

Research Paper

Under attack? Public accounts of health inequalities and the social determinants of health in Scotland

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Scotland experiences higher mortality rates and larger health inequalities than other high-income countries, including the wider UK. The predominantly epidemiological evidence-base identifies deprivation, inequalities in wealth, deindustrialization, health behaviours and housing as important factors, while excess mortality has been attributed to a 'political attack' on the Scottish population in the late twentieth century. This paper synthesises 48 studies offering lay perspectives on the factors shaping health in Scotland, identified via systematic searches. The findings demonstrate that people with lived experience of disadvantage have a good understanding of the social determinants of health inequalities. We also identify five ways in which Scotland's disadvantaged communities experience a sense of 'attack': the structural violence of poverty; disadvantageous national policies; 'street level bureaucrats' gatekeeping welfare support; local profiteers (e.g., unresponsive landlords); and interpersonal violence. We argue that these findings provide support for the 'political attack' hypothesis and that they suggest research and policy needs to better grapple with the depth of poverty, the intersectional nature of inequalities and the roles that history, narratives, crime, violence and policy implementation each play in shaping Scotland's health outcomes. We call for research and policy responses that ground both diagnosis and future prescriptions in the experiential knowledge of those most negatively impacted.

Introduction

Scotland is an important case study for health inequalities, having experienced higher mortality rates, lower life expectancy and larger health inequalities than most comparable high-income countries over the past four decades (Grant et al. 2023). This outlier status has stimulated a substantial, predominantly epidemiological, evidence-base, which identifies multiple causes of poor health outcomes, most of which coalesce in the outer layers of Dahlgren and Whitehead's '(2007) widely reproduced 'rainbow model' of the determinants of health: 'General socio-economic, cultural and environmental conditions' (the outermost layer) and 'Living and working conditions' (the second most outer layer). Analyses highlight rising poverty, persistently high inequalities in income and wealth, growing inequalities in educational

attainment, differential access to decent housing, growing inequalities in drug and alcohol related deaths, the unequal impacts of austerity measures on social support and vulnerability to COVID-19, and inequalities in people's health and social care access (Miall et al. 2022). In recent years, researchers have moved beyond these material factors to offer accounts of how policy decisions create the context for these inequalities. This paper builds on these recent explanations for Scotland's unusually unequal health outcomes, employing a systematically-conducted review of qualitative evidence to consider how people's accounts of life in Scotland might support, enrich, or contest research-led accounts.

Research has extensively explicated the factors that contribute to entrenched health inequalities. An international 'umbrella' review of the macroeconomic determinants of health and health inequalities found that employment, working conditions, welfare state generosity and the regulation of tobacco, alcohol and food all play an important role (Naik et al. 2019). A systematic review exploring the impact of political economy on population health identified public spending, fair trade policies, compulsory education provision, health and safety policies, healthcare access, and high-quality affordable housing as positive contributors (McCartney et al. 2019). A policy briefing produced by NHS Health Scotland (2015), informed by a larger review (Scott et al. 2013), maps social and material determinants to three 'fundamental causes of health inequalities': income ('money received by individuals or groups over a specific time period'); power ('the ability or capacity to do (or not to do) something and control, force or influence through a variety of means'); and wealth ('accumulated material and capital assets which provides a reserve of financial resources and often provides an income stream'). Many of these factors are shaped by wider socio-economic, cultural and environmental conditions arising from policy decisions. For example, McCartney et al.'s (2019) review found social democratic welfare states were positively associated with health while neoliberal restructuring and higher income inequality were associated with poorer health outcomes.

The pathways connecting these high-level decisions to health outcomes in Scotland have been unpacked across multiple studies examining how macro-economic policies implemented in the 1970s-1980s negatively impacted on health (Collins & McCartney 2011, Garnham 2015, 2017, Mackenzie et al. 2017, McIvor 2019, Scott-Samuel et al. 2014). These studies document how UK policies in this era functioned to substantially increase unemployment in specific localities (which, in Scotland, were concentrated in the Greater Glasgow conurbation), while simultaneously reducing welfare safety nets via benefits reforms and reductions in social housing stock, and restricting trade unions' ability to promote workplace safety and provide affected communities with political voice (e.g., heavily policing industrial disputes; see Kelliher 2021). Over the same period, analysis by Walsh and colleagues (2017) suggests that decisions taken by regional and local decision-makers in Glasgow led to urban planning decisions that resulted in poor-quality housing estates (which are larger than those of other UK cities and are often located in urban peripheries with limited amenities), lower investment in housing maintenance, and a greater emphasis on the kind of high-rise developments subsequently shown to negatively impact on mental health (Evans et al. 2003).

These findings have informed an influential hypothesis that Scotland's excess mortality (i.e., mortality over and above that which we would expect based on measures of socio-economic deprivation) may be partially explained by the concept of 'political attack' (McCartney et al. 2011, 2012). This idea is underpinned by three dimensions: 1) the UK's specific experience of neoliberal policies from 1979 onwards; 2) Scotland's particular vulnerability to these policies, especially in the West and specifically Glasgow areas; and 3) distinctive reactions to these policies based on Scotland's 'democratic deficit', which repeatedly subjected the population to policies designed and implemented by political parties that the majority of Scottish citizens did not vote for (Wray et al. 2022). The hypothesis has attracted international attention from health inequalities researchers (Mackenbach 2012) but is harder to measure than more material social and commercial determinants of health. Nonetheless, McCartney and colleagues' (2012) application of the Bradford-Hill criteria for causation to available evidence led them to conclude, just over a decade ago, that 'the political attack hypothesis' is the best placed explanation 'to

bring together the most likely behavioural, cultural and structural determinants of health into a coherent narrative' to 'explain the post-1980 mortality phenomenon'.

If the political attack hypothesis is true, it is reasonable to expect that a sense of being subject to political attack would be evident in 'lay' accounts of the social determinants of health and health inequalities in Scotland. Yet, these qualitative insights have been given limited attention in evidence reviews. This paper is (as far as we are aware) the first attempt to comprehensively address this gap. Our aim was to synthesise qualitative research to answer the following question: 'What do qualitative accounts tell us about public understandings of health inequalities, the social determinants of health and excess mortality in Scotland?'

The first part of our findings aligns with a 2018 meta-ethnography, which synthesised qualitative studies from across the UK, and found that people generally, 'have sophisticated understandings of the underlying causes of socioeconomic health inequalities, which closely mirror popular, research-informed theories about health inequalities' (Smith & Anderson 2018). However, in reviewing lay accounts specifically in Scotland, we identify a clearer sense of communities who feel 'under attack' and we outline five distinct sources of attack. Somewhat surprisingly, in the context of 25 years of political devolution, studies report little differentiation in people's accounts between decision-makers operating at local, national (devolved) and UK levels. In the concluding discussion, we consider the implications of these findings for research and policy.

Methods

We undertook three linked searches to identify relevant literature: two focused on academic literature (both in SCOPUS) and one on grey literature. Academic searches focused on identifying papers published since 2016, which were supplemented by papers included in the previous 2018 meta-ethnography that included relevant Scottish data (Smith & Anderson 2018). The grey literature search also started with publications from 2016, to aid comparability across the two strands. Since the meta-ethnography did not include grey literature, the exclusion of earlier grey literature is a limitation, as is the exclusion of long-form autobiographies (e.g. Barr 2014; McCormack 2009). This resulted in a data set of 48 publications: 37 academic publications and 11 grey literature reports (four studies were written up across two publications so this mapped to 44 distinct studies). See Appendix I for a full and detailed account of our methods and search terms.

Our analysis focused on identifying themes substantially evident across included publications. As such, we may not have fully captured diversity between included studies, though we were surprised by the consistency of many accounts and often found there was greater diversity between the experiences and perspectives of different social groups within studies (e.g., parents compared to children, or women compared to men) than between included studies.

Results

The included studies (summarised in Appendix I Table II) are dominated by research focusing on the perspectives of socially-disadvantaged communities in Scotland's central belt (particularly those living in urban areas). Only a handful of studies focus on the experiences of Scotland's remote and rural populations (Bramley al. 2019, Lorimer et al. 2018, Macaulay et al. 2021). Methodological approaches vary but there is shift over time away from reliance on qualitative interviews towards more creative and participatory methods, especially in the grey literature, which includes innovative examples of socially-disadvantaged communities co-authoring reports.

Across studies, participants express sophisticated understandings of the multiple pathways through which social determinants shape health (aligning with Smith & Anderson 2018). As Tables 1 and 2 illustrate, people frequently described an interplay between material conditions (income, housing, neighbourhoods and employment opportunities), individual behaviours and social relations (both positive support networks and peer-pressure to engage in unhealthy behaviours, e.g., Copeland 2004).

Determinant	Illustrative extract(s)
Poverty, low income	'Inability to cushion for (un)expected expenses also led to negative mental health outcomes and longer-lasting dissatisfaction with life for some, as shown by reports of stress, sleeplessness, feeling pressure from making difficult financial decisions. [...] Many [...] expressed feelings of shame and guilt if unable to provide for their children. This became so severe that some had suicidal thoughts.' (Ibrahim et al. 2021)
Poor quality housing and homelessness	'Participants highlighted problems of poor housing, cold and damp, which was often associated with respiratory conditions, particularly in children'. (Burningham & Thrush 2003)
Unemployment / job loss	<i>"I've watched my son who is now twenty-two...I've watched him over a period of time having to go onto websites, having to apply for jobs, no' getting any word back, no' even getting notified whether he's getting an interview, or whether he's successful, or unsuccessful. You just watch the... sorta esteem just drain oot them."</i> (Alex, quoted in Mackenzie et al. 2017)

Table 1: Lay accounts of the health impacts of poverty, unemployment and job loss

These complex and layered accounts reflect researchers' frameworks for understanding the social determinants of health and health inequalities (Dahlgren & Whitehead 2007). Multiple studies highlight determinants identified as important for population health in systematic reviews (e.g. Naik et al. 2019, McCartney et al. 2019). There is a recurrent emphasis on the negative impacts that unfair working conditions and a lack of employment can have on people's self-esteem, confidence and mental health (Table 1 and Appendix I). Qualitative accounts are particularly effective at conveying the cyclical nature of these determinants, showing how struggling to secure decent employment can harm mental health (Table 1), and in turn make securing decent employment harder: *"I have an interview tomorrow, and my anxiety is through the roof, I feel overloaded, I used to do this all the time, I feel like I can't go back"* (participant quoted in Yaqoob and Shahnaz 2021).

Qualitative studies are also effective in capturing the ways in which intermediary factors coalesce to shape health (Backett-Milburn et al. 2003, Davidson et al. 2006, 2008), with material, social and structural factors often cited as explanations of behavioural factors; the similarity with which people describe alcohol, illicit drugs, tobacco and unhealthy food is striking (Table 2). These accounts underline the importance of considering the material and social contexts of these behaviours as well as examining these behaviours collectively.

Behaviour	Lay explanation		
	'Coping' mechanism	Accessibility	Social networks
Alcohol consumption	'Some Irish narratives suggested that in order to cope with working in Britain between the 1950s and 1970s, Irish men had adopted unhealthy lifestyles that included heavy alcohol and tobacco consumption,' (Scanlon et al. 2006)	'The accessibility of alcohol (e.g., via pubs) was also identified as problematic, e.g.,: <i>"At our end [...] we have got teenagers burning bins, fire engines coming all the time. That's because pubs allowing them to get alcohol at such a young age. Pubs here are a negative influence on our</i>	'The peer researchers also felt that seeing alcohol, cigarette or drug related litter might normalise alcohol and drug taking behaviour. This means people might get used to seeing it happen and think it is ok to participate in it'

		<i>health.</i> ” (Kapilashrami & Marsden 2018)	(Young Peer Researchers et al. 2020)
Smoking	“The respondents in our study clearly indicated that in their lives there was a lack of substitutes for the habitual properties of smoking. Smoking helped them deal with circumstances in which high stress and boredom were ever-present facts of life.” (Bancroft et al. 2003)	“Legal, illegal and informal sources were plentiful: <i>“Every shop in Possil is designed for alcohol and cigarettes” “If you’re skint, you just take the coupons tae the van [mobile shop] an’ get fags” “The vans coming round” “And the smugglers” “Chap [knock] on someone’s door—there’s always someone selling fags, always—fags and drink”</i> ” (Stead et al. 2001)	“The strength of the normative pressure to smoke was such that non-smokers described having needed a legitimate reason not to smoke as teenagers, such as asthma or a place in the school football team.’ (Stead et al. 2001)
Consumption of unhealthy food and/or insufficient nutrition	“ <i>people are always going to buy cakes, it’s just the pills of life. They eat cakes and biscuits and sweets and so on, that taste nice so they make you think of different things</i> ” [FG6, inner city estate, lower SES, Greater Glasgow].’ (Davidson et al. 2008)	“ <i>I do worry about fast food. Because they are so easily accessible, order on phone. And our children rely a lot on these. If you don’t find food at home, then just dial in a pizza.</i> ” (Kapilashrami & Marsden 2018)	Describes few participants saying that they ate three meals a day and notes that this appeared to have been normalized for some: ‘Some viewed this pattern as their normal...’ (Douglas et al. 2020)
Use of illicit drugs	“ <i>I used them to escape but that just made more problems for me.</i> ” (Male J) “ <i>I was trying to escape reality... things in my head</i> ” (Female S)’ (Copeland 2004)	“The influence of their peers (friends) was the most common reason given by interviewees for starting to use drugs. One interviewee expressed clearly what others said too about the influence of friends: <i>“People I was mucking about with got me into downers and I just sort of followed suit ... because they were my mates.”</i> ” (Copeland 2004)	

Table 2: Lay explanations of the higher rates of smoking, alcohol harms and unhealthy diets in Scotland’s more disadvantaged communities

Reflecting the cyclical nature of pathways connecting material circumstances to health, alcohol was cited as a contributor to “poverty and desperation (including hunger)” (Lorimer et al. 2018) as well as a ‘coping’ mechanism (Table 2). All of the behaviours listed in Table 2, with the exception of unhealthy food, were described as having negative health impacts on bystanders (e.g., being affected by the presence of alcohol and drugs - and associated violence - in their homes, schools, workplaces and neighbourhoods). The focus of these accounts is therefore much broader than individual decisions to engage in risky behaviours (or not); they capture the ripple effects of these behaviours when they are normalised in particular places and communities.

The Structural Violence Of Poverty

Having established that the ways in which research participants in Scotland talk about factors shaping their health aligns with research on the social determinants of health, we now consider the associated sense of feeling ‘under attack’. The most obvious source of feeling under attack is poverty; an inescapable feature of many accounts, with direct, material impacts. Some participants describe struggling to meet basic human needs (e.g., food, warmth, shelter) (e.g. Douglas et al. 2020, Garnham 2015, Ibrahim et al. 2021, Isaacs et al. 2020, Mackenzie et al. 2017). There are also multiple psychosocial pathways connecting

poverty and mental health, ranging from the shame, embarrassment and stigma of poverty (e.g., contributing to social isolation, feelings of devaluation, low self-esteem and depression; Davidson et al. 2008, Inglis et al. 2019), to the fear, stress and anxiety arising from a belief that local neighbourhoods are unsafe (Burningham & Thrush 2003, Davidson et al. 2008; Egan et al. 2015, Kapilashrami & Marsden 2018, Rolfe & Garnham 2020, Shortt & Ross 2021, Watson & Douglas 2012, Wiseman & Watson 2021). While the links between poverty, deprivation and poor health are well recognised in Scotland, the extremes of poverty described by some participants suggest that current quantitative indicators and analyses dividing the population into quintiles, or even deciles, are insufficient (see Edmiston 2022, Timpson et al. 2023).

