Urban regeneration and mental health and wellbeing challenge: In support of evidence-based policy

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Abstract

The rising attention given to mental health and wellbeing in urban policy, urban regeneration projects and place making practices has led to an increase in the production of a supporting research evidence base. This article presents a reflective review of a subset of this research, that which focuses upon urban mental health and wellbeing as they unfold in the context of relatively disadvantaged urban communities in the UK. Particular attention is given to research which interrogates the role played by the meaningful involvement of communities in decision-making in the cultivating good mental health. The article concludes by identifying where evidence gaps still exist and where the evidence-base might be improved.

Key words: Place-based policy; Wellbeing; Community wellbeing; social determinants of mental health.

Introduction

The rising attention given to mental health and wellbeing in urban policy, urban regeneration projects and place making practices has led to an increase in the production and collation of supporting primary and secondary research evidence. Embodied particularly clearly in the work programme of the UK's *What Works Centre for Wellbeing* (from 2015-), this research has focussed upon the impact of city spaces, neighbourhoods and communities on the psychological and the social wellbeing of local residents. This article presents a reflective review of a subset of this research, that which focuses upon urban mental health and wellbeing as they unfold in the context of relatively disadvantaged urban communities in the UK. The paper introduces the concept of community wellbeing and outlines the

core ingredients of interventions in places that show promise in terms of improving wellbeing. Attention is given in particular to the meaningful involvement of communities in local decision-making. The article concludes with a critical stocktaking of the state of the present evidence base, identifies where evidence gaps still exist and signposts where the quality of the evidence-base might be improved.

A brief history of urban centred mental health policy and the search for evidence

The pledge to begin to tackle the UK population's declining mental health and wellbeing appeared to begin in earnest in 2011 with the publication by the coalition government of a key strategy document; a "cross-government mental health outcomes strategy for people of all ages" [1]. In the foreword to *No Health Without Mental Health* the then prime minister and his deputy stated that the success of the United Kingdom would be judged not just by the success of its economy, but also by its levels of wellbeing. With its talk of mainstreaming mental health, tackling the determinants of mental distress and unequivocally aiming for parity of esteem between physical and mental health across prevention and treatment agendas, it looked like things were about to move forward. Adopting a life course approach to understanding mental distress and recognising the need to get things right in the early years as well as acknowledging the key role played by socio-economic inequalities, it seemed that horns were being grasped. Sense seemed to have prevailed. Even the title appeared to signal a new and deeper understanding of the importance of mental health. Things seemed set to change so that that the despair, playing out in homes, streets and hospitals across the country, especially noticeable and sustained in certain geographical hotspots, would diminish because the complex systemic factors that inevitably made some of us more prone to despair than others would be tackled.

Then came austerity and, with it, widening inequalities, food banks, zero hour contracts and the expansion of the precariat. The UK's young people, already struggling, found it hard to contemplate a positive future for themselves in this glum new world. Academics in the department of public health at the University of Liverpool began exploring the extent to which austerity could be regarded as a cause of increased deaths and, in particular, deaths by suicide [2]. The same city's own Liverpool Mental Health Consortium told of the lived experience of deprivation and of changes to welfare processes and decisions in one of their pieces of, work *Austerity Times*. In a predictable, if ironic, turn austerity heralded the end of this Consortium that had been set up, during better times, to undertake the vital service of insuring that the voices of those who used services, and those who cared for them, were heard as local mental health policy was considered and enacted.

In short, despite the goodwill articulated (albeit with a scattering of the inevitable, oft-heard tropes) in the Government's key policy document, mental health continued to play Cinderella. Her fairy godmother had failed her, and she would not be going to the Ball after all. Nowhere was Cinders more despairing than in the country's deprived inner cities and fading coastal towns [3].

All the time, research has underscored the need for intervention. International thinkers in the field of public health have, over the years, made mainstream their arguments that it is not the individual who is at fault for their ill-health, but rather it is the consequences of the systems within which they operate [4]. The logical extension to this social understanding is that the best way for individuals to take action to improve their health and wellbeing is for them to develop strong local networks of people who share common circumstances, concerns and interests. Such groups can come together to fight

damaging decisions taken 'about them without them' that often, if inadvertently, serve to widen inequality gaps. While there is nothing that innovative in this thinking, the strength of community voice has become a real force for political change within the last decade. Often aligning in the wake of trouble or to prevent disaster, we have seen the power of the Grenfell community, of extinction rebellion and, on social media, of #metoo. As Haidt (2012) said, human cooperation is the most powerful force on this planet [5].

