Local Government and Regeneration Committee

Regeneration Inquiry

Submission from GoWell

Further to your email and letter of 8 May, we are pleased to provide the following submission for consideration by the Committee.

GoWell is a research and learning programme that was launched in 2005 to investigate the impacts of public and private investment in housing and neighbourhood renewal on the health and wellbeing of individuals, families and communities in Glasgow. It focuses on some of the poorest, least healthy, least stable and most ethnically diverse communities in Scotland, and through a spectrum of research approaches, aims to build an understanding of the ways in which a range of area-based interventions impact on those communities.

The programme involves various research and learning methods, and at its core is a community survey of fifteen areas of the city, grouped into five intervention area types (see Appendix). Three surveys have now been completed (in 2006, with a sample size of 6,016; 2008, with a sample of 4,657; and in 2011 with a sample of 4,063). The availability of data over these three time points begins to yield insights into trends over time. However, health impacts may take many years to be realised, and the pace of intervention has slowed down with the economic recession, so future surveys will be crucial to establishing whether such effects materialise.

GoWell is a collaborative partnership between the Glasgow Centre for Population Health, the University of Glasgow and the MRC/CSO Social and Public Health Sciences Unit, and is sponsored by Glasgow Housing Association, the Scottish Government, NHS Health Scotland and NHS Greater Glasgow and Clyde. Further information about the programme, including access to publications and opportunities to sign up for newsletters and events, can be found at www.gowellonline.com.

Many of the programme’s findings will be of interest to the Committee, and we are grateful for the opportunity also to provide verbal evidence. In this written submission, we have distilled seven headline points as follows:

1. Improvements in health and wellbeing, and reductions in health inequalities, are important policy aims of regeneration. However, there is a lack of clarity about how these aims might be achieved in practice.

2. Measures of individual and community health and wellbeing are not routinely deployed to assess the impact of regeneration or progress over time in relation to neighbourhood improvement. There would be considerable benefits in establishing the routine use of health and wellbeing measures for this purpose.

3. The importance of neighbourhood quality as a determinant of health and wellbeing is becoming increasingly apparent in our GoWell findings. Detailed consideration should be given to means of specifying and assessing
the various dimensions of neighbourhood quality, and to strengthening the ability of regeneration processes to positively impact these.

4. There is clarity of responsibility and clear resource allocation for some aspects of regeneration, but this is not the case for social regeneration. GoWell findings indicate that the social dimensions of community life have a major impact on people’s lives and that some of these could be positively impacted by regeneration processes if a clear action plan were developed.

5. Large-scale regeneration often involves relocating people from their homes. The effects of relocation are generally positive for individuals and households, but in and of itself, relocation is not a transformative experience. There are also some indications of negative impacts on new ‘host’ communities.

6. For people living in areas undergoing regeneration, the time period from planning to completion can be very lengthy, often involving substantial periods of decline and uncertainty. This appears to be exacerbated in the current economic climate. It is important for the sake of the affected communities to have a defined end-point and a clear strategy for getting there.

7. Experience in our study communities suggests that there is not a clear understanding about the respective rights and responsibilities of the community and of developers and service providers during consultation and delivery processes. We have evidence that people increasingly feel they have some influence both over major strategic plans and over specific plans affecting their own household – but many do not. Independent advice and support to communities in situations of change is important and helpful.

The pages that follow expand on each of these points, and we are also pleased to provide copies of three reports that provide further information on relevant findings:

GoWell Progress Report 2012/13, including key findings and developments.

A synthesis of GoWell research findings about the links between regeneration and health. Egan et.al. 2013.


We trust that this submission will be helpful.

Yours faithfully

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Prof Ade Kearns, Professor of Urban Studies, University of Glasgow
Prof Anne Ellaway, Programme Leader (Neighbourhoods and Health), MRC/CSO Social and Public Health Sciences Unit, Glasgow
LOCAL GOVERNMENT AND REGENERATION COMMITTEE
INQUIRY ON REGENERATION:
EVIDENCE SUBMITTED FROM THE GOWELL PROGRAMME

1. Improvements in health and wellbeing, and reductions in health inequalities, are important policy aims of regeneration. However, there is a lack of clarity about how these aims might be achieved in practice.

The regeneration vision set out in “Achieving a Sustainable Future” is of a Scotland where our most disadvantaged communities are supported and where all places are sustainable and promote well-being. In our experience, wellbeing outcomes are regarded by people from across different sectors of society as being some of the most important outcomes of regeneration. There is, however, little clarity about what needs to happen to achieve better health and wellbeing through regeneration processes, and the prevailing assumption seems to be that better health will ‘emerge’ as a consequence of other actions. Moreover, there is limited evidence to date that better health, or reductions in health inequalities, have been achieved as a result of past regeneration programmes. In other words, there is a disconnect between the policy aim and its achievement in practice.

The issues that follow are highlighted because they all have the potential to have a positive and sustained impact on health and wellbeing.

2. Measures of individual and community health and wellbeing are not routinely deployed to assess the impact of regeneration or progress over time in relation to neighbourhood improvement. There would be considerable benefits in establishing the routine use of wellbeing measures for this purpose.

Population health is one of the best barometers of the consequences of all of a society’s activities. Health is an indicator of the nature of the society, the quality of life of its people, and the cultures and values expressed through its policies, priorities and civic activities. Health therefore illuminates much about the nature of communities in Scotland. Regeneration activities impact on many of the established determinants of health within communities, but assessments of progress or ‘success’ in regeneration often fall short of looking at impacts on health and wellbeing – looking instead at measures of satisfaction; at quantifying physical improvements; at reducing levels of young people not in employment, education or training; and so on.

It is our view that a range of measures of individual and community health should routinely be deployed in assessing the success of regeneration within Scotland. The currently identified outcomes relating to physically, economically and socially sustainable communities do not achieve this. Unless there is a more consistent translation of the vision (that all places will … promote wellbeing) into measurable outcomes, the disconnect (described above) between the policy aim and its achievement will continue.
3. The importance of neighbourhood quality as a determinant of health and wellbeing is becoming increasingly apparent in our GoWell findings. Detailed consideration should be given to means of specifying and assessing the various dimensions of neighbourhood quality, and to strengthening the ability of regeneration processes to positively impact these.

The establishment of the housing quality standard within Scotland has resulted in notable improvements in housing, and associated improvements in tenant satisfaction. Our survey findings show that housing satisfaction has improved in all area types since our study started in 2006\(^2\). A national standard such as this, therefore, brings benefits to all with little local variation.

We are aware of the potential for a neighbourhood quality standard to be developed for Scotland and we see considerable potential value in this. Many aspects of neighbourhood quality have an association with health and wellbeing in our study areas. For example:

- Use of local amenities is associated with more walking\(^3\) and may be influenced both by the provision and perceived quality of those local amenities;
- Nutritious food retail outlets are associated with healthier snacking\(^4\);
- The attractiveness of the local environment, the extent to which it is quiet and peaceful, and feelings of safety walking in the area are associated with better mental wellbeing\(^{5,6}\).

We would encourage the use of a neighbourhood quality standard as a tool to set objectives for regeneration within specific communities, and call for it to be as comprehensive and specific as possible, including for example the full range of commercial and public sector amenities in a neighbourhood.

Regeneration strategy should not leave such provision to be solely determined by the market, since local amenities can significantly influence attitudes and behaviours, and enable or limit opportunities for healthier lifestyles. In our study areas, for example, we have found relatively low resident ratings of youth and leisure services, and in some areas low or declining ratings of local shops\(^7\). Thus, we think these elements of neighbourhood quality should be more firmly entrenched in local regeneration strategies. The variation that exists in Scotland in relation to community access to facilities such as schools, reinforces the need for a clearer specification of the features that should be in place to foster community wellbeing across the country.

It is also worth highlighting the important role of community consultation and involvement in informing plans for local neighbourhoods. Findings from the Equally Well test site in Glasgow, for example, highlight this point\(^a\).

\(^a\) http://www.gcphealth.co.uk/assets/0000/2517/Glasgow_City_Test_Site_Summary_and_Evaluation_Findings.pdf
4. There is clarity of responsibility and clear resource allocation for some aspects of regeneration, but this is not the case for social regeneration. GoWell findings indicate that the social dimensions of community life have a major impact on people’s lives and that some of these could be positively impacted by regeneration processes if a clear action plan were developed.

A good, supportive social environment is important for people’s quality of life. GoWell has looked at social outcomes in terms of neighbourly behaviours, social networks and social support, safety and trust in the local area, and people’s sense of community.

Overall we have found relatively high proportions of respondents in all areas saying they have someone they can rely on for support, and also that they have regular contact with friends and neighbours. Over time, these findings have generally been sustained.

Our findings are less positive, however, in relation to indicators of wider community cohesion. As a whole, there are negative trends in feelings of safety, perceptions of honesty and informal control exercised by co-residents, and feelings of being part of the community. In the language of Social Capital, it is these wider links (‘bridging’ capital) beyond immediate circles of family and friends that enable people to move on and make changes in their lives when they need to. We have found several of these aspects of community cohesion to be associated with levels of mental wellbeing and feelings of loneliness among residents, thus emphasising the importance of social regeneration to health and wellbeing outcomes.

In our presentations and discussions about GoWell findings, we regularly note a strong recognition among policy-makers and practitioners, as well as tenants and community organisations, of the importance of these social dimensions of communities. We also regularly note that there is an absence of clarity about where responsibility lies for social regeneration, and about what it involves. We have previously provided a working definition of social regeneration, which incorporates action on a variety of capitals other than economic and physical capital (the more usual targets of regeneration), including on human, social, community, cultural and residential capital.

5. The effects of relocation are generally positive for individuals and households, but in and of itself, relocation is not a transformative experience. There are also some indications of negative impacts on new ‘host’ communities.

Large-scale regeneration often involves moving people out of their homes and neighbourhoods to facilitate demolition and redevelopment. Overall, in our study communities in Glasgow, we have not found such relocation to amount to so-called ‘displacement’ of residents, nor to be detrimental to people’s social relations or sense of community. This is partly because prior social conditions in regeneration areas are often poor and not as cohesive as often
assumed (see above), but also because housing staff have been able to take their time and exercise flexibility to meet residents’ relocation needs\textsuperscript{13, 14}.

However, relocation has not transformed people’s residential circumstances or lives in the way that relocation programmes in other countries attempt to do (for example: the Moving to Opportunity programme in the USA). We have found that people relocated from regeneration areas do not move very far, typically no more than a mile, and often move to other deprived areas (even if not quite as deprived as those they came from)\textsuperscript{11}. Tenants who are relocated locally exhibit mixed views about the outcome. They often preferred to be relocated locally, but they also experience continuing problems of antisocial behaviour in their new location, and are somewhat disappointed that their new neighbourhood is not more mixed than it is in housing tenure and social terms\textsuperscript{12}. Ironically, if redevelopment had progressed quicker in their original neighbourhoods (see next point), more of the residents may have opted to stay, and as a result eventually lived in more mixed communities.

At the same time, relocation through regeneration involves moving significant numbers of people to nearby communities. This has the potential to adversely impact on these receiving communities, through so-called ‘negative spillover effects’. Within GoWell we are studying several communities near regeneration areas (our Wider Surrounding Areas), and we have evidence of several negative trends in such areas including in relation to: perceived neighbourhood attractiveness; feelings of progress; ratings of service provider responsiveness; trust and reliance in neighbours\textsuperscript{15 16}. There may therefore be an issue here for policy and services to consider, namely how to support communities who are due to receive incoming residents being relocated from regeneration areas.

6. For people living in areas undergoing regeneration, the time period from planning to completion can be very lengthy, often involving substantial periods of decline and uncertainty. This appears to be exacerbated in the current economic climate. It is important for the sake of the affected communities to have a defined end-point and a clear strategy for getting there.

While it is the case that the support, care and maintenance of disadvantaged communities is an ongoing activity, we are nonetheless concerned that transformational regeneration processes and the development of mixed communities appear to be programmes with flexible timetables, frequently adjusted in response to public spending cuts and private sector downturns in activity.

The completion of regeneration within areas is important for several groups. Those who are relocated are often concerned afterwards to know that the redevelopment of their previous neighbourhood has been completed and that their move has been worthwhile; this is especially so for those who did not want to move in the first place\textsuperscript{12}. Those who move and those who remain express concern about how long they have had to wait for rehousing and/or for the redevelopment of their area\textsuperscript{12}. So far, we have not found continuing to
live in an uncompleted regeneration area to be detrimental to residents’ health. However, we have found that physical health declined in the first half of our study period among those remaining in regeneration areas who have no educational qualifications, and we are concerned for the health and wellbeing of such residents if the regeneration process continues for much longer. If that were to be the case, such vulnerable residents could face deteriorating housing and neighbourhood conditions and dwindling social relations.

We are of the view that Government should consider how the completion of major regeneration programmes might be ensured in a more timely manner for the sake of the communities, rather than allowing them to continue without firm target completion dates.

7. Experience in our study communities suggests that there is not a clear understanding about the respective rights and responsibilities of the community and of developers and service providers during consultation and delivery processes. We have evidence that people increasingly feel they have some influence both over major strategic plans and over specific plans affecting their own household – but many do not. Independent advice and support to communities in situations of change is important and helpful.

Feelings of empowerment – both as the recipients of housing and other services, and as residents within neighbourhoods undergoing change – are important to people’s mental wellbeing, and thus to the outcomes of regeneration. There are several levels or types of community empowerment: being satisfied as a consumer of services; being kept informed by service providers and the authorities; being consulted and feeling that your views are listened to by those making decisions; being involved in decision making itself; and being able to take action on your own or others’ behalf when needs be. We have found all these forms of empowerment, from the passive to the proactive, to be associated with mental wellbeing, the associations seeming to be most strong in relation to satisfaction with the housing services provided by one’s landlord, and feeling able to influence decisions affecting the local area.

Satisfaction with housing services shows a mixed picture over time, with improvements in some areas and declines in others. This mixed picture may be a consequence of changes in housing governance arrangements and housing organisational reconfigurations across Glasgow. This requires further examination. If there are trade-offs between housing system efficiency and tenant services and empowerment, then these should be identified.

Generally through our surveys we have found that residents’ perceptions of their own empowerment in relation to neighbourhood change processes has improved over time, apart from in the Wider Surrounding Areas (see earlier discussion). However, it is still the case that only about two-in-five people feel they can influence decisions affecting their area – most people do not.
In our qualitative research within regeneration areas, where consultation processes had taken place involving members of the communities concerned, we found a number of weaknesses in the design and delivery of community engagement that should be addressed for the future. In order for communities to be better empowered through such processes, we would recommend that the following should be considered:

- Communities should be given more information about how and by whom decisions are made, and service and other developments are provided. We found that communities can be relatively ignorant about who is doing what, which gives them less scope for influence.

- Communities need ongoing continuing capacity building support, both as social entities (see earlier comments on social regeneration) and in relation to their knowledge of regeneration processes, possibilities and alternatives. Communities should also have access to independent advice and support. This will enable them to engage more critically with service providers and decision-making bodies. Such critical awareness is an important element of community empowerment.

- In regeneration situations, where key decisions are being made and consulted about, it is important that organisations which are given an official voice on behalf of the community are democratic and representative. We have found that this is not always the case. It is important not only that the majority view of the community is heard but also the views of hard-to-reach or minority groups, and that community representations and decisions are adequately fed back to the community.

- The standards for community engagement within regeneration processes need strengthening, and there should be some active monitoring or verification of community engagement processes, outcomes and follow-through. This would help to appraise the actual degree of empowerment of the communities involved – assessing the impact of the processes that are undertaken, as well as of the nature and openness of those processes. In light of the recommendations of the Christie Commission and the emphasis being placed nationally on new models of public service, existing good practice in community empowerment and coproduction needs to be captured and replicated more widely; and substandard practice improved.
Appendix: GoWell Intervention Area Types

- **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 areas 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 a range of housing organisations. A large number of new builds are planned for these areas, partly to attract home owners (areas: Castlemilk and Drumchapel).
References:


9 Ibid. Tables 3, 4, 5, and 6.


14 Kearns A and Darling L. (forthcoming 2013) “Giving the all clear”: Housing staff experience of the rehousing process in transformational regeneration areas. Glasgow: GoWell.


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 and Clyde.
Introduction

GoWell is a complex, multi-faceted programme that seeks to examine the processes and impacts of neighbourhood regeneration across a range of outcomes and using a variety of research methods.
The programme commenced in 2006, and since then the team has completed and reported on:

- Two large cross-sectional surveys of the GoWell study areas;
- Focus group discussions following each survey wave, to explore particular issues in more depth;
- A programme of qualitative research into issues of governance, participation and empowerment;
- Reviews of the historical and policy contexts for regeneration in Glasgow;
- Profiles of the study areas and their health, in relation to Glasgow and Scotland as a whole;
- A series of community-based (‘nested’) studies of specific interventions and policy priorities, including mixed tenure neighbourhoods, youth diversionary projects and environmental employability programmes.

One of the ways in which GoWell is distinct from many other research programmes is in its commitment to close working with its sponsor organisations, local communities, and policy and practice communities more generally. From the outset, priority has been placed on disseminating our findings, discussing their implications with our many stakeholders, and using the research to inform plans and ways of working. These processes have in turn informed our research priorities and approaches, and have helped to ensure the ongoing relevance of GoWell as contexts change and new priorities emerge. The key challenge is to enable the rich data emerging from our research processes to be translated into meaningful insights – and thereafter recommendations for policy and practice – through being brought together with the experience of local residents and those working to improve the circumstances of the deprived communities. We recognise that such insights need to be built up from across the different programme components, and over time.