Examples of neighbourhood deprivation were often attributed to decisions by ‘those in charge’, resulting in a visceral sense of not being cared for:

The participants noted that in the more deprived area, the presence of large piles of rubbish “*makes it look like a bad area*”. This also made people have negative feelings towards their own neighbourhoods, making them feel “*horrible*”. [...] They discussed how those in charge appear not to care, as bins are not provided. (Shortt & Ross 2021)

Terms such as ‘*minging*’, ‘*minky*’ and ‘*disgusting*’ were used to describe the aesthetics of the Area and how this made them feel. For example, one young person identified a lack of investment in the Area as making them look poor and boring, while graffiti was described as making them feel depressed (Watson & Douglas 2012)

This belief (which we return to below) appeared to exacerbate mental ill-health and was hard to escape; although some studies noted efforts by participants to resist neighbourhood stigmatization (Burningham & Thrush 2003, Fraser & Clark 2021), these efforts often appeared unsuccessful. Indeed, even leaving an area did not always enable participants to escape. In several accounts, participants describe feeling that the area they are from contributed to what Wacquant and colleagues (2014) call ‘territorial stigma’, that is, discrimination that impacted opportunities to access employment and services (including financial services). For example (see also Airey 2003):

Respondents in our study were acutely aware of being labelled and stigmatised because of their postcode. It was widely felt that employers regarded people from ‘*the schemes*’ as work-shy, unreliable and anti-social, and that the “*wrong*” address on job application forms could prejudice their chances. Several had been refused credit, such as catalogue selling or TV rental, because of their postcode: “*You’re all tarred with the same brush*”. (Stead et al. 2001)

Viewed collectively, these accounts suggest that living in poverty and/or in areas of high deprivation in Scotland amount to ‘structural violence’ (Galtung 1969) since these experiences contribute to a myriad of pathways restricting people’s capacity to achieve their full potential. Although the definition of ‘structural violence’ is that individual arbitrators are not identifiable, this does not mean that there is an absence of blame; across many people’s accounts, there is a strong belief (discussed further below) that people with resources and power do not care about their communities (or, therefore, about them). This belief contributes to an ‘us/them’ dichotomy in Scottish society, evident in several studies, in which participants describe feelings of alienation (Davidson et al. 2008) and social division (Davidson et al. 2006, Lorimer et al. 2018), and of acquiring identities that ‘set them apart from the rest of society’ (Copeland 2004). This, in turn, contributes to a sense of distrust, especially in those making decisions, which can mean that investments in disadvantaged areas are not necessarily viewed as ‘for’ the local communities. For example:

[With reference to new cultural facilities being built in Dundee]: “*What’s that for? It’s no’ for us. That’s no’ for us. It might benefit the city in general wi’ tourists and things, but when you come out o’ Dundee you’ll see it,*

it's a nice place, but behind that it's still Dundee. It's still the shithole that's here". (Daniel, age 38, Dundee, Int2)
(Lorimer et al. 2018)

Targeted Political and Policy Attacks

As the section above about the structural violence of poverty suggests, despite 25 years of devolution and claims that Scotland has developed distinctive approach to policymaking centring on community empowerment (Cairney 2020), studies included in this review suggest that Scotland's more disadvantaged communities do not feel well understood, represented, engaged with, listened to, or supported by politicians and policymakers (Box 1). In short, the causes of poverty and deprivation are consistently attributed to decisions by 'government' and 'politicians', with few distinctions between local, devolved or UK national policy arenas. Politicians are depicted as making decisions that have consequences for the communities affected, but also as not understanding or adequately caring for those communities (Garnham 2017, Watson & Douglas 2012). There is a persistent sense of powerlessness to change policies that are negatively impacting communities, to the extent that it seems plausible to consider this a key psychosocial pathway via which material experiences contribute to poor health in Scotland (e.g. Burningham & Thrush 2003).

More historical

TIME

More recent

'Research participants from lower socio-economic groups [...] talked eloquently about feeling that their communities were unheard and ignored. [...] One man described his belief that whole sections of society were now seen as disposable 'fling away people', and another declared: *'the government's made us feel, as if we're a carpet for [them] to wipe their feet on, and to be brushed aside. I'm talking about me personally, I feel rejected by the government, like I've been told, 'we don't need you, I mean, who cares about you up there, right, we'll just deal with people that's in our category, with the suits.'* (Davidson et al. 2006)

Participants' frustration at local neglect was often directed at government, local decision-makers and public services, who were often seen not to be doing anything to improve the situation, e.g.: *'We've all been ignored all the time by the police and the government'.* (Watson & Douglas 2012)

Joan, oral history participant: *'They couldn't care less, north, as was said, of the Watford Gap. They're not even interested in the North England or anywhere, they're only interested in a little bit down there, they're not interested in anywhere else. And that's only by my experience of what I've seen. I've lost, I've really lost heart in politicians, I'm sick of all the, I mean come on! They're the biggest thieves out! The biggest thieves out! ... So there's something sadly wrong with government, isn't there?'* (Garnham 2015, 2018)

'A lack of trust in governments and politicians was prevalent across juries, with frequent expressions of cynicism concerning motives, competence, integrity and (lack of) concern for, or understanding of, *'people like us'*. This informed a belief, evident across juries, that governments 'waste' money.' (Smith et al. 2021)

Box 1: Illustrative data extracts demonstrating the perceived distance between disadvantaged communities and Scotland's policymakers and politicians

Analysed collectively, the included studies contain three recurrent examples of macro-level economic policies described as having been pursued at the expense of disadvantaged communities: (1) the closure of large industrial employers (especially coalmines) during Margaret Thatcher's time as UK Prime Minister, which some participants viewed as a deliberate attempt to damage unions (Garnham

2017, Mackenzie et al. 2017, McGarrol 2020); (2) the combination of conditionality and austerity policies implemented by the Labour governments that were in power during 1997-2010 and the Conservative governments that were in power from 2010 onward (Garnham 2017, Mackenzie et al. 2017); and (3) policy decisions that enabled individuals working in financial services to accrue vast wealth, despite the 2008 global economic crash, at the same time as conditionality and austerity were being rolled out in disadvantaged communities:

'They'd built up the financial services to such a strength that It outweighed manufacturing, it outweighed any other service in the UK. But they were the kings and everybody else was the minions...financial services I would say were the main cause of what has happened, the greed. And what gets up oor noses is that we still see bankers' bonuses being paid, we still see the very rich getting tax breaks and we're looking at people living in our community getting hit wi' sixteen pound a week [benefit reductions]...there's no a God, at this moment in time.' (Participant referred to as Alex, in Mackenzie et al. 2017)

Such accounts point to the importance of focusing on those who benefit from growing inequalities, as well as those who are most disadvantaged. Additionally, a study focusing on asylum seekers and refugees in Scotland identifies the UK's 'hostile environment' policy as an 'explicit example of structural violence' (Isaacs et al. 2020). A participant in Mackenzie et al.'s (2017) study highlights how media narratives and television shows can target particular social groups, concluding, "*I think that's Tory sponsored TV to be quite honest wi' you...it's like stigmatising full groups at a time.*" (Mackenzie et al. 2017, p. 244). These studies highlight the importance of considering: 1) how national policies may be differentially experienced; 2) the necessity of considering multiple axes of inequality; and 3) the need to critically analyse the interplay between policy and media narratives. Despite 25 years of devolution, there is a notable absence within these studies of disadvantaged communities reporting a sense of improved political representation and voice. This is likely to reflect the continued impact of reserved policy areas (those that remain at UK parliamentary level) on reported experiences (especially social security until 2016, and immigration) and the more gradual development of community understanding of complex multi-level governance systems, as discussed next.

'Street Level Bureaucrats' Gatekeeping Support

While the blame for the negative impacts of some policies was, therefore, commonly located with the UK government, lay accounts also draw attention to people's experiences of how policies are *implemented*. Here, issues such as dignity, respect and responsiveness seem key. Crucially, community accounts make clear that the same policy can be implemented differently for different places/groups and can have varying consequences. For example, while the national policy context may appear to provide a particular combination of disability benefits, people with disabilities recount trying to avoid claiming benefits in what they perceived to be a hostile and stigmatising culture (Young 2021). Systemic complexity, a lack of transparency, and difficulty accessing good-quality advice and information, were all also identified as barriers to accessing benefits (Young 2021).

Another study identified a lack of confidence in core public services. This included accusations (in one older study) that councils and housing associations fail to adequately maintain housing stock, as well as claims that police ignore reports of crime and anti-social behaviour in some poorer neighbourhoods:

Participants characterised themselves as engaged in a constant battle to get the police and the council to do their job, recounting many occasions on which they had phoned one or the other about specific problems, to be met with what they considered an inadequate response. (Burningham & Thrush 2003).

The difficulties of accessing support were widely discussed (Table 3). Recent studies describe applying for welfare benefits as 'a nightmare' (Kapilashrami & Marsden 2018), the process of navigating support

systems as ‘fearsome’ (Robertson 2020), and the challenges of meeting a requirement to ‘make three bids a week to an online index of available housing’ as virtually impossible for people already experiencing homelessness (Kapilashrami & Marsden 2018).

Issue raised	Illustrative extracts from Robertson (2020)
Not knowing where to get support when it is needed	<i>“It’s not easy to find. [...] It’s very stressful trying to, trying to even look for help and finding help and, it’s such an invaluable resource... so many didn’t even know about the Warm Homes Scheme. That’s something they keep real hidden.” (Sophie)’</i>
Inadequate public service support provided when sought	<i>‘Sasha had applied for and had been waiting for a council property for 18 months. [W]orking 25 hours a week and caring for her child meant she struggled to fit in time for bidding for houses which she described as a constant process. She described “being very scared about the next winter” in her current flat because of the cold and her child’s health. Sasha had contacted the Council on several occasions to find out if she was any nearer to getting a property. Her frustration was clear here: “So I call them, they said, ‘meh, to be honest, you have like five hundred and something points. There’s people that has got four times the points that you have, and they’re still waiting’. Basically, they say you don’t have hopes to get nothing.”’</i>
Concerns about the ways support is provided (e.g. treatment by staff, lack of staff knowledge)	<i>“It’s a fearsome process (the work capability assessment), like, I mean, if you havenae already got depression and anxiety, you will have after you’ve gone through that assessment thing, like, you know. It’s murder.” (John)’</i> <i>“They don’t really care where you’re living, even you explain to them... In fact, even my key worker’s write some letters for the arrears that I had to show to the Jobcentre that I’m gonna be made homeless again because they have to do something with, I need some support. But I went there, they’re like “We can’t do nothing,” (Leo)’</i>

Table 3: Lay accounts connecting public services limitations to poor health

In several accounts, the three issues highlighted in Table 3 combined, with people reflecting that uncertainties about how support services were supposed to operate, limitations in available support, and perceptions that front-line staff did not care, combined to cause mental and physical distress:

“The Job Centre, that turns my stomach. I gotta go there every fortnight, it’s only every fortnight, but still, leadin’ up to that I can feel it in my stomach and my stomach turns and, y’know, it’s just not a pleasant experience for me ... Well it’s called the job centre but I don’t think it actually tries to really get you a job. You go in there and they’ve got procedures and you’ve got to do what they want because they’ve got bosses on top of them and if they’re not seen to be doin’ what you’re supposed to be doin’ then they get intae trouble. I’ve got tae apply tae a job every week, but if I can’t find a job I’m told I’ve tae send a CV tae any company, which I do to keep them right. If I don’t do that then they get intae trouble ... So that just physically upsets me, and mentally.” (Owen, photovoice participant, cited in Garnham 2015)

In sum, while multiple participants, across studies, provide compelling critiques of national policies, their accounts also identify problematic experiences with local actors, such as Job Centre staff, the kinds of people Lipsky (1980) refers to as ‘street-level bureaucrats’. An important exception to these accounts of public services is the way health services are discussed. In most studies, health services are not mentioned but, where health services and health professionals are discussed, they are often referred to positively (e.g. Douglas et al. 2020; Kapilashrami & Marsden 2018). In the small number of cases in which people raised concerns about health services, it related either to a sense that health professionals were not sufficiently aware of people’s life circumstances (e.g., giving advice that was not economically feasible; Douglas et al. 2020) or to a sense that health professionals could be judgmental of people’s circumstances and behaviours (Parkes et al. 2021).

The ‘Profiteers’

Community accounts identify a range of ‘profiteers’, who extract resources from Scotland’s disadvantaged communities, with negative health impacts. It is important to acknowledge that some local businesses were described positively, including some fast food outlets that were described as providing safe and relatively affordable social spaces (Kapilashrami & Marsden 2018) as well as responsive housing providers (Garnham et al. 2022, Rolfe & Garnham 2020). However, there were also multiple negative examples. A recent study of people claiming Disability Assistance in Scotland noted multiple ways in which participants described private sector companies as extracting a ‘poverty premium’ from disabled people living in poverty, with examples including higher pre-payment meter energy rates, and the high cost of basic aids for independent living (Young 2021). Similarly, landlords were commonly described as prioritising profits over people, by leasing poor quality properties, ‘ripping off’ families, and taking advantage of marginalised communities (e.g., migrants) (Smith et al. 2021). Businesses involved in selling unhealthy products and services were often described as contributing to local problems. For example, businesses selling alcohol were frequently singled out as exacerbating a sense that particular local areas are unsafe, especially for women and children (Kapilashrami & Marsden 2018, McGarrol 2020).

Local profiteers perceived to cause health damage were not restricted to the formal sector; a recent study highlighted the importance of organised criminals and gangs in Scotland’s ‘hidden economy’ (Fraser & Clark 2021). Focusing on deindustrialized areas, these groups are described as exhibiting ‘a keen knowledge of vulnerabilities in the local area—debt, addiction, ill-health, lack of family support, and old age’ which they leverage ‘to build defensible fiefdoms’ (Fraser & Clark 2021). While this can result in substantial financial rewards for some individuals involved, the fall-out for affected communities in terms of the availability of drugs and the fear of crime is substantial, and this is exacerbated by a sense that public sector actors (the ‘street level bureaucrats’ described above) step back, where organized crime takes hold (Fraser & Clark 2021).

Finally, some studies featured participants who described corporations that negatively impact on health more broadly by, for example, promoting unaffordable lifestyles (Davidson et al. 2006, Davidson et al. 2008), providing poor working conditions and low pay (McHardy et al. 2021), or undermining the public sector via tax avoidance (Smith et al. 2021). This suggests a need to broaden public health’s conceptualization of the ‘commercial determinants of health’ to better capture the range of profit-driven actors shaping people’s health.

Direct, Interpersonal Attacks

Studies exploring links between interpersonal violence and health inequalities in Scotland have tended to focus on gang-related violence, especially knife crime (e.g. Neville et al. 2015). Our findings suggest that interpersonal violence is more widespread, and that it is consistently linked with a toxic interplay of poverty, disaffection and addiction:

[W]e were struck by the shadow cast by poverty, drugs and violence, which appeared never to be far from the doorsteps of almost all participants, and for many it was an intrinsic part of negotiating everyday life. (Lorimer et al. 2018)

Multiple studies recount experiences, or fear, of violence and aggression (Bramley et al. 2019, Burningham & Thrush 2003, Copeland 2004, Egan et al. 2015, Fraser & Clark 2021, Garnham 2017, 2018, Lorimer et al. 2018, Marzetti et al. 2022, McGarrol 2020, Shortt & Ross 2021, Watson & Douglas 2012, Wiseman & Watson 2021). These accounts (which often also mention alcohol and/or drugs) suggest the health and wellbeing implications are profound:

Violence and drugs heavily present in participant accounts. [...] Throughout interviews, it is clear that organized crime penetrates every level, with street-level crime intrinsically linked to local criminal markets, which also manifest through violence, intimidation, and financial pressure. (Fraser & Clark 2021)

Looking across studies, three types of inter-personal violence were commonly identified (Table 4).

Type of violence	Illustrative example
Youth and gang related violence	'Men who discussed their experiences of engaging in youth violence – commonly, but not exclusively, our Glasgow participants – gave a variety of reasons for this, from boredom to the acquisition of status, mirroring others' findings [...]. In these narratives, we read a mixture of choice ("Just dinnae [didn't] feel coerced intae [into] it, just actively joined in") and obligation (often even at different points in the same interview), suggesting that their violent behaviours were unavoidable and normalised in their community.' (Lorimer et al. 2018)
Violence against women and girls ('domestic abuse')	'We heard men talk about domestic abuse as a common feature of their communities, or personally witnessing domestic abuse. [...] Of the 16 women interviewed, 13 said they had witnessed and/or been subject to personal experiences of domestic abuse.' (Lorimer et al. 2018); 'Women reported experiences of sexual violence as children and adults.' (Wiseman & Watson 2021)
Harassment and violence targeting minority groups (e.g. people with disabilities and people with LGBTQ+ or minority ethnic identities)	'Being subjected to violence was part of people's everyday experiences throughout the life course and was experienced in various community settings such as schools, participants' homes, public transport, and in care settings. Participants described trajectories of harassment and bullying that started from a young age. Schools were often the first space where participants experienced violence'. (Wiseman & Watson 2021)

Table 4: The three types of violence commonly featured in qualitative accounts

What is striking across all three forms of inter-personal violence featured in Table 4 is their depiction in participants' accounts as *normalized* within affected communities. Unsurprisingly, in this context, a fear of violence also seemed pervasive, with negative consequences for mental health and physical exercise:

Walking was one of the few health-promoting practices that was considered financially accessible. However, an additional structural constraint – a sense of othering, reinforced by awareness of being audibly foreign, and visibly black, led to restrictions in terms of what ASR [asylum seeker and refugee] participants felt they could engage in outside of their home. Participants recounted racist experiences in their everyday interactions such as going to the local shops and travelling on buses. These encounters then shaped their willingness to partake in ostensibly free, healthy activities such as walking in their local area. Female participants in particular, sought to minimize time outside lest others became suspicious about them. (Isaacs et al. 2020)

Where participants described experiencing targeted harassment and violence in public, in situations where bystanders could have intervened but chose not to, this experience appeared to exacerbate the negative health impacts of violence, reinforcing a sense of being devalued and dehumanized (Wiseman & Watson 2021).

