GENTRIFICATION AND HEALTH IN THE BLACK COMMUNITY OF SEATTLE'S CENTRAL DISTRICT: Framing the Issue and Potential Next Steps

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Introduction

What is gentrification?

In casual conversation, gentrification is thought to be the rapid increase in investment into previously underdeveloped urban neighborhoods often resulting in a sharp increase in housing costs. However, for the amount of conversation around gentrification, there is surprising little agreement about how to formally define it. Sociologist Ruth Glass is frequently cited as having been the first to attempt a definition in her studies of urban change in London, framing gentrification as forced displacement of low income communities from urban areas by the middle and upper class[1] which places the emphasis on class dynamics and the desirability of neighborhoods. More contemporary thinking about gentrification is strongly influenced by geographer Neil Smith, as he encouraged a shift in thinking about gentrification to focusing on the flow of capital into previously under-capitalized urban areas, which gives more attention to the role of property developers and real estate speculation.[2]

What does gentrification have to do with health?

While many stakeholders in urban areas would agree that gentrification can lead to serious negative consequences for communities, the link to health may not be as clear. The truth is that we know very little about the relationship between the two, but the areas that are typically most affected by gentrification already experience a disproportionate burden of negative health.

In our region specifically, the City of Seattle's Department of Planning and Development has identified the urban villages of Chinatown-International District as well as 23rd & Union-Jackson particularly vulnerable to displacement from gentrification.[3] Meanwhile, both areas are also thought to experience particularly poor health overall, as compared to the rest of the region.[4] While little previous work has investigated the direct impact of gentrification on health, considerable literature has accumulated linking health outcomes to factors associated with gentrification such as housing instability,[5] eviction[6], and changing physical environment.[7]

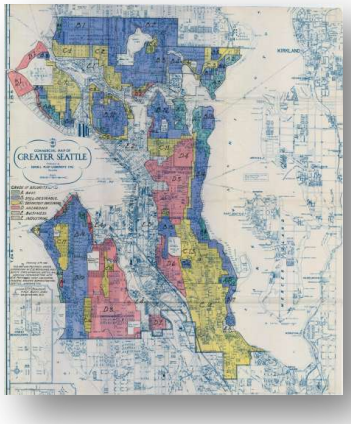
Central District, Seattle

Located east of Capitol Hill and south of Montlake, Central District (CD) has historically been known as the center of the Black community in Seattle, serving as the home for fixtures such as Mount Zion Baptist Church and the historical residence of figures such as Quincy Jones and Jimi Hendrix. As of 1970, CD boasted by far the highest proportion of Black residents of any area in the city, estimated at around 90%(IPUMS). Individuals who lived in CD during this time often speak of its vibrancy and sense of

community,[8] with Black owned businesses often serving as community gathering places.[9]

It is important to note, however, that the historical clustering of Black Seattleites in Central District was due in part to policies that severely limited where Black families could live or purchase property. Redlining refers to the federal act of categorizing neighborhoods based on the perceived safety of insuring mortgages. The Federal Housing Administration produced color coded city maps, with red areas representing areas in which mortgages were the riskiest to insure. One of the primary criteria considered in determining the categorization of an area was the proportion of Black residents. In practice, redlining led to credit-worthy Black families being denied mortgage loans in most areas and frequently being charged interest rates several times their white counterparts for comparable loans.[10–12]

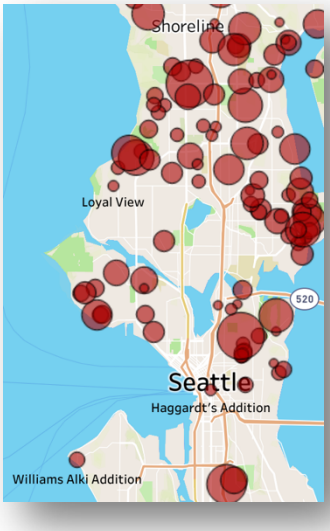
Figure 1: Map of "Redlined" Neighborhoods



In addition to redlining, the use of racially restrictive covenants explicitly restricted Black families from living in many areas of the city. Such covenants were inserted into land deeds, often en masse in the case of large subdivisions, and explicitly prohibited current and future owners of the property from selling or even renting the property to Black and other minority families. When the location of communities and developments in which property deeds contained these covenants are mapped, it creates a clear picture of large swathes of the city that were completely off limits to Black families.[13]

> "...no part of the lands owned by him or described following their signatures of this instrument shall ever be used or occupied by or sold, conveyed, leased, rented, or given to negroes, or any person or person of the negro blood"
> Capitol Hill, 958 Properties

