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The Wider Social Determinants of Mental Health in Scotland: Review of Key Policy Documents and Qualitative Literature

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This research was conducted as part of the Systems Science in Public Health and Health Economics Research - SIPHER Consortium, for the Wider Social Determinants of Mental Health Programme (WSDMHP). We thank both our SIPHER colleagues and our partners in the WSDMHP for the valuable input and discussions that have informed this report.

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Executive Summary

Report Aims: To analyse the Scottish Government's 2017 and 2023 mental health strategies to identify changes in the way mental health and wider social determinants have been conceptualised within Scottish policy; to synthesise qualitative literature exploring how disadvantaged communities in Scotland describe links between wider social determinants and mental health; and to consider emerging insights could be used to help inform the development of the Wider Social Determinants of Mental Health Programme (WSDMHP) currently being led by Public Health Scotland in partnership with the Scottish Government, COSLA, and the SIPHER Consortium. While the WSDMHP is a collaborative programme, this is an independent report produced by the SIPHER Consortium.

Methods: A combination of content analysis and frame analysis was used to analyse the Mental Health Strategy 2017-2027 (Scottish Government, 2017) and the renewed Mental Health and Wellbeing Strategy (Scottish Government & COSLA, 2023a), with an analytic focus on wider social determinants. We then worked to identify and synthesise qualitative literature capturing the views and experiences of disadvantaged communities living in Scotland on the role that wider social determinants play in mental health, with a view to identifying emerging insights for the WSDMHP.

Findings: We identify a notable shift in language between the Mental Health Strategy 2017-2027, and the 2023 Mental Health and Wellbeing Strategy, that reflects a less medicalised, more preventive approach to mental health and mental wellbeing. Several key wider social determinants of mental health are referred to more frequently in the newer strategy, including poverty, housing, and employment. There is also a clear and consistent call to tackle mental health stigma, a commitment to developing 'whole system' approaches to mental health, efforts to incorporate intersectionality and references to the value of lived experience insights. The WSDMHP is one of the actions now being taken to elaborate the pathways between wider social determinants and mental health, to identify clear actions and intervention points to address wider social determinants of mental health, and to operationalise commitments to 'whole system', preventative approaches.

The synthesis of qualitative evidence identifies a relatively small literature but one that is replete with sophisticated, often harrowing, lived experience accounts of the links between wider social determinants and mental health and wellbeing. Across multiple studies, poverty, place and meaningful employment recurrently feature as important wider social determinants of mental health. This reflects the 2023 Mental Health and Wellbeing Strategy's focus on poverty, housing and employment, but points to a need for the WSDMHP to consider neighbourhoods alongside housing, and to centre job quality in employment focused work. Additionally, the qualitative literature suggests that alcohol and drugs, which impact both consumers using substances to cope with poor mental health and bystanders (via associations with violence, crime and anti-social behaviour) play an important role in people's mental health experiences in Scotland. Although alcohol and drugs are often framed within public health research and policy as behavioural issues, the qualitative literature identifies these substances as important contextual features of some disadvantaged neighbourhoods, suggesting they warrant consideration in the WSDMHP.

Qualitative accounts also discuss a wider range of types of stigma (e.g. of poverty and place) in ways that imply the WSDMHP might usefully consider stigma to be an important psychosocial pathway connecting structural and material determinants to mental health experiences. Finally, the qualitative accounts reveal how negative interactions with those in positions of authority combine with a widespread sense of being part of communities and neighbourhoods that are uncared for, to help explain the consistently low trust that people seem to have in politicians, government and other authority figures. This, in turn, contributes to a pervasive sense of hopelessness which, itself, seems likely to be negatively impacting on people's mental health and wellbeing.

Implications for the WSDMHP: The qualitative literature suggests that poverty, place (neighbourhoods) and meaningful employment are core wider social determinants impacting on people's mental health experiences in Scotland, with alcohol, drugs and violence also worthy of attention in the WSDMHP. Qualitative accounts also suggest that multiple different types of social stigma impact on mental health experiences, with stigma operating as in important psychosocial pathway connecting wider (material) determinants to mental health and wellbeing outcomes. Finally, qualitative accounts suggest that disadvantaged communities frequently describe multiple negative experiences with authorities (including in the public sector). This appears to inform widespread low trust in politicians, governments and other authority figures which, in turn, contributes to a pervasive hopelessness about the future. The WSDMHP could explore working with affected communities to examine whether/how developing stronger political voice within communities, or clearer mechanisms for enabling community members to influence national and local policy decisions, could benefit mental wellbeing.

The multi-factor accounts of wider social determinants of mental health that people provide in qualitative research lend support to the WSDMHP's investment in 'whole system', preventative approaches. The qualitative evidence supports the current policy focus on preventative approaches and suggests that the WSDMHP should focus on identifying policy and practice options for effectively operationalising this preventative approach. This is likely to involve identifying effective intervention points and actions that will help achieve the kind of systemic, whole systems changes that will help achieve the transformative improvement in mental health that the Scottish Government is aiming for. While the current academic literature lacks easy solutions, the WSDMHP's systems approach may help enable a move from analysing which wider determinants are important for mental health in Scotland, to developing an evidence-base that identifies causal pathways and promising intervention points. Given concerns around political trust and voice, it will be important to ensure that disadvantaged communities are effectively engaged in the WSDMHP.

Chapter 1: Introduction - Context, aim and research questions

This report seeks to provide contextual insights to support Public Health Scotland's development of a Wider Social Determinants of Mental Health Programme (WSDMHP), in partnership with the Scottish Government, COSLA (the Convention of Scottish Local Authorities), and the SIPHER Consortium. In June 2023, the Scottish Government and COSLA jointly launched a Mental Health and Wellbeing Strategy. This replaced a 10-year Mental Health Strategy published in 2017 by the Scottish Government. The latest Mental Health and Wellbeing Strategy aims to place a greater emphasis on prevention and to adopt a 'whole-systems' approach to addressing mental health inequalities. It was followed by a Delivery Plan 2023-2025 [PDF], also developed jointly by the Scottish Government and COSLA, which specifically initiates Public Health Scotland's WSDMHP:

> *'Public Health Scotland will lead a collaborative programme of work to develop a whole systems approach to understanding and taking action in relation to the key social determinants of mental health. This will involve: bringing together communities, practitioners and policy makers across the system to build a collective understanding of the social determinants of mental health; having a focus on understanding and promoting primary prevention approaches; identifying and testing specific actions for improving population mental health and reducing mental health inequalities.'*
> (Scottish Government & COSLA, 2023b: 29)

The previous Mental Health Strategy was intended to cover the period 2017-2027, with plans for annual progress reports and a full progress review at the mid-point of 2022. These progress reports, and the Covid-19 pandemic, prompted the Scottish Government to revise its strategic approach, in partnership with COSLA. The new Mental Health and Wellbeing Strategy 2023 describes a "*long-term vision and approach*" (p4), this time without a specific time-frame, but accompanied by shorter-term Delivery Plans containing more specific actions and progress updates.

This report explores how wider social determinants of mental health have been discussed within these recent mental health policy documents. Our analysis is informed by a synthesis of qualitative research capturing the perspectives and experiences of people adversely affected by wider determinants of mental health in Scotland, which subsequent sections summarise. The report is part of the first stage of the WSDMHP systemic inquiry work strand; it is one of several desk-based projects underway, each of which synthesises and reviews different sources of evidence concerning the wider social determinants of mental health in Scotland. The aim of this first stage is to ensure the WSDMHP is 'evidence-

informed', whilst also identifying gaps, conflicts and weaknesses in the existing evidence that later stages of the systemic inquiry might begin to address.

The three research questions addressed in this report are:

- *How have the wider social determinants of mental health (WSDMH) been conceptualised in the two recent mental health policy documents in Scotland, published in 2017 and 2023, and what are the key changes that feature in the most recent strategy?*
- *In qualitative research, how do people in Scotland who have been adversely impacted by the WSDMH describe and make sense of these experiences?*
- *Do these qualitative accounts align with accounts of wider determinants in Scotland's 2023 mental health strategy and/or offer any insights that may be useful the developing wider social determinants of mental health programme (WSDMHP)?*

Chapter 2: Methods

This chapter explains how we analysed Scotland's mental health strategies (2.1), found and synthesised qualitative literature (2.2), and reflects on some limitations of our approach (2.3).

2.1 Analysis of Scotland's 2017 and 2023 Mental Health Strategies

This first stage of this research involved comparing the Mental Health Strategy 2017-2027 (Scottish Government, 2017) to the renewed Mental Health and Wellbeing Strategy (Scottish Government & COSLA, 2023a). The aim was to identify any shifts in the conceptualisation of mental health within Scottish mental health policy, and the types of issues being prioritised.

Two methods of analysis were conducted on the policy documents. First, ND undertook a word frequency analysis, using the qualitative data analysis software, NVivo. A co-author, AB, checked the word counts using Adobe Acrobat Reader. A combination of inductive (developing a theory or idea) and deductive (testing an existing theory) reasoning guided this process. Word frequency clouds were used to gain a rapid sense of the language within both documents and the topics being explored. A more detailed, thematic analysis was then conducted on both documents (using a thematic framework developed in NVivo), with additional word frequency analyses then being used to further investigate emergent themes.

Second, AB conducted a 'frame analysis' of both strategy texts. This entailed a line-by-line content analysis, also using NVivo, looking for causal stories, problems, solutions, relevant actors, and moral language relating to mental health or wellbeing, in each strategy document. By categorising text this way, this method allows for an analysis of how each document frames mental health or wellbeing (Entman 1993; Lynch 2020). By further applying these codes to the six original Marmot Principles (see Box 1 below) and a seventh category for healthcare, this method allows an assessment of whether problems and solutions are located within the first five Marmot Principles concerning 'upstream' determinants of health, or within the sixth or seventh categories, representing behaviour change or healthcare responses, which are further 'downstream' determinants of health.

Box 1 : Marmot Principles (Marmot et al., 2010)

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

2.2 Analysis of qualitative literature

The second aspect of this research involved thematic analysis of qualitative studies capturing the views and experiences of people adversely impacted by the social determinants of mental health in Scotland. We identified limited research literature explicitly examining this topic. KS had recently led an evidence review exploring 'lay' perspectives of health inequalities and the social determinants of health in Scotland (Smith and Stewart, 2024). While this did not have an explicit focus on mental health, many of the included publications did refer to mental health so it provided a comprehensive reference list of potentially relevant sources, which we reviewed for relevance to this report, using the inclusion/exclusion criteria set out in Box 2. A total of 30 articles were identified via this process.

Box 2: Inclusion & Exclusion criteria for qualitative review

Inclusion criteria:

- Published research studies that include, qualitative empirical data relating to the perspectives and/or experiences of members of the public who have been adversely impacted by the wider determinants of mental health
- Studies must include members of the public living in Scotland (where studies have a UK-wide focus, it must be possible to identify Scottish perspectives)
- Studies must be written in English

Exclusion criteria:

- Grey literature, essays, opinion pieces which do not include empirical data
- Studies which only include quantitative data
- Studies which only include data providing the perspectives of professionals or practitioners (even if these perspectives concern community/public experiences)
- Studies in other areas than Scotland/where Scottish perspectives cannot be extracted
- Studies not available in English

As Smith and Stewart's (2024) review focused on 'health' broadly, a further search, specific to mental health, was conducted in the SCOPUS database, using the search string in Box 3.