Concluding Discussion

This review explores the contribution that lay accounts can make to understanding health inequalities, social determinants of health and excess mortality in Scotland. Although most qualitative studies are small-scale and focus on the views and experiences of specific communities, the literature has been growing rapidly. This means that, when synthesized, we have a large empirical foundation for understanding public views about – and experiences of – health inequalities and social determinants in Scotland, incorporating the perspectives of diverse social groups across income level, place, gender and age. Here, we outline six key conclusions based on this synthesis.

First, the review shows that members of the public, especially those who have experienced disadvantage, can provide visceral and sophisticated accounts of the interplay between material and social circumstances and health outcomes. These findings align with those of existing reviews of qualitative research from the wider UK (Smith & Anderson 2018) and beyond (Elliott et al. 2016). Yet, they remain important in the context of survey-based claims that there ‘is a mismatch between the public’s perceptions of what influences health (namely individual behaviour and access to care) and the clear evidence base demonstrating the significance of wider determinants of health’ (Kane et al. 2022). Different methodological approaches can reach opposing conclusions about public understanding of the social determinants of health and health inequalities. We therefore propose responding cautiously to calls to correct public misunderstandings by working to tell ‘a more powerful story about health inequalities’ (The Frameworks Institute & The Health Foundation 2022). Indeed, our review highlights the need for researchers and policy actors to do more to listen and learn from disadvantaged communities, including paying attention to existing qualitative research. For example, the internationally reproduced ‘rainbow model’ of the social determinants of health (Dahlgren & Whitehead 2007) mentions neither crime nor criminal justice, yet the pervasiveness of violence in people’s accounts of the factors shaping their health suggests these are all important social determinants of health in Scotland and warrant more consideration.

Second, the consistency with which intolerably deep poverty is described demonstrates the limitations of prevalent approaches to measuring poverty (Timpson et al. 2023), including population segmentation into deciles and quintiles. Indeed, our findings support Edmiston’s (2022) call to ‘re-think how we currently conceptualise poverty by better attending to internal heterogeneity within the broader analytical and methodological category of ‘the poor’.

Third, and relatedly, many of the included studies drew attention to forms of disadvantage and discrimination that are not solely about poverty or deprivation; examples include migration status, ethnicity, gender and sexual identity, substance dependency and disability. This points to a need to expand the dominant focus on socio-economic and area-based health inequalities in Scotland. Indeed, some more recent studies are already demonstrating the value of acknowledging multiple, intersecting axes of inequalities (e.g., De Andrade 2016, Kapilashrami & Marsden 2018, Lorimer et al. 2018). There are also specific groups for whom research in Scotland is lacking, including: racialised minorities (in the 2011 census, minority ethnic groups accounted for 10-18% of the population in Scotland’s cities, where most health inequalities research focuses); people with disabilities (just under a third of the Scottish population and 43% of those in the most deprived quintile, according to the 2017 Scottish Health Survey); and people living in rural areas (around 17% of the Scottish population (Scottish Government 2021)).

Fourth, psychosocial explanations of health inequalities might be best understood as *pathways* connecting material factors to health outcomes. Scholars, not least in *Critical Public Health* (Green 2014) have argued that a focus on quantitative evidence in public health, especially from randomised controlled trials, can narrow debates on population health and focus attention on downstream interventions. We proposed a parallel risk that, if psychosocial *pathways* are presented as *determinants*, this may distract from underlying structural factors generating and entrenching inequalities.

Fifth, the findings support the idea that a sense of ‘political attack’ plays a role in Scotland’s poor health outcomes (McCartney et al. 2011, 2012) and we identify five contributing sources which we

described above. Despite the intentions of many who work in public policy, the experience of political attack implicates macro-level policy decisions. It is sobering to note that 25 years of political devolution appears to have done little to address a perceived lack of political representation within Scotland's most disadvantaged communities. However, this sense of being 'under attack' is mediated by a broad range of other actors, including the 'street-level bureaucrats' who implement policies, and an array of individuals and organisations who are depicted as profiting from people's desperation. Neither the concept of 'political attack' nor public health's notion of 'commercial determinants of health' quite captures the diversity of inter-connected organisations and individuals that feature in people's accounts. Researchers may need to move beyond national level policy analyses to examine those who work to influence policies and who benefit from policies with unequal impacts (Sayer and McCartney 2021), and to better understand local implementation experiences.

Sixth, across people's accounts of how social determinants of health matter, the importance of history (of people and places) and narratives emerge; while historical experiences can cast a long shadow, via inter-generational trauma and privilege, narratives shape what people believe about themselves, about others, and about the past and the future. To better understand social determinants of health and to effect positive change, we need to examine the historical dimensions of places and communities, and design policies and interventions with historical trauma and cumulative disadvantage in mind. As well as critically engaging with narratives of blame and despair, we should also explore alternative narratives of hope. It is notable that people's accounts of positive historical moments were often tied to a sense of opportunity, and effective political leadership within communities (Garnham 2015, 2017).

Rather than cast publics as audiences to be re-educated, this review demonstrates the value of grounding both diagnosis and prescriptions for a more equal future in the experiential knowledge of people living with experience of social and economic disadvantage. This involves researchers and policymakers working *with* the communities most negatively affected by Scotland's poor health outcomes to better understand their experiences and to co-develop policies and interventions. This recommendation is not innovative; indeed, it aligns with existing high-profile policy reports in Scotland (e.g., Christie Commission 2011). Yet, it requires public health to relinquish an attachment to a hierarchy of evidence that pays low regard to qualitative research; it also requires responses that take serious aim at inequalities in wealth, power and political voice. Without such a shift, researchers and policymakers risk failing to adequately understand the experiences of Scotland's disadvantaged communities, while unintentionally exacerbating inequalities in political voice.

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Appendix I: Methods, Limitations and Summary of Included Studies

Methods

Two searches, outlined in Table I, were undertaken in SCOPUS (one of the largest academic databases, with good coverage of the social and health sciences). Both searches were undertaken on 11th March 2022. The main search string returned 2,908 hits. These were reviewed up to and including publications in 2016 (we did not assess earlier studies as this search string was very similar to the one used in Smith and Anderson's 2018 meta-ethnography so we used this earlier review to identify relevant studies published prior to 2016). After reviewing titles and abstracts returned in this search, 38 publications were downloaded to EndNote for further consideration.

On the same date (11th March 2022), a supplementary search was undertaken to try to capture relevant studies exploring public perceptions or understandings of the links between key social determinants highlighted in the *Marmot Review 10 Years On* report (Marmot et al, 2020) and health outcomes. An initial version of this search returned too many hits to be feasible for the team to assess so the search was re-run with the addition of 'Scotland OR Scottish OR Glasgow OR Edinburgh OR Dundee OR Aberdeen', to limit the results to publications explicitly focusing on, or written by authors based in, Scotland. After reviewing titles and abstracts of the 654 publications returned in this search, 41 were downloaded to EndNote for further consideration.

Additionally, the following questions were entered into a database called elicitor.org, which uses artificial intelligence to identify relevant publications:

- What do the public think about health inequalities?
- What do the public think about health inequalities in Scotland?
- What do communities think about health inequalities in Scotland?
- How do members of the public understand social determinants of health in Scotland?
- How do members of the public understand social and economic determinants of health in Scotland?

This identified 12 relevant articles (although, on checking, all of these had been identified by the other searches and so these were removed as duplicates).

Finally, all of the studies within Smith and Anderson's (2018) meta-ethnography with a substantive Scottish component were downloaded to EndNote. Once this had been undertaken, 17 duplicates were removed.

Search string	Aim	Hits returned
<p>ALL (("health inequalities" OR "inequalities in health" OR "poor health" OR "social determinan* of health") AND (qualitative OR "citizens' juries" OR interviews OR ethnograph*) AND (lay OR "public understandin*" OR "public perspectiv*" OR communit*) AND (scotland OR scottish OR glasgow OR edinburgh OR dundee OR aberdeen)) AND (LIMIT-TO (AFFILCOUNTRY , "United Kingdom"))</p>	<p>This was the main search string. The aim was to identify literature explicitly examining lay/public understandings of, or perspectives on, health inequalities and/or the social determinants of health in Scotland</p>	<p>2,908</p>
<p>TITLE-ABS-KEY (("focus group*" OR interview* OR deliberative OR ethnograph* OR qualitativ* OR "citizens' juries" OR "mini publics" OR lay OR "public understand*" OR "public perceptions" OR communit*) AND (disadvantage* OR poverty OR depriv* OR poor OR inequ* OR "social determinan*" OR "early years" OR education OR schoo* OR employ* OR jobs OR "zero hours" OR "in work" OR unemploy* OR "labour market" OR wealth OR income OR debt OR housing OR "built environment" OR "climate change" OR "neighbourhood" OR place OR violence) AND (health OR mortality OR morbidity OR suicid* OR depress* OR anxi* OR cancer OR cardiovascular OR 'heart AND disease' OR stroke OR diabetes OR "non-communicable diseas*" OR ncd OR "life</p>	<p>This was a supplementary search string which aimed to identify qualitative research exploring lay/public understandings or perceptions of links between key social and economic determinants of health and health outcomes within Scotland</p>	<p>654</p>

<p>expectanc*" OR psychosocial) AND (scotland OR scottish OR glasgow OR edinburgh OR dundee OR aberdeen)) AND PUBYEAR > 1996 AND (LIMIT-TO (AFFILCOUNTRY, "United Kingdom"))</p>		
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Table I: A summary of search strings used to search SCOPUS

Grey Literature Search

For the grey literature search, we began by using Google to identify organisations likely to be producing qualitative research on the topic of how socio-economic circumstances shape health and wellbeing in Scotland, and supplemented this with organisations we knew to be working in this area (this was informed by conversations with the Expert Advisory Group, supporting the 2022-2023 Health Foundation review of health inequalities in Scotland). In May 2022 we used the academic search string on relevant organisational websites, except where the search facility was not sophisticated enough to allow us to input so many terms. Where that was the case, we used simplified strings (Scotland + inequalit* + qualitative* and Scotland + inequalit* + interview*). We additionally ran the full search string on the Policy Commons database (www.policycommons.net) on 19th May 2022.

We appraised identified documents using the same inclusion and exclusion criteria that we used to assess the academic literature. We also applied the date restriction of outputs published since the beginning of 2016. Although the original review (Smith and Anderson 2018) had not incorporated grey literature, project capacity required us to replicate the date restriction, and so grey reports where data collection took place before 2016 are not included.

Most of the research reports we identified were from the Glasgow Centre for Population Health, Joseph Rowntree Foundation Scotland, and Poverty Alliance Scotland. In several cases, we made direct contact with these organisations to request background research reports or technical appendices which we could not access via the public website. Following a helpful suggestion from a member of the Expert Advisory Board, we also added one additional report by Lankelly Chase which had not been identified through our initial searches (Bramley et al. 2019).

Including grey literature was particularly helpful in identifying very recent (post-COVID) data, because the academic peer-review process tends to slow down sharing of new findings. A cluster of reports focus their recommendations on social security reform, likely reflecting the policy window of new Scottish powers in this area. Many of these reports also included explicit engagement with people ‘at the sharp end’ of health inequalities, including innovative approaches to co-analysis of data and a commitment to coproducing recommendations with people with lived experience of the issues. However, applying methodological criteria to the grey literature was more complicated because these reports tend to focus on advocating for policy goals, rather than prioritising knowledge generation via conventional academic reporting. Several reports which included quotes from members of the public, often via project advisory boards, were excluded after discussion among the research team because they provided insufficient details to allow us to understand how these quotes were generated (i.e. no methods section or technical report provided). In other reports, it proved difficult to distinguish public

or community perspectives from those of frontline professionals. In sum, the grey literature included in the review significantly enriched our understanding of health inequalities in Scotland and was especially useful in providing up-to-date data, and in providing a sense of the kinds of policy actions Scotland's disadvantaged communities are seeking.

Synthesis

The next stage was to assess the full text of the remaining 93 publications against our inclusion/exclusion criteria (Box I). At the end of this process, 47 relevant publications were identified (mapping to 44 distinct studies; there were four cases in which a single study had been written up as two publications).

Inclusion criteria – to be included, we decided publications must:

- Examine/present empirical data concerning community/lay/public accounts of, or perspectives on: health inequalities OR social/economic determinants of health (while explicitly recognizing a health link & incorporating at least one inequality axis)
- Either: focus exclusively on people living in Scotland; or include a substantial focus on people living in Scotland and make clear which data relate to people living in Scotland.
- Focus on exploring 'lay' (i.e. members of the public who not recruited on the basis of relevant professional expertise) perceptions or accounts. This may include studies focusing on public perceptions of interventions intended to contribute to reducing health inequalities/addressing inequalities in a recognised social determinant of health *and* where included data relate to participant accounts of health inequalities/social determinants of health (as well as the intervention).
- Be available in English

Exclusion criteria – we did not include the following types of publications:

- Opinion pieces, essays or reviews which did not present relevant empirical data
- Studies focusing on public perceptions of specific interventions where the included data were restricted to views on/experiences of the intervention, even if publications claimed the intervention rationale was intended to contribute to reducing health inequalities.
- Studies that presented only professional/practitioner perspectives (e.g. the views of healthcare/policy professionals on health inequalities).
- Community/lay/public accounts of health issues that provided no inequalities angle.
- Publications that did not provide any account of methods used to collect presented data.
- Publications not available in English

Box I: Inclusion and exclusion criteria

Next, the webpages/Google Scholar profiles of lead authors were checked to identify any additional publications of relevance and we consulted the Health Foundation Expert Advisory Group. As Figure I illustrates, these checks helped identify one additional published academic study, one academic study that was in press/under review (written up as two papers) and one additional grey literature report. Finally, reference lists and citations of all included publications were assessed to try to

identify any additional studies that might meet inclusion criteria (but no further relevant publications were identified).

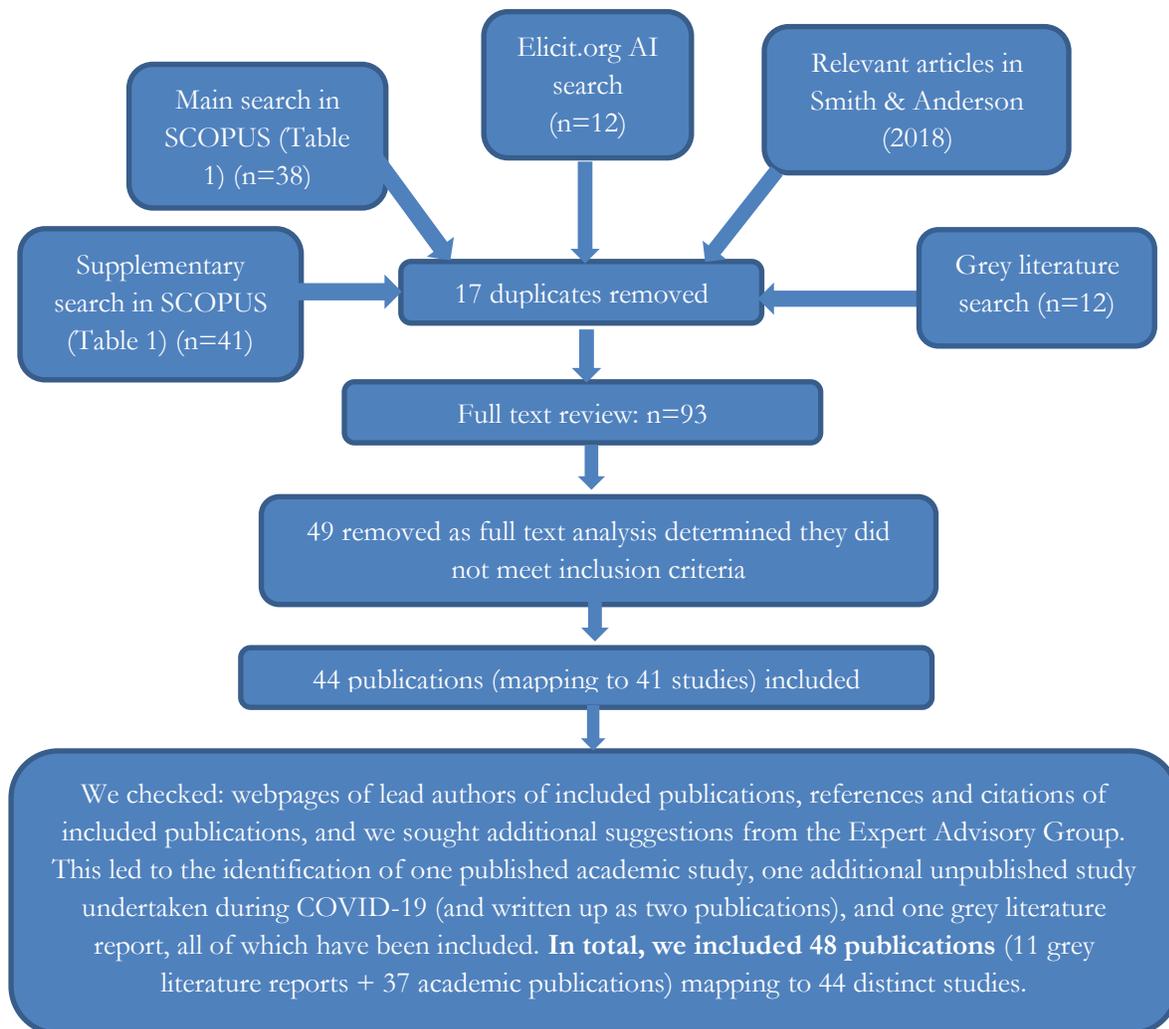


Figure I: Flowchart of the review process

Review Limitations

Even though we undertook extensive searches, and checked the results in multiple ways, the broad nature of the social determinants of health mean we may have missed some relevant literature. As we note in main article text, we did not have capacity to include grey literature published prior to 2016. We decided to include academic literature published before 2016 to gain some insights into the ways in which research on public understandings of health inequalities and the social determinants of health in Scotland has changed over time. However, this decision brought its own challenges since it means our synthesis combines perspectives from very different time points. To mitigate this, we comment on

publication dates (where it seems important to do so) and we explicitly acknowledge where key insights were only identified in studies from particular time points.

