

"I don't know how I'm still standing"

A Bakhtinian analysis of social housing and health narratives in East London

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Abstract

Housing is a significant determinant of health and substandard housing is a public health issue. East London has long had a shortage of social and affordable housing, worsened in recent years by a combination of stressors. In one of East London's most deprived boroughs, Newham, changes brought about by the 2011 Localism Act and the unique demands of being the host Olympic borough in 2012 have brought considerable pressures to bear on social infrastructure. This paper examines how these pressures were experienced by local residents via their narratives of social housing and health. The data reported here are from a qualitative study comprising two waves of data collection. Narrative family interviews and go-along interviews were conducted with 40 Newham residents at wave one and 28 at wave two. A narrative analysis with a Bakhtinian interpretation was undertaken. This revealed that residents framed experiences of social housing in terms of an inherent system-level ideology based on notions of need and waiting. A particularly striking feature of this ideology was the extent to which descriptions of ill health and impairment were implicated in constructions of housing need; participants directly attributed a range of health complaints to their housing predicaments, including stress, depression, cancer scares, panic attacks and loss of sleep. Understanding the contested ideology of social housing can illuminate both the dynamic processes of social exclusion and the ways in which its subjects seek to resist it.

Key words: Housing, East London (Newham), Qualitative, Health, Bakhtin

Introduction

Housing conditions are significant social determinants of health. Inadequate housing directly impacts upon health in numerous ways, including respiratory infections, asthma, injuries and mental health problems (Krieger & Higgins, 2002). Temporary and precarious housing in particular can have a substantial negative impact on health in the longer term. People who feel that they cannot adequately control their life circumstances – especially where they have limited control over where they live or the quality of their home – are at increased risk of depression and physical illness (Leng, 2011). It follows that affordable, good quality and secure accommodation in the form of social housing may be an effective mechanism to reduce health inequalities. In the UK, the social housing sector is made up of a range of different types of properties and providers: local councils, not-for-profit organisations (mostly housing associations), private landlords who rent to Housing Benefit supported social tenants, and private rented sector (PRS) properties that are leased by local councils to provide temporary accommodation (which includes Bed and Breakfast accommodation). Social

housing properties and Housing Benefit payments are allocated on the basis of assessed need and can help people avoid poor housing conditions and homelessness. Until relatively recently, the UK social housing system was widely considered to be among the most effective in Europe (Bradshaw et al., 2008). And yet, an estimated one-third of the 8 million people currently living in social housing in England are in poverty (Lloyd, 2010). In addition to the direct effect of poor quality housing, a 'residualisation' effect, whereby public housing estates have progressively deteriorated, has resulted in concentrations of disadvantaged groups who have higher rates of unemployment, ill health and disability than the average. Social residualisation impacts negatively on wellbeing; producing feelings of exclusion and low self-esteem (Leng, 2011).

Newham, East London, one of the London 2012 Olympic Host Boroughs, is among the most deprived boroughs in the UK. The area has high concentrations of both poor housing and poor health (Pevalin, 2007). Newham has one of the most acute housing shortages in London, with 32,000 of its residents on the social housing waiting list (Caritas, 2012). As a result, pseudo-private renting in the borough is rising steadily with buy-to-let landlords setting themselves up to rent exclusively to Housing Benefit supported tenants within the private rent sector (London Borough of Newham, 2010). These landlords accommodate those who cannot afford to rent privately without subsidy and who are, therefore, waiting for a state-owned social property. Such an arrangement means that landlords retain the right to approve or decline potential renters and their payments are guaranteed by the local council, not the tenants themselves. This serves as something of a financial enticement to rent to social tenants. However, this trend has raised questions of access and housing opportunities for those in poor health (Smith, 1990). Added to which, concern about the quality of such properties is a topic of ongoing public debate with accounts of squalid, cramped and structurally unsound conditions increasingly common (Greenhalgh et al., 2015; Hurst, 2012). Council owned social housing in the area has similar problems. Nearly 10,000 council owned residential properties were considered to require further improvements to bring them up to a 'decent standard' in terms of Housing Health and Safety ratings (London Borough of Newham, 2011). The not-for-profit sector owned social properties (housing associations) tend to be in somewhat better condition overall (Buck et al., 2016), but this is reflected in higher rents.