It follows therefore that the most complex, 'wicked' problems we face as societies, like inequality and mental distress, are most likely to be addressed through cooperative forces. At our best we are a profoundly prosocial species where our evolved altruistic tendencies, our capacity for communication and empathy and our desire for shared cultures steer us towards outcomes that favour our in-group.

The same UK prime minister responsible for *No Health with Mental Health* had, in 2010, spoken of the panacea of *Big Society*. Regarded suspiciously, at the time, as a political ploy that disguised local government budget cuts, the policy was not well received. However, with its roots in more socialist thinking and supported by theory and evidence from public health and psychology, *Big Society* could have been a cornerstone of successful, scalable outcomes. Instead, it died a speedy death because of a fundamental lack of trust in the politicians felt by the people.

Eventually, in its wake, and building on the work of the Office for National Statistics' measurement of national wellbeing and the Commission on Wellbeing and Policy, the new kid on the What Works Network block was born. Aiming to synthesise the available evidence on interventions that promote wellbeing and to conduct new secondary data analyses, the UK's What Works Centre for Wellbeing launched in 2015. With the ultimate objective of making the improvement of the nation's wellbeing a cross policy target, community wellbeing was amongst its four evidence programmes. Now well into its 4th year, the Community Wellbeing Evidence Programme has produced in the region of 70 outputs that combine scholarship with real world understandings. The initiative has enabled academics from several universities to work with civil society partners and government departments to investigate and interrogate the best evidence about the determinants of wellbeing in the nation's neighbourhoods, authorities and regions and to discover what works, where and for whom when it comes to improving wellbeing in UK places.

Amongst this evidence base, there appear to be a few core ingredients that we might think of as necessary to herald improvements in place-based wellbeing. These will be discussed below.

Urban Mental Health: entrenched and complex

> The city is not merely a repository of pleasures. It is the stage on which we fight our battles, where we act out the drama of our own lives. It can enhance or corrode our ability to cope with everyday challenges. It can steal our autonomy or give us freedom to thrive. It can offer a navigable environment, or it can create a series of impossible gauntlets that wear us down daily. The messages encoded in architecture and systems can foster a sense of mastery or helplessness. The good city should be measured not by its distractions and amenities, but by how it affects this everyday drama of survival, work and meaning. [6](p.36)

Social scientists back in the 1930s reported the higher prevalence of both common and severe mental health difficulties (i.e. depression and schizophrenia) in inner cities compared to more rural areas [7]. This high-income country finding is so robust and enduring that it has earned the name – the *urbanicity effect* [8]. The relative toxicity of cities for mental health and wellbeing trumps the facts that farmers have amongst the highest suicide rates as an occupation across the world [9,10] and that rural homes tend to be more isolated suggesting a lack of contact with others who could provide social support. The causes of the urbanicity effect continue to be explored and debated to this day [11,12]. Indeed, neuroscientists have reported detecting the effects of urban living and upbringing on brain functioning in the form of social stress responses [13]

Two particularly important findings stand out in this literature, which clearly indicate that this effect is not simply one of 'social drift'. These are that there is a dose response association between urban living in childhood and later risk of adult mental ill-health and, that the effect seems to have something to do with the perceived quality of the urban living environment [14,15,16]. These are particularly important findings because they indicate, in tangible ways, when and how we should consider intervening to lessen the effect of inner city living on mental distress.

As the above quote from Montgomery (2013) emphasises, our modern 21st century cities are the stage sets of human pleasure and challenge – hedonia and anhedonia. The implication is that we can improve urban experience to banish the toxic while retaining the beneficial effects for us all. However, this is neither a zero-sum game nor a level playing field. Unfortunately, it seems that more often than not, improving the benefits for some means increasing the negative effects for others in our unequal, growth dominated society. We know that poverty and impoverishment are devastating for mental health and wellbeing and that disadvantaged circumstances lead to poorer general health. It therefore follows that addressing systemic inequalities is the best way to address ill-health and sustain good health [17,18,19]. As poverty is relative, eradicating it will inevitably mean a levelling of resources – upwards for many and downwards for a few.