There are 15 GoWell communities, grouped into five ‘intervention area types’. Most of our analysis takes place at the level of an area type (and these are defined at the start of each section of this report), but sometimes we will focus on a particular area or on Glasgow as a whole. Our job is primarily to understand the patterns and trends that emerge as the regeneration processes are implemented in different parts of the city, rather than to study any particular area in detail.

The purpose of this report is to bring together findings that have emerged from our analyses to date, over the past three years. The report is in three parts, and looks in turn at issues of Housing and Neighbourhoods; Communities; and Health and Human Capital. Each part draws on various components of GoWell and thereby paints a richer picture than can be seen from the separate findings reports presented to date. We hope that it is a picture that will cause people to reflect and will also stimulate action.
0.1 Housing and Neighbourhoods

One of the main areas of interest for GoWell is to explore how the environments in which people live affect their quality of life and health and wellbeing. In this, we are examining the role of housing and of the surrounding neighbourhood.
The impacts of these works were also evident in the survey responses. The numbers of people who said they were ‘very satisfied’ with their homes increased significantly between 2006 and 2008 in all types of study area, and stood at a third or more of respondents in the three non-regeneration area types in 2008 (and half this amount in the regeneration areas).

By 2008, around 80-90% of people in non-regeneration areas derived a range of psychosocial benefits from their home (such as enjoying feelings of privacy, retreat and status), and in the WSAs in particular, there were marked increases since 2006. In the regeneration areas in 2008, only around 60% of people derived these psychosocial benefits from the home, but there were significant increases since 2006 in the numbers deriving feelings of safety and retreat at home, due we suspect to the addition of secure doors and locks.

Thus, we can begin to see that housing improvement works are having an impact on people’s quality of life, and in fact 90% of those involved said they were satisfied with the improvement works. We explored these issues further in a set of focus groups with residents in HIAs and WSAs. The positive impacts came from both the process and the outcomes of improvements. People said they were consulted about what was to be done, and felt they got works that were needed; they were kept informed about when and how works were to be carried out; and they were given stylistic options for internal improvements.

The GoWell study areas are atypical in housing terms for two reasons. First, in three of the types of study area (Transformational Regeneration Areas (TRAs), Local Regeneration Areas (LRAs) and the Peripheral Estates (PEs)), the vast majority of the accommodation (80% to 95%) is social housing. In addition, in the regeneration areas (TRAs and LRAs) around 80% of the housing stock is in the form of high-rise flats.

**Housing Improvements**

Social landlords in the city are currently investing in their housing stock to bring it up to the Scottish Housing Quality Standard (SHQS) by 2015. This also affects home owners whose houses were previously in the social sector, as they often have works carried out to their homes under the same contracts. Overall, we found that over a third (36%) of GoWell respondents had had improvement works done to their homes between 2006 and 2008, with the highest numbers being in the Wider Surrounding Areas (WSAs) and the Housing Improvement Areas (HIAs), where this effort is most concentrated. In areas where the housing is possibly due for demolition in the future (mainly the regeneration areas), the most common improvement works were new secure front doors and locks, whereas in other places the most common works were new kitchens and bathrooms, new heating systems and double glazing.
-fixtures and fittings. The main impacts of the works were that people’s homes were now “comfortable, warmer, quieter, less damp and more secure”. This was said to make people feel “proud, happy…more relaxed in their homes” and with “an increased sense of responsibility for their homes” so that they “care more for them”.

Our aim now is to examine these general findings at the individual level through further analysis of the GoWell Wave 2 data, so that we can find out what specific types of works had particular impacts upon people in terms of psychosocial benefits and mental wellbeing. We will also look to see if there is any added impact upon individuals and communities from having a large number of homes improved in an area.

**High-Rise Flats**

One of the dilemmas facing housing providers in several of our study areas, and indeed throughout the city, is whether to improve or demolish high-rise flats. On the one hand, some people like living in high flats with views over the city and secure door entry and concierge services. On the other hand, some blocks are both technically and financially difficult to keep warm, dry and in good repair. When provided in large numbers high-rise blocks can provide a ‘harsh’ environment to live in, susceptible to anti-social behaviour, and contributing to the stigmatisation of communities. The future of high-rise blocks will be decided in different ways in different situations, and so in GoWell we are following the fate and the performance of high-rise flats as residential environments in the city.

We are pursuing this work by undertaking detailed analysis of responses given in our surveys by people who live in high-rise flats compared to those given by people living in other types of dwelling. For example, looking at both the Wave 1 (2006)\(^1\) and the Wave 2 (2008)\(^2\) data, we find that there is a clear gradient in terms of the attainment of psychosocial benefits from the home, with houses offering occupants the most benefits and high-rise flats the least. At Wave 3, we will be able to return to this issue to look at some of the high-rise blocks that have been comprehensively improved in the meantime. What our analysis so far tells us though is that even improved high-rise blocks will have to be managed and maintained better than they were in the past to have any chance of performing as well as other flats and houses as residential environments for people.

**NEIGHBOURHOODS**

The neighbourhoods in which people live can be considered as physical, social and service environments. What those neighbourhoods contain, their quality and the atmosphere they help create, may affect how people behave (for example whether they choose to do very much in their local area), how they interact with others (how frequently, where, to do what), and how they feel about themselves (for example, whether they feel they are doing well in life
and are positive about their futures, or conversely feeling ‘stuck’ in a place they don’t want to be).

**Quality of Environment**

We found that residents’ ratings of their neighbourhood environments had improved in many places over the period 2006 to 2008. This was true nearly everywhere for the ratings of shops, parks and open spaces, children’s play areas, and for a quiet and peaceful environment. The biggest improvements in quality of buildings and environments were reported in the WSAs and HIAs, and we believe this is mainly a result of widespread fabric improvements to housing properties.

As Figure 1 below shows, this places three of the five GoWell area types at or above the average rating of neighbourhood environments for large urban areas and the most deprived areas in Scotland (albeit that the question asked in the Scottish Household Survey (2007-8) was slightly different to the GoWell question). However, the regeneration areas in the study, especially the Transformational Regeneration Areas (TRAs), have some way to go to reach these national norms in terms of neighbourhood environmental quality.

To take this issue further, in the GoWell data analysis group (GoWag) we have been looking to see whether the neighbourhood

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**Figure 1: GoWell Wave 2 (2008) ’Attractive Environment’ compared with Scottish Household Survey (2007-8) findings**

<table>
<thead>
<tr>
<th>Area Type</th>
<th>% 'Attractive' or 'Pleasant'</th>
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<tbody>
<tr>
<td>TRA</td>
<td>30</td>
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<tr>
<td>LRA</td>
<td>35</td>
</tr>
<tr>
<td>WSA</td>
<td>70</td>
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<tr>
<td>HIA</td>
<td>80</td>
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<td>PE</td>
<td>60</td>
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<tr>
<td>SHS Deprived</td>
<td>50</td>
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<tr>
<td>SHS Large Urban</td>
<td>55</td>
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</tbody>
</table>

Notes: Figure compares those in the GoWell (2008) survey who rated the attractiveness of their neighbourhood environment as ‘fairly good’ or ‘very good’, with those in the Scottish Household Survey (2007-8) who said the ‘pleasant environment’ was one of the things they particularly liked about their neighbourhood.
environment is associated with mental wellbeing; in other words, could it be important that public actions are raising people’s ratings of their local environmental quality? Our initial findings are that indeed people’s ratings of the aesthetic quality of their local neighbourhood are associated with their level of positive mental wellbeing, more so than their assessments of anti-social behaviour or of local amenities. The strong message for policy-makers and practitioners is that taking action to make buildings, streets, parks and open spaces attractive does matter to residents’ wellbeing.

**Evaluating Interventions in the Neighbourhood Environment**

The quality of the environment is a priority issue for housing and regeneration practitioners. In addition to looking at changes in the quality of the environment through our 2006 and 2008 surveys, we have also studied and evaluated two programmes that aim to address specific aspects of the environment in depth: Glasgow City Council’s (GCC) and Glasgow Housing Association’s (GHA) play areas improvement programme; and the Environmental Employability Programme.

In order to evaluate the impact of the GCC/GHA play areas improvement programme and understand more about how play areas are used, a series of evaluations were conducted, including before and after audits of the physical condition of a sample of play areas, interviews and focus groups with local housing organisations (LHOS) and residents living near the play areas, and group discussions with children and young people to obtain their views 45.

Overall, it was concluded that significant improvements have been made to play parks across Glasgow as a result of the improvement programme. These improvements were also reflected in the GoWell 2008 Wave 2 survey findings which reported significant positive change in the ratings for children’s play areas in most areas. The improvements were welcomed by local residents and LHO staff who indicated that play areas are a vital community resource and that the improvements provided more opportunities for play, with increased usage of the existing play areas after refurbishment. Residents also recognised that the refurbished parks provide an opportunity for parents to mix while children play.

Key learning points from the study which should be considered when developing and planning future improvements include the importance of consultation during the planning stages, as satisfaction and community ownership were higher where there had been effective consultation in advance of improvements; the value of incorporating natural landscapes more in the design of play parks; and the finding that play parks would be used more if children and young people felt safer and concerns about the threat of bullying and violence were reduced.
The second ‘nested study’ is the evaluation of GHA’s Environmental Employability, or Community Janitors, Programme. This combined employability and environmental maintenance programme aims to help local unemployed residents into employment through paid training, while at the same time providing an environmental service to GHA’s LHOs helping them respond to and manage local maintenance issues and needs.

The evaluation considered outcomes from the commencement of the programme in 2006 to end-March 2008 and the findings were very positive overall\(^8\). In terms of environmental outcomes, 48,849 tasks were completed including de-littering, sweeping paths, weeding, grass cutting, hedge trimming and uplifting bulky items. LHOs spoke positively about the programme, and felt the community janitors were a valuable asset in addressing environmental problems and in turn improving their relationship with tenants. Tenant awareness of the programme was low overall, but it varied across areas. However, those tenants who had seen the community janitors in their area were very positive about them, with over three-quarters rating their work as either very or fairly good, and over two-thirds agreeing their work had improved the area’s appearance.

The evaluation highlights the ‘local, responsive and flexible model of service delivery’ as a key aspect of the positive environmental outcomes. Mainstream services, in contrast, tend to be carried out by different agencies, resulting in difficulties in achieving integrated and co-ordinated delivery.

**Safety and Anti-Social Behaviour**

One of the other striking findings from our Wave 2 survey in 2008 was that feelings of safety in the neighbourhood at night-time had dropped since 2006 and the identification of a range of anti-social behaviours in the local area had risen\(^2\). Feelings of safety dropped in all five types of area in the study, with large increases in the number of people who said they ‘never walk alone after dark’.

To put this in context, if we compare our findings with those of the New Deal for Communities (NDC) evaluation (2009)\(^8\) in England (Figure 2, overleaf), we find that the PEs in GoWell perform similarly to the English regeneration areas in terms of safety after dark, and other types of area (WSAs and HIAs) perform even better. However, the regeneration areas in our study returned figures for ‘not safe after dark’ akin to those for the NDC areas six years previously, when the NDCs were in their first ‘trimester’ of intervention. This suggests that we might expect to see improvements in feelings of safety after dark in our regeneration study areas in future, as the NDC evidence indicates that feelings of safety improve as regeneration progresses.

In three of the area types in the GoWell study (TRAs, WSAs and PEs), the mean number of anti-social behaviour problems reported per
Figure 2: GoWell Wave 2 (2008) Unsafe after Dark compared with NDC (2009) findings

Note: GoWell figures represent the percentage of respondents who said they felt 'a bit unsafe', 'very unsafe' or that they 'never walk alone after dark'. NDC findings are those who said they felt 'a bit unsafe' or 'very unsafe'.

Table 1: GoWell Anti-Social Behaviour Problems compared with Scottish Household Survey Findings for Deprived Areas, 2008

<table>
<thead>
<tr>
<th>GoWell Study Area Types</th>
<th>TRAs</th>
<th>LRAs</th>
<th>WSAs</th>
<th>HIAS</th>
<th>PEs</th>
<th>SHS(^{3}) Deprived</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vandalism</td>
<td>59</td>
<td>71</td>
<td>44</td>
<td>31</td>
<td>59</td>
<td>39</td>
</tr>
<tr>
<td>Intimidation</td>
<td>50</td>
<td>45</td>
<td>31</td>
<td>19</td>
<td>37</td>
<td>28</td>
</tr>
<tr>
<td>Drugs</td>
<td>65</td>
<td>61</td>
<td>53</td>
<td>28</td>
<td>56</td>
<td>35</td>
</tr>
<tr>
<td>Rowdiness</td>
<td>68</td>
<td>67</td>
<td>53</td>
<td>31</td>
<td>62</td>
<td>41</td>
</tr>
<tr>
<td>Nuisance neighbours</td>
<td>42</td>
<td>38</td>
<td>29</td>
<td>14</td>
<td>34</td>
<td>23</td>
</tr>
<tr>
<td>Rubbish and litter</td>
<td>55</td>
<td>59</td>
<td>42</td>
<td>29</td>
<td>58</td>
<td>51</td>
</tr>
</tbody>
</table>

Notes: Table shows the percentage of respondents who said the item was either a ‘slight problem’ or a ‘serious problem’ (GoWell), or who said it was ‘very common’ or ‘fairly common’ (Scottish Household Survey). Scottish Household Survey figures are for the 10% most deprived neighbourhoods in Scotland.
person rose by 10% or more from 2006 to 2008. Table 1, opposite compares the GoWell findings on a number of anti-social behaviour items, with similar evidence from the Scottish Household Survey 2007-8. Only one of our study area types (HIAs) compares favourably with the most deprived areas across the country. In our regeneration areas and PEs, it appears that people are much more aware of anti-social behaviour problems than in other very deprived areas across Scotland.

We face the task, therefore, of trying to find out why GoWell respondents in some of the most deprived parts of Glasgow have unusually high perceptions of anti-social behaviour problems. Is it due to worse behaviour; inadequate management and supervision of the area; the effects of particularly poor environments (affecting perceptions), particularly in regeneration areas going through deconstruction before renewal; or the vulnerability of the residents?

**Identifying Teenagers as a ‘Problem’**

We have begun to explore anti-social behaviour further by examining perceptions of youth behaviour as problematic. In both GoWell surveys to date, the most commonly cited anti-social behaviour problem was ‘teenagers hanging around on the street’: in 2008, 54% of all respondents said this was a problem in their neighbourhood; including 23% who said it was a ‘serious problem’. What is more, people who said teenagers were a problem, were also more likely to identify a number of other local problems, such as gangs, rowdiness and problem families. Thus, understanding and being able to address youth-related anti-social behaviour problems is a key to the transformation of these places, fundamental to their social regeneration and future as sustainable communities.

We examined our 2006 data to see in what circumstances people said teenagers were a serious problem. Rather than finding that older people were the ones to have a particular problem with youth, we found that it was more likely to be people who were vulnerable or who had more exposure to young people who say ‘teenagers hanging around’ is a serious problem: this was people who see their doctor a lot; people who lack social support; those with children themselves; and people who use the neighbourhood a lot. We also found that respondents who had a negative perception of the neighbourhood in general (who were dissatisfied with it, or who thought it had a negative reputation), were also more likely to cite teenagers as a problem. Thus, people’s own characteristics, and their general view of an area, may cause them to be more likely to cite anti-social behaviour issues.

But equally, people who rated a number of neighbourhood services and amenities as poor were also more likely to cite youth as a problem, especially if they also reported things such as poor policing, poor schools and poor shops. Hence, youth anti-social behaviour may itself be a product of poor
services and amenities (providing more opportunities for misbehaviour alongside weaker controls), and/or its reporting may be a reflection of a perception that an area is generally run-down. We have yet to ascertain whether youth-related problems are also a function of the density of young people in an area (i.e. a neighbourhood compositional effect), and whether the actual conduct of anti-social behaviour bears a strong relation to residents’ perceptions.

**Youth Problems as a Community Issue**

To find out more about the position of young people within a community, we commissioned focus groups with parents and, separately, with children and young people in our two peripheral estate study sites to discuss anti-social behaviour by youth.

The discussions revealed that issues about the neighbourhood and the community fed into youth anti-social behaviour. These related to the neighbourhood environment and its management, services and activities for young people, and trust, relationships and culture.

The context for uncaring behaviour was provided by environments with a lot of rubbish, litter and graffiti on the streets and in public space partly as a result of incivility (by adults and youths) and vandalism, but also due to a lack of bins and inadequate clean-up services. Shopping centres which were either run-down (with empty shops etc) or were poorly supervised spaces, were highlighted as places that both adults and children should avoid, as it was perceived they attracted collections of ‘junkies’ and knife-carrying youths looking for trouble. Children and young people also identified several other places where they felt unsafe on the estates. Both adults and young people welcomed a greater police presence and greater use of CCTV on the estates to tackle crime and to promote safety, but all agreed that current levels were not enough and both groups called for more people on foot in their areas to make them feel safer.

The discussions also raised questions about activities for young people on the estates. Whilst adults thought there was a reasonable amount for young people to do and cited problems of lack of motivation and negative peer pressure, they also recognised that activities for older youngsters were not so good, that there might be issues of affordability, and that several organised activities had closed down due to withdrawal of funding. Young people themselves were clear that many things were too expensive for them and not enough was free and that many things they might want were not available locally, or that what was provided was not what they wanted. They routinely described their estates as ‘boring’. However, they also felt they did not have enough information about what was available to them.

Drugs, gangs and alcohol were said to underlie much of the worst crime and anti-
social behaviour on the estates. Alcohol consumption by young people was said to be getting worse, partly due to low expectations and lack of ambition amongst youth, but also helped by adult complicity. Parents themselves identified inadequate parenting as a problem; parents were said to promote bad behaviours, avoid disciplining children, and fail to instil respect for others in children. Adults thought young people lacked respect for adults and thought themselves to be above the law. Adults tended to avoid contact with youngsters they did not know for fear of unpredictable behaviour fuelled by drink and drugs. Whilst adults said they did not trust youngsters, young people conversely felt that adults expected all young people to behave badly and that there were not good relations between children and adults. Yet adults recognised that they could not improve their estates without help from teenagers – but felt that the young people were currently not bothered. Thus, issues of social relations at a community level between adults and young people are an important underlying factor in estates getting stuck in an anti-social behaviour ‘rut’.

