What mental health stigma and discrimination looks like for women and girls in Scotland and what works to reduce it

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Introduction

See Me is Scotland's national programme to end mental health stigma and discrimination. See Me's vision is for a fair and inclusive Scotland, free from mental health stigma and discrimination. Tackling stigma and discrimination and addressing the barriers they create is central to any action to improve mental health.

See Me has entered Phase Three of its programme of work, marked by a refreshed Strategy *With Fairness in Mind* (2021- 2026) which aims to:

- Achieve change at scale to tackle the deep-rooted stigma and discrimination that directly affects people who experience mental health problems in Scotland today.
- Make Scotland a global leader in anti-stigma activity.
- Increase learning by gathering, applying and testing the evidence of what works to change attitudes, behaviours and cultures to end mental health stigma and discrimination.

To bring about lasting and sustainable change, See Me is identifying key priority groups in Scotland and working with partners to share and apply learning to build capacity and mainstream action to end stigma and discrimination. Women and girls have been identified as one of the key priority groups, and subsequent, therefore this review focuses on specific challenges facing women and girls in Scotland today with regards to mental health stigma and discrimination. It seeks to explore what forms stigma and discrimination takes and how it negatively impacts on mental health and wellbeing.

To do this, seven key issues were identified and subsequently investigated: COVID and employment, body image and eating disorders, women's health, sexual orientation, women and families, women from ethnic minority backgrounds, violence against women and women in the criminal justice system. Each of these issues provides different examples of where mental health stigma and discrimination are present and negatively impacting women and girls. This reflects See Me's alignment with current policy trends within Scotland to recognise and address the challenges and inequalities that women and girls face with regards to health and wider socioeconomic issues and to tackle gender inequality. The Scottish Government recently released The Women's Health Plan which seeks to *''underpin actions to improve women's health inequalities by raising awareness around women's health''* (Scottish Government, 2021). The National Advisory Council on Women and Girls (NACWG) 2019 recommendations are challenging the Scottish Government to do more to tackle gender inequality in Scotland.

The evidence provided in this review will help to not only inform See Me's programme activities for Phase Three, but also to generate implications for policy and practice that can ensure that the mental health stigma and discrimination that women and girls face is better understood and challenged effectively at a community, local and national level.

Methodology

The review takes a non-systematic approach to reviewing evidence, providing an informative but not exhaustive overview of the literature of what mental health stigma and discrimination looks like for women and girls in Scotland.

An issues-based approach was taken when examining the available evidence: as an initial scoping review, it was important to be able to conduct a broad search to allow for the key issues to be identified, and this approach provided the initial flexibility needed. It also allowed for an in-depth, comprehensive exploration of the specific challenges facing women and girls and for identification of sub-themes within each issue, providing clarity in recognising exactly where mental health stigma and discrimination is present.

The evidence in this review comes from a combination of academic and grey literature, which allows for a good overview of the current evidence relating to women and girls and mental health and discrimination.

The main limitation of this review is the paucity of literature available on mental health stigma and discrimination in general and in Scotland in particular. As such, academic and grey literature relating to the whole of the UK was used, in order to provide enough evidence for a meaningful review. Whilst there are specific contexts that are unique to Scotland, it was assumed that research from the rest of the UK was still similar enough to the general Scottish context to provide validity. Where Scottish data or research is used, this is clearly identified.

Even with the addition of wider UK research, the overall lack of mental health stigma and discrimination data meant that for some issues wider, relevant evidence on the impact of the issue on mental health and wellbeing has been included. Additionally, there is very limited stigma and discrimination data available about intersectionality and mental health of women.

In recognition of the lack of available evidence, search terms were expanded beyond just ‘stigma’ and ‘discrimination’ to include broader topics of ‘shame’, ‘guilt’, ‘self-stigma, ‘self-esteem’ ‘barriers’ and ‘embarrassment’. This helped to ensure that any evidence women and girls experiences of mental health stigma and discrimination could be identified more easily.

COVID and Employment

Women and men had different levels of economic wellbeing before COVID-19, with women already experiencing gendered barriers and inequalities that negatively impact on employment such as the gender pay gap, childcare responsibilities and a lack of flexible working, and this has only been exacerbated by the pandemic. Whilst research on this topic is still ongoing and emerging, the pandemic has a greater economic impact one women than men, both as frontline workers and at home (Chapman et al., 2020). The negative financial impacts are likely to grow and increase as furlough ends, as are the socioeconomic and mental health impacts. The 2021 Status of Young Women in Scotland report concluded that COVID-19 has had a ‘’disproportionate impact on women’s wellbeing, mental health and financial security’’ and that the socioeconomic consequences of the pandemic have the potential to deepen existing gender inequality in Scotland. The mental health implications that disruption to employment and financial stability can create must be recognised - and it is important to highlight the stigma and barriers that women face in the workplace that can compound poor mental wellbeing.

COVID has aggravated labour market challenges for many women, especially those groups who already faced barriers. Women in minority groups face an additional range of barriers within the labour market – such as discrimination, inaccessible workplaces and a lack of employer support (Engender 2021). 32% of women in Scotland believe they will have more debt after the pandemic, compared to 17% of men - this increased to 38% of disabled women and 39% of BME women, highlighting further disparities for minority groups (Engender 2021). Disabled women reported higher levels of anxiety and that they are facing additional barriers to employment due to changes to social care during the pandemic (Engender 2021).

Young women were also more likely be negatively impacted economically: a survey run by Engender (2021) asking about employment stability during the pandemic found that 51% of young women had been impacted: 25% were furloughed, 8% were made redundant, and 20% were unable to find work during the pandemic (Engender 2021).

Evidence suggests that younger women are more likely to be facing financial precarity, as they are more likely to be working in sectors such as hospitality that have been negatively impacted by lockdown rules - 31% of women aged 18-30 had concerns about paying their rent or mortgage, compared to 19% of women aged 31-45 (Engender 2021). Financial concerns can have a severe impact on mental wellbeing and with the end of furlough, these anxieties are likely to increase.