Box 3: Search string for literature search focused on social determinants of mental health

("mental health" OR "mental ill health" OR "mental illness" OR "mental wellbeing" OR depression OR suicide OR stress OR anxiety) AND (determinants OR causes OR causality OR drivers) AND (lay OR public OR communit*) AND (qualitative OR interviews OR ethnograph* OR participatory OR co-production OR photovoice OR "focus groups") AND (scotland OR scottish OR edinburgh OR glasgow OR dundee OR inverness OR aberdeen OR stirling)

We did not apply a specific time-period cut-off and instead took account of the date of publications (and underpinning data) during our analysis and in considering the potential relevance of the findings to the current (social, political and economic) context. This search identified 38 potentially relevant publications, which was reduced to seven studies once assessed against our inclusion and exclusion criteria (Box 2). One further study which was missed by the above search string (Knifton, 2012) was found during further reading and added to the analysis.

In total, this means we included 38 qualitative publications in the final analysis (within this four qualitative datasets were each used in two separate publications; where this is the case, we assessed the relevant publications collectively, as one study). The 38 qualitative publications analysed are marked by an asterisk in the Reference List and are summarised in Appendix 1.

2.3 Limitations

This was a time-limited, small-scale piece of research which is intended to highlight areas for further consideration in the WSDMHP systemic inquiry which included some quick and simple approaches to content analysis, such as word frequency analysis. We did not, for example, take account of proportionate weighting (i.e. the length of each document) so it is worth noting that the 2023 strategy is around one-third longer than the 2017 strategy. The purpose of this analysis was to provide an indicative sense of major conceptual shifts between the 2017 and 2023 strategies, as a starting point for our subsequent (more in-depth) framing and critical analyses. Further, we did not include an analysis of the Delivery Plan 2023-2025 (Scottish Government & COSLA, 2023b) in our comparison with the 2017 strategy, as this is a different type of policy document. Instead, we read the Delivery Plan 2023-2025 carefully to inform our broader observations about the 2023 strategy.

Further, our analysis is limited to two policy strategy texts specifically aimed at mental health and developed primarily by policy teams within the Scottish Government's Directorate General for Health and Social Care (in partnership with COSLA in the case of the 2023 strategy). Given that policy responsibilities for wider determinants of mental health are distributed across social, economic and health teams at UK, Scottish and local authority levels, our analysis is unable to consider many of the policy approaches to wider determinants taken by other policy teams, which may mean important policy actions with implications for mental health outcomes are missing from this analysis. In discussing this report with individuals involved in developing and operationalising the 2023 Mental Health Strategy, it was evident that multiple conversations and collaborations between mental health and other policy teams are ongoing within the Scottish Government; this work is not

captured by this analysis, which focuses on analysing policy documents in the public domain.

Given the limited availability of qualitative studies that explicitly examine the wider determinants of *mental* health, the findings of the qualitative evidence-review undertaken for this report need to be contextualised as having been drawn from research publications that largely focus on broader issues and topics (e.g. health inequality; food insecurity). In some cases, the relevance was inferred, rather than being stated explicitly within the papers/by participants. For example, given there is 'robust evidence that individuals with low self-esteem are more likely to experience mental health problems' (Orth and Robins, 2022), we treated discussions of 'self-esteem' as relevant to mental health and wellbeing, even where participants/authors did themselves not explicitly make this link.

Finally, each qualitative study is a small-scale study of a specific population group, which has not been designed to represent the broader Scottish population. This report synthesises the 38 included publications to identify common accounts within these studies of wider determinants of mental health and of pathways connecting these determinants to mental health and wellbeing experiences. By combining multiple small-scale studies in this way, we are able to identify findings that recur, and which therefore appear to capture experiences that are shared across different population groups. Nonetheless, most studies focused on understanding the views and experiences of specific population groups who have been subject to particular forms of disadvantage (often poverty / deprivation), and not all of the groups experiencing social disadvantage in Scotland have been researched (for example, as we note in the findings, research on minority ethnic community experiences in Scotland is limited). The relevance of the insights emerging from this evidence synthesis for the wider Scottish population can therefore not be assumed.

To help address this limitation, a rapid scoping review of similar qualitative literature in the rest of the UK (England, Wales and Northern Ireland) was also conducted by AB. The purpose of this review was to surface any significant differences between the identified Scottish qualitative literature and similar literature from the wider UK. The Box 3 search string was again used in SCOPUS but without the final parentheses introducing the Scottish specific focus. This identified 248 potentially relevant articles, which was reduced to 27 after applying the same inclusion and exclusion criteria (replacing the requirement for studies to focus on Scotland with one requiring studies to focus on the wider UK). This additional review identified broadly similar themes, with poverty, place and meaningful employment again featuring as important wider social determinants. However, this literature has a stronger focus on the different conceptualisations of mental health within the multiple

minority ethnic groups within the UK population, with additional insights relating to stigmatisation and help-seeking. This wider UK work also helped identify an article focusing on Indian, Pakistani and Chinese community participants in Scotland (Knifton, 2012), which was subsequently reviewed and incorporated into the main qualitative findings presented in this report. The insights from the wider UK-wide literature, which are particularly useful for considering intersectionality and multi-layered stigma, are briefly discussed in Chapter 3.

Chapter 3: Findings

This chapter is organised around our three research questions (see p6 for a summary).

3.1 How have the wider social determinants of mental health (WSDMH) been conceptualised in the two recent mental health policy documents in Scotland, published in 2017 and 2023?

The word clouds below (Figure 1) provide a quick, visual cue to some conceptual changes between the 2017 and 2023 mental health strategies. Prominent words in the 2017 strategy which are less prominent in the 2023 strategy include ‘services’, ‘treatment’, ‘help’, ‘problems’, ‘action’ and ‘children’. Words that are more prominent in the 2023 strategy include ‘wellbeing’, ‘community’, ‘across government’, ‘right’, ‘outcomes’ and ‘workforce’.

Mental Health strategy 2017-2027

Mental Health and Wellbeing strategy 2023

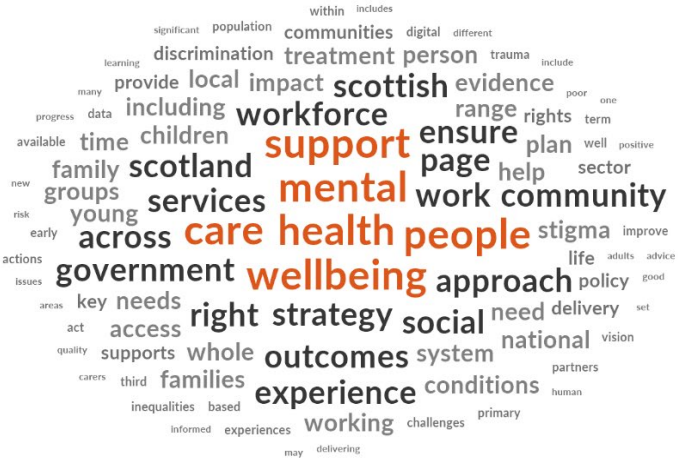

Figure 1: Word clouds representing word frequency within each strategy document

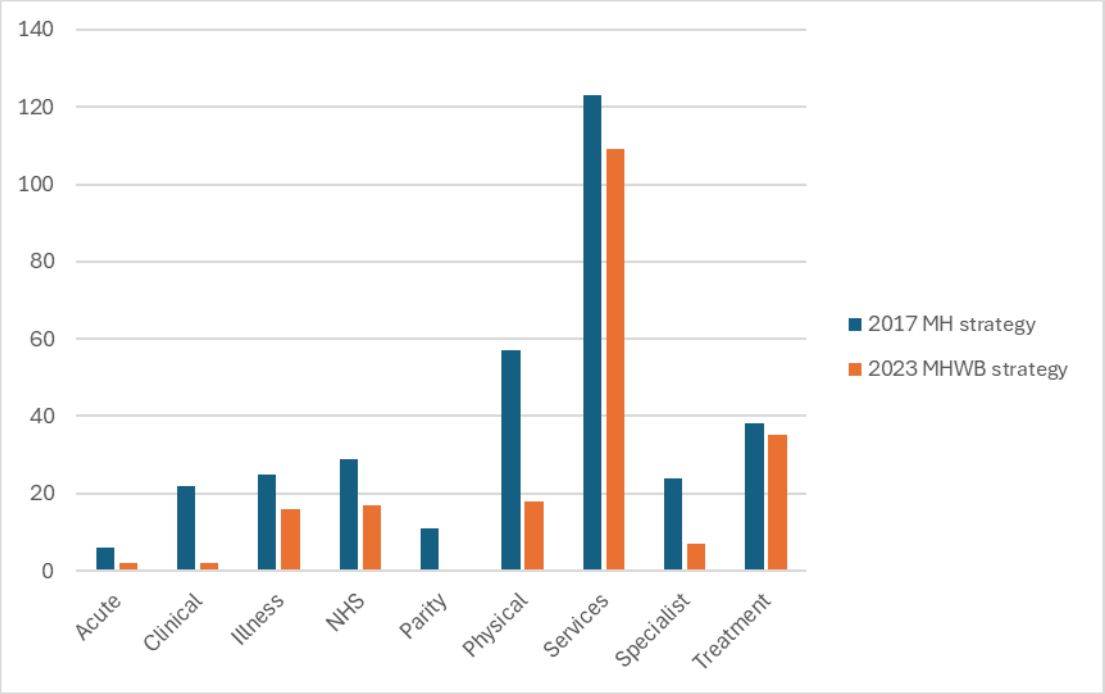

Figure 2: Bar chart comparing frequency of terms associated with 'medical model' of mental health in the 2017 and 2023 mental health strategies

Table 1: Summary of frequency of terms associated with 'medical model' of mental health in the 2017 and 2023 mental health strategies

Word	Frequency: 2017 strategy	Frequency: 2023 strategy
Acute	6	2
Clinical	22	2
Illness	25	16
NHS	29	17
Parity	11	0
Physical	57	18
Services	123	109
Specialist	24	7
Treatment	38	35

While both documents present mental health as a 'continuum', a 'medical model' of health is more evident in the earlier, 2017 strategy. A medical model of mental health attributes physiological, biochemical or genetic causes to psychological distress, and responds to such distress with medical diagnoses and treatments (Chakravarty, 2011: 266). In contrast, social

models of mental health tend to emphasise the social and environmental factors, including systemic disadvantage and structural inequalities, that lead to psychological distress (Tew, 2005: 21). A comparison of the frequency of terms that might be associated with a 'medical' model within each strategy are captured in Figure 2 and Table 1. This comparison suggests that a medical model of mental health may be less prevalent in the more recent mental health strategy.

It might be argued that a more medical conception of mental health was utilised in the previous strategy as part of the mission to achieve 'parity of esteem between mental and physical health' (Scottish Government, 2017: 7). Whilst the 2023 strategy encourages a recognition that mental health is as important as physical health, there is less focus on achieving 'parity' (see Table 1). Since the 2017 strategy often focuses on parity of access to services and treatments, this shift appears to relate to a move away from a medical, treatment focused model of mental health. Reinforcing a move away from a medical model, the 2023 text also places more emphasis on mental *wellbeing*, including the addition of *wellbeing* to the new text's title. Linked to this, we identify a greater acknowledgment of the wider social determinants of mental health in the most recent strategy. As Figure 3 (and Table 2) illustrate, inequality, poverty, income, housing and unemployment all feature, as do experiences of stigma and discrimination. All of this informs an ambitious vision of moving towards a Scotland 'free from stigma and inequality' (2023a: 2).