Addressing Youth Issues through Interventions

Meanwhile, housing practitioners and regeneration managers are attempting to tackle the problems that are perceived to exist with young people within communities through wider actions aimed at youth. As part of our theme of work on youth, we have been studying these projects. Three youth diversionary schemes were evaluated using questionnaires with participants, and interviews with programme co-ordinators and young people\(^\text{10,11}\). A key finding was that the youth diversionary projects were perceived positively by residents, stakeholders, and participants: especially for the Operation Reclaim (OR) project. Other important impacts of the OR project were the reclaiming of public spaces for use by the community; and the reported improved health, wellbeing and confidence of participants.

There were consistent reports of reductions in crime and gang activity in the OR neighbourhoods, although we cannot determine whether these reductions can be attributed to the youth diversionary projects, and if so, whether they can be sustained. Other initiatives may also have had an impact including CCTV, an increased police presence and environmental improvements linked to regeneration.

The evaluation recommended that changes be made to attract more girls and that the personal and social development content of the projects should be enhanced in order to increase the focus on bringing about sustainable changes to the attitudes, behaviours and expectations of participants. Lastly, in line with our aim to more accurately assess reports of anti-social behaviour, we recommended that in order to monitor the impact of youth diversionary programmes, better and more consistent data on vandalism and anti-social behaviour incidents and
Area Reputations

Both the physical quality of neighbourhoods and reports of crime and anti-social behaviour can feed into negative reputations about areas. Indeed, in the GoWell Wave 2 survey, in four of the five study area types, a majority of people thought their area had a bad reputation across the city. We have begun to consider how this might be an important issue for transformational regeneration, and for the wellbeing of residents.

First, we extended our research approach to include media analysis. We took the Sighthill regeneration area as an example, and examined how it had been portrayed in national newspapers over the last decade. Newspaper coverage of the estate had increased since 2001, mainly due to the arrival of asylum seekers into the area and the plans for redeveloping the area. What is more, the majority of the stories (two-thirds) contained negative content that conveyed a bad image of the estate, principally related to three issues: asylum seekers; crime and violence; and the poor environment.

Regeneration itself resulted in positive news stories, where the agencies implementing regeneration conveyed a positive vision of the future of the estate, but also many mixed stories which contained negative reports about the impacts of deconstruction on residents and poor communication and decision-making by those in charge of the process. Our analysis also looked at what generated positive stories about Sighthill (such as the local festival and progress in the local primary school) and suggested that a media strategy linked to a social regeneration agenda might help to shift the balance of coverage of the estate. This is important if a redeveloped Sighthill is to become sustainable in housing demand terms in the future, but the point probably applies to other regeneration areas as well.

We are also conducting analysis of the GoWell Wave 2 data to see whether residents’ perceptions of the reputation of their area appear to influence their wellbeing. If someone thinks they live in a place that other people denigrate, does this make the person less positive in their own outlook in general? An interesting issue here is whether people are more affected by what they think people who live in other parts of the city think about the place, or by what they think other local people think. We hope to be able to report on this in the near future, alongside investigations of other aspects of what is called ‘relative deprivation’ – how people think they are socially positioned compared to others.
Within GoWell, we are conducting a lot of research into communities themselves, i.e. the social groups who live within residential neighbourhoods which are subject to renewal and improvement works. Regeneration has a social dimension as much as a physical one, including seeking to impact upon the psychosocial benefits people derive from where they live (such as feelings of attachment, inclusion and empowerment). In some areas there are attempts to re-shape the social composition of communities in income and housing tenure terms and to change for the better how people live their lives and relate to those around them.
England has said are important for protecting and promoting the health of children. Meanwhile, GoWell’s Housing Improvement Areas (HIAs) and Wider Surrounding Areas (WSAs) contain relatively high numbers of people of retirement age. As a result, whilst the dependency ratio (the proportion of the population comprised of children and of old people) was 44% for Glasgow in 2005, in the case of nine of the GoWell study areas (mainly the regeneration areas plus the HIAs) it ranged from 50 to 70%.

Looking forward, dependency ratios are likely to remain high, since fertility rates (number of live births per 1,000 women aged 15-44 years) are very high in many areas. Figure 3, below, shows that whilst the fertility rate for Glasgow is around 50 per 1000 women aged 15-44 (which is comparable to that for

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**Disadvantaged Communities**

An initial task was to understand the characteristics of our study communities. We did this for the period prior to the start of the GoWell study (2000-2006) as part of our Ecological Team’s work, mostly using health service data on GP registrations and hospital utilisation rates, as well as component data from the Scottish Index of Multiple Deprivation (SIMD).

This analysis revealed several striking facts about the communities in GoWell. Compared with Glasgow and Scotland, GoWell areas contain more children as part of their populations. In addition, the regeneration areas contain relatively few people aged 65 or older – there is a very ‘thin’ grandparent generation in these areas, a group which the Chief Medical Officer for

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**Figure 3: Fertility Rates in GoWell Study Areas: Annual Average Numbers of Live Births and Fertility Rates (2003-2005)**

![Figure 3: Fertility Rates in GoWell Study Areas: Annual Average Numbers of Live Births and Fertility Rates (2003-2005)](image)
Scotland as a whole, the GoWell regeneration areas plus Townhead (one of the HIAs) have fertility rates of 70 or more.

These community compositional characteristics have been reflected in the GoWell surveys. In the Wave 1 (2006) survey we found that whilst the ratio of adults aged 25 years or over to young people aged less than 18 years was close to 1.9 or above in WSAs and HIAs, it was below 1.2 in PEs, TRAs and LRAs. In the Wave 2 survey (2008) we found that 40% of households in regeneration areas were families (much higher than elsewhere in the study), with just over half being single-parent families. A major factor here is that the regeneration areas are unusual in another important respect, namely that they have been used to house large numbers of asylum seekers and refugees since 2000, as well as other migrant workers. By 2008, we found that two-in-five adults (39%) in the TRAs were non-British citizens, as were one-in-four adults (28%) in LRAs.

Furthermore, many households in GoWell areas are headed by relatively young adults. Using health service population data for our study areas, we found that in 2008, between 50 and 60% of the adults in the GoWell regeneration areas and PEs were aged up to 39 years; this compares with 31% of all adults in Scotland being aged up to 34 years.

Thus, some of the challenges arising in many of our study areas may stem from the fact that populations and parents are relatively young and there are a lot of children – characteristics which raise potential problems for the exercise of informal social control.

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**Figure 4: Income deprivation by GoWell Study Area, 2005**

Source: Derived from DWP and SIMD data

<table>
<thead>
<tr>
<th>Study Area</th>
<th>% Total Population Classed as Income Deprived</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Andrews Drive</td>
<td>54.1</td>
</tr>
<tr>
<td>Shawbridge</td>
<td>52.2</td>
</tr>
<tr>
<td>Townhead</td>
<td>50.0</td>
</tr>
<tr>
<td>Drumchapel</td>
<td>43.2</td>
</tr>
<tr>
<td>Govan</td>
<td>42.1</td>
</tr>
<tr>
<td>Gorbeth Riverside</td>
<td>42.1</td>
</tr>
<tr>
<td>Castlemilk</td>
<td>39.9</td>
</tr>
<tr>
<td>Red Road MSFs</td>
<td>39.8</td>
</tr>
<tr>
<td>Sighthill</td>
<td>34.8</td>
</tr>
<tr>
<td>Carntyne</td>
<td>29.1</td>
</tr>
<tr>
<td>Scotstoun Surround</td>
<td>29.0</td>
</tr>
<tr>
<td>Red Road Surround</td>
<td>26.6</td>
</tr>
<tr>
<td>Scotstoun MSFs</td>
<td>26.6</td>
</tr>
</tbody>
</table>

Scotland: 14%  
Glasgow City: 25%
Moreover, in some areas there are a lot of older people, whilst in other areas very few older people reside to help with the upbringing of children.

In addition, our study areas are relatively poor, and this is also a root cause of many current difficulties. Our Ecological Team established the extent to which GoWell areas are deprived by specially calculating income deprivation rates for each area, using data on receipt of income-related benefits and population data from GP registrations, both matched to our study areas through post-codes and census output areas\textsuperscript{15}. This is the same methodology as used in the SIMD, but calculated at a smaller spatial scale. Figure 4, previous page shows the resulting picture, which is that all but one of the GoWell study areas are more deprived than the Glasgow average, and all fall within the 15% most deprived areas in Scotland (for which the cut-off point is 25% income deprived). In quite a few of the study areas 40 to 50% of the population are income deprived.

Our analyses of health service data show, in stark detail, some of the outcomes resulting from disadvantage and deprivation, for the GoWell study areas over a five year period. Emergency admissions to hospital indicate how susceptible people are to illness and accidents. Figure 5, below shows that whilst the average rate of emergency admissions for Glasgow’s population (standardised by age and sex) is around 7,500 per 100,000 (itself 20% above the Scottish average), all GoWell study areas have higher rates than this, with eight areas having rates of 10,000 – 12,000, and the worst areas having rates nearly twice the Scottish average.
If regeneration is about the futures of communities, then it must hope to impact upon how long people live healthier lives. Figure 6, below shows prospective survival rates for 15 year old boys in the first few years of the new century. Across Glasgow, around seven-out-of-ten boys will survive to age 65, 10% less than across Scotland as a whole, but in many GoWell study areas the survival rate is a further 10 to 20% lower. In LRAs, only two-in-five 15 year old boys can expect to reach retirement age if current health trends remain unchanged, a truly shocking statistic and a clear indicator of the ‘transformational’ challenge faced in many areas.

**Belonging and Cohesion**

Since regeneration is trying to provide places where people want to live in future, an important issue of interest is what people think about their areas, how they relate to them and whether they can form an attachment to them, in a functional or psychological sense. Since belonging and cohesion are relative concepts, we have sought to establish measures which can be compared to findings for other disadvantaged communities.

In the GoWell Wave 2 (2008)\(^2\) survey, we asked people a set of questions about their neighbourhood similar to those asked in the 2005 Citizenship Survey (CS) in England and Wales\(^{16}\), exploring issues of social harmony, enjoyment and belonging. The findings are compared in Table 2, overleaf. We can see that our study areas perform similarly to other deprived areas in terms of social harmony, with a mixed picture in terms of the other two measures. TRAs currently

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**Figure 6: Male Survival Rates by GoWell Study Area Type, 2002-2005.**

% of 15 year-old boys surviving to 65 by area type, 2001-2005. Source: Calculated from GRO(S) mortality and CHI population data
have relatively low levels of belonging and enjoyment, whilst HIAs have relatively high levels of both. However, the national average figure for high enjoyment of living in the neighbourhood is 65% for England, so all GoWell study areas have some way to go to reach that level. PEs perform similarly to other deprived areas on all three measures, maybe even slightly better on feelings of belonging.

As well as asking respondents for their views about living in the neighbourhood, we also wanted to find out how people related to those around them. We asked a series of questions about the community and neighbours, some of which can be compared to findings for regeneration areas in England from the NDC evaluation, as shown in Table 3, opposite.

From Table 3 we can see that people’s sense of inclusion within the community is far higher in the GoWell study areas than in regeneration areas in England. Familiarity with neighbours and views about the attitudes of neighbours in the area are also more positive in the non-regeneration GoWell study areas than in NDC areas. However, in terms of neighbourliness, the GoWell regeneration areas appear to be at a lower point than regeneration areas in England were in the early period of their intervention, so the challenge in terms of generating an active sense of engagement amongst neighbours in Glasgow’s TRAs is a difficult one.

Our Wave 2 survey findings indicated that within regeneration areas, migrants (asylum seekers, refugees and migrant workers) had a lower sense of social inclusion (feeling part of the community) than they had of social harmony (that people from different backgrounds get along well together).
Community Empowerment

One of the central themes and objectives of regeneration policy is to empower communities. Community empowerment, however, is a multi-faceted phenomenon involving several things, including: the ability to control what happens in a community on a day-to-day basis; the ability to influence key decisions affecting the area; the ability to influence public services, making them more responsive to local needs and demands; and the ability to be proactive in finding improvements or solutions to local issues. Over time, we have increased our inquiries on empowerment, both through the survey and through qualitative research, and now look at several of the aspects mentioned.

On two of these issues, influencing local decisions and the exercise of informal social control, we can compare the GoWell
In our qualitative research to date we have looked at community empowerment through housing stock transfer and management through Local Housing Organisations (LHOs) and through community engagement in the regeneration process. In relation to the stock transfer of housing to community organisations we developed a three-part model of empowerment comprising: raising awareness; having opportunities to make decisions; and instituting actions. We studied nine LHOs across Glasgow and found there to be no automatic relationship between housing ownership and community empowerment, but empowerment was influenced by factors of community context (local challenges and committee composition and behaviour) and organisational context (the size, type and ethos of the LHO matters). Community empowerment through housing depends upon how the LHO relates to wider community agendas through its own organisational development strategy.

Table 4 Community Empowerment in GoWell compared with England and Wales

<table>
<thead>
<tr>
<th></th>
<th>GoWell 2008</th>
<th>Citizenship Survey 2005&lt;sup&gt;16&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TRAs</td>
<td>PEs</td>
</tr>
<tr>
<td>Collective efficacy</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Influence over decisions</td>
<td>29</td>
<td>46</td>
</tr>
</tbody>
</table>

Notes: Collective efficacy: GoWell figure is the percentage of respondents who ‘agreed’ or ‘strongly agreed’ that ‘It is likely that someone would intervene if a group of youths were harassing someone in the local area. CS figure is the percentage agreeing that it is likely someone would intervene ‘if there was a fight in the neighbourhood’. Influence: GoWell figure is the percentage of respondents who ‘agreed’ or ‘strongly agreed’ with the statement ‘On your own, or with others, you can influence decisions affecting your local area’. The CS figure is the percentage who agreed ‘that you can influence decisions affecting your local area’.

findings with national figures for England and Wales from the 2005 Citizenship Survey. Table 4, above shows that levels of perceived collective efficacy are relatively low by national standards in GoWell study areas, and extremely low in the TRAs. On the other hand, as reported from our Wave 2 survey, perceived community influence over decisions affecting the local area has increased over time in GoWell study areas. In 2006 it lay below the national average, but by 2008 it had risen above the national norm in many areas, though it still remained low in regeneration areas, where arguably it matters most. However, the figure for TRAs in 2008, at 29%, is better than the figure reported for NDC areas, which changed very little from 23% in 2002 to 25% in 2008, so the progress made in regeneration areas in Glasgow (a 10% rise in two years from 2006-8) represents relatively good progress.

In our qualitative research to date we have looked at community empowerment through housing stock transfer and management through Local Housing Organisations (LHOs) and through community engagement in the regeneration process. In relation to the stock transfer of housing to community organisations we developed a three-part model of empowerment comprising: raising awareness; having opportunities to make decisions; and instituting actions. We studied nine LHOs across Glasgow and found there to be no automatic relationship between housing ownership and community empowerment, but empowerment was influenced by factors of community context (local challenges and committee composition and behaviour) and organisational context (the size, type and ethos of the LHO matters). Community empowerment through housing depends upon how the LHO relates to wider community agendas through its own organisational development strategy.
Mixed Communities

As a means of tackling the range of disadvantages faced by poor communities, to give them a more sustainable future, regeneration planners often seek to create neighbourhoods that mix social rented tenancies with owner occupied homes. This ‘mixed tenure’ approach is purported to provide wide ranging benefits to residents in terms of psychosocial and physical wellbeing, in particular addressing issues such as better neighbourhood reputation, more support for facilities and services, increased social cohesion and community participation, and role models for work and education.

Several of the GoWell study communities have become more mixed in tenure terms over the past two decades, and others (like the TRAs) are due to become mixed in the future. We have embarked on a programme of work to examine how mixed tenure is delivered, and with what effects, given that this approach has been, and remains, important not only within Glasgow but as a core principle of national housing and regeneration policy.

As a broader contribution to the policy evidence base, we have critically reviewed past reviews and syntheses of mixed-tenure research, and conducted our own systematic review of primary and secondary research on mixed-tenure in the UK. Our review-of-the-reviews found that if one compares the conclusions from different reviewers, one can ascertain that they concur in finding positive

We intend to look again at empowerment through LHOs once the decisions about their future ownership and management arrangements have bedded in.

We have also studied the impacts of community engagement processes during the planning and early implementation phase of activity, in our three TRAs. We identified seven aims of engagement in area regeneration, relating to governance and policy implementation, community level outcomes (such as community capacity building and cohesion) and wellbeing (e.g. personal development for individuals). We explored the impacts of community engagement through interviews with officials, consultants and residents involved in the planning of regeneration. We found engagement to date to have focused mostly on governance objectives relating to the inclusion and legitimacy of decision-making, with little attention given to its potential contribution to community development objectives. Uncertainty about the ‘how’ and ‘when’ of regeneration has hindered communication and engagement processes, to the detriment of potential community and wellbeing outcomes.

We will continue to examine the effects of community engagement and empowerment through our survey data, and through a further round of qualitative research with residents not formally involved in any decision-making processes within the study areas.
effects from mixed tenure in only two areas: improving the physical environment, and improving the popularity of an area. There are also some areas where reviewers concur that the research base provides no evidence of effects: creating social capital among residents, and creating job opportunities. But there are also many areas where the evidence is very mixed, making it difficult to draw conclusions about the circumstances in which mixed tenure might have effects. Our systematic review of primary studies is ongoing but nearing a conclusion; we hope this will be a significant contribution to the field, since past reviews have not been systematic or sufficiently critical of the evidence for mixed tenure effects.