Housing related health complaints are an established problem in the area. Commonly reported issues of dampness, cold and mould have been shown to have a significant relationships with various aspects of reported health in East London (Hyndman, 1990). Added to which, Newham is one of the most overcrowded areas in the UK with the highest rate of households in temporary

accommodation and the highest rates of those in receipt of homelessness assistance in all the London boroughs (Aldridge et al., 2015). Overcrowding has been linked to a variety of health problems including respiratory and infectious diseases, injuries in the home, and tuberculosis (ODPM, 2004). In fact, Newham has the highest incidence of tuberculosis in England (PHE, 2015). Evidently, the quality and quantity of social housing (in all its variations) is an ongoing public health challenge for Newham.

A changing social housing landscape

London's social housing sector has been shrinking since the 1980s (Watt, 2009). More recently, the 2011 Localism Act heralded a major shift in the way social housing need is managed by devolving power from central Government to Local Authorities (DCLG, 2011). Alongside the introduction of fixed-term tenancies, the Act gave Local Authorities the power to set their own policies about who should qualify to go on the social housing waiting list - with a controversial new emphasis on prioritising those in paid employment (DCLG, 2011). The practical application of these measures has invited extensive criticism, especially in London, which has some of the highest levels of overcrowding in the country (Boff, 2011). In practice, the Act has allowed local authorities to set narrow criteria for social housing and make stipulations that could be viewed as excluding some vulnerable groups. Changes to homelessness policy means that London councils can stipulate that residents accept rehousing to more 'affordable' areas outside of London. This move has been interpreted by some as a form of forced migration of those on low incomes out of London boroughs (Osborne, 2014). Newham was one of the first boroughs to implement the provisions of the 2011 Localism Act and, in doing so, effectively reduced provision.

In parallel to policy changes, hosting the 2012 Olympic and Paralympic Games generated additional housing pressures. The Host Boroughs Strategic Framework identified 'Homes for All' as a key aim of Olympic regeneration in order to reduce overcrowding, homelessness and social housing waiting lists; and improve the quality of private housing stock (Olympic Host Boroughs, 2009). The East Village housing complex (formerly the Athletes' Village) was publicised as a local housing legacy. However, the development planned to provide only 675 units for social rent (Burns, 2014). Bernstock argues that the East Village and the numerous private housing developments in the borough are indicative of a symbolic housing legacy rather than a material one (Bernstock, 2013). Watt (2013) goes further and describes how the housing landscape of East London at this time represents the intersection of regeneration, state-led gentrification and residential displacement

common to many urban areas, a point illustrated in the findings of a recent qualitative study in Newham. The relative luxury of the private housing developments was commented upon by local residents as being in stark and unwelcome contrast to the often substandard nature of local social housing (Kennelly & Watt, 2012).

At this critical juncture in the rapidly changing social and material environment of Newham, exploring local perceptions provides an insight into how housing features in the health trajectories of local residents. The data reported here are from the qualitative component of a mixed-methods study of the health and social legacy of the 2012 Olympic Games: ORiEL (Olympic Regeneration in East London) (Anonymous et al., 2012). Social housing narratives emerged as a dominant feature of the data set. These narratives were striking in regard to two particular aspects. Firstly, while housing narratives were a dominant feature of the data, they were also very static. The research team certainly anticipated that policy changes and structural pressures would be liberally referenced in participants' narratives. However, this was not the case. Added to which, social housing was spoken about in a very specific way: characterised by accounts of complex interactions with state agencies, lengthy waits, and critiques of the various social housing rules and qualifying criteria. Secondly, these narratives made continued reference to ill health and incapacity. This was particularly salient given that, at interview, eliciting accounts about *health*, as a stand-alone topic, proved problematic. If we asked participants a direct question about their health we got a very short answer. But, if asked about their housing issues then they talked about health at length, albeit in relation to their housing problems. Healthfulness itself was less of a priority than concerns such as employment, safety, and, of course, housing. Indeed, Health considerations can often be subsumed by more pressing problems in socio-economically deprived communities (Wills et al., 2011). So, in order to explore both the entrenched nature of social housing narratives and the ways in which they were so intricately linked to health, we revisited the analysis by incorporating a Bakhtinian theoretical interpretation into our narrative analysis (Skinner et al., 2001). Bakhtinian theory was utilized to highlight the ideological features of housing narratives because ideology, in this theoretical tradition, refers to specific ways of knowing, and being (Bakhtin, 1981).