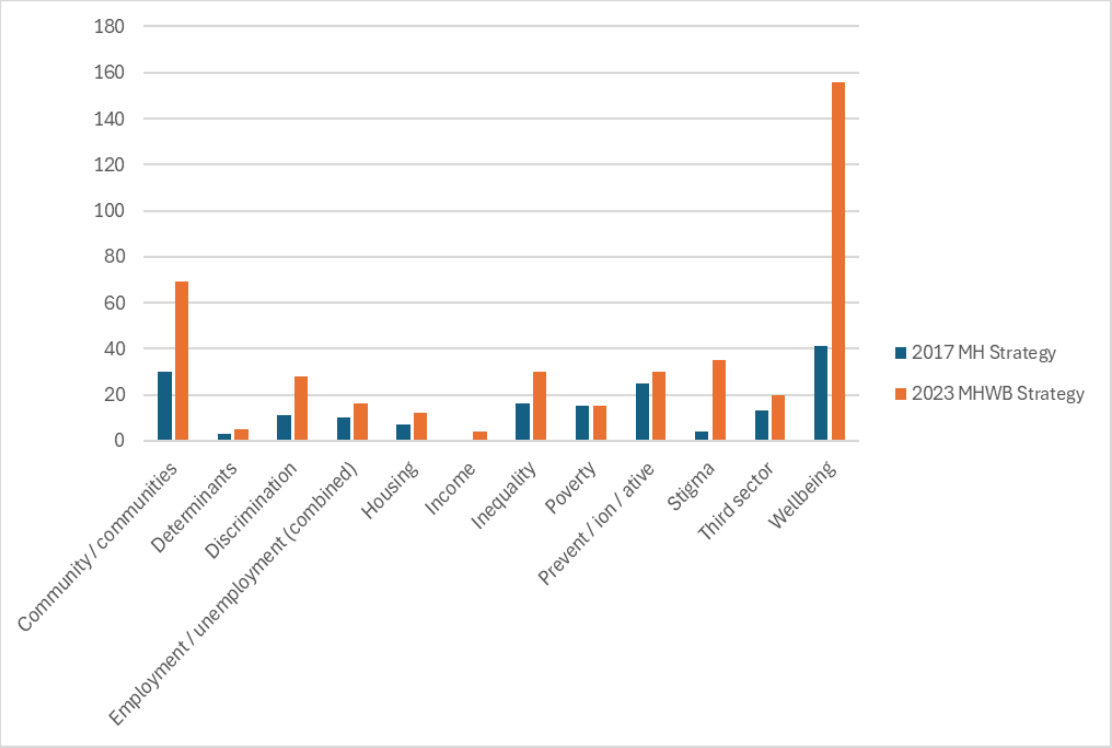

Figure 3: Bar chart comparing frequency of terms associated with preventive approach to mental health in the 2017 and 2023 mental health strategies

Table 2: Comparative analysis of terms associated with prevention

Word	Frequency: 2017 strategy	Frequency: 2023 strategy
Community / communities	30	69
Determinants	3	5
Discrimination	11	28
Employment / unemployment	10	16
Housing	7	12
Income	0	4
Inequality	16	30
Poverty	15	15
Prevent / ion /ative	25	30
Stigma	4	35
Third sector	13	20
Wellbeing	41	156

This shift away from a more medical model that focuses on individuals (in 2017), towards a more social model that emphasises the importance of social and economic context (in the more recent Strategy), is evident in how each document discusses crime, for example:

'There are many opportunities to develop and improve actions that promote good mental health for people who come into contact with the justice system ***as a result of their offending behaviour,*** *or who contact the police in distress. The Justice Strategy, due to be published shortly, explicitly frames the challenge of the "relatively poor mental health and wellbeing of those in the justice system", making reference to the prevalence of mental health and addiction problems for those in police custody.'* (Scottish Government, 2017:18 – emphasis added)

'People in prison often have a combination of mental and social care needs, arriving in prison ***disproportionately from the most deprived areas in Scotland****, and with higher mental health needs relative to the non-prison population.'* (Scottish Government & COSLA, 2023a: 13 – emphasis added)

This shift aligns well with wider research on the social and economic determinants of health (e.g. Marmot et al., 2010, 2020) as well as the community perspectives within the qualitative research we reviewed (see section 3.2).

Reflecting this more social model of mental health, the 2023 strategy also has a more sophisticated approach to describing social disadvantage, drawing on the concept of 'intersectionality' (which did not feature at all in the previous strategy):

> *'We also recognise that underlying factors, inequalities and types of disadvantage affect certain groups of people who may suffer disproportionate impacts on their mental health. We must learn from evolving evidence about intersectionality by recognising that people are multifaceted and that different experiences or aspects of their identity can interact and combine to affect their mental health in ways that are not the case for everyone.'*
> (Scottish Government & COSLA, 2023a:2)

There is also a new commitment within the latest strategy to 'cross government' working, and repeated references to the adoption of a 'whole system' approach (see table 3), which further acknowledge that many options for intervening to improve mental health lie outside the traditional 'health policy' domain.

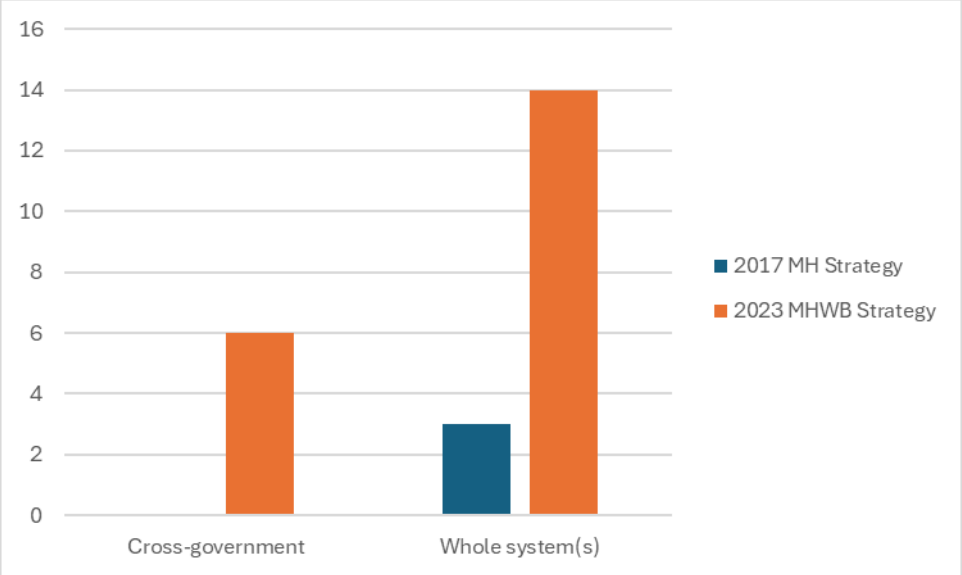

Figure 4: Bar chart comparing frequency of terms associated with broader approach to mental health policy in the 2017 and 2023 mental health strategies

Table 3: Comparative analysis of terms associated with broader approach to mental health

Word	Frequency: 2017 strategy	Frequency: 2023 strategy
Cross-government	0	6
Whole systems	3	14

While a wide range of social and economic influences on mental health are acknowledged, our analysis suggests further work is needed to identify specific actions to improve these wider social determinants. For example, while both texts say that "*poverty is the single biggest driver of poor mental health*", there is limited discussion of how poverty will be addressed. Similarly, housing is identified as an important determinant of mental health in both strategies, with a "*lack of adequate housing*" being clearly identified as important for mental health, yet it is unclear (within either strategy text) how the Scottish Government is responding to this challenge. As described in the Introduction, the 2023 strategy takes a high-level strategic approach, leaving detail on policy actions to the accompanying Delivery Plan 2023-2025 (Scottish Government & COSLA, 2023b). The Delivery Plan identifies several 'strategic actions' of relevance to poverty, housing and employment, sets out specific commitments in relation to mental health aspects of these determinants (see illustrative examples in Figure 5), and commits to the Wider Social Determinants of Mental Health Programme, which is aiming to identify clearer pathways between wider determinants and mental health with a view to informing options for intervening.

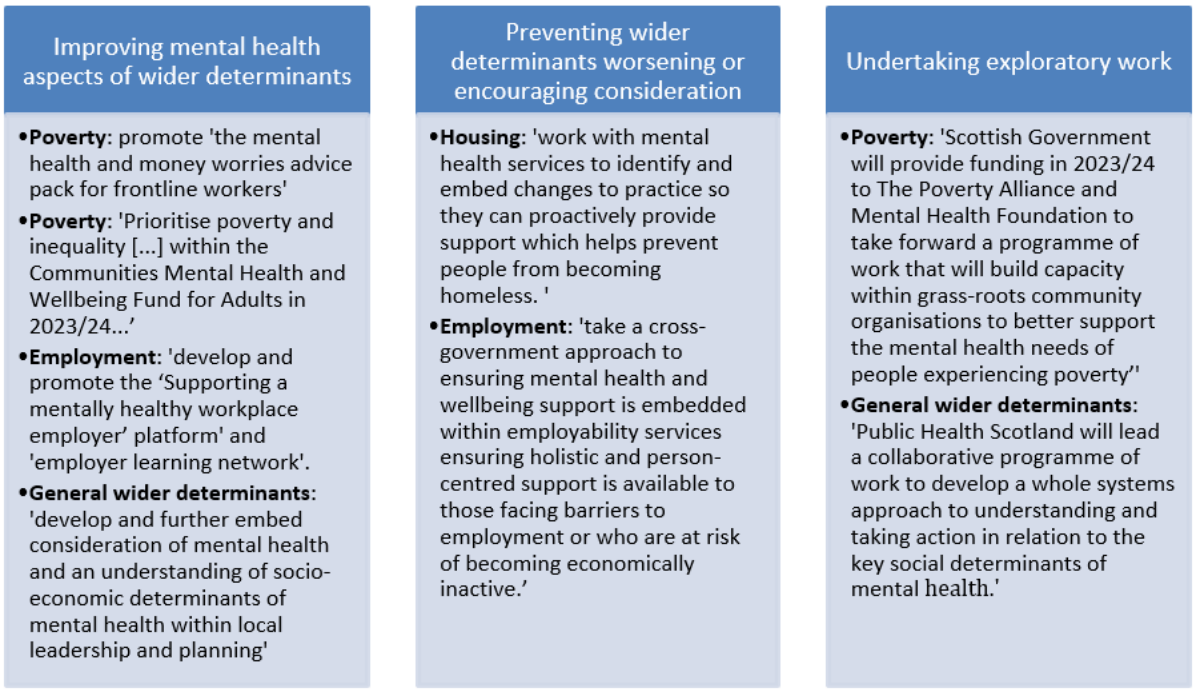

Figure 5: Examples of action on key wider social determinants (poverty, employment and housing) in the Mental Health & Wellbeing Delivery Plan (Scottish Government & COSLA, 2023b)

This may be because the substantive policy actions capable of addressing wider social determinants largely sit with other policy teams (and research suggests that 'Health in All Policies' type efforts often struggle to overcome policy silos - Cairney et al., 2021). Indeed, many such policies are listed in Appendix 2 of the Delivery Plan, which helps illustrate the cross-government nature of tackling wider determinants. However, the specific ways in which these broader policies might be expected to improve mental health and wellbeing remains unclear in both the Strategy and the Delivery Plan, suggesting one potential contribution of the WSDMHP will be to clarify the more detailed pathways connecting recent/anticipated policy changes to mental health and wellbeing outcomes. It may also be that, within the context of limited resources and policy levers that are impacted by decisions at multiple policy levels (including at UK government level), there is uncertainty about which intervention points and actions relating to wider social determinants are most promising for improving mental health and wellbeing in Scotland. As we discuss in the final section, the systems approach of the WDMPH seeks to help with both challenges.