Summary of Included Studies

Reference	Study aims	Key findings
(Blaxter 1983)	Examination of the concept of 'disease' and its causes held by a group of middle-aged women brought up in poor social circumstances. Research questions: What diseases were mentioned by the women? Was there much speculation about cause? What categories of cause were most popular? Were the etiological models similar to those of medical science, either in principle or in detail? Do the answers to these questions offer any insight about the way in which this group typically reacts to illness, or any useful information to doctors attempting to diagnose their diseases or treat their ill health?	Participants were resistant to acknowledging health inequalities based on wealth/class. However, participants were able to speak about the links between poverty and illness, the main pathway for which was thought to be stresses brought about by experiences of poverty, in living and working environments (though family histories/genetics also seen to play a role). Poor working and living conditions were also described as having direct impacts on chronic illnesses, including in children, and there was a sense of guilt and frustration associated with these accounts. Traumatic events, poor living and working conditions were described in ways that suggested they combined to contribute to high levels of stress, self-neglect and health damaging lifestyle behaviours, all of which had negative health impacts on mental health and chronic diseases/illnesses: 'In most of the examples where 'neglect' was being offered as a cause [of ill health] [...] self-responsibility was explicitly denied. Yes, it was this behaviour that caused the disease, but in the circumstances, no-one could have behaved differently.' (p65) Communicable diseases are mentioned more than Non-Communicable Diseases (e.g. TB, Measles and Bronchitis were the diseases mentioned most often). The potential randomness of disease was seen as frightening and so often resisted. Psychosocial pathways strongly evident, e.g. stress, strain, anger, resentment, frustration and despair all mentioned.
(Stead et al. 2001)	To explore 'the ways in which smoking might be fostered (and smoking cessation hindered) by residence in communities excluded economically, culturally and physically from mainstream society'	Participants (especially men) 'described feeling resentful of and persecuted by bans on smoking in public places, and by perceived discrimination against smokers within the health service and the job market'. Smoking was described as 'a means of coping with the many and related stresses of residence in a disadvantaged community', e.g. 'the struggle to cope on a limited income, often in tandem with caring for children and other family members, was intensified by a poorly

		<p>resourced local infrastructure, high levels of crime and drug use, and severely limited opportunities for recreation or respite from the immediate environment.' Availability of tobacco and alcohol products was described as high (whereas other products and services, e.g. women's clothes and banking, required travelling out of the area). Participants described high crime and drug rates (which seemed to contribute to stress and fear for some). A lack of leisure facilities aside from pubs was noted as an issue. Smoking was described as one of the few cheap pleasures and was framed as a means of coping with 'the frustration and demotivation of widespread unemployment'. High unemployment levels, especially for those with limited educational qualifications, informed feelings of hopelessness regarding future employment potential. Participants described how family members and friends smoked in ways which normalised and enabled smoking, sometimes contributing to peer-pressure to start smoking, to smoke more and to undermine cessation. This was exacerbated by the fact the geography and poor infrastructure of these neighbourhoods made 'them appear physically and socially disconnected from nearby more affluent suburbs'. Low income and lack of reason/means to travel (e.g. for employment) meant that participants seemed to have 'limited exposure to non-smoker and ex-smoker 'role models''. Participants described experiencing placed-based discrimination and stigma. 'In the face of this feeling of being rejected by wider society, residents took strength from the communities. There was strong local identification, and a sense of belonging engendered by having been born there and grown up among a large network of friends and family. Borrowing cigarettes from family and friends seemed common and 'could ease the stress of social interactions, and give and receive social and emotional support.'</p>
<p>(Backett-Milburn, Cunningham-Burley, and Davis 2003)</p>	<p>To illuminate children's everyday experience of inequalities and the production of health inequalities through qualitative research with boys and girls in the latter years of primary school and their parents</p>	<p>Found that children tended to downplay inequalities (parents were clearer about the negative impacts of poverty on health and wellbeing) but, where children did discuss inequalities, this was located in relationships and social life as much as material concerns. However, children did have a strong sense of fairness/unfairness. Children's accounts suggested social relations mattered</p>

	<p>(notes absence of children's voices in this area of research to date).</p>	<p>more to them than material circumstances, that control over their life-worlds was important and that 'being cared for' and respected (e.g. not bullied) were all important, but their accounts nonetheless showed evidence of awareness of material limitations and attempts to mitigate this. While there were differences between the samples from the two areas (those who had less experience of poverty provided more abstract accounts, while 'Parents from both areas who had experienced or had direct contact with poverty had no doubts about its effects on health.'). the findings also highlight that individual experiences differ within areas.</p> <p>Undesirable/stressful circumstances were described in ways that suggested stimulated efforts by adults to escape (e.g. through consumption of alcohol or drug use), while undesirable places and poor families were stigmatised (e.g. links between certain streets and drug dealers, and between impoverished families and a sense that children were not being cared for). Most of the children's accounts showed 'considerable awareness of the multi-factorial nature of illness as well as the diversity of its experiences' (as did the adult's) and, although they tended to claim individuals had responsibility for their own health (and rehearse individual health promotion messages), there was a reluctance to blame individuals, 'especially when discussing people they knew'. Poverty was described in ways which suggested it led directly to stress and depression. A lack of play spaces was perceived to contribute to obesity. A lack of self-belief (and the narratives people come to have about themselves) was linked to unemployment. Poor living conditions were linked by some parents to childhood deaths. Families and friends who provided care, love, respect and acceptance were described by children in ways which suggested they offered some protection against negative impacts on their health and wellbeing, while familial and personal challenges (e.g. bullying, divorce and learning difficulties) cut across structurally based differences. 'They [children] all said that having a good parent involved: being cared for and looked after; being given the opportunity to make choices and enter in to dialogue; and being listened to. For them, a bad parent was one who smacked, shouted, and ignored or</p>
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		<p>neglected children.' Similarly, adult accounts also emphasised that health, health behaviours and illness were mediated through social attitudes and psychological wellbeing.</p>
<p>(Airey 2003)</p>	<p>The primary focus of this paper is on exploring the ways in which the subjective experience of place might influence individual “well-being”, as distinct from “health” (in the sense of physical health).</p>	<p>Almost all of the respondents defined health in both physical and mental/emotional terms (and seemed to understand well-being as a dimension of health that is distinct from physical health). Nine of the 12 respondents stated that they thought that where one lives can influence wellbeing (the three respondents who stated that they did not think that there was a relationship between area of residence and health made numerous indirect comments which suggested that living in [area where research was undertaken] does in fact have a bearing upon their sense of wellbeing) but they were less clear about the links between place and physical health. 'Indeed, respondents with chronic health problems explicitly resisted the notion that where they live might have had any influence upon the development of their health problems. Instead, these respondents tended to draw on other explanatory discourses, such as lifestyle factors and life events, else claim that they were unable to account for why they had particular health problems'. Analysis focuses on concept of neighbourhood 'incivilities', defined as: 'certain visible neighbourhood conditions such as dilapidated buildings, litter and vandalism, and such things as noisy neighbours, unruly youths hanging about, and drunks on the street (collectively termed incivilities) can come to signal to outsiders and residents alike that the neighbourhood is in decline.' Incivilities are presented as impacting wellbeing via psycho-social pathways, e.g. fear and stress. Some participants talked about more positive experiences of 'how things were in the past' and suggested an influx of undesirable residents had contributed to decline of area (evidence of racialisation and racism at play in at least one account presented, though this is not commented on by author). 'Roughly half of the respondents directly expressed an awareness that [the research area] has something of a negative, stigmatised reputation within Edinburgh' and participant accounts suggested this had impacted on residents, via psychosocial pathways (e.g. stress and shame) and discrimination (which informed</p>

		<p>anger). In response, several participants were keen to defend the area as a 'good' area.</p>
<p>(Birmingham and Thrush 2003)</p>	<p>To examine how people living in disadvantaged communities experience, and talk about, inequalities in environmental inequality, 'both in terms of the disproportionate exposure of poor people to environmental 'bads' (such as pollution) and their lack of access to sufficient environmental 'goods' (such as fuel)'. NB This study includes Possilpark in Glasgow but also an area in Wales and London, England.</p>	<p>Participants highlighted problems of poor housing, cold and damp, which 'was often associated with respiratory conditions, particularly in children.' (p525) Relating to this, participants discussed issues of fuel poverty as being problematic, particularly in winter (where only one area of homes could be heated, this also impacted space available to live in). Residents of flats in Possilpark and Bromley-by-Bow also raised fears about their safety at home, drawing attention to issues of personal security, dirt and disease'. In Possilpark, this included rat infestations. 'Many of the interviewees had experienced break-ins or felt threatened by people hanging about in communal areas'. 'For those living in old tenements in Possilpark the ease with which drug takers could get into communal areas was a particular concern'. There was a lack of confidence in the public services that should have been protecting participants against some of these risk factors, from accusations that councils and housing associations failed to maintain housing stock to claims that police turned a blind eye to reports of crime and anti-social behaviour in some poorer neighbourhoods. 'Participants characterised themselves as engaged in a constant battle to get the police and the council to do their job, recounting many occasions on which they had phoned one or the other about specific problems, to be met with what they considered an inadequate response.' 'Local authorities were seen as primarily responsible for remedying problems. Although some felt they did their best, much criticism emerged: they fail to understand "how difficult it is" (Bromley-by-Bow, lone mothers); they are uncaring and uninterested ("they don't give a toss for us"; Cefn Mawr, unemployed men); they pass the buck ("they say it's not their responsibility so you get a phone number and then another phone number and they just pass the buck"; Possilpark, parents); they delay repair and improvements; do not deal with individuals responsible for mess and litter; and spend public money on the wrong things. Failure to remedy problems quickly led to further deterioration'. Powerlessness and experiences of stigma emerge as key psychosocial pathways linking these</p>

		<p>experiences to stress and poor health. Dog mess, litter, vandalism and blocked drains were all identified as environmental problems with implications for health and safety, especially for children. Participants in all of the localities expressed pride in their area and seemed concerned and angered by negative images of the place they regarded as home. 'Participants were concerned and angered by negative images of the place they regarded as home' 'Possilpark, participants were troubled by the press 'hype' about the area's status as 'the smack capital of Europe'. "This highlights the need to think very carefully about the manner of presenting any link between disadvantaged people and poor environments. Many of the interviewees would not see themselves or their environment as unequivocally poor and would resent such an assumption.'</p>
<p>(Bancroft et al. 2003)</p>	<p>The study from which this paper emanated aimed to develop a holistic, in-depth understanding of smoking behaviour in the context of disadvantage. This paper focuses on the day to day stresses associated with living in disadvantaged circumstances and explores the role of gender within this.</p>	<p>Smokers who reported encountering restrictions on smoking (e.g. at work) described cramming smoking in around these restrictions. Impressions of area deprivation and the stresses it placed on residents' lives were reflected in the way respondents talked about their neighbourhoods. Fear of crime strongly evident in illustrative extracts. Cigarettes assume different meanings to smokers at different times of the day. Respondents emphasised the lack of alternatives to smoking, in phrases like "smoking is my only pleasure". The specific uses which respondents attributed to cigarettes included smoking as a reward for tasks accomplished ('F50 (a single woman retired on medical grounds) described some cigarettes as "the wee treat with the cup of tea".'), smoking to deal with stress, and smoking to counteract boredom. Some respondents framed smoking as an addiction ('M45, compared this dependency to illicit drug use, "we're just junkies, we need nicotine".') Others described smoking going up when bored. "The respondents in our study clearly indicated that in their lives there was a lack of substitutes for the habitual properties of smoking. Smoking helped them deal with circumstances in which high stress and boredom were ever-present facts of life. Services for disadvantaged smokers will have to address the habitual as well as the addictive properties of smoking.'</p>

(Copeland 2004)	To explore the sense of self of a group of hepatitis C positive injecting drug users in order to set in context their knowledge and feelings about being hepatitis C antibody positive.	12 of the 16 participants reported having experienced traumatic childhoods (violent fathers commonly featured). An 'exploration of interviewees' early years also served to illustrate that part of their current identity was created through childhood trauma, which gave feelings of low self-esteem that were evident in many narratives and conclusive with other research into the impact of physical, emotional and sexual abuse of children' which 'manifested itself by interviewees' perceptions of themselves as being worthless and useless'. Interviewees described struggling with relationships and feeling socially isolated. Several interviewee accounts lacked a clear sense of the future. Peers (friends & family) commonly cited as a reasons for interviewees starting to use drugs. Attempts to escape bad memories and problems recognised as a reason for starting drug use by some interviewees. Boredom was also mentioned as a reason for experimenting with drugs. Interviewees commonly had low educational attainment and also described having had negative experiences at school. A lack of meaningful employment (informed by low educational attainment) contributed to some interviewees engaging in criminal activity (several had experienced periods in prison). Some interviewees had low awareness of Hepatitis C transmission risks (e.g. around blood contact, toothbrush sharing, needle sharing). There was general sense that little could be done about Hepatitis C and that it was not as pressing as other issues in their lives. Paper argues interviewees had acquired (and disliked) identities as 'problem drug users' and there was a sense this was a negative identity that 'set them apart from the rest of society'. 'A strong sense of regret was evident in all of the narratives given.' 'They viewed themselves as people who had no work role, had poor health, low expectations and low self-esteem, and all had an underlying sense of hopelessness.' 'Throughout the narratives, it was common for participants to say that they did not value their lives. It was also evident that they related the difficulties of their current lifestyles to their history of drug misuse. They regarded themselves as marginalized and even their role as 'sick people' was not the same as that afforded to those who became ill in mainstream society; for example, there was a degree of
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		<p>stigma attached to being hepatitis C antibody positive.' 'Realistically, there was little or no opportunity to escape the negative effects of years of social and economic deprivation. For most, holding down paid employment was not a viable prospect due to lack of qualifications, little or no work experience, a criminal record and poor health.' Participants 'were still [...] very much a part of the local drug-using culture.' All of the participants had made several attempts to detoxify but a common pattern of service referral disengagement, followed by being discharged, was described. Author suggests a wider range of more flexible support services (including mental health and counselling) are likely to be required and that more research on psychological dimensions of drug users lives is required.</p>
<p>(Scanlon et al. 2006)</p>	<p>To explore explanatory models (lay beliefs) used by Irish and white British people to understand their cancer-related beliefs and behaviours, focusing on how cancer beliefs are shaped by culture, gender, socio-economic circumstances and generational status.</p>	<p>Few reported having received information about cancer from their GP or from leaflets. 'Many of the beliefs and experiences surrounding cancer were common to both the Irish and white British participants'. 'Knowledge and beliefs about cancer were constructed around narratives (using anecdotes) from either own or familial experience of cancer or, for those with no direct experience of cancer, from popular narratives in the media. Among both groups there was confusion about causation, poor knowledge of signs and symptoms, and a general pessimism about cancer prevention and treatments. 'Poorer knowledge of signs and symptoms appeared to be associated with socio-economic disadvantage, regardless of age and ethnicity, but first generation older Irish appeared to have poorest cancer knowledge.' The narratives of the Irish participants were 'qualitatively different from those of the white British'. Historical, cultural, social and economic circumstances, both in the UK and in the past in Ireland, appeared to influence views of cancer and health-seeking behaviours. 'Irish participants portrayed cancer using more pessimistic language and imagery, such as 'a demon', 'a terrible curse', 'a scourge', 'a scab' and 'being riddled with it'.' 'Many of the older Irish participants suggested that any illness (including cancer) was a sign of 'weakness' and believed to bring 'shame' and 'stigma' on the family. Accordingly it was commonplace for families to try to keep cancer 'hidden' or 'secret' and not to talk about</p>