Nowhere is it easier to see and to experience poverty and impoverishment than in our cities. In one study conducted as part of the Prosocial Place Research Programme, groups of young adults were taken on a 2-mile urban walk across an area to the south of a city centre where most of them had not ventured before [20]. The walk was dissected by a metropolitan park that acted as a restorative 'washout' between the data collection areas that flanked it. Experiential data was collected from the individual walkers at sixteen stopping points along the walk – eight in a relatively affluent area and eight in a relatively deprived area with the walks balanced to progress in both directions. Among the many variables measured were the level of on-the-spot threat felt by the walkers, which was higher in the more deprived area, and the extent to which the walkers felt they would trust the residents of the area, which was lower in the more deprived area. One of the most important findings of this research was that the extent to which the walkers felt they would trust the residents of the areas was very highly correlated with how wealthy the residents of the area were judged to be, demonstrating how area disadvantage effects judgements of traits that collectively contribute to social capital. It seems that, in the urban context, we have a tendency to trust those who we think have more resources. This is perhaps unsurprising but nevertheless extremely important if we are to address place stigma, an issue that is only now rising up the public health research agenda [21]. Indeed, earlier findings that really add insult to injury, have shown that there is an individual penalty to pay, in the form of increased risk of depression, if we become attached to a stigmatised, disadvantaged place [22].

In different research, this time conducted under the auspices of a large NIHR programme grant spread across the North West Coast of England, itself an area defined by health and wellbeing inequality, network analyses was used to examine data collected as part of a Household Health Neighbourhood Survey [23]. This analysis showed how network connections between a mental health cluster of symptoms (including anxiety, depression and feelings of persecution) and a cluster of neighbourhood (anti-)social factors were markedly absent for the least deprived wards as measured by the Index of Multiple Deprivation. These inter-cluster connections began to appear in the form of a direct relationship between symptoms of anxiety and reported neighbourhood incivilities in the moderately disadvantaged neighbourhoods and progressed to denser direct connections between mental health symptoms, namely feelings of persecution, and neighbourhood incivilities in the most disadvantaged areas. It is through analyses like this that the trajectories and relationships between the determinants of urban distress can begin to be understood.

When we start to consider the psychology that may underpin the associations between impoverished living environments and mental distress, the true complexity of the issues is further revealed, alongside their deep-seated nature. One study, for example, found that even just contemplating photographs of impoverished residential urban areas can make us anticipate more threat heading our way in the near future [24]. Other research has found that the diverse psychological underpinnings of mental distress, such as locus of control (i.e. the extent to which we feel in control of the things that happen to us) and future directed thinking, are often similarly associated with experiences characteristic of inner-city living [25 – 28].

As we begin to take action to address urban mental health, we must not lose sight of the complexity of these relationships lest we inadvertently promote costly but ineffective, possibly even damaging, urban policy and practice.

Green is Good: the risks of distilling complex evidence into over-arching practice: the case of urban greening

If, in Clapham omnibus fashion, a random group of people were to be asked what they think can be done to improve mental health and wellbeing in our cities, it is likely that at least one or maybe all of them would recommend that there should be more green spaces. To be fair, this is exactly what the growing body of evidence in the area suggests. From epidemiology to qualitative sociological research and neuroscience, this applied message has rung out as clear as a bell over the past decade or so [29 – 32]. Furthermore, although this finding has not been subjected to much longitudinal scrutiny, it does seem to withstand examination across time as a result of natural churn between places with and without green assets [33]. It is also good to note links made to established theory such as attention restoration theory [34, 35]. All of this implies that this wealth of evidence is compelling and, indeed, it has been well used in the support and development of city-wide green strategies, for example.

However, there is need to fear the generic spread of simple ‘green-washing’ solutions for 6 compelling reasons.