In the sections that follow this paper will: outline the rationale for deploying a Bakhtinian interpretation; describe the study in which these data were collected; and explore narratives of social housing and health {For the purposes of this paper the term 'housing' refers exclusively to dwellings and not the surrounding neighbourhood. We have reported on perceptions of Olympic related neighbourhood change elsewhere (Anonymous et al 2015)}

A Bakhtinian approach: exploring the dialogic nature of social housing narratives

The work of Mikhail Bakhtin and his collaborators has had considerable influence on a variety of areas within the humanities and the social sciences. His work on the philosophy of language, in particular, has influenced the development of social theory (Brandist, 2002). A Bakhtinian approach treats language as a dialogue which can be shaped and resisted by individuals; it is the site of conflicting ideological forces and ongoing negotiations of meaning and identity (Maybin, 2001). Individuals, therefore, are conceptualised as being in dialogue with wider social discourses. They are always in a state of being addressed and in the process of answering, which means that they can 'choose' their response, even if only from the multiplicity of genres and voices. This heteroglossic theory of language implies a perpetual state of negotiation (Tate, 2007). Bakhtin theorises this negotiation in terms of centripetal and centrifugal forces. Centripetal forces are those which perpetuate authoritative and official discourses. By contrast, centrifugal forces are those which stratify language according to its users and their identity, they are the means of resisting and disrupting dominant discourses (Maybin 2001). Society, therefore, can be thought of as a vast argumentative texture through which people construct reality and within which their exchanges are necessarily situated (Laclau, 1993).

Narratives of social housing and health in Newham encompassed a diversity of experiences, affective states, agencies and spaces. These narratives also described events unfolding over extended periods of time, often many years. A Bakhtinian view of language is congruent with the multi-faceted nature of these narratives and the complex contexts from which they emerged. Such a view assumes that words (utterances) cannot meaningfully be isolated from the sequence in which they occur. They are in a dialogic relationship to previous utterances which have been voiced, and in anticipation of those that will be voiced. Speech and language, therefore, are inseparable from the ongoing dialogue of ideologies (Maybin, 2001). The use of narrative analysis with a Bakhtinian interpretation allows us to examine how social housing, as a social determinant of health, was perceived and experienced by East London residents against the backdrop of a very particular combination of developments and changes.

Methods

The data reported here are from a qualitative study comprised of two waves of post-Games data collection with Newham families: the first in 2012; and the second in 2013.

Recruitment and sampling

Participants were recruited from a longitudinal quantitative survey of parents and their high-school-aged children (11 – 16 years) which formed the major component of the main study. We wrote to all adult survey participants who had indicated that they were willing to be re-contacted and followed up with a telephone call. One-hundred and thirty people were contacted in this way, of which 20 ultimately made themselves available for interview. We asked that these core participants invite other members of their household to participate where they saw fit.

Twenty families participated at wave one (and comprised a total of 40 participants). At wave two the sample fell to 15 families (comprising a total of 28 participants). Participant characteristics are described in Table 1.

Of the 20 families who started the study at wave one, one was headed by a private landlord who rented exclusively to Housing Benefit supported tenants, a further three owned or were buying their own home, one was in a joint equity mortgage scheme, two rented privately, and one had owned a house at wave one which had been repossessed and had subsequently moved to social housing by wave two. The remaining 14 families were in social housing of various types (including council housing, housing association properties and housing benefit supported rentals).

Full ethical approval was obtained from the Anonymous Research Ethics Committee. All participants were given an information sheet, a consent form, and a verbal explanation of the study, which included information about what would happen to their data and their right to withdraw.

Data collection

The following data collection methods were used at both waves:

i) Narrative family interviews - Narrative family interviews were conducted with the core adult participants and whichever family members they chose to invite (see table 1). These interviews took place in the family home. Initially, participants were given prompts such as ‘How long have you lived in this house?’ or ‘What is it like to live in Newham?’ At wave two the housing narratives were revisited, with participants encouraged to retell their stories – thereby allowing us to examine similarities and differences in the accounts over time.

ii) Go-along interviews (*with a sub-sample of the family group selected for depth of responses*). A go-along interview is an ethnographic mixture of observation and interview, concentrated around a particular place, journey or activity (Carpiano, 2009). The interviewee takes the researcher on a particular journey or visits a place. This is a participant-led method that is intended to explore participants’ interactions with their environment. The interviewer approached those participants who had talked about particular sites in detail during the family narrative interviews and who had also expressed a willingness to take the interviewer to see them. Six go-along interviews were conducted at wave one and four at wave two.