		<p>cancer within the family unit so as ‘not to burden the family’. Recollections of negative family experiences of cancers linked to ‘stigma’ and ‘secrecy’, poor outcomes and medical practices in rural Ireland, particularly among the older Irish, influenced Irish understanding of cancers and help-seeking behaviours. The second generation also appeared to retain some beliefs that were common amongst the first-generation migrants. ‘Fear of cancers was considered by all participants to be the main barrier to early detection and prevention’. The ‘Irish narratives (irrespective of gender, age, generation or socioeconomic circumstances) suggested that Irish men were even more reluctant to talk about cancer, or indeed any other health or emotional problem. They attributed this to an Irish ‘macho’ or ‘hard man’ culture where illness was considered a weakness.’ Experiences of surviving tough industries was linked to this. ‘Although both groups identified poverty and socio-economic inequalities as possible explanations for the poorer health of disadvantaged people in Britain, the Irish participants appeared to place greater emphasis on these factors. More particularly, Irish participants tended to think that the high cancer incidence amongst the older first-generation Irish population in Britain was linked to lifelong socio-economic disadvantage, beginning before migration in poor rural Ireland and continuing in Britain. This view was expressed by both male and female participants, across all generations and socio-economic circumstances.’ ‘Some Irish narratives suggested that in order to cope with working in Britain between the 1950s and 1970s, Irish men had adopted unhealthy lifestyles that included heavy alcohol and tobacco consumption, and lived in low-quality rented housing. The social networks of Irish men were often centred in the pub, and drinking alcohol was one way to ‘feel like you belonged’, and also ‘cope with missing Ireland and working in Britain.’ ‘Disadvantaged men from both groups reported delaying seeking advice from health professionals citing fear of a cancer diagnosis, having other priorities, waiting to see if the problem would go away and having poor access to health care services.’ Long waiting times to see a GP and rushed appointments were frequently mentioned as a problem.’</p>
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		<p>'Some Irish participants also suggested that many of the older (first generation) Irish people were still influenced by childhood experiences of help-seeking behaviours in Ireland, where people delayed seeking medical care because of the financial implications.'</p>
<p>(Davidson, Kitzinger, and Hunt 2006; Davidson, Mitchell, and Hunt 2008)</p>	<p>The aim of the 2006 paper is stated as to explore 'how people see inequality, how they theorise its impact on health, and the extent to which they make personal and social comparisons'. The stated Research Questions in the 2006 paper are: 1. Do people accept that health inequalities are associated with socio-economic status? 2. How do they explain this association? 3. Do they consider relative socio-economic status to be important, and do they compare themselves to, or feel judged by, others? The aim of the 2008 paper is stated as to examine 'how people see and express their experience of inequalities through place and how they understand the impact of place on health'.</p>	<p>Among all the lower socio-economic groups in the research, 'there was widespread acceptance of the idea that sharp inequalities exist within contemporary society.' Indeed, in the 2007 paper, there are extracts in which participants suggest the information they have been presented with (about Glasgow taking five years off people's life expectancy) is inaccurate and that the impact is actually far bigger than this. In contrast to earlier studies, this study contrasted with earlier research in that it found people in more deprived circumstances openly acknowledged the impact of inequalities on their health and wellbeing. Moreover, higher socioeconomic groups were found to be more resistant to the idea that health inequalities were linked to socioeconomic inequalities (though some generational differences in beliefs were observed). Participants' accounts suggest that the interactions between socioeconomic circumstances and health are complex, dynamic and involve multiple factors. 'As people talked about living in particular places, a strong sense of social and physical distance and alienation between areas was apparent.' 'Research participants from lower socio-economic groups also talked eloquently about feeling that their communities were unheard and ignored.' Some participants 'described feeling victimised by an obstructive or uncaring government at both national and local level'. Some participants suggested the stigma/poor reputation of areas had 'sticking' power and a 'domino effect'. People talked about how social cohesion and community reciprocity had been stronger when mining was a large employer but that communities had subsequently broken down. 'A language of division permeated all groups in the study with research participants talking in 'us' and 'them' terms about different 'classes' of people.' 'There was also a widespread consciousness across all the groups about how they were placed in social hierarchies and how they might be seen by others.' There was some discussion of how media coverage of areas (including</p>

	<p>poor health of areas) contributed to stigma of area but may also stimulate social resistance/change. People discussed the impact of areas on people in ways which suggested deprivation and place and poverty related stresses physically (and visibly) aged people. Some participants suggested health issues were cumulative so that, over time, what might be a relatively small chronic health problem to someone living in an affluent area, would have a much more negative impact on someone already experiencing a lot of stress and negative health impacts in a more deprived area. Mental stress was identified by participants as key mediator linking socioeconomic circumstances and health outcomes (while richer people were perceived not to experience all of the same stressors and also to be able to relax via holidays, going to the gym, etc). Psychosocial factors perceived to impact directly on mental health including fear (e.g. of gangs, crime, antisocial behaviour), stress, shame, stigma, guilt (especially around not being able to provide for children), anger, frustration, rejection, injustice, alienation, fearful, anxious, stressed, sleepless, not being listened to/respected, sense of self-worth. Poor neighbourhoods were perceived to suffer from relatively more anti-social behaviour which increased stress and fear. The participants from more deprived communities described feeling unsupported (e.g. by government and social services) and those who need to access welfare benefits but they described feeling like they had to continually fight to access sufficient benefits to get by (causing stress, fear and a belief that public services would value them less, and therefore treat them less well, than other people). Poor housing was perceived to have direct consequences for mental health and high rise flats were highlighted as particularly problematic. Related to this, the effort required to get access to sufficient housing and the poor conditions were described as combining to take years of one participant's life. Poor housing was also perceived to lead to shame and stigma and also to contribute to arguments within the household and limit the space available for children to undertake homework. People discussed unhealthy lifestyle behaviours (smoking, 'pills' and sweets and cakes) as a response to the stresses of life in deprived</p>
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		<p>areas – things that helped people to keep going with life. Poverty and unemployment were perceived to contribute to some unhealthy lifestyles, such as poor diet, which were in turn perceived to impact on chronic conditions and obesity. A sense of hopelessness was described as contributing to alcohol and drug use and gambling. Marketing of unhealthy lifestyle behaviours/products and of unaffordable lifestyles (or consumerism in general) were described in ways that suggested they ‘amplify’ the negative effects of socioeconomic deprivation and play an important role in low self-esteem. The sympathy of people in the more affluent areas to those living in more deprived areas, and explanations of health inequalities, varied by experience (those who had experience of living or working in more deprived areas tended to give more sympathetic accounts while those who did not, tended to give more detached, judgmental accounts). 2006 study notes: "The potential stigma of talking about inequalities was certainly evident in the groups. Research participants engaged in careful linguistic ‘work’ in order to manage the implications of the discussion for their own identities."</p>
<p>(Watson and Douglas 2012)</p>	<p>To explore how young people attending a youth project based in a deprived inner-city neighbourhood in Scotland identified and understood neighbourhood impacts on their mental well-being. "The study also explored young participants’ ideas about changes they believed could and should be made to ameliorate the problems they identified."</p>	<p>Youth project seemed to be effective partly because it provided something to do and partly because it made participants feel 'at home' and 'special'. Participants also indicated support for interventions that would demonstrate visible investment in the area, contribute to social capital, reassure (e.g. higher police presence), improve communication and respect (e.g. from council). The interviews and photos demonstrate the directly negative impact on sense of wellbeing and mental health that neglected environments can have on young people, contributing to them feeling uncared for, anxious, hopeless, ashamed and disgusting: "Terms such as ‘minging’, ‘minky’ and ‘disgusting’ were used to describe the aesthetics of the Area and how this made them feel. For example, one young person identified a lack of investment in the Area as making them look poor and boring, while graffiti was described as making them feel depressed". A sense that investment was uneven (and that other areas were invested in) contributed to a sense of unfairness. The authors note that participants 'seemed sensitive about their social status, and believed</p>

		<p>themselves low down the ‘pecking order’ within the city. There was obvious sense throughout the interviews of participants not wanting to appear poor to others’. Throughout the interviews, participants demonstrated that they were politically aware, i.e. about who was making decisions about the distribution of resources within the city’. Participants’ frustration at the neglect of some areas was often directed at the government and local decision-makers and public services who were often seen not to be doing anything to improve the situation, e.g.: ‘We’ve all been ignored all the time by the police and the government’. Participants talked about financial worries in negative terms and in ways that suggested financial difficulties ‘caused them considerable anxiety’. The authors note that ‘fear’ was a common theme across interviews and was associated with specific individuals (e.g. loan sharks), particular behaviours (e.g. drug and alcohol addictions), specific places that were considered unsafe and aggressive. The youth project that the participants all attended seemed to be of central importance to the participants, ‘providing the time and space to develop their social and personal skills, and, somewhere where they can feel safe, relaxed and independent’.</p>
<p>(Garnham 2015; Garnham 2017)</p>	<p>2015 paper describes study aims as being to describe ‘participants’ lived experiences of deindustrialisation and analyses those experiences in terms of the (economic, social, symbolic and political) resources enhanced, diminished and put to use in strategies of action throughout that process of change, with a focus on the relevance of such processes for health.’ And later to ‘shed light on the lived experience of this period and the extent to which the town’s inhabitants were able to employ and develop their cultural toolkits to generate new and effective strategies of action in response to such rapid socio-political change,</p>	<p>Large-scale industrial employment in the area in 1950s-1970s provided people with collective employment which in turn provided people with a sense of purpose, collective pride and social cohesion. The loss of large scale employers in Clydebank has contributed to high rates of unemployment, a sense of limited opportunities for employment, low self-esteem, lack of individual purpose, lack of investment in the local area, declining pride in, and increased stigma associated with, the area, limited/poor quality public services and housing, sense of not being cared for / injustice, increased anti-social behaviour and crime, increased fear of anti-social behaviour and crime, and guilt relating to the lack of opportunities for children. The combination of the ‘right to buy’ policy with an under-investment in housing led to poor housing conditions which participants describe impacting on their health and wellbeing directly (e.g. dampness contributing to eczema) and indirectly (in terms of how people felt about their living situation).</p>

	<p>with a focus on those of most relevance to health." The 2017 paper states its aim as: 'to explore some of the processes through which successive waves and incarnations of neoliberal policy have been implicated in the lived experiences of the inhabitants of a formerly industrial part of west central Scotland.'</p>	<p>The level of poverty described is extreme, e.g. with one participant describing sleeping on the floor until she found a bed in a skip and trying to sterilise bottles for her baby in an ice-cream tub.</p> <p>Other social determinants of health mentioned include: overcrowding (earlier cohorts), unemployment (variable for earlier cohorts - consistent for youngest), poverty, poor housing (for oldest and youngest cohorts), lack of facilities including for children (middle and younger cohorts), political disempowerment and lack of community engagement (younger cohort). The increases in anti-social behaviour participants described was linked to a perception that people with issues (e.g. addiction) had been collectively re-housed into the same areas. This contributed to what the author calls 'social anomie'.</p> <p>Participants described experiencing/witnessing extreme violence and being fearful of crime and violence. The increased conditionality of welfare payments, along with sanctions and austerity-justified restrictions, is contributing to increased fear and stress around interactions with unemployment services (job centres, etc). The author argues the findings demonstrate a decades long 'process of [political] disempowerment, which saw the inhabitants of many deprived areas such as Clydebanks begin to disengage from political participation from the 1980s onwards, but which became significantly more deeply embedded from the mid-1990s onwards'. This was linked by participants to Conservative government policies under Thatcher and the Labour Party's subsequent adoption of more neo-liberal policies, which 'meant that the election of Blair's government in 1997 did not herald a return to left-of-centre governance' and rather 'removed any genuine choice that voters had in terms of whether or not neoliberal policy should be implemented at a national level.' Politicians (especially those based in London) perceived not to care and there is clear anger towards politicians. While earlier generations benefitted from resources (both financial and in terms of local leadership and community support) that they could use to protect themselves against the impacts of large-scale industrial closures, more recent generations did not have these resources (given long-term unemployment and neoliberal</p>
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		<p>policy decisions). New Labour's approach to increasing the conditionality of welfare contributed to participant accounts of stress, anxiety and fear around engaging with the JobCentre and benefits system. The results of the 2017 paper are similar in terms but there is a clearer emphasis on the importance of analysing the cumulative impacts of policies and of considering generational impacts, with the author arguing that three distinct cohorts of participants are evident in the data: the first born around 1930, the second born around 1955 and the third born around 1980. While the earlier cohorts had some positive experiences and means of resilience to challenges and, linked to this, some positive associations with the area, for the youngest cohort, 'their view of their hometown was almost entirely negative'.</p>
<p>(Egan et al. 2015)</p>	<p>To 'explore in-depth, the experiences of residents during a period of clearance, demolition and relocation to new or improved properties in order to identify mechanisms by which neighbourhood demolition involving largescale resident clearance and relocation may differentially impact up on health and wellbeing.'</p>	<p>Participants gave wide ranging explanations for health problems, including early life disadvantage, genetic factors, behaviours and different types of environmental exposures. However, many also made clear that they felt health problems had been caused or, more typically, exacerbated by current problems with their homes and neighbourhoods. Key factors identified as impacting on health were: Damp (linked to asthma, skin conditions and other illnesses), cold houses (linked to the high cost of pay-as-you-go energy) linked to difficulties in managing existing illnesses, inadequately sized homes (linked to mental health problems and a range of other factors impacting mental health including noise challenges, family arguments and a lack of a sense of privacy and control). Damp also reduced space as participants described some rooms as not be useable due to damp. Shame and embarrassment (of poor housing/neighbourhood) was linked to social isolation and mental health problems, not feeling safe was also highlighted as a problem in homes and, more commonly, the local neighbourhood, which increased social isolation and reduced opportunities for physical exercise (including for children) and increased participants' sense that they/their children could come to harm (e.g. from anti-social behaviour, racism - among participants who were asylum seekers and refugees, violence, alcohol, drugs, discarded needles, smoking, urine). Participants talked about the positive role of local social networks</p>

		<p>and worried that relocation might disrupt these. The findings on relocation were mixed, with some positive experiences and other accounts of no change or negative impacts, leading the authors to conclude: 'Disadvantaged residents often have illnesses that are not primarily caused by their current residential environment and it can be unrealistic to expect modifications in that environment to influence those health problems substantially. [...] When evaluating the effects of complex social interventions, researchers need to consider the likelihood of wide-ranging and unpredictable impacts.' They also argue that 'Relocation may be more effective if treated as a critical moment by specialist health agencies to ensure that chronically ill residents' therapeutic regimes are enhanced rather than disrupted, and that positive feelings associated with the move are built upon to encourage health enhancing lifestyle and behavioural changes.'</p>
<p>(De Andrade 2016)</p>	<p>To: (i) gather specific BME groups' perceptions of a number of pre-identified and emerging health related issues (including tobacco and shisha use; smoking cessation; acceptability of services; alcohol consumption; and addiction), and (ii) to explore how an asset-based approach and co-production could be used to engage with minority ethnic groups.</p>	<p>Different communities have different needs when it comes to disseminating health information. For example, some Polish participants talked about the importance of word of mouth for disseminating health information (given variability around ability to read English) but others felt this would not work. In contrast, 'Some Pakistani community members said they trust only in good friends and God, but not family'. There was a fear of embarrassment through gossip. There were some sense that asset-based approaches were not always being implemented in the kind of participatory manner that might be expected, given the ethos - a sense that there need to be more organisational level training. Individuals from minority ethnic groups may not engage in community organisations/spaces, where they are perceived to be 'white spaces'. On asset-based approaches: 'The position that policymakers are using these approaches as rhetorical devices and practitioners failing to apply them 'properly' was prominent.' Lack of trust is identified as a key barrier to meaningful engagement. The research also identifies concerns that research on minority ethnic communities can do more harm than good, contributing to 'fixing' and potentially stigmatising /pathologising some groups.</p>

