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Interviews with Community Professionals

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Abstract

Interviews were held with nine peripatetic professionals—district nurses, health visitors and social workers—working in New Deal for Communities (NDC) urban areas in the English West Midlands. They spoke of health in the community in three distinct ways: health as individual and family lifestyle; the local environment and health; and 'life is a struggle for some'. Those who emphasized the individual and family lifestyle approach expressed frustration in their professional role. The two alternative discourses, while recognizing the influence of social determinants of health, were problematic in different ways, reflecting the lack of a clear alternative to the individual and family lifestyle model for public health professions.

Keywords

- *community health*
- *individual lifestyle*
- *New Deal for Communities*
- *urban regeneration*

Introduction

THERE HAS now accumulated a large body of evidence demonstrating that inequalities in health are related to social position even within comparatively wealthy countries such as those in Western Europe (Acheson, 1998; Townsend & Davidson, 1982). This large body of literature shows that the same kind of social gradient appears, not just for premature death, but also for measures of ill-health, both physical and mental; that the gradient appears when social inequality is indexed in a variety of different ways; that social inequalities in health exist across the life-span from birth to older age; and in all European countries. There is evidence suggesting that people who are poorer or who are of lower occupational status are less ready to recognize the existence of such inequalities (Blaxter, 1997; Macintyre, McKay, & Ellaway, 2005).

A complementary approach is to examine variations in health, not by the social position of individual people, but by the areas in which people live. Although area effects on health are not straightforward and invariant, the areas studied often do not correspond to natural communities, and the logic of trying to separate out statistically individual and place effects has been questioned (Oakes, 2004), multi-level analyses of area and health in developed countries have been fairly consistent in finding at least a moderate effect of place once individual socioeconomic status has been controlled. Studies have included those of adult mortality, adult morbidity, infant birth weight, health behaviours such as smoking and mental health (Pickett & Pearl, 2001; Ross, 2000; Weich, Twigg, Holt, Lewis, & Jones, 2003). Exactly how place might exert effects on such health outcomes remains controversial. Those who have examined that question through qualitative studies in areas such as West Central Scotland and the North-West and West Midlands areas of England have concluded that the link between place and health is usually complex and rarely direct (Macintyre, Ellaway, & Cummins, 2002; Parry, Mathers, Laburn-Peart, 2007, Orford, & Dalton, 2005; Popay et al., 2003).

The UK Labour government has recognized that health varies from area to area of the country, and that has been a rationale for government schemes such as Health Action Zones and more recently the New Deal for Communities (NDC) urban regeneration programme which is taking place in 40 of the most deprived urban areas in England. The latter scheme has also recognized that area health is inseparable from states of housing, education, employment and crime in the area, and has also sought to improve on previous area regeneration schemes by encouraging resident participation and partnership as important principles (DETR, 1999; NRU, 2002).

The present article reports results of one component of a programme of evaluation of the impact of the NDC scheme on health in West Midlands NDC areas. The evaluation is being carried out jointly by the Department of Public Health and Epidemiology and the School of Psychology at the University of Birmingham. Part of that work uses health impact assessment methods to compare statistically health indicators for NDC and control communities. As a complement to health impact assessment, qualitative work is being used to: identify health outcomes pertinent to individual identity groups (e.g. parents of young children, black and ethnic minority groups, older residents); generate hypotheses about how a link between NDC-sponsored interventions and improvements in health might be mediated (or alternatively why changes in health do not occur or are not detected); and to help identify more subtle impacts of the NDC initiative (Parry, Laburn-Peart, 2007, Orford, & Dalton, 2004; Parry et al., 2005).

Among the qualitative methods to be used were individual interviews with members of particular stakeholder groups or certain expert informants who might be in a special position to provide that sort of detailed information. One such group consists of professionals who are sufficiently peripatetic in their work that they might be expected to have special insight into the connections between the local communities in which they work, the health of residents living in those communities and the NDC schemes operating there. Furthermore such professionals may themselves be mediators in the process whereby regeneration interventions reach the local population, and their understanding of the relationships between place and health may be particularly important if regeneration schemes such as NDC are to have an impact. In-depth interviews, analysed qualitatively, may provide insight about the views of key professionals. The present article reports the results of a set of such interviews carried out between March and October 2003.

Method

Nine interviews were held with community professionals working in three of the West Midlands NDC

Table 1. Nine interviews with health Professionals

Area	*Professional group*	*Number of interviewees present*
A		
Old market town, now part of conurbation; predominantly white	District Nurses	2
	Social Worker	1
B		
Near city centre, multi-ethnic	District Nurses	2
	Health Visitor	1
	Social Worker	1
C		
Edge of city, mainly social housing, predominantly white	District Nurse	1
	Health Visitor	1
	Health Visitor	1
	Social Worker	1

regeneration areas (referred to here as Areas A, B and C). As shown in Table 1, interviews were held with District Nurses, Health Visitors and Social Workers. Interviews were held in Health Centres/Surgeries or Social Service Offices, which were the interviewees' work bases within the NDC catchment areas. All interviews were carried out by SD, a psychologist with a main interest in critical health psychology, who was working as a research associate in a research group, located within a university department of psychology, which had a main focus on alcohol and drug use and misuse. Interviews lasted between 35 and 80 minutes. Two were joint interviews with two interviewees each, the remainder being interviews with individual professionals. The interview was semi-structured, following a simple interview guide that required the interviewer to explore, using whatever question wording and probing methods that were appropriate, the following topics: the professional's role in the community; description of the community; perception of health in the community; awareness and evaluation of NDC locally. The present article will focus on the first three of those areas. Professionals' specific comments on NDC will be reported elsewhere.