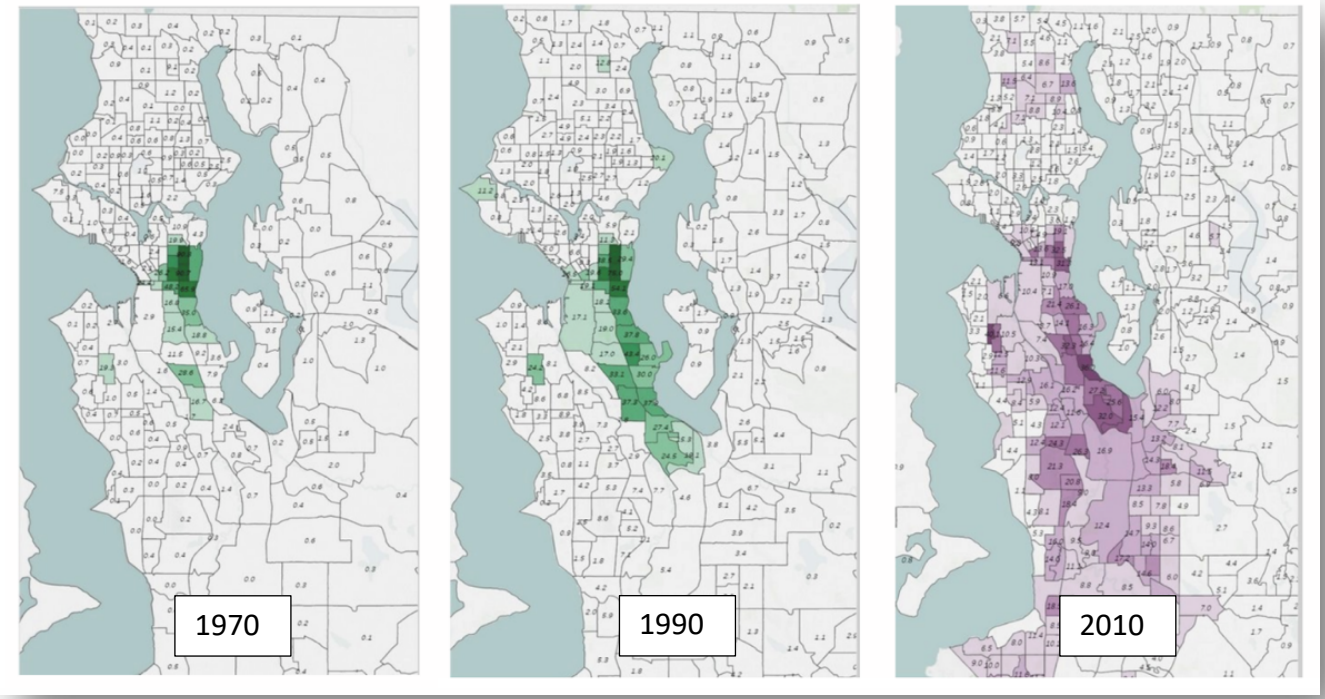
Figure 2: Map of Identified Racially Restrictive Covenants*



Blank areas do not denote an absence of such covenants.
https://depts.washington.edu/civilr/covenants_map.htm

* As of November, 2019 only around half of publicly available property deeds from 1923-1950 had been analyzed for the presence of racially restrictive covenants.

Figure 3: Proportion of Black Residents by Census Tract in King County: 1970-2010



The gentrification of Central District

A cursory web search of "gentrification" and "Seattle" will inevitably produce countless articles about CD. Beginning in the mid to late twentieth century, a variety of factors including in-migration of new groups, increased community investment, and the easing of restrictions of where Black families could live led to a change in the demographics of CD[9]. While Black families made up larger proportions of the areas throughout King County from the 1970's to the 2000's, the proportion of Black residents in CD declined considerably.[9,14]

Central District Today

Though the face of CD has changed over the previous decades, it remains a vibrant community with many of the institutions of old enduring. The data from the American Community Survey estimate that just over twenty thousand people from around nine thousand households call CD home. Residents are largely younger adults and predominantly white, with Black residents making up the second most populous group. Though the unemployment rate is fairly low (3.7%), a considerable proportion of the community live under the federal poverty level (13.1%), and over a third of renters pay a substantial proportion of their income on rent.[15]

As a community, CD experiences particularly poor health compared to the rest of the city. Data from Public Health – Seattle & King County paints a particularly bleak picture. Life expectancy in CD is estimated to be 76.6-79.7, compared to 83.5-86.2 for the Montlake neighborhood immediately to the north. Additionally, death rates from stroke, diabetes, and cancer are among the highest in the county. As with any area level estimate, it is not clear the extent to which this is

influenced by in- and out-migration, but there does appear to be cause for concern.