(Mackenzie et al. 2017)	To explore understandings of the causes of (ill)health in local communities in two deindustrialised areas in Scotland.	<p>Participants ‘typically had highly integrated explanations of health, including vivid articulation of links between politics, policies, deindustrialisation, damage to community fabric and impacts on health’. ‘For both periods of austerity, in both places and reported by younger and older participants, material circumstances were described as having direct health effects.’ The findings highlight how cold/energy poverty reduces the space available in which to live. Participants recalled the ‘good times’ when there were plenty of employment opportunities so even if jobs were hard, people had choice and also pride in their work. The manual labour common in these times was described in ways which suggested it was both health giving (especially in terms of meaning and pride it gave people) and have negative impacts (e.g. impact of heavy lifting on physical health). The 1980s were identified as a difficult period, with rising poverty (in the context of increased unemployment). ‘More recently, food banks and unaffordable heating were common signifiers of health compromising poverty.’ ‘Neoliberal political attack’ was rendered almost viscerally in some accounts and there is a very clear sense of political attack in several interview extracts, contributing to a sense of injustice, unfairness and anger. There is also a clear sense of inequalities impacting on people’s self-esteem. There is a consistent sense through interview extracts that employment issues are connected to government policies and that governments serve ‘powerful elites’. Psychosocial pathways feature strongly, including references to people feeling ‘absolutely worthless’, ‘really depressed’, with self-esteem being described as ‘hard to sustain’. The sense that community has been lost in policy transitions is also strong, as is a sense that the closure of large employers impacts negatively on morale across neighbourhoods. The paper also evidences widespread awareness of the negative impact of smoking, drinking, etc. There were some more individualising and blame orientated discourses, especially around parenting. However, these accounts were also situated in accounts of the negative impacts of government policy, e.g. “The poor are only poor because the government have made them poor.” Meaningful employment was described in ways that</p>
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		<p>suggest it protects against some negative health behaviours, while sudden large-scale unemployment was linked to problematic behaviours. Some participants also commented on the tendency to 'other' and 'blame', noting the role of the media in encouraging these kinds of discourses (e.g. Jeremy Kyle show) which was believed by some to be a deliberate means of dividing people.</p>
<p>(Lorimer et al. 2018)</p>	<p>To explore constructions of masculinity in relation to sexual health and wellbeing (taking an SDH approach).</p>	<p>Sense that small-scale interventions are likely to be insufficient, e.g.: 'people just don't realise what it's like to live and kind o' grow up in some o' these places and I think that they're kind o' ignorant when they think that they can just change a couple o' things and it'll make everything awright (Thomas, age 32, Glasgow, Int5)'. 'The language many men and women used to describe their areas was, at times, stark ('hellhole', 'shithole', 'rough') [...] People, and more often women, invoked strong emotional responses when recalling the youth violence in these areas (e.g., feeling 'petrified'), although many offered accounts of change, such as reductions in gang violence or drug misuse problems, in their areas.' '[W]e were struck by the shadow cast by poverty, drugs and violence, which appeared never to be far from the doorsteps of almost all participants, and for many it was an intrinsic part of negotiating everyday life. Hence, the stresses and strain of residing in some challenging environments varied across accounts but appeared present in some form.' Alcohol use was linked to poverty and desperation (including hunger). Belief that cultural investments in their area were not for people like them. Participant accounts interwove class, masculinity and politics (including xenophobic politics). 'Two particular types of violence narratives emerged across our data: youth violence and domestic abuse'. Emphasises that peer networks are not always positive when talking about masculinity practices relating to social approval, etc.: 'The 'doing' of gender was protective, chivalrous and potentially violent'. 'we discerned the living of almost separate lives by women and men across these communities, impacting on how the sexes understood, and communicated with, each other'. 'Across interviews and focus groups, it was clear that men's and women's biographies commonly conveyed gender practices rooted in a domestically violent milieu. We heard men talk about</p>

		<p>domestic abuse as a common feature of their communities, or personally witnessing domestic abuse,' 'far more men rejected the practice of violence towards a woman. Despite this, it remains prevalent.' 'We were struck by the level of blame attributed to women for incidents of sexual violence, which regardless of the extent of their discussions, with caveats and considerations, seemed always to lead to some level of blame upon women; although, some of the most aggressive views towards women emerged in relation to women who were deemed to have transgressed gender norms for 'appropriate' femininity in relation to sexuality and sex'. 'The blaming of women for incidents of sexual violence was salient in the data'. Women tended not to trust men or view them positively. Of the 16 women interviewed, 13 said they had witnessed and/or been subject to personal experiences of domestic abuse. Historical personal histories and childhood trauma seemed key. 'Littered through the childhood stories were substance use issues (alcoholic mother or violent drunken father), violence – particularly domestic abuse – and fragmented relationships.'</p>
<p>(Kapilashrami and Marsden 2018)</p>	<p>To: 'illustrate the value for health inequalities research in employing an intersectionality lens to research design and analysis, operationalised through a participatory action paradigm to reach marginalised populations. Specific questions answered in corresponding sections of this paper are: What resources do participants find health enabling? What, if any, are the differences in access to health enabling resources for people occupying different social locations?'</p>	<p>There was considerable agreement across groups and communities as to what healthful living (in general) means, entailing 'a combination of material, environmental, socio-cultural and affective resources including: a sense of belonging and of purpose, feeling valued, self-esteem, safe/secure housing, reliable income, and access to responsive and sensitive health care when needed. [...] The conditions/aspects of their living environment that affected their access to and ability to translate these resources into improved health also appeared to vary with social location.' 'All groups indicated that healthcare services of one sort or another were beneficial to their health. [...] While all participants identified services as serving an important function to maintain good health, only the older BAME group identified 'health information' as an important resource along with services.' 'All but two groups of participants identified specific public/community resources – libraries, places of worship (local church, mosque and temple) and a community centre. 'Physical exercise and urban spaces that facilitate this were cited by all groups,</p>

	<p>though the way they benefited from this varied considerably. 'Public amenities such as the roads and transport services emerged as a resource appreciated across all groups.' 'Food and good diet was identified in various ways.' 'Most groups mentioned the importance of good housing where they felt safe, well and warm.' 'Income was explicitly identified as essential to take advantage of many resources, including social and affective resources (e.g. by the Craft group of elderly women).' 'All groups identified some form of social resource as health enabling. A variety of social spaces were noted, either where social activities were organised (e.g. weekly social drop-in for men, craft activity groups, bowling, sports, yoga etc) or where they could meet friends (e.g. cafés, parks or group outings to the beach). Generally, having something to do, including social outings was valued for the social connection it enabled. 'Whilst social networks of place were generally found to be good for health this was not always so for those struggling with addiction. 'The opportunity to volunteer and to give 'back' to the community was viewed as an important social resource across all groups.' 'Trust of workers delivering services [...] was identified as a key resource enabling use of those services, through for instance, longer term relationships with individual workers reducing the fear of being refused help or losing support they have come to rely on. 'A sense of belonging either to place or group was expressed as a resource' though different groups valued different aspects (e.g. history, reputation, diversity, resources such as shops). 'Although often the same resources are identified by the groups as health enabling, significant differences were observed in the richness of resource maps generated of the area and what mix of resources people at different social locations access to achieve healthful living. These differences were most notable along race/ ethnicity, gender, poverty and age lines. 'Digital exclusion was cited as an issue for those seeking housing. The difficulties of accessing safety net support were widely discussed and linked to a sense of fear and dread. 'The most notable dis-affective resource was the stress of not having a reliable income and the constant grind of having to watch every penny,' though a range of</p>
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		<p>environmental factors also mentioned. The accessibility of alcohol (e.g. via pubs) was also identified as problematic and impacted people’s sense of safety (an issue that seemed more common for women, younger and ethnic minority participants. Intersectionality key: 'Results are telling of how differential aspects of their social location and living environment (e.g. poor living conditions and chaotic lifestyles) impinge on their capacities and agencies to translate availability of resources into healthy practices. Here, contrary to the dominant understandings of inequalities, differences were not patterned along socio-economic position or ethnicity or gender. Instead, what emerged was how multiple disadvantages interacted to limit knowledge of HER in the area and affected individuals’ capacity to benefit from these. For instance, intersections of gender, ethnicity and age along with poverty, longstanding health conditions (including mental health) shaped older women’s agency to access green spaces and other community provisions for physical activity.'</p>
<p>(Garnham 2018)</p>	<p>'To explore residents’ and community workers’ perspectives on the past, present and future of these four parts of the city of Glasgow, in order to meet three objectives: 1 To improve our understanding of the less easily measured aspects of the processes of change that have taken place within the four study areas and the influence that these processes have had on residents’ quality of life, health and wellbeing. 2 To support positive future trajectories in these four parts of the city, by working with residents and local organisations on developing their plans, hopes and expectations for the future. 3 To provide insights for future research into how to work co-productively with residents and community organisations in public health</p>	<p>The primary issues that residents identified as negatively affecting their quality of life were poverty, poor quality work and unemployment. These issues were described as being underpinned by a lack of access to qualifications that could secure well-paid, meaningful work, both for adults and young people, a lack of affordable, reliable care services, a high prevalence of physical and mental health problems, and challenging welfare reforms. NB "Participants saw many of the root causes of poverty and inequality as originating outside of the neighbourhood, driven by processes and decisions made at the international, national and regional levels. As such, they understood planned neighbourhood regeneration as a potential contributor to improving their ability to negotiate a difficult economic environment, but not as a primary means to improve the economic environment itself."</p>

	research, emerging issues that influence quality of life and health in these four parts of Glasgow, as well as across the city as a whole.	
(Bramley et al. 2019b)	Qualitative part of study aims to: (1) illuminate the routes into severe and multiple disadvantage experienced by people in contemporary Scotland, and in particular any 'missed' opportunities for preventative or early interventions; and (2) explore interviewees' interaction with relevant services, to identify opportunities for systems improvement and change.	Good services characterised by interlinked features: The provision of emotional as well as practical help, 'personalised' support tailored to the specific individual, and a focus on positive goals/something to live for. Prison (and pre and post release support from CJSW there) framed by some as respite from living on street. Substance abuse support useful where personalised. Concerns about waiting lists for housing, residential rehabilitation services, and lack of mental health support before crisis points (e.g. extreme self-harm). Negative perceptions of child protection social work. Difficulties with faceless/impersonal benefits system. Findings presented as narratives of how disadvantage intersects, including: difficult early lives (violence, unstable homes); disrupted schooling; early substance dependence after trauma; poor mental health and sometimes also poor physical health; unstable housing; worklessness; relationship issues including violence; disrupted relationships with own children (if parents). "Asked about missed opportunities for earlier interventions that could have helped them avoid [severe and multiple deprivation] as adults, some service users could not identify any such opportunities, or emphasised their own agency and that of other people in a similar position"
(Inglis et al. 2019)	To explore how individuals with experience of living on a low-income in Scotland perceive and experience various forms of poverty stigma, with a view to understand how these experiences may affect health.	Five main themes were identified, reflecting aspects of poverty stigma operating at various structural, public and individual levels: media representations of poverty; negative encounters with social security systems; perceived public attitudes regarding poverty in Scotland; lowered self-esteem and internalisation of negative attitudes, and; emotional responses to stigma.' 'Poverty-based stigma represents a range of psychosocial pathways through which [socio-economic position] may affect health and therefore contribute to health inequalities'. 'Participants viewed public stigma as stemming from both media representations of poverty and from a lack of public understanding about the causes of poverty.' Participants considered stereotyping TV programmes to be highly influential in shaping public

		<p>attitudes toward people experiencing poverty, especially benefit claimants. 'Participants' experiences of claiming benefits and interacting with social security systems in the UK were often described as being degrading, punitive, and generally unsupportive. Participants described encountering stigma through the behaviour and attitudes of JobCentre staff, for example. A recurring theme was that there is a lack of support available to claimants and a lack of guidance and information available to individuals concerning the benefits that they are eligible to claim. Participants said they felt out-of-work benefits claimants are expected to meet conditions that are unfair or unrealistic, which nevertheless carry a harsh penalty when not met, such as claimants' benefits being temporarily revoked. 'A common theme throughout these discussions was the view that individuals living in poverty are often blamed by others for their situation, where poverty is attributed to laziness or some other personal failing. Such explanations that frame poverty as an issue of personal responsibility were seen to be accepted by members of the public at the expense of alternatives that acknowledge the wider social or structural causes of inequalities.' 'Some participants discussed how public stigma can be place-based, where certain neighbourhoods are associated with negative stereotypes. Joanne for example, explained how others often look down on the area where she lives as being a "dive" and "scummy." These stereotypes are further applied to the individuals who live there'. 'Participants frequently referred to the negative consequences of poverty stigma, and specifically, the effects that stigma can have on individuals' identities and sense of worth, noting that public stigma can become internalised, affecting both individuals' self-esteem and self-efficacy.' Participants' accounts detailed 'a sense of being looked down on by others, which was described as leaving individuals feeling "horrible", "rubbish", and "depressed".' Efforts to avoid shame or embarrassment may cause individuals to avoid accessing certain services (e.g. free bus passes that work in such a way everyone on bus can see you have one).</p>
(McHugh et al. 2019)	To examine shared perspectives on, and relationships between, why	Broadly summarised these accounts for 'Causes' are: i) 'Unfair Society', ii) 'Dependent, workless and lazy', iii)

	<p>health is worse in low-income communities (“Causes”) and the ways that health could be improved in these same communities (“Solutions”) among professional stakeholders and community participants.’</p>	<p>‘Intergenerational hardships’ and for ‘Solutions’: i) ‘Empower communities’, ii) ‘Paternalism’, iii) ‘Redistribution’. ‘Despite the plurality of views there was broad agreement across accounts about issues relating to money.’ ‘However, even among those identifying structural causes... as the main problem, structural solutions... were not recognised. It is unclear why this is the case, but one explanation could be community participants internalising an individual responsibility discourse in the UK of ‘strivers’ and ‘skivers’ with welfare recipients being particularly stigmatised and prejudiced’. ‘There is consensus that unpredictability of finances (#6) and job insecurity (#15) lead to worse health and that welfare benefits should not be cut as a way to improve health (#14). Moreover, the importance of making sure people have enough money for their basic needs (#13) as a way to improve health was important for all accounts. While these findings do not offer prescribed policies they do point to the importance of income security and having enough money for basic needs.’ ‘Professional stakeholders and community participants share accounts that view structural and generational issues as the causes of poorer health in low-income communities, which are associated with upstream solutions based on redistribution and empowerment. However, community participants also focused on more-individualistic causes and paternalistic solutions that were not found among professional stakeholders.’</p>
<p>(McIvor 2019)</p>	<p>To explore how the process of deindustrialisation in the UK impacts on people’s bodies and health via an in-depth examination of the Clydeside area of Glasgow.</p>	<p>‘Loss of work was identified as responsible for low self-esteem, shame, embarrassment and stigmatization. Work was seen as inhibiting illness and its loss as creating vulnerability.’ ‘Heavy industrial work forged masculinity, and a “hard man” style of masculinity was particularly defined in working-class communities like Clydeside in the heyday of industrialisation’ and the loss was experienced as having ‘their life taken away from them’. Not being able to act as ‘breadwinners’ to families impacted on men’s identities and masculinity. All this was linked to ‘going downhill’, alcohol, drug use and domestic violence. There is a sense of hopelessness in the data: ‘Young men were denied opportunities to progress into adulthood.’ The impacts were worse for</p>

		<p>those with existing health issues or disabilities: ‘Certain groups, including older workers and people with injuries, illnesses and disabilities, were particularly vulnerable to the long-term unemployment, work rationalizations, and intensifications generated by deindustrialisation and the adverse effects it had upon health. The recession resulted in a shakeout of workers with disabilities, who found it more difficult thereafter.’ The occupational health risks of hard industries, such as mining, were also emphasised by some participants and so the reduction of employment in these sectors was also described as having some health benefits. Occupational risks are noted as unevenly spread: ‘black and ethnic minority migrant workers were among the most vulnerable to bodily damage and were clustered in the most dangerous and unhealthy downsizing industrial jobs – as with the Irish Catholic community in Glasgow. Catholics dominated the most dangerous work on the docks and on construction sites across Clydeside as well as the highly dangerous work of asbestos insulation – the ‘lagging’ of pipes and boilers across the shipyards, locomotive and others works across the city. Following this pattern, from the 1950s new waves of Pakistani migrants could be found clustered in toxic heavy chemical plants in Glasgow – jobs that were increasingly unpopular with endogenous Scottish workers.’</p> <p>‘Disempowerment led to more workers taking more risks, and to more accidents and longer exposure to chronic occupational disease risks,’ ‘Work intensification and increasing job precarity led to higher levels of stress.’</p> <p>‘Trade unions and community activism, allied with radical medicine and sympathetic politicians, undoubtedly alleviated the threats to health and safety in deindustrialising communities.’</p>
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<p>(Robertson 2020)</p>	<p>To explore people’s individual experiences of living in poverty in Edinburgh, specifically on their experiences of accessing support and navigating services as well as their perceptions and experiences of their local area.</p>	<p>Most participants reported struggling to know where to go for advice or support and felt over-whelmed attempting to navigate the various services and systems in Edinburgh. Negative experiences with statutory services (particularly Jobcentres and organisations contracted to deliver work capability assessments) were common. Some examples were given in relation to negative treatment they had received but the main issue for participants was frustration with the lack of support/advice that had had any real impact on improving their circumstances. For most participants, the advice/support they had received from a local third sector organisation had done more to help them navigate the system in Edinburgh. Perceived problems with services included: 1 Turnover of staff; 2 Lack of information or misinformation provided; 3 JobCentres and DWP assessments confusing and 'fearsome'; 4 Housing market difficult and services/support failing to help. Overall, local communities were framed as depleted by a lack of amenities and services.</p>
<p>(Robertson, Wright, and Stewart 2020)</p>	<p>This report offers a rich account of early experiences with Universal Credit in Glasgow in the months marking full-service roll-out.</p>	<p>Claimants widely reported that the initial waiting period for the first payment was the worst part of moving onto Universal Credit. People were mainly negative about Universal Credit because of resulting financial difficulties. In terms of the uptake of Scottish Choices, most claimants opted for the housing element to be paid directly to their landlord because they thought it would be easier or they feared rent arrears and potential eviction. Only three participants chose to receive their Universal Credit payment twice a month, despite the inadequate monthly amount causing difficulties for many. Some were satisfied with monthly payments although many said that they would prefer to be paid every two or four weeks. Disabled claimants and claimants with a health condition found attendance requirements and job-search expectations unrealistic. Claimants highlighted supportive work coaches and greater leniency in conditionality than anticipated as helpful, although most did not view Jobcentre Plus as a supportive organisation. Participants agreed that the lack of human contact as a result of the digital system was unhelpful and said that they would like to have the option to speak to</p>