For working mothers, there have also been new challenges. With schools and nurseries closed and older people being forced to shield, many working mothers have found their responsibilities changing to include home schooling, additional caring duties for children and elderly relatives and increased housework – whilst continuing their paid employment. These additional responsibilities can have a significant impact on mental wellbeing. There is evidence to suggest that women have taken a greater burden of responsibilities than men for the new challenges: one study found that British mothers spent an average of 3.5 hours a day providing

childcare and more than 2 hours home schooling, whilst fathers spent under 2.5 hours on childcare and less than 2 hours home schooling (Adams-Prassl et al., 2020). Another study by the Institute for Fiscal Studies, found that nearly half (47%) of the hours working mothers were paid for were split between their job and additional household duties, compared to just 30% of the working hours for working fathers (Andrew et al. 2020). Concerns over work performance and inability to work as much as usual due to childcare duties have been identified as a source of stress for many working mothers during the pandemic. Additionally, working mothers were 23% more likely than working fathers to have lost their jobs (temporarily or permanently) during the pandemic and 14% more likely to have been furloughed, creating financial hardship and increasing levels of uncertainty and stress (Andrew et al. 2020).

Despite the additional challenges that women have faced during the COVID-19 pandemic, women in Scotland have reported less support for their wellbeing from their employers. An Engender (2020) report found that 17% of women said that the wellbeing support from their employer had decreased since the first lockdown, compared to 9% of men. With regards to home schooling, women were more than twice as likely as men (14% of women compared to 6% of men) to say the support from their employer to balance home schooling and work had dropped from the first lockdown.

The issues discussed above offer insight into why women’s economic and mental health has been negatively impacted by COVID-19 to a greater extent than that of men's. Covid-19 has highlighted that more needs to be done in order to make the workplace more gender-accommodating, especially for women who have caring responsibilities and that employers must not discriminate against women with caring responsibilities in terms of support offered.

Body image and eating disorders

Body image

Women are more likely to have poor body image than men, making this a concern that is particularly gendered (Mental Health Foundation 2019). This is an issue that appears to be exacerbated by the media and social media and the unattainable standards of physical appearance that they can set. One in ten women are not satisfied with their body and it is perhaps an issue that is prevalent amongst young women with 46% of girls aged 13-19 in the UK reporting that their body image causes them to worry 'often' or 'always' (Mental Health Foundation 2019). This has a direct impact on how they live their life and the lifestyle choices that they make and therefore on their mental health.

The 2020 Status of Young Women in Scotland report found that 80% of young women said that their body image had stopped them from doing something and 56% said that it impacted their participation in sport and exercise. This report also revealed that 17% of women said they would not go to a job interview, and 8% would avoid going to work, if they felt badly about their appearance (MHF, 2019). Women with poor body image were also less likely to be socially engaged (Mental Health Foundation 2019). Struggling to participate in jobs and activities can have an effect on relationships and self-esteem which has an impact on mental health.

Those who suffer with body image issues appear to have high levels of anxiety and depression. With 40% of women reporting that they felt anxious and 45% of women reporting that they felt depressed because of their body image (Mental Health Foundation 2019). It was also found that 15% of women had suicidal thoughts or feelings due to their body image concerns, while another study found that young women who had more extreme weight controlling behaviour, such as the use of diet pills, were more likely to have suicidal thoughts (Mental Health Foundation 2019).

Body image issues can be a problem that follow women throughout all stages of their lives, not only in young adulthood. For example, as women face many changes to their bodies through pregnancy there is notably lower positive body relationships in those who have been pregnant. 41% of women have more negative feelings towards their body image after pregnancy than they did before (Mental Health Foundation 2019). Women appear to face another body image crisis when they experience menopause. Evidence suggests that the stigma around ageing and being 'old' can have a negative impact on body image, but it can also be seen that women who had a positive attitude towards menopause were less likely to experience negative symptoms than those with a negative attitude (Mental Health Foundation 2019). It is important to note however that it has been found that black women are less likely to have body image issues than white women (Mental Health Foundation 2019).

The evidence that we have found on body image often falls into three different life stages that women experience. It can therefore be suggested that body image issues are closely linked to the fact that women's bodies go through three important stages as they age: puberty, pregnancy and menopause. All three of these lead to big changes in how their bodies look and how they function. Yet the beauty

standards that they are held to do not always appear to be accommodating to those changes. The stigma that is associated with aging can be linked to the beauty standards that are forced on women by both the media and social media and through the judgements of mental health practitioners.

The stigma that women face relating to body image has strong links to how women's bodies are portrayed in the media that women consume. For young women who are still in school or university, social media has likely always played a part in their childhood and teenage years. Young women in Scotland have expressed that the images that they see on social media have a direct impact on their body image and confidence (Young Women's Movement 2021).These young women have also reported that the ideals that they are influenced by are often achieved through editing, and when they do not look like the images then they feel stigmatised (Young Women's Movement 2021). The 2020 Status of Young Women in Scotland report also found that young women want to see material change in the way that young people are educated about the impact that social media has on mental health, self-esteem and wellbeing (Young Women's Movement 2021).

Stigma and discrimination relating to body image disproportionately affects people from minority ethnic groups, LGBT people, people in later life, people with disabilities, and people who are overweight and obese. For those who are overweight, this discrimination can be twofold because of the bullying that they face from others and internalised body discrimination (Mental Health Foundation 2019). This stigma can lead to a reluctance to take part in activities and social events for fear of judgement which then leads to mental health problems. Another study also found that women who are overweight face stigma and discrimination from mental health practitioners who may be more likely to label them as at greater risk of mental health problems, including impaired judgement, inadequate hygiene, emotional behaviour, hypochondriasis and self-injurious behaviour, than women who are of average weight (Rothblum, 1992).

Eating Disorders

Eating disorders more proportionately affect women than men, with 75% of those with eating disorders being women and approximately 15% of women and girls experiencing anorexia nervosa or bulimia nervosa at some point in their lives (Micali et al. 2017). During the COVID-19 pandemic, there has been a large increase in eating disorders amongst children and young people in Scotland. This is evidenced by the fact that CAMHS in Scotland has reported a huge increase in referrals and severity of children and young people with eating disorders during the pandemic – in seven health boards there has been a combined 86% increase in referrals between 2019 and 2020 (with range of between 33% - 280%) (Scottish Government 2021a). It can be seen that despite the prevalence of eating disorders, the support services that are on offer in Scotland are lacking in what they provide and there are inequalities regarding where these services are available, with gaps particularly noticeable in rural areas and the West (The Royal College of Psychiatrists in Scotland 2014). People with eating disorders also struggle with stigma at work, with one in three people experiencing stigma and discrimination in the workplace (BEAT

2021). More than 80% of those with an eating disorder felt that this stigma came from a lack of education (BEAT 2021).