In addition to reviewing the existing evidence, we are also conducting our own primary research of mixed tenure delivery and effects on three social housing estates in Glasgow: Castlemilk, Drumchapel and Gorbals. This has comprised three elements. First, we have used Glasgow City Council council tax register data to map housing tenure by postcode in each estate. This was done in order to see how well integrated the tenures were ‘on the ground’: in other words, what had policy delivered in practice in terms of tenure mixing? The results for two of the estates can be seen in Figure 7, opposite. This shows that in Drumchapel there is more owner occupation to the south and west of the estate than to the east; and that as well as mixed tenure areas in the west, there are also segments of entirely owner occupied housing built on the western edge. In the redeveloped area of the Gorbals, there are fewer entirely social rented areas, the estate being more characterised by mixed tenure areas. Some predominantly owner occupied areas sit very close to social rented and mixed tenure areas.

Having produced maps of the housing tenure configuration as it now stands on each estate, we proceeded to conduct in-depth interviews with practitioners and policy-makers who have been involved in the estates’ development over the years, to find out what they considered to be the barriers and opportunities to delivering mixed tenure in these areas, to help explain the patterns we have found. We also sought to find out what they, as practitioners, expected the impacts of mixed tenure to be on the estates. Finally, we have conducted in-depth interviews with families living in social rented housing and owner occupied housing in a variety of locations on the three estates. We used our post-code housing tenure maps to locate our potential interviewees. Our aim was to find out what residents with children think about the quality of their environments and social life on the estates, and to what extent their views vary according to the degree of proximity of the two housing tenures in different parts of the estate. We hope the findings from this research will provide an original contribution to the evidence base about mixed tenure, as well as informing policy-makers in Glasgow about the outcomes of mixed tenure as progressed across the city over the last two decades.
Figure 7: Housing Tenure by Postcode on Two Estates, 2008
DRUMCHAPEL and GORBALS

Type of tenure per postcode unit:
- Entirely Social Rented
- Predominantly Social Rented
- Mix: Social Rented/Owner Occupied
- Predominantly Owner Occupied
- Entirely Owner Occupied
- Mix: Owner Occupied/Private Rented
- Private Rented
Health and wellbeing have become important objectives for housing and regeneration policies in Scotland and the UK. Within GoWell we are monitoring changes in physical health, health behaviours and mental health and wellbeing across our study communities and within the context of the city of Glasgow.
A CAPITALS FRAMEWORK

In order to organise our thoughts about how housing and regeneration policies might impact upon health, we developed a Capitals Framework, that identifies six ‘capitals’ upon which policy interventions may act to change the residential, neighbourhood and community contexts within which people live and operate in the domestic sphere\(^2\). The framework is shown in Figure 8, below, with brief explanations of each capital given after the figure. We are using this framework as a tool for organising our data analysis and the identification of areas where intervention has more or less impact, with consequences for health and wellbeing.

HEALTH INEQUALITIES

We begin by looking at rates of mortality from the ‘big three’ killers across our study area types (coronary heart disease, cancer and stroke) using our ecological data\(^3\). In the following three figures, the bars

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**Figure 8: Regeneration and Health: A Capitals Framework**

- **Human and Political Capital**: capabilities of individuals; access to decision-making and sense of empowerment.
- **Social and Community Capital**: social networks and social support between individuals; trust and reciprocity; community organisations and their networks.
- **Residential and Cultural Capital**: psychosocial benefits of the home and neighbourhood; status; area reputation.
- **Economic Capital**: individual and collective assets; incomes; employment.
- **Fixed Capital**: the amenities and services of an area.
- **Environmental Capital**: the quality and aesthetics of the local built and natural environment.
As in the case of heart disease, deaths from strokes are also lowest in the areas surrounding high-rise estates. However, in a different pattern from that seen for heart disease and cancer, Housing Improvement Areas (HIAs) have the highest mortality rates from strokes, one-and-a-half times the city rate (Figure 11, opposite).

We can already see that there are health inequalities across our study areas, but also between our study areas and the city as a whole, with most mortality rates in the GoWell study areas being above the city average. The rank ordering of the study area types varies according to the cause of death being considered: the TRAs for example perform better on cancer mortality than on heart disease mortality; meanwhile, the PEs perform worst on mortality from cancers, especially lung cancer.

Figure 9: Mortality from Coronary Heart Disease in under 75’s by GoWell Study Area Types
Numbers (5 year totals) and Rates (2001-2005)

represent the absolute numbers, and the line shows age and sex standardised rates. Figure 9, above shows that death rates from coronary heart disease were twice as high in regeneration areas as they were in the surrounding areas at the start of the GoWell study.

A different picture exists for cancer deaths however, with the age and sex standardised mortality rates being highest in Peripheral Estates (PEs) and Local Regeneration Areas (LRAs), but lowest in the Transformational Regeneration Areas (TRAs) (Figure 10, opposite). PEs and LRAs have the highest mortality rates from lung cancers in particular, with Drumchapel having the highest rate at around 190 per 100,000, compared with a rate half this level in two of the TRAs, Red Road and Sighthill.
Figure 10: Mortality from Cancers in under 75’s by GoWell Study Area Types
Numbers (5 year totals) and Rates (2001-2005)

Figure 11: Mortality from Strokes and Cerebral Haemorrhages in under 75’s by GoWell Study Area Types
Numbers (5 year totals) and Rates (2001-2005)
These differences between area types are not a reflection of the different demographic compositions of the areas (as these have been taken into account in the analysis, through age and sex standardisation), so may be a consequence of differences between area types in environmental, occupational, social and behavioural risk factors now and in the past.

Healthy Migrants?

The population composition within many of our study areas is affected by the presence of migrants. All six regeneration areas in the study have significant numbers of asylum seeker, refugee and other migrant residents (e.g. migrant workers; students), and the other nine study areas have small numbers present. Such migrants, should they choose to remain living in these areas, may represent a relatively healthy source of human capital for the future.

We considered this issue by examining the health of migrant groups in the GoWell Wave 2 survey, looking at migrants residing in regeneration areas in the north of the city. Generally, after adjusting for differences in age, sex and household type, we found migrant groups to be healthier than British people living in the same regeneration areas, and in some respects also healthier than British people living in other areas within the study.

For example, the relative risk of an asylum seeker having less-than-good self-rated health was two-thirds lower than for British respondents in the 2008 survey, and the relative risk of an asylum seeker reporting one of several stress-related symptoms (such as sleeplessness, palpitations, chest pains; and headaches) was 60% lower than for British respondents. On the other hand, asylum seekers had significantly poorer scores on a measure of positive mental wellbeing (see below) than local British people, though refugees scored much better than both groups, perhaps reflecting the removal of uncertainty about their right to remain in the country.

We are conducting more analysis to see whether the health or social integration of migrants is affected by the length of their stay in this country: in particular, do outcomes for migrants improve over time? We shall also be examining the health of migrants in future GoWell surveys to see if their relative health advantage is maintained as they ‘settle’ into living in Scotland.

HEALTH BEHAVIOURS

One might expect many health behaviours to be worse in deprived communities due to a combination of poverty and lack of purposeful activity for many people. Housing and regeneration activity can help provide health-promoting environments for residents, with more opportunities for healthy behaviours. However physical and
service-related interventions will probably not be enough, and behavioural change programmes may also be required as part of a holistic public policy approach to regeneration.

In GoWell, we are monitoring the health behaviours of residents through the reports they give us in our surveys. This is not an easy thing to do, as people tend to under-report unhealthy behaviours and over-estimate healthy behaviours. To this end, although a few questions remained, we changed some of our questioning in the GoWell Wave 2 (2008) survey from those asked in Wave 1 (2006) to get more accurate accounts of health-related behaviours over the past 24 hours (eating) and the past week (physical activity and drinking). This means we cannot accurately measure changes over time in health behaviours until we conduct the Wave 3 survey in 2011.

Drinking and Diet

Although alcohol consumption is a problem of increasing public policy concern in Scotland, we found a large number of people in our study areas saying that they did not drink (44% in 2008), a figure similar to rates of abstinence over the past week reported for the most deprived parts of the country in the Scottish Health Survey (2008). Poverty is one possible explanation for high rates of non-drinking, though we found rates of abstinence lowest among those with jobs. Another explanation for abstinence, at least in the regeneration areas, is the presence of migrants, who are less likely to drink alcohol than British citizens. Among those who do drink alcohol, levels of consumption were highest among the unemployed and long-term sick, which may compound problems of preparedness for work or other purposeful activity.

In relation to diet, our Wave 2 (2008) findings are relatively positive. Responses to one question asked at both survey waves, indicated that there was a small reduction in the number of people who had eaten their main meal of the day from a fast-food outlet at least once in the past week (from 47% in 2006 to 43% in 2008). On the basis of going through a check-list with people about what they had eaten in the last 24 hours, we also found a high number of respondents (55%) reporting that they had eaten five portions of fruit and vegetables. This figure is over twice the national rate, leading us to be sceptical as to its accuracy. Once again, the unhealthiest behaviours existed among the unemployed and single people: one-in-ten single adults under retirement age living alone, and one-in-seven unemployed people reported eating no fruit or vegetables in the previous 24 hours.

Smoking

So far, we have found a small reduction in rates of smoking, from 44% of all respondents in 2006 to 40% in 2008 –
similar to the rate reported for the most deprived areas in the country by the Scottish Health Survey (2008)\(^3\). However only one-in-ten current smokers in 2008 had an immediate intention to try to quit smoking (in the next six months), and two-in-five were clear that they do not intend to give up smoking at any time. The impact of smoking was seen earlier in higher rates of lung cancer mortality, especially in Peripheral Estates, where we found the highest rates of smoking in our Wave 1 (2006) survey.

**Physical Activity**

We have asked respondents in our surveys about three types of physical activity: walking; moderate activity (including light housework and sports or leisure activities done at a regular pace); and vigorous activity (heavy work or fast sports). The Scottish Government’s recommended level of physical activity is for individuals to accumulate 30 minutes of moderate activity at least five days per week\(^2\). In the GoWell Wave 2 (2008) survey, we found that two-thirds of respondents had not done any moderate activity (lasting at least 10 minutes) in the past week. Further, one-in-four adults had not walked for at least 10 minutes in the past week. These rates of inactivity are very high by national standards: the Scottish Household Survey\(^4\) reported that 37% of adults in the most deprived areas in Scotland had been physically inactive over a four week period.

People in the GoWell survey who were more likely to be physically inactive were: renters; those born in the UK; those living alone; those in flats; and the unemployed and long-term sick. Thus, there is a big public policy challenge across our study areas to encourage or enable more people to be physically active as a route to better mental wellbeing, improved physical fitness, and as a means of avoiding later illness.

We examined in more detail the extent to which people in our Wave 1 (2006) survey said that they walked in their local area, and the influences upon this: 29% of respondents said that in a typical week they walked around their neighbourhood at least five days per week\(^2\). Walking in the local neighbourhood might feasibly be a form of physical activity that regeneration programmes might expect to have some impact upon. We found that the likelihood of being a regular local walker was increased if someone felt safe in the neighbourhood after dark, felt a strong sense of belonging to the neighbourhood, and made use of local amenities. Higher rates of walking also coincided with being a drinker and regularly eating fast food meals, again probably reflecting increased use of local amenities. The likelihood of being a regular walker was reduced if someone strongly felt their area had a negative reputation across the city. Several of these factors are things that regeneration could aim to improve: through better neighbourhood supervision and management (to impact on safety); through more and
better quality local amenities (to impact on usage rates); and through management of an area’s image and reputation (to impact on people feeling positive about their area).

MENTAL WELLBEING

In the GoWell Wave 2 (2008) survey, we included a new outcome measure, the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). This consists of 14 questions about subjective happiness and effective psychological functioning and is intended to assess the extent to which people are in a positive frame of mind. Feeling positive is something that improvements to people’s residential circumstances and environments might be expected to have an impact upon. The potential for this is illustrated by Figure 12, below, which shows (unadjusted for any personal characteristics) how the mean score on the WEMWBS scale decreases notably as people feel less positive about their neighbourhood.

In order to more fully understand how the residential environment might influence people’s psychological outlook, we have been analysing our Wave 2 data to look at the relationships between WEMWBS scores and perceptions of housing and neighbourhoods, this time controlling for a range of personal characteristics which might also be influencing mental wellbeing (such as age, sex, ethnic group and household structure). Early indications are that the aesthetics of buildings and the local environment are important influences.

**Figure 12: Positive Mental Wellbeing by Sense of Neighbourhood Progress, 2008**

![Figure 12](image-url)
upon mental wellbeing, more so than negative factors such as perceptions of anti-social behaviour. People are more likely to score highly on WEMWBS if they also rate the attractiveness of their neighbourhood as ‘fairly’ or ‘very good’. Similarly, if people rated the external appearance of their own home as ‘fairly’ or ‘very good’ they also reported higher mental wellbeing.

JOBS AND TRAINING

It has been argued that people need worthwhile things to do in order to feel fulfilled. Work, for example, has been identified as the third most important influence upon happiness because ‘we need to feel we are contributing to the wider society’28. However, although ‘work is vital...it is also important that the work be fulfilling’. People need to be reasonably healthy, motivated and skilled to be able to make such a contribution, but in turn having things to do helps keep people physically, mentally and socially well. Hence, providing and enabling people to have useful activities of various sorts is an important goal for regeneration.

There have been improvements in rates of employment in many of our study areas over the period 2006-2008, more so and consistently for men but also in some areas for women too2. By 2008 at least half the working age men were in employment in three of our five study area types (not so the regeneration areas), whereas this was true of only one study area type in 2006. Employment rates remain much lower for women than for men. Only one of our study areas types, the Wider Surrounding Areas (WSAs) with 68%, came close to the 2008 national employment rate for working age men (73%3); none came close to the national rate of employment for women (65%), the highest being Housing Improvement Areas (HIAs) with 50%.

There has also been a small reduction in the numbers of young adults not in employment, education or training (NEETs), from 34% in 2006 to 29% in 2008. Rates of NEET, like rates of not-working for all adults, are highest in the regeneration areas.

However, these findings still mean that by 2008 around half the working age men in the regeneration areas in the study were economically active but without work, and about a fifth to a third likewise in the other study areas. Furthermore, in the PEs, around a fifth of the men and over a third of the women of working age were economically inactive.

Since regeneration and economic development programmes will aim to get workless people closer to the labour market, and possibly into jobs, we made more enquiries in our Wave 2 (2008) survey about what actions respondents had taken to get work, including searching for a job, applying for a job or being interviewed for a job. We found that one-in-six (17%) of
those of working age not in employment or full-time education had sought work in the past year (i.e. done any of the three things listed)². This included a quarter of the unemployed, a fifth of the temporary sick, and one-in-25 of the long-term sick or disabled. Thus, in 2008, the vast majority of those adults not in work did not do anything about getting a job in a twelve month period. Job-seeking was highest in the regeneration areas however, and lowest in the PEs, indicating the long-term nature of this problem in some of the city’s largest, post-war social housing estates.

Attempts to improve human capital through education and training were also assessed in the 2008 survey². One-in-eight adults (12.8%) had taken part in education or training in the past year, the proportion falling steadily with age. Those already in employment were much more likely to participate in education and training (20%) than those unemployed (9%), homemakers (7%) or the long-term sick (4%). Attempts within regeneration programmes to boost participation rates in life-long learning – if conducted locally and collectively – would contribute not only to raising levels of employability, but also to preserving mental wellbeing and contributing to people’s sense of community. This is particularly the case since we found fewer than one-in-ten people had taken part in any group, club or organisation for leisure or for any common interest in the past year, which is much lower than rates of associational activity nationally¹⁶.
Conclusion

This report demonstrates the benefits of having a multi-methods study by showing how we can bring together findings from different parts of the GoWell Programme to aid our understanding of the issues.

Our range of methods enables us to do a number of things: build a fuller picture of current social and environmental conditions and how they change over time; place changes in our study areas in the context of wider trends within the city of Glasgow; elaborate on policy intentions and identify limitations and constraints on implementation; achieve fuller understanding of resident experiences of interventions in their communities; and evaluate in detail specific components of regeneration.

Our research to date shows that physical regeneration is proceeding effectively in many study areas, and making contributions to people’s quality of life. This can be seen in residents’ responses to both housing and neighbourhood environmental improvements, with the former also contributing to the latter. The findings also highlight the importance of housing and neighbourhood aesthetics to people’s sense of wellbeing. Uncertainties remain however about the pace of physical renewal in the Transformational Regeneration Areas; the impacts upon residents of any protracted renewal processes; and the relative merits of demolition versus improvement of high-rise blocks in these areas.

The picture with regard to social regeneration is much more variable between study areas. Although there have been general gains in terms of social harmony and to a lesser extent also improvements in rates of employment, several significant challenges remain. In regeneration areas there are weaknesses in relation to residents’ lower sense of belonging, narrower extent of neighbourly behaviours, and relatively low sense of collective influence over local decisions. These issues are particularly problematic for regeneration areas where there is high residential instability, extensive social diversity and important choices to be made about the future of the communities.

Across many study areas, there are weaknesses in perceived informal social control and a rising identification of anti-social behaviour problems. There are also widespread problems of worklessness and very low rates of participation in education and training by those people out of work.

In relation to health behaviours, the two most obvious issues to be tackled among our study communities are high rates of smoking and low rates of physical activity. We often found that particular problems of health and human capital behaviours were worse among specific groups in specific areas – be it the unemployed, the long-term sick, single adults under retirement age living alone,
“Almost all respondents agreed with the holistic model of regeneration…but doubted whether there was the capacity for coordinated delivery across all the dimensions. They were not clear who had the training or resources to deliver the wider community action needed on a scale that could really make a difference.”