The method of recording interviews involved a report written by the interviewer (SD) shortly after each interview, based on field notes made during the interview and tape-recordings made at the time. Each post-interview report consisted of a detailed description of all the points made by the interviewee, with some exact verbatim quotes where they were of particular value in explicating the interviewee's meaning. Those post-interview reports, which were between 1250 and 2500 words in length, constituted the source of data used for the present analysis. This method of producing data for qualitative analysis is one that we have developed and tested in our group (Orford & Dalton, 2005; Orford et al., 2005). We find it to be an accurate and economical way of producing textual data for analysis, but its justification is principally epistemological. We are interested in the substantive points made by the interviewee and not in the precise language used, except where the exact words employed particularly well express or illustrate the point being made. Detailed transcripts are not produced. The interviewer is in the role of a field worker, exploring with the participant the latter's views on the topic of interest. The post-interview report is seen as a report from the field, which provides a detailed summary of what has been found from speaking to an expert informant.

The initial analysis, carried out jointly by the authors, was based on the grounded theory method (Strauss & Corbin, 1990), beginning with open coding followed by grouping related codes under superordinate headings, further selective coding and the choice of an overall structure for reporting the results. The qualitative analysis computer package N-Vivo was used in the initial stages of the analysis. When thought was given to producing a unified model that might represent what the professionals were telling us, it became clear that different informants were talking about health and community in some very different ways. A decision was therefore

made to base the later stages of the analysis on trying to identify and describe in detail those differences.

Three ways of talking about health in communities

The structure that has been chosen for the presentation of these results is based upon three different ways in which the professional interviewees talked about health in the regeneration communities in which they worked. Although the first was more prominent in the interviews with one of the professional groups, the District Nurses, and the third more prominent in interviews with Health Visitors and Social Workers, all three ways of talking about health were present in what was said by each of the three professional groups.

Health as individual and family lifestyle

In this way of talking responsibility for health is seen as located at the level of the individual person who chooses to engage in relatively healthy or unhealthy forms of behaviour. Occasionally it is family attitudes and traditions that are referred to as responsible for healthy or unhealthy lifestyle behaviours, but health remains, according to this way of talking about it, a largely private matter. It is a community concern only to the extent that there may be a concentration of individuals or families in the area who are adopting a particular lifestyle. Specific behaviours that are referred to include dietary behaviour, smoking and alcohol and drug use and to a lesser extent exercise. Sexual behaviour is also referred to in the context of teenage pregnancy. Standards of upkeep of the home can also be seen as part of this way of talking about health.

According to that view, health education is seen as being of greatest importance, and the role of a community health professional is seen as the raising of individuals' awareness of healthy behaviours and their responsibility for adopting a healthy lifestyle. The goal is seen as individuals living in the community becoming independent agents in the promotion of their own health and hence less reliant on health professionals. Individuals are often seen as resistant to that approach. Health professionals see themselves as engaged in a struggle in which they are frequently frustrated in their attempts to win people over to their professional viewpoint.

Lifestyle behaviours All interviewees were asked about their awareness of lifestyle behaviours in their areas, and members of all three professional groups gave evidence that supported an individual lifestyle discourse. In one interview it was the younger, more career-minded people in the area who were seen as taking 'more responsibility' for their health. Another thought that,

A lot of people are aware that lifestyles can be healthier, but for a lot … it's money … they may have other vices such as alcohol and smoking where the money will go on feeding those vices, rather than putting fresh fruit and vegetables on the table.

Education was thought to be a key: 'Just look at the postcodes … those who live in the more affluent postcodes, better education, more aware of their health'. An interviewee working in the ethnically diverse Area B said, 'if we could tackle the dietary issues, if we could tackle the smoking … South Asian men have the highest rates for smoking, the Bangladeshis, Pakistanis ... they don't seem to get the messages at all, to stop smoking'. Another referred to, 'nutrition … it's a middle-class thing now for people to eat healthy meals, so many of the clients that we work with just live on burgers', and another, when asked about the most pressing health problem in the area, responded, 'diabetes … overweight, sluggish, not being a fit person has a lot to do with that'. More than one spoke of high rates of alcohol and drug problems in their areas, referring to them as individual or family problems.

It was in the interviews with District Nurses that the family influence on healthy lifestyle behaviour was identified. One saw less responsible attitudes towards health as something that was passed down through the generations of families who had always lived in the area and who carried on with their 'old ways' regardless of any attempts to teach other healthier lifestyles. It was those families that were reported as having relatively strong social networks, often with several members of the extended family living within a short distance of each other. Another pointed out that many people in the area resisted changes on the grounds that their parents had enjoyed a traditional diet or had smoked, and had lived to an old age (although in fact these older parents were often suffering from a number of diseases).