One way in which the WSDMHP's systems approach might enhance understanding of the pathways connecting wider determinants to mental health and wellbeing is via a broader, more multi-faceted approach to psychosocial pathways. Compared to the 2017 strategy, the 2023 strategy demonstrates increased engagement with stigma and hopelessness. For

example, the latest strategy makes far more mentions of stigma than the previous strategy (35 compared to just 4 mentions in the earlier strategy). However, these challenges are not always linked to wider determinants, since the focus is primarily on tackling the stigma of poor mental health. This contrasts with the way disadvantaged communities commonly talk about stigma; as the following section makes clear, the qualitative literature suggests stigma is a pathway connecting wider determinants to poorer mental health experiences: a cause of poor mental health, as well as a consequence. The Delivery Plan 2023-2025 (Scottish Government & COSLA, 2023b) does commit to taking a broader view of stigma, saying: "*we will explore wider approaches to tackling mental health stigma, for example, the relationship with other types of stigma such as substance use*". The WSDMHP may be able to assist with this commitment to considering other types of stigma.

One final, important difference between the 2017 and 2023 strategies is the emphasis that the new strategy places on lived experience as a "*rich and diverse type of evidence"*, and intersectionality, as a means of drawing attention to the way multiple axes of inequalities can intersect within people's lives. The new strategy mentions 'lived experience' 13 times, in contrast to the previous strategy, which did not use the term at all. In the new strategy, the shaping of policy by people with lived experience is described as both a key outcome and a core principle; and its achievement is suggested partly through the proposed institution of new 'lived experience panels'.

Intersectionality is a concept coined by Black feminist Kimberlé Crenshaw (1989), which draws attention to the way different axes of inequality intersect to generate multifaceted experiences of discrimination and disadvantage. The concept of intersectionality can be applied here to understand how different forms of stigma and discrimination inter-relate with one another, rather than existing as independent levels of experience. Qualitative accounts of people adversely impacted by the social determinants of mental health indicate how stigma operates through systems, processes, and ideologies, playing out through interactions with people and within local environments, creating psycho-social impacts for individuals. Therefore, it seems likely that greater policy attention to lived experience will allow for further understanding and consideration of intersectional challenges, as the qualitative accounts given by individuals very often include these inter-related experiences of disadvantage. The WSDMHP could usefully consider what the consequences of this more intersectional approach to understanding inequalities and disadvantage may be for

understanding the pathways connecting wider determinants to mental health experiences, and for actions to improve mental health in Scotland.

3.2 In qualitative research, how do people in Scotland who have been adversely impacted by the WSDMH describe and make sense of these experiences?

Broadly, the qualitative literature we reviewed suggests that people who have been adversely impacted by wider social determinants in Scotland have a good, multi-faceted understanding of how wider determinants shape their mental (as well as physical) health (see also Smith and Stewart, 2024). Across the included studies, participants emphasise the association between factors such as poverty, inequality, unemployment, housing conditions and mental health and wellbeing (Burningham and Thrush, 2003; Copeland, 2004; Davidson et al., 2008; Egan et al., 2015). Criminal behaviour, too, is depicted by participants as a response to a lack of resource, opportunity and status (Lorimer et al., 2018; Fraser and Clark, 2021).

There are a small number of contradictory examples, in which participants blame others for their poor social circumstances and life choices (e.g. see examples in Mackenzie et al., 2017; McHugh et al, 2019; Smith et al, 2021). However, in most studies, even when participants referred to individualising discourses within the media and policy spheres, they often described them critically, noting the role that such discourses can play in social fragmentation (e.g. Mackenzie et al, 2017). Some studies suggested these discourses might prohibit popular acceptance of explanations based on social determinants of health (Inglis et al., 2019; McHugh et al, 2019), or at least lead to people from more disadvantaged groups feeling stigmatised and disempowered (Copeland, 2004; Smith et al., 2021).

Notably, we did not identify any examples of people blaming others for having poor mental health experiences; indeed, some studies specifically noted participants stating that mental health problems can be experienced by anyone, ‘rich people’ or ‘poor people’ (Smith et al, 2021). This may reflect the dominance of biological explanations for mental health, which are associated with perceptions of uncontrollability and therefore less blame (Weiner, 1993; Haslam & Kvaale, 2015). These explanations have become more prevalent following campaigns to destigmatize mental ill-health (Schomerus et al., 2012).

However, one study which focused on the views of Chinese, Pakistani and Indian ethnic minority communities found a distinction between responses to stressful social conditions such as economic deprivation, poor accommodation and racism, which were seen as ‘part of life’, and other mental health problems, which were sometimes framed as having spiritual,

rather than medical, causes (Knifton, 2012). Therefore, neither adverse experiences of wider social determinants, nor more 'severe conditions', were necessarily considered to be 'health' issues. These findings mirror major themes found in the scoping review of broader UK literature, suggesting that there are some important cultural variations in how mental health, and mental illness, are viewed (see e.g. Lavender et al., 2006; Palmer, 2007; Mantovani et al,. 2017). In undertaking any community engagement, or lived experience work, it will be important for the WSDMHP to consider these potential variations

While few of these studies explicitly set out to understand the pathways connecting wider social determinants to mental health outcomes, they collectively provide five key insights described in the following sub-sections of this chapter.

Together, these qualitative studies:

1. Help unpack the pathways that connect wider social determinants to mental health experiences;
2. Provide insights as to which structural and material determinants might be most important for mental health;
3. Highlight the roles that a wide array of systems and actors play in shaping people's lived experiences of wider social determinants;
4. Demonstrate why people living in Scotland's more disadvantaged communities often have low trust in public authorities, which itself appears to contribute to a sense of hopelessness that impacts on mental health; and
5. Begin to identify protective characteristics and potential policy solutions.

3.2.1 People's accounts of the pathways connecting wider social determinants to mental health experiences

In the qualitative literature we reviewed, people connect wider social and economic determinants to mental health experiences via multiple, intersecting psychosocial pathways. This suggests it is important to understand psychosocial experiences as pathways that connect wider determinants and mental health, rather than as distinct determinants. These most commonly include stigma, shame, embarrassment, anxiety and guilt (sometimes manifesting as anger), fear and a pervasive sense of hopelessness, each of which is grounded in material and social experiences.

People's accounts of stigma frequently demonstrate how structural stigma and social stigma intersect, manifesting as a 'feeling state', such as embarrassment or shame. For example, all groups of working age participants involved in an Edinburgh-based study of multiply disadvantaged residents described their engagement with welfare services as '*demeaning,*

anxiety provoking and discriminating' (Kapilashrami and Marsden, 2018: 10). Participants also referred to the challenge of accessing welfare support; those on varying incomes could experience frequent delays to their benefit payments, leaving them at risk of rent arrears (Ibid). The internalisation of these institutional processes was said to manifest as 'brown envelope phobia', as people developed a fear of the information contained within the formal letters they received through the post (Ibid: 10). In a small-scale research project exploring the experiences of people impacted by health inequalities in Glasgow, the precarious nature of the labour market, welfare system and of caregiving through adversity was found to impact family relationships and could be internalised, with negative consequences for mental health:

> "*I feel like a failure. It's [her son's] birthday tomorrow. I haven't been able to get him what I would normally*" (participant in Lynch and King, 2023: 6)

Participants often described striving to meet the social norms around caring and parenting, sometimes worrying that, when structural factors meant they could not meet these expectations, it appeared (or felt) like a personal failing. In another study, involving financially excluded community members engaging with a microcredit scheme, those with children expressed feeling shame, guilt and even suicidal thoughts in relation to their financial circumstances (Ibraham et al., 2021). Qualitative findings also suggest that there is widespread awareness of public stigma against people in poverty, particularly people in receipt of benefits. Some felt that this was fuelled by poor understanding of the causes and reality of poverty, particularly among higher income groups and the media, who were seen to promote inaccurate representations of low-income families and communities as financially irresponsible (Airey, 2003; Inglis et al., 2019).

3.2.2 Which wider social determinants emerge as important for mental health in experiential accounts?

With the exception of a couple of studies (McHugh et al, 2019; Smith et al, 2021), included studies were not designed to identify which determinants people felt were *most* important for mental health. However, by looking across the 38 publications, we can see that three wider social determinants - poverty, place and meaningful employment – are consistently described as having important mental health impacts (see Table 4, below). We propose these accounts suggest that poverty, place and meaningful employment are foundational wider determinants for mental health and wellbeing.

Table 4: Illustrative examples of the way poverty, meaningful employment and place feature in qualitative accounts of the wider social determinants of mental health

Determinant	Illustrative extract(s)
Poverty or low income	"*…the strain does cause illness, depression, sickness, and it can be like a vicious circle then because you are not able to work, and I know for some people that aren't working but want to work but just can't get a job. I would say for them depression, and illness would be even higher because they don't have that stability in the finances that they have.'"* ('Hilary', Ibrahim et al., 2021)
Meaningful employment (or lack of it)	*"'A man no' working was a bad thing in those days, it was the men that kept the women and their families afloat.' Interviewer: Although a lot of women here would've worked as well? Mary: 'That's right, but the men got depressed because that was their job tae [provide] for their family.'"* ('Mary', quoted in Mackenzie et al., 2017a)
Place (neighbourhood)	"*I think if you've got a nice outlook on life, I mean, if you come from, for talking's sake, [names affluent local area], and you open your door and everything's rosy, you'll feel rosy. But if you open your door and it's full of rubbish and what have you, it makes you feel depressed, you know."* ('Margaret', FG3, inner city area, lower SES, Greater Glasgow, quoted in Davidson et al., 2008)

Poverty

Poverty and low incomes are foundational because multiple pathways are described as connecting this determinant to poor mental health outcomes. This includes direct impacts, with accounts describing how experiences of poverty and financial exclusion can leave people (living in a highly unequal Scotland) feeling 'guilty', 'unworthy', 'stigmatised' and even 'suicidal' (Table 4 and Ibrahim et al, 2021). In-depth interviews with people attending foodbank services in North-East Scotland, for example, referred to the lack of choice over the food they could access which they felt negatively impacted their mental health (Douglas et al., 2020). Other studies capture multiple indirect impacts of poverty on mental health, such as using unhealthy behaviours (e.g. alcohol or drugs) to 'escape from' or 'cope with' poverty, with the consequence that these behaviours then further negatively impact on mental and physical health; or making decisions (such as only heating one room in the home or not inviting people to come over) which then lead to situations that worsen mental health (such as family conflict or social isolation). Housing quality likewise appears to be a vital problem related to poverty, with accounts proposing addressing poor living conditions as an essential first step in tackling deprivation and poor mental health (Smith et al, 2021).

The wider societal context was also emphasised as important for understanding the ways poverty and housing shape mental health. For example, for people with experience of

poverty or surviving on low incomes, pressures to be able to have certain products or lifestyles worsened the feeling of being unable to afford these items (e.g. Davidson et al, 2008) and led to a sense of being 'looked down' on and judged (Fergie et al, 2023). This reflects the fact that social, economic and political inequalities are fundamental to each of the issues featuring in Table 4.

Meaningful employment

Meaningful employment is foundational partly because it directly impacts on people's income and partly because it appears to provide a purposeful role for individuals within their families or communities. The literature describes the lack of such a role as potentially triggering a vicious cycle, in which the struggle to secure employment directly harms mental health in ways that make securing 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).