The stigma surrounding eating disorders comes from a public that does not have a good understanding of eating disorders and what they are. Studies have shown that the public perceive those with eating disorders as people who are attention seeking and weak (Griffiths et al. 2015) with just over a third (34.5%) of British adults believing that those with eating disorders "only had themselves to blame" and 38.1% believing that they should be able to "pull themselves together" (Crisp et al. 2000). Studies also show that those with bulimia nervosa experience different stigma to those with anorexia nervosa. They may be seen as being more responsible for their problem and as someone who is more self-destructive and with less self-control (Griffiths et al. 2015). The stigma that people with eating disorders experience is deeply rooted in the fact that there is a public misunderstanding of the problem as a mental health problem. This leads to self-stigma which means that people are less likely to seek help (Dimitropoulos et al. 2016) when they need it most.

Women's Health

Accessing health services

Whilst it is crucial for many women to access mental health services when they are recovering from a mental health problem, it has been found that many women do not access these services when they need to. Some researchers have suggested that services have been developed with men in mind and so they are not always able to adequately accommodate the needs of the women who use them. The Women's Mental Health Taskforce (2018) found that the key reasons why women do not access services or have negative opinions of them are:

- They fear that they will be deemed as unfit mothers.
- High turnover of staff making it difficult to form trusting relationships with healthcare workers.
- For those who have experienced abuse and trauma, the services can be re-traumatising and disempowering.
- A lack of control or voice over their care and how and where it is provided.
- A lack of support when they leave services.

It was also found by Taskforce that women from minority ethnic communities faced even more barriers to accessing mental health services. Women from these communities can experience a power imbalance between them and providers due to lack of cultural sensitivity and language barriers. They were also less likely to recognise and accept mental health problems in part due to the social and self-stigma (Women's Mental Health Taskforce, 2018).

There was also concern from the Taskforce that women who have complex trauma were not receiving the correct support due to them being diagnosed with other conditions such as borderline personality disorder, which led to increased stigma. This stigma for women often meant that they were less likely to seek support from services when they needed it.

The stigma surrounding perinatal mental health often leaves mothers feeling unable to come forward and seek help, with 30% withholding negative feelings for fear that their child may be taken away from them (Smith et al. 2019). Some women also felt a level of guilt and shame because they thought that they were supposed to feel happiness during the perinatal period, and they also felt that they would be stigmatised by other family members (Smith et al 2019).

Research suggests that this is particularly an issue for women from Black, Asian and minority ethnic groups, where a high proportion are found to have bad experiences with services for perinatal mental health care and one study found that women were less likely to access these services because they did not want to be treated by someone who was from a different ethnic background, did not have a positive previous experience or they did not want to be put on medication (Watson et al. 2019). It has been found however that once they do access appropriate services, they make “good use of them” (NIHR, 2021) which highlights the importance of reducing the stigma and barriers for women from these communities.

Health and social care

Those working in health and social care settings work under conditions of high stress and pressure, often on long shifts that can be exhausting both physically and mentally. These are issues that have been exacerbated during the COVID-19 pandemic, with health and social care workers putting their health on the line in order to care for others. Many of these people have experienced high levels of trauma during the pandemic and the mental health impacts will be huge. One report found that levels of anxiety amongst social care workers are 44% higher than in the wider working population which has been influenced by the pandemic (GMB 2021). There are high levels of self-reported depression, anxiety and post-traumatic stress disorder, particularly among clinical staff who were working in high COVID-19 exposure roles (Bell and Wade, 2020). Nurses and midwives – the majority of whom (90.8%) in Scotland are women – are more at risk of stress, burnout and mental health problems including depression and anxiety (Nursing and Midwifery Council, 2020). This can be linked to their work teams being understaffed, with rising demands and diminishing resources, and in part because women who work shift patterns with long hours are more likely to suffer from symptoms of depression (Kinman et al. 2020). It has also been found that the rate of suicide among female nurses is higher than the general working population (Kinman et al. 2020). Nurses and midwives may not report their mental health problems for fear that they will be deemed as unable to cope with the job and therefore they do not access support that may be on offer. In a profession where staff may put their patients' needs before their own, they may not wish to put their ability to work as risk, especially when there are already staff shortages. There are real concerns in the sector around stigma and confidentiality, particularly where nurses and midwives are not able to self-refer – 39% of the workforce are in this position (Kinman et al. 2020)

In order to reduce the stigma associated with mental health for health and social care staff, there needs to be a culture change where staff do not fear that they may not be able to practice. There needs to be open and easy access to support that staff

can access without fear of stigma and discrimination, whilst still being able to carry out their duties where possible.

Postnatal Depression

Up to 10-20% of women will experience mild to moderate mental health problems such as postnatal depression (PND) during pregnancy or during the first year after birth, meaning that around 11,000 women in Scotland will be affected each year (ScotPHO 2021). The perinatal period is a time where many mothers may face challenges for their mental health such as lack of sleep, isolation, unmet expectations of parenthood, adjustment to new roles, birth and breastfeeding. Whilst some 'baby blues' are considered normal, PND is a problem that should be treated and appropriate support provided. However, PND often goes untreated and a major reason for this can be that women frequently fear stigma or negative reactions from others. Fear of social services involvement and that a diagnosis of PND by health services may constitute a mother being viewed as a threat to her child have been identified as reasons why mothers are reluctant to seek help (McLoughlin 2013).

The stigma attached to mental health problems can also compound negative self-image and add to the feeling that mother's suffering from PND have 'failed' as a mother or are incompetent (Papworth et al. 2021; Thorsteinsson et al., 2018). Thus, a PND diagnosis can be viewed as a weakness by new mothers and themselves as undeserving of help and or as 'bad mothers' because they are struggling, and this self-stigma is another barrier to help seeing behaviour for women who are experiencing PND (McLoughlin 2013). In a study by Patel et al. (2013), it was identified that mothers with PND experienced guilt at not meeting their own expectations of motherhood, further reducing self-esteem and the potential likelihood of seeking help. The stigma of being diagnosed with PND and receiving a label of a mental health problem made many women in the study fearful of disclosing their diagnoses to friends and family and thus depriving themselves of social support that could help them (Patel et al. 2013).

Using data from the Growing up in Scotland Study (Bradshaw et al., 2014) found that young mothers under 20 were most likely to experience PND but least likely to access formal support services. Reasons for this include fear of judgement from service providers and other, older mothers. Research by Young Scot (2015) confirmed that one of the greatest challenges to mental wellbeing identified by young mothers was the stigma and negative attitudes from others as a result of their age.

