Social Work & Social Sciences Review 25(1)70-80. Festschrift for Peter Huxley. DOI: 10.1921/swssr.v25i1.2299

The Health Variations Programme revisited

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Abstract: This contribution focuses on a period between 2000 and 2004 and centres on collaborative work funded by the ESRC health variations programme. This programme of research represented a shift in Peter's work away from mental health in formal health settings towards a focus on the social determinants and amelioration of mental health problems. The social origins of mental health problems and how to tackle them has traditionally been a poor relation to the medical clinical institutional way in which most research and attention is placed. Thus this study marked a departure from the study of mental anguish in the closed systems of medicine including primary care to more open systems of the causes and potential solutions of mental health problems. It came at a point of optimism about regeneration and the social democratic social and welfare policies of new labour.

Keywords: health inequalities; urban regeneration; mental heath; social interventions.

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Date accepted: 24th January 2024
Date of first (online) publication:11th April 2024

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Introduction

This short paper focuses on a period of research undertaken by and with Peter Huxley between 2000 and 2004 and centres on collaborative work funded by the Economic and Social Research Council. Colleagues working on the programme of research included myself and academics from differing disciplines. The team included Richard Thomas, Professor in the School of Geography in Manchester, Brian Robson, Professor of Geography and Founder of Centre for Urban Policy Studies, Dr Sherrill Evans, a researcher with a background in psychology, and Dr Claire Gately, who at the time was an applied health researcher with a background in psychology. The paper explores some implications of the Health Variations Programme.

Background

The Health Variations Programme was an ESRC programme of research focused on the social determinants of health inequalities from 1996 to 2001. It aimed to undertake multi-disciplinary social science research in order to advance understanding of social processes underlying and mediating socio-economic inequalities in health and the associated methodology of health inequalities research.

Participating in this programme of research represented a shift in Peter's work away from studying mental health in more formal health settings towards a focus on the social determinants and amelioration of mental health problems. The social origins of mental health problems and how to tackle them have been a poor relation to the medical-clinical-institutional way in which most research and attention is placed. For Peter, this was established early on in his academic career with his doctoral research illuminating that, in terms of the course of minor psychiatric disorder, the most important set of variables predicting mental health outcomes were the patient's material social circumstances (Huxley et al., 1979). Thus this programme of research marked a departure and opportunity of a shift away from studying mental anguish in the closed systems of medicine, including primary care, to more open systems of the causes and potential solutions of mental health problems. It came at a point of optimism about regeneration and the social and welfare policies of New Labour.

The social policy context at this time was one of a wide-ranging policy change to tackle inequalities. Specifically, the government's strategy was centred on tackling urban poverty and health inequalities, emphasising action to bring about change through area-based initiatives such as the *single regeneration Budget*,

Health Action Zones, Sure Start and the *New Deal for Communities*. These policy innovations provided researchers with 'natural experiments' through which to map the effect of area interventions on the well-being of local communities. In this context, the urban regeneration research represented an important contribution in terms of documenting a specific zeitgeist in the history of social policy under New Labour. In terms of its success, but also, perhaps more importantly, its apparent failure, the reasons for that, and meaning in terms of interpretation, provided implications for future understandings of the regeneration efforts, and in lessons for researching and understanding community mental health.

In terms of the generation of knowledge in the field of mental health during the period before the research took place, a well-known link between social disadvantage and mental health had been established by social epidemiological research in the post second world war era. The notion that changing socio-economic circumstances effect the mental health of communities emphasised the relevance of social structure, evidenced by an association between psychiatric morbidity, social disadvantage and adversity (Hollingshead and Redlich, 1958). Recognised links were established between mental health and disparities in resources such as income, occupation, and type and years in education (Bartley et al., 1998). Identified proximate contributions to the onset of mental distress included precipitating personal factors like the experience of stressful life events and changed social circumstances that emanated from the social situations that people found themselves in (Dohrenwend and Dohrenwend, 1982). The evolution of social-orientated research witnessed a gradual shift from a preoccupation with the psychiatric epidemiology elicited from individuals being treated for mental illness to a more nuanced focus on the origins of signs of distress among the community as a whole. With this came a greater trend towards considering initiatives aimed at improving the local environment as a means of indirectly tackling the mental health of local people.