Teenage pregnancy The issue of high rates of teenage pregnancy was elaborated upon in each of the interviews with Health Visitors, and in one of

the interviews with a Social Worker. Family attitudes and traditions were again thought to play a role. One Health Visitor said, 'my feeling is, women who have their children very young, then their children tend to do the same', and another was of the view that unplanned teenage pregnancies were taken as a matter of course, without shock, in 'settled families [in a] working-class close-knit community'.

Several interviewees supported the theory that teenage pregnancy was often part of an individual lifestyle choice or for reasons to do with individual needs or self-esteem. One Health Visitor described life for many such young women as somewhat chaotic. They could not be bothered to take contraceptive pills regularly and condoms were not used for many reasons including self-esteem being too low to insist. In some cases it was thought that young mothers 'seemed to want to get pregnant', perhaps because of the sense of 'kudos' for those who otherwise had no prospects. One interviewee said that among young girls in the area there was 'a real culture of having a baby and all the status that goes with it … passports to various things'. One interviewee, working in Area B, made the point that alongside 'the 16-year-old who has gone out and got herself pregnant', there were other girls in the area who were 'told to get married … arranged marriages when they are just 16 or 17, still get counted in the statistics but aren't there for the same reasons'. Although that interviewee recognized two very different sets of circumstances in which teenage pregnancy might occur, it was implied that both were influenced by chosen lifestyle, in one case an individual choice, in the other a family choice.

Home upkeep More than one interviewee spoke of home upkeep in a way that implied individual responsibility for the maintenance of unhealthy conditions. The following is particularly clear on that point:

> they're council, they are absolutely disgusting, the living conditions that they are living in are very very poor, the families that live in those homes don't seem to think that there is anything wrong with the way that they're living, the fact that their home is unkempt and untidy … and they tend to be smokers … [in cases of very poor housing conditions, it was because] the people tended to keep their homes in poor condition … whether it is because most of the time they are drunk and can't manage to do it [or because] physically and mentally they are not able.

Another interviewee spoke of surprise that some older people were quite happy with conditions in the home that were thought by the professional to be 'horrendous'. As an example one had refused the offer of a washing machine, saying that she preferred to wash by hand and use a mangle. Another older person, the professional interviewee had come to realize, had found the prospect of central heating threatening because it created anxieties about how to use it and about whether the bills could be afforded. In these cases the professional seems to be implying, rightly or wrongly, that there is individual resistance to modern health-enhancing technology.

Use of health and other services A final topic addressed by a number of interviewees, in the language of individual attitudes and behaviours, concerned attendance at health-related services or health-promoting events. One District Nurse described some people in the area as being reluctant to use such facilities as a nurse practitioner unit or a walk-in centre because they viewed it as their entitlement to have the nurse visit at home. Such people were resistant to the idea of moving towards independence. Another interviewee spoke of 'dysfunctional' families, which included individuals who had a background of care, or neglect and had never been 'loved or cared for'. This group of individuals was perceived by the professional as the one that needed the most time and input from the services, as they were often isolated and socially disadvantaged. As such this group were identified for this professional as one requiring a lot of support, for example taking several low-level home visits to persuade one mother to take her child to the clinic. The same interviewee talked about the time-consuming and slow process of involving people in Fun and Fitness classes. People needed to be reminded to attend the day before, and although participation had been achieved, none of the participants were willing to take on further responsibility for organizing the classes. Professionals needed to be sensitive to the balance between supporting and 'nanny-ing'. In Area B one of the professionals referred to a 'high usage of health services, some of it inappropriate'. By comparison poor mental health was not easily acknowledged by South Asian residents, and part of the high health care usage might be due to presenting with physical problems in place of the underlying psychological issues. One of the Social Work interviewees referred to mixed attitudes towards the Social Services in the area: ' some of them feel that they

don't really want us involved … but they just can't cope, and them some of them feel that they shouldn't be doing it, it just depends on the individual'. There was rarely overt hostility towards Social Workers but there were circumstances in which the Social Worker had felt threatened.

Professional roles It was when interviewees spoke of their professional roles in promoting health in the community that differences between the three professional groups were clearest, District Nurses being the ones who most strongly expressed the importance of health promotion and the resistance they encountered.

In one District Nurse interview the theme of taking responsibility for individual health ran through much of the conversation. The aim was that of 'promoting independence' in their patients, 'the need for residents to look long-term at their health', to take on board the 'care now, benefit later' message. The big problem in the area was 'not getting the message across'. There was talk of how a nurse would sometimes come away with the feeling that the nurse had 'gone through all that [care instructions] so many times'. Another District Nurse, when asked about people's attitudes to their health, said 'generally they see it as someone else's responsibility', particularly older patients who had more of a 'tendency to let professionals get on with it, rather than take the onus themselves … You can advise, but it's not always taken on board.' Diabetic care was given as an example, as was smoking: 'People just say things like "I enjoy a fag or I enjoy a drink" and you're not going to change it, they are very aware of the health risks.' The matter was put particularly strongly by a third District Nurse interviewee who spoke of the opportunities for health promotion when young women attended baby clinics or antenatal clinics:

I think we have a lot of nodding heads … [information is] going in one ear and out the other … they would love someone to come in and take over the whole of their health care … [it's] a major problem as part of our role is to promote independence … it's a fight, it's a struggle … but we do get there … and they do listen to us … and eventually do start looking after themselves … but we have difficulties. The families say 'it's not our job' … and we say 'no actually it's not our job either, … we're here to help educate you … make you use your body as best you can … we want you independent' … a whole new philosophy, way of thinking for them … they have difficulty accepting the concept … we have a lot of discussion about it … if we want society anywhere to go forward, we are talking about Education, Education, Education … Educate them about their health, educate them about how to live a healthy life … educate them about morals, behaviour … informing the population would empower them to make decisions … informed decisions.