Some additional groups have added vulnerability in developing PND including:

- Care experienced young mothers are at a higher risk of PND than non-care experienced young mothers and are also more likely to experience stigma from service providers (Fallon et al., 2015).
- BME mothers, especially where family support is unavailable and barriers to service access are experienced because of language barriers or culturally inappropriate services
- Single mothers, who may lack social support and are more likely to be on a lower income

- Working mothers, who have to adapt to a new identity and balance multiple priorities
- Women who have experienced trauma or have previous experience of mental health problems (NHS, 2020).

Increasingly, screening for PND is being carried out across all NHS boards in Scotland using the Edinburgh Postnatal Depression and Screening Tool, although presently data is not collected on a Scotland-wide basis. Additionally, inequalities in perinatal mental health service provision across Scotland means that some women may not be able to access the specialist services they need - half of Scottish health boards have no provision of perinatal mental health specialist services (Maternal Mental Health Alliance, 2019). This is worrying because PND often goes untreated and specialist health teams able to identify and support mothers with PND are vital in effective early interventions and in combatting stigma around it.

Menopause

Whilst having a baby is certainly a major transition for many women, it is by no means the only one. Menopause, which occurs in the UK at an average age of 51, brings with it many changes but receives little public attention or acknowledgement – yet for many women, it's symptoms can have a huge impact on their daily life. Up to 80% of women will experience symptoms including brain fog, anxiety, depression, sleeplessness, exhaustion, vaginal dryness and stiff joints (NHS, 2021). However, the lack of understanding and stigma of menopause in society means that symptoms are often misunderstood or belittled. The impact that menopause can have on mental health can be significant. Research shows a correlation between menopause and increased likelihood of depression as a result of reduced oestrogen, experiences of challenging physical symptoms and disruption to emotional wellbeing due to occurrence of 'exit' events for women during the menopause period such as end of fertility - as well as the potential to exacerbate symptoms of pre-existing mental health problems (Rasgon et al., 2005).

Despite having impactful symptoms during menopause, many women are reluctant to visit their doctor for help for fear of not being believed or of having their symptoms trivialised (Nosek et al., 2010). Concerningly there is a lack of knowledge of menopause in medical professions: 41% of UK medical schools do not have a mandatory menopause education section in their curriculum meaning that many GPs may lack knowledge in supporting women during menopause (Menopause Support, 2021). Additionally, alongside a lack of general understanding, many women experience feelings of shame or embarrassment when entering the menopause period which can have a significant impact on mental health and wellbeing. A recent survey found that nearly half of women aged 45-65 were not confident in talking to their doctor about menopause symptoms (Menopause Support 2021). The stigma of menopause can be argued to stem in part from the socio-cultural value that Western societies place on female youth and fertility, with the unfair corresponding negative cultural stereotypes of older women, and subsequent shame associated with ageing (de Salis et al. 2018). Other issues such as the existence of negative assumptions about women experiencing menopause being incompetent or 'hysterical' and the embarrassment of having physically visible symptoms such as hot flashes can act to

create a negative picture of menopause and compound public and self-stigma and impact on mental wellbeing (Nosek et al. 2010). Women may not be getting the right support at the right time from health professionals in order to manage and improve their symptoms – one survey found that 66% of women experiencing menopause were inappropriately offered or given antidepressants when talking to their GP about low mood, rather than specific treatments for menopause symptoms (Menopause Support 2021). Whilst addressing low mood is important, the root causes should be investigated by medical professionals and it is vital that women are listened too by health professionals, and given appropriate support for their needs.

Many women experience stigma in the workplace when going through menopause, which can also have a huge impact on mental wellbeing and ability to retain employment. In the UK, there are 3.5 million women over 50 in the work and they represent the most rapidly growing demographic in the workforce. A recent survey found that nearly two thirds (59%) of working women experiencing menopausal symptoms identified that it had had a negative impact on their work performance, with 65% stating that they were less able to concentrate and 58% saying they felt more stressed (CIPD 2019). Yet only a quarter of women felt able to speak to their employer about their symptoms with fear of stigma or a negative response from unsympathetic employers being a major reason for this (CIPD, 2019). A Guardian investigation found that female doctors in male dominated specialities in the NHS were unable to speak about their symptoms to peers or managers or ask for adjustments to help them manage their symptoms at work as they faced stigmatising attitudes from colleagues and managers suggesting that they were ‘past it’ and that future career opportunities could be withheld (Guardian 2020).

Women, Suicide and Self Harm

Suicide

In 2020, 230 women and 575 men died from suicide in Scotland (71% male, 29% female) (National Records of Scotland 2021). Men are much more likely than women to die by suicide, but suicide rates for women in Scotland have increased - in the last year, the percentage of female suicide deaths rose by 3% due to an increase in the number of female suicides and a decrease in the number of male suicides (National Records of Scotland 2021).

Currently in Scotland, a range of support services cater for people who are bereaved by suicide, but these are not equitable across the country. Stigma exists around suicide, both for those who have attempted suicide and for those who have been bereaved by suicide. Those bereaved by suicide may experience specific components of complex grief, such as feelings of shame, stigma, guilt, and the need to conceal the cause of death (Bellini et al. 2018; Andriessen et al. 2019). Pitman et al. (2016) found suicide bereavement to be most stigmatised of all types of sudden bereavements and to be associated with associated with shame, guilt, and responsibility for the loss.

There is little evidence around what interventions are most effective in supporting people who have been bereaved by suicide – Patel et al. (2016) identify that however considering stigma is important as it has the potential to ‘‘influence help-

seeking, limits support available, is linked to risk factors for suicidality.'' Research undertaken by the Mental Health Foundation (2020) found that general bereavement support groups were not always accessible to the those who had been bereaved by suicide because of perceived stigma from other members of the group.

Self-harm

Self-harm affects people of all ages and genders, however young women are nearly twice as likely to self-harm than young men. In Scotland, 21% of women aged 18 – 34 have self-harmed compared to 12% of men aged 18 – 34 (Samaritans 2019). Young women are also more likely to be hospitalised for self-harm than any other demographic group. Reasons for self- harm are complex and varied - risk factors for self-harm include depression & anxiety low self-esteem, sexual abuse, peer/parental self-harm, relationship issues and drug abuse(McMahon et al. 2010) There is also evidence to suggest that shame and self-harm can create a perpetuating cycle and amplify each other, meaning that shame can be both a cause and consequence of self-harm (Gunnarsson 2020).