Gentrification and Health

To date, very little previous research has investigated the link between gentrification and health. This section will introduce a conceptual framework to identify areas for future research and policy considerations, providing an overview of existing literature and publicly available data relevant to each subsection of the model.

The link between gentrification and health will be conceptualized in three primary categories: incidence health effects of gentrification, exacerbation of existing conditions, and access to healthcare. Though there will certainly be overlap between these categories, they maintain their utility in conceptualizing

Incident Health Effects of Gentrification

Limited large-scale research has attempted to measure the health effects of individuals displaced by gentrification. A 2017 study followed New York City (NYC) residents who had been displaced by gentrification and found them to be twice as likely to visit the emergency department (ED) than comparable residents who were not displaced, the majority of excess visits due to mental health related issues.[16] An additional study of NYC residents found an apparent association between gentrification and poor adolescent mental health particularly in market rate (versus public) housing.[17] Moreover, some smaller scale, qualitative studies have added important insight to the academic literature. Community focus groups identified gentrification as a considerable source of neighborhood stress[18], and individuals living with HIV in the San Francisco Bay Area communicated that food insecurity was a significant concern due to gentrification-driven rent increases.[19]

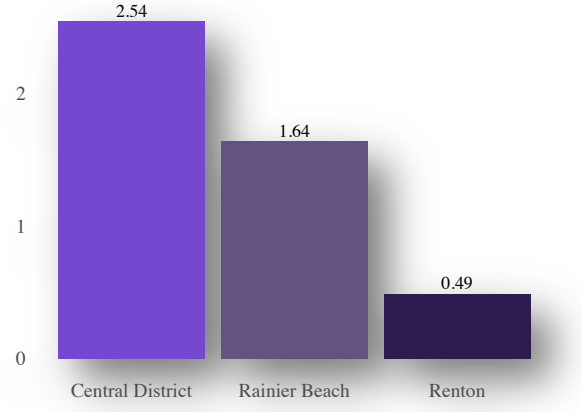
More work has been done attempting to quantify the connection between health and factors that are associated with gentrification, rather than gentrification itself. Mental health struggles seem to be particularly associated with housing instability. A large scale study from the Fragile Families and Child Wellbeing Study found mothers having been evicted experienced considerably worse depression and parenting stress at least two years post-eviction than comparable mothers who had not been evicted [6]. An additional study estimated that mothers that had experienced foreclosure showed almost twice the level of depression symptoms as their comparison group [20]. Additionally, there is some evidence that individuals experiencing housing instability may be at higher risk of exposure to substandard housing conditions harmful to health [21].

An additional association with health may be conceptualized through the effect of gentrification on neighborhood social factors. Factors such as neighborhood social cohesion and social capital are thought to be largely negatively affected by gentrification [22,23] and are increasingly thought of as important protective factors against negative health. A considerable body of literature has linked neighborhood social cohesion to both mental and physical health outcomes [24–26]. Social capital is also thought to be an important component in explaining health outcomes of communities [27–29].

Lastly, much of the work around health and physical/built environment can be incorporated into thinking about the health implications of gentrification.

The change in characteristics associated with physical space, particularly among those displaced, is likely to play an important role in this discussion. A mass of literature has illustrated associations between built environment, such as access to parks and walkability, to a variety of health outcomes [30,31]. This is particularly relevant to gentrification of areas such as CD, where investment in built environment may benefit individuals who are able to remain in a neighborhood, but such investment may accompany increases in costs of housing leading to displacement and thus inability of some of the most vulnerable to benefit. It is also possible that these effects differ by race, as some previous work has suggested that in Black communities the relationship between built environment and physical activity is particularly strong [7].

Figure 3: Community Health Clinics per 10,000 Residents



Data from ACS 5-Year Estimates and Washington State Department of Health

Gentrification and Existing Health Conditions

The second major component of the proposed conceptual model is that of the effects of gentrification on individuals with existing health concerns. Areas at risk for gentrification are regularly thought to experience a disproportionately large burden of negative health. Some of the most up to date work on community health in Seattle estimates that CD experiences particularly poor life expectancy, cardiovascular disease, and diabetes outcomes [4] while much of the area remains at high risk for displacement [3]. Further contributing to this concern is the reality that the Black community in the United States continues to experience disproportionately poor health outcomes compared to almost all other racial groups. [32,33]

Gentrification and Access to Care

The last major component of the proposed conceptual framework is gentrification and access to healthcare. Displacement in particular is likely to have some impact on access to healthcare, and this is particularly of interest in light of the concerns raised in the previous two components about the health of individuals affected by gentrification.