But it was not only District Nurses who talked of their role in that way. One of the Health Visitors spoke of her work as moving people along a continuum towards a state where they would be 'perfectly healthy and free-wheeling' individuals who could participate in society and make informed choices about their lifestyles. Social Workers said that advising on lifestyle behaviours was not something they got involved in, and was certainly not 'at the heart of what we're doing'. Nevertheless each of the Social Workers admitted to giving advice on lifestyle to some of their clients, or making specific agreements with clients, for example with mothers, that they would not smoke in a baby's presence or encouraging mothers to set routines and buy healthy food for children. Another Social Worker, asked what she would like to see the New Deal money spent on, also spoke of certain health topics in this way:

I'd hit at the youths and the children growing up in the area because they are the ones who are going to grow older addicted to drugs … focus on them … probably do drug awareness, alcohol awareness, sexual awareness … focus on these because these are the problems that I'm aware of because if they escalate they can lead to what our older people are now suffering … with depression and alcohol problems.

The local environment and health

All of the interviewees, in one way or another, spoke of features of the area environment that it might be supposed would impact upon the health of the residents (although the link with health was not always made explicit). General features of the environment, positive and negative, were described, including ethnic mix and whether there were ethnic tensions. The availability of social support for residents was a recurring topic, as was housing policy and the condition of local housing. The impact on residents of crime, drugs and relationships with neighbours was an important theme.

Each of the participants described their areas as a mix of owner-occupied and rented housing containing both poor and more affluent families. All areas received at least one comment stating that there was

a lot of poverty. The three areas were perceived to contain parts (generally the owner occupied), which were 'nicer' and others as 'kind of slum-ish' with 'rubbish piled up both inside and outside'. Each area was perceived to have a high percentage of unemployed people and to contain a significant number (albeit possibly only a minority) of families experiencing multiple problems. The specific problems faced by isolated older people, and by vulnerable lone parents, were repeatedly referred to in each area. A high prevalence of physical and learning disabilities was mentioned by one of the Area B professionals, and a high rate of premature births and a high premature mortality rate was mentioned by one of those from Area C.

More than one participant referred to the need for more money for more resources in Area B, one putting it particularly strongly:

I think it's a black hole in the city, I think it's just forgotten in terms of everything … Services here are appalling, there are very few of them, and … there are the basic public services here, but as for anything else, forget it … I don't think services in the area provide for … even remotely a small percentage of that … certainly from the mothers' and children's point of view.

Area C, on the edge of the city, was described as having the healthy advantage of being next to the countryside, but the problem was seen as lack of facilities and difficulty of access to facilities elsewhere in the city. Although the local bus service was described as good, and there were local shops, it was not easy for residents to get to larger supermarkets and leisure facilities such as swimming baths. A lack of parks and playgrounds was mentioned by one interviewee. The lack of good pubs and 'not a lot there for socializing' was mentioned by another. Better transport was required. For one thing that would enable people to access a wider and cheaper variety of healthier foods.

Ethnic issues In terms of ethnic mix, Areas A and C were identified as predominantly white. One interviewee who worked in Area A said that racism was 'a pervasive force' in the area, and that there were certain roads where 'black workers need to be very careful'. In fact the stereotype of the local male resident as 'a thuggish football fan type beer drinker' had made the national newspapers, although there were said to be many caring people in the area who by no means fitted that stereotype.

There was no mention of ethnic issues in Area C, but there was recognition of the fact that the area contained a number of identifiable and different areas. One in particular had a reputation as an 'undesirable area to live in' and residents who lived in that part felt that many who lived in other parts of the area 'looked down on them'.

Area B was described as multi-cultural, with a majority of residents from the Asian sub-continent, with a fair number of African-Caribbean residents, as well as white English and other European. Although the interviewee who used the expression hated to do so, there was perceived to be a 'kind of ghetto-ism', the area being a big ghetto within which there were distinct groups, such as Pakistanis and Bangladeshis who formed the largest groups in the area (Bangladeshis being more likely to live in social housing) and who were hostile to one another and would not mix. The situation was described as 'like a brewing kettle … blow any minute'.

Social support Many comments were made about social support for individuals and families who needed it. While some of the comments clearly suggested the existence of factors contributing to social support, others identified aspects that suggested a lack of support.

The impression given by the analysis of the interview reports was that support is found within certain enclaves or sub-groups of the community. References were made to settled families within the working-class, close-knit communities in certain parts of Areas A and C where families were reported as having strong social networks, including family. Family support to look after the elderly, the sick or teenage mothers could be found in parts of Area B, and in the more affluent parts of that area it was reported that this supportiveness would cross ethnic groups to provide help for a neighbour from a different ethnic background. However, generally the health professionals perceived support as being greatest among the poorer families although this was explained as being possibly due to less mobility in and out of the area within these groups of residents.

