Scottish Government
Riaghaltas na h-Alba

Mental Health Equality Evidence Report 2023

HEALTH AND SOCIAL CARE

social
research

Contents

Glossary of terms

ACEs	Adverse childhood experiences
ADHD	Attention deficit hyperactivity disorder
APMS	Adult Psychiatric Morbidity Survey
ASD	Autism spectrum disorder
BAME	Black, Asian and minority ethnic
BME	Black and minority ethnic
BPoC	Black and people of colour
BSL	British Sign Language
CAMHS	Children and Adolescent Mental Health Services
CBT	Cognitive behavioural therapy
CHARIS	Covid Health and Adherence Research in Scotland
CPAG	Child Poverty Action Group
DES	Disability Equality Scotland
FGM	Female genital mutilation
GDA	Glasgow Disability Alliance
GHQ-12	General Health Questionnaire 12 item version
GIC	Gender identity clinic
GP	General practitioner
HBSC	Health Behaviour in School-aged Children
HNA	Health needs assessment
HSCP	Health and social care partnership
IAPT	Improving Access to Psychological Therapies
IFS	Institute for Fiscal Studies
IPV	Intimate partner violence

IYS	Intercultural Youth Scotland
LGBTI+	Lesbian, gay, transgender, and intersex
MHEHRF	Mental Health Equalities and Human Rights Forum
NACWG	National Advisory Council on Women and Girls
NAIT	National Autism Implementation Team
NHS	National Health Service
NRS	National Records of Scotland
NSPCC	National Society for the Prevention of Cruelty to Children
NSPLG	National Suicide Prevention Leadership Group
OCD	Obsessive-compulsive disorder
ONS	Office for National Statistics
PHS	Public Health Scotland
PMDD	Premenstrual dysphoric disorder
PMHN	Perinatal Mental Health Network Scotland
PMS	Premenstrual syndrome
PPE	Personal protective equipment
PT	Psychological therapies
PTSD	Post-traumatic stress disorder
RNID	Royal National Institute for Deaf People
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SAMH	Scottish Association for Mental Health
ScotSID	Scottish Suicide Information Database
SDQ	Strengths and Difficulties Questionnaire
SHAAP	Scottish Health Action on Alcohol Problems
SHELS	Scottish Health and Ethnicity Linkage Study
SHeS	Scottish Health Survey

SRUC	Scotland’s Rural College
SSCQ	Scottish Surveys Core Questions
UCL	University College London
UNICEF	United Nations Children’s Fund
VAWG	Violence against women and girls
WEMWBS	Warwick-Edinburgh Mental Wellbeing
WHO	World Health Organisation

1. Key findings and cross-cutting themes

This report provides an overview of the current evidence relating to mental health inequality in Scotland. It provides a summary of available evidence relating to each of the characteristics protected under the Equalities Act 2010 [1], with the exclusion of marriage and civil partnership and the inclusion of poverty and deprivation, geographical location and carers. The report explores the following topics relating to each characteristic: existing inequalities and mental health disparities (including social determinants impacting mental health); inequity in accessing services and support; experiences of using mental health services and support; impacts of the COVID-19 pandemic; and data and evidence gaps. The report is based on a rapid review of evidence from population level survey data undertaken in Scotland and the wider UK, relevant academic and third sector literature and insights provided by organisations participating in the Mental Health Equalities and Human Rights Forum (MHEHRF).

Several cross-cutting themes were identified around mental health inequalities and social determinants of mental health, experiences of accessing and using services, and data and evidence, which relate to multiple different groups. While these impact different groups in a multitude of ways and are shaped by a variety of experiences and circumstances, they indicate key areas for future focus on equalities and mental health. The table below provides a general overview of the findings, with additional detail in the relevant sections of the report. The identification of groups most impacted by each theme has been based on the strength of the evidence currently available and identified for this report. These themes may also apply to additional groups, but where evidence for their inclusion has not been identified at this time.

Theme	Sub-theme	Description	Groups/characteristics most impacted
Data & evidence gaps	**Lack of data**	There is a lack of quantitative and qualitative data and evidence relating to the mental health of some protected characteristic groups. This is due to the lack of statistically representative samples in population-level surveys (such as minority ethnic groups in the Scottish Health Survey), the absence of appropriate questions in existing surveys and the relative lack of recent qualitative and lived experience evidence.	• Minority ethnic groups • Belief and faith groups • Trans people and intersex people • Men • Carers

	Lack of disaggregated data	A lack of disaggregated statistical data can make it difficult to understand the experiences of specific sub-groups. This can reinforce a false perception of homogeneity. In reality, there are more diverse experiences and perspectives which need to be understood.	• Minority ethnic groups • Disabled people • Belief and faith groups
	Lack of intersectional evidence	There is a need for greater intersectional evidence and analysis to understand the experiences of those with multiple protected characteristics, particularly where there are multiple intersections.	• All groups
Social determinants of mental health	**Experiences of minority stress, discrimination, and trauma**	Experiences of living in hostile and/or stressful environments have distinct impacts on people with protected characteristics in many ways, which takes different forms for different groups, but has severe impacts on mental health and wellbeing.	• Minority ethnic (including racialised and generational trauma) • Women and girls (including gender-based violence) • LGBTI+ people (including discrimination, harassment and hate crime) • People of certain religions (including Islamophobia and antisemitism) • Disabled people (including discrimination and hate crime)
	Poverty and deprivation	There is a strong relationship between poverty and deprivation and mental health conditions. However, these affect some groups disproportionately.	• People from minority ethnic groups • Disabled people

			• Women (particularly those who are lone parents) • Carers
	Loneliness and isolation	Loneliness and isolation can contribute to worse mental health and wellbeing and are more likely to be experienced by some people and groups.	• People living in rural and remote areas • Older adults • Women at certain life stages (such as with children and in older adulthood) • Carers • LGBTI+ people
	Impacts of the pandemic	The COVID pandemic and measures put in place to reduce the spread of the disease impacted mental health across the population but were specifically felt by some groups more than others. This was due to increased care burdens, anxiety around catching COVID-19, social isolation, increased financial stresses and other factors.	• Women • Those with caring responsibilities • Older adults • Disabled people • People living in deprived areas. • Children and young people
Accessing services	**Mental health stigma**	Among certain groups, mental health stigma acts as a barrier to seeking help and talking about mental health.	• Men • Older adults • Some minority ethnic and religious groups • People living in remote and rural areas

			• People in the perinatal period
	Geographical inequalities	There are geographical inequalities in the services available to support mental health and practical barriers to accessing them, such as having to travel long distances on public transport. There are also geographical inequalities in accessing non-medical social support, such as peer groups.	• People living in rural areas • LGBT+ people • Children and young people
	Lack of inclusive communication	For some groups, a lack of accessible, inclusive communication acts as a barrier to being able seek mental health support . This includes language barriers, as well as non-inclusive formats of communication and non-culturally appropriate signposting material.	• Disabled people • Some minority ethnic groups
	Lack of targeted information	Lack of information targeting specific groups relating to awareness, education and signposting of both mental health issues and services available acts as a barrier to reaching out for support.	• Men • Disabled people • Older adults • LGTBI+ people • Some minority ethnic groups
	Diagnostic overshadowing	In some cases, mental health concerns are dismissed, undiagnosed and untreated due to a focus on other health needs or disabilities.	• Older adults • Disabled people (particularly those with learning disabilities) • Women • Adolescents

	Impacts of the pandemic	The pandemic caused significant disruption to mental health services and support, which reduced some people's ability to access support and worsened mental health conditions. This also impacted wider health and care services which had a knock-on impact on mental wellbeing.	• Trans people • Older adults • People in remote and rural areas • Disabled people • women
	Waiting times	Long waiting times for mental health and other health care and support were highlighted generally but were highlighted with specific consequences for some groups.	• Children and young people • Trans people
Experiences of using services	**Training for support of equalities groups**	Evidence highlighted a need for additional training within the mental health workforce so that practitioners were more aware of and could support the specific needs of some equalities groups.	• Minority ethnic and religious minority groups (including the need for culturally sensitive services) • Women and girls (including the need for trauma-informed mental health services) • LGBTI+ people (including the need for knowledge about and sensitivity to the experiences of LGBTI+ and particularly trans people)
	Workforce diversity	The issue of mental health workforce diversity was highlighted in evidence around some groups, particularly in providing more culturally aware support. Diversity can also contribute to more inclusive communication throughout service delivery.	• Minority ethnic groups • Religious minority groups • LGBTI+ people

	Choice and agency in support received	For some groups, a lack of agency or choice in what services are available and how support is provided was highlighted as an issue. This also relates to a lack of continuity of care and concerns around “slipping through the gaps” highlighted in evidence for some groups.	• Minority ethnic groups • Disabled people • Women and girls • Children and young people • Trans people

2. Introduction

Structure and areas of focus

This equalities evidence summary report is structured around some of the characteristics protected under the Equalities Act 2010 [1], with the exclusion of marriage and civil partnership and the inclusion of poverty and deprivation, geographical location and carers. It was produced to support the Equalities Impact Assessment that accompanies the 2023 Scottish Government Mental Strategy.

There are sections dedicated to each of the following groups/characteristics:

- Age
- Disability
- LGBTI+ (this section includes characteristics of both gender reassignment and sexual orientation)
- Pregnancy and maternity
- Race (this includes minority ethnic groups, gypsy and traveller communities, and asylum seekers and refugees)
- Religion or belief
- Sex
- Poverty and low-income
- Geographical location
- Carers

The following topics are addressed as they relate to these characteristics:

- Existing inequalities and mental health disparities
    - Existing mental health inequalities
    - Social determinants of mental health
- Inequity in accessing services and support
- Experiences of mental health services and support
- Impacts of the COVID-19 pandemic
- Data and evidence gaps

Where there is evidence relating to sub-groups within these characteristics, this has been included within that section and where possible, intersectional evidence relating to people with experiences and identities spanning multiple characteristics has been highlighted in the relevant multiple sections. Evidence relating to groups such as asylum seekers and refugees has been broadly categorised within the minority ethnic section as being the most closely relevant section, though with key distinctions.

Evidence sources

Key sources of quantitative data come from several population-level sources, including the Scottish Health Survey (SHeS) and Scottish Surveys Core Questions (SSCQ). Given the disruption to data collection during the COVID-19 pandemic, much of the evidence included from these surveys is taken from 2018 and 2019.

Additional quantitative and qualitative evidence targeting specific protected characteristic groups has been sourced from a range of relevant UK and Scotland-based government, third sector and academic publications through a process of rapid literature review. International academic evidence is used where relevant, primarily drawing on review-level evidence. Organisations participating in the Mental Health Equalities and Human Rights Forum (MHEHRF) contributed significantly to the evidence gathering via consultation throughout 2021, as well as highlighting evidence gaps and insights from the lived experiences of the people that they work with. This has been particularly valuable in providing insights across the period of the pandemic, in addition to the specific bodies of work which have taken place exploring the impact of the pandemic on mental health, wellbeing and influencing factors. A membership list of organisations involved in this process is included in Appendix A.

While most of the evidence is from Scotland, in some sections this is also supplemented with evidence from the wider UK, including sources such as the Adult Psychiatric Morbidity Survey (APMS). The APMS provides data on the prevalence of both treated and untreated psychiatric disorders in the English adults population (aged 16 and over).

The majority of evidence used in the report dates from 2015 or later, to utilise the most up-to-date findings. Earlier research is included where it has particular relevance, such as where more recent evidence is not available, particularly for underresearched groups.

Note of the limitations of this report

This report is based on the evidence on mental health and protected characteristics identified during the rapid review process and via engagement with the MHEHRF. It should be acknowledged however, that there is an underrepresentation of some protected characteristic groups within mental health research. This has resulted in an imbalance in both the quantity and quality of evidence available for some groups. The smaller body of research and relative lack of data and evidence for some groups does not mean that these groups do not experience inequality with regards to their mental health and their experiences of accessing services. This report highlights key gaps as they relate to specific groups, as identified through the review process and engagement with the MHEHRF.

A limitation relating to data reporting relates to the types of groups represented in statistical data, either due to the lack of demographic indicators recorded in the data, or insufficient sample sizes to access more granular insights. This is particularly apparent within the race section of this report. Consequently, within the report there has been unequal dependence on different information sources, with some sections able to include clear, recent statistical evidence from Scotland, while others rely on statistics from elsewhere in the UK and lived experience insights from the MHEHRF and third sector reports. The nature and quantity of the peer reviewed academic literature available for some groups also varies; for some groups there is a much greater quantity of qualitative literature compared to quantitative literature. For example some groups can have limited abilitity to participate in research around mental health, for instance, people with dementia, young children and people with learning disabilities. This can cause gaps in our understanding of the experiences of people in these groups. For other groups included in this report, such as older adults, some minority ethnic communities and men, different and subjective perceptions of mental health and illness may impact the extent to which qualitative and quantitative research can fully reflect lived realities. Self- and societal stigma may also impact some groups more than others.

This report includes evidence relating to social determinants which are believed to negatively impact mental health and wellbeing, which provide a broad, indicative understanding of the underlying experiences and circumstances which may affect people with each protected characteristic. However, much of the evidence relating to these factors are based on observational findings (i.e. non-experimental research), where caution should be excercised in making assumptions about causal relationships between these factors and mental health and wellbeing outcomes. This is particularly the case where there may be multiple overlapping and confounding factors which affect the mental health and wellbeing of specific groups of people to varying extents.

The report includes insight from the MHEHRF based on their work and the lived experience insights of their members and communities they support. While this adds valuable depth to the findings and enables insights based on rapidly changing events around the pandemic and cost of living crisis, it is challenging to comment on their generalisability without triangulation with other evidence. This means that while key issues are flagged, there are some gaps in our understanding of the extent of the impact of these issues.

Measurement metrics

Many of the sources used in this review utilise a range of metrics to measure mental health and wellbeing. This includes the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), the 12-item General Health Questionnaire (GHQ-12) and the Strengths and Difficulties Questionnaire. These tools are useful in providing comparable measures of wellbeing and mental health longitudinally, across different groups and different geographical regions. Other measures, such as the Revised Clinical Interview Schedule (CIS-R) for anxiety and depression are also used in several surveys but are not quoted directly in this report. Brief explanations of the metrics are provided below.

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

WEMWBS was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing [2]. WEMWBS is widely used, including in the annual Scottish Health Survey (SHeS) which is frequently referenced in this report [3]. It is designed to be self-completed. WEMWBS is suitable for adults aged 16 and above and also for use at a population level in teenagers aged 13 and above in samples of over 100.

WEMWBS includes both a 14-item scale and a short 7-item scale (referred to by the acronym SWEMWBS). The questions included revolve around a set of feelings and thoughts that the respondent indicates their experience of in the previous two weeks. WEMWBS is designed to assess: positive affect (optimism, cheerfulness, relaxation) and satisfying interpersonal relationships and positive functioning (energy, clear thinking, self-acceptance, personal development, mastery and autonomy). The scale uses positively worded statements with a five-item scale ranging from '1 - none of the time' to '5 - all of the time'. The lowest score possible is therefore 14 and the highest score possible is 70, or 7 to 35 in the short version [4].

WEMWBS scores are approximate to a normal distribution, where, in general, population samples in the UK, it has a mean score of 51.0 and a standard deviation of 7. This means that 15% of the population can be expected to have scores of less than 42.3 and 15% of the population can be expected to have a score greater than 59.7. It is recommended that a low cut point is set at 42 for low wellbeing and a high cut point is set at 60 for high wellbeing [5].

General Health Questionnaire (GHQ-12)

GHQ-12 is a widely used standard measure of mental distress and mental ill-health, which is also used in the SHeS and other surveys, including the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), cited in this report. GHQ-12 consists of 12 questions on concentration abilities, sleeping patterns, self-esteem, stress, despair, depression and confidence in the previous few weeks [4]. Responses to each of the GHQ-12 items are scored, with one point allocated each time a particular feeling or type of behaviour is reported to have been experienced 'more than usual' or 'much more than usual' over the previous few weeks.

These scores are combined to create an overall score of between zero and twelve. A score of four or more (referred to as a high GHQ-12 score) is commonly used to indicate the presence of a possible psychiatric disorder. A score of zero on the GHQ-12 questionnaire can, in contrast, be considered to be an indicator of psychological wellbeing. GHQ-12 measures deviations from people's usual functioning in the previous few weeks and therefore cannot be used to detect chronic conditions.

Strengths and Difficulties Questionnaire (SDQ)

SDQ is a commonly used indicator of child wellbeing and happiness, which is also used in surveys such as the SHeS, cited in this report. SDQ is applicable for 4 to 12 year old children and is comprised of five dimensions: emotional symptoms; conduct disorder; hyperactivity; peer problems; and prosocial behaviour. The “total difficulties score” can range from 0 to 40, with a higher score indicating more difficulties. SHeS utilises a traditional three-band categorisation (a newer four-band categorisation is in use elsewhere), whereby an if individual has a score between 1-13, they are deemed “normal”; 14-16, they are “borderline”; and 17-40, they are “abnormal” [6].

3. Age

Key points

Existing mental health inequalities	• Mental health and its effects change across the life course. Some age groups experience factors which make mental health concerns more or less likely within certain age brackets. • Mental health concerns are more common amongst adolescents than in younger children, though concerns about the mental health of children have increased in recent years [7]. • Eating disorders are one of the most prevalent mental health conditions affecting young people, with anorexia having the highest mortality rate of any psychiatric disorder in adolescents [8]. • People aged between 16 and 24 are particularly vulnerable to mental health concerns, with 75% of mental health conditions being established by the age of 25 [9]. • SHeS showed higher mental wellbeing among older than young adults (WEMWBS scores of 46.0-49.5 for those aged 16-64 versus 52.0-51.0 for those aged over 65, with the lowest for those aged 25-34) [10]. • Working aged adults are most at risk of dying by probable suicide in Scotland, with the median age of death being 44 for men and 45 for women [11]. • Older adults tend to report better mental health outcomes, but there are limitations in self-reporting methodologies. • SHeS analysis showed that those aged 75+ reported having poorer mental wellbeing than those aged 65-69 [12].
Social determinants	• Evidence shows that social determinants which make a child or young person more vulnerable to having mental health needs include: being from a minority ethnic background; being looked after and accommodated in care; having a learning disability; having a parent with mental health difficulties; having refugee status; identifying as LGBTI+; involvement with the criminal justice system; and living in poverty. Poor mental health can often result because of discrimination or stigma relating to these factors. These intersect with experiences of psychological trauma and adverse childhood experiences (ACEs), such as experiences of domestic abuse and sexual assault, homelessness or having a chronic health problem [13]. • Supportive networks are an important protective factor for children and adolescents in having resilience against the impacts of ACEs and trauma [14], [15], [16]. • Social media [17] and body image concerns [18] are highlighted as having impacts on young people's mental health.