Data analysis

The dataset consisted of 45 interviews (narrative and go-along), 70 pages of field notes and 147 photographs. Data analysis was conducted in two phases. Firstly, a conventional narrative analysis was undertaken on the whole data set to identify key storylines and narrative forms. Subsequently, this preliminary narrative analysis was enhanced by a Bakhtinian interpretation of the subset of data that specifically related to housing.

Narrative analysis

All interviews were transcribed verbatim and NVivo9 software used to facilitate a narrative analysis. A narrative approach is based on the phenomenological assumption that experience can, through stories, become part of consciousness. The stages of this narrative phase were synthesised from descriptions of narrative analysis in the literature and were as follows:

- 1) The partitioning of complex stretches of interview data into ‘narrativizations’ (Riessman, 1993).

2) An exploration of how the narrativizations were structured and their content in order to inductively develop an analytic framework of themes (Riessman, 1993)

3) An examination of the way individuals deploy wider cultural discourses within their personal narrativizations (Squire, 2008) and draw upon shared meanings (Greenhalgh et al., 2005, Milligan et al., 2004).

The narrative analysis thus examined a range of accounts about post-Olympic Newham. This interim dataset provided the raw material for an added Bakhtinian interpretation.

Interpreting data using Bakhtinian theory

The primary empirical application of a Bakhtinian approach is an exploration of the dialogic structure of 'utterance' (Maybin, 2001). More than one 'voice' is present in all uses of language because life, by its very nature, is dialogic (Bakhtin, 1986). The component parts of language are the material of ideology; the essential symbolic medium through which all social relations are constituted (Voloshinov, 1973). Bakhtin deployed the term ideology in a markedly different way from the Marxist tradition. It is not the same as the 'ideology' described by Marx or the 'false consciousness' of Althusser, in which the mental representations of the subordinate class systematically obscure the realities of their subordination. Rather, it is used in a more nuanced way to indicate a social tendency (ways of behaving) connected to a particular group or institution (Petrilli & Ponzio, 2005). Ideology, therefore can be constructed, negotiated and resisted. Thus, language can be understood as a dialogical system of conflicting ideological forces. The overall aim of applying a Bakhtinian perspective was to explore the ideological and discursive aspects of housing narratives. This aim was operationalised by undertaking the following stages of (theoretical) interpretation:

1) Identifying the ideological characteristics and conflicts around talk of social housing (Gardiner, 1992).

2) Examining how speakers take up these ideological forces and negotiate meaning within them (Tate, 2007).

3) Exploring how reality, subjectivities, affective states and cause and effect are constructed through the argumentative texture of interactions and utterance (Laclau, 1993).

Results

Overall, participants' experiences and perceptions of social housing were far from positive. As previously stated, two main areas are of particular interest. Firstly, talk about social housing was underpinned by its own inherent ideology and, secondly, social housing narratives featured continued references to health, illness and incapacity.

The ideology of social housing: needing and waiting

The Bakhtinian interpretation helped to characterise the ways in which the social housing system was constructed as an opposing 'other' in discourse, as an authoritative system with its own ideology, or idea-system (Emerson, 1981), based on specific types of 'needing' and 'waiting'. These ideological facets are a product of the social and material context in which housing narratives are situated. The ideology of social housing, therefore, achieves the discursive function of making sense of and giving meaning to local of experiences of long, repeated and often fruitless attempts to obtain social housing. Operating within the social housing system's inherent ideology compelled individuals to appropriate specific subjectivities and performances of need, often in relation to health status, and go through the ideologically defined pathways towards obtaining housing.