Where people described being unable to secure long-term meaningful employment, it often appeared to directly contribute to an inability to envision a positive future, as the following participants reflected:

> *"I'm 44, I cannae see any prospects. I'm out of it"* (male participant, quoted in Stead et al, 2001)

> *"So if you're no' working, what are you daein? Your system's shutting doon. And that's what's wrong wi' all these men round aboot here. Their systems are shutting down."* (Tommy) and 'Symptoms are unmasked by redundancy: *"I don't know whether it was people kind o' lost hope, in a way."*" (Rose) (Mackenzie et al, 2017)

In short, participants from low-income areas frequently referred to the limited availability of perceived opportunities regarding education and employment and the potential of this to negatively impact self-esteem, leading to feelings of hopelessness (Davidson et al., 2008; Mackenzie et al., 2017). Situating these extracts in the wider literature also allows us to see how important the wider societal context is for shaping the experiences described. This is perhaps most obvious when it comes to employment, with an absence of suitable local jobs informing people's beliefs that they (or their family members) are unlikely to secure employment (e.g. Garnham, 2015; 2017; Stead et al, 2001). The blame for this was often attributed to politicians, particularly UK politicians (notably Margaret Thatcher) (e.g. Garnham, 2015; Mackenzie et al, 2017; Stead et al, 2001), a point we return to later.

Place

Likewise, in Table 4 above, we see 'Margaret' (Mackenzie et al., 2017a) emphasising the local neighbourhood in which a house is situated (rather than the condition of the house itself) and the outlook that this provides. Several other studies similarly emphasise the importance of place for how people feel about themselves (e.g. Kapilashrami and Marsden, 2018; Inglis et al, 2018; Shortt and Ross, 2021). Indeed, the emphasis on place across multiple studies, and the centrality of place for people's identities, their sense of belonging and being valued or of being actively stigmatised and discriminated against, suggest that 'place' (or neighbourhood) is a foundational determinant of mental health, above and beyond people's immediate housing. For example, dilapidated buildings, graffiti and the closure of local amenities were said to visually represent the lack of investment in a place and instil a sense of being 'forgotten about' among residents (Fraser and Clark, 2021; Clark, 2023). Similar findings appear in other studies: children living in low-income areas in Aberdeen described their areas as 'mingy, minky and disgusting' (Watson and Douglas, 2012: 285); while children in deprived areas of Glasgow and Dundee reflected that:

> '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".* In both areas, the young researchers paused on their walks to photograph rubbish piles, dog waste, broken glass, beer bottles and cans, and cracked and damaged pavements.' (Short and Ross, 2021: 5/6)

Participants across multiple studies expressed concern about the reputation of the area in which they lived and the negative stereotyping of residents (Ibid; Airey, 2003; Garnham, 2015; Inglis et al., 2019). Some felt this led to 'postcode prejudice' in job applications (Davidson et al., 2006). Others reflected on the way in which this limited social support from friends and family that they could access as they were too embarrassed to invite people over (e.g. Davidson et al, 2008).

Place was also important because of various aspects of risk present in the local environment. For example, poorly kept shopfronts, worn equipment in playparks, evidence of substance misuse, and the presence of groups of young people (Nimegeer et al., 2018) all influenced perceptions of safety. While crime was not necessarily at the forefront of discussions, it is a recurring theme in studies focusing on disadvantaged neighbourhoods, with one study specifically exploring the struggles facing people living in a neighbourhood in which organized crime dominates (Fraser and Clark, 2021). Relatedly, violence (especially inter-personal, gang-related violence and gender-based violence), and fear of violence, was a common feature across multiple studies (e.g. Fraser and Clark, 2021; Garnham, 2015;

Lorimer et al., 2018; Wiseman & Watson, 2021). These perceptions appear to be associated with anxiety and are frequently described as restricting people's freedom to move around, as people avoid areas deemed unsafe, limiting opportunities to socialise and for fresh air and exercise (Egan et al., 2015; Rolfe and Garnham, 2020).

The physical condition of an area and perceived safety does not always appear to be synonymous: in one study (Egan et al., 2015), asylum seekers and refugees relocated to better quality housing following neighbourhood demolition in Glasgow reported experiencing racist abuse in the new (less multi-cultural) area; in another, racist abuse was said to limit engagement with health practices:

> '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.' (Isaacs et al., 2020: 427)

These accounts underscore the role of place and identity in the construction of health and health inequalities (Davidson et al., 2006). Physical features of local environments appear to invoke psycho-social responses, including anger, frustration or shame. There is also a relational aspect, influenced by stigmatising discourses played out through social interactions and the media. Accounts of place-based stigma illustrate the importance of distinguishing between different forms of internalised stigma (i.e. 'felt-stigma' vs. 'self-stigma') to fully understand the implications for mental health and wellbeing. Residents in areas experiencing 'place-based stigma' frequently rejected external stereotypes, instead seeking to maintain a positive local identity grounded in loyalty to local people with shared experiences of adversity.

Relatedly, in several studies in which people describe navigating their local neighbourhoods, alcohol is repeatedly identified as an important commercial determinant of mental health which has consequences for bystanders as well as consumers (e.g. Shortt and Ross, 2021; Kapilashrami and Marsden, 2018; Watson and Douglas, 2012). For example, a desire to avoid the potential conflict and violence associated with people consuming alcohol was described as transforming local areas, including green spaces, from health resources into sources of stress, anxiety and fear. This was partly because alcohol was linked to violence, another commonly mentioned factor contributing to people's mental health experiences (e.g. Lorimer et al, 2018; McGarrol, 2020). Although the impact of drugs was often describing similarly to alcohol (e.g. making bystanders fearful of unpredictable, potentially violent behaviour), the more widespread availability of alcohol contributed to it being a more

frequent feature in people's accounts. For example, a research participant in a study focusing on the Leith Walk area of Edinburgh, recounted:

> *"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 health."* (Participant in Kapilashrami & Marsden, 2018)

The accounts provided by people who used health-harming products, such as alcohol, drugs and tobacco, underlines the importance of considering the material and social (i.e. placed-based) contexts of these behaviours. For example, 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. Indeed, accounts of why people consumed drugs, tobacco and even unhealthy food were often similar; a means to escape stressful realities (see also Smith and Stewart, 2024) such as unemployment, living in high crime areas and, crucially, mental distress (often linked to experiences of trauma earlier in life, especially during childhood*):*

> '[S]moking provided a means of coping with the many and related stresses of residence in a disadvantaged community. For many respondents in our study, the struggle to cope on a limited income, often in tandem with caring for children and other family members, was intensified by a poorly resourced local infrastructure, high levels of crime and drug use, and severely limited opportunities for recreation or respite from the immediate environment.' (Stead et al, 2001)
>
> *"My problems were worse than any risks...I felt like people looked at me and thought "look at you, you're just a piece of dirt". I felt I was ugly and horrible."* (Female K, who had been sexually abused by family members as a child) (Copeland, 2004)
>
> *"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"* [FG6, inner city estate, lower SES, Greater Glasgow].' (Davidson et al., 2008)

High availability and social norms were also commonly cited as factors in people's consumption of health-harming products as well as being a barrier to efforts to make healthier decisions (e.g. Copeland, 2004; Kapilashrami & Marsden, 2018; Stead et al, 2001), further underlining the interaction of behaviours with place. Therefore, these accounts portray health-harming products as impacting the mental health of both consumers and bystanders: alcohol, drugs, tobacco and unhealthy foods are used by individuals in response to poor mental health, harming physical health and hindering decision-making; while alcohol

and drugs are cited as contributing to the poor mental health of non-consuming neighbours, who can be fearful of violent or unpredictable behaviours.

3.2.3 The wide array of systems and actors shaping lived experiences of wider social determinants

Across the qualitative studies, people's accounts often draw attention to the importance of understanding policy implementation, systems and processes with issues such as dignity, respect and responsiveness appearing key. Yet, processes for accessing social security and other benefits were often described as hostile or stigmatising (Young, 2021). For example, a study of 39 people living on low incomes in Scotland found that participants felt the welfare system was deliberately designed to make the process of claiming benefits challenging for claimants, to reduce public spending (Inglis et al., 2019). As a result, they believed aspects of the system were designed to embarrass and stigmatise:

> "*I always feel embarrassed going into the job centre … or even standing there and you see a person you know and you're like, oh my God, do you know what I mean? Because people look down on it*." ['Hayley', focus group 5]" (Inglis et al, 2019: 46)

Looking across the studies, it is evident that some social groups experience greater and more frequent negative experiences when interacting with local processes and systems. For example, research with asylum seekers and refugees across Scotland captures the uncertainty built into the asylum process which can leave people feeling that they are in a 'perpetual state of limbo' as they wait to hear the result of their application while having no recourse to public funds:

> *'*Participants described 'sitting', 'waiting', and 'doing nothing' for years on end. For Mufaro (Zimbabwe, AS), the unending nature of the process sapped her energy to such an extent that she did not feel she could do much else, leading her to say 'there is nothing I can do which can keep me healthy'.*'* (Isaacs et al., 2020: 426/7)

Being forced to rely on others and having no choice when it came to accessing food, which could be poor quality and culturally inappropriate, was also referred to in this context as causing low mood, as well as a sense of powerlessness and isolation (Vidal et al., 2023).

A further example from the qualitative literature reviewed related to systems and processes related to the criminal justice system (CJS). Families affected by imprisonment described the impact of their encounters with the CJS, again emphasising uncertainty and a lack of control. This includes feeling victimised by the police, but also stigmatised by the wider public:

> '"*I hate going to sleep now, because as soon as you hear a noise you think that somebody's going to batter your door in*." [Case 8: young person, mother released from prison]'
>
> (Long et al., 2022: 1898-1899)

Issues were also frequently raised in relation to prison visits including close observation, restrictions on physical contact, the searching of those under the age of 16, and children and young people witnessing how their family member was being treated (Ibid). Weaved through these accounts is an awareness of social stigma towards imprisonment; for children and young people, fear of stigmatisation at school could discourage them from opening up to others or even from attending, thus impacting their educational attainment (Ibid).

In an example related to precarity and agency in the school system, families of children with additional support needs and disabilities (ASND) from more economically advantaged backgrounds reflected on the impact of COVID regulations on their families (Couper-Kenny and Riddell, 2021). Parents who were given minimal guidance were left feeling 'useless, uneducated, low-skilled and completely guilty' for not being able to teach their children with ASND (Ibid: 29), while one parent said she could "*weep with rage and frustration*" at the long-term implications of education missed by their child (Ibid: 32).

The education system was also identified as a site for bullying in a study of LGBTQ+ young people who perceived this as a form of stigmatisation for the non-conformist nature of their gender identities (Marzetti et al., 2022). Linking back to the different forms of internalised stigma, whilst some expressed feeling that their experience of bullying had long-term implications for their self-esteem and led to suicidal distress, others normalised and minimised bullying behaviour appearing to resist victimisation (Ibid).

Accounts of victimisation and abuse within the local community were also cited by people with learning disabilities across four cities in Scotland who avoided leaving the house, contributing to social isolation and depression (Wiseman and Watson, 2021). Furthermore, LGBTQ+ youth described feeling judged by people in their local towns based on their appearance; looks, comments and questions were said to establish and re-establish cis-heteronormativity in the community on an everyday basis (Marzetti et al., 2022). This was believed to be connected to residents having a 'small-town mentality' and thus not being open to difference; although this stigmatisation was not limited to the physical spaces encountered by young people, as online platforms could also be sources of discrimination (Ibid). Other groups, such as refugees, people with learning disabilities and LGBTQ+ youth, also described feeling marginalised and victimized by people in their local areas for aspects of their identities/personhood.