	- For older adults, issues around social isolation were highlighted as a risk factor for mental health [19], particularly in remote and rural areas [20].
Inequity experienced in accessing services and support	- Referrals to CAMHS services have risen significantly in recent years [21]. During 2022 and 2023 over 25% of referrals to CAMHS services took longer than 18 weeks, with over one-fifth of referrals being rejected [22], [23]. - For both young people and older adults, mental health stigma and lack of mental health literacy are highlighted as barriers to accessing services. - While psychological interventions are effective amongst older people, older adults are less likely to receive psychological therapy treatments in Scotland.
Experiences of services and support	- The limited availability of age-specific mental health services was highlighted, resulting in long waiting times and poorer or inconsistent care provided for both young people and older adults [24]. - Transitions between age-specific mental health services were highlighted as being disruptive and can leave patients vulnerable to deterioration in their mental health [25], [26]. - Evidence indicates that older adults' mental health issues might be neglected particularly if they are diagnosed with dementia. Use of mixed wards (i.e., patients with dementia, mental health issues or both) are viewed as detrimental for older adults with mental health issues [12]. - There are also challenges around a lack of skill or confidence to diagnose later-life depression amongst practitioners, prioritisation of older people's physical health over their mental health and a lack of awareness regarding the effective treatment options that are available amongst practitioners [27], [28].
Data and evidence gaps	Evidence gaps relate to intersectional characteristics including: - Mental health experiences of older LGBTI+ people - Mental health of older adults with caring responsibilities and living in areas of deprivation - Mental health of people from minority ethnic groups across different age categories - Disaggregated evidence across working age adults

Introduction

There is significant evidence that mental health needs and experiences vary across age groups, as do the barriers to and experiences of accessing support and services. This section provides an overview of the mental health inequalities experienced among different age groups, with a predominant focus on children and young people and older adults.

Overall, the evidence shows that while mental health is generally good amongst children, this can be impacted by several factors including living in poverty and experiences of trauma and adverse childhood experiences (ACEs). Mental health needs are more common amongst adolescents and young adults compared to children. While older adults tend to report having better mental health, this could also be impacted by more stigmatising views about mental illness and a lower likelihood of reporting concerns. Older adults are at particular risk of social isolation.

There are barriers to accessing services for children and young people, where there are long waiting times and challenges in accessing necessary referrals to specialist services. For older adults, age related stigma is seen to impact the provision of mental health care, and diagnostic overshadowing has been raised as concern, particularly for people with dementia. The transitions between services (e.g. from child and adolescent (CAMHS) to adult mental services and from adult and to older adults mental health services) can be challenging.

The disruption to education and lack of access to friends and family during the COVID pandemic had significant impacts on the mental health of children and young people. High numbers of young people reported concerns about their mental wellbeing. Older adults were shown to have poorer mental health during the pandemic, with a significant risk of isolation as a result of being asked to shield and/or living in residential care homes without visits from family and friends. For many older adults, disruptions to care services meant increased unpaid care responsibilities, which disproportionately fell on women.

Existing inequalities and mental health disparities

Existing mental health inequalities

Children (aged 0-12)

The Scottish Health Survey (SHeS) utilises the Strengths and Difficulties Questionnaire (SDQ) to understand child wellbeing and happiness [6]. For the period from 2016-2019, 12% of children aged 4-6, 18% of those aged 7-9 and 19% of those aged 10-12 reported “abnormal” or “borderline” emotional symptoms. This is an increase from previous years indicating that the mental health of children may be getting worse. Notably, for children in the 7-9 and 10-12 age brackets these increased from the rates recorded in the period from 2013-2016 (from 14% and 17% respectively).

Adolescents (aged 13 to 19)

Mental health difficulties are more common amongst adolescents than in younger children and there is widespread concern about worsening mental health among the adolscent population. In 2018, the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) [29] found that 63% of pupils had a normal overall score on the SDQ, 18% had a borderline score and 20% had an abnormal score. The proportion of pupils with borderline or abnormal SDQ scores has continually risen since 2010, and the proportion of pupils with normal scores has fallen. Since 2010, 15 year old girls have had the highest rate of borderline or abnormal SDQ scores, although the gap between 15 year old girls and other groups has been narrowing since 2013 [29].

Data on adolescent health and wellbeing from the World Health Organisation (WHO) collaborative cross-national Health Behaviour in School-aged Children (HBSC) study in

Scotland conducted in 2022 found that 80% of young people reported high life satisfaction, with younger adolescents more likely to report this than older adolescents [30]. Boys were more likely to report feeling very happy than girls (32% vs 21%). For girls, this was the lowest prevalence of feeling very happy since the 1994 survey. In 2022, the lowest levels of confidence in 28 years were observed for both boys and girls. The survey found that 35% of young people were classified as having either low mood or risk of depression and 32% of young people reported anxiety, with higher levels among girls than boys at ages 13 and 15 [30].

These findings are reflected in the Scottish Government report ‘Secondary School-aged pupils in Scotland: Mental wellbeing, relationships and social media’ [31], which is based on survey findings from 2021 at secondary local authority schools. It found that female pupils reported poorer mental wellbeing compared to male pupils, as well as feeling lonely more often, and female pupils were less likely to feel optimistic. Older pupils also reported poorer mental wellbeing than younger pupils.

Eating disorders are one of the most prevalent mental health conditions affecting young people. Eating disorders are seen in the UK to be most common amongst individuals between the ages of 16 and 40 years old, up to 90% of those affected are female [8]. While most develop during adolescence, there are cases in the UK of children as young as six and adults in their 70s. However, the average age of onset for anorexia nervosa is 16-17 years old and for bulimia nervosa is 18-19 years old. Anorexia nervosa has the highest mortality rate of any psychiatric disorder in adolescence [8].

Adults (aged 16 to 64)

People between 16 and 24 are seen to be particularly vulnerable to mental health concerns, with 75% of mental health conditions being established by the age of 25, highlighting the need for interventions on prevention and early treatment focused on young people [9]. Evidence from the English APMS that there was an increased prevalence (from 15% to 19%) of common mental disorders for 16- to 24-year-olds between 1993 and 2014 [32]. Younger adults were more likely to have suicidal thoughts, attempt suicide and self-harm than other age groups [33], [34]. Research also highlights the higher prevalence of post-traumatic stress disorder (PTSD) amongst young people and adults aged 16-24 years old (3% in the general population compared to 5% of young men and 4% of young women) [33].

There is a significant gender component to mental health needs in this age group, where the proportion of 16-24 year old women experiencing common mental disorders is much higher than for men in this age group and for women across other age groups, though there are potential nuances in the reporting of mental health difficulties across gender groups [33].

Research into past-month distress, as measured with the Kessler Psychological Distress Scale between 2020 and 2022 (over the course of both the COVID-19 pandemic and the cost-of-living crisis) amongst adults in England, highlighted an increase in severe distress that was particularly pronounced since late 2021 among adults younger than 25 years of age [35]. The proportion of adults reporting severe distress increased from 13.6% in December 2021 to 20.2% in December 2022 [35]. This highlights evidence of potential growing mental health concerns amongst young adults.

Amongst all aged adults, high level figures show that, in general, older people tend to have better mental wellbeing and lower levels of mental ill health than working aged people. Younger adults (aged 16-24) often have the highest levels of mental ill health and lowest mental wellbeing [36]. In the 2021 SHeS, mental wellbeing was seen to be higher among older than younger adults, with an average WEMWBS scores for those aged 65 to 74 and 75 and over of 52.0 and 51.0 respectively [10]. Comparatively, those aged 16 to 64 had scores ranging from 46.0 – 49.5, with the lowest being for those aged 25-34. These were broadly consistent with previous years' results [37]. The proportion of adults with a GHQ-12 score of four or more (indicative of a possible psychiatric disorder) generally decreased with age from 31% among those aged 16-24 to 12% of those aged 65-74 and 13% of those aged 75 and over [10].

Combined analysis of the 2018/2019 SHeS showed how the prevalence of reporting two or more symptoms of depression varied significantly by age for all adults, with the highest proportion among those aged 45-54 (17%) and the lowest among those aged 65-74 (8%) [37]. It also showed that the prevalence of reporting two or more symptoms of anxiety decreased with age, with the highest rate recorded among younger people aged 16-24 and the lowest among older people aged 75 and over (21% and 8% respectively) [37].

Also based on the 2021 SHeS data, younger people were more likely than older people to have ever self-harmed (25% of those aged 16-24 compared with 1% of those aged 75 and over) [10]. Younger age groups were also more likely to have ever attempted suicide.

Young adults were more likely than older adults to have felt lonely 'often' or 'all of the time' in the previous two weeks with 14% of adults aged 16-24 reporting this compared with around one in twenty (4%) aged 65 and over [10]. The 2023 Office for National Statistics (ONS) 'State of Loneliness' report highlighted that significantly more under 30s have been lonely throughout 2021 and 2022, with a pattern of chronic loneliness declining with age [38]. However, there have been significant increases in chronic lonliness in people over the age of 30 and under 70 since 2020 [38].

Based on data from the Scottish Suicide Information database (ScotSID) database from 2011 to 2019 [11], working age adults were at most risk of dying by probable suicide, with the median age at death for men being 44 years of age and 45 years for women. Almost half of all suicide deaths (46%) were among people aged 35-54 years and for both men and women the largest number of deaths occurred in the 45-54 year age group, while the age group with the highest suicide rate was 35-44. Since 2000, the average age of death for suicides has generally risen, from 41.9 years of age to 46.6 years of age. The average age of death for probable suicides has risen from 41.9 years of age in 2000 to 46.6 years of age in 2021 [39].

Older Adults (aged 65+)

While older adults appear to report better mental health outcomes than younger adults, there are limitations in methodologies which require the self-reporting of poor mental health, particularly due to more stigmatising views of mental health amongst older age groups and a potential inability for those with dementia to advocate for themselves. There are also potential differences across the 65+ population, with those aged 75+ reported to have poorer mental wellbeing than those aged 65-69 based on the SHeS analyses from 2016-2019 [37]. The Lothian Birth Cohort Study 1921, a longitudinal study of cognitive ageing based on a sample followed since birth, found that participants reported poorer psychological quality of life at 90 years old than when they were 79 years old [40].

There is, however, mixed evidence from other sources, with a 2020 Scottish Government survey finding that older adults aged 70+ were more likely to report being 'completely happy' than those aged 55-69 [41]. Age Scotland's 2021 Big Survey of 3,562 adults over 50 also found that respondents in their 50s and 60s were less likely than those older than them to describe their mental health as good and more likely to state that it had got worse over the last 5 years [42]. In the period between 2018 and 2021, probable deaths by suicide have also increased amongst age groups 65-74 and 75+, while they decreased amongst all other age groups [39].

Social determinants of mental health

Mental health is fluid and varies throughout people's lives and certain risk factors mean that specific mental health needs or conditions may be more prevalent at particular times in life. The following sections address the underlying mental health inequalities and experiences of children and young people, working-age adults, and older adults.

Children and young people

There are many underlying factors which appear to influence children and young people's likelihood to experience mental health issues. Based on evidence provided by Public Health Scotland, social determinants which make a child or young person more vulnerable to experiencing difficulties with their mental health include: being from a minority ethnic background; being looked after and accommodated in care; having a learning disability; having a parent with mental health difficulties; having refugee status; identifying as LGBTI+; involvement with the criminal justice system; and living in poverty [43]. Many of these intersect with experiences of psychological trauma and ACEs alongside experiences of domestic abuse and sexual assault, homelessness or having a chronic health problem, which can also contribute to experiencing difficulties with their mental health.

Abuse and neglect

Evidence collated by the National Society for the Prevention of Cruelty to Children (NSPCC) highlights many of the factors that are associated with children and young people's long term mental health [44]. The impact of trauma including abuse and neglect increases the likelihood of children developing a range of mental health issues both in childhood and later in life. These include anxiety, depression, self-harm, substance use, eating disorders and post-traumatic stress disorder (PTSD) [45]. Specific types of abuse may be connected to certain mental health issues: children who have experienced emotional abuse may be more likely to develop anxiety and depression compared with children who have experienced other types of abuse [46] and one study found that 74% of young people who had experienced sexual assault developed PTSD [47]. Abuse and neglect can also make children more vulnerable to experiencing more than one mental health condition at a time (known as composite mental health issues) [48].

Care

Care-experienced children are more likely than their peers to have mental health difficulties [49]. Children whose early needs have not been in met a sensitive, loving and timely way by their primary carer can be more vulnerable to coping with future relationships and life events [49]. Children who are cared for can experience isolation and loneliness and may also have experienced trauma in the form of abuse or neglect [50]. Evidence also suggests that looked-after children experience a greater number of moves between homes or units than children in the general population, which may present an additional traumatic experience and which can mean that health problems get overlooked and appointments are changed, missed, delayed or cancelled [50].

Poverty and deprivation

The SALSUS survey in Scottish schools found that there was a clear link between deprivation and emotional and behavioural problems [7]. WEMWBS mean scores (indicating better mental wellbeing) increased as deprivation decreased, with the exception of 15 year old boys, whose scores showed no consistent pattern across deprivation levels. Analysis of data from the Health Behaviour in School-aged Children (HBSC) surveys undertaken in Scotland from 1998 to 2018 found that social inequalities increased over time and that declines in mental health were greatest among adolscents from low affluence backgrounds [51]. This is thought to be linked to young people in more disadvantaged circumstance being more likely to experience stressors across financial, social and educational domains, and less likely to have access to resources such as social support and health or community-based services [51].

Family and friendships

Supportive networks, including having trusted adults, have been found to be an important protective factor for children and adolescents in having resilience against the impacts of adverse childhood experiences and trauma [14], [16], [15].

The Scottish Government ‘Secondary school-aged pupils in Scotland: Mental wellbeing, relationships and social media’ report showed that pupils with a mental health condition were also less likely to report having family with whom they talked about their problems or enjoyed spending time [31]. Pupils living in rural settings were less likely to report having friends to whom they could talk about their problems than pupils living in urban settings.

Similar findings were reported in the SALSUS survey, which showed that pupils who were unlikely to talk to their parents about something that was worrying them were more likely to have a borderline or abnormal overall SDQ score and lower WEMWBS mental wellbeing scores than those who were likely to talk to their parents [7]. The greater the number of close friends a pupil reported, the less likely they were to have a borderline or abnormal SDQ score and the more likely they were to have higher wellbeing scores.

Social media

Numerous sources highlight the potential impact of social media on young people’s mental health, which has been linked to worsened mental health, particularly for adolescent girls [52], though without robust evidence to suggest a causal link [17], though this may depend on the regularity and intensity of social media use [53]. Research links the use of mobile phones and social media as disruptive to sleep, as well as perpetuating body image concerns and being a source of cyberbullying [17]. There is, however, evidence of social media’s potential benefits on mental wellbeing, including promoting social connectedness and self-expression and providing emotional support [17].

Body image

Concerns around body image have a disproportionate impact on the mental health of young people, particularly young girls [18]. Negative body image can be influenced by social media and cultural pressure to conform to certain expectations of physical appearance. This can contribute to higher levels of eating disorders, as well as depression and anxiety.

Life transitions

There are some physiological factors which may influence mental health during adolescence, including developments associated with going through puberty [54], [55]. There are also social factors associated with life transitions which have an influence on experiences of mental health concerns. The 2022 Glasgow Centre for Population Health report ‘Young people’s transitions to adulthood: qualitative research with young people in Glasgow’ highlights the experiences of young people transitioning to adulthood. Mental health was mentioned in nearly all the interviews and focus groups in the study, with young people highlighting their concerns around mental health and experiences of social and general anxiety, panic attacks, depression, anger, paranoia, low self-confidence and body image insecurities [56]. The report highlights the prevalence of mental health concerns as reflective of a mental health crisis amongst young people at stage where mental health issues become prevalent, as well as an intergenerational shift in openness to talk about mental health.

Alcohol and substance use

The experience of mental health issues is correlated with psychoactive substance use among adolescents and young adults [57]. Externalising disorders (including conduct disorder, oppositional defiant disorder and attention-deficit and hyperactivity disorder) in early or middle childhood are known to predict problem drug and alcohol use and dependence in adolescence and young adulthood. For internalising disorders (including depression and anxiety) the evidence is less clear [57].

Disabled children and young people

The NSPCC highlight that children and young people with additional needs and disabilities may face challenges including reduced mobility, prejudice, discrimination and bullying that may lead to lower self-confidence, difficulty forming peer networks, and social exclusion, putting them at higher risk of developing mental health issues [44]. Signs of learning disabilities can be confused with symptoms of mental health issues, which can mean concerns are not recognised and addressed quickly or appropriately.

The SALSUS survey in Scottish schools found that pupils who reported that they had a long-term illness or disability were twice as likely as those who did not to have a borderline or abnormal overall SDQ score [7]. Those with a long-term illness or disability also had lower WEMWBS wellbeing scores than those who did not.

The Scottish Government ‘Secondary school-aged pupils in Scotland: Mental wellbeing, relationships and social media report’ highlighted that students with physical or mental health conditions reported poorer mental wellbeing, feeling lonely more often, getting less sleep, and were less likely to report feeling optimistic [31].

Minority ethnic children and young people

Children from minority ethnic groups can experience racism, discrimination and prejudice, which can be direct, indirect and/or institutional, as well as potential barriers such as increased stigma around mental health issues in certain communities. These can lead to inequalities and challenges in accessing appropriate care and support for mental health needs [58].

LGBTI+ children and young people

LGBTI children and young people may experience prejudice, discrimination and bullying, fear of rejection from family and/or friends and in many cases feelings of exclusion.

Experiences of gender dysphoria also cause distress for some. These factors and experiences mean they are more likely to experience a range of mental health concerns than their heterosexual and cisgender peers [59], [60].

Students

Increasing levels of suicide rates at UK universities has led to concern about the mental health of the student population (of whom 64% of the population are between 16 and 24 years old, rising to 83% of the undergraduate population) [61]. This particularly impacts men (who are less likely to report common mental disorders, suicidal thoughts and suicide attempts than women in the general population). Male students were more than twice as likely to die by suicide than female students between 2012/12 and 2016/17 [61]. Coming from a more socially disadvantaged background increases the risk of experiencing common mental health disorders for university students. Financial and academic stressors associated with university life are also thought to be a concern for the mental health of students [61].

Working age adults

Many of the underlying inequalities which impact mental health for working-age adults relate to wider intersections covered in other areas of this report, but particular risk factors for poor mental wellbeing include low educational attainment, material disadvantage and unemployment, as well as trauma and ACEs [62].

Older adults

Social isolation and loneliness

Older adults are suggested to be at particular risk of experiencing social isolation and not having regular contact with others [38]. Before the pandemic, such isolation was suggested to be prevalent for several reasons including: experiences of mental health stigma and discrimination in earlier adulthood which can lead to increasing social isolation over time [19]; bereavement following the loss family and friends, resulting in smaller social networks [20]; and a lack of access to and/or ability to use digital communications [42]. A survey of older adults in the Highlands, undertaken in 2016, found that older adults living in urban areas were least likely to experience loneliness (60%) compared to those living in very remote, rural and accessible small towns (72% and 71% respectively) [20]. However, for those experiencing ‘intense’ loneliness (described on a scale of not lonely, slightly lonely, moderately lonely and intensely lonely), older adults living in very remote small towns and urban areas were more likely to experience this feeling (10% and 9% respectively), compared to those living in accessible rural settings (5%) [20]. Experiencing a bereavement is a key risk factor for depression amongst older adults [63], [64].

Older women

A common insight in feedback from several stakeholders in the MHEHRF was that older women’s mental health is not seen as a sufficiently serious issue by policy makers and health care services, with Age Scotland highlighting evidence from their engagements of older women feeling invisible. They further highlighted that stressors, such as being more likely to be unpaid carers [65] and living in poverty [66], may put them at higher risk of poor mental health outcomes. In the MHEHRF, the Scottish Women’s Convention also highlighted societal expectations that women should be able to manage their own problems and assumptions that they should be able to handle stresses better.