At the time of the research, a small number of studies had involved looking at how mental health problems could be reduced through: interventions targeted at those who experienced ongoing deprivation; those living in disadvantaged areas; job loss; and poverty. There was some logical indication that the mental health of the population could be enhanced by making improvements to housing and the local area, but little in the ways of systematic research into the impact of large-scale changes in people's socio-economic circumstances on their mental health. Thus, the overall aim of the study was to assess the impact of an urban regeneration project on mental health. The study focused on the regeneration programme in Wythenshawe, a disadvantaged area in Manchester, and investigated the impact of changes in socio-economic circumstances on mental health by comparing the local population with a control area (also in Manchester)

where no such initiative existed. The social innovation to be tested centred on the Single Regeneration Budget (SRB) changes established in the North West of England. The SRBs were established between 1995 and 2001, and were funded jointly from the State and from the private sector. The focus was on multi-agency urban regeneration targeted health, sport and cultural opportunities, as well as initiatives on employment, training, economic growth, housing, crime, environment and quality of life.

Urban regeneration, social disadvantage and mental health: the research

Research components

There were three key components to the research. The first part was a baseline postal survey of 2600 people (1300 in the index and control areas). Information collected included mental health status, quality of life, personal circumstances and consulting behaviour of residents. A second survey was conducted two years after the first, enabling assessment of the nature and extent of change in these items. The measures of mental health we used included the General Health Questionnaire (GHQ-12), together with measures of vulnerability and life events, quality of life (QoL) and community experience derived from work by Sorensen et al., (Sorenson et al., 2000).

A second longitudinal phase of the research centred on a sub-group of 200 people who were selected from the first phase for interview to enable exploration in greater detail of three main things. These were mental health status, quality of life, and perceptions of the community. A second interview with this group of people took place one year later.

The third element of the research constituted 20 in-depth qualitative interviews undertaken with a sub-group of selected respondents, chosen because of their particular experiences of the Single Regeneration Budget changes. (Rogers et al., 2001)

In order to establish the leverage that the urban regeneration initiative was likely to have on mental health, we first needed a picture of the quality of life in the two disadvantaged areas. The picture at baseline provided us with an insight into community experience and mental health needs. The areas was associated with a high risk of mental health vulnerability characterised by high disadvantage and high area dissatisfaction. As expected, the 'experimental' and control areas both scored highly on disadvantage, measures of standard deprivation and personal factors which increase vulnerability to mental illness (such as living

away from parents before 16 and not working for two years or more). However, there was a higher proportion of residents living in poorer socio-economic circumstances in the index group, with low QoL and with a longstanding illness. Disaffection and dissatisfaction with living in the areas of deprivation were very high. High levels of dissatisfaction were reported in both areas, and these were much higher than the national average but was also higher in the area where the regeneration innovation was to be introduced. Residents were asked to tell us how they felt about living in the area, expressed as the strength of their desire to stay or to move away, and their degree of satisfaction with the area. Only a minority of residents in the index area were happy to stay: 11% very strongly wanted to move, 18% preferred to move, 31% had mixed feelings about the area and 40% were happy to stay. The traditional link between mental health and social disadvantage was clear to see. Higher socio-economic status was associated with better quality of life and better mental health, with higher scores reported by employer/managers and homeowners. People with better quality of life scores reported fewer longstanding illnesses, and fewer mental health risk and vulnerability factors.

An exploration of dimensions of community life, such as local employment prospects, co-operation, safety and community identity, leisure facilities and local leadership suggested that residents saw both negative and positive aspects to living in Wythenshawe. Negative aspects included low levels of co-operation ("no-one wants to join in projects that start here"), poor job prospects, a perception of area decline and fears about safety. The quality of leadership, solidarity, neighbourliness, and a sense of belonging/community emerged as the positive features of living in Wythenshawe. Our analysis highlighted the way in which the items of community experience that related to children focused on safety and crime. The association between children and safety also emerged in the interview survey, which showed that the major concern of people on the estate was the need for safe play areas for children.