In Areas A and C older residents and young mothers were picked out as often lacking necessary social support. Older people were often sole survivors of their families and often house-bound and, despite often having good neighbours, were comparatively isolated. Young mothers also, sometimes because they had been re-housed away from family, friends and other supports, were thought to be vulnerable as a

result. According to the participants from Area C, young mothers or those re-housed to escape domestic violence were often housed in the area simply because the undesirability of the area meant housing stock was available, but these re-housed individuals often did not want to be in the area and consequently neither cared for the property nor mixed with the neighbours. As one interviewee said 'if you're not happy somewhere then you're not going to be committed to an area, it doesn't matter, you don't keep your garden up … you don't invest in the area'. In Area B, although family support was thought to be high among Asian and African-Caribbean families, one interviewee was of the view that families were becoming 'more westernized' and were not taking care of their elderly in the way their families used to: 'The younger generation are actually starting to say "no", there are services out there, and will bring the services in.'

Housing Standards of housing were described as mixed in all areas. Particular comments were made by professionals in Areas B and C. One professional from Area B thought that the condition of housing stock in the area was better than that in some other areas and represented a feature that was positive for health. Another from the same area, however, was of the view that housing conditions had improved slightly in the last few years but that 'there are still some areas which are quite bad … in terms of conditions of the property … I'm talking about tower blocks as well; some are really, really bad.' Among the most pressing health needs in the area was 'housing, in terms of renovating buildings'. One interviewee from Area C said the tower blocks were 'generally reasonable … less bad than [Area B], but some tower blocks leave a lot to be desired'. Another interviewee from the same area said that housing was often sub-standard, particularly high-rise and walk-up blocks that people just wanted to get out of. Some houses were also very bad. There was:

> [the] odd house with no heating upstairs, maybe just a coal fire … you see the walls are black and you feel the mattress and it's damp … [you could] walk into some of these houses with a coat on and be so cold sitting there and children running around with runny noses.

The reliance of some residents on professionals to deal with authorities was mentioned a few times in the interviews, and mostly in relation to housing authorities. Two professionals working in Area A referred to their role in assisting residents overcome delays in response from housing authorities. One interviewee in Area B said that response times regarding housing repairs had improved over the years but that the professional was still asked to help, for example by older residents who 'don't want to be seen to be bothering the Council'.

Crime, drugs and the neighbourhood The professionals' reports suggested that the building of trust between residents was mainly inhibited by the levels of crime, violence and fears for personal safety or being identified as due retribution for reporting anti-social behaviour or crime to the appropriate authorities. The majority of references to crime and violence were associated with Areas B and C. Residents in Area C had told one of the interviewees, 'It's terrible round here, in the night, we've got helicopters, … the youths riding motorbikes and riding on the pavement through houses and things like that … so there's problems'. The interviewee added that (s)he personally would not 'feel very safe around there in the night. Clients don't go out at night … shut the door … just hoping nothing comes to their doorstep'. Another, working in Area C, commented,

> [the area] obviously is known for the violence in the area … I suppose they pick up what they hear on the television as well, … you know … with all the … especially in the [area] because as you know there's a … we often go out and see hordes of police and cars around a certain area … and eight times of 10 now we know there's probably a shooting that's gone on.

Another, from Area B, referred to cul-de-sacs with 'burrow ways', which were a 'mugger's paradise' and dangerous for the young and healthy let alone the old and frail who, as a result, remained stuck in their homes. One professional from Area A talked about anxiety and the fear of crime, saying that several clients had been mugged or pushed over, although the situation was thought to be improving.

All three areas were described as having drug-associated problems that affected feelings of safety in the community. For example one interviewee working in Area C referred to: 'A lot of drug addicts living next door to older adults that cause a lot of problems … see a lot of needles.' An example was given of an elderly couple who did not want their neighbours, whom they described as 'drug-sellers', to see the professional person arriving as 'he might think that you're from the police'. Another interviewee, working in the same area, reported that there

was a large drug problem in the area. That professional, through working in the area, knew some of the drug dealers, which had led to receiving some intimidation from some of them. Younger residents were thought to be subjected to 'peer group pressure' to participate in drug taking. One interviewee from Area B when asked what was perceived as the greatest potential threat to health for people living in the area, replied 'I think the drug problem; the current issue is the gun crime which is certainly on the increase … that's incredibly stressful for people living here'. Another mentioned drugs as an environmental issue affecting clients' well-being: 'You do see people congregating and there's activities going on and you know ….' One interviewee from Area A said that there 'were pockets of … [the area] that have quite high problems with heroin usage and drug use'. The latter was impacting on children where parents were using drugs, and this professional had also worked with children as young as their early teens who were using heroin and congregating in disused factories on a particular estate. However that same interviewee did point out that there was a

general lack of understanding about drug use, and the fact of it, and there's a bit of that sort of demonization … decriminalization would probably help … I think a lot of the top police officers are saying the same thing.