On the individualised approach to regeneration, the summary of policy-maker and practitioner views was that “There was a lack of confidence that current regeneration activity could deliver this”. In our concern for how change is delivered to and with communities, we shall be looking to see whether a firmer strategy for social regeneration is put in place for many of the communities we are studying, and what the means of co-ordinating and delivering such a programme might be.

or middle-aged women or men – indicating the possible benefit of targeted support programmes, a question that also came up in our earlier research into the theory of change which informs regeneration policy.

When we interviewed policy-makers and practitioners about the aims and expectations for regeneration, we found that they expressed concern that social regeneration expenditure was insufficient and lagged behind expenditure on physical renewal. Their definition of ‘social regeneration’ included community involvement in development decisions and in decisions about local services, as well as education, life-long learning and training activities. These were seen as means to improve people’s skills, confidence and participation in communities. In addition, we found policy-makers arguing for a more ‘holistic’ version of regeneration that included, in addition to environmental and economic components, a stronger ‘people-focus’, with individualised support programmes to help enable people to achieve ‘greater confidence, higher aspirations and more positive mental health’, and to encourage more people to move towards paid work, voluntary work or community involvement.

This understanding of social regeneration chimes with much of what we have found to be the remaining challenges to be tackled in many of our study areas. However one of the other findings from our policy investigation is less encouraging though still valid:
References


25. GoWell. A capitals-based context for examining characteristics associated with neighbourhood walking in Glasgow’s regenerating environment (forthcoming).


27. GoWell. Housing and neighbourhood influences on mental wellbeing in deprived areas (forthcoming).


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

Welcome to this report on the progress of the GoWell programme through 2012/13. It is a pleasure to be associated with the GoWell programme, the team that drives the research and the Steering Group that meets regularly through the year.

The year has seen further progress in the team’s work to understand the relationship between regeneration and health in Glasgow. However, GoWell’s findings and its influence range much wider than the city areas that form the study.

Following the third sweep of information collected from residents in the study areas, a great deal of analysis has followed, and further findings have yet to come. The picture that is emerging is rich and complex. It shows that health may gain from regeneration but health has many dimensions and better lifestyle and wellbeing is not an automatic consequence of moving to a new home with new surroundings.

A strengthening finding is that the results of regeneration are not enough to assure improvements in the health of residents. How the process of regeneration takes place seems to be as important as what regeneration happens. The nature of involvement of people in decisions about regeneration happening around them is key.

GoWell is proceeding amidst circumstances of profound change. Over recent years, we have seen a marked change in economic circumstances that has affected the residents and the developers of Regeneration Areas. A steady rise in energy prices for consumers has added to economic hardship. There have been important changes in the population, with the arrival of a rich and diverse variety of groups from overseas into several of the areas under study. And, with the Commonwealth Games in the city in 2014, the programme has expanded to include GoWell: Studying Change in Glasgow’s East End.

GoWell’s research has been increasingly influential. Its findings have already shaped the programme of regeneration in the city with the intention of benefiting the residents in study areas. GoWell is making a substantial impact on understanding ways that public services affect the lives of local people in urban Scotland and further afield. At a national level GoWell is influencing Scottish Government strategies on regeneration, community empowerment and healthy places.

The GoWell Steering Group has seen many changes over the life of the programme. A notable event is the forthcoming departure of one of the research programme’s Principal Investigators, Professor Lyndal Bond. We wish her well on her return to work in Australia, and look forward to continuing our close collaboration with the MRC/CSO Social and Public Health Sciences Unit at the University of Glasgow.

The confidence and continuing commitment of GoWell’s main sponsors remains a source of great support to the research team, and we are grateful to them. I trust that the value of their investment of resources and confidence in the programme will be apparent from both the content of this report and the wider work of the programme that is set out in publications and on the website www.gowellonline.com.

During the reporting year, I have joined one of the sponsor organisations, NHS Health Scotland, and it is clear that the benefits of GoWell’s work contribute to Health Scotland significantly. GoWell’s aims are to impact on people in Glasgow, in particular its Regeneration Areas, and to contribute learning for the future that maximises benefit from regeneration in urban areas across Scotland and the wider world. This report describes the progress the programme has made to those objectives.

Dr Andrew Fraser
Chair
GoWell Steering Group
Forward look 2013-14

Phase 2 of GoWell began in 2012 and will run for another two years ending in March 2014 and for the full phase we remain vigilant in the 2012-13 Annual Report, which is available from www.gowellonline.com. For specific proposals for 2013-14 we are currently being reviewed by our sponsors. If the plans are approved we will undertake the following research activities during this period.

Compositional survey

Maps of the areas are under running and the longitudinal data, the first part of the year will involve focus on new and six area of analysis, as follows.

Health and wellbeing outcomes from housing and regeneration

In addition to the above, we will be planning for the wave 4 survey in 2013/14. This is an opportunity to build on the previous work and to explore other aspects of well-being in the context of housing. The survey will take place in late 2013 to early 2014.

Community involvement

We will be working with the residents and the voluntary sector to support the specific themes for both local and national events, such as the 5th anniversary of the Longitudinal Lived Realities study. In addition, we will seek to set up and maintain a community forum via the website and other media.

Other influences on health and wellbeing

We will measure the impacts of work transitions and life events on the health and wellbeing of those who are living elsewhere and those who have relocated out of the areas. This will enable us to examine the health and wellbeing of those who remain living in Regeneration Areas with those who have moved out.

Other influences on health and wellbeing

We will examine the health and wellbeing impacts of housing and regeneration interventions, by using the longitudinal survey data collected during Phase 1 of GoWell. This will enable us to assess the effectiveness of the interventions in improving the health and wellbeing of those who are living in the areas. We will also be examining whether these interventions have made a difference to the wellbeing of those who are living in the areas. This will enable us to assess the effectiveness of the interventions in improving the health and wellbeing of those who are living in the areas.

Other influences on health and wellbeing

We will use a range of health outcomes measures. Lastly, we will examine the health and wellbeing impacts of housing and regeneration interventions as investments in health and wellbeing. The aims of GoWell’s economic evaluation views housing and regeneration interventions as investments in health and wellbeing. The aims of GoWell’s economic evaluation views housing and regeneration interventions as investments in health and wellbeing.

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Other influences on health and wellbeing

We will use a range of health outcomes measures. Lastly, we will examine the health and wellbeing impacts of housing and regeneration interventions as investments in health and wellbeing. The aims of GoWell’s economic evaluation views housing and regeneration interventions as investments in health and wellbeing.
Regeneration of the GoWell communities involves a range of interventions which we are studying through a spectrum of research approaches, specifically looking at the impacts they may have in terms of four key sets of outcomes.

- **Interventions**
  - Housing Improvements
  - Transformational Regeneration
  - Resident Relocation
  - Mixed Tenure Communities
  - Change of Dwelling Types
  - Community Engagement and Empowerment

- **Outcomes**
  - Residential
  - Social and Community
  - Empowerment
  - Health and Wellbeing

*Plus new development: GoWell: Studying Change in Glasgow’s East End*
Key findings and developments

This section highlights findings from our recently published reports, based on the cross-sectional surveys from 2006, 2008 and 2011. Key developments for 2012/13 are also highlighted.

The findings report change ‘year on year’ in terms of four main outcomes of interest: health, housing, neighborhood and community.

### Health outcomes

- **General health**: Health behaviours and life satisfaction across GoWell’s five intervention area types. Surveys’ report outcomes over time: a comparison across the past five weeks. The TRAs had their health as being at least ‘good’, however a greater increase in the proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

- **Health services use**: The perception that local drug dealing is a serious problem has increased in all IA types. The rate of increase in the size of the ‘very serious’ proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

- **Health behaviours**: Smoking rates in the TRAs, LRAs and PEs, and decreased in the WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

- **Health-related quality of life**: There is a higher proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

### Neighbourhood outcomes

- **Satisfaction with the home**: Overall there was an increase in the size of the ‘very serious’ proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

- **Health benefits of the intervention area types**: The perception that local drug dealing is a serious problem has increased in all IA types. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

### Housing outcomes

- **Housing services and conditions**: Smoking rates in the TRAs, LRAs and PEs, and decreased in the WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

- **Health-related quality of life**: There is a higher proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

### Community outcomes

- **Perceptions of local facilities and services**: Smoking rates in the TRAs, LRAs and PEs, and decreased in the WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

- **Perceived informal social control**: Smoking rates in the TRAs, LRAs and PEs, and decreased in the WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

### New developments in 2012/13

- **Community transport services**: Smoking rates in the TRAs, LRAs and PEs, and decreased in the WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

- **Local and public transport**: Smoking rates in the TRAs, LRAs and PEs, and decreased in the WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.

- **Neighbourhood and community development**: Smoking rates in the TRAs, LRAs and PEs, and decreased in the WSAs. The PEs had decreased in incidence between 2006 and 2011 in the Regeneration Areas. The proportion of respondents reporting that they were in ‘very good’ to ‘excellent’ health was observed in the TRAs and WSAs. The PEs had decreased in incidence between 2006 and 2011.
Forward look

Phase 3 of GoWell began in 2012 and will run to end-March 2014 and plans for the full phase were highlighted in the 2011/12 Annual Report, which is available from www.gowellonline.com. Our specific proposals for Phase 3 of GoWell are as follows:

1. We will undertake a series of audits of the main survey areas, to make sure we are following up issues found in the main survey. Possible areas for follow-up include:
   - Health and wellbeing impacts of housing and regeneration interventions
   - Evidence of health behaviour change following relocation
   - Wellbeing of those who remain living in Regeneration Areas with those who have moved to other areas
   - The impacts of interventions on health and wellbeing
   - The health and wellbeing impacts of housing improvements

2. We will measure the impacts of work transitions and life events on health and wellbeing outcomes from housing and regeneration interventions, as follows:
   - We will undertake a focus on several new areas of research during this period.
   - We will use a range of health outcomes measures. Lastly, we will examine the health and social determinants of health, focusing on health outcomes and the other on social outcomes.
   - We will undertake some further qualitative research in our study areas, focusing on health outcomes and the other on social outcomes.
   - We will produce two outputs from this work, one focusing on health outcomes and the other on social outcomes.

3. We will be planning for the wave 4 survey later this year, with the survey expected to be completed by the end of March 2014.
   - We will undertake a focus on several new areas of research during this period.
   - We will use a range of health outcomes measures. Lastly, we will examine the health and social determinants of health, focusing on health outcomes and the other on social outcomes.

4. We will measure the impacts of housing and regeneration interventions on health and wellbeing. We will also be examining the health and social determinants of health.
   - We will undertake a focus on several new areas of research during this period.
   - We will use a range of health outcomes measures. Lastly, we will examine the health and social determinants of health, focusing on health outcomes and the other on social outcomes.

5. We will undertake a series of audits of the main survey areas, to make sure we are following up issues found in the main survey. Possible areas for follow-up include:
   - Health and wellbeing impacts of housing and regeneration interventions
   - Evidence of health behaviour change following relocation
   - Wellbeing of those who remain living in Regeneration Areas with those who have moved to other areas
   - The impacts of interventions on health and wellbeing
   - The health and wellbeing impacts of housing improvements

6. We will measure the impacts of work transitions and life events on health and wellbeing outcomes from housing and regeneration interventions, as follows:
   - We will undertake a focus on several new areas of research during this period.
   - We will use a range of health outcomes measures. Lastly, we will examine the health and social determinants of health, focusing on health outcomes and the other on social outcomes.
   - We will produce two outputs from this work, one focusing on health outcomes and the other on social outcomes.

7. We will be planning for the wave 4 survey later this year, with the survey expected to be completed by the end of March 2014.
   - We will undertake a focus on several new areas of research during this period.
   - We will use a range of health outcomes measures. Lastly, we will examine the health and social determinants of health, focusing on health outcomes and the other on social outcomes.

8. We will measure the impacts of housing and regeneration interventions on health and wellbeing. We will also be examining the health and social determinants of health.
   - We will undertake a focus on several new areas of research during this period.
   - We will use a range of health outcomes measures. Lastly, we will examine the health and social determinants of health, focusing on health outcomes and the other on social outcomes.
Our outputs

Below is a list of the publications produced from the beginning of April 2012 to end-March 2013. In addition to these reports, briefing papers and journal articles, we have delivered a number of presentations and seminars at a local, national and international level, which are also listed. All of these are available to download from the GoWell website or in hard copy from Jennie Coyle: jennie.coyle@drs.glasgow.gov.uk.

Reports and briefing papers

- Health outcomes over time: a comparison across the 2006, 2008 and 2011 GoWell community surveys.
- Housing outcomes over time: a comparison across the 2006, 2008 and 2011 GoWell community surveys.
- Community outcomes over time: a comparison across the 2006, 2008 and 2011 GoWell community surveys.
- Neighbourhood outcomes over time: a comparison across the 2006, 2008 and 2011 GoWell community surveys.
- Residents’ perspectives on mixed tenure communities: a qualitative study of social renters and owner occupiers.
- Policymaker and practitioner perspectives on mixed tenure communities: a qualitative study.
- A synthesis of GoWell research findings about the links between regeneration and health.
- Briefing paper 20: neighbourhood structures and crime rates in Glasgow.

Journal articles

- Bond, L., Egan, M., Kearns, A., Clark, J., and Tannahill, C. Smoking and intention to quit in deprived areas of Glasgow: is it related to housing improvements and neighbourhood regeneration because of improved mental health? Journal of Epidemiology and Community Health 2012 (E-pub ahead of print. DOI: 10.1136/jech-2012-201828).

There are also a number of other articles that are currently being reviewed by various journals. To make sure you receive alerts of these and other new publications, sign up for the GoWell Learning Network by emailing your contact details to Jennie Coyle, or follow us on Twitter: @GoWellOnline.

Conference and seminar presentations

- An introduction to GoWell: studying change in Glasgow’s East End. Urban Studies; University of Glasgow: 2013.
- Challenges to undertaking economic evaluation of public health interventions: Glasgow’s housing and regeneration interventions. University of Glasgow; Glasgow: 2012.
- Overview of GoWell. Royal Environmental Health Institute of Scotland; Edinburgh: 2012.
- The lived realities of regeneration. Glasgow Housing Association Community Health and Wellbeing Meeting; Glasgow: 2012.
- Mental wellbeing and its associations with physical activity, health and aspects of deprived neighbourhoods in Glasgow. 8th World Active Ageing Congress; Glasgow: 2012.
- Change over time in Glasgow’s communities. Glasgow Housing Association Regeneration seminar; Glasgow: 2012.
- The Lived Realities of Regeneration. Springburn Area Committee; Glasgow: 2012.
- Investment in housing, regeneration and neighbourhood renewal: measuring impacts on the health and wellbeing of people and communities. Centre for Housing, Urban and Regional Planning; University of Adelaide, Australia: 2012.
- Housing, regeneration and neighbourhood renewal: measuring impacts on the health and wellbeing of people and communities. School of Geography and Environmental Science, Monash University; Melbourne, Australia: 2012.
Our accounts

Income 2012/13

<table>
<thead>
<tr>
<th>Sponsor</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow Centre for Population Health</td>
<td>£50,000</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>£85,257</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td>£40,000</td>
</tr>
<tr>
<td>Scottish Government</td>
<td>£113,676</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£288,933</td>
</tr>
</tbody>
</table>

*Glasgow Housing Association contribute funding of approx £100,000 per annum towards the community health and wellbeing survey and supporting qualitative focus groups. The survey contract is managed directly by GHA so this funding does not appear as 'income' into the GoWell accounts.
†GoWell: Studying Change in Glasgow’s East End is accounted for separately.
‡The significant in-kind contributions made by partner organisations are not shown.

Expenditure 2012/13 (from 1 April 2012 to 31 December 2012)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and support staff and associated costs</td>
<td>£111,467</td>
</tr>
<tr>
<td>Communications, events and outputs</td>
<td>£18,574</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£130,041</td>
</tr>
</tbody>
</table>

Our team

Sheila Beck (Ecological Monitoring Team)
Lyndal Bond (Principal Investigator)
Julie Clark (Researcher)
Jennie Coyle (Communications Manager)
Fiona Crawford (Ecological Monitoring Team)
Angela Curl (Researcher)
Matt Egan (Researcher)
Ade Keirns (Principal Investigator)
Kenny Lawson (Health Economist)
Louise Lawson (Researcher)
Mark Livingston (Researcher)
Phil Mason (Researcher)
Martin McKee (Researcher)
Jennifer McLean (Ecological Monitoring Team)
Kelda McLean (Programme Administrator)
Carol Tannahill (Principal Investigator)
Hilary Thomson (Researcher)
David Walsh (Ecological Monitoring Team)

We are also pleased to have four PhD students (Camilla Baba, Joanne Neary, Oonagh Robison and Nick Sharrer) working with us.
The links between regeneration and health: a synthesis of GoWell research findings

March 2013

Matt Egan, Carol Tannahill, Lyndal Bond, Ade Kearns, Phil Mason
Introduction

GoWell is a complex, multi-faceted programme that seeks to examine the processes and impacts of neighbourhood regeneration across a range of outcomes and using a variety of research methods (see Box 1 for aims and objectives). The programme commenced in 2006, and since then the team has completed and reported on:

- **Community surveys:** our study communities (15 in total) have been surveyed three times so far, in 2006, 2008 and 2011. The community survey enables us to record how communities change in composition and character as interventions progress, and also to monitor residents’ opinions, feelings and behaviours. The survey includes a longitudinal study of the occupants of existing dwellings within the communities as well as a survey of occupants of new build properties. Table 1 outlines the survey sampling strategies, achieved sample sizes and response rates.

Table 1. Sampling strategy, achieved samples and response rates for the GoWell cross-sectional surveys.