In terms of a relationship between mental health, quality of life and community experience, better quality of life was associated with a greater sense of belonging, less isolation, better leadership, more leisure opportunities, more neighbourliness/security and the absence of the perception that the area was in decline. Higher symptom scores for mental health problems were associated with less neighbourliness/security, fewer leisure opportunities and the feeling that the area was in decline.

Follow up occurred at twenty-two months in the SRB area and the control area in South Manchester. 1344 participants responded to a postal questionnaire survey. The main outcome measures were GHQ12 (mental health) status, MANSA (life satisfaction), and GP use. The results showed that mental health outcome in

the index and control areas had not improved over time. Health satisfaction declined slightly in the index compared to the control area. GP use was unchanged. Restricted opportunities, a variable closely related to mental health, were not removed by the urban regeneration initiative. (Huxley et al., 2004). Further analysis showed that despite considerable improvements to the housing of people on the estate, stress was nonetheless raised significantly among the SRB residents because of the likely additional environmental nuisance they encountered, which translated into heightened personal psychosocial risk. (Thomas et al., 2005)

Learning points and lessons for the future of socially orientated research in mental health

There are a number of considerations which act as learning points for the future of looking at social interventions in mental health.

Method and measures

It may have been that a longer follow-up period was required to demonstrate an effect of the programme on population mental health. In this and other studies, it proved notoriously difficult to show changes in mental health outcomes using experimental designs in open settings. This extends to randomised control trials of numerous community interventions, as well as non-medical intervention. A particular problem is the availability of sensitive measures of subjective feelings and experiences of people, and a definition of mental health as one which adequately reflects a state of satisfaction with life and emotional equilibrium. Qualitative research illuminates some of the short comings here; the richness of accounts in this and subsequent research contrasts with the paucity of information obtained via quantitative measures. Qualitive research is able to tap the understandings and meanings of people, and subjective mental wellbeing. In other research, Peter and colleagues showed that failure to address aspects of quality of life was a key contemporary methodological problem, plaguing measurement in mental health studies more generally (Evans et al., 2007). Others have argued that addressing the notion of 'flourishing', rather than symptoms, seems to be a more relevant conceptualisation of mental health for community studies.

Failure to address the interests and priorities of people; the need for capability theory

At the time of the research, it was clear that the regeneration initiative failed to address the concerns of local residents or remove restrictions to opportunities. Enhancement of quality of life and mental health would have required the agencies involved in these urban initiatives to, as a minimum, promote security, increase leisure opportunities, and improve the image of the locality. This did not happen. Themes derived from narrative accounts provided by the qualitative interviews were replete with concerns about: the absence of social control in the locality; the reputation of the area; a lack of faith in local agencies to make changes considered important to local residents; an over- reliance on personal coping strategies to manage adversity; and perceived threats to mental health, which reinforced a sense of social isolation (Rogers et al., 2008). These latter elements were clearly implicated in restricting opportunities. Additionally, for local residents, enhanced feelings of 'entrapment' contributed to low levels of local collective efficacy. This gap between social capital capacity at an individual level and links with collective community resources may, in part, have accounted for the absence of improvements in mental health during the early life of the urban regeneration initiative.

Public health research on urban regeneration innovations generally concentrates on the *means* that may be used to enhance quality of life. This, it could be argued, detracts from the actual *nature* of quality of life, and thus the extent to which the means can result in the desired outcome. Quality of life and how it can be generated is one of the facets that emerged strongly in the urban regeneration work and formed the basis of new work on this topic undertaken by Peter and colleagues (Evans et al., 2007). Amaryta Sen's (2008) capabilities approach, a human rights-based theory, emphasises flourishing as a product of the conditions under which people live. The concept has the capacity to enhance a focus in future research of this type. This is because it draws attention to the means to ameliorate risks to mental health through supplying people with the possibility of realising their capabilities, and engaging in practices and ways of living that they subjectively value. For individuals and communities, this includes: being knowledgeable; having and maintaining self-respect; being able to participate in the life of the locality or community as a means of cultivating individual agency; and reversing constrained lives through the ability to pursue chosen and valued goals. The latter is dependent to an extent on the social characteristics of individuals and the prevailing social and environmental conditions within which people reside. Since we undertook this research, this perspective has been more in evidence in a turn toward 'assets-based' approaches to community approaches

to overcoming mental health adversity. Whilst acknowledging inequalities, this approach gives a primary focus to creating opportunities and choices provided by the environment. This, in turn, holds possibilities for enabling the generation of the freedoms and resources essential to mental health and a reciprocal investment by community members in the assets of the local area (Lewis, 2012).