Social housing narratives covered extended periods of up to 20 years. Within these narrative episodes, speakers invariably referred to how their circumstances did or did not correspond to specific aspects of 'need' that they perceived to hold currency within prevailing social housing ideology. Recognised types of need included overcrowding; joblessness; extremely poor quality of current housing; having 'nowhere else to go' (homelessness); and health problems. Participants' reporting of this was more than a simple matter of reciting the Borough's housing allocations policy. They negotiated and challenged aspects of the recognised types of need. The contested nature of housing narratives is an 'ideological becoming' (Bakhtin, 1981); a development of specific ways of knowing and being in relation to social housing. Participants talked about their housing needs almost as if presenting-their-case: giving a strong sense of having had to 'perform' various versions of this narrative for housing officials in the past. An example of this can be seen in the below quotation from Loretta, a 40-year-old mother of four who had been living with her family in a three-

bedroom high-rise council flat for eight years. When they moved in it was intended to be a 'temporary' solution until a bigger property became available.

Well would have been eight year ago, yeah, as we moved in here. Because originally we lived in a two-bedroom and they moved us into here, and then shortly afterwards I went, I applied straightaway because I knew its timescale and that, and as I say we've got nowhere. I mean in the bidding; I think we're still in about the three hundred odds for a like four-bedroom place [.] Well that's it, that's our problem, we can't get out sort of thing. Newham Council just don't seem to be helping us at all. I've also applied obviously to move because we're overcrowded.

As Loretta explains, her wait was a very long one. In referencing and rationalising these particular aspects of housing need, Loretta's narrative is in dialogue with an imagined 'other' embodying this ideology; with a symbolic super-addressee (Gardiner, 1992). Attempting to get out of precarious housing and into secure, reasonable quality social housing required a long term strategy of 'waiting it out', which was characterised by the need to endure the temporary and insecure almost indefinitely while waiting to 'get to the top of the (housing) list'. The goal of obtaining adequate permanent housing was considered, at best, difficult, and at worst impossible to achieve. Secure social housing, preferably in the form of a local council owned property (a 'council house'), represents an elusive 'gold standard' for Londoners in housing crisis (Watt, 2009).

'Waiting it out' required individuals to both passively wait and, at the same time, continually check-in with the relevant agencies to verify that they were indeed still waiting, waiting in the same area, waiting in an appropriately sanctioned property, and updating on their health needs and their employment status. Loretta 'performed' her waiting via this process of checking-in at the required intervals: restating and evidencing her 'need' to various social housing officials. 'Waiting it out' required spatialized performances and undertakings over the span of many years. Place of dwelling, family circumstances and needs are expected to remain relatively constant over the lengthy passage of time over which a family's particular 'case' gradually and figuratively progresses up the waiting list. Changes to circumstance or location can result in the whole process being set back or even starting again. This can be seen in Beth's story below, when she describes being evicted and

rehoused by the social housing system. Beth, a 41-year-old mother of three, had been in her current council property for 12 years and had been in some type of social housing for more than 20.

They (council) said to us “go down with the ... eviction papers on the day of the eviction and they will give us temporary accommodation”. Which I was led to believe that they would give us ... a house or a flat or something but we ended up in a bed and breakfast which I turned down initially because that’s not what they led us to believe. And I was a bit upset so we went to stay with a friend for a while ... then you know like we felt that we’d overstayed our welcome so I decided to go back to the Council and then they sent us to [the housing advice centre] and they sent us to Southend and we went to the hotel and it looked like a building site, all Albanians ... And you know, when we took this place [their current home] ... because of the understanding that they said to me after a year I can put in for a transfer. And then they turned round and told me after the first year that I had to be here seven years before they’d move me. And now if I want a house I have to wait the full capacity of 12 years! Next year, the 13th, for me to be able to fill the criteria of having a house.

After being placed unexpectedly in bed and breakfast, Beth opted to stay with a friend for a while instead. This meant that she forfeited her ‘place’ on the waiting list. When she tried to re-enter the system the family were allocated an even less desirable placement than the one they had left. Not only did they go back into bed and breakfast, this time they were sent out-of-borough to a hotel on the coast, far away from their family and her son’s school. Beth had to wait her way back up the list. This type of predicament highlights the ‘ideological environment’ (Bakhtin & Medvedev, 1991) in which utterances and experiences occur: the social and material contexts in which people live (Costa, 2016). In this case, the context is a severe social housing shortage which local government attempts to deal with by implementing rigid and complex entitlement criteria. Therefore, the ‘needing and waiting’ ideology of social housing can be understood as having material and social causes; as shaped by the ideological environment. However, the relationship between the ideological and the material is dialogic. Beth’s forfeiting of place can also be understood as a material outcome of social housing ideology; as a penalty for failing to consistently perform need and, thereby, carrying out the required strategy of ‘waiting it out’.