Additionally, stigma from healthcare staff can prevent people who self-harm from seeking support In Curtis' (2016) study with young women who had engaged in non-suicidal self-injury, the judgment and reaction from others about the injuries they had self-inflicted was a cause of concern and a barrier to help seeking. Where scarring from self-injury is present and visible, negative reactions from others or internal feelings of shame and embarrassment can create ''social anxiety, depression, and suicidal ideation'' (Curtis 2016)All contact with mental health services after self-harm is should be an opportunity to target self-stigma and to promote positive engagement with service providers and encourage future help seeking behaviour by removing the stigma and shame often associated with self-harm (Aggarwal et al., 2021).

Women and Sexual Orientation

There are higher rates of mental illness for bisexual and lesbian women compared with heterosexual women, and bisexual women have higher chances of poor mental health (Public Health England, 2018). Bisexual women were 37 percent more likely to self-harm; 64 percent more likely to have an eating disorder and 26 percent more likely to feel depressed or sad in the past year than lesbian women (Colledge et al. 2015). The research highlights how internalised stress impact on bisexual women's mental health as a result of the concealed sexuality and the discrimination and stigma associated with it. It is suggested that healthcare staff may not be appropriately trained to deal with mental health issues for lesbian and bisexual women, and a lack of awareness of services and stigma prevent these women seeking support (Public Heath England, 2018). For example, lesbian and bisexual women may not disclose their mental health problems as they would have to inform GPs about their sexual orientation, and risk the possibility of homophobia (Psarros, 2014). Intersectionality compounds their mental health experiences and Colledge et al., (2015) raise the need for the bisexual identity to be accepted in order for services to be tailored equitably to address mental health needs. Some research has suggested minority sexual groups within the wider LGBT communities have higher rates of suicide, self-harm and mental illness (Public Health England, 2018; Hickson et al., 2014; Public Health England, 2014; Varney, 2014). Some groups such as

Black and minority ethnic bisexual women, experience ‘minority stress’ impacting on their mental health (Bignall et al. 2019).

Women and Families

Caring responsibilities

Women make up the majority of carers (59%) in Scotland (CarersUK 2019). Whilst many women maybe be happy to take care of family members and friends who need assistance, it is important to acknowledge that certain gender norms create assumptions that women are more suited to caring roles: this can create external social and internalised pressure for women to assume roles that they do not necessarily want or feel equipped for (Carers UK 2019)Thus, women may face stigma in refusing or in feeling unwilling to take on this role. Potentially in part because of this, it has been found that female carers are also more likely to suffer adverse mental health impacts than male carers (Brenna and Di Novi 2016).

Whilst caring responsibilities can occur throughout life, they often coincide with the peak time of women’s careers, where raising children and caring for older relatives must be done in conjunction with paid employment. Female carers were found to be more likely to self-report anxiety and depression than female non-carers (Sanders 2020). Lack of sleep, financial concerns, isolation, lack of support, loss of social network, loss of independence and recreation time, anxiety and the necessity of ‘hands on care’ all negatively impact mental health (Cottagiri and Sykes 2019). Concerningly, research conducted by Stigma Free Lanarkshire found that:

- 75% of carers in Scotland said they had suffered mental ill health as a result of caring.
- 58% of carers in Scotland expect their mental health and well-being to get worse in the next two years
- 40% of carers in Scotland expect that they will be able to provide less or no care in the future because of poor mental health (Stigma Free Lanarkshire 2019).

Additionally, carers of people experiencing mental health problems are often more likely to face external stigma than carers of people with physical health problems. In a report by Stigma Free Lanarkshire (2019), 65 % carers caring for someone with a mental illness stated that fear of being treated differently has stopped them from asking for help and 60% stated that mental health stigma has had a negative impact on their caring role. When asked about the types of stigma they had experienced, Scottish carers for people experiencing mental health problems identified the following main issues:

- Public Humiliation - Being verbally abused, insulted and ridiculed
- Exclusion - Avoided by family and friends, ignored by professionals or refused access to services, not taken seriously, discouraged from applying for certain education and/or jobs
- Workplace bullying - Dismissal, employers unaware of employee rights and/or unwilling to provide support

- Inequity of support - Less support relating to mental illness vs physical illness, less knowledge of mental illness by support agencies (Stigma Free Lanarkshire, 2019)

For women with lived experience of mental health problems and caring responsibilities, their experience of stigma can be felt in different ways. The Women's Mental Health Taskforce Report identified cases of mothers who were experiencing mental health problems being deemed unfit to parent and having their children removed from their care rather than receiving appropriate support, demonstrating the stigma that exists for mothers experiencing mental health problems(The Women's Mental Health Taskforce 2018) Separation from children or loved ones, or the fear of having dependants taken away as a result of their mental health problems can be very damaging. The Report also highlighted the barriers than women faced in trying to access mental health support, including the competing demands of care giving, parenthood and childcare responsibilities making it harder to attend appointments and the limited provision of flexible arrangements to help support those with caring responsibilities to maintain appointment schedules (The Women's Mental Health Taskforce Final Report 2018).

Women's roles as mothers and carers, and the practical and emotional impact of this, is often not recognised in the delivery mental health services, and thus female carers face discrimination in terms of service delivery and access. Both disruption to appointments and ''the stigma or judgement they felt they faced as to whether they were seen to be a fit parent" were identified by women in the Report as being a barrier to accessing mental health support help early, rather than at crisis point, where unfortunately more extreme interventions were more likely (The Women's Mental Health Taskforce Final Report, 2018).

Women from Minority Ethnic Backgrounds

According to the 2011 census data, 4% of Scotland's population identified that they came from an ethnic minority background (Walsh 2017). Research by the Mental Health Foundation highlights how challenges such as racism, stigma and inequalities can affect the mental health of people from minority ethnic communities. Rates of mental health problems can be higher for some people from Black, Asian and minority ethnic groups than for white people. For example, older South Asian women are an at-risk for suicide (Mental Health Foundation 2021). Rethink Mental Illness reiterates that compared to white people, Black women are more likely to experience a common mental illness such anxiety disorder or depression and that there is a disproportionately high suicide rate among South Asian women, who also experience higher levels of anxiety and depressive disorder than women from any other ethnic group.

A systematic review found high rates of common mental health disorders among refugees and asylum seekers (Turrini et al. 2017) with rape and sexual violence identified as the most common causes of post-traumatic stress disorder among women (WHEC et all., 2017). There are specific issues relating to migrants accessing healthcare, such as incorrect information or documentation or fear of being reported, and these barriers are deterrents to seeking help for vulnerable

migrants. Those who have reported delaying or avoiding case because of these barriers have included heavily pregnant women. In one study, refugee and asylum seeker women were not accepting of mental health conditions and the need to engage with mental health services because of the stigma associated with mental illness (Psarros, 2014).