Also warranting greater attention are social cohesion and collective efficacy for the study of mental health in different living settings. Social cohesion depends on social networks and social trust. Collective efficacy in neighbourhoods has been conceptualised as "social cohesion among neighbours combined with their willingness to intervene on behalf of the common good." (Sampson et al., 1997). Social networks (namely, the loose connections among people) are sources of power and action. The generation of collective efficacy requires the mobilisation of social networks which function to integrate community membership and help establishing social resources through bringing together disconnected groups Social networks are important in other ways for mental health. Interaction with weak ties, for example, have been associated with a greater decrease in loneliness and increased flourishing, because they are numerous and seemingly add to a general feeling of social connectedness (Brooks et al., 2022)

The wrong elements of the urban environment might have been by the policy innovation

Overall, evidence for the impact of built-environment interventions on mental health and quality-of-life continues to be fairly weak. The components of the area-wide regeneration scheme in England contrasted with other forms of regeneration and may have underestimated the focus and amount of investment required to reverse poverty and living conditions. However, studies suggest that improvements to 'green infrastructure' have greater impact than traditional urban regeneration projects, insofaras the former have some effects on quality-of-life outcomes and improvements in social isolation (McKinney et al., 2020). Furthermore, a key ingredient in the success of urban regeneration programmes seems to be the amount of financial support aimed directly at the households of residents, with a relatively high investment needed to have an impact on health (Gowell, 2011). There is always the danger that piecemeal urban fixes become a weak remedy for the depth of the problems created by the urban environments, with overwhelming negative features of the environment in which people are located and the likely to impact on their mental health. Barriers to the generation of these conditions

are social structural. The entrenched features of urban environments seem to have worsened in some respects. Many city environments include the precariousness and low-renumeration of work, ingrained inequality, exclusory and expensive housing markets, transport congestion, air pollution and social exclusion.

Conclusion

The New Labour government's strategy for tackling urban poverty and health inequalities emphasises area-based initiatives, through the Single Regeneration Budget. This provided the opportunity for Peter together with other researchers to conduct a 'natural experiment' through which to map the effect of area interventions on the mental well -being of local communities in the early 2000s. The research made a contribution to both social psychiatric epidemiology and to social science applied to mental health.

Whilst urban regeneration initiatives cannot, it seems, easily serve as life-affirming spaces for those who are disadvantaged, or bring about a change in mental health status or inequality. Exploring the relationship between what people desire, their concerns and how they experience the urban environment has been important to ascertain. In order to contribute to the building of well-being and wellness in deprived neighbourhoods, lessons from this research on urban regeneration in a small way challenged mental health and policy orthodoxy, by bringing attention to the reasons for failure. It provides the basis for a move towards an enhanced view of subjective well-being in the context of people's everyday lives and priorities in deprived urban spaces.

This research marked a transition in Peter's work towards the social causes of mental health, which had emerged in his early career as he found that these were more important than other factors amongst the risks for recurrent common mental health problems. This work sits together with his interests in social exclusion and inclusion, quality of life and stigma in mental health. Whilst our health variations research indicated failure of a particular policy of urban regeneration, it did, in hindsight, draw attention to other facets of mental health promotion and the social nature of the genesis of mental health problems from which much could be learned. In particular, it flagged up the need to focus much more on an understanding of the nature of quality of life; how this is constructed; how it relates to people's feelings of mental well-being; and how it may be deployed in the future in devising effective social interventions for tackling community mental health risks.Notions of subjective mental health, such as collective efficacy, social networks and activi-

ties that people value, warrant further attention in both the genesis of new socially orientated interventions and in the outcomes worthy of development in the future.

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