LGBTI+ older adults

Also highlighted at the MHEHRF were the specific experiences of older LGBTI+ adults, which could negatively influence their previous and current mental health. This includes marginalisation, lack of acceptance, discrimination and criminalisation, along with the subsequent minority stress [12] (see LGBTI+ section for more details). Stakeholders stressed how isolation is an issue amongst older LGBTI+ people, who may choose to conceal their identities when forming new connections and feeling ignored by younger LGBTI+ people and LGBTI+ spaces. Age Scotland also highlight that services catering to older adults, such as care homes may not be inclusive and welcoming to people of LGBTI+ identities.

Disabled older adults

Older adults are more likely to have existing disabilities or physical health issues, which can contribute to an increased risk of mental health challenges. The SHeS 2016-2019 analyses found that older adults (in each age range) who rated their general health as poor reported poorer mental wellbeing than those rating it as good [37].

Inequity experienced in accessing services and support

Children and young people

Individuals' experiences of mental health and wellbeing varies across the life course, as does their need for services and interventions. In addition to mental health services, the need for independent advocacy services has been highlighted by the Mental Welfare Commission [67].

Availability and waiting times

The Scottish Children's Services Coalition highlight the challenges in accessing mental health support for children and young people [68]. They argue that a lack of resources and inadequate staffing as key factors in the significant and growing number of children and young people waiting to access the support they need, particularly in terms of improving preventative and early intervention services. They argue that the number of specialist beds for children and young people with mental health needs is inadequate to meet demand, particularly given geographical inequalities in available care. Referrals to specialist Children and Adolescent Mental Health Services (CAMHS) have risen over the past decade, with Audit Scotland noting a 22% increase between 2013-2014 and 2017-2018 (from 21,486 to 26,071 accepted referrals) [21], which has since increased to 29,309 referrals in 2022-2023 (an increase of 12% since 2017-2018) [69]. This increase has potentially been driven at least in part by decreased stigma and greater awareness of mental health needs, alongside increased need for mental health support.

The SAMH report 'Going to be alright?' on the mental health of young people in Scotland highlights access to support for children and young people [24]. The report highlights the waiting times for referrals to CAMHS services, as well as the number of rejected referrals [23]. For the quarter ending in June 2023, 73.8% of children and young people were seen within 18 weeks of referrals (the Scottish Government standard states that 90% of children and young people should start treatment within 18 weeks of referral to CAMHS), with 25.1% of referrals being rejected [69]. In the SAMH report, families who have received rejected referrals from CAHMS describe how the experience can cause children and young people's mental health needs to worsen, as well as significant strain on family relationships and lead to feelings of despair and anger [24]. There is also variation in the waiting times between different health boards [24]. Further concerns from families highlighted several barriers to seeking help, including fears about not being taken seriously, being judged and about confidentiality. Young people also wanted better information on where to go for help, and more and better support from non-professionals.

The ‘LGBT Youth Health Report 2023’ highlighted that for many, in addition to the length of time spent by many young people on waiting lists for healthcare services, including mental health care, the lack of of communication during the waiting period exacerbated the distress people experienced [70]. In the nationwide survey of LGBTI+ young people, respondents highlighted feeling unsure if there were on the list or had been lost in the system, where not knowing if or when they would be offered an appointment was stressful and made them feel unimportant and unsupported.

Mental health stigma

Research undertaken by See Me Scotland with young people in Scotland highlighted some of the stigma-related barriers children and young people may feel in speaking out and accessing support for their mental health [71]. Their research found that children and young people were afraid of not being listened to, not being believed or not being taken seriously by adults if they raised an issue, and experienced fear of the consequences of speaking out, such as the anticipated reaction of others. Some were concerned about having a label or diagnosis and how this would be viewed by peers, wider community and society. Young people also described having seen other people being treated unfairly as a result of their mental health concerns or because of disclosing a mental health need. This research echoes a systematic review which showed that perceived stigma and embarrassment, problems recognising symptoms (poor mental health literacy) and a preference for self-reliance are important barriers to help-seeking [72].

Engagement with support at school and university

Research undertaken by Samaritans Scotland and described in their report, *‘Hidden too long: self-harm in Scotland’*, highlights that self-harm often emerges during adolescence and occurs at times of major change, including moving away from home to university or start work. These changes can cause a gap in support, for example in registering with a new GP, reduced contact with family and changing friendship groups [34]. Respondents to the Samaritan’s research in the UK and Republic of Ireland were less likely to seek support from school or university following their experiences of self-harm, suggesting that education may be an underutilised source of support [34]. Stakeholders involved in the research highlighted the importance of addressing stigma around self-harm in these contexts.

Transition from CAMHS to adult mental health services

The transition from CAMHS to adult mental health services is highlighted by numerous sources as a potentially difficult changeover which can cause disruption for patients and, without appropriate care, can leave patients vulnerable to deterioration in their mental health [25]. Research highlights the need for transitional care to provide accessible, responsive and age-appropriate provision of services [73].

Older adults

Age-related self-stigma

Age-related self-stigma (i.e., when someone holds negative and unfair beliefs about themselves) was particularly emphasised in consultations with stakeholders from the

MHEHRF as making it less likely that older adults will access mental health services. For example, seeking help for mental health might affect older adults' self-esteem, as they might view it as embarrassing or self-indulgent, or as affecting how others view them (e.g., as having lost status or the ability to make decisions for themselves). Relatedly, older adults were suggested to potentially feel too proud or stoic to seek help, find it difficult to be open about their mental health, want to avoid being a burden, and believe that other people require the services more [19].

There is evidence that older adults with common mental health conditions are less likely to be referred to psychological therapies than younger adults, as seen in England [74]. Although psychological interventions for depression are effective amongst older people, older adults with depression are less likely to receive treatment than younger people [75]. During the quarter ending June 2023, 18,450 people began Psychological Therapies treatment in Scotland, of which only 1,398 (8%) were aged 65 or over [76] (compared to this age group comprising of around 17% of the population [77]), though this may reflect a lower level of need.

Knowledge about mental health and support

Knowledge about mental health and support was also indicated in the MHEHRF consultations to affect older adults' accessing of mental health services. Specifically, compared with younger adults, older adults were suggested to be less aware of signs of mental health issues, modern therapies or treatments for these issues, or how to access mental health support [19]. In research concerning local authorities' COVID-19 helplines, findings suggested that callers to these helplines were often older, and seemed distressed, anxious and isolated [78]. This could therefore suggest that older adults do not have sufficient knowledge about mental health and associated services and, as a result, they reach out to less appropriate services.

Transition between adult and older adult mental health services

Voluntary Health Scotland and Change Mental Health (formerly Support in Mind Scotland) highlight concerns about how adults transition between adult and older adult mental health care services [26]. There are regional differences in the age-specific services provided for mental health in different health boards and differences in accessing services based on whether or not people have lived with mental health needs throughout their life or have developed them for the first time in later life [26]. Access to services becomes dependent on people's ability and experience of navigating systems to find support and knowledge of self-management, which could result in a gap in care for many [26].

Perspectives highlighted by stakeholders in the MHEHRF show the lived experiences of accessing both formal and informal support for mental services. Anecdotal evidence from the Scottish Women's Convention highlights that older women find their problems are belittled, even by health care workers, including having issues being blamed on their age or on going through menopause.

Experience of services and support

Children and young people

Inconsistency of treatment

Research by the Scottish Youth Parliament suggests that most respondents felt comfortable speaking with a GP or other medical professional as well as someone they are close to about their mental health [79]. Young person-specific mental health services were seen as a positive, though shortcomings were identified including lack of accessibility, lack of confidentiality, not being taken seriously due to age and non-person-centred treatment. This was echoed in SAMH report ‘In their own words: the mental health of children and young people in Scotland’, which also highlighted long waits and inconsistency of treatments. The report also noted as poor responses from NHS mental health services and lack of choice [24].

Support within schools

A key source of support for children experiencing mental health difficulties comes from schools. However, research from SAMH highlights that many school staff feel underequipped to respond to mental health concerns. Based on a survey undertaken by SAMH in 2017, only 12% of teachers felt they had adequate training in mental health and only 1 in 100 respondents recalled doing detailed work on mental health when they were student teachers, despite many reporting seeing increasing numbers of pupils approaching them with mental health and wellbeing issues [80]. Research undertaken in England found wide variety in the level of health and wellbeing training for teachers, with just 40% of classroom teachers reporting feeling equipped to teach children in their class who have mental health needs and only 32% knowing how to help pupils access specialist mental health support outside school [81].

Older adults

Availability of services

In terms of the availability and quality of older adult mental health support, the psychiatrists consulted for the Mental Welfare Commission for Scotland’s 2020 themed visit report into older people’s functional mental health wards in hospitals suggested that, for older adults, there was a smaller range of social work services, a lack of crisis assessment and support teams for those in crisis, longer waiting times for multidisciplinary team services, and fewer specialist services (e.g. eating disorders) [82]. Staff lacking experience of working with older adults was also highlighted in the Mental Welfare Commission for Scotland’s report, such as nursing staff turnover being seen to result in less experience working with older adults [82]. Research conducted for the Age in Mind project by the Scottish Mental Health Cooperatve into mental health discrimination and stigma in later life found that older adults using mental health services reported experiencing discrimination from health and social care staff, such as overhearing abusive comments, not being believed or listened to, and being made to feel worthless [19].

Respondents to the Scottish Mental Health Cooperative’s research reported reduced access to psychiatrists and community psychiatric nurses, psychological therapies and medication reviews once turning 65, with clients generally falling into the cohort of people growing older with pre-existing mental health conditions, as opposed to supporting newly referred clients over the age of 65 [19]. Several mental health providers reported not being contractually allowed to accept clients over the age of 65. Voluntary Health Scotland and Change Mental Health have also highlighted the lack of funding for community mental health services and projects for people aged 65 and over [26].

Older women’s mental health

Anecdotal evidence from the Scottish Women’s Convention consultation highlights that older women find their problems are belittled, even by health care workers, including having issues being blamed on their age or on going through menopause. There were concerns that older women fell through gaps in wider mental health provision and support.

Dementia

Evidence indicates that older adults' mental health issues might be neglected particularly if they are diagnosed with dementia. Mixed wards (i.e., patients with dementia, mental health issues or both) are viewed as detrimental for older adults with mental health issues [12]. PHS data also indicates difficulties in accessing post diagnostic support for people with dementia, which can help them live well and be supported, and in itself contributes to good mental wellbeing [83]. Dementia itself is also associated with experiences of trauma, with links made between PTSD and dementia. However, the relationship between them is complex and not well understood [84].

Age stigma

The role of age stigma was highlighted within consultations for the MHEHRF, where numerous barriers to older people accessing appropriate mental health treatments were identified. These include health care providers' assumptions that older people are unwilling to discuss mental health concerns and a view amongst some health care providers that later life depression is a justifiable response to the challenges of ageing, and therefore unamenable to treatment. There are also potential challenges around a lack of skill or confidence amongst practitioners to diagnose later-life depression, prioritisation of older people's physical health over their mental health and a lack of awareness regarding the effective treatment options that are available amongst practitioners [85], [28].

Impacts of the COVID-19 pandemic

Children and young people

Disruption to education and daily lives

Many of the key concerns around the COVID-19 pandemic, and particularly measures put in place to stem the spread of the disease, were about the possible impact on the mental health and wellbeing of children and young people. According to UNICEF report 'The state of the world's children 2021; on my mind: promoting, protecting and caring for children's mental health', globally it is anticipated that lockdowns, pandemic-related movement restrictions, time away from friends and family and disruptions to education and recreation will likely have an impact on the mental health of children for many years to come [86].

According to a pandemic impact assessment undertaken by the Children and Young People's Commissioner Scotland, 39% of 11-24 year olds have reported concerns about their mental wellbeing and 32% of UK 16-24 year olds report feeling overwhelmed by panic and anxiety every day [87]. Based on a UK survey undertaken by Young Minds, 83% of young people with existing mental health concerns said the pandemic had made these worse [88]. Research from the 2022 HBSC study showed that 38% of young people said that their mental health was quite or very negatively affected by the pandemic [30].

Evidence from 2022 and 2021 shows that COVID-19 and measures such as lockdowns caused anxiety and stress, particularly for older children and young people [89], [90], [91]. UK-wide research indicated that young people with a history of mental health needs reported a substantial negative impact from lockdowns, with concerns that these impacts would be long term [88].

Evidence on mental wellbeing from UK-wide studies showed a sharp decrease in behavioural, emotional and attentional difficulties amongst primary and secondary school-aged children following the lifting of lockdowns [92]. The negative mental health impacts were found to persist even when all children had returned to school [93].

The Scottish Government report, ‘Coronavirus (COVID-19) – experiences of vulnerable children, young people and parents’ found that drivers of low mental wellbeing among participants (children, young people and parents) during lockdown periods included feelings of isolation due to being unable to see peers; tensions with family due to spending all day in the same space; excessive screen use; pressures related to social media; absence of activities which were not screen based; and a lack of routine leading to poor sleep [94]. Challenges around home learning were also common, where some children and young people found the learning difficult to follow or struggled to motivate themselves to complete the work. Parents also reported a substantial decline in mental wellbeing, with many having no ‘respite’ from childcare responsibilities due the closure of schools [94]. Most participants reported improved wellbeing once restrictions eased, and some identified positive impacts of lockdowns, including more time spent with family and exploring the local area [94].

Poverty and deprivation

Research by the Child Poverty Action Group (CPAG) Scotland undertaken in early 2021 found that many low-income families in Scotland still lacked devices and sufficient internet connections needed for home learning during the pandemic and spent more on bills while their children were at home [95]. Nearly 9 in 10 families who responded to their online survey said they faced additional costs during the pandemic and were spending substantially more on food, electricity and other essentials. Around half said this had affected their ability to pay for housing and child-related costs.

Abuse

NSPCC data from UK helplines showed sharp increases in calls regarding abuse of children and requests for mental health support [96]. A regular survey undertaken through the pandemic by University College London, which included questions on abuse, indicated that people living in households with children continued to report higher levels of physical or psychological abuse [97].

Disabled children and young people

Young people with special educational needs and disabilities or long-term illnesses, and young carers reported consistently worse physical and mental wellbeing during lockdown periods [98]. Across the UK, evidence showed that young people with special educational needs and disabilities and from low-income households showed elevated behavioural, emotional and attentional difficulties [92]. It was found that in the first year of the pandemic, younger children (4-10 year olds) experienced greater changes in their mental wellbeing (as reported by their parents/caregivers) than adolescents (11-17 year olds). The pandemic also impacted on the wellbeing of girls particularly, with more reporting feelings of loneliness, sadness, anxiety and worry [99].

Minority ethnic children and young people

Surveys found that minority ethnic respondents felt less positive about their physical health and were less happy once back at school and felt less safe there than White respondents [98]. UK and international evidence continued to show a disproportionate impact of the pandemic on the wellbeing and experiences of young minority ethnic people [100], [101]. Studies in both Scotland and the UK (Lockdown Lowdown and Just Like Us) also confirm more pronounced mental wellbeing impacts on LGBTI+ young people, particularly Black LGBTI+ young people [98], [102].

Older adults

Loneliness and isolation

Overall, evidence generally indicates that older adults reported poorer mental health during the pandemic than before. Across the first four waves of the Scottish COVID Mental Health Tracker study [103], older adults (defined in the study as 60+) reported feeling less lonely than younger adults. However, sources indicate that older adults were more lonely during the pandemic than before, particularly during periods of lockdown [12], [104]. At different points during the pandemic, two surveys of Generation Scotland participants found that a higher proportion of participants aged 80+ experienced some loneliness in the previous week compared with participants in their 70s [105].

Older adults' risk of isolation likely increased during the COVID-19 pandemic, with 68% of Age Scotland's Big Survey 2021 sample reporting difficulty accessing friends and family – 24% did not see anyone else during a typical week and only 21% saw someone every day [42]. Added to which, many older adults were advised to, or have chosen to minimise in-person contact during the pandemic. Approximately 9% of Scotland's older adult population (91,463) was asked to shield in June 2020, and an estimated 45-50% of adults aged 60+ choose to shield despite not being asked to do so [12]. Furthermore, restrictions on visitations to care homes might have isolated some older adults living in residential care from family and friends, even if they were not on a shielding list or did not choose to shield [106]. The increased reliance on digital communications also likely impacted older adults' contact with others, particularly for those less comfortable with digital communications and with lower digital literacy.

Even after pandemic restrictions were lifted, evidence shows that older people may not have returned to socialising to the extent that they did pre-pandemic, both through having "got out of the habit" of socialising or having had reduced confidence due to declining mobility and potential fears about the ongoing threat of COVID-19 [42]. In the MHEHRF, the Scottish Women's Convention highlighted engagements with older women who said that they experience isolation and anxiety, attributed to lower interactions with family and friends, which has continued to be low beyond the ending of pandemic restrictions.

Health and care services

The impacts of the pandemic on the provision of statutory services had a specific impact on older adults. Disruption and the reduction in care services meant that many had to manage with lower support than previously and that, for many, there were increases in unpaid caring responsibilities, which are likely to disproportionately fall on older women.

Data and evidence gaps

The data available for the mental health of different age groups is generally better than for other protected characteristics, as age is collected within population level surveys and many routine data collection processes.

However, there are some evidence gaps which particularly relate to specific age groups and intersections with other characteristics, as well as those in age categories who are less likely or unable to participate in research. These gaps include:

- Mental health experiences of older LGBTI+ people
- Mental health of older adults with caring responsibilities and living in areas of deprivation

- Mental health of people from minority ethnic groups across difference age categories
- Mental health of very young children and older adults who may be less likely to be reached in research, for example, those with dementia

4. Disability

Key points

Existing mental health inequalities	• Based on SHeS, adults living with a limiting long-term health condition have lower WEMWBS wellbeing scores than those living with no long-term health conditions (45.4 and 51.8 respectively) [37]. • Disabled adults are more likely to report mental ill health: 30% of those with a long-term condition reported a possible psychiatric condition, compared to 11% of those with a non-limiting condition and 9% with no condition [107]. • Many disabled people have multiple physical and mental health conditions, adding to the complexity of understanding their needs [108].
Social determinants	• Environmental and social stressors can contribute to poorer mental health for disabled people, including increased exposure to adverse life events, such as childhood poverty, violence, unemployment and experiences of social exclusion [109], [110], [111]. • Survey data suggest that those with physical health problems, long-term conditions or disabilities are two times more likely to report severe loneliness than the general population [112]. • Mobility, inclusion and accessibility issues can also have a direct negative impact on disabled people's mental health and wellbeing [113].
Inequity experienced in accessing services and support	• Evidence highlights that many disabled people feel like their experiences may not be heard or taken seriously when trying to access mental health services [114]. • Disabled people may face barriers in accessing services particularly in rural areas and through digital exclusion [115].
Experiences of services and support	• Disabled people report lack of inclusive communication as an issue when using mental health services, with survey research showing that up to 41% of disabled people have difficulty accessing health information in the formats required [114]. • Effective treatments which are adapted to the needs of disabled people are also lacking [116]. • Research also highlights concerns around diagnostic overshadowing and lack of awareness and training within services.
Data and evidence gaps	There are challenges in understanding the full extent of mental health inequalities for people with disabilities, in part because of the

	breadth and diversity of experiences, needs and perspectives within the disabled population. Data gaps include disaggregated and comparable data on the mental health of people with different types of disabilities. Particular evidence gaps are seen in: - Evidence relating to mental health and dementia and sensory impairment - Intersectional evidence relating to age, sex, deprivation, LGBTI+, minority ethnic people and mental health outcomes [117] - Evidence relating to multiple intersections for under-represented groups, for example, older disabled women - Evidence to support our understanding of the under-reporting of mental health concerns for and by certain disabled groups, including people with learning disabilities [118] and older adults [119].