A feeling of lack of trust of people in the area was a theme that recurred, often taking the form of trouble with neighbours who participated in crime or other anti-social behaviours. One professional from Area C felt that many clients did not get on well with their neighbours. An example was given of a family with neighbours who had an old caravan outside, furniture and old refrigerators in the garden, and were constantly banging and playing music.

Fear of retribution from criminal or anti-social neighbours was perceived to be an important factor. For example a young man living in Area C was reported to have been beaten up and bullied and robbed by someone living in the area. After going to court the family had 'things thrown through their window, mess put through their letterbox and they were looking to be re-housed'. A young man in Area B was described as basically imprisoned in his home due to intimidation and threats:

news gets around in the area … especially in terms of benefits, people knew what days people cash their benefits etc., so they're obviously stalked on those particular days or approached because they have money … These people will go to any lengths to get their own back, take your car number etc. etc. … so I suppose even as professionals sometimes you are a little bit wary of getting involved when you do experience these things.

A social-ecological model A social model was implicit in much of what the professionals said about the areas they worked in, the facilities available in those areas, social support, housing, crime and neighbourhood. But the model was made more explicit by one of the Health Visitors and one of the Social Workers. The former was in no doubt that there was clear link between poverty and poorer health:

The community plays an enormous role in health. If you are ever in a position where you feel outside and not understood and isolated from the community, and the community feels hostile to you, it's very damaging for your health.

Nowadays Health Visitors were asked to work to a social model of health rather than a purely medical model and the poverty of some of their clients 'forces you to work in a social way' because it involved issues of inadequate housing and isolation. It was pointed out, though, that while this was heralded as a new approach, it was something many Health Visitors had been aware of and had been applying in a commonsense way for many years. The Social Worker described the ecological model as follows:

the national assessment framework encourages us to look more widely at things rather than focus on specific incidences … a government-produced project that came in three, four years back now, and it's a framework that social workers have to work by. The theory behind it is an ecological theory … about taking a holistic view of clients' circumstances … The idea was to make us think a little more holistically about what happens with families, to look at children's developmental needs and parenting capacity, environmental factors.

Life is a struggle for some

There was a third way of talking about the community and health which may be distinguished from the two already described. In some ways it is an individualistic way of talking about the subject because it focuses on a struggle that some residents have in coping with their daily lives, and the associated difficulties and deficits that those people suffer in the form of low self-esteem, low self-confidence and in some cases mental health and substance

problems. At the same time, this way of speaking of health in the community recognizes that people are struggling with limited resources, for example in conditions of poverty, unemployment and literacy problems, each of which was said to be prevalent in the areas in which the professional interviewees were working. For example one District Nurse referred to anxiety problems (now seen as improving) that were associated with fear of crime, and another referred to poor education and high unemployment, although the problems were partly attributed to low motivation: 'poor achievements from the young males … happy to live off the dole and have secondary jobs'. But it was the Health Visitors and Social Workers who were more likely to speak about health and the community in this way.

For example one Health Visitor spoke of the low self-esteem of many people who were damaged from past experience or struggling in the present, and said that many of the people were blighted by a 'lack of choice', and that their life situations severely limited their options and left them struggling and isolated: 'Whatever life throws at you, you are not in a position to do anything at all.' This professional often thought, 'The amount you have to put up with, you cope very well.' Another Health Visitor referred to the low level of life skills and self-confidence of many residents. For example it was difficult to move people from isolation into joining a group, and if that could be achieved residents might become comfortable with a group and feel confident enough for the next stage of moving onto a larger group or the wider world. Individual examples were given of people having difficulty doing such simple things as going to the bank, 'because they feel uncomfortable and out of their depth in a bank and fear criticism'. Limited literacy and feelings of inadequacy in dealing with authorities inhibited many residents from initiating or organizing things, and a lot of the professionals' time was put into discussing such issues and trying to build such very basic life skills. A Social Worker put it in the following way:

> the sense of hopelessness that quite a lot of people in the area have got, they might just think 'what's the point anyway, I can carry on smoking' … 'cause we're raising people's desires really to participate in the mainstream of things as well, and I don't know how you do that with any amount of money really … I think people do feel like they're pushed out a lot of the time, that they are not really part of … what's really happening in the mainstream of society. They just feel like they are different and not … involved and I think a lot of the problems follow on from that ... and they just sort of … fall off the bottom somehow.

People's struggles might be attributed to poverty. One Social Worker, when asked what it was thought residents were looking for, replied, 'Money … most of them … what grant they can get'. Another Social Worker listed poverty as one important factor as poor people 'buy what's cheapest as opposed to what's best for them'. For example even though a house might have sufficient heating facilities, some residents, especially elderly people, might not turn it on due to concern regarding cost. A Health Visitor thought there were a number of reasons for the chaotic survival-style life of clients, poverty being one of them. It placed limitations on people, so that the effort to sort out or arrange things was huge and time-consuming, for example needing to get themselves and children ready and onto a bus. Even for those with mobile phones (generally pay-as-you-go) the credit had often run out. People in other areas might have more money to manage problems and options might be open to them that were not open to poorer people. For example going to classes was something that middle-class people could just buy into if they wanted to, but that was not so for the very poor.