- First, the theoretical base needs further challenge from other disciplines, beyond biophillic accounts. These could include exploring Appleton's Prospect-Refuge theory and Gilbert's evolutionary model of human emotions[36,37,38].
- Second, the idea that the psychological effects of living in deprived places can be compartmentalized into the effects of parks, streets, roads and dwellings, whilst suitable for the purposes of research, in no way reflects our everyday experience of places. After all, to get to our local green space we typically have to walk through other forms of public realm that themselves contribute to negative affect and elevated cortisol responses. The quality of the wider environment within which the green space sits needs therefore to be taken into account. However, measures of that allusive attribute, 'quality of place', are hard to find.
- Third, hidden amid the 'green is good' narrative is an assumption of a universal preference for the pastoral type of landscape that European and North American parks and green spaces tend to emulate. There is a critical lack of research evidence about cross-cultural differences in 'natural landscape' preferences. Snaith's (2015) [39] doctoral thesis is a notable and welcome exception, showing that such preferences are, in fact, far from universal.
- Fourth, there is a limit on what green infrastructure can realistically accomplish when it comes to improving health including mental health. Street trees must be selected for species attributes and need to be planted in appropriate places to avoid becoming pollution traps or hazards. Asthma and hay fever from urban trees will not improve mental health and we cannot expect trees to continue to 'mop up' emissions from our vehicles which themselves contribute significantly to walkability, urban stress and threat.
- Fifth, those who suffer the most severe forms of mental distress are unlikely to benefit from green space because they often become housebound due to social anxiety, agoraphobia, deeply black moods and feelings of persecution.
- Finally, with pressed local authority budgets and the need to plan generously for sustaining adequate stewardship of green infrastructure so that it does not become a toxic asset that supports threat instead of having restorative effects, we must be mindful that other spending options exist. Those that may have as good or better effects on urban mental health and wellbeing include improving streets and 'grey' spaces, encouraging active travel, street cleaning, establishing and running community hubs and supporting local events or projects [40].

The concept of Community Wellbeing

It is possible to foresee a bright future for urban mental health and wellbeing if research, policy and practice come together to address the right questions in the right way. It uncontroversial to assert that urban centres can facilitate the good in our human species. Our antisocial and threatening 'no-go' areas or down-at-heel towns can be turned around to become prosocial and welcoming niches but experience tell us that this is unlikely to be achieved through top-down urban regeneration approaches. It is more likely to result when we adopt social sustainable approaches that properly engage the key asset of cities and towns –their people. The international Transition Towns movement provides a template for this kind of optimistic, grounded approach to change. Making these changes without falling on the Damocles' sword of gentrification is a matter of further concern, however.

The concept of community wellbeing has been explored through multidisciplinary and cross-sector lenses where it is claimed that community or social wellbeing emerges when neighbourhoods can support strong networks between people by providing the context in which people can come together to do things they enjoy and together, enact the meaningful changes they need in common [41]. In time, a stronger sense of place and a restoration of the people-place bond will develop to restore a sense of belonging to our places. This merging of communities of place with communities of interest is the way to establish 'we-ness', a necessary and sufficient ingredient of community wellbeing [42.43]. In the long-term poverty and disadvantage need to be abolished but, in the meantime, they need not inevitably be one-way streets to mental distress as long as there is social support and neighbourliness. If 'authorities' can be prevented from taking control of decisions that should made by communities then the changes that occur in our places are much more likely to morph into improved community wellbeing [44, 45].

These assertions are not utopian but instead are consistent with the growing social movement in the prevention and treatment of mental distress [46]. At the heart of this approach is a belief that recovery, even from serious mental distress, is possible because we can experience high wellbeing in the context of unwanted symptoms. It is a matter of reducing the salience of distressing symptoms by engaging in activities that encourage positive feelings, enjoyed alongside supportive others, activities that provide a sense of sustainable meaning and purpose. In the UK the progress being made by the devolved nations to address improved mental health and wellbeing in all policies provides room for optimism and hope. Wales' Wellbeing of Future Generations Act (2015) and Scotland's Community Empowerment Act (2015) embed excellent visions and clear paths along which to progress.

Doing things well: the processes of intervention

Throughout the review work conducted for the What Works Centre for Wellbeing including on whether and how interventions in place infrastructure [47] on joint decision-making in communities [48]and on historic places and assets [49] impact individual and community wellbeing, two process-related factors have stood out as core ingredients that can strongly determine whether or not place and community level changes make significant differences to the wellbeing of individuals and communities. They are, first, the *meaningful* involvement of people in planning, doing, progressing and evaluating activities or interventions and, second, the proper consideration of differential impacts on certain people in the community who are most likely to be affected by changes taking place.