Introduction

One in five people in Scotland have a disability, including 21% of women and 18% of men. Over one third of adults and one in ten children in Scotland have a limiting longstanding condition which limits their daily activities or the work they do, including problems that are due to old age [37].

Overall, there is evidence that, in Scotland, disabled people have lower levels of mental wellbeing compared to non-disabled people, and higher rates of depression, anxiety and severe mental illness. While there are gaps in evidence in understanding the specific experiences across different types of disabilities and across different intersections, there is evidence that this poorer wellbeing and mental health is impacted by a higher rate of adverse life events and social stressors as well as increased rates of poverty, isolation, exposure to abuse, experiences of bullying, discrimination and hate crime.

There are numerous barriers to accessing mental health services, including diagnostic overshadowing and lack of inclusive communication and adaption of therapies to support disabled people.

Existing inequalities & mental health disparities

Existing mental health inequalities

While there is nuance across the range of different types of disabilities and intersectionality with a range of other characteristics, there is evidence that disabled people in Scotland often have higher rates of mental illness and mental ill health. Mental illness itself also falls within the definition of disability.

Based on the 2019 SHeS, adults living with a limiting long-term health condition scored lower in mental well-being than those living with no long-term health condition (indicated by WEMWBS scores of 45.4 and 51.8 respectively) [37]. A higher proportion of adults living with a limiting long-term health condition had a GHQ-12 score of 4 or more (indicative of a possible psychiatric disorder) than those living with no long-term health condition (32% and 10% respectively). Disabled adults are also more likely to report mental ill-health: 30% of individuals with a long-term condition reported a possible psychiatric condition, compared to 11% of those with a non-limiting condition and 9% with no condition [107].

The UK disability survey provides some quantitative and qualitative insights into mental health within the disabled population [108], though was critiqued for a lack of questions directly on mental health. It highlights that many disabled people have multiple physical or mental health conditions, adding to the complexity of understanding their mental health needs. The survey also indicated that 73% of disabled respondents who had a physical or mental health condition, or illness lasting or expected to last for 12 months or more, had an impairment related to mobility. Over half (57%) had an impairment related to mental health [108].

Mental illness

Mental illness which has a substantial, adverse and long-term effect on the ability to carry out normal day-to-day activities is itself a disability, which can cause a wide range of physical health, economic and social inequalities [120], [121]. Individuals with serious mental illnesses experience a range of physical health inequalities, starkly demonstrated by the relatively high rate of premature mortality (defined as deaths occurring before the age of 75 [122]) amongst this population. For example, analysis of health records from the Welsh population between 2004-2013 revealed that individuals with a serious mental illness had a two to three times higher death rate than the general population during the study period [123].

There is evidence that these health inequalities have grown in recent years. Research on primary care records has examined mortality outcomes among a cohort of over 39,000 persons with bipolar or schizophrenia in the UK between 2000 and 2014 [124]. Analyses revealed that the overall mortality rate declined during the period from 2000 to 2014 for both patient groups, but that the mortality gap between those with either condition and the general population had grown since the mid-2000s [124]. These widening health inequalities can be attributed to the differentially greater health improvements observed among the general population, including efforts to reduce negative health behaviours (e.g. smoking) which have been less successful for those with bipolar disorder or schizophrenia. This suggests that efforts to improve the health of those with bipolar disorder or schizophrenia, including the prescription of new medications and attempts at deinstitutionalisation, have not been sufficient to reduce the mortality gap [124].

The excess mortality among people with serious mental illnesses is caused by a wide range of factors, including health behaviours, the organisation and delivery of health services and socioeconomic inequalities faced by people with mental illnesses [125].

Autism and learning disabilities

There is varied evidence on the rates of mental ill health amongst people with learning disabilities. The NHS Scotland report ‘People with learning disabilities in Scotland Health Needs Assessment’ highlights that while the exact prevalence rates are unknown and vary widely, rates of anxiety and depression are at least as prevalent for people with learning disabilities as in the general population [126]. Schizophrenia is also reported to be more common in people with learning disabilities than in the general population [127]. Other sources, such as APMS undertaken in England, indicate that people with learning disabilities were twice as likely to have an anxiety disorder or depression as people without (25% compared to 13%), and a higher disparity for rates of probable psychotic disorders [32]. Deficits in communication and health literacy and difficulties in accessing services may mean that mental ill-health in people with learning disabilities is under-recorded.

There is evidence to suggest that autistic people have increased risk of mental health conditions. Autistic people are at a higher risk of suicide than non-autistic people, where research indicates that between 11% and 66% of autistic adults have thought about suicide during their lifetime and up to 35% had planned or attempted suicide [128]. The highest risk is seen in autistic people without co-occurring learning disabilities, and autistic women [129]. There is also evidence to suggest that undiagnosed autism can be a factor in increased suicidal thoughts and self-harm [130].

Deaf and hard of hearing and visual impairments

Based on a UK cross-sectional study, deaf and hard of hearing people experience higher rates of mental disorders [131]. Deaf children for example have been estimated to be 1.5 to two times more likely to develop mental health needs than hearing children. Visually impaired older adults are also at higher risk of mental disorders, based on a cross-sectional study of older adults in Scotland [132]. Higher rates of depression and anxiety disorders are also seen in international studies relating to sensory impairment [133].

Intersectional evidence

Intersectional data on the prevalence of mental illness for disabled people is currently lacking, though there are indications that some groups of disabled people are at particular risk of mental ill health. For example, there are indications that mental disorders were highly prevalent among older people in care homes [134] including 10% for major depressive disorder and 29% for depressive symptoms [135].

Research from Stonewall Scotland indicates that 26% of LGBTI+ disabled people have self-harmed in the past year (compared to 11% of LGBTI+ people who are not disabled, and 6% of adults in Scotland over the course of their lives) [136]. LGBTI+ disabled people are also more likely to take their own lives than non-disabled LGBTI+ people. Research from the Glasgow Disabilities Alliance (GDA) indicates that women are more likely to be disabled, live in poverty and have insecure and low-paid jobs, which are factors which may increase the risk of experiencing mental health problems [137].

Social determinants of mental health

There are numerous underlying inequalities for many disabled people in Scotland, including increased exposure to adverse life events and social stressors which can contribute to poorer mental health.

Evidence collated by Public Health England indicates that social and environmental factors are likely to influence and mediate the development of mental health needs in people with learning disabilities [138]. Exposure to social disadvantages such as lone-parent family, income poverty, and households with no paid employment has been shown to be associated with mental health needs in children and young people with learning disabilities [139]. People with mild learning disabilities are at significantly greater risk than their peers of being exposed to common social determinants of poorer mental health including childhood poverty, violence, unemployment and other social forms of social exclusion. Survey data from Scotland and the UK indicates that children between the ages of 11 and 15 years old with a limiting long-term condition or disability were at greater risk of peer relationship problems and being bullied [140], [110]. Reports on disability hate crime show that disabled people can also be the subject of persistent attacks [111].

Loneliness and Isolation

The 2017 NHS Scotland report 'Social isolation and loneliness in Scotland: a review of prevalence and trends' highlighted that poor physical health and long-term conditions that limit daily functioning are risk factors for poor social support and less frequent social contact [141]. Survey data from Glasgow and the UK suggest that those with physical health problems, long-term conditions or disabilities are two times more likely to report severe loneliness than the general population, which is particularly impactful on older adults and those living in areas of deprivation [112], [141], [142], [38]. Adults with poorer social support are more likely to have mental health conditions and those experiencing anxiety, depression or stress are at increased risk of severe loneliness. Sensory impairment can particularly result in social isolation and loneliness [143].

Accessibility and inclusion

The impacts of mobility, inclusion and accessibility issues for health and social care services have a direct negative impact on disabled people's everyday mental health and wellbeing. In the MHEHRF, the ALLIANCE highlighted the Health and Social Care Academy's 'Exploring Scotland's 20-minute neighbourhood' series [144], which examine the benefits and challenges of the 20-minute neighbourhood concept through the lens of inclusivity, diversity and accessibility. This project found that disabled people, people living with long term conditions and unpaid carers often experience inaccessible community services, green spaces and town centres. Examples of lack of access to public accessible toilets or changing places, poor public transport links and inaccessible buildings were highlighted as environmental factors which can impact people's mental health and wellbeing.

Inaccessible services are a critical issue for people living with sensory loss. Communication exclusion and 'sensory poverty' can have a significant impact on a person's mental health and wellbeing. This was highlighted in a summary report between deafscotland, Deafblind Scotland, the Royal National Institute for Deaf People (RNID), Sight Scotland, and the ALLIANCE, which highlighted the impact of 'sensory poverty' on the sensory loss community as being the cause of poor mental health and a barrier to accessing support [113]. They advocate for policy, funding and service decisions which support providing universal sensory literature services and communication.

Issues around digital exclusion, also impact many disabled people's mental health and wellbeing. This includes lacking access to the digital skills, connectivity and accessibility required to use computers, online services and platforms [145]. One quarter of disabled adults in the UK have never used the internet, compared to just over 10% of the entire UK population [146]. This intersects with older people's experiences of digital exclusion. According to Age Scotland, around 500,000 people over 50 in Scotland do not have access to the internet. Digital exclusion can create barriers to participation in everyday life and for accessing many services, as well as contributing to increased isolation [145].

Poverty and employment

The linkages between disability and poverty, and the mental health implications of these, are highlighted in numerous sources. The 2021 Scottish Health Survey found that 18% of disabled people experienced food insecurity compared to 5% of non-disabled people [147]. Age Scotland highlighted concerns in the MHEHRF around the cost of living crisis. They emphasise the debilitating impact money worries can have on mental health, felt severely by disabled people (particularly those over 50). YouGov polling undertaken in January 2023 in Wales showed the 58% of adults who have a health or disability issues say that their financial position has had a negative impact on their mental health, compared with 42% of those with no health or disability issues [148].

Disabled people are more likely to not be in paid employment, which can lead to financial problems, stress and isolation. Rates of employment range from 45% of disabled people at large (compared to 72% of the general population) to 7% of people with severe learning disabilities [149]. Two-thirds of work-age people who are registered as blind or partially sighted in Scotland are not in paid employment [113]. Evidence collated in the Glasgow Indicators Project, based on data from the Annual Population Survey, indicates that 24% of Glasgow's working-age population are disabled people, of whom fewer than half have a job [150]. Research from the University of Glasgow under the Disability Workstream, co-convened by the GDA, concludes that disabled people disproportionately face chronic poverty and barriers to work, caused by inadequate social security benefits, higher costs affecting disabled people, economic inactivity and lower pay experienced by those disabled people who are in work [151].

Also highlighted in the MHEHRF were the impacts of claiming benefits and relying on social security systems. The Scottish Women's Convention highlighted engagements with disabled women who described the stigmatising experiences of using such systems and the feelings of hopelessness and desperation impacting wellbeing.

Carers

Many disabled people are unpaid carers for other adults and children. The 2021 UK disabilities survey found that 34% of carers reported physical or mental health conditions or illnesses lasting or expected to last for 12 months or more. Of these, 71% stated that their condition or illness reduced their ability to perform day to day activities [108]. This highlights how many carers are also disabled people and the potential mental health implications of this. Additional evidence relating to the mental health inequalities affecting carers can be found in the carers section.

Domestic abuse

People with disabilities are more vulnerable to domestic abuse, experience domestic abuse for longer periods of time and experience more severe and frequent abuse than non-disabled people [152]. This disproportionately impacts disabled women and can have severe long-term mental health impacts. Certain disabilities, particularly physical disabilities, may decrease a person's ability to physically defend themselves and escape from abuse, while other disabilities can limit a person's ability to understand and recognise potential signs of abuse. Some disabilities can create social isolation via exclusion due to physical and environmental inaccessibility or via stigma and discrimination in social activities. Therefore, many people with disabilities are left with a much smaller support network than those people without a disability. This makes it more difficult for family members and friends to recognise the signs of abuse. Frequent interactions with institutional and medical settings and personal care assistants coming into their homes may also increase the risk of domestic violence [153]. Some disabled people's reliance on care can increase their situational vulnerability to other people's controlling behaviour. This dependence can create power inequalities within a relationship. It has been suggested that perpetrators of abuse are more likely to target the most vulnerable to whom they have access [153].

LGBTI+ and Discrimination

The 2015 ‘Scottish LGBT Equality Report’ determined that disabled people in the LGBTI+ community are more likely to experience increased levels of discrimination, prejudice and disadvantage compared to their non-disabled LGBTI+ counterparts [154]. Furthermore, Stonewall’s ‘LGBT Health in Scotland’ Report determined that almost three in five LGBTI+ disabled people have felt like life is not worth living, compared to three in ten LGBTI+ people who are not disabled [136]. LGBTI+ disabled people are also more likely to experience inappropriate curiosity from healthcare staff than other groups, with 18% of disabled LGBTI+ people avoiding treatment for fear of discrimination because of their sexual orientation, compared to only 12% of non-disabled people [136]. Overall, this evidence indicates that LGBTI+ disabled people can experience poorer mental health in comparison to non-disabled LGBTI+ people.

The Equality Network highlight that young disabled LGBTI+ people may be at higher risk for compromised sexual health due to a lack of diverse and appropriate sex education [154]. Disabled people are often considered cis-heterosexual by default which can lead to a feeling of invisibility of LGBTI+ status for disabled people. Some disabled people are treated as non-sexual, which is problematic when someone is not self-declared as asexual [154].

Inequity experienced in accessing support and services

Rurality

Change Mental Health highlighted in the MHEHRF that rurality should be a key consideration in understanding the mental health of people with a range of disabilities. They note that public transport is vital for rural and remote communities, but is often limited, sporadic, unaffordable and in some cases non-existent. For those reliant on public transport (including many disabled people), this can act as a barrier to receiving proper care and support to manage their mental health needs, including being able to visit friends and family [115].

Digital exclusion

Also highlighted at the MHEHRF was the likelihood that the digital exclusion, which already impacts disabled people, is heightened in many rural areas due to financial situations, lack of trust and familiarity with digital approaches and lack of digital infrastructure to access online mental health services. In feedback to the forum, for instance, Change Mental Health estimate that 40% of their Mental Health and Money Advice Service clients reside in rural and remote areas of Scotland.

Distrust in services

A 2022 report from the Glasgow Disability Alliance engaged with disabled participants to understand their experiences of mental health and ways to support their wellbeing [155]. The participants in the research highlighted their experiences of not feeling heard or taken seriously when trying to access mental health services. Many also expressed fearfulness of statutory mental health services and the resulting stigma from accessing services.

Organisations in the MHEHRF also highlighted the experiences shared by disabled people and people living with long term conditions of not being listened to or having their symptoms believed when engaging with healthcare professionals, which can lead to feelings of distress and a deterioration in mental health and wellbeing. This was particularly highlighted by women [156], people with long covid and people with pre-existing health conditions [157].

Barriers for disabled LGBTI+ people

While noting the lack of empirical data and evidence relating to the lived experiences of LGBTI+ disabled people, the Equality Network highlight that through their work they have found that disabled LGBTI+ people in Scotland face specific barriers to accessing the services and support that they might need [154]. Disabled LGBTI+ people can have their expression of gender identity and sexual identity/orientation stifled due to a lack of competent care and support, particularly within services and social spaces which are not intersectional and inclusive.

Disabled people sometimes rely on small networks of people who may not know or refuse to acknowledge the person's sexual orientation or gender identity [154]. Some disabled people may risk losing the support that they need when coming out to family and friends. Some disabled LGBTI+ people may also experience isolation and marginalisation within the wider LGBTI+ community. Disabled people with same-sex partners often find their partners are treated primarily as carers or friends, this can especially impact people under a compulsory treatment order for mental health or those who need hospital treatment [154]. LGBTI+ friendly counselling and peer support are often not fully physically accessible due to lack of funding [154].

Experience of services and support

In the 2021 UK Disability Survey, disabled respondents reported that better mental health support and decreased stigma of mental health conditions would significantly improve their lives [108]. Respondents highlighted that mental health (particularly long-term mental health issues) should be considered as important as physical health. Suggested improvement measures included greater funding and more mental health support resources specifically for disabled people. The need for improved mental health services was also highlighted by carers (both for themselves and for the people they care for).

Inclusive access to services

One of the key issues highlighted in the literature about accessing mental health services is the lack of inclusivity. In the MHEHRF, Change Mental Health highlighted some of the measures which could help make mental health services and support more inclusive for disabled people. They noted that when disabled people first access mental health services, information on their rights should be available in inclusive formats for all disabilities [158]. This relates, in part, to the issues around digital exclusion previously noted.

There are also concerns about accessing information in required formats, which is particularly relevant to those with sight and/or hearing loss [113]. The GDA, for example, note that 41% of disabled people have difficulties accessing information in the formats required [114]. This acts as a barrier to disabled people receiving appropriate support and prevents them from being able to make informed decisions about their care and treatment options. Examples of this include the lack of adequate information in British Sign Language (BSL) and relevant mental health services not booking BSL/English interpreters or electronic note takers for patients [113].

Lack of effective treatments

Another challenge in the provision of mental health support for some disabled people is that clinicial interventions which are effective in treating mental health conditions in the general population may not always be accessible to people with learning disabilities [126]. Highlighted by Public Health England, there is a lack of compelling evidence supporting interventions aimed at improving mental health needs in people with mild to moderate learning disabilities, although cognitive-behavioural therapy (CBT) seems to be a promising intervention for the treatment of depression [159]. There is also a lack of research on effective treatments for mental health conditions experienced by children and adults with severe and profound learning disabilities [160]. Whilst talking therapies such as CBT are considered first-line treatments of choice for many types of mental health conditions, limitations in communication skills and understanding means people with severe and profound learning disabilities cannot be assumed to find talking therapies as accessible as other people do. In England, rates of prescription of psychotropic medications (e.g. anti-psychotics and anti-depressants) for people with learning disabilities exceed rates of diagnosis of corresponding mental health conditions [161]. Given the potential serious long-term side effects associated with these types of medication, there have since been programmes specifically aimed at reducing their prescription [116].

Lack of awareness and training within services

Sources highlight concerns related to the diagnosis and support provided for mental illness and the role of diagnostic overshadowing [126]. This is a term used to describe an exclusive approach whereby health professionals and others assume that a patient's disability or existing health issues explain behaviours and experiences without exploring other factors which may relate to mental health and wellbeing, or vice versa.

Evidence from the National Autism Implementation Team (NAIT) indicates that delayed or missed diagnoses of autism have a negative influence on health and wellbeing [162]. NAIT also highlight that supportive assessment processes and diagnosis can provide a positive and affirming identity, a community of peers and information to help individuals understand themselves and their experiences as people who are not 'broken' but different [163]. There is also a lack of assessment tools which have been adapted for people with learning disabilities [164], [165].