<table>
<thead>
<tr>
<th>Year and survey wave</th>
<th>Sampling</th>
<th>Sample size</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006 – Wave 1</td>
<td>All areas: random property selection</td>
<td>6,016</td>
<td>50.3</td>
</tr>
<tr>
<td>2008 – Wave 2</td>
<td>Regeneration areas: all properties Other areas: random selection</td>
<td>4,657</td>
<td>47.5</td>
</tr>
<tr>
<td>2011 – Wave 3</td>
<td>Regeneration areas: all pre-existing properties, plus all new builds Other areas: return to all previous interview addresses, plus all new builds.</td>
<td>4,063</td>
<td>45.4</td>
</tr>
</tbody>
</table>

- **Outmovers surveys:** in order to assess the effects of relocation, we have been tracking people who have moved out of the regeneration areas in our study after 2006.

- **Qualitative research:** often our survey work raises issues that require further in-depth research in order to develop better understanding or explanations. In order to pursue these issues, we also conduct qualitative research with residents and practitioners involved in the interventions or living in the study areas. Using qualitative research methods we have gained insights into a range of issues including: the experiences of particular subgroups (e.g. asylum seekers and refugees); the ‘lived realities’ of residents in transformational regeneration areas; resident and practitioner perspectives on mixed tenure neighbourhoods; clearance processes; the experiences of young people living through regeneration; and governance, empowerment and participation processes in our study areas.
• **Ecological analysis**: as well as studying a particular set of communities, we also examine changes across the city as a whole. Our ecological analysis allows us to consider whether our study areas improve or deteriorate over time compared with trends for other parts of the city, particularly in terms of health and deprivation indicators.

• **Studies focused on specific issues, core to GoWell objectives**: these include evaluations of interventions (e.g. youth diversionary projects, environmental employability programmes); linked data analysis on policy issues (e.g. crime, education* and financial insecurity*); and research to highlight areas for action (e.g. media coverage of regeneration areas).

Box 1. GoWell aims and research objectives.

<table>
<thead>
<tr>
<th>Aims:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To investigate the health and wellbeing impacts of regeneration activity associated with the Glasgow investment programme.</td>
</tr>
<tr>
<td>To understand the processes of change and implementation which contribute to (positive and negative) health impacts.</td>
</tr>
<tr>
<td>To contribute to community awareness and understanding of health issues and enable community members to take part in the programme.</td>
</tr>
<tr>
<td>To share best practice and knowledge of ‘what works’ with regeneration practitioners across Scotland on an ongoing basis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To investigate how neighbourhood regeneration and housing investment affects individuals’ health and wellbeing.</td>
</tr>
<tr>
<td>To assess the degree to which places are transformed across a range of dimensions through processes of regeneration and housing improvement.</td>
</tr>
<tr>
<td>To understand the processes that support the maintenance or development of cohesive and sustainable communities.</td>
</tr>
<tr>
<td>To monitor the effects of regeneration policy on area-based health and social inequalities across Glasgow.</td>
</tr>
<tr>
<td>To develop and test research methods appropriate to the investigation of complex, area-based social policy interventions.</td>
</tr>
</tbody>
</table>

There are 15 GoWell communities, grouped into five ‘intervention area types’. Most of our analysis takes place at the level of an area type (see Box 2 for description of the five intervention area types), but sometimes we will focus on a particular area or on Glasgow as a whole (see Figure 1 for a map of the 15 study areas). Our job is primarily to understand the patterns and trends that emerge as the regeneration processes are implemented in different parts of the city, rather than to study any particular area in detail.

* Current studies – not yet reported
Box 2. GoWell intervention area types.

<table>
<thead>
<tr>
<th>Intervention area type (IAT)</th>
<th>Description</th>
<th>Study areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transformational Regeneration Areas (TRAs)</td>
<td>Places where major investment is underway, involving a substantial amount of demolition and rebuilding over a long period. Many residents who remained in these neighbourhoods during the study period were waiting to relocate while nearby properties were cleared for demolition.</td>
<td>Red Road, Shawbridge, Sighthill.</td>
</tr>
<tr>
<td>Local Regeneration Areas (LRAs)</td>
<td>Places where a more limited amount and range of restructuring is taking place, and on a much smaller scale than in TRAs.</td>
<td>Gorbals Riverside, Scotstoun, St Andrews Drive.</td>
</tr>
<tr>
<td>Wider Surrounding Areas (WSAs)</td>
<td>Places of mixed housing types surrounding areas of multi-storey flats subject to transformation plans, and being used for decanting purposes from the core investment sites. These areas also receive substantial amounts of core housing stock investment.</td>
<td>Wider Red Road, Wider Scotstoun.</td>
</tr>
<tr>
<td>Housing Improvement Areas (HIAs)</td>
<td>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.</td>
<td>Birness Drive, Carntyne, Govan, Riddrie, Townhead.</td>
</tr>
<tr>
<td>Peripheral Estates (PEs)</td>
<td>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 housing association core stock improvement works both take place on these estates.</td>
<td>Castlemilk, Drumchapel.</td>
</tr>
</tbody>
</table>
One of the ways in which GoWell is distinct from many other research programmes is in its commitment to close working with its sponsor organisations, local communities, and policy, practice and research communities more generally (Box 3 outlines our learning objectives). Priority has been placed on disseminating our findings, discussing their implications with our many stakeholders, and using the research to inform organisational plans and ways of working. These processes have in turn informed our research priorities and approaches, and have helped ensure the ongoing relevance of GoWell as contexts change and new priorities arise. The key challenge is to enable the rich data emerging from our research processes to be translated into meaningful insights – and thereafter recommendations for policy and practice – through being brought together with the experience of local residents and those working to improve the circumstances of the communities. We recognise that such insights need to be built up from across the different programme components, and over time.

Box 3. GoWell learning objectives.

Learning objectives:

- To distil learning from across the various components of GoWell, in a way that enables regeneration policy and implementation to take greater account of opportunities to improve health and wellbeing.
- To make opportunities to influence policy across Government Directorates and at a regional and local level.
- To facilitate capacity of the GoWell communities and their local structures to use learning in a way that empowers them.
- To disseminate methodological developments and research findings to academic and practitioner audiences, through a range of written and verbal communications.
The purpose of this report is to bring together findings from our analyses to date. It focuses on the findings that help to build an understanding about the relationships between neighbourhood regeneration and health and wellbeing. It draws on various components of GoWell and thereby paints a richer picture than can be seen from the separate reports and briefing papers. We hope it is a picture that will cause people to reflect and will also stimulate action.

Regeneration and health

Health and wellbeing have become important objectives for housing and regeneration policies in Scotland and the UK. Within GoWell we have reflected this national priority through having done the following: reviewed the literature about regeneration and health links; considered further the routes by which regeneration might improve population health; monitored changes in physical health, health behaviours and mental health and wellbeing across our study communities and within the context of the city of Glasgow; and looked at how health is changing for individuals living through different forms of regeneration or experiencing housing improvements.

The recognition that neighbourhood regeneration needs to be multi-faceted is now well established in national policy as well as local strategies and plans. From an early analysis of policy that we undertook at the time of the GoWell baseline surveys in 2006, there was clear evidence of a policy commitment to a holistic approach to regeneration and a remarkable level of agreement (in policy terms and among interviewees comprising community residents, practitioners and people involved in regeneration strategy) about the necessary ingredients for effective regeneration. The key ingredients were seen as being:

- Housing regeneration – quality housing, affordable housing, mixed tenures, and accessible housing support
- Environmental regeneration – high-quality public realm, improved amenities and buildings, and enhanced natural environments
- Economic regeneration – opportunities for sustained employment and good quality work, transport infrastructure providing improved access to opportunities, and business growth
- Social regeneration – effective community involvement, reduced crime and antisocial behaviour, learning and training opportunities, wider community participation and empowerment.

In addition, policy interviewees in this study felt that more emphasis should be placed on incorporating a ‘person-centred’ approach, fostering confidence, life-skills, and higher aspirations. Better health and wellbeing were regarded as likely outcomes to emerge from this holistic approach, rather than as a direct consequence of any particular intervention. This is an important point. Many factors, operating in different ways, have a cumulative effect on people’s health over the life-course. It will take large-scale multi-dimensional change, sustained over time, to turn around the health statistics in communities that have
experienced poor population health for many years. To date there is an absence of evidence that area-based regeneration approaches have achieved this.

That said, the research literature includes many findings demonstrating important relationships between neighbourhoods and health, and impacts of regeneration of the different types described above. Box 3 highlights some of these. In GoWell we are able to add to the evidence-base. Our programme has particular strengths in being long-term and also longitudinal; in looking at a range of different interventions (see Box 4); and incorporating several measures of health outcome.

**Box 4. Neighbourhoods and health: key messages from the literature.**

- On a wide range of measures, the health of people living in poorer areas is much worse than the health of those in areas with less deprivation. This is not just about a comparison of the most affluent and most deprived communities: there is a steady health gradient between the two extremes.

- The effects on health of living in an area of deprivation are less for people of higher social status/grade (e.g. in employment or financial terms), either because they can use their individual resources to protect themselves from local stressors or because they are able to separate themselves from the worst parts of the neighbourhood.

- An area's history matters, as well as its current level of deprivation. For example, deindustrialised areas have a higher chance of being in poor health, controlling for other factors.

- Aspects of community are also important for health – including civic engagement, social engagement, and feeling part of the local community.

- Large US studies have shown significant and consistent findings that moving out of the poorest neighbourhoods results in improved mental health (using a range of measures).

- Experiences of prolonged, chronic stress have both psychological and biological consequences. It may be that one of the important health impacts of neighbourhoods is whether they provide a stressful, or stress-free, residential context.

- It matters not only what regeneration does, but also how things are done.
Box 5. Interventions being studied through GoWell.

**Housing Improvements:** Through the implementation of the Scottish Housing Quality Standard and the investment programme undertaken by Registered Social Landlords (RSLs) and by Glasgow Housing Association (GHA) since housing stock transfer in 2003, there is a substantial programme of housing improvement works being applied to all social housing in the city. Most of our study areas have received large numbers of housing improvements, and residents may therefore be experiencing the twin effects both of individual housing improvements, and of area-level impacts from multiple improvements which transform the appearance of a neighbourhood.

**Transformational Regeneration:** Three of our study areas are undergoing transformational regeneration involving almost entire redevelopment over time. Three further study areas are experiencing restructuring that is less than full redevelopment. Regeneration involves physical change through the replacement of residential and other buildings, other neighbourhood improvement works (such as to green spaces and shops), and housing and social restructuring towards mixed tenure communities. Economic development, cultural activities and wider skills development/educational processes may also form part of the intervention.

**Resident Relocation:** A necessary element of transformational regeneration is the relocation of residents to housing elsewhere in order to enable restructuring to occur. Some people may move more than once as a part of this process, and very few people will move back to the restructured area even if they had originally thought they might do so. Relocation has generally been considered to be a negative experience and to have detrimental impacts upon people, due to loss of attachment and disruption to social connections, though as researchers we need to retain an open mind on this.

**Mixed Tenure Communities:** Mixed tenure communities is a central tenet of housing and regeneration policy, with an associated set of desired outcomes relating to residential satisfaction, area reputation, community pride and place attachment, and resident aspirations and behaviours. Mixed tenure is occurring in the regeneration areas within the study, but also, more incrementally, in the Peripheral Estates.

**Dwelling Types:** All the above interventions involve changes in dwelling types for communities and residents. Urban, planning and housing policy provide support and incentives for different types of dwelling to be provided for populations, with potentially different consequences for health and wellbeing and their determinants. We are particularly interested in the effects of living in high-rise versus lower-rise flats, and whether any differences between them are altered by housing improvement works; and in the individual and community level effects of residing in houses with gardens rather than in flats of whatever kind.

**Community Engagement and Empowerment:** Housing and regeneration policy-makers and practitioners regard community engagement and empowerment as core tenets of their approach to delivering services and change. Public sector organisations (individually, and collectively through community planning processes) are required to engage with relevant communities/user groups in the development and implementation of strategies and new initiatives. This is held to have benefits for the effectiveness of services and for service providers, as well as having positive impacts upon communities in terms of confidence, capacity and cohesion – all seen as virtuous in themselves but also as necessary for other outcomes, for example in relation to health and wellbeing and employment. GHA, for example, has a strategic aim of ‘Empowering communities to extend wellbeing and opportunities’.
Before moving on to consider GoWell findings, it is worth pausing to think in more detail about the ways in which community interventions might impact on health. Community health profiles are available for all areas of Scotland. These incorporate many of the routinely measured and monitored aspects of communities, across a range of domains, and are useful to inform local planning and identify priorities. They also clearly illustrate both the gradient that exists across the country in terms of community health, and the clear difference between our most affluent and least affluent communities (see Figure 2).

In the community profiles shown here, the vertical line at ‘0’ represents the Scottish average; bars going to the left are ‘better’ than the average, and those going to the right are ‘worse’. Using these profiles as our starting point, the relationship between area-based regeneration and health can be conceptualised in three broad ways.

1. **Action on influential factors.** Actions can be directed at the individual factors in communities (the individual ‘bars’ in Figure 2), for example to improve housing quality, increase the amount of greenspace, reduce worklessness, and so on. These approaches can all contribute to better population health, but none will have enough impact to make the health of the community on the right close to that of the community on the left.

2. **Action on fundamental determinants.** Alternatively, the focus can be placed on the factors that perpetuate differences in health regardless of the issue of interest. These factors cut across several of the bars, rather than sitting within any one of them. They include resources such as knowledge, power, social connections, money and language, which are protective to health no matter what risks are relevant at any time. Because of this, they are referred to as the ‘fundamental determinants of health’. Crucially, ‘how’ things are done has a big impact on several of these fundamental determinants. The distribution of power in decision-making is a prime example.

3. **Holistic approach.** Thirdly, a system-based response to Figure 2 is possible. This emphasises the need to attend as much to the relationships between the components as to the components themselves. This approach moves our thinking from a series of separate issues and the cross-cutting ‘fundamental determinants’ towards a multi-faceted approach where influences interact. It requires public services to work together, with the communities they serve, and with private and third sector partners, to deliver a more holistic and context-specific response to the needs of, and assets within, communities.

Our analyses of the data from the GoWell community surveys fall largely within the first of these three approaches. We are able to show associations between health outcomes and many dimensions of our study communities; we are able to show how things are changing over time; and we are able to test whether the changes are likely to have been caused by the interventions we are studying. Moving forward we will be able to use our survey data in ways more aligned to the other two approaches – but we are still at an early stage in this regard. However, as we will show, findings from the qualitative research studies provide some important insights into the other approaches.
Figure 2. Comparison of health outcomes and determinants of health in two Glasgow communities.

Newton Mearns – G77 5.

Dalmarnock – G40 4.

Each bar on these charts represents that community’s position on a specific indicator, with bars to the left indicating a position better than the Scottish average, and those to the right indicating a worse position. The indicators include both measures of health and measures of the determinants of health.
Area deprivation and health

GoWell areas have a higher than average burden of ill health compared to Scotland as a whole\(^5,6\). Longitudinal research conducted by the Medical Research Council suggests that residence in low income areas of Glasgow increases the risk of future health problems (after controlling for other factors)\(^7\). Findings such as this underpin assumptions that deprivation is an important cause of ill health. As all the GoWell neighbourhoods meet the Scottish Government’s definition of income deprived areas\(^5\), this gives us grounds for assuming that the relatively poor health of GoWell residents can, to an extent, be explained by theories that give income deprivation a key causal role.

However, routine indicators suggest that the social patterning of health across the GoWell areas does not follow the pattern of income deprivation exactly. Some GoWell areas have a better health record than others. It cannot be assumed that those GoWell areas with the best general health are always the ones that have higher average incomes. Equally, those areas with the worst health are not consistently the most income deprived. Relationships between health and place are more complex than that and can vary depending on the health outcome in question. So, while there is a rationale for supporting interventions that aim to raise low incomes among disadvantaged groups either directly or indirectly, income deprivation is not the only driver of area-based health inequalities. For example, it is possible for areas to buck the trend for specific health problems so that neighbourhoods with similar levels of deprivation vary in terms of their population’s health (a comparison of Glasgow, Manchester and Liverpool, which have similar deprivation levels but different health outcomes, suggests that this phenomenon also occurs at a city-wide scale\(^8\)). This provides a rationale for policymakers and urban planners to look beyond income and scope out other social and environmental characteristics that might become the focus of regeneration. These approaches are not exclusive of one another; policy recommendations for reducing social inequalities tend to include poverty reduction and broader socioenvironmental improvements\(^9\).

GoWell research methods

GoWell’s work in scoping out social and environmental factors that link to health is multi-staged and involves a range of methodologies. What follows is a brief summary of the different approaches we have taken.

**Cross-sectional analysis**, as the name suggests, focuses on data from a cross-section of the population taken at a single point in time. In the case of this report, the cross-sectional data come from GoWell’s community surveys and are explored using various types of quantitative analysis. Using statistical analysis, we have identified individual, home, neighbourhood and community characteristics that appear to be associated with health and wellbeing. This can help planners focus their attention on characteristics of people and place that appear to have health links and decide if there are plausible theories to suggest how modifying a particular characteristic might affect health. In addition, comparing successive cross-sectional waves (2006, 2008 and 2011) can help us measure how communities have changed since baseline. We have used the repeat cross-sectional data to compare changes over time across the five types of GoWell intervention areas.
Cross-sectional comparisons also allow us to compare outcomes for communities that have experienced different types of regeneration. For example, GoWell has conducted a detailed cross-sectional analysis comparing residents who relocated from neighbourhoods undergoing transformational regeneration and demolition, with residents who remained in those Transformational Regeneration Areas (TRAs).