Lack of awareness about poor mental health, cultural expectations, ongoing stigma, culturally fragmented health services and interactions with health providers who are not trained in culturally-tailored healthcare (who can come across as dismissive) impact on ethnic minority women's ability to receive adequate mental health support in the UK (Watson et al. 2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions specifically (Watson et al. 2019) found that Black Caribbean and South Asian women believed that depression was culturally unacceptable because of its impact on women fulfilling their role in society. These women explained that Black Caribbean culture has been influenced by the impact of their history of slavery, and women are expected to be strong and hold the family unit together and are not allowed to have depression as this would be a sign of weakness or not coping (Edge and Rogers 2005). This results in low levels of disclosure of mental health problems in this group for fear of stigma.

> *"I do think that Black people get depression, but I don't think we're allowed to have depression. I think it's quite a matriarchal society and therefore you've got to cope. You've got to sort your family out, and so therefore you are not allowed to be depressed." Black Caribbean Woman (Edge and Rogers 2005)*

Literature shows that Black Caribbean women can feel that it is culturally unacceptable to talk about problems, feelings or emotional issues to people outside the family or home and that if 'these things' were revealed it would result in stigma (Gardner et al. 2014). While minority and majority women report a fear of stigma if their mental ill health is revealed, it has been found that stigma disproportionately affects people who may encounter 'double stigma' or the intersectionality of experiencing stigma and discrimination in healthcare settings along with the public and self-stigma associated with struggling with their mental health (Clement et al. 2015).

> *"Black, Asian and minority ethnic women spoke powerfully about a perceived imbalance of power and authority between service users and providers, alongside cultural naivety, insensitivity and discrimination towards the needs of BAME service users. Interaction with services could also be impeded by language barriers for women for whom English is a second language. Evidence similarly suggests that BAME women face additional barriers to accessing mental health support and services and that can affect the relationship between service user and healthcare provider (Memon et al., 2016). These include issues with recognising and accepting mental health problems, a reluctance to discuss psychological distress and seek help, negative perception of and social stigma against mental health as well as financial factors."* The Women's Mental Health Taskforce Final Report 2018

Black and minority ethnic women in Kalathil's 2011 study gave similar descriptions including a belief that mental illness was 'hereditary madness' that needs to be hidden from others. Such responses to mental illness as a result of stigma not only isolates the individual but impacts negatively as the individual's mental illness could escalate. Members of the Gypsy, Roma and Traveller communities have also highlighted stigma associated with mental illness. In a study by Psarros (2018) Gypsy and Traveller Women were concerned that a mental health diagnosis could lead to social services involvement and having children removed from their care. Research in Scotland (Bradby, 2008) with families who had engaged with CAHMS found that stigma was a barrier to South Asian women's interactions with the service, for fear of 'gossip' about their children's 'madness' was a barrier to using the service. Most participants wanted to keep these issues private as they were 'family problems'.

Moving to the different setting of workplace, the Business in the Community: Race at Work 2018 Scorecard report found that 39% of Pakistani women and 29% of Black African and Caribbean women said that they had experienced bullying and harassment from managers compared to 14% of white women. The scorecard reported that these issues need to be monitored with the intersectional lens of ethnicity and gender, so that ethnic minority women who are so often 'invisible' in the workplace, can have their issues spotlighted, their voices heard, and where necessary, the appropriate support they need (BITC 2018). The Scorecard recommends that, particularly in the context of the Covid-19 pandemic, employers should be taking steps to look at the health and wellbeing of their employees, and also be mindful of the additional impact that may exist due to existing disparities, given that people from Black, Asian and ethnic minority backgrounds are more likely to have underlying health conditions.

The Women's Health Plan Event Report (ALLIANCE 2021) highlighted that women from minority backgrounds felt that there was still a lot of stigma attached to mental health in many of their communities due to the fear of being labelled. This underscored the further work needed to break down the barriers to talking about mental health for women from minority ethnic backgrounds.

More broadly, Scotland's population has become increasingly ethnically diverse(Walsh et al. 2019). The Scottish Government's Women's Health Plan (2021-2024) reminds us that different ethnic population groups can often experience very different health outcomes, representing stark inequalities (Scottish Government 2021c). The plan underlines the importance of considering wider socio-economic factors at play. There is evidence of the link between living in or at risk of poverty and poor overall health, and women's ability to access healthcare services. The risk of poverty is much higher for certain groups of women, including minority ethnic people.

The Women's Health plan highlights that inequality has a disproportionate impact on minority ethnic people, for complex reasons including a combination of socio-economic disadvantage, high prevalence of chronic diseases and the impact of long-standing racial inequalities. With the proportion of the population belonging to a non-

White ethnic group having increased fourfold in Scotland between 1991 and 2011, and projects suggesting that by 2031 around 20% of the total population (and 25% of children) will belong to a non-White minority group (Walsh et al. 2019), it is important that the healthcare system is responsive to these changes.

> *"It is also important that all health and social care professionals approach people from all cultures with openness and without judgement and are responsive to the individual needs of their patients and community. The importance of healthcare professionals acknowledging and addressing unconscious bias has also been highlighted by the Royal College Of Gynaecologists in their position statement on racial disparities in women's healthcare" (RCOG 2020).*

Violence against women and girls

Gender based violence comes in many forms - physical, emotional, sexual - and is a serious public mental health problem. The most common forms of violence against women and girls are domestic violence and abuse and sexual violence (Oram et al. 2017). There were 115 incidents of domestic abuse recorded by the police in Scotland per 10,000 population in 2019-20 (Scottish Government 2021). 13,364 incidences of sexual assault against women and girls were recorded in Scotland in 2019 -2021 (Scottish Government 2021b).

Research shows that women and girls with serious and enduring mental health problems experience higher rates of violence than women in the general population (Du Mont and Forte 2014). It has been estimated that 40% of women presenting to Sexual Assualt Referral Centres in England and Wales have a pre-existing mental health problem (Mimos 2021)Even for those that have no previous experience of mental health problems, experiencing violence means that women are more likely to go on to develop depression, anxiety, PTSD, substance misuse, self-harm or suicidal feelings.

Contact with mental health and abuse support service providers should provide an opportunity for support related to both experiences of violence and mental health problems. But the stigma that exists round mental health means that often women are reluctant to disclose existing mental health problems to service providers for fear of being treated less favourably, having children removed from their care or not being believed (Spotlight 2017). Additionally, women facing abuse may have had their mental health used as a weapon against them by their abuser, who may have used threats of them being forcibly institutionalised, having children taken away, of telling family, friends or employers about their mental health problems or of no one believing them if they report abuse because they have a mental health problem to prevent them from seeking help (Spotlight 2017). As such, stigma around mental health can be internalised and women facing abuse may hide mental health problems rather than seeking support.