In some cases, frontline bureaucrats were described as actively complicit in stigmatisation (for example see Garnham, 2015; 2017). Private sector actors, notably landlords who are seen to prioritise profits over tenants' wellbeing, also came in for critique (Garnham et al, 2022; Smith et al, 2021). And while health care workers were generally described far more positively (Smith and Stewart, 2024), there were several exceptions. For example, individuals with experience of homelessness reflected on the perceived stigma they experienced from the GP, preventing future engagement with the service:

> "*My GP doesn't gi' a fuck. I don't even bother. I've already told them they look and talk to me like I'm something on their shoe. So I've never been back*." (participant in Parkes et al., 2021: 9)

In another study, young people reported that GPs dismissed their symptoms when they sought help with mental health problems, and were made to feel that they were attention seeking (Marzetti et al., 2023). Even in studies where participants spoke positively about healthcare workers, some participants explained that they were not asked about their financial situations (and did not feel they had the time to raise such issues), meaning it was not always feasible to follow health advice or seek help for mental health concerns (Douglas et al, 2020).

3.2.4 Low trust in authorities informs a pervasive sense of hopelessness

A lack of investment in disadvantaged areas by local and national government was frequently raised as an issue, with a sense of injustice arising from the unequal nature of investments often being noted (Kapilashrami and Marsden, 2018; Shortt and Ross, 2021; Clark, 2023). This was informed by the place-based inequalities described in 3.2.2 and the hostile experiences of interacting with the kinds of public sector 'support' systems described in 3.2.3. Meanwhile, blame for the closure of large employers was commonly attributed to the UK government, especially in the 1980s.

Reflecting these experiences, across many people's accounts, there is a strong belief that people with resources and power do not care about disadvantaged communities in Scotland (or, therefore, about the people within these communities). 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), social division (Davidson et al., 2006; Lorimer et al., 2018) and 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)

Indeed, despite 25 years of devolution and claims that Scotland has developed a distinctive approach to policymaking that centres community empowerment (Cairney, 2020), the qualitative studies synthesised in this report suggest that Scotland's more disadvantaged communities do not feel well understood, represented, engaged with, listened to, or supported by politicians, policymakers or other authority figures. In short, people in authority are depicted as making decisions that have consequences but not understanding, or adequately caring for, the communities affected (Garnham, 2017; Watson & Douglas, 2012).

There is a recurring sense of powerlessness about policies that negatively impact poverty, meaningful employment or place, to the extent that it seems plausible to consider this a further key psychosocial pathway. Indeed, much of the literature conveys a similar despondency, disempowerment and lack of sense of control as identified as resulting from a 'democratic deficit' by work reviewing evidence that attempts to explain Scotland's excess mortality (Walsh et al., 2016). For example:

> '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 yous 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)
>
> "'*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?*'' (Joan, oral history participant in Garnham, 2017a, 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)

Analysed collectively, 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 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 welfare conditionality and austerity policies implemented by the Labour governments in power 1997-2010 and the Conservative governments in power from 2010+ (Garnham, 2017; Mackenzie et al., 2017); (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.'* (Mackenzie et al., 2017)

Indeed, 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 low trust appears to inform a pervasive sense of hopelessness; if affected communities do not believe that those in a position to make a difference sufficiently understand or care about their communities to make a difference, it is hard to imagine how the future might be better. This provides support for the idea that a sense of ‘political attack’ (Collins & McCartney 2011; McCartney et al, 2011; 2012) – in the sense of alienation from the political system and a perceived lack of representation - may itself be a determinant of mental health in Scotland. It also suggests that there is a great deal of work to do, if policymakers are going to gain the trust of disadvantaged communities in Scotland to begin addressing wider social determinants collectively.

3.2.5 Protective characteristics, resistance, and potential policy solutions.

In addition to the experiences participants perceived to negatively impact their mental health, many also identified factors they believed were beneficial, and thus potentially protective of mental health and wellbeing. Demonstrating the complexity of the issues explored, the same factors could be identified as being either beneficial or damaging to mental health and wellbeing in different contexts. Having a job, for example, was often associated with improved mental health and the ability to afford to engage in positive health behaviours such as sport and social activities in the local area (Macauley et al., 2021). Yet, the precarity of insecure employment described above appeared to contribute to mental distress, illustrating the importance of work conditions (Lynch and King, 2023). The experience of financial inclusion gained through participating in a micro-credit scheme in Glasgow was associated with increased confidence, feelings of acceptance and reduced stigma, whilst the ongoing accumulation of debt caused stress for some (Ibraham et al., 2021).

Other examples related to resources included the suggestion by children in low-income areas that forest parks could be beneficial for mental wellbeing (inducing calmness and happiness) (Shortt and Ross, 2021). Witnessing investment in the local area (e.g. clean up efforts or house building) was also cited as positive for mental wellbeing by children in Aberdeen (Watson and Douglas, 2012), though appeared to have less impact on older participants who had come to distrust authorities (Lorimer et al, 2018).

Some children in economically deprived parts of Glasgow and Dundee also said they felt that people in key roles could be protective, such as teachers and the police could make them feel safe; in this context school emerged as a ‘safe place’ (Shortt and Ross, 2021). However, different social groups spoke very differently about the way in which schools and the police impacted on their health, emphasising the importance of intersectionality. Young people who had experienced exclusion from education, and those with LGBTQ+ identities, gave far more negative accounts of the education system and its impacts on their mental wellbeing (e.g. Fergie et al, 2023; Marzetti et al., 2022). Likewise, people with learning disabilities described being dismissed by the police when they attempted to report hate crimes, which directly undermined their sense of self-worth (Wiseman and Watson, 2021).

Multiple studies refer to the importance of social connection, for example, positive relationships with neighbours and close family networks, for increasing feelings of belonging and safety within local communities (Knifton, 2012; Nimegeer et al., 2018; Rolfe and Garnham, 2020; Wiseman and Watson, 2021). The ability to access free spaces in the community that support local gathering has also been found to support social connection and feelings of safety (Nimegeer et al., 2018). A study of asylum seekers and refugees found that maintaining social connection with loved ones via media platforms created

feelings of hope, purpose and a sense of agency (Vidal et al., 2023). The opportunity for children and young people to develop social capital through recreational projects (e.g. sport and music) was found to develop self-confidence and encourage a sense of belonging (Watson and Douglas, 2012), whilst involvement in a social enterprise helped to tackle isolation and loneliness for participants in the Highlands and islands (Kelly et al., 2019). However, participants in other studies noted that community spaces are not always inclusive, particularly for people from minority ethnic backgrounds, thus potentially perpetuating experiences of marginalisation (De Andrade, 2016; Kapilashrami and Marsden, 2018). Furthermore, concerns have been raised for the mental health and wellbeing of staff and volunteers involved in running poorly resourced community-based services (De Andrade, 2016).

There are also examples of social resistance with qualitative accounts, especially when it comes to resisting negative representations of local neighbourhoods (further highlighting the importance of place for people's identity):

> 'F: "*You couldn't get a friendlier place than Possilpark*. F: *That's right*." (Female participants in Burningham and Thrush, 2003: 531)
>
> *"I just get angry with people who you know tar everyone with the same brush basically… the majority of people are nice people, it only takes one or two… to give the place a reputation."*" ('Mary' in Airey, 2003: 133)
>
> *"There's a lot of brilliant work, brilliant people, but you never hear that good news story. . . And, as much as there are issues going on in the community, it is a thriving community. . . Ah could quite easily have left and went to live somewhere else. But ah chose not tae".* ('Fiona' in Clark, 2023: 347)

Only a small number of studies explore people's views about potential policy responses to social determinants of health, none of these studies focused exclusively or specifically on mental health, and the studies that do exist reach mixed conclusions. While Smith et al.'s (2021) citizens jury participants were supportive of upstream policy measures (e.g. implementing more redistributive tax and welfare systems and improving living and working conditions), this support was undermined by low trust in (local and national) government to invest public money transparently or appropriately. A study by McHugh and colleagues (2019) combining qualitative and quantitative techniques found community participants tended to focus on individual (less structural) responses (even though many acknowledged more structural causes of ill-health). The authors propose that this may be a reflection of people "internalising an individual responsibility discourse in the UK of 'strivers' and 'skivers' with welfare recipients being particularly stigmatised and prejudiced" (McHugh et al, 2019:

p11). This highlights the importance of carefully designing research and policy conversations with communities about the wider social determinants of mental health in order to ensure that stigmatising discourses are not inadvertently reinforced.

3.3 Do these qualitative accounts align with accounts of wider social determinants in Scotland's 2023 mental health strategy and/or offer any insights that may be useful the developing wider social determinants of mental health programme (WSDMHP)?

The aim of this report was to explore how wider social determinants of mental health have been discussed within recent mental health policy documents published by the Scottish Government, and to compare this with the accounts of people in disadvantaged communities that are prevalent in qualitative research. Here, we reflect on the findings to identify potential implications for the WSDMHP work, while also identifying some important gaps in existing qualitative research in Scotland.

- The qualitative review in this report suggests that people in Scotland who have experienced social disadvantage have a good understanding of how wider social determinants (such as housing, unemployment and poor quality jobs and unemployment) impact on mental health and that these accounts provide insights into the pathways connecting wider social determinants to mental health. This suggests that the emphasis that the WSDMHP is placing on lived community engagement is appropriate and may provide one means of better understanding the causal pathways connecting wider social determinants to mental health and, therefore, promising intervention points.
- The qualitative review findings strongly reinforce the Scottish Government's focus (within the 2023 Mental Health and Wellbeing Strategy and the linked Delivery Plan) on poverty/low income as an important wider determinant of mental health in Scotland. Beyond this, the qualitative literature suggests the WSDMHP should focus on meaningful (or decent quality) employment (rather than employment per se) and on place (neighbourhood), which includes (but goes beyond) housing.
- The qualitative literature also identifies some additional wider social determinants, such as alcohol, drugs and violence, which feature only briefly in policy strategies, and seem worthy of further attention in the WSDMHP (especially in terms of the way these factors shape people's experiences of different places in Scotland).
- The analysis of the 2017 and 2023 policy strategy texts surfaces a long-standing challenge in tackling policy problems that require 'joined-up government' (Pollit, 2003). While the current academic literature lacks easy solutions, the WSDMHP

might be able to harness systems science in to help facilitate, embed and evidence stronger cross-government links around work to improve mental health and wellbeing.