		<p>someone face to face. They shared their experiences of struggling to manage financially between monthly Universal Credit payments and their preference for receiving more frequent payments. They reflected on the lack of recognition of mental health as an illness under Universal Credit and felt that more advice and support was needed for people affected by mental health issues. They shared their experiences of feeling under pressure to take an advance payment on the day and said they would have liked to have more information about what the advance payment would involve beforehand in order to decide.</p>
<p>(Douglas, MacIver, and Yuill 2020)</p>	<p>To explore the challenges facing food insecure people in terms of: 1 their self-care condition management practices; 2 disclosing and discussing the experience of managing their condition with a health care professional; and 3 notions of the support they might wish to receive from them.</p>	<p>Findings suggest some healthcare interventions, medications and guidance are undermined by a lack of food security and that health professionals are often unaware of this and don't ask. 'Participants' health condition management aspirations were undermined by the experience of food insecurity, 'and their health care consultations in were, on the whole, devoid of discussions of those challenges' 'Eating was commonly described as an erratic and solitary activity, which provided little enjoyment, or the nutritional balance necessary for good health. Choice and agency over food consumed was severely limited. This dictated not only what participants said they were able to buy or were given to eat by the food bank, but also where and when they were able to eat. For example, this participant talks about being advised by his doctor to stay off work for a few days, which he ignored to acquire to milk for his tea'. 'Few participants ate three meals a day. Most reported eating one meal a day or going without food for several days and living on beverages such as tea and coffee during those times. Some viewed this pattern as their normal.'. 'It was also evident that people had a clear system of prioritising other family members' food needs were prioritised above their own. In particular, mothers described ensuring that their children's nutritional needs were satisfied first.' Bills, such as housing costs and heating were prioritised and paid for first. 'Food assumed lesser status as an area of spending and was often minimised to accommodate other necessary household</p>

		<p>expenditure'. Participants expressed appreciation for food banks but found that these sources of food could not always meet their needs. Some participants reported they were living with conditions such as diabetes and bowel problems that required dietary monitoring and management. Diet (quantity and quality) was also a key issue in many other types of conditions because it played an instrumental role in medication regimes, and people's overall health and well-being.' Those who reported having diabetes or a condition that required care and monitoring of their dietary intake, such as bowel conditions, indicated they had good knowledge of the sorts of foods they believed they should be eating to manage their condition. However, realising that knowledge was not always possible due to financial constraints. Those participants described using a range of coping strategies to help them deal with fluctuations in their household food supplies. These included; skipping meals, cutting back on medication because of food scarcity, adopting a "trial and error" approach to eating potentially troublesome, but affordable foods, and, food hoarding during times when financial constraints were less severe. Participants also commonly recounted that 'lack of food, lack of choice over food, and/or unappetising food had an adverse effect on their mental health'. 11/20 participants said they were suffering from depression at the start of the interview. 'We asked participants about their experiences of discussing their food access challenges with their health care professionals including their general practitioner. [...] We were struck by the extent to which their narratives revealed that this issue remained unspoken and seemingly invisible in those discussions. Most believed their GP was unaware of their struggle to put food on the table and commonly indicated it was not a subject that their GP raised with them during a consultation. 'Other types of health care professionals were cited as giving participants advice that was not economically feasible for them to follow either.</p>
(McGarrol 2020)	<p>To investigate how different contexts can influence lay understandings of lifestyles and health behaviour & 'how different</p>	<p>Changing their 'lifestyle,' a message which participants felt they were bombarded with after their heart attack, 'was not perceived as straightforward, or attainable, in part, due to the many uncertainties about what caused</p>

	<p>social contexts shape expectations of, and responses to, heart health recovery, and influence barriers to engagement with cardiac rehabilitation services'.</p>	<p>their heart attack in the first place'. 'A common theme emerged for those not participating [in Cardiac Rehabilitation - CR - that had been offered]. CR just 'wasn't for them.' Not only was the purpose and usefulness of CR queried, but CR itself was viewed by some participants as completely contrary to their usual lifestyles and social practices' 'Stoical characteristics, a strong sense of identity, and a tendency to resist help, featured heavily in accounts from participants not engaging with CR from mining deprived and non-mining deprived areas. 'Participants associated affluent areas, as 'healthier.' 'In contrast, 'unhealthy' places frequently 'mapped' onto de-industrialised areas in Fife and included areas which had suffered the consequences of economic and social decline over many years.' In disadvantaged areas, some participants identified unhealthy commercial venues as an issue (e.g. chip shops, pubs and take-aways) [i.e. commercial determinants of health]. 'Unhealthy' places were viewed as ostensibly creating 'unhealthy' populations. In particular, former mining areas, were described as having distinct 'health' cultures with high rates of smoking and alcohol consumption. Mine closures were seen as 'political'. 'The accumulation of... negative circumstances were observed as being written into the bodies of those enduring the hardships in these places'. Participants in more deprived areas described feeling negatively towards their area and also expressed fear of violence, etc, with certain areas and certain times being described as 'no-go'. Overall, participants from more deprived areas were less confident about their health and expected poorer health, earlier than participants from affluent areas.</p>
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<p>(Rolfe and Garnham 2020)</p>	<p>To examine 'different aspects of neighbourhood experience and their relationship to health and wellbeing outcomes' & 'explore the effects of the neighbourhood on health and wellbeing, drawing on a longitudinal, mixed methods study of predominantly low-income tenants from three housing organisations operating in west central Scotland, UK. '</p>	<p>'The findings suggest a strong relationship between tenants' perceptions of neighbourhood quality, as local social support networks, and wellbeing outcomes. The 'data suggest that tenants who feel that they can trust their neighbours are likely to have better health and wellbeing than tenants who do not trust their neighbours. There are also significant correlations regarding help and friendships within the neighbourhood.'" 'Participants highlighted the value of local amenities, shops, greenspace and transport links in their home neighbourhood. 'Where a new tenancy involved a move to an area with lower perceived levels of crime or anti-social behaviour, participants highlighted the impact this had on their ability to feel at home, which in turn affected their wellbeing and quality of life' 'tenants' fears and sense of safety were heavily influenced by their sense of vulnerability, both for themselves and their family members. Thus, participants with existing mental health problems or with children were more likely to express reservations about safety, whilst young, male tenants were often dismissive of such risks'. Some participants felt positively about immediate locality but not the wider neighbourhood and others vice versa. Social networks (proximity to family and friends) often positively linked to social support. "There were also a number of participants who deliberately avoided building close relationships with their neighbours, because they were concerned about problems that might arise. These concerns were typically based on previous, negative experiences with neighbours' (personal histories key). Housing organisations could play a role in enhancing participant experiences but different housing organisations offered different types of solutions. The impacts of neighbourhood aspects such as crime and anti-social behaviour are heavily mediated by tenants' expectations, previous experiences and personal/household characteristics.</p>
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(Isaacs et al. 2020)	To explore 'ASRs' experiences of health, wellbeing, and health practices in the context of their lived realities in Scotland' [ASRs = Asylum seekers and refugees]	<p>The experience of navigating the UK asylum system was described as all-encompassing and highly stressful, while simultaneously removing participants' agency. The stress of awaiting an asylum application decision severely undermined capacity to prioritise health even if individuals wanted to.' 'The all-consuming nature of the process also shaped what participants felt they could do to maintain their health. 'Waiting for a response to their asylum claim, asylum seekers were kept in perpetual limbo.' Argues that current policy context in UK 'has a profound impact on the mental health of asylum seekers' and that 'participant narratives suggested that it [...] [also] limited activities and created exhaustion.' 'The experience of poverty took participants yet further from the practices required to maintain health. The many participants who raised healthy eating as important immediately referenced their financial situation as a barrier. 'Walking was one of the few health-promoting practices that was considered financially accessible. However, an additional structural constraint – a sense of othering, reinforced by awareness of being audibly foreign, and visibly black, led to restrictions in terms of what [...] participants felt they could engage in outside of their home. Participants recounted racist experiences in their everyday interactions such as going to the local shops and travelling on buses. These encounters then shaped their willingness to partake in ostensibly free, healthy activities such as walking in their local area. Female participants in particular, sought to minimise time outside lest others became suspicious about them. Thus, racism and discrimination in local communities had a dual negative impact on health. It contributed to poor wellbeing due to insults on personhood, and it led to vulnerability to poor health through limiting capacity to engage in health practices.' 'the structure of the asylum system places individuals in a position of vulnerability for both poor physical and mental health.' Anxiety, sleeplessness, social isolation and depression all mentioned by participants. Notes that participants had often experienced trauma prior to arriving in UK, which can exacerbate negative consequences for mental and physical health. 'In the UK the establishment of a 'hostile environment' as government policy is an explicit example</p>
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		of structural violence operating to make life uncomfortable for both waiting and failed asylum seekers'
(McHardy et al. 2021)	To understand what works, what does not work, and what should be changed in relation to tackling poverty in Scotland, with a particular focus on experiences in relation to mental health, employment and employability, digital access and support in the community.	1) Precariousness of Universal Credit compared with Scottish Child Payment highlighted, alongside importance of advice and support to navigate entitlements. 2) Personalisation of employability support, including focus on sustained hours and routes to progression, framed positively. 3) Need for maintenance and improvement of public spaces in consultation with communities articulated by participants. 4) Better digital support and access for digital connectivity also sought. 5) More dignified crisis support (e.g. Scottish Welfare Fund) desired. When talking about health specifically, pandemic related issues viewed as compounding challenges of living in poverty for those with mental ill-health. Income precariousness and adequacy (real living wage) also viewed as an important factor in unequal health outcomes.
(Yaqoob and Shahnaz 2021)	To learn more about the experiences of low- or no-income single parents on entering, staying in and progressing in, the Scottish labour market.	Single parents, predominantly women, trapped in low paid often zero hours industries. Working is not being experienced or viewed as a route out of poverty. People's confidence and self-esteem is being negatively impacted by the approach of many employers and employment agencies. This is all exacerbating and causing poor mental health.
(Shortt and Ross 2021; Young peer researchers et al. 2020) [A report + linked academic article]	Questions listed in report and academic publication: How do community and place impact on health and wellbeing for children and young people? How might this contribute to health inequalities between different areas? Topics chosen to focus on by peer researchers: littering, safety and family & friends. From academic publication: "The research aimed to uncover how children living in more deprived neighbourhoods	Stigma and shame can contribute to a number of health issues or things that can damage your health (place-based stigma particularly emphasised). Green spaces as opportunity for play and social engagement but also as spaces with crime, substance abuse and violence. Local fast food restaurants viewed as affordable way for family and friends to be together. Healthier options not accessible or affordable. Support and lack of action on crime and substance abuse in communities seen as a reflection of these communities not being care for. Positive, trusting relationships with adults are potential positive influences on health and wellbeing. Authors conclude that children have a deep understanding of the

	<p>perceive their environments, and in turn, how features of their neighbourhoods contribute towards shaping the canvas upon which their health and well-being is produced.'</p>	<p>link between environment. They note that participants 'conveyed a sense of exclusion from the places and spaces they experience on a regular basis. This exclusion resulted from a complex interplay of personal encounters, financial barriers, public attitudes and limited child-friendly resources. In particular, a lack of financial resources was emphasised, with this and contextual barriers converging to construct spaces where children experience exclusion. Related to this, the participants reported feelings of boredom, depression, and unfairness.' They also note: 'The children's sense of abandonment, reflected in broken play equipment, litter and the lack of resources, underpinned the spatial comparisons that they made between neighbourhoods of varying affluence. The participants connected these inequalities and the reputation of the area to their own health and well-being, including stress and anxiety.'</p>
<p>(Young 2021)</p>	<p>To explore the poverty reducing impact of Disability Assistance payments in Scotland for working-age people.</p>	<p>Levels of Disability Assistance payments clearly do matter but they are not the whole story. Most people felt hopeful that the new Scottish system would do much to repair the harm they feel is caused by current methods of assessment. There is concern about the legacy of DWP approach and a fear that Social Security Scotland will fail to live up to the principles and values outlined at its inception in a document called "Our Charter" (Social Security Scotland) without adequate ongoing training and development of all staff, and the continued engagement of disabled people as advisors and critical friends with more than token powers of scrutiny. Participants described a lack of access to good-quality independent advice and advocacy was raised – such support was framed as a necessity, yet not perceived to be clearly provided for within current Scottish Government proposals. The findings suggest that avoiding making claims for disability assistance is often attributed to the fear of entering what has been described repeatedly as an intrusive and dehumanising assessment process, and the stigma and embarrassment of claiming benefits in what disabled people perceive to be a hostile culture. When it comes to low take-up of "passport" benefits people refer to the system's complexity and lack of transparency as well as the difficulty many have in accessing good-quality advice and accessible information. Low-paid work</p>

		<p>and barriers to accessing paid work, such as discrimination and unconscious bias, or lack of accessible transport, affect disabled people disproportionately. These structural drivers of poverty were often mentioned along with the unjust ways in which some companies extract a poverty premium from the disproportionate number of disabled people in poverty, ranging from pre-payment meter rates for utilities to the high cost of basic aids for independent living.</p>
<p>(Fraser and Clark 2021)</p>	<p>To elaborate 'the complex landscapes of identity, vulnerability, and harm that are embedded in the symbiosis of crime and deindustrialization.'</p>	<p>Participant accounts of life in a deindustrializing society show the sense of the structural violence felt when services are removed, or physical sites abandoned. There is no sense of civic improvement, but a long-term process of destruction with little foresight for what will come next. 'Amid this process of ruination [...] [study area] became increasingly cut-off.', leaving residents isolated. A 'lack of leisure opportunity for young people was frequently connected with visible instances of vandalism, further contributing to a sense of environmental degradation'. Violence and drugs heavily present in participant accounts. A 'lack of investment in housing is closely related to the opportunities for exploitation, indebtedness and coercion'. 'Throughout interviews, it is clear that organized crime penetrates every level, with street-level crime intrinsically linked to local criminal markets, which also manifest through violence, intimidation, and financial pressure.' Authors note that residents 'are aware of who exerts power and control, and the potential ramifications of challenging this.' Rise of drugs linked to 1980s deindustrialisation and lack of employment opportunities. 'There was a strong perception that the growth in local addiction emerged in tandem with the evolution of local organized criminal groups. Authors note that the 'repeated demonization of the community over time can lead to the passive acceptance of criminal behaviour, rather than as a stimulus for resistance.' Participants suggested that popular and media reporting' significantly downplays the importance of deindustrialization as an explanatory factor in increased criminality, placing the "blame" on the affected communities.' This characterisation is then resisted by residents. Authors observe 'a measure of prestige attached to involvement in crime, interacting</p>

		<p>with notions of masculine “respect” and toughness.’ Jobs opportunities outside the organised crime networks are limited and lack appeal because of the relatively low pay on offer compared to illicit economy activities. ‘Criminal groups exhibited a keen knowledge of vulnerabilities in the local area—debt, addiction, ill-health, lack of family support, and old age. Against this backdrop, local criminal groups have leveraged the opportunities afforded by environmental, physical, and social degradation of the community to build defensible fiefdoms’, while the public sector appears to have stepped back.</p>
<p>(Wiseman and Watson 2021)</p>	<p>To examine the impact of one of these “causes of causes: targeted violence and persistent victimization. We do this chiefly by exploring their role in structuring people with learning disabilities” experiences of communities and, in turn, their health and wellbeing’</p>	<p>Disrespect and devaluing profoundly erode wellbeing. Violence is a ‘central contributor’ to inequalities experienced by people with learning disabilities. ‘Being subjected to violence was part of people’s everyday experiences throughout the life course and was experienced in various community settings such as schools, participants’ homes, public transport, and in care settings. Participants described trajectories of harassment and bullying that started from a young age. Schools were often the first space where participants experienced violence’. ‘Women reported experiences of sexual violence as children and adults.’ Participants described feeling worse about experiences of violence because people around could have intervened to stop it but didn’t. Harassment also a common feature of accounts.’ Participants’ sense of being devalued was epitomized by other people doing nothing. ‘They legitimized the permissible dehumanization of people with learning disabilities. This permissibility indicates that shared moral value and moral proximity does not extend to them.’ ‘Acts of violence were not only in themselves painful and destructive, but these events had profound consequences on participants’ long-term health and wellbeing.’ One participant described feeling ‘too scared to leave his home’, others described how fear led them to self-harm. ‘What is perceived to be “low levels” of bullying, such as name-calling, kicking doors, or shouting significantly harmed participants. ‘Where services failed to intervene, responding to violence or targeted harassment fell to participants, either by remaining at home or moving elsewhere.’ ‘The devaluing of people</p>