Concerningly in their study, Oram et al. (2017) found that when some women using mental health services and facing violence tried to raise their experiences of abuse with mental health staff, they were not taken seriously or felt that staff stigmatised

and blamed them for their situation. The study found that the lack of acknowledgement by staff was exacerbated by there being few opportunities for women to fully discuss violence and abuse during mental health consultations or appointments, thus failing to provide appropriate support (Oram et al. 2017). Additionally, medicalising and pathologizing issues related to abuse in mental health settings has been found to minimise women's experience of violence and to be unhelpful in challenging symptoms and developing strategies to prevent future abuse (Trevillion et al. 2014).

Women and the Criminal Justice System

Scotland has one of the highest female prison populations in Northern Europe. The growth in the female prison population appears to have been driven by increases in custodial convictions for serious violent crime, drugs offences and common assault (Scottish Government 2015).

A report produced by NHS Scotland in 2017 highlighted that being a victim of violence is associated with poor mental and physical health and a number of long-term health conditions that create 'interrelated stigma'. The evidence tells us that statistically women are more likely (although not exclusively) to be the victims of violence than men. The evidence of victimisation experience being overrepresented in female offenders has led to the conclusion that many women in custody 'can be described as victims as well as offenders'.

A higher proportion of people in contact with criminal justice services have mental health problems (NIHR 2010). The number of women in prison has increased significantly increased over the last 20 years- most women entering prison have committed a non-violent offence. Around 53% of women (compared to 27% of men) in prison report having experienced emotional, physical or sexual abuse and 46% of women report a history of domestic violence (NIHR 2010)

The Corston Report (2007)highlighted research indicating that women who are persistent offenders are more likely to have been exposed to violence as a child, experienced childhood sexual abuse, had a violent partner, have severe and enduring mental health issues, or alcohol and drug problems. Approximately 50% of female prisoners suffer from depression or anxiety, with 25% of women reporting symptoms indicative of psychosis (NIHR 2010). The NHS report (2017) states that media reporting can contribute to public fear of offenders thereby increasing social exclusion and stigma of those with severe and enduring mental health problems. Within the prison system, there is some evidence to suggest that mental health disorders are higher for women, older people and those from ethnic minority groups.

A guide for prison staff about the mental health and wellbeing of women in prison was published by Penal Reform International and the Prison Reform Trust in 2020. The guide reveals that a high proportion of women in prison have poor mental health. It highlights that women who have been in prison and have experienced poor mental health are often doubly discriminated against because of the stigma attached to both being in prison and having mental health problems. Some women with poor mental health do not tell anyone about how they are feeling about their mental health because they are worried that their children will be removed from their care after

release. Women who are separated from dependent children or pregnant in prisons face additional distress, with adverse mental health consequences for both mothers and children.

Women prisoners often face more stigma than men and may be rejected by their families, and the stigma of being an incarcerated women and the attached associations of being a 'bad' wife, partner or mother can contribute to a women's prison experience, which can be hard to find freedom from after release (Corston, 2007).

Women and Girl's Anti Stigma Interventions

The best way in which to tackle the stigma surrounding women and girl's mental health is through using effective interventions that make a real and long-lasting difference. There appear to be few intervention programmes that have been delivered in the UK that are specific to women and girls and their needs although there are interventions aimed at people living with mental health problems more generally. Some of the areas of research in this report had more associated interventions than others.

Population level interventions

Although not COVID or gender specific, it can be seen that the interventions that were put into place by Time to Change had a positive impact on mental health stigma and discrimination. The whole population programme had three national components: anti stigma marketing campaign activities, mass physical exercise events (Time to Get Moving) to facilitate social contact between people with and without mental health problems, and an online resource on mental health and employment (Time to Challenge). The evaluation showed that between 2008 and 2009 significantly less discrimination was reported from a number of common sources, including family (reported by 53% in 2008 and 46% in 2009), friends (53% and 39%), finding employment (24% and 16%), and keeping employment (from 17% to 13%) (Henderson et al. 2012). Given that much of the stigma that women face is related to their fear of judgement by family, friends and employers, it can be hoped that this type of intervention will have a positive impact on women and mental health stigma.

Body Image and Eating Disorders

Body image interventions were mostly through awareness raising and educational campaigns. A recent campaign that looked at body image and how we understand it was the Mental Health Foundation's 'Mind Over Mirror' 2021 campaign1. This campaign used comic strips, blogs and tips for individuals and parents in order to educate people about body image using data from their 2019 body image report and a 2021 survey. Although this was not specifically about women and stigma, the campaign did break down stereotypes relating to body image and highlighted how we can have a healthier relationship with our bodies. This campaign could lead to

[1] https://www.mentalhealth.org.uk/publications/mind-over-mirror.

decreased stigma relating to body image as people gain a more in-depth understanding of mental health and body image.

There did not appear to be formal interventions that were specifically about women, stigma and eating disorders however, BEAT has found that found that there are a number of informal interventions that could improve the workplace for people with eating disorders2. They found that in many workplaces, employers were not taking actions to understand eating disorders and those who have them. One of their suggestions focused on tackling stigma by educating staff on eating disorders and recognising that they are complex mental illnesses.

Women's health

It was challenging to find formal interventions specifically designed to tackle mental health stigma and discrimination for women and girls, however informal interventions can make an impact and in some cases, mental health stigma can be caused by a general public who are not educated or informed on issues. In studies on postpartum depression, it was found that partner support leads to more positive outcomes as the journey to parenthood is less stressful. Studies also find that partners and families need to be more understanding when women are experiencing perinatal depression, as many women get help too late because their partners do not spot the signs or the women feel that they may be judged poorly if they do (Sambrook Smith et al. 2019).

The Scottish Government has outlined in its Women's Health Plan (2021-2024) that it will launch a public health campaign to remove stigma and raise awareness of the symptoms of the menopause. Through its Women's Health Plan, the Scottish Government has also committed to building a basic understanding of menopause among all healthcare professionals and acknowledge the importance of menopause, menstrual health and enometriosis within mental health policy, ensuring policies recognise the impact these conditions can have on women's mental healthas well as physical health.

An area where there appears to be more formal interventions in place is for women who are from minority ethnic backgrounds. This is perhaps because they are a group who already face stigma and discrimination and so mental health stigma may be tackled as part of a wider anti-stigma campaign.