Housing and health: 'to be honest you know ... I'm like just on the borderline of survival'

As described at the outset, the concept of actively maintaining health was not a topic about which participants had a great deal to say. However, health in the context of housing need and housing problems was spoken about at length. Health and illness were linked to social housing in two distinct ways. Firstly, the stresses of housing problems made participants unhappy, exacerbated existing medical complaints and sometimes made them ill. There were numerous accounts of dangerous, dilapidated and overcrowded dwellings that had long been identified by the social housing system as being in need of repair or upgrade, but that never seemed to actually receive these improvements, adding to the overall depiction of local housing problems as permanent and insurmountable. Secondly, ill health and incapacity status were heavily deployed in the social construction of social housing need. Historically, UK social housing policy has been underpinned by a broad commitment to allocation according to need, as opposed to market-based priorities of ability to pay or social desirability. As a result, institutional rules and discretionary judgements draw heavily on health-related criteria (Smith, 1990). Accounts of ill health, therefore, are embedded in social housing narratives and are a fundamental component in the identity politics of being recognised as deserving. Housing narratives were riddled with accounts of ill health both as a commodity and as a direct result of personal housing issues. Both of these discursive features are explored below.

Accounts of poorly maintained and unsafe social housing were common. Tasha, a 20 year-old who was working as a childminder and living with her mother, brother and, sometimes, her cousins at wave one, described how their family had been renting with Housing Benefit from a registered private landlord for the last five years. Despite numerous efforts, they had been unable to move or secure any improvements to the property.

Our landlord doesn't do anything. Our windows, everything breaks and, I'm not going to lie, the day after we moved into this house, I remember like it was yesterday, my sister touched a banister, it literally fell down the stairs. The windows ain't double-glazed, so the heat has come on; it's just going straight through the windows. You can feel the cold.

Tasha went on to explain that her mother had reported their landlord to the local council and had taken him to court in order to force him to repair the property but, even at wave two, no requested

repairs had been carried out. Such problems, along with damp, leaks, overcrowding and anti-social neighbours, are the types of issues that participants described contending with while they 'waited it out' for a better property. The reported effects of dealing with these problems included numerous health problems, stress, depression and strained relationships. This can be seen in the experiences of Jalika, a 43-year-old mother of three who lived in a local council owned social property (a 'council flat'). She explained that long-term overcrowding had caused severe problems for both her family and her health. By wave two, Jalika's husband had moved out of the family home and she had experienced a number of health scares, as she explains:

And so I'm sharing the bedroom with Darren (son) who's four years old and we were sharing the bed and it's only on Sunday that I managed to find a bed at IKEA so I moved him in his bed now, but he's still in the same room as me Since we met last time it has caused a lot of trouble in the family. Yeah, because two teenagers, one child, no space for them to do their homework, to have peace of quiet with Darren around, it's been, I would say 2013 has been hell for us [laughs]. I'm really really struggling family wise, I've got a lot of problems with my family at the moment [.] I was at the hospital yesterday even for a check-up ... because of all the stress I went through this year I started to have some pains here and the breast pain on that side, so .. I went to see my GP who referred me to the breast clinic ... and I feel so scared because when the doctor touched it he quite felt a lump ... and luckily it was, yesterday when I went for my result everything is fine. Ah, I didn't know about it, but now I know. I know what stress can cause now.

Jalika draws direct causal relationships between housing and her health and family life. The ongoing pressure of inadequate housing is described as having a cumulative and corrosive impact on her wellbeing, health and relationships, and was the cause of tremendous stress. Additionally, illness and incapacity were commodified as resources in the course of Jalika's interactions with the social housing system. As can be seen when she explains the extent and impact of her overcrowding problem, Jalika references her middle son's health needs as a further rationale:

My son needs his own bedroom, the one with a disability, why hasn't he got that?

it's been seven years, nearly seven years we have been bidding for him to have his own room, it's too much. And there's no other way for me, even if I work ... I can't have a mortgage so I will have to bid on the council's property, so it's the same thing for me. So it has really been a struggle [laughs]. It's okay because people don't... I think I manage quite well, when I go out I try not to show, but it's very very very hard, I don't know how I'm still standing, yeah, it was very very ... oh and Newham didn't help me at all for that ... I didn't know where to go, I was lost ...

