002). Macintyre and Ellaway also suggested that community spaces and facilities can play a role in determining general health of residents, general health obviously involving elements of physical and mental health (Macintyre and Ellaway, 2000).

To end this paper, we note that it is based on data from an exploratory qualitative case study with modest aims. Thus, answers to our research question are not definitive and the paper’s prime value may be in suggesting areas for further study rather than making concrete suggestions regarding relevant interventions. The data suggests a mild relationship between some aspects of urban regeneration and mental health. We have attempted to unpack some of these factors, noting which appear to be the most important in helping those living with mental illness. Comparing coping and recovery in a variety of neighbourhoods undergoing different (or no) forms of urban regeneration may be the next step in assessing how non-medical population interventions can affect mental health. Although our ethnographic approach has raised a number of interesting issues, applying this in tandem with longitudinal epidemiological analysis in different sites would allow for a fuller exploration of urban regeneration and mental health.

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