A Health Visitor mentioned the large number of unemployed people in the area with many consequently living on very tight budgets. There was also thought to be a higher than normal number of people 'who don't read or write or if they do it is at a very minimal level', and a minority of youngsters who dropped out of school and a delay for as long as two years before the welfare system caught up with them. A Social Worker also commented about education not being treated as so important as it should be, and also much unemployment among young people and a general lack of opportunity.

All the Health Visitors and Social Workers referred to mental health and/or substance problems experienced by individual residents in the areas in which they worked. One Health Visitor felt that, while everybody in all walks of life had down days and their share of family problems, in this area there was a greater incidence of depression, not clinical depression but more a low level of depression as life was 'so hard … every day was a struggle' for these poorer families. It was estimated that at least 60 per cent of clients smoked and there were also substance abuse problems. Another Health Visitor discussed

the amount of apathy, lethargy and low level of depression that existed among the client group, and the difficulties experienced living on a very limited week-by-week income, which meant that there were no financial reserves and always some trepidation about what tomorrow might bring. A Social Worker was of the opinion that it was when family support was lacking that people tended to struggle, and that depression and anxiety were more likely in mothers who were isolated and without support. Another emphasized drinking and drug problems, depression, binge-eating and obesity and a high mortality rate, to which suicides and overdoses contributed.

Discussion

Most studies of the social representations of health have been of lay representations, and those of health professionals have been less often studied (Flick, Fischer, Schwartz, & Walter, 2002). When professionals have been the focus of study, as in Flick et al.'s (2002) study of German doctors and nurses providing home care for older people, representations of health have been found to be complex, and by no means confined to absence of illness. The present results indicated an equally complex picture. We saw in our data three different health narratives. Each was represented in interviews with each of the three different professional groups. Nor were the three ways of talking about community and health completely distinct from one another. For example, social class and financial resources were recognized as influences when professionals spoke about the importance of individual lifestyle behaviour. Similarly, individual vulnerability was alluded to when talking about the relevance of the local environment. Nevertheless we believe that the three ways of talking about health in communities are distinctly different.

The lifestyle behaviour discourse was dominant in a number of the interviews, particularly those with district nurses. Central to that discourse were the ideas of individual (and sometimes family) responsibility for one's own health, the active choice of lifestyle, and resistance to health promotion efforts on the part of health professionals. This represents a way of thinking about public health and health promotion, elements of which were dominant throughout most of the 20th century. The history of public health in Britain is a long one, going back at least as far as the unequivocally environmental approach of Chadwick and mid-19th century medical reformers such as Simon, but that approach had given way by the time of the First World War to a more personal one emphasizing what individuals could do to ensure personal hygiene (Lewis, 1991). Socialist campaigners Sidney and Beatrice Webb, for example, were strong supporters of public health, encouraging local authority public health departments to create 'in the recipient an increased feeling of personal obligation and even a new sense of social responsibility … the very aim of the sanitarians is to train the people to better habits of life' (Webb & Webb, 1901, p. 206, cited in Lewis, 1991, p. 201). Two aspects of this way of talking about health were notable in the present results. First, it was recognized that lifestyle was often not solely individual but also based on *family* norms and traditions. Some community residents were members of strong local family networks whose ways were not always thought to be in line with modern ideas about looking after your health. Second, a strong theme in the present data was the *struggle* that health professionals experienced in trying to educate local residents about the need to take responsibility for one's own health. Some of the language health professionals used, when expressing their frustration about this, implied the necessity of using a forceful approach in order to overcome resistance (e.g. 'hit them with …' 'blast away at …').

By the end of the 20th century the lifestyle behaviour approach to health was coming in for much criticism from certain quarters. The authors of the Black Report, who favoured a social causation, or materialist or structuralist explanation of health inequalities, made it clear that they thought lifestyle explanations implied that people were to blame for harming themselves by, 'unthinking, reckless or irresponsible behaviour or incautious lifestyle' (Townsend & Davidson, 1982, p. 118). Those concerned with the practice of health education were critical that the lifestyle approach ignored environmental causes, might have little impact on those who had limited access to health-supporting resources, ran the risk of reinforcing people's perceptions of themselves as inadequate, and, by facilitating healthy practices among the relatively advantaged, might in fact perpetuate inequalities (e.g. Travers, 1997). Health education has also been criticized for being overly based on expert, professional knowledge (e.g. Nelson, Pancer, Hayward, & Kelly, 2004). Health promotion theory has been rapidly shifting from an exclusive focus on changing individual and family behaviour towards social and community

interventions, with greater acknowledgement of the knowledge base accessed by people in their day-to-day lives.