Change Mental Health emphasises the need to consider community support for individuals, as those with lived experience of poor mental health would prefer to be supported pre-crisis in a low-level non-clinical setting, which can be place-based, interest group-based or workplace-based [166]. They also support a greater emphasis on non-medical approaches to mental health. Research by the Mental Health Foundation found that 78% of GPs reported prescribing anti-depressants, despite believing that an alternative treatment would be more appropriate, but other approaches were either not available or had long waiting lists [167]. Whilst medication has a role in mental health recovery for some people, there should be an easily accessible alternative to respond pre-crisis in the community. Change Mental Health advocate for non-medical approaches such as social prescribing, which could potentially alleviate pressure on mental health services. Research has indicated that partnerships which include third sector organisations could help to strengthen local areas and create new referral pathways between sectors that help provide a wider range of appropriate mental health support options [166].

Involvement of carers

Consultations undertaken by VOCAL and Thrive Edinburgh with people caring for people with mental health conditions highlighted some of the challenges experienced in using mental health services specifically [168]. Respondents to the research described perceived negative attitudes from mental health professionals towards carers, and many said they felt judged, abandoned or ignored by them. This was noted particularly in the case of discharge arrangements, where carers felt unsupported and that there was a lack of responsibility taken by professionals and agencies. Carers also highlighted the lack of recognition and involvement they felt in processes of accessing services, with respondents overwhelmingly saying they wished to be treated as equal partners in care.

Impacts of COVID-19 pandemic

The pandemic had severe implications for many disabled people, both from COVID-19 itself and from the impacts of many of the disease containment measures. Research indicates that across the UK, disabled people reported more frequently feeling that the COVID-19 pandemic was affecting their wellbeing, compared to non-disabled people. Office for National Statistics (ONS) data shows that over two fifths (41%) of disabled people reported that the pandemic was making their mental health worse (compared to 20% of non-disabled people), 45% said they were feeling lonely (compared to 32% of non-disabled people), 24% said they felt like a burden to others (compared to 8% of non-disabled people) and 24% said that they had no one to talk to about their worries (compared to 12% of non-disabled people) [169]. Analysis by Scotland’s Mental Health Partnership of the COVID Mental Health Tracker showed that having pre-existing ill health was the strongest indicator for experiencing high levels of psychological distress, having suicidal thoughts or experiencing anxiety during the pandemic [170].

Risks from COVID-19

Disabled people were more likely to become seriously ill or die from COVID-19, with deaths most commonly occurring in those who had at least one pre-existing health condition [41], [171]. The most common pre-existing condition amongst those who died was dementia and Alzheimer’s. Those with learning disabilities were more than twice as likely to be infected with COVID-19 and to experience severe outcomes resulting in hospitalisation and were more than three times more likely to die than those in the general population. A survey of disabled people in Glasgow conducted by the GDA found that 90% of the respondents have been worried about their physical and mental health during the pandemic [114] and Inclusion Scotland found that respondents to their April 2020 survey were anxious about their own health and about the health of the people they care about, with many “fearful for the future” [172]. This research also reflected concerns that disabled people would not receive the same care as non-disabled people if they were seriously ill or admitted to hospital.

Impact of COVID-19 measures

Disabled people were disproportionately impacted by government public health advice to shield during the pandemic. According to the survey research undertaken by Inclusion Scotland, impacts of this included people who were shielding lacking the support they needed, causing significant stress in accessing food and medications, particularly as a result of food shortages, and gaps and delays in receiving shielding support and priority deliveries [173]. There was also concern over the long-term impacts of shielding on physical and mental health, including loss of healthcare appointments and lack of physical exercise. Respondents to the survey said they felt left behind and abandoned, with the services intended to support them failing as a result of the crisis. Numerous sources highlight the impact of isolation and loneliness on those shielding, as people were unable to socialise with friends and family or to access social spaces and support outside their homes. Survey research undertaken by Age Scotland highlighted that for over 50s (who were more likely to be asked to shield), 53% of respondents said lockdowns had made them lonelier and this rose to 65% for people living alone [42]. Disabled women highlighted how the crisis forced them to increase their dependence on others and placed them more at risk of domestic abuse, increasing levels of mental distress [174].

Many of the measures implemented to reduce the spread of COVID-19 had specific implications for disabled people. For example, the introduction and widespread use of facemasks presented particular issues. According to research collated by deafscotland, people with hearing loss and affected by deafness had difficulties in daily life, and found themselves more isolated and left out of society [175]. While there were exemptions for the wearing of masks by disabled people for whom it was not appropriate, data gathered amongst members of Disability Equality Scotland (DES) showed that although a majority of respondents were in favour of wearing face coverings, many disabled people who were exempt had faced difficulties when shopping, including verbal abuse [176]. In addition, further DES polls showed that disabled people felt that they were experiencing a higher level of disability-based hate crime [177]. As noted by ALLIANCE in their report *Mental Health, Sensory Loss and Human Rights*, physical distancing can prevent disabled people from attracting attention by touching another person’s arm or a shoulder. There were also accessibility issues for disabled people in using public transport, shopping and eating out as a result of busier streets, more street furniture, one-way systems, potential queuing and the requirement to physically distance.

Health and social care services

There was considerable disruption to health and social care services during the pandemic which impacted many disabled people, who are more likely to require such services. For many, there was limited access to health care (including mental health services) as appointments and support were stopped, reduced or deprioritised. This reduced the availability of services which were critical for many disabled people to be able to self-manage and live well [178].

Respondents to the GDA report, *Triple whammy: disabled women’s lived experiences of COVID-19,* which provides an in-depth, qualitative account of how disabled women were impacted by the pandemic, reported that mental health services being under-resourced, led to many being turned away or had support curtailed during the pandemic [137]. Reductions and cuts in access to social care provided, which have been slow to resume, were also reported. In some cases, the support provided since the pandemic has been at a lower level than the individuals’ needs assessment originally determined, which has had a negative impact on health outcomes [137]. The reduction in access to social care has meant that many disabled people, and particularly disabled women (as highlighted by the GDA), took on increased caring responsibilities as support was withdrawn.

Some mental health services were moved online during the pandemic, which had mixed implications for disabled people. While for some, online appointments may have had positive impacts – such as reducing stress, expense and inconvenience - for those with lower levels of digital literacy or comfort, including older people and some people with learning disabilities, online services made things more difficult. In some studies, people described concerns around privacy and a negative impact of using online services on their symptoms [179]. ALLIANCE research with young disabled people, and their carers and parents, highlighted the mental health concerns which had arisen during the pandemic [180]. The report explores the experiences of accessing support and services during the pandemic, where respondents frequently highlighted the challenges associated with long waiting times. Specifically regarding mental health support, respondents said that their conversations with psychotherapists were not engaging, too short, and that their concerns and problems were insufficiently explored [180].

At the MHEHRF, Age Scotland highlighted that since March 2020, many people living with dementia have experienced a deterioration in their symptoms. This may be because they have been unable to access community-based care including day centres, meeting centres and peer-support groups, which may have had to close due to COVID-19 restrictions. People living with advanced dementia continue to feel the effects of the pandemic– as do unpaid carers. With less support available to them, and a lack of time to look after their own health, unpaid carers face the impact of physical and mental health challenges going untreated or undiagnosed for longer periods of time.

Easing of restrictions

There is also evidence of concerns about what would happen once shielding, lockdowns and COVID-19 mitigation measures were lifted. Evidence provided by the GDA indicates that for many disabled people, it was felt that as restrictions were eased, society would forget about disabled people and that ultimately disabled people's rights have regressed over the course of the pandemic [137]. Inclusion Scotland research highlighted concerns about some disabled people being expected to return to work once lockdowns were restricted, despite being clinically vulnerable, as well worries about the general population and whether they would continue to respect social distancing and other measures to protect those at risk [172].

Poverty and employment

Concerns around employment also relate to increased poverty and financial struggles for disabled people [181]. There is evidence that disabled people, who are more likely to experience poverty, and more likely to work in sectors which have suffered economically as a result of COVID-19, or not be in employment, are facing increased debt and economic difficulties [171]. Disabled people not working also contributed to increased feelings of isolation.

Data and evidence gaps

There are challenges in understanding the full extent of mental health inequalities for people with disabilities, in part because of the breadth and diversity of experiences, needs and perspectives within the disabled population, which may not be reflected in population level data collection. Lack of acknowledgement of this can lead to viewing disabled people as a homogenous group.

Current data gaps include:

- Disaggregated and comparable data looking across different types of disabilities

Particular evidence gaps are seen in:

- Evidence specifically relating to the mental health of people with dementia and sensory impairment

- Intersectional evidence [117] across disability and age, sex, deprivation, LGBTI+, minority ethnic people and mental health outcomes, as well as specific evidence with people from under-represented groups with multiple intersecting identities, including older disabled women, for example
- Evidence to support our understanding of the under-reporting of mental health concerns for and by certain disabled groups, including people with learning disabilities [118] and older adults with long term health conditions [119]

5. LGBTI+ (Sexual orientation and gender reassignment)

Key points

Existing mental health inequalities	• Meta-analysis of UK population health surveys shows that lesbian, gay and bi populations are around twice as likely to report symptoms of poor mental health (including anxiety and depression) than heterosexual adults [182]. The 2017 SSCQ found that lesbian, gay and bi people have significantly lower mental wellbeing compared to groups with other protected characteristics, with only those with a long term limiting health condition having lower mental wellbeing scores [183]. • Bi people, and especially bi women, report particularly higher rates of mental health concerns, including anxiety, depression and stress, self-harm, eating disorders and suicidal ideation [184], [136]. • Trans people face a higher burden of mental health conditions compared to cisgender people [185], [186]. • Research into young LGBTI+ people's lives in Scotland found that 96% of trans young people felt that they had experienced a mental health concern or associated behaviours, with high rates of anxiety (84%), stress (72%) and depression (74%) [187]. Only 9% of non-binary and 12% of trans masculine people rated their mental and emotional health positively in research undertaken by PHS [184]. • Self-harm and suicidal ideation are seen to be high amongst trans people, with research from Stonewall Scotland showing that 7% of trans people aged 18-24 attempted to take their own life in the previous year (compared to 2% of non-trans lesbian, gay or bisexual people) and 52% having thought about taking their own life in the previous year [136].
Social determinants	• LGBTI+ people are impacted by minority stress, which refers to experiences of stigma, prejudice, discrimination, bullying and the pressure felt by some to conceal their identities in hostile and stressful social environments [188]. This can have a severe negative impact on mental health. Survey findings from 2019 show that 65% of non-binary people, 62% of trans masculine and 55% of trans women reported having being discriminated against in the previous year [184]. • Access to gender-affirming medical interventions can improve the mental health of trans people. However, there are frustrations with the long waiting times, continued dysphoria and lack of communication, which contributes to worsened mental health outcomes [184]. • Other social determinants include high rates of intimate partner violence and the mental health impacts of these experiences [189], higher rates of drug and alcohol usage [190] and experiences of conversion therapy [191].

Inequalities in accessing services and support	• A lack of proactively LGBTI+ inclusive spaces in rural areas was highlighted as a barrier to access services [192], as well as long waiting lists for mental health services [70]
Experiences of services and support	• Survey research found that 25% of LGBTI+ people who used NHS mental health services in the previous year rated these services as ‘poor’ or ‘extremely poor’ [193]. Over half (55%) of LGBTI+ people have experienced NHS staff making incorrect assumptions about their sexual orientation or gender identity, while 22% of LGBTI+ people feel uncomfortable being open about their sexual orientation or gender identity with NHS staff (this rises to 33% for adult social care) [193]. • Survey research with young trans people accessing CAMHS services highlighted the following issues: staff not being confident talking about or knowledgeable on trans identities; trans young people being asked to focus solely on their trans identities when they are not the cause of their poor mental health and trans young people not being given the space to discuss their trans identities when relevant to their mental health; young people not feeling able to ‘come out’ to CAMHS staff due to a fear of the response or impact on their treatment; young people not feeling listened to and not being given information regarding their diagnosis or treatment; the style or setting of appointments worsening their mental health, including anxiety [194]
Data and evidence gaps	Key data gaps primarily relate to data on mental health service usage for LGBTI+ people. Key remaining evidence gaps include: • Evidence on the mental health of intersex people [194] • Evidence relating to the experiences of LGBTI+ people with intersectional experiences relating to LGBTI+ minority ethnic people and disabled LGBTI+ people

Introduction

There is significant evidence to indicate that LGBTI+ people in Scotland are at much higher risk of mental health concerns than heterosexual/cisgender people, with self-reported mental health concerns being highest among trans-masculine, non-binary and bi women populations. Many LGBTI+ people have experiences of stigma, prejudice and discrimination which contributes to a hostile social environment that can increase the risk of mental health conditions. Access to mental health and other support services is also challenging, with specific issues in rural areas. There are, however, indications of good mental wellbeing for LGBTI+ when there are supportive communities, family and friends and positive experiences of coming out.

This section covers the protected characteristics of BOTH sexual orientation and gender reassignment. They are included in one section largely because of the overlap in evidence sources and shared experiences, however, where there are distinctions in the mental health evidence for people within different groups in the LGBTI+ communities these are highlighted throughout the section.

Existing inequalities & mental health disparities

Existing mental health inequalities

Depression, anxiety and stress

Based on a meta-analysis of UK population health surveys, lesbian, gay and bi populations are around twice as likely to report symptoms of poor mental health (including anxiety and depression) than heterosexual adults [182]. Based on the 2017 SSCQ, lesbian, gay and bisexual people have significantly lower mental wellbeing compared to groups with other protected characteristics, only those with a long term limiting health condition have lower mental wellbeing scores [183].

While many population studies have not included adequate questions on gender identity and trans status, meaning that directly comparative statistics are often missing, all available research indicates a high incidence of depression, anxiety and suicidality amongst trans people with an increasing body of evidence. For example, research into LGBTI+ young people's lives in Scotland, has found that 96% of trans young people felt that they had experienced a mental health concern or associated behaviours [194], with high rates of anxiety (84%), stress (72%) and depression (74%) [187]. Reviews of international research have found evidence that trans populations face a higher burden of mental health conditions compared to cisgender people [185], [186].

A 2022 report by NHS Greater Glasgow & Clyde, NHS Lothian and Public Health Scotland, 'Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people' (abbreviated to HNA throughout this section) found that over half (54%) of the LGBTI+ respondents to the survey said they had a mental health concern, such as depression, anxiety or stress [184] (compared to around one in four in the general population). This ranged from 38% of gay men to 75% of trans masculine, 72% of non-binary and 61% of bi women. Only 25% of respondents rated their general mental and emotional health positively, which was lowest for non-binary (9%) and trans masculine (12%) people [184]. Similarly, data from Stonewall Scotland research in their 2019 report 'LGBT in Scotland', indicated that 49% of LGBTI+ people surveyed had experienced depression in the previous year, including 72% of trans people and 59% of bi people. LGBTI+ disabled people (70%), LGBTI+ people aged 18- 24 (67%), and LGBTI+ people who have experienced a hate crime based on their sexual orientation and/or gender identity (65%) were also more likely to have experienced depression [136]. The same report found that 60% of LGBTI+ people experienced anxiety in the previous year, including 77% of trans people, 75% of LGBTI+ people aged 18-24 and 72% of bi women [136]. Those from lower-income households were more likely to experience depression and/or anxiety. Stonewall UK research highlights that rates of depression in the previous year are higher among Black, Asian and minority ethnic LGBTI+ people (62%) [195].

Self harm

Overall, 58% of the HNA survey respondents had self-harmed. Self-harm was most prevalent among trans masculine (83%), non-binary people (82%) and bi women (70%) [184]. Research from Stonewall Scotland indicates that young and disabled people are particularly at risk, with 41% of LGBTI+ people aged 18-24 and 26% of disabled people having harmed themselves in the last year [136].

Eating disorders

Evidence points to a high prevalence of eating disorders amongst some LGBTI+ groups: 64% of respondents to the HNA survey indicated signs of eating disorders (eating and making themselves sick, restricting or binging on food), which were most prevalent among trans masculine, non-binary people and bi women [184], [184].

Suicidal ideation

Literature indicates a high prevalence of suicidal thoughts and behaviours among LGBTI+ people. The HNA report indicates that trans and non-binary people were particularly likely to speak about suicidal thoughts, although these tended to subside after transition [184], [184]. For all LGBTI+ groups, those who appeared most susceptible to suicidal thoughts included those growing up in cultural or religious groups who were not accepting of LGBTI+ identities, those who felt isolated or did not have supportive family or friends, and victims of abuse. LGBTI+ asylum seekers were especially likely to have attempted suicide. Of those who responded to the question in the HNA survey, nearly one in three (31%) said that they had an attempt to end their life [184]. Although the prevalence of suicide attempts was high across all LGBTI+ groups, it was highest among trans masculine and non-binary people, with nearly half of respondents in these groups saying they had made a suicide attempt [184].

Research from Stonewall Scotland echoes these findings, indicating that 9% of LGBTI+ people aged 18-24 had attempted to take their own life in the previous year, including 7% of trans people, compared to 2% of non-trans lesbian, gay or bi people [136]. A further 32% of LGBTI+ people had thought about taking their own life in the previous year, rising to 52% of trans people [136]. Bi women (48%) and bi men (36%) were more likely to have thought about taking their own life in the last year than lesbians (23%) and gay men (26%) [136].

Autism and ADHD

Literature has highlighted evidence that Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) may be more prevalent amongst LGBTI+ people, particularly trans people (for example, the HNA survey found that 23% of trans masculine and 26% of non-binary people indicated that they had ADHD; 29% of trans masculine and 26% of non-binary people indicated that they had ASD) [184]. People with these conditions could be particularly isolated and/or vulnerable to abuse. Wider research has found both stigma and ASD-related cognitive/neurodevelopmental factors were associated with worse mental health in trans people [196].

Social determinants of mental health

Minority stress

Evidence points towards the role of minority stress in impacting mental wellbeing and mental illness among LGBTI+ people, illustrating the close relationship between social environment and mental health [197]. The term minority stress recognises that experiences of stigma, prejudice, the expectation of rejection, experiences of discrimination, bullying and the pressure felt by some to ‘conceal’ their identities creates a hostile and stressful social environment that causes mental health concerns [188]. Stressful social environments impact different groups within the LGBTI+ community in different ways and these intersect with wider characteristics and social structures.

A key factor highlighted across numerous sources is the role of discrimination and societal perceptions of LGBTI+ identities in the wellbeing and mental health of these groups. From qualitative research undertaken in 2019 and 2020 for the HNA report, LGBTI+ people felt that, generally, society had become more accepting of same-sex couples and lesbian, gay and bi identities [184]. However, attitudes towards trans and non-binary people were not felt to have become as accepting and, indeed, some felt these had taken a 'backward step' and a negative narrative around trans identities had become prevalent. This was considered to be particularly the case on social media, and often in reference to the debate around the Gender Recognition Act [184]. The Scottish Social Attitudes Survey indicates that public attitudes are lagging behind government policy legislation and its aspirations towards making Scotland safe, welcoming, inclusive and healthy for LGBTI+ people [198], [184]. In 2015, 18% of the population believed same-sex relationships to be always or mostly wrong and 39% held discriminatory views in relation to trans people [198]. Research also highlights the issue of biphobia and 'bi-erasure' by bisexual men and women, which includes discrimination and prejudice relating to someone's actual or perceived bisexual orientation and the denial or questioning of bisexuality as a sexual orientation [199]. Nearly half (44%) of LGBTI+ people in the HNA survey said they had been discriminated against in the last year, but this was highest for non-binary (65%), trans masculine (62%) and trans women (55%) [184]. The prevalence of negative social attitudes can result in LGBTI+ people feeling marginalised and socially isolated, the mental health impacts of which is noted across relevant literature [184].