Although it is often taken for granted that co-production and joint decision-making between communities and authorities will lead to wellbeing benefits for those involved, our review work on joint-decision-making in communities demonstrated that there is precious little evidence to show that this is, in fact, the case. The problems seem to be two-fold. First, the understanding of what it meant to be meaningfully involved in co-production include all sorts of different levels of 'involvement' from tokenistic community consultation to meaningful and empowering involvement. Finding and identifying the studies that fell into the latter category was a challenge. However, we showed that the extent of meaningful involvement determined the translation into wellbeing benefits both to the individual and to the wider community. Indeed, being involved at a rung lower down the seminal

Arnstein's ladder of participation[50] was more likely to lead to negative impacts on the wellbeing of those directly involved. Frustration, exhaustion and a feeling of being brushed aside and not listened to were reported. It seems that ineffectively or half-heartedly 'doing with' may be as problematic for wellbeing as 'doing to' communities. On this point, it is significant that in the systematic review exploring the role of place infrastructure no primary evidence, even of a poor quality, was identified that pointed to wellbeing improvement from interventions that were delivered in an entirely 'top-down' fashion. On the other hand, when communities were meaningfully involved in the many forms of interventions that this large-scale evidence review captured, the transition to improved wellbeing was seen.

[Insert Figure 1 – What works well: wellbeing public dialogues]

Fortunately, much of the primary studies reviewed within the community wellbeing evidence programme have involved interventions in areas of relative disadvantage in the context of high-income, OECD countries. However, the reporting of evidence was rather poor in terms of the involvement of people with protected characteristics or of those whom interventions were likely to impact most directly. There was also very little in the way of coverage about the distribution of impacts across different groups. It seems clear that more work needs to go into meaningfully involving under-represented groups if the aim is to change wellbeing at scale and to reduce wellbeing inequalities known to be spatially distributed and entrenched over time [51] Notable exceptions exist, of course, including Wandsworth Coproduction (http://wcen.co.uk/wandsworth-coproduction/) which, over 15 years, has focused on the coproduction of community care and prevention using a whole system cross-faith, community empowerment network approach. The role that locally rooted social enterprises and community businesses play in addressing these matters of inclusivity can be critical and the expanding role and fortunes of initiatives like the Bromley-by-Bow centre are notable in this and other respects.

On the quality of the evidence and the existence of gaps

It is important to begin with an acknowledgement that documenting and evaluating the process and effects of interventions carried out in the messy, unpredictable and uncontrollable real world is extremely challenging. For this reason, anyone who embarks on this venture deserves encouragement for they are up against factors such as national policy changes, unknown and unmeasured parallel activities, the implications of local government initiatives, the vagaries of funding decisions and the voluntary nature of involvement. The challenges seem particularly pronounced for quantitative research that, in these contexts, can often lack statistical power due to issues such as high dropout rates. Smaller scale qualitative studies stand more chance of meeting quality criteria assessed using standard scales like GRADE and GRADE-CERQual which also rate the method of evaluation being undertaken [52] In this regard, randomised control trials inevitably win out as the method of choice, even though, in this area they are near impossible to accomplish.

To improve the quality of evidence in the areas of urban mental health and community wellbeing so that we can feel more confident that what is reported is robust and meaningful, there are a number of things that can be done. Some are simple, others more challenging.

First, it would be a good start if, when planning evaluations, investigators look at the quality assessment tools like those mentioned above and try to document and report as many of the factors of interest as they can. This should include a clear description of the context in which the intervention has taken place, including location, IMD, ethnic diversity, and any recent or historical changes that provide the background context to, and the need for the intervention.

Increasingly, in order for an implementation or intervention to be adopted further afield for wider impact, the findings may need to be scrutinised using cost-benefit economic analysis which could include a Social Return on Investment approach. This means that some indication of costs associated with setting up the intervention should be included as well as, for health economic assessment, the use of standardised tools to measure health and mental health status. Examples include the EQ-5D-5L questionnaire[53], the Generalised Anxiety Disorder Scale - 7 [54],the Patient Health Questionnaire-9 [55] and perhaps a suitably abridged Client Service Receipt Inventory [56] . In reviews carried out as part of the Community Wellbeing Evidence Programme the information needed for anything more than a cursory 'back of the matchbox' cost-benefit assessment was generally missing from primary papers.