In this context, her son's 'disabled identity' functions as a survival strategy for the family (Whyte, 2009). It is a means of securing recognition from state agencies (such as the social housing system) and achieving access to forms of welfare inclusion that can offset their social exclusion (Petryna, 2002). A recognised medical condition can be used as a pathway into social housing by either 'getting on' or 'moving up' the (housing) waiting list. Accounts of housing need featured a range of conditions including musculoskeletal disorder, mental health problems, arthritis and epilepsy. These narratives can be understood via the lens of biological citizenship: through the study of the new connections between biology, self-identity, and the 'rights and duties' of citizens and states (Cooter, 2008). The commodification of ill health in these narratives demonstrates how actors relate to state agencies through their health identities by inventorying elements of the self (Whyte, 2009). In this sense, the nature and meaning of 'need' and 'health' are the subject of perpetual negotiation. The centripetal (authoritative) discourse of medicalised and categorised types of ill health that confer need are taken up by speakers and applied within a centrifugal discourse that reframes them as points of leverage, entitlement and state obligation. It is a dialogic interaction: ill health and incapacity statuses are hails and claims that require a response from the state. Jalika rhetorically questions why her son's health-related housing need has not been responded to when she states *'My son needs his own bedroom, the one with a disability, why hasn't he got that?'* Similarly, Beth, quoted previously, stated that *'I should have a ground floor property because of my illness but the Council don't care, they've given me a full medical award and they turned round and told me "You have to bid like everybody else".'* Her 'full medical award' represented a rhetorical and material resource. The commodification of ill health is a discursive act: it achieves something. In this case, using 'damaged biology' as the basis for making claims (Petryna, 2002). However, as can be seen, these claims rarely result in the desired outcome. This is further evidenced in the extract below, where Dawn, a 51-year-old mother of four, expresses her exasperation over the local council's failure to adequately house her severely disabled eldest son.

He (son) walks with a stick, he has seizures now, he's on tablets and he's going blind and he's only twenty-three and the council ... Newham were rubbish to him, rubbish, he's in temporary (accommodation) because he lived here but he had to sleep on the settee because of the stairs, he can't do stairs.

Just under half of all social housing tenancies in England involve someone with a disability or incapacity and yet around one in six disabled adults live in properties that are not suitable for them (Ryan, 2014). There is simply not enough suitable social housing stock to meet health related housing needs. As demonstrated above, lack of provision was typically rationalised as a matter of the local council being uncaring or inept. This depiction and personification of the social housing system helped to position it as a unified 'other' in discourse.

The circuitous framing of ill health as both a legitimate pathway into social housing an outcome of poor housing experiences posed additional challenges. Adopting a strategy of 'waiting it out' incorporates situated performances of need which make public things that individuals might reasonably wish to keep private. A particularly dramatic example of this can be seen in Karim's story, a 42-year-old father of three who narrated a traumatic housing crisis. At wave one, Karim reported having been made redundant from work and, subsequently, was unable to make the mortgage repayments on the family home. Naturally, Karim found this very distressing and had been prescribed anti-depressants by his doctor as a result. At wave two, Karim's family home had been repossessed and they were living in temporary social housing: a privately owned property rented-out by the local council on the family's behalf. Karim and one of his daughters, Nusayb, aged 13, gave a detailed account of their housing experiences that year. In the extract below, from a family interview at wave two, he recounts a recent telephone conversation with a Social Housing Officer:

Karim: The Case Officer who took our application, she phones me last Monday and saying ... "Oh I'm going to make a decision next week", which is this week, it's likely to be a negative decision, meaning that she's going to discharge the duty of homelessness so we're not going to get any help [...] I said "Look, I suffer from panic attacks and what you are telling me, you are giving me a panic attack, you know, I

wouldn't have any other option other than coming to your office and committing suicide in front of you". She said "If you mention it again I'll put the phone down", I said "That's fine, I'll do that, you know, I'll come and commit suicide in front of you because you are bullying me, you are harassing me; you're not telling me anything which makes sense." Yeah, more, oh God, there's huge a huge effect with children as well, you know, the elderly person, my mother ... she lost sleep and she's worried, they're all asking me questions, "What's happening here, what's happening there?" [...] But in terms of comparing that to people's health, it's like having a heart attack, okay, when you lose a job and become homeless, you know, through repossession, things like that, it's like in your lifetime, you had a heart attack, you know, it's that severe, yeah?