- Mental health stigma can significantly worsen mental health, by contributing to feelings of shame and hopelessness, suppressing help-seeking, and detrimentally affecting personal relationships and access to life opportunities (Krupchanka & Thornicroft, 2017). The 2023 focus on mental health stigma is therefore welcome. However, the multiple forms of stigma that are described in lay accounts of how wider determinants contribute to mental health outcomes suggest that the WSDMHP could usefully build on the 2023 strategy's acknowledgement of other forms of stigma. In qualitative accounts, stigma appears to be an important causal pathway for, as well as a consequence of, poor mental health. This seems is likely to be important in respect of the Scottish policy commitment to taking a more preventive approach.
- The multi-factorial accounts of wider determinants shaping mental health that people provide in qualitative research lend support to the WSDMHP's focus on wider determinants. The policy analysis suggests that work is now needed to effectively operationalise these approaches: to find effective intervention points and actions to achieve systemic, whole systems changes that achieve the kind of transformative improvement in mental health that the Scottish Government is aiming for. The WSDMHP may be helpful in supporting a move from analysing which wider determinants are important for mental health to developing an evidence-base that identifies causal pathways and promising intervention points. However, in the current challenging resource environment, there is a risk that such a vast array of wider determinants may be viewed as too overwhelming, or too complex, to catalyse policy action. This is a persistent policy challenge that has long been documented when it comes to the wider social determinants of health (Petticrew et al, 2008; Scott-Samuel and Smith, 2015) and may be even more difficult for preventive policy approaches to mental health (Cairney & St Denny, 2020). Unfortunately, this is not a challenge for which the existing evidence-base seems to provide easy answers (Alegría et al, 2018) but it is possible that systems science tools can help.
- The qualitative research affirms the value of the WSDMHP's commitment to draw on a wide range of expertise, including communities, and those involved in running the various systems they encounter. Authors suggest that the absence of lived experience is particularly notable in the development of solutions to health inequalities (McHugh et al., 2019; Macauley et al., 2021) and there are calls for

greater dialogue between policymakers, professional stakeholders and local communities (McHugh et al., 2019; Smith et al, 2021). The WSDMHP may explore options for bringing different groups together when focusing on co-designing solutions, if there is a genuine commitment to managing unequal power dynamics and responding to the proposals developed through this process. This may also be a route to helping address the lack of political voice, and the sense of distrust in policymakers and other figures of authority that qualitative research in disadvantaged communities identifies. The current evidence base could also be strengthened by more engagement with affected communities in research aiming to identify (or develop) promising interventions and policies.

- Although the qualitative accounts capture the views of diverse communities in Scotland, the emphasis that current policy and qualitative accounts place on intersectionality underlines the importance of considering whether there are gaps in research that map to particular social groups. This is particularly important for mental health, since we know conceptualisations and understandings of mental health change over time and place and vary within and across cultures. The scoping work to explore similar qualitative literature in England, Wales and Northern Ireland, and the themes found in Knifton (2012), reveal that some minority ethnic communities in the UK have very distinctive conceptualisations of mental health, with important consequences for mental health stigma and help-seeking. This underlines the importance of considering diversity in community facing work within the WSDMHP and suggests there is a need for further research to engage a broader range of ethnic groups in research on wider determinants of mental health in Scotland.

- The evidence synthesis presented in this report demonstrates the value of qualitative insights for enhancing understanding of the psychosocial mechanisms that appear to underpin the way that wider determinants impact on mental health and wellbeing. It will be important to capture these in the WSDMHP systemic inquiry process. Utilising methods such as rich pictures (Bell et al., 2016) may provide further detail of these pathways, surfacing subjective meaning, feelings and values, while work to develop systems maps connecting wider determinants to mental health outcomes may help identify particularly important pathways and intervention points, including for teams working outside of health policy.
- Although the literature we identified provides a series of insights into the way wider determinants shape mental health and wellbeing, few of the included studies focused specifically on exploring people's accounts of how wider social determinants impact on mental health. Instead, most studies set out to explore people's accounts of

broader health or wider wellbeing impacts. While mental health consistently features in these accounts, it seems plausible that research with a specific focus on how people connect wider determinants to mental health could provide additional insights. This suggest that the WSDMHP's plans for working with community groups may be particularly insightful.

- Given the potential for research fatigue (see, for example, De Andrade, 2016), and the intensive nature of involvement for participants with lived experience in the WSDMHP systemic inquiry, the WSDMHP team should be prepared to justify the purpose and value of the programme; it could help to emphasise the commitment to developing solutions. Given this, and the likelihood of financial hardship, it will be important to ensure that participants are appropriately compensated for their involvement.

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*Please note that articles include within the qualitative review are indicated by an asterisk. A summary of these articles is available in Appendix 1.

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Appendix 1: Summary of articles included in qualitative review

Airey (2003): "Nae as nice a scheme as it used to be": lay accounts of neighbourhood incivilities and well-being'

This paper explores the influence of place on mental wellbeing, focusing on the experiences of women from two areas in Edinburgh with contrasting socioeconomic and health profiles. It is based on a qualitative PhD project involving 12 women aged between 45-59 who participated in in-depth, repeat interviews. 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. 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 vis 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. 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 anger). In response, several participants were keen to defend the area as a 'good' area.

Backett-Milburn et al. (2003): 'Contrasting lives, contrasting views? Understandings of health inequalities from children in differing social circumstances'

This study sought 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. 35 children, boys and girls aged between 9-12 years from a large Scottish city were interviewed twice using child-friendly techniques. The sample represented children living in relatively advantaged and relatively disadvantaged areas. The study also involved interviews with 30 parents, observational work and community profiling. The study 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 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. 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.

Blaxter (1983): The causes of disease - women talking.

This study explores the concept of 'disease' and its causes held by a group of middle-aged women brought up in poor social circumstances. 46 women from a Scottish city participated in unstructured interviews. 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 has 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 impacts on mental health and chronic diseases/illnesses. Psychosocial pathways strongly evident, e.g. stress, strain, anger, resentment, frustration and despair all mentioned.

Burningham and Thrush (2003): 'Experiencing Environmental Inequality: The Everyday Concerns of Disadvantaged Groups'

This paper examine how people living in disadvantaged communities experience, and talk about, inequalities in environmental inequality. The study includes Possilpark in Glasgow but also an area in Wales and London, England. 68 people participated in focus groups across the three sites. Participants discussed issues of fuel poverty as being problematic, particularly in winter. Residents also raised fears about their safety at home, drawing attention to issues of personal security, dirt and disease. 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. Powerlessness and experiences of stigma emerge as key psychosocial pathways linking these experiences to stress and poor health. Participants were concerned and angered by negative images of the place they regarded as home. Participants were troubled by the press 'hype' about the area's status as 'the smack capital of Europe''. Many of the interviewees would not see themselves or their environment as unequivocally poor and would resent such an assumption.'

Clark (2023): 'People just dae wit they can tae get by': Exploring the half-life of deindustrialisation in a Scottish community

This study utilises qualitative data from interviews with 24 current/former residents and 25 local service providers in an area with 'significant organised crime presence' in Scotland's central belt. This was part of a wider study conducted between 2016-2018. The author applies the concept of 'the half-life of deindustrialisation' as a theoretical framework. This concept refers to longer-term, more subtle impacts of deindustrialisation manifested in the everyday lives of local residents. Examples of the 'half-life' are observed in relation to poverty, addiction and mental health; the physical environment and external stigmatisation. Whilst the author suggests that the lives of residents are shaped by the threat of crime and violence, negative external perceptions of the locality are resisted and findings point to a strong, communal, working-class identity.

Copeland (2004): The Drug User's Identity and How It Relates to Being Hepatitis C Antibody Positive: A qualitative study

This study sought to explore the sense of self of a group of hepatitis C positive injecting drug users. 12 of the 16 participants reported having experienced traumatic childhoods (violent fathers commonly featured). Interviewees described struggling with relationships and feeling socially isolated. Several interviewee accounts lacked a clear sense of the future. Attempts to escape bad memories and problems recognised as a reason for starting drug use by some interviewees. 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). 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. 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.

Couper-Kenney & Riddell (2021): The impact of COVID-19 on children with additional support needs and disabilities in Scotland

A study assessing 'the extent to which children’s rights have been prioritised during the COVID-19 crisis'. This was a qualitative study of 16 families that included a child with additional support needs. 16 parents were interviewed via email (14) or online (2). 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, ‘such as enjoying more time together and a release from school-generated stress''. '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'. 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. 'In general, there was a sense that the experience of school closure had a profound impact on the entire family'.

Davidson et al. (2006): The wealthy get healthy, the poor get poorly? Lay perceptions of health inequalities; Davidson et al. (2008): Location, location, location: The role of experience of disadvantage in lay perceptions of area inequalities in health.

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 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'.

Among all the lower socio-economic groups in the research, 'there was widespread acceptance of the idea that sharp inequalities exist within contemporary society.' 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. ‘As people talked about living in particular places, a strong sense of social and physical distance and alienation between areas was apparent.’ 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 discussed the impact of areas on people in ways which suggested deprivation and place and poverty-related stresses aged people. Mental stress was identified by participants as key mediator linking socioeconomic circumstances and health outcomes. Psychosocial factors perceived to impact directly on mental health including fear (e.g. of gangs, crime, anti-social 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. Poor housing was perceived to have direct consequences for mental health and high rise flats were highlighted as particularly problematic. 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. 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. 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.'

De Andrade (2016): Tackling health inequalities through asset-based approaches, co-production and empowerment: Ticking consultation boxes or meaningful engagement with diverse, disadvantaged communities?

This study sought to: (i) gather specific BME groups’ perceptions of a number of pre-identified and emerging health related issues, and (ii) to explore how an asset-based approach and co-production could be used to engage with minority ethnic groups. Research

involved 35 semi-structured interviews and a six-month ethnography in an ethnically diverse, disadvantaged Scottish neighbourhood.

Different communities have different needs when it comes to disseminating health information. 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. Individuals from minority ethnic groups may not engage in community organisations/spaces, where they are perceived to be 'white spaces'. 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.

Douglas et al. (2020): A qualitative investigation of lived experiences of long-term health condition management with people who are food insecure

A study exploring the challenges faced by people with lived experience of a long-term health condition and food insecurity in terms of: their self-care condition management practices; disclosing and discussing the experience of managing their condition with a health care professional; and notions of the support they might wish to receive from them. 20 in-depth interviews were conducted with individuals attending a food bank and food pantry in North East Scotland.

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. '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. Bills, such as housing costs and heating were prioritised and paid for first. 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 were struck by the extent to which their narratives revealed that this issue remained unspoken and seemingly invisible in those discussions.'

Egan et al. (2015): Neighbourhood demolition, relocation and health: A qualitative longitudinal study of housing-led urban regeneration in Glasgow

A qualitative longitudinal study to explore how adult residents of disadvantaged urban neighbourhoods in Glasgow experienced neighbourhood demolition and relocation. Data from 23 households was collected in 2011 and 2012. This study sought to 'explore in-depth, the experiences of residents during a period of clearance, demolition and relocation to new or improved properties'.

Participants gave wide ranging explanations for health problems. 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 included 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). 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 and worried that relocation might disrupt these.

Fraser and Clark (2021): Damaged hardmen: Organized crime and the half-life of deindustrialization

This study draws on qualitative data from a study based on an area with 'significant organised crime presence' in Scotland's central belt. Interviews were conducted with 55 participants (24 current/former residents and 25 local service providers). The paper argues that organised crime in this locality should be understood as a 'residual culture grafted onto a fragmented, volatile criminal marketplace where the stable props of territorial identity are unsettled'. The authors consider the 'enduring legacy' of deindustrialisation on young people, social relations and communal identity.

Garnham (2015): Understanding the impacts of industrial change and area-based deprivation on health inequalities, using Swidler's concepts of cultured capacities and strategies of action; Garnham (2017): Public health implications of 4 decades of neoliberal policy: A qualitative case study from post-industrial west central Scotland

The 2015 paper describes its study aims as being to describe 'participants' lived experiences of deindustrialisation... with a focus on the relevance of such processes for 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.'

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 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 level of poverty described is extreme. 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. 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 Clydebank 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. Politicians (especially those based in London) perceived not to care and there is clear anger towards politicians. The results of the 2017 paper are similar but there is a clearer emphasis on the importance of cumulative impacts of policies and of generational impacts, with the author arguing that three distinct cohorts of participants are evident in the data. While the earlier cohorts had some positive associations with the area, for the youngest cohort, 'their view of their hometown was almost entirely negative'.

Garnham et al. (2022): Intervening in the cycle of poverty, poor housing and poor health: the role of housing providers in enhancing tenants' mental wellbeing

This paper aimed 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. Where the property was uncomfortable or did not feel private, for example, participants became increasingly unhappy, anxious and worried. 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. Participants in this study emphasised the importance of home, not just as a secure base from which identity and a positive sense 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.