In contrast, tracking longitudinal cohorts over time helps us to move beyond evidence simply of associations between factors, to stronger evidence from which causal direction and intervention attribution may be inferred. We began a process of data linkage following the 2008 survey to identify participants who took part in both the first and second survey wave. This was a major undertaking (one which is currently being repeated for the 2011 survey), but it has enabled us to conduct controlled longitudinal analysis to explore changes experienced by individuals over time and how these changes differ according to their experience of regeneration.

**Qualitative research** moves our study beyond discussions of prevalence and statistical associations, and allows us to explore in more detail how residents view their own experiences. From this we can assess, for example, whether residents consider regeneration to be a major or minor part of their lives, and which aspects of regeneration affect them. As well as yielding deeper insights into people’s experiences, feelings and beliefs, qualitative research findings can be brought alongside those from quantitative studies, to explore similarities and differences. Qualitative data can also be used to help generate hypotheses about causal pathways and suggest explanations for findings obtained using quantitative methods.

All of these approaches to research and analysis are included in the research synthesis presented in this report. The report is split between cross-sectional findings on associations between health and place, and research of various kinds comparing population sub-groups who have contrasting experiences of regeneration. Each section covers a range of health outcomes including health behaviours, health service use, physical and general health, and mental health or wellbeing. Data are also drawn from different GoWell surveys. In order to provide as complete a view as possible we have not focused only on the most recent findings but rather used findings from throughout the life of the programme. However, some questions have not been asked in all three survey waves, limiting our ability in these cases to describe changes over time.
Findings on health behaviours

Any behaviour that can potentially affect a person’s health is a ‘health behaviour’ but health researchers often focus on a relatively small number of key topics such as diet, physical activity, smoking, and the consumption of alcohol – and these are the types of health behaviours covered in the GoWell surveys. Improvements in residents’ health behaviours could be a potential outcome of regeneration. For example, improvements to the quality and safety of neighbourhood environments could encourage more people to walk around the neighbourhood and provide opportunities for other physical activities. Health behaviours are also important mechanisms by which regeneration can ‘get under people’s skin’\(^1\). If certain types of regeneration do help people to adopt healthier behaviours, this may lead to further health benefits such as improved mental wellbeing, lower rates of physical morbidity and reduced mortality.

Self-reported health behaviour data can, however, be particularly problematic\(^{10}\). They often rely on assumptions that participants are able to define, recall and quantify activities and consumption patterns in an accurate and standardised way. These assumptions may not be justified (there are widely reported issues, for example, about people’s accuracy in reporting their alcohol consumption; and understanding of what constitutes a portion of fruit or vegetables), and we therefore have to interpret with caution the absolute levels of behaviour reported. However, analyses of changes over time and differences between subgroups are likely to be more reliable.

Diet

On the question of diet, we have focused particularly on ‘snacking’ – on the grounds that our participants seem to have found questions about snacks easier to answer than questions about ‘portions’ of fruit and vegetables\(^i\).

There are many types of snack and some are often considered healthy while others are considered unhealthy. Our wave 2 questionnaire asked about two types of snack in particular. Participants were asked if, in the last 24 hours, they had snacked on a ‘packet of crisps or similar’ (treated in our analysis as the unhealthy choice), or if they had snacked more healthily on an item of fruit. We also asked about drinks people consumed, focusing on fizzy soft drinks (considered less healthy) or unsweetened fruit juice (considered healthier).

It is sometimes assumed that deprived areas have few healthy food outlets, and that this may be an environmental factor that can help explain why diets in disadvantaged areas are generally poor. Most people in Glasgow live relatively near shops that sell food, but previous studies have looked at whether or not the type of food being sold in local shops varies by area deprivation. We found that the findings from these previous studies have been mixed, particularly as many disadvantaged neighbourhoods (including GoWell neighbourhoods) are located near supermarkets or other shops that sell a wide range of healthy and unhealthy products\(^{11}\).

\(^i\) Surveys that focus on portions generally devote more space than we had available to providing detailed definitions of the types and quantities of food being asked about (and even these questionnaires are often considered to be unreliable)\(^{11}\).
Using mapping software, we measured residents’ proximity to food outlets, and in particular outlets considered to sell nutritious food. We found that proximity to healthy food outlets varied from one locality to another. Furthermore, healthy snacking was associated with living near to (up to ten minutes walk away from) a supermarket; it was also associated with living up to 15 minutes walk away from other shops selling nutritious food. These findings are important because they suggest that even though disadvantaged areas may have access to nutritious food outlets, this access is not uniform and a relative lack of access is associated with less healthy dietary behaviours (at least where snacking is concerned).

We also found associations between snacking and psychosocial aspects of the home and neighbourhood environment. Feeling secure at home and feeling that the neighbourhood has changed for the better over the previous two years were both associated with healthier snacking. We think it plausible that (a) the psychosocial benefits that some residents derive from their home and neighbourhood may influence their health behaviours; and/or (b) that people who are generally positive about their lives may demonstrate this positive attitude through their health behaviours and their appraisals of home and neighbourhood.

**Alcohol**

Alcohol has been linked to a variety of health problems. In addition, ‘people being drunk or rowdy in public places’ is one of the neighbourhood behaviours most commonly cited as problematic by our survey respondents. The negative impacts of drunkenness on communities has also been a recurring theme in our qualitative research into residents’ neighbourhood experiences. Furthermore, geographical analysis of routine data on neighbourhood characteristics and crime in Glasgow has found that the number of licensed alcohol outlets in an area was strongly associated with relatively high local crime rates.

The self-reported alcohol data from our participants are therefore surprising. They suggest that GoWell respondents tend to drink less than the national average and that a greater proportion of the GoWell sample abstain entirely from alcohol in comparison to the Scottish population. Furthermore, these differences between GoWell and national figures are large. For example, 44% of our respondents reported in 2008 that they never drink alcohol. A further 24% said they drank alcohol occasionally but had not done so in the last seven days. The Scottish Health Survey, 2008, 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.

There is a reported tendency towards polarised alcohol consumption among more disadvantaged populations: more people reporting drinking to excess and more people claiming not to drink at all. The potential problem with our data is that they demonstrate the latter (greater abstinence) to a surprisingly large degree, but provide less evidence of the former (more drinking). It is possible that our findings under-represent the true level on alcohol consumption, although there is no obvious way to demonstrate this claim or explain why it may have occurred. Possible explanations include factors to do with the composition of our sample, and factors to do with reporting bias (e.g. confusion over the questions, or an unwillingness to admit to drinking).
Neighbourhood and housing characteristics tend to vary between our participants who state that they don’t drink alcohol and those who do drink. Abstention was more common in the TRAs than the other area types, and more common among high-rise flat dwellers than residents who live in other types of building. High-rise flats, particularly those located in the TRAs, contained more residents born outside the UK (e.g. asylum seekers, refugees and economic migrants). Around three out of every four of our participants born outside the UK (76% in 2008) stated that they abstain from alcohol, compared with one out of every three participants born in the UK (35%)\textsuperscript{13}. Therefore, non-UK born participants tend to boost alcohol abstention rates in the GoWell areas that house them. That said, across the whole sample the majority of abstainers (n=1,297 in 2008) came from our UK-born participants (most of whom were born in Scotland), and only a minority of abstainers were born overseas (562 abstainers were not born in the UK in 2008).

In addition, men were more likely to drink than women; people living with children reported alcohol consumption more than adults in childless households; and older working age adults (40-64 years old) were more likely to drink than younger adults or retired people. Two proxy indicators of higher social status were also associated with drinking: being employed as opposed to unemployed or in education; and living in an owner-occupied home rather than renting\textsuperscript{13}.

**Smoking**

Unlike the alcohol figures discussed above, smoking prevalence among our participants was closer to what we expected from disadvantaged Scottish neighbourhoods. Self-reported smoking prevalence among our respondents was 40% in 2008, almost identical to the figure reported in that year’s Scottish Health Survey for the population in Scotland’s most deprived quintile (as measured by the Scottish Index of Multiple Deprivation)\textsuperscript{16}. In contrast, across all of Scotland’s population, 27% of men and 25% of women over the age of 16 years reported being a smoker in 2008. These findings are consistent with other evidence that demonstrates the link between area deprivation and smoking\textsuperscript{13,15}.

The fact that our data on smoking prevalence are consistent with national figures for a similarly deprived population helps us be more confident about the reliability of our smoking data. A closer look at smokers’ characteristics allows comparison of the social patterning of smoking with the social patterning of drinking within the GoWell population\textsuperscript{13}.

Echoing the figures for alcohol, the lowest prevalence of smoking was in the TRAs. Residents of high-rise flats (along with houses) had lower smoking prevalence than those in low-rise flats; and residents born outside the UK were particularly unlikely to smoke. Similarly, males and older working age adults were particularly likely to smoke (just as they were more likely to drink)\textsuperscript{13}.

However, the proxy indicators of social status – housing tenure and employment – tell a different story. Whereas drinking was associated with home ownership and employment, being a smoker was associated with social renting and unemployment. Adults who lived without children, particularly single working age men, were more likely to smoke, while adults who lived with children were more likely to drink\textsuperscript{15}. Smoking seems to be more strongly associated with markers of deprivation and exclusion than does drinking.
**Physical activity and inactivity**

Physical inactivity increases the risk of many chronic diseases such as coronary heart disease, type 2 diabetes, and cancer of the colon\(^\text{17}\). Most sports are a form of physical exercise but everyday activities such as walking, gardening or housework also help to reduce sedentary time. Engaging in everyday, moderate physical activities, even for relatively short times on most days can bring health benefits. These everyday activities have distinct advantages from a public health perspective: most people can engage in them to some degree, they are cheap or free, and they conveniently fit into people’s everyday life. There are also environmental justifications for choosing active travel over motorised transport\(^\text{18}\).

We looked at whether people’s everyday physical activities are associated with characteristics of the place they live in; and we focused particularly on neighbourhood walking because we hypothesised that if regeneration interventions were successful in making people feel better about the area they lived in, this could potentially encourage an increase in neighbourhood walking\(^\text{19}\).

In the 2006 survey, residents were asked ‘*In a typical week, on how many days do you go for a walk around the neighbourhood?*’ Overall, 29% of respondents reported walking around their neighbourhood on five or more days per week but this figure varied widely by study area (ranging from 10% to 51%). Frequent neighbourhood walking was more common in the PEs (35%) than in the inner-city neighbourhoods regardless of whether those inner-city neighbourhoods had relatively high or low density dwelling designs. In the higher density inner-city neighbourhoods (post-war estates dominated by multi-storey flats) 26% of participants reported frequent neighbourhood walking, whereas in lower density inner-city neighbourhoods (dominated by cottages and tenements with single or shared gardens) the figure was 28%\(^\text{19}\).

Unsurprisingly, respondents who were older, whose physical health was poor, or who had specific health problems were less likely to walk frequently. Neighbourhood walking did not vary by measures of socioeconomic status (although our analyses are limited by the fact that our sample does not have a substantial amount of variation in socioeconomic status since most participants are relatively deprived).

People were more likely to walk frequently in their neighbourhood if they felt a sense of belonging to the place where they lived, considered the community cohesive, and if they felt the streets were safe to walk in at night. However, people who expressed higher levels of trust in others living in their area, were less likely to walk frequently\(^\text{11}\).

Walking was associated with aspects of the physical environment in a number of ways. First, the presence of local amenities that support physical activity was important. Respondents who used local sporting facilities, parks and play areas were all more likely to walk frequently in their neighbourhood. In the case of parks and open spaces, respondents were more likely to walk if they also believed that those facilities were of good quality. Third, the use of other types of local amenities was also associated with frequent neighbourhood walking: for example, general shops, social venues, libraries and even fast food outlets.

\(^{11}\) These analyses control for other factors like age, gender, ethnicity and level of education.
Frequent neighbourhood walking was also found to be associated with better physical and mental health\(^\text{19}\), although the direction of causality here is not yet clear.

Table 2 below outlines who has the least healthy behaviours when we look at some personal, social status and home type characteristics.

**Table 2. Who has the least healthy behaviours?**

<table>
<thead>
<tr>
<th></th>
<th>Diet</th>
<th>Alcohol</th>
<th>Smoking</th>
<th>Physical activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td>Men</td>
<td>Men</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Working age</td>
<td>Middle age</td>
<td>Middle age</td>
<td>Retired</td>
</tr>
<tr>
<td><strong>Country of birth</strong></td>
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<td>UK</td>
<td>UK</td>
<td>UK</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td>Unemployed</td>
<td>Employed</td>
<td>Unemployed</td>
<td>Retired; sick; unemployed</td>
</tr>
<tr>
<td><strong>Tenure</strong></td>
<td>Renters</td>
<td>Owners</td>
<td>Renters</td>
<td>Renters</td>
</tr>
<tr>
<td><strong>Building type</strong></td>
<td>High-rise flats</td>
<td>House; low-rise flats</td>
<td>Low-rise flats</td>
<td>Low-rise and high-rise flats</td>
</tr>
</tbody>
</table>

**Findings on mental wellbeing**

Systematic review evidence suggests that mental health and wellbeing are key health outcomes that can result from regeneration. Consequently, a strand of our cross-sectional research has explored mental wellbeing and its associations with various characteristics of people and place.

The findings generally provide evidence to support the link between mental wellbeing and the quality of local environments. An analysis of our wave 2 (2008) survey data, using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)\(^\text{20}\) as a measure of mental wellbeing, found that people who reported that their home had a ‘very good’ external appearance were also more likely to have higher WEMWBS scores (a higher score indicates better mental wellbeing). The quality of front doors was a characteristic of people’s homes that had particularly strong, positive associations with mental wellbeing. This is of interest because replacement front doors are the most frequently implemented housing improvement in Glasgow’s regeneration programme. A good quality door can add aesthetic value to a home but also be valued in terms of feelings of security and control\(^\text{21}\).

Associations with wellbeing were particularly strong in cases where environmental characteristics were rated as ‘very good’ rather than merely ‘good’. This observation applies to the home characteristics discussed above. It also applies to neighbourhood aesthetics: residents who reported that their neighbourhood had very good aesthetic qualities were likely to score more highly on WEMWBS\(^\text{21}\). We do not yet know if these associations are causal (with the environment having an influence on mental wellbeing) but if they are, the findings suggest that environmental improvements need to achieve a high level of quality if
they are to impact upon residents’ wellbeing. Such associations are consistent with the idea that homes and neighbourhoods are important restorative environments for people to relax and recover in.

Psychosocial characteristics of the home and neighbourhood also had strong associations with mental wellbeing. People who thought that their residential environment helped them feel they were doing well in life tended to report better mental wellbeing. Similarly WEMWBS scores tended to be higher among people who believed that their home made them feel in control and where people believed that local residents thought highly of the neighbourhood, i.e. it had a high ‘internal reputation’.

Relative social positioning provides a further mechanism by which the psychosocial environment was associated with mental wellbeing. It has been theorised that people’s assessment of their own social status may have associations with health and wellbeing that are independent of material or economic markers of status. It has also been theorised that people may make different types of social comparisons to help them assess where they are positioned on the social scale. We found evidence that people who positioned themselves, their home or the neighbourhood relatively favourably compared with others were more likely to have a higher WEMWBS score (compared to those who positioned these aspects of their lives lower down the social scale). Our findings suggest that these very local comparisons people make may be more important to wellbeing than previously thought.

Another theory to explain how residential environments may influence health through psychosocial pathways relates to residents’ sense of empowerment, and in particular their relationship with local service providers. This is one of the ‘fundamental determinants of health’ described earlier. ‘Empowerment’ can be conceptualised in various ways. Our survey includes questions that refer to different levels or ‘doses’ of empowerment: the most basic level is simply being satisfied with a service provider; a second level refers to whether or not residents feel the service provider gives them adequate information about their plans and activities; and a third level considers reciprocal engagement in which residents feel they can influence the service provider’s decisions. Specifically, we asked residents how satisfied they were with their landlords, and whether they believed they were being kept informed about, and given a chance to influence, decisions affecting their local area. Typically, our respondents were most likely to provide a positive answer in response to the satisfaction questions and least likely to respond positively to the participation question, but all three levels of empowerment were found to be positively associated with mental wellbeing.

**Findings on health following neighbourhood change**

The findings described above are relevant to the planning of home and neighbourhood interventions, but they do not describe how such interventions may have affected residents. There are other GoWell outputs that have focused on area-based regeneration and its impacts. These are considered below.
Housing improvements

Across all our study areas there has been an extensive programme of housing improvement driven by national and local changes to Housing Quality Standards24. Properties have received internal and external improvements according to need – including improved roofs, external cladding, doors, windows, bathrooms, kitchens, heating and electrics13. Registered Social Landlords (RSLs) are compelled to ensure that all their properties meet the new national standard by 2015. RSLs manage social rented and, to a lesser extent, owner-occupied properties (as factors). The scale of the improvement programme required an incremental approach spanning the available time period and, in effect, creating a ‘waiting list’ for improvements. In spite of this incremental approach, housing improvement was arguably the most widely implemented physical regeneration intervention in the early years of GoWell. In 2008, 36% of our respondents reported receiving housing improvement during the previous two years13.

There is research evidence demonstrating that housing improvement can benefit residents’ health24-27. A systematic review found that improvements in respiratory, general and mental health have been observed following housing improvement25. However, much of the identified evidence of health benefits came from studies of interventions that target homes with specific health risks – most notably heating improvements for cold, damp dwellings. Hence, the review concluded that the "potential for health benefits [from housing improvement] may depend on baseline housing conditions and careful targeting of the intervention."25 The improvement work we have evaluated was targeted to a degree, in that homes were managed by RSLs, located in disadvantaged neighbourhoods and were assessed to be in need of intervention. However, improvements were designed to meet generally applied housing quality standards. To this extent, we explore the impact of less targeted, population-level housing improvement programmes on mental health.