Nusayb: And the thing that we will say is like everyone has a bad impression .. negative like you know ... they assume that homeless people are bad they are, you know, robbers they're like, you know they're alcoholics, they're like beggars ... And then I thought well I'm homeless as well but I don't want to tell them, everyone will hate it like, you know, go away from me.

Karim refers to the fact that he has an existing health problem and reasons that his Housing Officer should have been more mindful and helpful because of this. Also, and much more dramatically, he uses this to lead into a framing of the severity of his housing crisis as a matter of life and death. Karim's narrative is illustrative of the way in which accounts of ill health are instrumental to the construction of housing need in its most extreme form, where he resorts to using his own life as leverage to force a resolution. Karim's very extreme narrative episode is followed directly by his daughter's comments on the shame she felt at school when the family lost their home and entered 'emergency' social housing. Her father is fully engaged in the discursive act of constructing 'dire' need. He utilises the phrases and terms of the 'official' language of the housing. Bakhtinian theorists refer to these 'official' terms and ways of speaking as sociolects – in using them the speaker passively takes on the communicative practices associated with that particular group and, in doing so, identifies with them (Skinner et al., 2001). Taking on the sociolect of social housing is a way of discursively legitimising 'housing need'. By contrast, Nusayb's framing is very different. She

was concerned with having the extent of their 'need' made public and worried that being identified in this way would lead to further exclusion and embarrassment among her peers. The family's social housing narrative thus demonstrates how conflicting forces and ideologies operate through the hybridity of talk (Tate, 2007).

Conclusion

The period in which the data were collected was a time of significant change in Newham's housing landscape. While local narratives did make reference to both Olympic housing regeneration and characterisations of broader welfare reforms, these references were mostly fleeting. For the most part, explicit reference to these topics or accounts of change more generally did not feature heavily. In fact, quite the reverse. Social housing narratives were characterised by frustration, waiting and a supposed *lack* of change.

Housing-related deprivation is particularly high in East London with issues such as homelessness, overcrowding and poor housing conditions affecting thousands of residents (Watt, 2013). Arguably, Olympic-led regeneration did little to address this. There is qualitative evidence suggesting that regeneration and private housing developments in the area had the undesired effect of highlighting the scarcity of social housing and the disparity in housing quality (Kennelly & Watt, 2012). Added to which, the Localism Act housing allocation reforms have exacerbated the effects of the capital's social housing shortage for some of its most vulnerable residents (Caines, 2011; Osborne, 2014). It is perhaps unsurprising then that against this backdrop narratives of social housing are interwoven with references to ill health and incapacity. They illuminate the myriad ways in which housing operates as a social determinant of health.

Applying a Bakhtinian interpretation allowed us to examine the construction of social housing need by those actually experiencing it. The ideology of social housing emerged in the context of severe structural pressures and shortages, and the ways in which need, deservedness, health and impairment feature within this ideology has direct bearing on individuals' sense of self and their interaction with the social housing system. Equally, the reciprocal and dialogic relationship between material social housing conditions and its inherent ideology influences how scarce social housing resources are distributed among the local population.

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Table 1: Participant characteristics

	Characteristic		N at wave 1	N at wave 2
Adult core participants	Sex	Male	8	7
		Female	12	8
	Ethnicity (collected in the quantitative survey phase by asking the 'ethnic group' question from the 2011 UK Census)	White British	5	4
		White Other	3	3
		Black African	4	3
		Black British	1	1
		Indian	1	1
		Pakistani	1	0
		Bangladeshi	1	1
		Asian British	2	1
Asian other		1	1	
Mixed	1	0		
Those family members also in attendance	a) High school aged participants (11-16 years old)	Sex		
		Male	10	9
		Female	9	6
	Ethnicity (collected in the quantitative survey phase by asking the 'ethnic group' question from the 2011 UK Census)	White British	4	3
		Black African	3	1
		Black British	1	0
		Indian	2	2
		Pakistani	1	0
		Bangladeshi	1	1
		Asian British	2	1
Asian other		2	2	
Mixed	3	1		
b) Adults	Sex	Female	1	2
	Ethnicity	Asian other	1	0
		White British	0	2
Total			40	28