Ibrahim et al. (2021): Microcredit as a public health initiative? Exploring mechanisms and pathways to health and wellbeing

This study aimed to qualitatively 'investigate the impact of responsibly-delivered credit on the health and wellbeing of borrowers' . 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'.

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.'

Inglis et al. (2019): Health inequality implications from a qualitative study of experiences of poverty stigma in Scotland

This study aimed 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 considered stereotyping TV programmes to be highly influential in shaping public attitudes toward people experiencing poverty, especially benefit claimants. 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. 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. 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.

Isaacs et al. (2020): ‘I don’t think there’s anything I can do which can keep me healthy’: how the UK immigration and asylum system shapes the health & wellbeing of refugees and asylum seekers in Scotland

This study aimed to explore asylum seekers and refugees’ experiences of health, wellbeing, and health practices in the context of their lived realities in Scotland. 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. Argues that current policy context in UK 'has a profound impact on the mental health of asylum seekers'. Participants recounted racist experiences in their everyday interactions. 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. 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.

Kapilashrami & Marsden (2018): Examining intersectional inequalities in access to health (enabling) resources in disadvantaged communities in Scotland: Advancing the participatory paradigm

This study aimed 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.

'All but two groups of participants identified specific public/community resources – libraries, places of worship (local church, mosque and temple) and a community centre'. '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'. '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'. 'The most notable dis-affective resource was the stress of not having a reliable income. The accessibility of alcohol (e.g. via pubs) was also identified as problematic and impacted people's sense of safety. Intersectionality key: 'What emerged was how multiple disadvantages interacted ... and affected individuals' capacity to benefit. 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.'

Kelly et al. (2019): Filling a void? The role of social enterprise in addressing social isolation and loneliness in rural communities

This paper explores the role of community-led social enterprise models in rural contexts. It draws on qualitative data from in-depth interviews with 35 stakeholders from seven social enterprises in the Highlands and Islands of Scotland, including service users, volunteers, staff and board members. Findings suggest that social enterprises provide activities that can counter the impacts of loneliness and social isolation resulting in wider benefits to health and wellbeing. However, the authors the sustainability of social enterprises is found to be

threatened by the reliance on small populations with limited knowledge and expertise and pressure placed on individual volunteers/staff members. The authors conclude that community-led social enterprise models positively impact the social determinants of health but must be tailored to meet the specific needs of local areas in rural contexts to support flexible service provision.

Knifton (2012): Understanding and addressing the stigma of mental illness with ethnic minority communities

This study aims to explore beliefs about mental health, stigma and anti-stigma messaging within BME communities in Scotland. Ten focus groups were conducted involving 87 participants from the three largest BME communities in Scotland: Chinese, Indian and Pakistani. Across the groups, mental health problems were attributed to stressful social conditions such as economic deprivation, social deprivation, and pressures of family responsibilities. In Chinese communities these were consistently described as pressures of life, while Pakistani and Indian participants described these, prejudice and violence as contributing to mental health problems. Newer migrants described processes of migration as particularly stressful. Most participants rejected that anxiety and depression were medical conditions, preferring that they were responses to social problems, crises of faith, or ‘part of life’. More serious conditions such as schizophrenia, bipolar illness or ‘just madness’ were heavily stigmatised, and sometimes connected to religious or spiritual explanations. These explanations, and the widely acknowledged stigma, reduced help-seeking.

Lorimer et al. (2018): Exploring masculinities, sexual health and wellbeing across areas of high deprivation in Scotland: The depth of the challenge to improve understandings and practices

This study aimed to explore constructions of masculinity in relation to sexual health and wellbeing (taking an SDH approach). '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’. Alcohol use was linked to poverty and desperation (including hunger). Belief that cultural investments in their area were not for people like them. ‘We heard men talk about domestic abuse as a common feature of their communities, or personally witnessing

domestic abuse'. 'The blaming of women for incidents of sexual violence was salient in the data'. Women tended not to trust men or view them positively. Historical personal histories and childhood trauma seemed key.

Lynch and King (2023): Engaging with communities and precarity theory to bring new perspectives to public mental health

This paper draws on data gathered through a qualitative, participatory research project conducted in 2021 involving 9 service users at a community organisation in North Glasgow. Participants were asked to record their daily lives over the course of 4 weeks through various methods including written diary entries, audio recordings, memos, mood boards and photographs. The authors considered the way in which precarity related to bio-political, economic, social and environmental conditions played out individuals' accounts of their daily lives and the way in which they talked about mental health and ill health. The authors conclude that political matters (understood as the 'biopolitics' of everyday life) should be more greatly considered in public health.

Macaulay et al. (2021): Public perspectives on health improvement within a remote-rural island community

The aim of this paper was 'to identify and describe the shared perspectives of residents of one remote-rural island community in Scotland, on how to improve rural health.' 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 recognition that providing access to services and amenities in rural communities, and addressing rural poverty, is important for improving the health of residents.'

Mackenzie et al. (2017): Working-class discourses of politics, policy and health: 'I don't smoke; I don't drink. The only thing wrong with me is my health'

The aim of this paper was to explore understandings of the causes of (ill) health in local communities in two deindustrialised areas in Scotland.

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'. 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 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. Psychosocial pathways feature strongly, including references to people feeling 'absolutely worthless', 'really depressed', with self-esteem being described as 'hard to sustain'. Meaningful employment was described in ways that suggest it protects against some negative health behaviours, while sudden large-scale unemployment was linked to problematic behaviours.

Marzetti et al. (2022): "Am I really alive?": Understanding the role of homophobia, biphobia and transphobia in young LGBT+ people's suicidal distress

This paper aimed 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.'

Concerns that identities would not be accepted informed feelings of hopelessness. 'The majority of participants reported bullying throughout their education. Other participants described experiences of violence and living in fear of violence. 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. 'Given these pressures, some participants expressed difficulties envisaging the future'. Some participants described how consistently negative comments/narratives could contribute to negatively change they way they thought about themselves.

Marzetti et al. (2023): A qualitative study of young people's lived experiences of suicide and self-harm: intentionality, rationality and authenticity

This study explores how young people in Scotland make sense of suicidal distress. Semi-structured interviews were conducted with 24 young people (aged 16-24) from urban and rural regions across Scotland, representing all deciles of the Scottish Index of Multiple Deprivation (SIMD). A distinction was made by participants between suicidal feelings,

understood as 'almost rational responses to adversities', and suicidal attempts which were depicted as being more impulsive. Participants described feeling dismissed by people within their close networks and by professionals which influenced their own perceptions of distress and how they sought support. The authors conclude that dismissive attitudes, stigma and challenges communicating suicidal distress could prevent help seeking.

McHugh et al. (2019): Who knows best? A Q methodology study to explore perspectives of professional stakeholders and community participants on health in low-income communities

This paper aimed to examine shared perspectives on, and relationships between, why 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.'

Broadly summarised these accounts for ‘Causes’ are: i) ‘Unfair Society’, ii) ‘Dependent, workless and lazy’, iii) ‘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).

Nimegeer et al. (2018): Experiences of connectivity and severance in the wake of a new motorway: Implications for health and well-being

This paper is based on a qualitative study exploring the impact of a motorway extension in Glasgow on the wellbeing of local residents. The research was part of wider, mixed-method, longitudinal natural experiment study. 30 residents participated in an initial semi-structured interview and 12 went on to complete a photo-elicitation interview. Half of respondents (15) were from Govanhill and half were from Rutherglen (15); all resided within 400m from the motorway extension. The authors found complex associations between the new transport infrastructure, connectedness and health. Specifically, findings suggest that the new road impacted places of social connection even where it did not physically sever them. The

authors emphasise the need to consider how people live and engage dynamically with people and services in wider geographical areas, rather than focusing just on local neighbourhoods.

Parkes et al. (2021): “You know, we can change the services to suit the circumstances of what is happening in the world”: a rapid case study of the COVID-19 response across city centre homelessness and health services in Edinburgh, Scotland

This paper aimed 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. 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. 'Some participants described not having family support to fall back on. The impacts of lockdown on participants' substance use seemed mixed. 'The rapid rehousing of people who were deemed street homeless across the city was described as a “massive triumph” and praised by staff, stakeholders, and people with lived/living experience alike.

Rolfe and Garnham (2020): Neighbourhood impacts on wellbeing: The role of housing among low-income tenants

This paper aimed 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.'

The findings suggest there is a strong relationship between tenants’ perceptions of neighbourhood quality, as well as their local social support networks, and their wellbeing outcomes. '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'. 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'. 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.

Shortt and Ross (2021): Children's perceptions of environment and health in two Scottish neighbourhoods

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? 'The research aimed to uncover how children living in more deprived neighbourhoods perceive their environments.

Stigma and shame can contribute to a number of health issues (place-based stigma particularly emphasised). Green spaces as opportunity for play and social engagement but also as spaces with crime, substance abuse and violence. 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. In particular, a lack of financial resources was emphasised, with this and contextual barriers converging to construct spaces where children experience exclusion. 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.'

Smith et al. (2021): Public understandings of potential policy responses to health inequalities: Evidence from a UK national survey and citizens’ juries in three UK cities

This paper aimed 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. 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' Notably absent from these constructions were ideas of community and solidarity. 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 motives, competence, integrity and (lack of) concern for, or understanding of, ‘people like us’'. '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'.

Stead et al. (2001): “It's as if you’re locked in”: qualitative explanations for area effects on smoking in disadvantaged communities

This paper aimed 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'. 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 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.'

Vidal et al. (2023): Rupture and liminality: Experiences of Scotland's refugee population during a time of COVID-19 lockdown

This paper considers the impact of the COVID-19 pandemic on refugees. The study draws on data from 51 semi-structured conducted with individuals across 14 local authority areas in Scotland at different stages of the asylum process or with refugee status. Findings highlight the experience of 'rupture' and 'liminality', linked to feelings of loneliness, hopelessness and mental wellbeing. The authors conclude that meaningful social connection could help to maintain a sense of hope, purpose and agency. The importance of recognising the unique needs of refugees in approaches to integration is emphasised.

Watson and Douglas (2012): "It's making us look disgusting ... and it makes me feel like a mink ... it makes me feel depressed!": Using photovoice to help 'see' and understand the perspectives of disadvantaged young people about the neighbourhood determinants of their mental well-being

This paper aimed 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.

Youth project seemed to be effective partly because it provided something to do. 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. 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 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'. 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. 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.

Wiseman and Watson (2021): "Because I've Got a Learning Disability, They Don't Take Me Seriously": Violence, Wellbeing, and Devaluing People with Learning Disabilities

Disrespect and devaluing profoundly erode the wellbeing of people with learning disabilities. Violence is a 'central contributor' to inequalities experienced by people with learning disabilities. Participants described trajectories of harassment and bullying that started from a young age. 'Women reported experiences of sexual violence as children and adults.' Participants described feeing worse about experiences of violence because people around could have intervened to stop it but didn't. One participant described feeling ‘too scared to leave his home', others described how fear led them to self-harm. 'The devaluing of people 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.'

Working together to tackle health inequalities and improve the health of the public.

The conditions in which we are born, grow, live, work, and age are key drivers of health and health inequalities. Preventing illness related to these 'social determinants of health' requires well-coordinated policies across many sectors, such as the economy, welfare, housing, education, and employment.

SIPHER's innovative systems science approach offers a powerful framework to explore the complex real-world relationships and interdependencies of diverse policies that shape our public health and wellbeing.

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