		<p>with learning disabilities emerged in myriad spaces and contexts. Not being believed, constructions of incredibility and rejections of stories of hate crime were frequent and pervasive. When violence was made visible by participants, to others, their reports were actively denied. Police were identified, by participants, as being key perpetrators of invalidation.' 'Families, support workers, and friends were, at times, also complicit in rejecting participants' reports of violence or hate crime.' 'Fear of being targeted meant that participants led segregated lives.' 'Simple acts of inclusion, recognition from others had lasting impacts on self-worth and acted as powerful expressions of the importance of belonging in the lives of participants.'</p>
<p>(Parkes et al. 2021)</p>	<p>To document the impact of the COVID-19 pandemic on individuals who were experiencing homelessness in Edinburgh city centre and to consider how services adapted in response.</p>	<p>Experiences of services to support homeless populations in Edinburgh during the pandemic were mixed. Those with lived/living experience of homelessness and problem substance use faced a range of additional challenges during the pandemic. Mental health and use of substances were affected, influenced by social isolation and access to services. 'The lockdown period in general, but particularly the very early lockdown period, was characterised by feelings of confusion, anger, loss, and fear, which further exacerbated the social isolation that many experienced prior to the pandemic.' 'All interviewees with lived/living experience described their mental health difficulties as being aggravated by the lockdown, as access to support became substantially limited alongside increased social isolation.' Several participants described having to 'shield' due to being high risk. This, combined with a lack of support staff, led to negative impacts on wellbeing. Some participants described not having family support to fall back on. The impacts of lockdown on participants' substance use seemed mixed: 'Some participants stopped use completely or reduced, others were able to maintain their recovery, whereas for some individuals their use continued to be heavy or increased.' Relatedly, 'Some reported no changes, others felt that drugs had become more expensive or more difficult to access, whereas some participants described drugs being more readily available and more people using them.' 'The rapid rehousing of people who were deemed street homeless</p>

		<p>across the city was described as a “massive triumph” (Naomi, Stakeholder), and praised by staff, stakeholders, and people with lived/living experience alike. There was a view that the support provided to people to quickly move them from the streets to hotels was positive, and had facilitated engagement with other services and supports' 'there were issues with ongoing housing support being suspended during the pandemic: people were unable to get the social care support required, most specifically for those living in supported accommodation and in their own tenancies. A lack of PPE also meant that staff and stakeholder participants highlighted being unable to visit people in their homes and provide the support needed' 'Participants with lived/living experience described either not being registered with a GP, or not attending their GP due to feeling judged or discriminated. These were issues that existed before the pandemic'. Digital/phone exclusion became more of an issue in pandemic: 'while many services were available via online methods during the pandemic, they were only available to those who could engage online or by telephone.'</p>
<p>(Ibrahim et al. 2021)</p>	<p>To 'investigate the impact of responsibly-delivered credit on the health and wellbeing of borrowers' by qualitatively exploring 'the different narratives and views of microcredit borrowers, on the possible associations between accessing and managing a microloan and health and wellbeing, and the mediating mechanisms and pathways that might facilitate these associations'. Microcredit is defined 'as a small loan provided at affordable interest rates to individuals who cannot access mainstream lenders due to a lack of collateral and/or credit history'</p>	<p>Participants described struggling 'to afford daily basic needs and had the constant worry of making ends meet. They struggled to find suitable jobs and were unable to access capital to improve their financial circumstances by starting their own business. 'Inability to cushion for (un)expected expenses also led to negative mental health outcomes and longer-lasting dissatisfaction with life for some, as shown by reports of stress, sleeplessness, feeling pressure from making difficult financial decisions'. 'Many with children, particularly single parents, also expressed feelings of shame and guilt if unable to provide for their children. This became so severe that some had suicidal thoughts. 'Financial exclusion also increased stigma associated with belonging to a low-income group, being unemployed, an immigrant or receiving welfare benefits.' 'Participants' experiences of being rejected from mainstream financial institutions made them feel unworthy and stigmatised; thus they approached microcredit lenders with apprehension'. Successful applications for microcredit loans made people feel accepted, improving feelings of self-worth as</p>

		<p>they perceived they were being given the same opportunity as others in society.' 'Participants who received welfare benefits or were unemployed also unexpectedly felt respected as loan officers did not differentiate between them and other clients. Being financially-included through access to microloans increased participants' feelings of acceptance, reduced stigma, and increased their confidence'. 'This accessibility made it easier for participants, especially single parents, to plan for large expenses, reducing anxiety about coping with emergencies and creating a sense of security'. 'It also reportedly affected family relations positively as parents were able to afford everyday needs without asking for help from other family members – which for them would be an invasion of privacy or a source of embarrassment'. 'Especially for business loans, participants thought the loan allowed them to start and manage long-awaited-for businesses, bringing a sense of control, confidence and reduced anxieties related to business management. It also increased social participation with greater control of working hours and having extra money for social activities'. 'However, for some borrowers, microcredit was viewed as another debt to be repaid and linked with increased stress levels. 'Flexibility around loan repayments helped ease her anxiety and stress, as reduced instalments could be paid over a longer time or repayment holidays taken. In contrast to other lenders, microcredit institutions were perceived as wanting to help borrowers with repayment difficulties, for example, refraining from going to borrowers' houses to demand repayment or shaming them about their predicament'. 'Participants were also aware that missed payments would not result in extra charges. This reduced the worry and pressure normally associated with debt and meant participants did not feel used to generate profit.</p>
<p>(Couper-Kenney and Riddell 2021)</p>	<p>To assess 'the extent to which children's rights have been prioritised during the COVID-19 crisis'. Focuses on the impacts of school closures during pandemic and associated decisions about providing education and support</p>	<p>Find that, in the early days of the lockdown, 'scant regard was paid to the rights of children with [additional support needs] as education and care services were suddenly withdrawn. Existing inequalities were exacerbated, such as unequal access to IT, varying levels of support and differences in family resources.' Note that some families also reported some positive experiences,</p>

	<p>for families of children with additional support needs.</p>	<p>‘such as enjoying more time together and a release from school-generated stress’. ‘The online delivery of education during the pandemic meant that local authorities were unable to ensure equal educational access, since children’s home environments reflect wider social inequalities. Local authorities were also unable to control educational quality or to ensure that reasonable adjustments, including auxiliary aids and services, were available, with negative implications children and parents with [additional support needs], including those for whom English is an additional language, those with particular communication needs and those with learning difficulties’. ‘It was also impossible for local authorities to ensure that ‘vulnerable’ children attended a hub school, since the category of vulnerable child was undefined, no data were available and the label was resisted by parents who regarded it as stigmatising’. Participants described a lack of resources for home schooling for children with additional support needs compared to other children. There was some anger among parents who had previously requested online learning and been told it was ‘impossible’ but this was now happening on a widespread scale. Accounts of how specific schools had responded to pupils with ASND seemed mixed: there was some bitterness towards those schools deemed not to have done enough, while others gave positive accounts of schools (and teachers) reaching out to support. The lockdown restrictions meant that carer support/personal assistance was often withdrawn, highlighting the unequal impacts of this policy response. Some families described exercise and diets of children being negatively impacted by the changes. ‘In general, there was a sense that the experience of school closure had a profound impact on the entire family’. Conclusion: ‘Overall, it is clear that children have suffered considerably as a result of school closure, with the burden falling disproportionately on those with [additional support needs], especially those experiencing additional social disadvantages.’</p>
<p>(Macaulay, McHugh, and Steiner 2021)</p>	<p>The aim of this paper was ‘to identify and describe the shared perspectives of residents of one remote-rural island community in</p>	<p>Identifies divergent perspectives ‘on rural health improvement’, showing that rural perspectives on poverty are ‘not homogenous within or between communities and should not be treated as such.’ Despite these divergent views, the research identifies ‘shared</p>

	Scotland, on how to improve rural health.'	recognition that providing access to services and amenities in rural communities, and addressing rural poverty, is important for improving the health of residents.'
(Smith et al. 2021)	To explore whether and how people's views evolve in the context of deliberative discussions and/or exposure to new ideas and evidence.	'There appeared to be an assumption that health inequalities are partly explained by a knowledge deficit among some groups, and that better information would translate into improved health. Support for investing in healthcare (e.g. General Practitioner services) seemed stronger within jury discussions where it incorporated this kind of 'proportionate universalism' design (Marmot et al. 2010). There was 'comparatively strong public support for improving living and working conditions as a means of reducing health inequalities'. While some participants strongly supported more progressive income taxes in response to health inequalities, others disagreed and there were divergent views among participants as to what counted as 'rich'. Increasing prices on unhealthy products was often not perceived to prevent consumption since this was often attributed to other factors (e.g. addiction and unsupportive socioeconomic environments) and some participants noted that illicit products would reduce impact of this measure. A less common critique was that the regressive nature of these taxes would have negative consequences for low-income families. 'In two juries, this concern informed a counter-proposal for reducing the price of healthier products'. Participants' accounts suggest they are more likely to support 'solutions' where the means of effecting change aligns with their perceptions of responsibility. 'Responsibility for addressing health inequalities was often constructed as complex and cutting across individuals, families, schools, health care services, corporations, employers, local and national government.' Notably absent from these constructions were ideas of community and solidarity, reflecting older participants' accounts of communities playing a less prominent role in social support over time.' Support for proposals seemed to be influenced by perceptions of who could be trusted to deliver change, especially where this involved generating or spending taxes. A lack of trust in governments and politicians was prevalent across juries, with frequent expressions of cynicism concerning

		<p>motives, competence, integrity and (lack of) concern for, or understanding of, ‘people like us’. This ‘informed a belief, evident across juries, that governments ‘waste’ money which undermined proposals involving taxation. Large corporations and private landlords were also deemed untrustworthy and problematic. ‘In contrast, the NHS was consistently framed positively, sometimes almost equated to health’. Jury participants often resisted ideas they appeared to experience as overly generalising, disempowering or stigmatising. This included challenging the idea that more disadvantaged communities are more likely to experience worse health’. ‘This concern was so pronounced in one jury that participants developed a proposal to tackle ‘stereotyping of people in poverty’.</p>
(Kelly 2022)	<p>To generate community evidence of what needs to be done to tackle child poverty in Scotland.</p>	<p>The results highlighted a childcare implementation gap between policy commitments to childcare and actual provision, a desire for a more inclusive social security system with increased take-up, an expansion of work to promote a Real Living Wage (including via public procurement) and measures to address stigma via practical and awareness raising (e.g. Cost of the School Day), with a focus on what can and should be done in response.</p>

<p>(Marzetti, McDaid, and O'Connor 2022)</p>	<p>To 'explore the ways in which LGBT+ young people themselves make sense of the relationship between their LGBT+ identity and suicidal distress; reporting on the findings of first qualitative exploration of LGBT+ young people's suicidal thoughts and attempts in Scotland.'</p>	<p>'Participants described how everyday comments, questions and looks could serve to establish and re-establish cis-heteronormativity on a day-to-day basis.' This included in person and virtual, online spaces. Concerns that identities would not be accepted informed feelings of hopelessness. 'The majority of participants reported bullying throughout their education. Many participants described this bullying as targeting their perceived gender non-conformity, which they believed was often interpreted as evidence of a non-heterosexual orientation.' Other participants described experiences of violence and living in fear of violence (e.g. 'Andrew (20; he/him): It's just your kind of playground kind of gay bullying, kind of gay bashing, if you like [...] Just the usual, it was just like being intimidated, I think I was beaten up a few times, I've been followed home a few times, only run of the mill [laughter];'). Accounts in which participants described feeling they were victims seemed to be linked to a sense of shame. Some of the young participants described being rejected by their families as a result of their identity and threatened with homelessness. 'For participants, this rejection could be understood as a rejection of their personhood as a whole; without their LGBT+ identity they simply did not exist in a manner recognisable to themselves.' 'Given these pressures, some participants expressed difficulties envisaging the future and described a sense of what we have termed 'queer entrapment', in which queerphobic conflict about their LGBT+ identity was perceived to be irresolvable and from which suicide was seen as an escape.' Some participants described how consistently negative comments/narratives could contribute to negatively change they way they thought about themselves: 'Sophie (18; she/her): At one point I would have people at school, my dad, and my brother, all at the same time, with different intents, telling me, you're disgusting, it's fucking wrong. And if someone tells you something enough, you start to believe it.'</p>
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(Garnham et al. 2022)	To 'elucidate some of the general causal pathways through which housing provision impacts on the wellbeing of low-income tenants, to improve our ability to effectively intervene in the cycle of poverty, poor housing and poor health'.	Key finding is that tenants need to be able to trust their housing provider. There were therefore two distinct pathways through which tenants' sense of home impacted on their mental wellbeing. The first was the potential for the home to contribute towards their resilience, by providing a recuperative space in which they could shelter and recover from day-to-day stressors. The second was the potential for the home to contribute towards their self-esteem, pride and identity.' ' for those who were proud of their home, either in appearance or function, it contributed to their self-worth. This was particularly the case for those who had put significant resources into improving the property. The sense of achievement this provided was a source of wellbeing that participants were surrounded by and reminded of on a day-to-day basis'. 'For others, however, the property was not a home, but an active source of stress and negative feelings. Where the property was uncomfortable or did not feel private, for example, participants became increasingly unhappy, anxious and worried'. 'These kinds of circumstances prevented the property from serving as a recuperative space and impacted negatively on participants' self-worth, leaving many feeling "in limbo" and unable to plan. This often had additional impacts on social relationships, in that tenants could not host guests and felt they were imposing on friends/family while escaping their own property. 'This, in turn, further threatened their sources of support and resilience in dealing with life's challenges.' 'A sense of home, then, was the central mechanism through which participants' housing situation impacted upon their wellbeing.' 'Aspects of housing that some might consider 'cosmetic' seemed 'pivotal to many participants' experiences in their new tenancy'. Establishing a sense of home could have a direct, positive impact on mental wellbeing and provide a source of resilience against outside threats to wellbeing. Further, it was particularly important that tenants were able to establish a sense of home quickly, as once negative experiences in the property began to take hold, it was often difficult for a tenant to recover and establish a sense of home later on in the tenancy.' 'participants in this study emphasised the importance of home, not just as a secure base from which identity and a positive sense
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		<p>of self can be built and maintained, but as a space in which the self can be defended from outside stressors. For low income households, these stressors are likely to be multiple. Thus, the ability of tenants to settle in a new tenancy and feel at home is important not just as an end in itself, but a means of enhancing the wellbeing of low those living in low income households, via the ‘psychosocial benefits of home’ 'Combinations of tenant characteristics, such as low income and lack of social support, together with problematic housing experiences, such as poor move-in condition and property-centred services, can undermine tenants’ sense of home, creating negative psychosocial effects and damaging health and wellbeing.'</p>
<p>(Fergie et al. under review; Fergie et al. 2023)</p>	<p>To 'explore young people’s understandings of how health inequalities are generated, and how concepts of meritocracy and individual agency are reflected in their discussions' and 'their perceptions of contemporary injustice and potential alternative visions for fairer societies where these health inequalities are reduced'</p>	<p>The notion that education was a central priority for all young people was expressed across the groups.' Participants generally described expecting gaining decent employment to be challenging, reflecting on 'constraints operating against young people, and the inequalities inherent in the systems of education and employment,' and the 'backdrop of austerity'. 'Participants’ explanations for health inequalities were vivid and complex, often aligning broadly with academic and policy understandings – with group consensus often built around the importance of socio-economic position, the early years, and broader socio-political choices'. While initial discussions focused on individual responsibility for healthy lifestyle behaviours, this evolved (during workshop discussions) to reflect the influence of family, friends and material circumstances (e.g. not being able to access healthy food or healthy leisure activities). 'Young people’s reflections on the social determinants of health, and the generation of inequalities in health suggested a broad concern with the life course, and how experiences across childhood and youth shape future health.' Housing, income and education positioned as key factors in health and teenage years were depicted as a critical period of development. 'Concerns with inequalities in pay, and who makes decisions related to this, were widespread. Across all groups participants discussed and explored the position of “key workers” in the UK, as publicly valued but underpaid and epitomising the unfairness of the socio-economic inequalities that lead to</p>

		<p>health inequalities. For most of the young people, it was the decisions of an elite group that were seen to introduce, exacerbate or mitigate inequalities related to Covid-19, and judgements were often questioned as reflecting self-interest rather than the needs of the population ' On potential solutions/responses, 'mental health, relationships, and education [were] among the most prioritised areas for action'. 'Concern for people's living and working conditions, and the systems which influence these, were broadly described as far likelier to impact inequalities than individual-focused interventions.' Many participants expressed some desire 'for a shift from the current system [of governance] to one centred around community and cooperation' (the term 'community-led socialism' was used). Although 'Visions of alternative systems of democracy' were not 'entirely unified' but 'consensus was built around a concern to disentangle control over policy change from governments which were largely seen as operating without participants', and citizens', best interests in mind.' 'improving the quality and sustainability of place' was commonly positioned as likely to have 'wide-reaching positive impacts' on health. As part of this, some participants advocated for a need to redistribute property (especially empty property). 'The young people also discussed possible changes to the welfare system that would provide a stronger social safety net, demonstrating high levels of support for universal basic income'.</p>
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Table II: Summary of included studies from oldest to newest (grey shading indicates 'grey literature' – others are all academic publications)

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