What might replace the individual lifestyle model is less clear. We identified two alternative ways of talking about health in the NDC areas. That, we suggest, may be a reflection of a conceptual vacuum that exists where individual lifestyle once held the dominant position. We conclude that health professionals in NDC areas are on the whole aware of the influence of social determinants of health outcomes, but are mostly trying to come to terms with such influence without the aid of helpful theory. Reference was made to an 'ecological' model but in very general terms. A number of concepts from psychology and the social sciences, such as empowerment (Rappaport, 1987), control (Marmot, Bosman, Hemingway, Brunner, & Stansfeld, 1997), social cohesion (Wilkinson, 1996), sense of community (McMillan & Chavis, 1986) and social capital (Campbell & Gillies, 2001) may be helpful but have not yet been incorporated into a theory that is acceptable and accessible to community health practitioners. Insights from research and writing of those who have specifically considered the link between place and health include: Popay et al.'s (2003) concept of a 'proper place' to live, that had community spirit, where neighbours were mutually supportive, where there was a good level of trust and respect for one another and for property, and where the environment was clean, safe and convenient; Parry et al.'s (2005) identification of fear as a likely common node through which might run several of the pathways linking negative aspects of place with poor health; Popay et al.'s (2003) idea of the 'privatization of everyday life' to describe what they were repeatedly told about the process of withdrawal into the security of personal or domestic space in deprived areas; and Frohlich, Corin and Potvin's (2001) concept of 'collective lifestyle' as a collection of shared habits and orientations. Like Frohlich et al. (2001), Macintyre et al. (2002) concluded that the health of the residents of an area was a complex function of individual compositional, collective social and material opportunity structures. For example an area might exhibit a high rate of smoking because it contained many individuals with personal characteristics predisposing to smoking, because there were many tobacco outlets and low-priced cigarettes and cigarette advertisements, and/or because of local pro-smoking norms and traditions.

What we identified as the local environment and health way of talking about health in communities had as central themes the poverty of the environment, poor resourcing in areas such as housing and transport, heightened risks such as high rates of crime and drug use locally and relative lack of social support. That discourse corresponds most closely to a materialist or structuralist explanation of health inequalities, but it was not clear how that would translate into altered practice that is likely to remain focused on the needs of individuals and families. More closely related to the idea of individuals and families in their community contexts was the third way of talking, which we termed 'life is a struggle for some'. The emphasis here was on the struggle to cope, given limited resources, relative disadvantage, lack of choice and associated relatively low self-confidence and self-esteem, and poorer mental health. Note the further use of the word 'struggle' here. Individuals and families struggle with their circumstances, which may be reflected in poorer health, and health professionals whose work is based on an individual healthy lifestyle approach struggle to get that message across to their patients or clients. Life is a struggle recognizes the constraints on health imposed by circumstances of life for many people in regeneration communities, but, unlike a purely structural or materialist explanation, has recourse to terms that imply individual, even intra-psychic difficulties and deficits, such as low self-esteem or self-confidence, anxiety, depression and alcohol and drug problems. There are those who see in such talk a retreat to a view of health that reduces this to an individual level, running the risk of continuing to blame people for their ill-health, or at least suggesting that solutions lie in the treatment of individuals rather than the transformation of communities. In so far as the life is a struggle discourse emphasizes individuals' weaknesses rather than social conditions, even though it may be believed that those weaknesses are exacerbated by living conditions, there is a danger that people will be viewed as limited in their possibilities according to their psychological characteristics, and in addition health practice may remain focused on specific difficulties or conditions, and fail to attend to the more general aspects of a community or macro-level aspects of the society and culture in which it is situated (Freitas, 1998). Smail in his review of Wilkinson's (1996) book on inequality and health argued:

Over and over again Wilkinson refers to the psychological *sense* of deprivation, as though it was some kind of disembodied phenomenon split off from the material world. What is damaged, he claims, is our *sense of* unity, *sense of* social cohesion, *sense of* common purpose, giving rise to a *sense of* insecurity, and so on … power is through-and-through *material:* it matters not to your 'sense of' security, but to your security full stop. (1998, pp. 169–170)

While recognizing the danger of material underpinnings being forgotten, Wilkinson replied as follows:

if the stresses on family life mean I am immersed in domestic conflict, I worry about money and job security, feel inferior and put down by others, so that I feel angry and chronically anxious—if that is the pathway through which health is affected, then the health effects are an objective indicator of a level of subjective—or psychosocial—pain which will have repercussions well beyond health. (1998, pp. 234–235)

Life is a struggle is therefore an ambiguous way of speaking of the health of communities, since it can lean in one of two very different directions. This ambiguity, a reflection of the lack of a clear alternative to individual lifestyle, is part of an ongoing debate about the direction to be taken by health professionals dissatisfied with a purely individualistic approach to health. The dilemma is certainly not limited to District Nurses, Health Visitors and Social Workers. There is a lively debate, for example, about the direction to be taken by the emerging discipline of health psychology (Murray & Campbell, 2003; Prilleltensky & Prilleltensky, 2003). Marks outlined four alternative approaches for the development of health psychology: clinical health psychology, extending the biomedical model to a biopsychosocial model, but leaving practice largely unchanged; public health psychology with a greater emphasis on health promotion and prevention but continuing to stress individual responsibility for health; community health psychology, working in coalition with members of vulnerable groups and communities, targeting conditions such as social exclusion and poverty, and aiming for empowerment as a main outcome; and critical health psychology, using 'theoretical analysis, critical thinking, social and political action, advocacy, and leadership skills … to analyse how power, economics and macrosocial processes influence and/or structure health' (2002, p. 15).

In conclusion, therefore, we suggest that health professionals working in underprivileged communities may be 'struggling' to find a satisfactory framework on which to base their practice. Some hold to a lifestyle approach but find it frustrating. Others are more conscious of the social context but as yet have no compelling and coherent model to link community, the family and the individual.

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