There is a high prevalence of hate crimes and incidents in Scotland directed at LGBTI+ people. According to research undertaken for the 2017 'Scottish LGBTI Hate Crime Report', by the Equality Network, 65% of lesbian respondents, 66% of gay male respondents, 53% of bi respondents, 77% of trans respondents and 77% of intersex respondents had been a target of a hate crime, with 90% of those who had been a target having experienced it two or more times [200]. Of those who experienced hate crime, 71% did not report the incidents to the police. Respondents emphasised the impact of these experiences on their mental health and highlighted the importance of support services, including counselling and helpline services.

Intimate partner violence

Sources highlight high levels of intimate partner violence (IPV) experienced by LGBTI+ people. The 2018 Stonewall UK report, 'LGBT in Britain: Home and communities', showed that amongst respondents, 13% of bi women, 10% of lesbians, 12% of bi men and 7% of gay men had experienced IPV within the previous year (compared with 6% of women and 3% of men in the general population) [189]. Almost one-fifth (19%) of trans people and non-binary people experienced domestic abuse from a partner in the past year. Rates were higher for Black, Asian and minority ethnic and disabled LGBTI+ people.

A 2022 research report looking at experiences of Scottish men who have been subject to IPV in same-sex relationships highlighted the impact of intimate partner violence on the health and wellbeing of participants [201]. This included mental health impacts both during and after ending the relationship. Anxiety and panic disorders, eating disorders, self-harm and the worsening of pre-existing conditions were all experienced whilst in relationships. There were also long term impacts, including sleep disturbances, PTSD, depression and suicidal thoughts that were reported by many participants after relationships had ended. Police involvement which required participants to recount or relive their experience appeared to exacerbate stress [201].

Alcohol and drug use

Research highlights higher levels of problematic drug and alcohol usage amongst LGBTI+ people in Scotland and the UK [190]. Research from Stonewall UK indicates that 16% of LGBTI+ people reported drinking alcohol almost every day over the previous year, compared with 10% in the overall population [195]. The highest levels of drinking are seen amongst older (65+) LGBTI+ people, with 33% drinking almost every day. The research highlighted that 13% of young LGBTI+ people reported taking drugs at least once a month, compared to 9% in the general population [195].

Respondents to the HNA described excessive alcohol use as a ‘self-medication’ and as a coping mechanism to dealing with depression, anxiety and stress [184]. Respondents commonly said that they only felt able to be themselves and be out about their identity in social spaces when they had drunk alcohol. Also noted was that LGBTI+ social spaces are often exclusively focussed on alcohol or in places where alcohol is served [184]. Use of drugs was also linked to mental health needs, both as a consequence and a cause; while used to alleviate feelings of anxiety and depression, they were seen by respondents to ultimately exacerbate these issues [184].

Qualitative research undertaken by the Scottish Health Action on Alcohol Problems (SHAAP) to understand LGBTI+ people’s experiences of alcohol services highlight the links made by respondents of alcohol use to mental health and experiences of shame, stigma or family rejection [190].

Conversion therapies

There is widespread and consistent evidence, both in the UK and internationally, for the mental health harms caused by the use of conversion practices to change sexual orientation and gender identity [191]. The Scottish Government Expert Advisory Group on Ending Conversion Practices report emphasises the need for a range mental health support for survivors of conversion practices, as well as addressing the barriers to accessing mental health support [202].

Access to gender-affirming care

There is evidence that receiving gender-affirming medical interventions can substantially improve the mental health of trans people [185]. However, qualitative research in the HNA report indicates frustration and dissatisfaction in accessing Gender Identity Clinics (GIC), including those in Edinburgh and Glasgow. Resondents noted long waiting times, continued dysphoria and lack of communication contributing to anxiety, depression and anguish with accounts of suicidal thoughts and self-harm from trans and non-binary people awaiting treatment [184]. The research has also indicated that those using GICs will often hide significant issues such as mental health conditions and suicide attempts.

Geographical location

Geographical location impacts on the wellbeing of LGBTI+ people in Scotland, where LGBTI+ people consistently outline the lack of support and community in rural and remote areas, as well as perceived more hostile attitudes. Respondents in the Equality Network ‘Further Out: the Scottish LGBT Rural Equality’ report attributed these attitudes to more socially ‘conservative’ views, lack of anonymity and lack of LGBTI+ awareness and education among rural populations. [192] This is seen to be a particular issue for young people, with LGBT Youth Scotland research indicating only 28% of LGBTI+ young people living in rural areas rate their area as a good place to be, compared with 62% of urban based respondents [203].

Experiences of coming out

For many LGBTI+ people, positive experiences of coming out can be a facilitator of improved mental health, however, this is often dependent on how the people around them react to their identity. The HNA supplementary report for transgender and non-binary people highlights that coming out can be a traumatic experience for trans and non-binary people, as they often face lack of understanding and may need to consider and implement how they present their identity [184].

Young people

The 2022 LGBT Youth Scotland report, 'Life in Scotland for LGBT Young People: Underlying inequalities and experiences', is based on survey data and provides insight into perspectives and experiences which also shape mental wellbeing for young LGBTI+ people in Scotland [203]. The majority of participants believe that homophobia, biphobia and transphobia are a problem, both across Scotland as a whole and in their local area. LGBTI+ young people also experience bullying in schools and workplaces, with 70% of gay/lesbian participants reporting experiencing bullying due to their sexual identity at school, while 54% said they felt safe to be their authentic self as an LGBTI+ person at work/in training [203]. The majority (73%) of LGBTI+ young people who experienced at least one mental health concern had been bullied in school [203]. This number rose to 83% of trans young people.

Older adults

Insights into the mental health of older LGBTI+ adults were highlighted through the MHEHRF feedback [12], which indicated that specific experiences throughout their lives may have negatively impacted on their previous and current mental health. Examples include lack of acceptance, marginalisation and prejudice (e.g., from family and society), discrimination (e.g., in employment, health and social care, being historically banned from military service), criminalisation, pathologisation (e.g., sexual orientations and trans status being considered as a mental illness), living through the AIDS epidemic, and participation in unwanted therapies (e.g., psychiatric conversion practices or so-called 'conversion therapy') and subsequently minority stress [12]. Isolation is a key issue for older LGBTI+ adults, where people may choose to conceal their identities when forming new social connections, lose friends and family through coming out, and feel "ignored" by younger LGBTI+ people [19]. Age Scotland highlight anecdotally in the MHEHRF that some older LGBTI+ people feel that social activities, groups and services for LGBTI+ are very focused on the needs of younger people. Bereavement also likely has specific complexities for older LGBTI+ adults, particularly for those who have chosen not to come out and who lose a primary partner, as they might experience less recognition from others of their loss, and a reduced connection with their LGBTI+ identity [12].

Inequity experienced in accessing services and support

Despite evidence showing that LGBTI+ people are disproportionately affected by poor mental health, research indicates that mental health services are underutilised by LGBTI+ people and especially young people. There are a number of factors which may contribute to barriers for LGBTI+ people accessing adequate support.

Waiting lists

Qualitative research describes how there is significant frustration at the long waiting lists for mental health services among young LGBTI+ people. Respondents to the LGBT Youth

Scotland 2023 Health Report particularly noted that accessing CAMHS was difficult, and that long waiting lists without updates left them feeling unsupported [70]. Participants felt that they had not been offered sufficient care and that staff in some case dismissed their level of distress.

Awareness and signposting of inclusive care

Research highlights that for all LGBTI+ groups, there is reliance on third sector providers for counselling and support, many of which are dedicated LGBTI+ services, as well as private mental health services. The 'Life in Scotland for LGBT Young People 2023 Health Report' noted that just 56% of participants felt they had enough information about mental health [70]. Of the participants, 57% had received formal classes on mental health in school, but of those, only 19% saw LGBTI+ topics addressed.

Participants in the 'Life in Scotland for LGBT Young People 2023 Health Report' highlighted that mainstream mental health services did not fully consider the effects of experiences related to trauma, homophobia, family acceptance and other issues experienced by LGBTI+ young people. They noted that services specifically targetting LGBTI+ people were more able to provide this support [70]. Respondents also highlighted the unknown factor of whether staff members they may come across in healthcare services might hold prejudiced views, or may be a supportive ally to the LGBTI+ community. This variation is also highlighted in other sources and acts as a barrier to accessing care and as a reason for LGBTI+ young people to withhold aspects of their identity [203]. Some participants relied on other LGBTI+ young people reporting their experiences, meaning that service reputation is an important aspect of seeking support [70].

Rural barriers to care

In rural areas in particular, the lack of services, safe spaces and LGBTI+ groups also creates barriers to accessing mental health support. In the 'Further Out: Scottish LGBT Rural Equality' report, respondents noted the comparative absence of services in rural regions compared to those in the central belt of Scotland, which included health services such as GPs and mental health services. It was recognised that these services were available for those willing to travel, but this furthered heightened feelings of isolation [192].

Experiences of services and support

There is evidence that LGBTI+ people have a poor experience in using mental health services, with some specific concerns which can affect LGBTI+ people attempting to access support. The HNA report highlighted that use of mental health services in the year before the survey was conducted was most common amongst trans masculine (44%) and non-binary (40%) people [184]. Of those who had used mental health services, 64% said that the staff showed an appropriate understanding of LGBTI+ issues. According to a 2015 Stonewall Scotland report, 'Your Services, Your say: LGBT Experiences of Public Services', 25% of LGBTI+ people who used NHS mental health services in the previous year rated these services as 'poor' or 'extremely poor' [193]. Over half (55%) of LGBTI+ respondents said they had experienced NHS staff making incorrect assumptions about their sexual orientation or gender identity, while 22% of LGBTI+ respondents felt uncomfortable being open about their sexual orientation or gender identity with NHS staff (this rises to 33% for adult social care) [193].

Discrimination within service provision

A scoping activity undertaken by LGBT Youth Scotland specifically focusing on Child and Adolescent Mental Health Services (CAMHS) asked LGBTI+ young people to provide feedback on their experiences of mental health services [194]. Nearly all (89%) respondents had accessed CAMHS and 45% had accessed counselling. Overall, when asked about their service experience, 'not okay' received the highest number of responses (41%), followed by 'terrible' (35%), 'okay' (24%), and 'great' (8%) [194]. Issues raised included: staff not being confident talking about or knowledgeable on trans identities; trans young people being asked to focus solely on their trans identities when they are not the cause of their poor mental health and, conversely, trans young people not being given the space to discuss their trans identities when relevant to their mental health; young people not feeling able to 'come out' to CAMHS staff due to a fear of the response or impact on their treatment (this was most prevalent among trans young people); young people not feeling listened to and not being given information regarding their diagnosis or treatment; the style or setting of appointments was described by young people as worsening their mental health, including anxiety [194].

Wider qualitative research and anecdotal evidence provided from organisations in the MHEHRF echoes these experiences in other LGBTI+ groups, where presumptions made about service users' gender identity and sexual orientation can be unhelpful and even damaging, and where the conflation of LGBTI+ identity and mental health concerns can mean service users are unable to discuss wider concerns and access appropriate support [204], [205].

Training and diversity within service provision

The qualitative component of the HNA report addressed the topic of whether mental health services should be provided for LGBTI+ people through specialist or mainstream services [184]. Respondents felt that mainstream services required greater awareness and understanding of LGBTI+ people, but that specialist services should also be available. Many participants highlighted the benefits of having a counsellor who themselves identifies as LGBTI+, including examples where those who had used counselling services only felt able to come out to their counsellor when their counsellor said they were LGBTI+ [184].

Several third sector organisations highlight the importance of mental health services which are free from discrimination towards LGBTI+ communities as well as those which have a strong understanding of LGBTI+ mental health needs [206], [194]. The importance of highlighting where mental health support is genuinely able to offer an inclusive service was also noted in LGBT Health Scotland's 'National conversation on LGBT mental health', where participants felt that visible symbols, including signage of advertising are important in encouraging LGBTI+ people to reach out for support [205].

COVID-19 pandemic impacts

The 2021 Just Like Us report 'Gowing up LGBT+' emphasised the negative mental health impacts of the pandemic on LGBTI+ young people, noting that 68% of LGBTI+ respondents to their research said their mental health had 'got worse' since the pandemic, compared to 49% of their non-LGBTI+ peers [102]. The HNA report highlighted that LGBTI+ people are much more likely than others to feel isolated and/or lonely and that the pandemic exacerbated this, particularly where they felt unable to connect with the LGBTI+ community and as a result LGBTI+ spaces being closed during the pandemic [184]. In a

2021 online survey as part of the HNA, 73% of respondents said they ever felt isolated from family and friends and 38% said they had felt lonely all of the time or often in the previous two weeks [184]. Over three quarters (78%) said this changed for the worse due to the pandemic. Trans and non-binary people showed the highest levels of isolation and loneliness.

LGBTI+ people in rural areas

Research undertaken by Change Mental Health in their ‘Marginalised Rural Communities Report’, published in 2021, highlighted the specific impacts of the pandemic in rural areas, where isolation in the form of disconnection from family members and friends, loss of education and employment opportunities and overall feelings of anxiety and uncertainty were reported [158]. Accessing health services, such as counselling, was also flagged as an issue, including the use of remote services, where safe spaces to speak in the home could not be ensured. Online support groups were seen as being particularly important.

The Equality Network also highlighted concerns from LGBTI+ people of isolation and lack of local support networks, particularly in rural areas, that were made more challenging with travel restrictions [207]. Lack of visibility for the LGBTI+ community, for example, with the lack of in person engagement and the cancelling of Pride events, was also felt by many. Online spaces, while important, were also seen by some as a threat to positive mental health, particularly with toxicity, bullying and hate speech experienced in online spaces.

Older LGBTI+ adults

Older and disabled LGBTI+ people who may have been shielding may have been particularly isolated during this period [12]. The COVID-19 pandemic might have raised a particular challenge for older LGBTI+ adults by triggering past traumas associated with the AIDS epidemic [12].

Trans healthcare

Third sector organisations have highlighted concerns around access to trans healthcare, including the reduced services provided by GICs during the pandemic and subsequent waiting times, interruptions to hormone therapy and hormone injections, and holds put on gender reassignment surgeries during the pandemic [208]. These all have significant mental health and wellbeing implications for those waiting for treatments and support.

Discrimination and hate speech

Also raised in the MHEHRF was the vulnerability of LGBTI+ adults, children and young people online, with reference to the rise in online hate speech, hate incidents, bullying and harassment throughout the pandemic, where anti-LGBTI+ rhetoric and anti-trans rhetoric can have an impact on the wellbeing and mental health of vulnerable individuals, including children.

Data and evidence gaps

Data on LGBTI+ identities are often not included in analyses of high level population surveys or consistently in service usage data. While data on mental health service usage for LGBTI+ people is lacking, there are also challenges and ethical concerns in accessing point-of-use data through statutory services, where several sources highlight the need for the disclosure of sexual and gender identities to be managed safely and consensually [184]. There is, however, a good availability of supplementary qualitative and smaller scale quantitative evidence from third sector and Scottish and UK government research.

Key remaining evidence gaps include:

- Evidence on the mental health of intersex people [194]
- Evidence relating to the experiences of LGBTI+ people within minority ethnic communities and disabled LGBTI+ people

6. Pregnancy and maternity

Key points

Existing mental health inequalities	• Childbirth is associated with an increased risk of mental disorders in mothers, with and without previous problems, and suicide is the leading cause of overall maternal deaths in the first year [209]. Up to 20% of women are estimated to experience a mental health need during pregnancy or in the first year after the birth of a child [210]. During pregnancy, 12% of women experience depression and 13% experience anxiety, while during the postnatal period between 5-7.5% of women experience an eating disorder, 15-20% of women experience postpartum depression and anxiety and 0.1-0.2% experience postpartum psychosis [211]. • Perinatal depression, anxiety and psychosis are estimated to carry a societal cost of approximately £8 billion for each one-year cohort of births in the UK [210]. • There is a large evidence base on the associations between perinatal mental disorders and childhood adverse mental outcomes, particularly for perinatal depression and antenatal alcohol misuse [212]. Untreated perinatal mental health conditions can have long-term impacts on the physical and mental health outcomes of babies, as well as mothers and families.
Social determinants	• Factors which can influence the likelihood of experiencing perinatal mental health concerns include: previous experience of mental health conditions; biological causes; lack of support and associated stress and exhaustion; difficult childhood experiences, including abuse, neglect and traumatic events; unplanned or unwanted pregnancy; experiences of abuse; stressful living conditions, such as with money problems or with insecure or poor housing and employment; and other major life events, such as bereavement, moving house or the breakup of a relationship [213]. • Women from socioeconomically deprived backgrounds [214] and immigrant, asylum seeking and refugee women [215] are seen to be at particular risk of perinatal mental health concerns. • Discrimination experienced in both the workplace and wider society during pregnancy and the postnatal period has a potential role in perinatal mental health and wellbeing [216].
Inequity experienced in accessing services and support	• There are stigmas around perinatal mental health needs which can act as a barrier to seeking healthcare [217]. • Challenges to accessing specialist care include limitations in the capacity to provide mother-infant psychological interventions, including the provision of beds and adequate staffing, and considerable variation about what is available in different regions [218]. • Women living rurally are more likely to experience perinatal mental health conditions, where accessing care can be more challenging

	due to the long distance, cost, time and practicality of travel to specialist services predominantly based in urban areas [219].
Experiences of services and support	• Research has shown regional inequality in the experience and provision of perinatal mental health services, with variation in the professional advice, behaviour and care experienced by respondents [220].
Data and evidence gaps	Key evidence gaps relating to perinatal mental health include: • Evidence around the mental health impacts of discrimination towards pregnancy and maternity, particularly within employment contexts • Evidence around the mental health of LGBTI+ parents, including same sex male couples and trans masculine and non-binary pregnancy

Introduction

Perinatal mental health is the overarching term for mental health during pregnancy and the antenatal period (varying by definitions include the first postnatal year up to two or three years after birth [221]). Common perinatal mental health conditions include perinatal depression, perinatal anxiety, perinatal obsessive-compulsive disorder (OCD), postpartum psychosis and postpartum PTSD [213]. In addition to the distress caused to mothers, perinatal stress, anxiety and depression also predict a range of poor developmental and health outcomes amongst children, including behavioural and emotional problems [222], [223], as well as mental health impacts for partners [224].

The impact of disrupted mental health in the perinatal period also has an impact on the infant, where problems can contribute to adverse mental health concerns throughout childhood.

There are also necessary considerations around the impacts of experiences of discrimination related to pregnancy and maternity on mental health, which has the potential to impact a much higher number of pregnant people.

Existing inequalities & mental health disparities

Existing mental health inequalities

The maternity period is associated with an increased risk of mental disorders in mothers, with and without previous problems, and suicide is the leading cause of overall maternal deaths in the first year [209]. While figures vary, overall, up to 20% of women are estimated to experience a mental health need during pregnancy or in the first year after the birth of a child [210]. During pregnancy, 12% of women experience depression and 13% anxiety, while during the postnatal period, between 5-7.5% of women experience an eating disorder, 15-20% of women experience postpartum depression and anxiety and 0.1-0.2% experience postpartum psychosis [211].