Within a consideration of access to healthcare, the first component to conceptualize is the physical availability of appropriate resources, particularly among those displaced. Data from Washington State suggests that as of 2019, CD was home to 8 community health clinics (Health Centers, 2019), which amounts to roughly 4,000 residents per clinic. Availability of clinics in other regions to which previous residents of CD are thought to have migrated varies considerably, from seven clinics in Rainier Beach (6,000 residents per clinic) to only five in the city of Renton (20,000 residents per clinic; population data from 2018 American Community Survey[15]). Moreover, recent public policy conversations have emphasized the need to pay more attention to the changing demographics of lower income Americans, particularly in light of the suburbanization of poverty, which often leads to a geographic disconnect between the availability of

resources and the areas to which communities in need are relocating [34].

Geographic access to care is only one component however, as interpersonal factors also play an important role. Minority groups have consistently been underserved by the healthcare industry, with a lack of representative diversity of its workforce cited as a driving factor of this disparity [35]. Beyond consideration of physical proximity to appropriate healthcare, it is unknown how the racial composition of healthcare providers differs by region, and how that may affect access to care particularly in those displaced by gentrification. Specific to CD, anecdotal reports suggest that some individuals having been displaced still travel considerable distances to visit healthcare providers near CD due to long established relationships sometimes spanning generations.

Next Steps

3 Research Questions

Do Marginalized Communities Know Their Rights?

A potentially worthy and immediately actionable direction for future research would be to measure the knowledge of tenants' rights in the communities already of interest from public health and healthcare activities. Compared to other major US cities, Seattle has some of the strongest protections for tenants in the country. It is not clear though the degree to which these policies have been communicated to community members. If a knowledge gap is identified, a worthwhile course of action may be to incorporate fairly simple communication around such protections within existing health programs.

How Does Displacement Affect Access and Acceptability of Healthcare?

Previous research has raised concern about shifting urban and suburban demographics leading to a mismatch between availability of social services and the communities who need them.[34] In healthcare this concern is likely further cofounded when communities are displaced to areas where the healthcare workforce does not reflect the demographics of the displaced community. Future research should focus on not just characterizing the physical access to care in communities to which displaced families relocate, but also how well the healthcare workforce reflects the demographics of newer residents of the communities they serve.

How Does Gentrification Affect Different Subgroups?

In order to best identify the needs and areas for intervention, future research should seek to identify how gentrification affects subgroups differently. For instance, home owners and renters are likely to be affected differently, as the former may be able to benefit from increased property values. Similarly, residential tenure ought to be considered, as those who have lived in an affected area for a considerable amount of time and are forced to relocate are likely to be affected differently than those who have not lived in the area long enough to build strong social ties. Lastly, and perhaps most importantly, the issue of intersectionality within this issue needs to be explored. Individuals within communities experiencing gentrification who are members of other marginalized groups such as the LGBTQ community, religious minorities, and the elderly may be at the highest risk of negative effects from gentrification.

Action

Strengths Based Approach

Though there is some relevant work to begin to guide thinking around this topic, what has been done overwhelmingly comes from a deficit based approach – one that works on the assumption that the most appropriate efforts focus on removing risks. While this is certainly an important consideration in this discussion, with gentrification likely introducing many

new risk factors to affected communities, it ignores and invalidates the considerable strengths inherent to communities such as CD. While the academic literature has largely missed this component, CD residents regularly speak of its sense of community vibrancy and many continue to identify with CD even after displacement [8,36,37]. With calls to shift towards a more assets/strengths based approach to population health research and intervention increasing,[38] the gentrification of CD poses a crucial opportunity to put such an approach into practice by not only looking to mitigate risk factors but also to reinforce existing strengths inherent to the community.

Power to Communities

As with most issues of health equity, gentrification largely revolves around power imbalances between subgroups of the population. In this case this imbalance has taken the form of wealth, capital, and home ownership. Gentrification becomes an issue of equity when marginalized communities do not have adequate power or say in the future direction of their neighborhoods. Future efforts to address the potential health impacts of gentrification ought to focus on ways in which to leverage community mass to empower vulnerable groups. Several such community lead movements are already at play in CD:

AfricaTown Central District – AfricaTown is a Community Land Trust (CLT) currently operating in CD. CLT's are non-profit organizations that own property frequently in areas at risk for gentrification and subsequent displacement. Similar to cooperative housing, community members are able to buy into housing within the CLT with pricing set at affordable levels and existing residents of the community prioritized. T CLT models differ, they allow residents to build equity at sustainable rates over time while ensuring affordability of properties in perpetuity. More information can be found at www.africatownseattle.com.

Liberty Bank Building – The Liberty Bank Building in CD represents a community led collaboration between several organizations to preserve the identity and physical presence of the Black community in CD. This collaboration leads several efforts including affordable housing, strengthening the Black economy in CD, and promoting the historical cultural identity of CD. More information can be found at www.libertybankbuilding.com.

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