Mental and physical health

We identified a nested longitudinal cohort (n=1,041) from two cross-sectional surveys (from 2006 and 2008) of householders experiencing different types of urban renewal in Glasgow, hypothesising that home improvements would benefit residents’ health in the short term and testing the hypothesis by comparing those participants who reported receiving housing improvement between 2006 and 2008, with those who did not (using the latter as a control group). We used a validated tool known as SF12 (version 2)28, for measuring self-reported mental and physical health at wave 1 (2006) and wave 2 (2008), and controlled for a number of potential confounders.

Our findings suggest that housing improvement probably had a small benefit to residents’ mean mental health in the short term26. This rather cautious statement reflects the fact that the improvement we detected was statistically significant, but only just. The SF12v2 survey is designed to be divided up into a number of subscales describing different dimensions of mental health. These include four physical health subscales dealing with physical function, bodily pain, general health and the extent to which physical health limits everyday roles. It also includes four mental health subscales focusing on vitality, social functioning, role limitations and a mental health subscale combining questions on anxiety and depression.
Importantly, our analysis found significant improvements in the social functioning and mental health subscales following housing improvement. We also found some evidence to suggest that mental health benefits were experienced more amongst residents with no educational qualifications compared to residents with educational qualifications. We found no evidence that other demographic characteristics (e.g. gender, age, household structure and country of birth) interacted with self-reported health as measured by SF12v2. We also found no evidence of intervention effects on self-reported physical health following housing improvement. However, this analysis relied upon occupants’ own reporting of housing improvements to their homes. Therefore, we are intending to repeat this analysis in the near future using a larger longitudinal sample from our three survey waves, as well as objective records from Glasgow Housing Association on housing improvements carried out to properties. In this way, we can better assess the tentative findings we have reported so far on the health impacts of housing improvements.

**Smoking and intention to quit**

As mentioned earlier, smoking is strongly socially patterned – being a much more common behaviour now in poorer communities than in more affluent areas. Smokers living in areas of multiple deprivation are also less likely to quit smoking. This may be due to a number of factors such as barriers to accessing cessation programmes; more deep-rooted reasons for smoking in the first place, such as having to deal with undesirable environments and circumstances, and coping with stress; or being exposed to more pro-smoking factors at the personal and community levels, such as cigarettes being more available, social norms more supportive and more permissive attitudes.

Such explanations have led to considerations about whether making changes to residential environments might influence smoking rates. Although there are few studies of regeneration and tobacco consumption, one of the largest health effects reported from a housing improvement study has been a reduction in smoking. Blackman et al.’s study of 98 households and 209 participants reported a 50% reduction in smoking for those who had received a housing improvement compared to those who did not. This is an unusually large effect which, if generalisable, would clearly have important public health implications. So it was surprising that we were unable to identify any other published studies that used quasi-experimental methods to measure the impact of housing improvement on smoking. Blackman et al. also proposed this reduction might be due to a decrease in stress but were unable to demonstrate this proposed relationship in their study: therefore we included mental health and wellbeing variables in our analysis.

In contrast to the Blackman et al. study, we found that providing residents in disadvantaged areas with better housing did not lead to a reduction in smoking, but, rather importantly, housing improvement was associated with intention to quit. Improvements in mental health did not explain this association. Housing improvement in Glasgow may not be sufficient to significantly reduce smoking rates, but such improvements may provide a ‘critical moment’ for more targeted smoking interventions. The implication of our finding is that linking health services to housing projects might provide an opportunity to develop interventions that capitalise on this ‘critical moment’, although such interventions should be evaluated for effectiveness.
Clearance, rehousing and demolition

**Quantitative findings**

Four GoWell areas have experienced substantial housing clearance and demolition (although not all to the same degree). The academic literature on this type of regeneration has often highlighted negative consequences. For example, Paris and Blackaby noted that such programmes have "frequently been accused of the 'destruction of communities'".31 This alleged 'destruction' is partly a social phenomenon involving the separation of neighbours and closing down of amenities which may have been used as social hubs (e.g. schools, community centres, cafés, and so on). It is also a physical phenomenon that increases the proportion of derelict properties, turns neighbourhoods into worksites and buildings into rubble.32,33 Furthermore, large-scale clearances can take years to complete, during which time residents who wait to be relocated remain exposed to local environments that steadily worsen.33 Given this background, we hypothesised that residents who spent two years living in neighbourhoods undergoing clearance and demolition would experience worsening health. We tested this hypothesis, drawing on the nested longitudinal cohort identified from linking participants from the 2006 and 2008 surveys (as described above).26

In fact, we found no evidence from our primary analysis to substantiate this hypothesis and in addition, some evidence from our subscale analysis appeared to repudiate it. Comparing the demolition group to the control group, there were no significant differences in the way that average mental health or physical health scores changed over time. Seven of the SF-12v2 subscales showed little or no intervention effect, while social functioning significantly improved in the demolition group relative to the control.26

These findings are surprising, given current understandings in the literature. If neighbourhood environments can deteriorate without substantially affecting residents' health, this raises questions about assumed causal pathways. If the findings do indeed reflect the experience of residents living in areas undergoing clearance/demolition, we might speculate a number of possible explanations for this: (a) harmful neighbourhood effects may have been a significant problem prior to 2006, potentially lessening the negative impact of the demolition programmes; (b) some residents may have viewed the clearance and demolition programmes positively (previous GoWell research suggests a majority of Remainers supported demolition13); (c) the interventions could have been delivered in ways that helped reduce potential negative impacts on residents; and (d) the residents who remained in the demolition neighbourhoods during the two-year period may have been particularly resilient compared to residents who relocated in the early phase of clearance.

**Qualitative findings**

Using qualitative methods we explored in more detail the experiences of residents who lived in neighbourhoods undergoing clearance and demolition.33,34 In terms of the four possible explanations stated in the previous paragraph, the qualitative study found that: (a) many of the residents' accounts included descriptions of long-running and complex problems with their homes and neighbourhoods – problems that predate the regeneration programme and which lend further weight to the view that urgent action has been necessary to transform the residential environments for these communities; (b) a desire to leave homes and the
neighbourhood was a common theme, although not all the participants shared this view; and
(c) the clearance and relocation process was portrayed positively in some (but not all)
participant narratives, particularly the role of local housing officers. The study did not find any
evidence to either support or refute the fourth explanation about greater resilience among
longer-term Remainers.34

The qualitative study participants suggested a range of perceived pathways and
mechanisms by which their physical and psychological health might be influenced by their
environment. Of particular relevance to housing-led regeneration, homes considered too
small, damp and costly to heat were perceived by residents to have adverse health
consequences in terms of mental wellbeing, childhood asthma and related illnesses.34

However, many of the factors considered to have important health consequences were not
directly linked to the physical condition of people’s homes. Figure 3 illustrates the various
causes of ill health described by the residents who participated in our qualitative study.34
Looking down the boxes on the left hand side of Figure 3, it is clear that although physical
environments, particularly at home, were blamed for some health problems, social problems
(including childhood and family problems) tended to figure more prominently in residents’
narratives about the causes of their ill health. Social relationships and support structures
within and beyond the local neighbourhood were considered to be important for a range of
health and wellbeing issues.
Figure 3. Perceived causal pathways to health problems affecting participants or their families.

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

Participants also identified a number of factors which they considered to be beneficial to their health and wellbeing, including participation within the community; individual or community support from community organisations and professional services (e.g. health, police, housing, and so on); and relocation as part of the clearance and new build programme. Again, social interaction and support issues rather than the physical environment tended to feature most prominently in residents’ accounts.

Therefore, a key message is that the social environment is perceived by residents to influence a greater range of health issues than the physical environments of homes and neighbourhoods. Therefore, we would expect the potential benefits of urban regeneration to be maximised when strategies include improvements to social as well as physical environments.

‘Remainer’ and ‘Outmover’ comparisons

We also conducted cross-sectional analysis that compared participants who remained in the three largest demolition neighbourhoods (the three TRAs) and participants who had recently relocated from those neighbourhoods. We refer to these two groups as ‘Remainers’ and ‘Outmovers’ respectively. A survey of Outmovers was conducted in 2009 and compared with Remainers from the main survey of 2008.

Most of the residents who relocated had moved to homes that were near to their original address, often in adjacent neighbourhoods. Furthermore, residential outcomes for Outmovers (such as housing satisfaction) compared favourably with those for Remainers, and most Outmovers seemed to have settled well into their new area within a relatively short period of time. Many measures of social connectivity and feeling part of the community appeared more positive among Outmovers than Remainers.

However, Outmovers appeared to have worse physical health than Remainers. Examples include general health, long-term illness (e.g. respiratory, cardiovascular, digestive and liver and kidney illness, and headaches), recent illness/symptoms (e.g. sleeplessness, migraines and headaches, palpitations or breathlessness, fainting or dizziness, chest pain, managing physical activities, persistent coughing) and General Practitioner (GP) consultations in the previous 12 months. Although Outmovers’ health appeared to be relatively poor, there was some variation in health outcomes amongst this group. Notably, Outmovers who reported being satisfied with their new home were more likely to have favourable health outcomes. This was not specifically associated with the built form of the home, access to a garden or available space.

Mental health outcomes tended to be poorer for Outmovers. Across four measures of mental health based on SF12v2 subscales (Role Emotional, Mental Health, vitality, Social Functioning), values were worse for Outmovers than Remainers. On average, Outmovers and Remainers with a long-term health condition had similar mental wellbeing scores, but, surprisingly, Outmovers with no long-term conditions scored significantly less well on this measure than did the equivalent Remainer group.

In some regards, Outmovers also reported less favourable health behaviour outcomes. Levels of smoking were generally high, but more Outmovers than Remainers smoked.
That said, Outmover smokers were more likely to have cut down since their move; and Outmovers who intended to give up smoking had more immediate plans to do so. Outmovers were more likely to drink alcohol than Remainers and moving appeared not to have influenced their alcohol drinking behaviour. Outmovers were significantly more likely than Remainers not to have walked anywhere for at least ten minutes in the past week, and were also less likely to have walked around their neighbourhood for 20 minutes in the past week.

Overall, the discrepancy between social and residential outcomes that consistently favour Outmovers, and health outcomes that favour Remainers is striking. Explaining this discrepancy is a challenge. We surmise from the longitudinal research referred to above, that Remainers’ health changed little during this period, relative to that of other GoWell participants. Therefore, it is unlikely that the Remainers have tended to become healthier in absolute terms over time, while Outmovers have not. Nor do we have good reason to assume that Outmovers have become less healthy over time – given that the major change in their circumstances during this period appears to be a general improvement in their residential and social environment.

It is possible that unknown and/or unmeasured factors have prompted a different health trajectory for the two sub-groups. Outmovers did report greater difficulty meeting costs and paying bills and perhaps this economic hardship influenced health outcomes35. However, we consider that the paradox between improved environments and worse health is most plausibly explained in terms of the composition of GoWell’s Remainer and Outmover subgroups36.

The Remainer and Outmover samples were similar in terms of age group and gender, but differed in terms of occupational status, citizenship and household type. Outmovers were significantly more likely to be in non-retired, non-working categories (long-term sick; looking after the home/family); and to be British citizens (who in our sample tend to have worse health than participants born outside the UK). Remainers were significantly more likely to be either unemployed or retired; to be asylum seekers and refugees; and to be from two-parent families and older person households. We cannot tell the extent to which the differences between the Outmover and Remainer samples are due to real differences between the groups or due to any bias in the way we have obtained the samples, though it is possible that we were less successful in tracing non-British citizens36.

We intend to examine again both health outcomes and changes in health behaviours for Outmovers from regeneration areas, as well as for other house movers in the near future to try to gain a better understanding of whether moving home has any consequences for health in our study population.

Changes in the health of GoWell communities over time

The previous sections have looked at the associations between people’s housing and neighbourhoods and their physical and mental health and health behaviours; and then examined some evidence from our longitudinal cohort studies regarding the impact of regeneration (including moving homes due to demolitions) on health and health behaviours. While these longitudinal data are valuable they are also limited at the moment to two time
periods. In this section therefore we examine changes in health and health outcomes from our three cross-sectional community surveys which encompass a six-year period (undertaken in 2006, 2008 and 2011). In particular this section focuses on differences over the full time period between 2006 and 2011.

There are several reasons why we might see changes (either improvements, declines or no change) in the various health outcomes we are studying and in the different types of regeneration areas. We may see changes in these areas due to secular trends (e.g. a decline might be due to economic recession affecting our participants and others in Scotland). We may also see changes in health due to changes in neighbourhood composition (regeneration can involve the movement of people in and out of neighbourhoods). Of course, we could also see changes in health that could have occurred due to changes in neighbourhood context resulting from regeneration interventions. In this section we compare changes over time within each area type (tested by statistical tests) and across area types, adjusting for the sociodemographic make-up of the areas and how that may have changed from 2006 to 2011.

**General health**

Generally, self-reported health appears to have declined since 2006 across all the GoWell intervention area types, although the rate of decline varies by area type. Percentages of residents reporting good, very good or excellent health have fallen by 4-15% in the intervention types. This decline is not explained by any changes in the sociodemographic make-up of the residents in the areas. The decline also appears to be counter to Glasgow’s general trend, as Scottish Health Survey findings from the geographical area covered by Greater Glasgow and Clyde NHS Board suggest that self-reported health improved from 69% claiming to have good or very good health in 2003, to 74% in 2011.

**Mental wellbeing**

We assessed positive mental wellbeing only in 2008 and 2011 (not 2006). Residents in the TRAs showed a significant increase (about 2 percentage points) in mental wellbeing; other areas showed smaller, but not statistically significant increases; and residents in the HIAs reported a decrease in their wellbeing. While positive mental wellbeing has not changed substantially over the period in most of the area types, in each case the mean WEMWBS scores at 2011 are higher than the national and Glasgow averages, as measured by the Scottish Health Survey. In addition, the mean WEMWBS scores for Glasgow and Scotland changed little during the 2008-2011 study period.

**Primary care**

Self-reported levels of General Practitioner (GP) consultation increased between 2006 and 2011, both for ‘any’ health problem and for mental health problems. Consultations increased particularly in the LRAs. While these findings likely reflect self-reported decline in health over time, they may also indicate a greater willingness to access health services.

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ii Data provided to GoWell on request by the Scottish Government. Thanks to Rosalia Munoz-Arroyo.
Health behaviours

As discussed above, changes to health behaviours may contribute to changes in health outcomes, and behaviour change may predate any changes in general physical or mental health. We found small improvements in diet (reductions in the frequency of fast food consumption) which varied by area type (6% to 14%), but after adjusting for the sociodemographic characteristics at each measurement point, these reductions were only statistically significant for the TRAs and LRAs. There was a small decrease in smoking rates (which was not statistically significant) and no significant change in those reporting intending to quit smoking. We also found a significant increase in those reporting drinking alcohol (8% to 23% increases), and there were some small but not statistically significant increases in physical activity (as assessed by people undertaking at least 20 minutes walking in the neighbourhood on five or more days a week).

Summary

We have presented a lot of findings, and it is challenging to interpret clear messages from them. We are also aware that, although housing improvement is now well advanced, the processes of transformational regeneration are still at a relatively early stage in some of our study areas. Similarly, we are still at a mid-stage in our research. Wave 3 findings are not fully analysed and the longitudinal analyses are at a relatively early stage. Our findings therefore need to be interpreted in that context.

1. We have shown clear associations between neighbourhood amenities and health-related behaviours. Specifically, people are more likely to walk if their neighbourhood has amenities for residents to use, and which are of good quality; and people are more likely to eat healthier snacks if they have access to supermarkets or other food outlets within a reasonable distance from their home.

2. Mental wellbeing appears to be the most sensitive health indicator for GoWell. We have found associations between mental wellbeing and a wide range of home and neighbourhood characteristics, including: neighbourhood aesthetics; the external appearance of the home; the appearance and security of the front door; a feeling that the home and neighbourhood give a sense of personal progress; and sense of control in the home. It appears that, in at least some of these cases, the home and neighbourhood characteristics need to be very good/achieve a high level of quality for the positive mental wellbeing links to be evident.

3. How the interventions are progressed also seems to be important. For example, mental wellbeing is associated with feelings of empowerment; and we have shown elsewhere that those who are relocated have more positive outcomes when they report being given a greater degree of choice during the process, and those who receive housing improvements derive more benefits thereafter when they have a positive view of their landlord’s service as a whole.37
4. We have also shown some indications of health benefits associated with the interventions we are studying. Housing improvement is associated with increased intention to quit smoking (though not with quitting itself). Housing improvement also brings small mental health benefits – at least in the short term. Relocation seems clearly associated with a number of social and community benefits (which may yield other benefits over time), although not at this stage with improvements in health behaviours or health outcomes. Residents in areas undergoing major transformational regeneration do not seem to be experiencing the health detriments that might be expected on the basis of previous research.

5. Our repeat cross-sectional survey data also indicate some encouraging findings in the TRAs – the GoWell areas with the highest levels of need. If these continue and are replicated in further analyses, they highlight the potential of regeneration to reduce the health gap within Glasgow.

6. Overall, however, self-reported general health is worsening in our study areas and this is contrary to the picture for Greater Glasgow and Clyde as a whole. GP visits are increasing.

7. A strong message from the qualitative research findings from residents in the TRAs is that the social environment is perceived by these residents to influence a greater range of health issues than the physical environments of homes and neighbourhoods.

This report started with a recognition of the scale and duration of change that will be required to impact on the long-established population health challenges in these areas of Glasgow. It concludes with a recognition that the change process is still in progress and that evidence of health benefits are, to date, limited. This is probably to be expected.

We are committed to distilling implications for policy and practice where possible throughout our study. The findings summarised above clearly reinforce the need to move from an area-based approach that involves tackling different issues in communities separately, to one which builds up fundamental community resources (knowledge, power, social connections, information and so on), and ultimately to one which is more holistic.
References


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