The agreement and standardisation of wellbeing and community wellbeing assessment 'toolbox' will also improve what can be taken from both individual evaluations and larger bodies of evidence. Just as health economists use the QALY – a standard Quality Adjusted Life Year measure to assess the overall burden of illness, so wellbeing researchers are calling for a WALY –a Wellbeing Adjusted Life Year - to be devised [57]. One difficulty is that while short measures may be the best choice for speed and ease of administration, they can often leave critical information about the main issues unmeasured. While they are invariably better suited to large scale surveys, there has been a tendency in recent years to reduce measures of wellbeing to a single question on life satisfaction such as that found in the Office for National personal wellbeing questions [58]. If more nuanced information reflecting psychological wellbeing, mental health symptoms or levels of distress is needed, then this degree of parsimony would not be appropriate. For this reason, a suite of approved tools and indicators, flexible enough to accommodate different research questions and rationales is required to move forward the quality of research in the area. The first step towards this has begun with the publication of a community wellbeing review of indicators [59].

Finally, it is not of much practical value to show that an intervention has improved hedonic wellbeing following a short period of immersion. For example, if you want to argue that a new park has had the effect of improving resident wellbeing then it is not sufficient to measure individual wellbeing before going to the park and then measure it again immediately on leaving. A more persuasive set of data would show that more frequent use of the park over time is positively correlated with improvements to wellbeing or negatively correlated with reduction of mental distress over the course of weeks or months. Even better, would be if a realistic evaluation was able to chart a reduction in visits to the GP or an increased level of productivity at work for example, alongside improved self-reported wellbeing.

In community wellbeing, there has been a concerted effort to pin down what is meant by the term and how we should approach its measurement. There is currently a gap in terms of capturing a collective understanding of community wellbeing in relation to neighbourhood, town, city or region. Thus, a method for gathering perceptions of how a place functions for residents in ways known to determine wellbeing is needed. This, alongside an agreed, practical and easy to get definition and concept that captures the system of community wellbeing should form part of a toolkit accompanied by a low-resource method to facilitate the active consideration of differential impacts and wellbeing inequalities.

Conclusion

As city builders work to imagine cityscapes which might better promote wellbeing, the research base suggest that a number of priority actions merit particular attention. The nexus between austerity, inequality, poor neighborhoods and the mental health of the precariat needs to be brought to the fore. A wellbeing toolkit could help urban policy makers, regeneration practitioners and place makers enhance the visibility of wellbeing centred interventions in regeneration projects. There needs to be a better understanding of the evidence and all its complexities; it is important to avoid broad brush assumptions – eg. not 'greenwashing' cities for its own sake and making sure we more fully understand what trees can and cannot do for mental health and human flourishing. There needs to be a re-appraisal of codesign and its processes and benefits; local knowledge and indigenous intellects need to be harnessed. And evaluation methods need to be devised to understand better the consequences and differential impacts of policy on the psychological experiences of local residents.

While chatting recently with the organiser of a very welcome conference on Planning for Good Mental Health organised by the North West of England branch of the Royal Town Planning Institute, I declared that nothing about addressing these issues is rocket science. 'No', he agreed, 'it's harder'. He was right, of course. In a world where resources were plentiful and where funding organisations had capacity to tolerate uncertain outcomes, unhindered by metrics, academics could play impactful parts in tackling urban wellbeing challenges. With an appropriate focus on rigour and on the asking of good questions towards real solutions, the further decline in the mental health of the growing urban population can be prevented. Doing things by 'tick box' or by implementing current, unsuccessful dogma is no longer an option. It therefore behoves academics across all disciplines to embrace the risk of multi-sector engagement and inter-disciplinary working to make the changes we need to see. As we get together to confront this challenge we should keep in mind that place-making, being an inherently optimistic process, is measurably good for wellbeing [60] and that every city, town and community has assets and treasures to draw on to support the improvement of mental health and wellbeing.

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