The prevalence of mental health needs during the perinatal period comes at a significant cost, and perinatal depression, anxiety and psychosis are estimated to carry a societal cost of approximately £8 billion for each one-year cohort of births in the UK [210]. The majority of these costs are accounted for by the adverse effect of perinatal mental health conditions on children and £1.2 billion of the total cost falls on the NHS and social services.

Social determinants of mental health

Risk factors for perinatal mental health needs

A range of psychosocial risk factors have been identified for developing perinatal mental health conditions, and in particular depression. These risk factors can broadly be described as a previous history of psychiatric illness, life stress and poor social support [225]. Factors which can influence the likelihood of experiencing perinatal mental health concerns include: previous experience of mental health conditions; biological causes such as changes to hormones during and after pregnancy; lack of support and the associated stress and exhaustion; difficult childhood experiences, including abuse, neglect and traumatic events; unplanned or unwanted pregnancy; experiences of abuse; stressful living conditions, such as with money problems or with insecure or poor housing and employment; and other major life events, such as bereavement, moving house or the breakup of a relationship [213].

Women from socioeconomically deprived backgrounds are at greater risk of developing perinatal mental health needs [214]. Immigrant, asylum seeking and refugee women are seen to be at particular risk of postnatal depression, with up to 42% experiencing it in developed country settings, compared with 10-15% of native-born women [215]. The relationship between ethnicity and perinatal mental health are not well understood. Some literature suggests that the influence of ethnicity in perinatal mental health depends on the peer/community network around the individual and it would be difficult to categorise ethnic minority groups as more or less at risk of poor perinatal mental health [226], though international evidence indicates that women from minority ethnic groups are at greater risk of developing mental health needs [227].

Discrimination during pregnancy and maternity

Research from Pregnant then Screwed shows that 53% of returning mothers link episodes of depression with poor treatment at work, while 30% of mothers who return to work after maternity leave encounter a mental health issue [216]. This highlights the role of wider structures of discrimination in impacting perinatal mental health and contributing to financial stress and job insecurity.

Evidence from the Equality and Human Rights Commission highlights that one in nine mothers reported that they were either dismissed, made compulsorily redundant (while others in the workplace were not) or treated so poorly they had to leave their job [228]. Additionally, one in five mothers said they experienced harassment or negative comments related to pregnancy or flexible working from their employer and/or colleagues, while 10% of mothers said their employer discouraged them from attending antenatal appointments [228]. While there is a lack of UK-based evidence to understand the specific mental health implications of this, international evidence highlights a link between workplace discrimination and postpartum depressive symptoms [229].

Infant mental health

There is a large evidence base on the associations between perinatal mental disorders and childhood adverse mental outcomes, particularly for perinatal depression and antenatal alcohol misuse [212], [222]. Untreated perinatal mental health conditions can have long-term impacts on the physical and mental health outcomes of babies, as well as mothers and families. Alongside these factors, there are a number of other influences on the social and emotional development of infants from the preconception period onwards [230].

Partners

Partners can also experience mental health concerns during the pregnancy and after giving birth [213], with evidence reviews of international literature suggesting that mental health conditions amongst men are relatively common during the perinatal period, including anxiety [231] and depression [232]. These problems are more likely when good support networks are not in place, there are other stressful life events, there are poor living conditions and financial stress or experiences of abuse in childhood [233]. This can also be compounded by extra responsibilities around the house, financial pressures, a changing relationship with their partner, lack of sleep and looking after several children [233]. Lack of supportive mental health services for fathers during the perinatal period can also be impactful, including the lack of father-inclusive treatment by health care professionals within maternity services, a lack of tools and training to support partners and a lack of referral routes to access specific support [233].

LGBTI+ perinatal mental health

There is some academic literature on mental health in lesbian mothers, which indicates that they are more prone to mental health concerns due to discrimination about their sexuality [234]. However, there are indications that lesbian women tend to have planned pregnancies and strong support from their partners [234]. Additionally, there is little available evidence for male same-sex couples and mental health needs during the perinatal period.

In the MHEHRF, Change Mental Health highlighted the diversity of family structures in Scotland and the lack of inclusion for some gender identities within perinatal mental health care and services, with the focus currently predominantly being on women who give birth. They highlight the requirement for tailored support which is inclusive of all gender identities, including trans men and non-binary people who are pregnant or postnatal.

Disability and perinatal mental health

There is some evidence of new, recurrent and ongoing mental health concerns across disability groups in the perinatal period [235], [236]. Parents with a learning disability are often affected by poverty, social isolation, stress, mental health concerns, low literacy and communication difficulties [237]. Some studies show that up to a third of pregnant women with a learning disability report moderate to severe levels of stress, anxiety and depression [238].

Inequity experienced in accessing services and support

There are stigmas around perinatal mental health needs which can act as barriers to seeking support. These include pressures to feel happy and excited and to give the impression that they are coping. There are also worries of being a bad parent if they are struggling with their mental health and concerns that someone could take their baby away from them if they are open about how they are feeling [239]. A review undertaken by See Me into perinatal and infant mental health highlighted the mismatch between expectation (including self-expectations) and experiences of motherhood, with literature highlighting the experiences of women including feeling shame and guilt around symptoms of mental health conditions, and pressure felt to portray an image of ‘coping’ to healthcare professionals and their own social networks [217]. Mental health stigma can also impact fathers, with research showing that gendered stereotypes around fatherhood act as barriers to seeking support [240].

Based on the Perinatal Mental Health Network (PMHN) Scotland report ‘Delivering effective services: needs assessment and service recommendations for specialist and universal perinatal mental health services’, some of the key challenges in accessing specialist care are limitations in the capacity to provide a range of mother-infant psychological interventions, including the provision of beds and adequate staffing, and considerable variation about what is available in different regions [218].

Support provided through the third sector was seen as important in providing practical and emotional support, counselling and psychological interventions to women and families where there is parental mental distress and disorder [218]. However, consultation for the report found that short-term funding structures can lead to the withdrawal of existing well-functioning services and highlighted the need to improve links between the third sector and perinatal mental health services within the NHS [218]. Peer support and women-led initiatives were highlighted as underdeveloped resources in perinatal mental health provision, but that those providing peer support may also require support themselves, as well as knowledge of other resources available and ways to access them [218].

A UK based cross-sectional study on the rural-urban differences in the mental health of perinatal women suggested that women living rurally are more likely to experience perinatal mental health conditions in comparison to their urban counterparts [219]. Currently, Scotland’s only two Mother and Baby Units specialising in perinatal mental health care are in the central belt [218]. As a result, expecting and new mothers with mental health needs in rural and remote communities can face barriers to accessing specialist inpatient care. The long distance, and the cost, time and practicality of travel are challenges to admission. Furthermore, if women from rural and remote communities are admitted to either of the Mother and Baby Units, they are then isolated away from their community experiencing limited face-to-face contact with family and friends, impeding on their recovery [219].

Experiences of services and support

A 2017 study by the Royal College of Obstetricians & Gynaecologists looking at women’s experiences of maternal mental health across the UK found geographical inequity of care and striking variation in the professional advice, behaviour and care experienced by respondents [220]. It found that there had been a marked improvement in the number of women asked about their mental health by a healthcare professional, with only 8% of women who had given birth in the year previous not having been asked about their mental wellbeing by any healthcare professional, compared with 24% of women who had given birth 4-5 years previously [220]. However, Scotland had some of the highest rates of women not being referred to further support compared to other regions of the UK and 41% of women who were referred to support services had to wait more than four weeks to be seen [220]. It should be noted, however, that the service landscape for perinatal and infant mental health has changed significantly between 2019 and 2023 [241], meaning that more updated research is required to understand experiences of access support.

A review by See Me found that women in several studies shared that they often relied on healthcare professionals to help them understand their symptoms as part of a mental health condition that can be treated [217]. However, women shared that sometimes healthcare professionals normalised, minimised, dismissed or did not recognise their symptoms, with some women feeling that screening was a 'tick-box' exercise without realistic support and referral options [217]. Lack of discussion on treatment options and preferences also magnified feelings of having no control over their lives.

Several studies report a lack of consensus among healthcare professionals about medications for existing mental health conditions during and after pregnancy, resulting in a variation in the advice provided and the experiences of women with pre-existing mental health concerns [220], [212].

Evidence on the perinatal mental health of minority ethnic women from the wider UK indicates that lack of awareness about mental ill health, cultural expectations, ongoing stigma, culturally insensitive and fragmented health services and interactions with culturally incompetent and dismissive health providers all impact ethnic minority women's ability to receive adequate perinatal mental health support in the UK [227]. The See Me review highlighted instances where women reported that their cultural preferences were not always taken into account, and the lack of availability of official interpretation services, meaning an overreliance on the partners of women for translations, which resulted in inaccuracies and ambiguity [217].

Training needs within services

Evidence highlights considerable variation in the levels of knowledge and confidence on perinatal mental health needs, treatments, referral pathways and the role of other professionals amongst health care professionals, especially for conditions other than postnatal depression [217].

The PMHN needs assessment report highlighted that while general practitioners provide expert management of mild to moderate psychological distress and disorder, feedback indicates that they would benefit from additional education and training in prescribing during pregnancy and breastfeeding [218]. The need for trauma informed care has also been highlighted as important to mitigate the potential adverse impact of trauma on pregnancy and birth [242].

Impacts of the COVID-19 pandemic

The Centre for Mental Health undertook a rapid review of the impact of COVID-19 on maternal mental health, which included a survey and consultation [243]. This highlighted the mental health challenges for women during pregnancy and early motherhood, where evidence indicates a decrease in mental wellbeing amongst women during the perinatal period. Reasons for this include: anxiety due to fear of infection and worries about their baby's wellbeing and that of other family members; experiences of infection and bereavement; reduction in available support; fears of partners being able to be present in hospital for labour and birth; worries of lack and clarity of information on maternity services; worries about being penalised if seeking support falls outside of government guidance; and concern over job security for expectant and new mothers and their partners (which was of higher concern for women of colour) [243].

High risk groups

The report found that the pandemic and restrictions particularly negatively impacted women from already marginalised groups. This includes women from minority ethnic communities (particularly South Asian and travelling communities), refugee and asylum seeking women, women and families where language is a language barrier and single-parent families [243].

Circumstances around relationships already being under strain, experiences of domestic violence, abuse or coercive control worsened mental outcomes. Women who have been anxious in normal times, including mothers who have lost one or more previous pregnancies, were often made more anxious by the restrictions and fear of infection, and mental health impacts were worse for those with a history of mental health conditions and severe postnatal mental illness [243].

Cuts to services

The pandemic worsened some of the existing gaps in perinatal mental health which were present even prior to the crisis [243]. This includes a lack of specialist services as well as cuts to statutory services such as health visiting and within the voluntary and community sector. Access to services which were moved online acted as a barrier to parents without internet access.

Lack of informal support

Informal support usually provided by family, friends and neighbours was detrimentally impacted by pandemic restrictions [244]. While some emotional support was sustained through virtual platforms, the lack of more practical support left women and their immediate families more isolated than before [244].

Changes to medical procedures

Changes to labour and birth because of the pandemic also increased stress and anxiety, particularly due to restrictions put in place on partners being present during labour and birth [243]. Restrictions on partner presence in maternity care, including scans, labour and post-birth visiting varied across the UK and over the course of the pandemic, but were highlighted by stakeholders in the MHEHRF as being a factor influencing the stress of pregnant women.

Impact on infants

There are widespread concerns about the impact of increased stress and anxiety on infants and babies, with reports of more clinginess, more introversion and greater alarm at strangers [243]. The limitations of face-to-face contact and the use of masks and other personal protective equipment (PPE) also have potential impacts. The long-term impacts of this are unknown but has been a concern for parents and experts participating in research.

Data and evidence gaps

Key evidence gaps relating to perinatal mental health include:

- Evidence around the mental health impacts of discrimination around pregnancy and maternity, particularly within employment contexts
- Evidence around the mental health of LGBTI+ parents, including same sex male couples and trans masculine and non-binary pregnancy

7. Race

Key points

Existing mental health inequalities	• Understanding current existing mental health inequalities and disparities relating to race is complex, with varying findings from different sources. These do not provide a clear picture of the mental health inequalities experienced by people from different minority ethnic groups. • Small sample sizes from minority ethnic groups within population surveys in Scotland often act as a barrier to understanding mental health and wellbeing amongst minority ethnic communities. There are indications that available figures may not reflect the full picture of mental health amongst minority ethnic groups due to underreporting and differences in health-seeking behaviours and service utilisation [245]. • The England APMS showed that psychotic disorders were found to be higher among Black men than among men from other ethnicities, but did not vary by ethnicity for women [32]. The prevalence of common mental disorders varied by ethnicity amongst women, but not men. They were less prevalent amongst non-British White women (15.6%) than White British women (20.9%), but more prevalent among Black and Black British women (29.3%). • When compared to the ethnic distribution of the general population, a higher proportion of Mental Health Act detentions (whereby patients can be detained for up to 72 hours to protect them from themselves or other people) from 2011 to 2021 were recorded in Scotland for White Other (4.9% vs 4.0% of White Other in the general population), Black (1.5% vs 1.0%), Mixed or multiple ethnicities (0.6% vs 0.4%), and other ethnic groups (0.4% vs 0.3%) [246]. • There are indications that Gypsy, Roma and Traveller people in the UK have increased likelihood of experiencing depression and anxiety and are six times more likely to die by suicide than the general population [247]. • Asylum seekers and refugees are more likely to experience poor mental health than the local population, including higher rates of depression, PTSD and other anxiety disorders [248]. 57% of interviewees in a study of newly-arrived asylum-seeking women in Glasgow showed symptoms of PTSD [249] and 45% of separated children accessing Scottish Guardianship Services in 2011 reported mental health difficulties [250].
Social determinants	• Minority ethnic communities are affected by a large number of social stressors which can impact mental health [251]. These include experiences of racism and discrimination [252], disproportionate likelihood to live in poverty [253], experiences of migration [254] and experiences of generational trauma and exclusion [251]. There are also nuances in the reporting of mental health conditions, particularly with culturally specific conceptualisations of mental health.

	• Asylum seekers and refugees are disproportionately likely to experience mental health impacts from trauma and a range of post-displacement stressors, including social isolation, poverty, lack of access to resources and discrimination [255].
Inequity experienced in accessing services and support	• The England APMS showed that individuals from minority ethnic backgrounds with a common mental disorder were less likely than White British individuals to be receiving treatment at the time of the survey [32]. • Factors including mental health stigma within some minority ethnic communities [245], lack of awareness of available services [251], lack of trust in formalised mental health services [256] and language and cultural barriers [251] in understanding are highlighted as barriers to accessing mental health care.
Experiences of services and support	• Evidence shows that there is variation in the types of therapies and treatments offered to people from minority ethnic backgrounds [256]. UK-based studies indicate that ethnic minority children were more likely to be referred to CAMHS via social services, education or criminal justice pathways (rather than through the GP), compared to White British children [257]. • The need for culturally aware services and support is highlighted in literature [258], alongside increased workforce diversity, as well as training with relation to cultural competency and sensitivity [246].
Data and evidence gaps	There are important gaps in the data available concerning the mental health of minority ethnic people in Scotland, which include: • High level data on the prevalence of mental ill health within minority ethnic groups in Scotland • Disaggregated data about the mental health outcomes and service usage of different minority ethnic groups • Data relating to those with the intersecting characteristics such as disability, LGBTI+ status, age, and sex. Key remaining evidence gaps include: • Greater understanding of the lived experience of mental health and wellbeing for minority ethnic communities • Updated qualitative and quantitative evidence to understand the extent of mental health needs within Gypsy/Traveller communities and experiences of mental health services for people from these communities • More systematic evidence to understand the extent of mental health needs amongst asylum seekers are refugees and more understanding of their experiences of using services and support.

Introduction

The experiences of minority ethnic people in Scotland relating to mental health vary widely, and are often under-represented in research around mental health indicators and outcomes. In general, there is a complex picture of rates of mental health among minority ethnic groups which indicate that some groups have higher risk of experiencing mental illness. This is linked to numerous social determinants, including experiences of racialised and generational trauma and discrimination, and a higher likelihood of living in areas of deprivation. Minority ethnic groups may have different experiences in accessing services, encountering barriers such as mental health stigma and a lack of access to, and availability of, culturally appropriate and sensitive support.

This section includes specific subsections for the both Gypsy and Traveller communities and refugee and asylum seekers. While these groups share some of the similar experiences and issues with the wider minority groups, there are also distinct issues to be considered.

Existing inequalities & mental health disparities

Existing mental health inequalities

Understanding current existing mental health inequalities and disparities is complex, due to a range of different findings from various sources, which do provide a clear picture of the mental health inequalities experienced by people from different minority ethnic groups. This complexity is reflected the Scottish Health and Ethnicity Linkage Study (SHELS), which examines linked health records for 4.6 million people with a self-identified ethnic group recorded in the 2001 Scottish Census. Analysis of records for first cases of hospitalisation for psychiatric disorders during 2001-08, and episodes of compulsory treatment during 2006-09, revealed a complex association between treatment for mental conditions and ethnicity [259]. During the study period, White Scottish men were more likely to be hospitalised for a psychiatric disorder than Chinese, White British and South Asian men, while women from Indian, Chinese and Other White British backgrounds were less likely to be hospitalised for a psychiatric disorder than White Scottish women, and African women and women from any mixed ethnic background were more likely to be hospitalised for a psychiatric disorder. Different patterns were observed when specific psychiatric diagnoses were considered. With regard to hospitalisations for psychotic disorders, for example, men from any mixed background and from African groups were more likely to be hospitalised than White Scottish men, and Other White British men less likely. Women from African, Pakistani and any mixed background were more likely to be hospitalised than White Scottish Women, and Other White Women were also less likely.

Data from the 2014 England APMS also show that rates of psychotic disorder are higher among Black men than among men from other ethnic groups, although the rate of psychotic disorder did not vary by ethnicity among women [32]. Conversely, the prevalence of common mental disorders were found to vary by ethnic groups among women, but not men: common mental disorders were less prevalent amongst non-British White women (15.6%) than White British women (20.9%), but more prevalent among Black and Black British women (29.3%) [32]. The same dataset also shows that individuals from minority ethnic backgrounds with a common mental disorder were less likely than White British individuals to be receiving treatment at the time of the survey, suggesting barriers in accessing healthcare [32]. Directly comparable data for Scotland are not available, although analysis of pooled data from the 2008-2011 Scottish Health Surveys did not find any ethnic group to be more or less likely to report a potential psychiatric disorder [107].

The 2022 Scottish Mental Health Inpatient Census (which provides an overall understanding of patients in mental health, addiction and learning disability beds who are funded by NHS Scotland at the point the survey is undertaken), found that 73% of patients identified as White Scottish, with 19% of patients identified as Other White, while Asian, Asian Scottish or Asian British made up 2% of the census, and African, African Scottish or African British made up a further 1% [260]. This is compared to an overall population breakdown of 96% White, 2.7% Asian, Asian Scottish or Asian British and just over 1% African, Caribbean or Black, based on the 2011 Scottish census [261]. These proportions of the Mental Health Inpatient census are relatively unchanged from previous years.