The Birmingham and Solihull Mental Health NHS Foundation Trust recognised that women of south Asian family origin were facing barriers to seeking help for mental health problems. In order to tackle this they introduced a group-based intervention where care was facilitated by psychological wellbeing practitioners who spoke Hindi, Urdu, Punjabi or Bengal. These groups were held in community centres that were already being accessed by these women, which helped remove some of the stigma associated with the use of mental health services. The most recent evidence from these sessions suggests that 95% of the women who took part had a positive experience and that for those who entered treatment with mild to moderate symptoms, there was a 54% recovery rate (NICE 2019). Addressing where the stigma comes from and how it is best tackled and then being effectively implemented

[2] https://www.beateatingdisorders.org.uk/news/beat-news/employers-support-world-mental-health-day/.

has been a large part of the success of this intervention. From our research, this is the only women and girls specific intervention in the UK, with the rest focusing more on specific stigma issues without a gendered approach.

Mindworks offers counselling, psychotherapy and faith based therapy. They work closely with women who have suffered or going through domestic violence and sexual abuse and work collaboratively with other agencies to support these women. Their approach includes faith based therapy which incorporates looking at faith, mental, physical and emotional self, your outside world as well as your inner world.

Similarly, there are examples of faith-based organisations reaching out to people who do not have a religious faith, such as Open Doors- a church-based project in East London for 40 Racial disparities in mental health literature and evidence review people of any belief or no belief. Their vision is to combat isolation and fight poverty by offering one-to-one support for vulnerable families, usually referred by statutory services.

Employment

The Business in the Community Race at Work 2018 Scorecard report recommends that employers create a network of mental health first aid mentors to support employees. Race at Work 2018 found that 56% of Black African women want a mentor compared to 22% of white British women and 39% of women from Black, Asian and minority ethnic backgrounds overall. The Scorecard suggests establihing a network of mental health first aiders with the appropriate training to support employees(BITC 2018).

Criminal justice

The criminal justice system has some interventions in place, perhaps because of the high rates on mental health problems within it. It is an area where practitioners may be able to make international comparisons and it's also an area that policymakers may have some interest in.

Just US is a group that has evolved from the Willow Project in Edinburgh. Just US is a group led by women who have experience of mental health issues, histories of trauma and have had involvement with the criminal justice system. Their aims are to challenge the discrimination faced by women who have had contact with the criminal justice system, improve their mental health and wellbeing and promote their recovery and address the issues around the barriers and stigma they face(Community Justice Scotland 2020).

International evidence on penal policy for women consistently emphasises the importance of addressing the particular (and multiple) needs of women in custody in a holistic and coordinated way. It is widely recommended that all women's needs, in particular criminogenic needs3, should be addressed in custody and beyond (e.g. physical and mental health, substance abuse, education, employment, parenting,

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[3] Criminogenic needs are risk factors associated with reoffending including pro-criminal attitudes, poor family relationships, substance abuse, financial difficulties, unemployment, poor educational attainment, and poor cognitive skills.

finances, housing and psychological wellbeing)(Bartels and Gaffney 2011). Much of the research on managing women offenders suggests that a gender specific approach is central to achieving better outcomes for women(Bartels and Gaffney 2011). This may take the form of gender-specific assessment/classification methods, staff training and female staffing levels4.

Birth Companions provide woman-centred, trauma-informed services in the community and within the criminal justice system to help improve the mental and physical wellbeing of these women, in a way that can support them to break cycles of disadvantage. These services include pregnancy and early parenting groups in women's' prisons. They have also sought changes at a policy level within the criminal justice system, encapsulated in their Birth Charter. These have been widely cited by the Ministry of Justice, Public Health England's Gender Specific Standards for Women in Prison, and in a dedicated annex (Annex L) to the HM Prison and Probation Service's new Women's Framework. They train women to work as peer supporters and as peer researchers, and have over 30 women in their Lived Experience Team – a group of women whose first-hand knowledge of severe, multiple disadvantage during the perinatal period is now regularly called on to inform service design, delivery and consultation by organisations including NHS England, the Care Quality Commission and HM Prison and Probation Service.

Some areas that were researched as part of this review did not have any interventions that we could find. These areas were: health and social care, women and families and suicide and self-harm.

While there are some interventions that have been effective, it is clear that a gendered approach needs to be put in place to tackle women and girl's experiences of mental health stigma. Being open to offering services in settings that are easier to access for women, making resources clear to understand and increasing education for women and their families and employers will lead to lower levels of mental health stigma.

[4] A number of countries have set targets for female prison staff. For example, in Queensland, Australia, the target is set at 70%; a Northern Ireland report recommended the baseline be set at 80% (see Bartels & Gaffney, 2011 p6).

Conclusions

Generally, this review found that data specific to mental health stigma and discrimination is limited in relation to women and girls. Evidence more broadly about mental health problems, and health and wellbeing is more easily accessible. Thus underlines the need to gather Scottish specific data about mental health stigma and discrimination that can be analysed by gender, such as the National Stigma Report Card programme of research that is currently underway, led by the Mental Health Foundation and See Me.

Where evidence about mental health stigma and discrimination relating to women and girls is more accessible, this tends to be found in areas that are already generated, such as body image, eating disorder, and some areas of women's health. This review identified reasonable data around mental health stigma associated with the menopause, perinatal mental health, suicide rates in Scotland, body image, eating disorders and criminal justice. Where this evidence was easier to locate, it was challenging to find stigma and discrimination specific evidence, which appears to be the case generally.

Additionally, Scottish-specific data was challenging to find, therefore much of the evidence in this review look at the UK-wide landscape.

Areas in which there was limited data about mental health stigma and discrimination include Covid-19 (possibly because studies are still ongoing and many yet to be published), employment, accessing broader healthcare services and Black and Asian minority ethnic women's experiences of accessing healthcare. One study considered for this review highlighted that there are a limited number of surveys designed to provide estimates of prevalence of mental health problems among specific minority groups.

There was also limited stigma and discrimination data available about intersectionality and how it affects women and girls. There is limited research on intersectionality and mental health of women generally.

In conclusion, there is work to be done to generate Scottish specific evidence on women and girl's experiences of mental health discrimination, either through primary research at national level and / or working with national partners to influence national health surveys to include questions about experiences of stigma and discrimination. While national polls have been produced over the years, these tend to have a focus on attitudes towards, rather than experiences of, mental health stigma and discrimination across the life course and in different life domains.

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