Analysis undertaken by the Mental Welfare Commission for Scotland into racial inequality and mental health, showed that when compared to the ethnic distribution of the general population, a higher proportion of Mental Health Act detentions (whereby patients can be detained for up to 72 hours to protect them from themselves or other people [262]) from 2011 to 2021 were recorded in Scotland for White Other (4.9% vs 4.0% of White Other the general population), Black (1.5% vs 1.0%), Mixed or multiple ethnicities (0.6% vs 0.4%), and other ethnic groups (0.4% vs 0.3%) [246]. There were higher proportions of community treatment orders for Black, Asian and other ethnicities compared to the general population ethnic distribution. Differences were found in how the Mental Health Act was applied in communities across Scotland, where more people who were Black or of mixed or multiple ethnicity were perceived as a greater risk to themselves or others, whereas categories of White people were more often perceived as a risk to themselves. This was gendered, where 48.4% of Black women were perceived of as a risk to both themselves and others, compared to 33.8% of White Scottish women [246].

There is evidence that there may be an increased risk of suicidal behaviour for Polish migrants to the UK and Scotland. Based on National Records of Scotland (NRS) records from 2012 to 2016, it was found that the adult suicide rate of Polish migrants living in Scotland was 21.6/100,000 compared to a rate of 14.1/100,000 for Scotland as a whole [263]. The rates were significantly higher for Polish men (31.5/100,000 compared to 19.4/100,000 for the rest of Scotland) [263].

Underreporting

High-level statistics and hospitalisation records do not reflect the full picture of mental health amongst minority ethnic groups [58]. Differences in the understanding and perception of mental health within different communities, as well as differences in health-seeking behaviours, service utilisation and the accessing of preventative interventions also have to be considered. Both qualitative research sources and stakeholder engagement have highlighted differences in how mental health conditions are perceived across minority ethnic communities, and the ways in which this can cause stigma, underreporting and barriers to accessing treatment [245]. A 2015 review of mental health service usage by British Pakistani women, for example, highlights that while women had high levels of social support through networks of family and friends, these networks also held high levels of mental health stigma, leaving women feeling like they had to deal with mental illness alone and less likely to use specialist mental health services than White women [264].

There are also intersectional considerations about the reporting and experience of mental health in minority ethnic communities. For example, the historical experiences of denial of women's mental health needs, and specifically how this has been experienced by minority ethnic women, was highlighcted in feedback from Intercultural Youth Scotland (IYS) in the MHEHRF.

Social determinants of mental health

There is considerable evidence of the disproportionate influence of underlying inequalities and experiences impacting mental health that affect minority ethnic communities.

Adverse life experiences

A report written by Glasgow City Health and Social Care Partnership (HSCP), ‘Mental health and wellbeing of Black and minority ethnic children and young people in Glasgow’ undertook extensive literature analysis and engagement with staff from organisations working with Black and minority ethnic (BME) children and young people or families. It aimed to understand the current context for mental health amongst minority ethnic young people in Glasgow [251]. The report highlighted the mental health impact of adverse life experiences, including racism, Islamophobia and other forms of discrimination, as well as instances of gender based violence, FGM and other deeply-rooted cultural practices [251].

Racism and discrimination

Research commissioned by the National Suicide Prevention Leadership Group (NSPLG) highlights an association between racism and suicidal ideation and attempts in racialised groups. This identifies several factors: racism, immigration, mistrust of services, and stigma and lack of knowledge within racialised communities [265]. This is part of a growing body of evidence that demonstrates how racism leads to mental ill health, depression, prolonged grief and periods of adjustment, and difficulty processing traumatic events. A report from Intercultural Youth Scotland, based on consultations with Black and People of Colour (BPoC) children and young people also highlighted the impacts of race and racism on mental health in Scotland [266]. This outlined the impacts of experiencing and hearing about racism. It also addresses the challenges of accessing support within families and communities, due to perceived stigma and intergenerational trauma, and with school staff and other adults, due to fears of not being taken seriously.

Research by the Mental Welfare Commission for Scotland, which includes interviews with people from minority ethnic communities in Scotland, highlight the role of micro-aggressions and discrimination as having an impact both on people’s mental health and on their sense of belonging in Scotland [246]. Academic evidence also supports the mental health impacts of racism as a trauma in and of itself [252]. Discrimination was also noted in the context of migration to the UK as making minority ethnic people feel like ‘second class citizens’ [254].

Poverty and deprivation

Poverty and deprivation have significant impacts on mental health (see poverty and low-income section), and are often experienced disproportionately by people from minority ethnic communities. The HSCP report from Glasgow also highlighted the role of poverty and deprivation in adverse experiences of minority ethnic community [251]. In Scotland in 2018, people from ethnic (excluding White) minority backgrounds were more likely than White British people to live in poverty, at a rate of 39.6% compared with 17.6% [253].

Within the context of the current cost of living crisis, the UK 2023 Living Standards Outlook survey of 10,470 adults from the Resolution Foundation found that the mental health of Black and Mixed-race people had worsened more than any other group, with the percentage of people facing emotional distress rising from 35% (for Black people) to 40%

(for mixed-race people) in October 2021 to 50% and 58% respectively in November 2022 (compared with a rise from 40% to 47% over the same period amongst the general population) [267].

Experiences of migration

The mental health impacts of experiences of being a refugee or asylum seeker in Scotland are outlined below. However, for members of minority ethnic communities who have experiences of migration to the UK or Scotland, there are potential challenges which can also impact mental health.

Evidence highlights the experiences that migrants to Scotland and UK may have that can impact mental health and wellbeing. Analysis of the Crown Office Record into the suicides of Polish people in Scotland found that many circumstances were similar to those in the cases of suicides of non-Polish people, including unemployment or irregular work, shift and manual work, relationship problems and substance use [263]. However, additional factors resulting from the challenges and stresses of moving to a new country were also superimposed onto other life events. This includes difficulties working in an English-speaking environment (and to be able to discuss mental or emotional health), being unfamiliar with Scotland and not knowing how to access public and health services and lack of family and community networks to offer social support [263].

A qualitative report looking at mental health and suicides among Polish men in Scotland also highlighted expectations and dynamics around work, finances and related pressures [254]. Unstable work in the UK and difficulties in accessing jobs created self-esteem issues, both in relation to local Scottish people and in relation to the expectation of those living in their home country. Debt, low wages and high living expenses also added pressures which had an impact on stress and wellbeing.

Generational dynamics within experiences of migration were also highlighted in the Glasgow City HSCP report [251]. This was especially seen within families and communities who have been in Scotland for several generations, and where young people have spent all or most of their lives here compared to parents or grandparents, who may have had different experiences of the immigration process and associated trauma [251]. Varying experiences of funding and service availability, cultural understanding and knowledge of navigating health systems, relationships with traditional community and faith leaders within the diaspora community, and feelings of identity and belonging were also highlighted as factors which added to the complexity of how mental health and wellbeing are experienced amongst Black and minority ethnic communities in Glasgow and further afield [251].

Gender and minority ethnic communities

There are also numerous intersectional considerations pertaining to a range of minority ethnic communities. Feedback from VOX noted the number of psycho-social dimensions of gender and poverty which exacerbate inequalities for minority ethnic women (particularly speaking to the experience of Muslim women), including an inability to participate in the social life of communities, a lack of control over life choices and a lack of social capital, leading to living with chronic stress.

There is also overlap with evidence including in the faith and belief section, where evidence from reports including *Sikh Women Speak* highlight the gendered inequalities associated with the specific experiences of minority ethnic and religious groups, and the mental health implications of these [268].

Inequity experienced in accessing services and support

Numerous barriers to accessing mental health services were found in existing qualitative research and engagement with those with lived experiences. There are numerous barriers to accessing mental health support and services within minority ethnic communities, stemming from both a lack of appropriate services and means of access, as well as perceived stigma and mistrust within communities [245].

Stigma

Stigma around mental health within many communities influences their willingness and ability to access mental health care. This affects different communities in different ways and has also been seen to be gendered [58]. Research looking at perceived barriers to accessing mental health services among Black and minority ethnic communities in Southeast England highlights the role of social stigma around mental health, as well as reluctance to discuss psychological distress amongst men particularly [245]. This was echoed in research with Polish men in Scotland, who described the self-stigma associated with help-seeking behaviours, and a concern that being seen to experience mental health challenges would be a sign of weakness [254].

The Mental Welfare Commission for Scotland also highlight media campaigns aiming to destigmatise mental illness primarily showing White people with mental illness, indicating a gap in challenging stigmas for minority ethnic communities and in opportunities to reach out to minority ethnic groups on mental health issues [246].

Awareness of services

A lack of awareness of available services was highlighted in the engagement informing the Glasgow HSCP report [251]. This includes the need to be able to understand the health system, know how GP appointments work, and to know which services are free and which are not. These present particular barriers for recent immigrants to Scotland, but engagement showed that people from second or third generation immigrant backgrounds also did not always have an awareness of where they could go for mental health. The report highlights that while NHS Inform provides fact sheets and videos in a range of language with information on how the system works, there are gaps in ensuring the information reaches the everyone [251]. Third sector organisations recommend utilising faith and community networks as a way to share information through more culturally appropriate methods [269].

Lack of trust and understanding from services

Lack of trust in more formalised services is a barrier for many communities, including, for example, those highlighted by the IYS ‘Speaking our Minds’ report [266], where young people felt their concerns may not be taken seriously or did not cater to their specific needs, such as with regards to racial trauma. This was echoed in anecdotal evidence from organisations in the MHEHRF, including the Scottish Women’s Convention, who highlight that lack of trust in the NHS and in healthcare professionals acts as a barrier to seeking healthcare. This stems from personal experience and the experiences shared by friends and family where issues have been seen as unimportant. This was seen as particularly gendered, with the experiences of women of colour highlighted. Academic research also highlights the role of the imbalance of power and authority between service users and providers [245].

The NHS Race and Health Observatory ‘Ethnic inequalities in healthcare’ rapid evidence review for England and Wales suggested that there are clear barriers to seeking help for mental health concerns that are rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare [246]. The review looked at a number of studies engaging with Black Caribbean, Black African, Pakistani, Indian, Bangladeshi and Chinese groups in the UK. It argued that one of the key reasons cited for lack of trust in health professionals was patients' views that health professionals did not understand what racism was, or understand how racist experiences and other individuals' experiences impacted both patients' experiences of mental health services and the outcome of the receipt of services [246]. The review highlighted cases where people of different ages and genders felt that mental health services did not account for experiences of racism and other discrimination, therefore failing to account for significant parts of their distress [246].

Language barriers

Language barriers are frequently highlighted as a challenge in accessing services for some people from minority ethnic backgrounds [254]. The ability to both explain problems and understand mental health professionals are also made more challenging by the use of medical and clinical terminology. Mental health is understood and can be talked about differently within different cultural contexts, which can create a barrier to engagement with services [251]. The Glasgow City HSCP report also highlights the challenges of using an interpreter, noting that there may be fears around confidentiality when speaking about mental health issues in contexts where community members may know each other [251]. The report also raises issues around the availability and reliability of interpreters.

Experiences of services and support

Different types of services and referrals

Literature indicates that there is variation in the different types of therapies and treatments offered to people from different minority ethnic backgrounds, with differences in referral rates and access [270]. The 'Ethnic inequalities in healthcare' review highlights evidence that, in the UK, ethnic minority groups were less likely to refer themselves to Improving Access to Psychological Therapies (IAPT) than White British people and less likely to be referred by their GPs [256], [58]. The review showed that minority ethnic people with psychosis were also less likely to be referred for CBT and were less likely to attend as many sessions as their White counterparts [256]. The review provided strong evidence that there were clear and persisting ethnic inequalities in compulsory admission to psychiatric wards as well as harsher treatment for Black groups in inpatient wards (e.g. more likely to be restrained in the prone position or put into seclusion) [256]. The review highlighted two large UK based studies which indicated that ethnic minority children were more likely to be referred to CAMHS via social services, education or criminal justice pathways (rather than through the GP), compared to White British children [271], [257].

Lack of culturally aware services & support

The need for culturally sensitive mental health services and support was highlighted by numerous organisations in the MHEHRF, who also noted that this requires integrating the participation of minority ethnic communities in a process of co-producing outcomes. Requirements cover the need for bi-lingual support, as well as shared understandings by people of different social and cultural identities [258]. Also raised was the need for support which acknowledges issues of power, oppression, privilege and racialised trauma and the ways in which these influence the mental health of different minority ethnic groups (the lack of formal recognition for racialised trauma in the diagnosis of PTSD was highlighted by IYS as an example of this).

Research by the Mental Welfare Commission found that 70% of staff acknowledge gaps in training relating to diversity and equality, with many describing a lack of awareness of the issues facing minority ethnic communities, a lack of data and a lack of senior representation as barriers to a culturally competent service [246]. Cultural competence was mostly understood in terms of tangible outputs, such as accessing knowledge about another culture and the availability of interpreters. Staff were keen for services to build relationships with third sector providers to act as a bridge between communities and statutory services [246]. Third sector organisations were also seen by those with lived experiences of mental health difficulties as a vital bridge between communities and services.

Within many minority ethnic groups, particularly for women, the specific role of social networks and support through family and friends also facilitates a mechanism for support. Feedback from VOX noted that their members felt that community networks were crucial to increasing cultural awareness and reducing inequalities, as well as reducing isolation by building connections. However, there are also experiences of the dilemma of wanting to access practitioners from their own cultural background whilst also fearing opening up due to risk of disclosure to the community [264].

Lack of workforce diversity

Organisations in the MHEHRF noted the lack of ethnic diversity within mental health practitioners and practitioner and support services in Scotland and the wider UK, as well as the lack of training with relation to cultural competency and sensitivity [270]. The Mental Welfare Commission for Scotland report also flags the challenges in understanding the ethnic diversity of the mental health workforce, with most health boards being unable to provide the data required [246].

Impacts of the COVID-19 pandemic

Minority ethnic groups made up a small number of the respondents in the Scottish COVID-19 Mental Health Tracker study, with high drop off rates after the first wave survey [103]. However, results indicated that during the first wave individuals from BAME backgrounds reported higher levels of depressive symptoms compared to White respondents, lower reported mental wellbeing scores and significantly more frequent suicidal thoughts, a trend which was seen in subsequent waves [103]. A booster sample included in the third wave tracker saw that those from minority ethnic backgrounds were nearly three times more likely to have experienced suicidal thoughts than those from White backgrounds, as well as higher rates of depression and anxiety [170]. Based on a comparison of the UK Household Longitudinal Study between pre-pandemic and during-pandemic data and changes in the GHQ-12, women – regardless of their ethnicity – and Black, Asian, and minority ethnic (BAME) men experienced a higher average increase in mental distress than White British men [272]. These ethnic-gender specific changes in mental health persist after controlling for demographic and socioeconomic characteristics.

Risks of COVID-19

Minority ethnic communities experienced higher death rates, had an increased likelihood of being frontline workers and often had higher rates of pre-existing health conditions [179]. This contributed to fears that minority ethnic communities were more likely to be infected with and die from COVID, and also intersected with a lack of trust in services and concern that racism may affect access to treatment [179].

Stigma and stressors

Qualitative research undertaken in the UK indicated that people from BAME communities experienced heightened anxiety, stigma and racism associated with the pandemic, impacting their mental health [273]. A survey of over 14,000 adults by Mind in England and Wales found that existing inequalities in housing, employment, finances and other issues have had a greater impact on the mental health of people from minority ethnic groups than White people during the pandemic [274].

Accessing services

A report by ALLIANCE into the health and wellbeing during the COVID-19 pandemic showed respondents sharing challenges in accessing care and support when English was not their first langauge [178]. This included limitations in accessing online services where a translator was required, as well as lack of access to carers who spoke their preferred language in some instances. It was also shared that in larger family units, which can be more common amongst some minority ethnic communities such as South Asian communities, confidentiality became an issue when attending virtual appointments. Barriers such as access to digital technologies and WiFi were also highlighted.

Data and evidence gaps

There is a significant and concerning lack of data relating to race and mental health in Scotland, in part due to insufficient sample sizes for minority groups in large quantitative studies. This is compounded by issues in how groups are categorised, which varies between sources and can run the risk of treating ethnic minorities as a singular block, as opposed to responding to the nuances between specific communities (i.e. ethnicity, nationality, national origin, race). This issue was highlighted by organisations (BEMIS and IYS) at the MHEHRF, who emphasised the importance of gathering data which acknowledges the nuanced experiences between different minority ethnic groups.

Key data gaps include:

- High level data understanding the extent of mental health concerns in minority ethnic groups in Scotland
- Disaggregated understanding of the mental health experiences and outcomes of different minority ethnic groups

Key evidence gaps include:

- Evidence relating to minority ethnic groups who are notably under-researched in the Scottish and UK contexts, including Eastern European communities (in addition to Polish) and Chinese communities [58].
- Intersectional evidence relating to minority ethnic disabled, LGBTI+ and different aged people
- Updated qualitative and quantitative evidence to understand the extent of mental health needs within Gypsy/Traveller communities and experiences of mental health services for people from these communities

- More systematic evidence to understand the extent of mental health needs amongst asylum seekers and refugees and more understanding of their experiences of using services and support.

Gypsy/Traveller Communities

It is difficult to estimate the health needs of Gypsy/Traveller communities, due to a lack of routine monitoring. However, it is widely accepted that Gypsy/Traveller communities typically experience poorer health outcomes and shorter life expectancy than the general population [275]. Scottish Census data, for example, demonstrates that this population is approximately twice as likely to report a limiting long-term health problem or disability compared to the White Scottish population, and is approximately 3.5 times as likely to rate their health as being either bad or very bad [276]. These health inequalities are likely attributable to a range of broader social inequalities experienced by Gypsy/Traveller communities, including relatively poor living conditions, high rates of homelessness, low educational attainment, social exclusion and stigma and discrimination [275].

Existing mental health inequalities

There is currently a lack of data on the mental health of Gypsy/Traveller communities in Scotland. However, a large-scale census study of Irish Travellers estimated that the rate of frequent mental distress experienced by these communities is approximately 2.5 times greater than in the general Irish population, at 12.5% [277]. This study further demonstrated that perceived discrimination and experiences of bereavement are important predictors of frequent mental distress amongst Irish Travellers, a finding which is replicated in other studies into the psychological effects of hate crime on Gypsy, Traveller and Roma communities [278].

Evidence collated in a report by Friends, Families and Travellers relating to Gypsy, Roma and Traveller people across the UK indicates that Gypsies and Travellers have an increased likelihood of experiencing depression and anxiety and are six times more likely to die by suicide than the general population [247]. Between 2005 and 2012, the voluntary sector organisation Roma Support Group reported that 43% of their Roma beneficiaries were suffering from mental health conditions including depression, personality disorders, learning disabilities, suicidal tendencies, self-abuse and dependency/misuse of drugs [247].

Inequity experienced in accessing services and support

Reports from third sector organisations and NHS Scotland highlight the challenges in accessing primary and specialist health care, including: accessing services without fixed address or proof of identification; longstanding experiences of discrimination and resulting mistrust of services, particularly in the absence of culturally appropriate service delivery; difficulty in establishing continuity of care within mobile lifestyles and difficulties in communication, particularly for those with low or no literacy and knowledge of navigating healthcare systems [279], [247], [280]. Similar concerns were identified in an international review of Gypsy, Roma and Traveller populations' use of, and engagement with, healthcare services [281]. This review also identified several facilitators that could enable Gypsy/Traveller groups to access services, including the provision of specialist roles, outreach work, dedicated services, and cultural awareness training. Outreach models, for example, may be an effective method for building trust with Gypsy/Traveller communities and in supporting these groups to engage with mainstream services. There is also a need to build increased understanding among NHS staff on how Gypsy/Travellers perceive and manage mental health needs [282]. Awareness of cultural differences and sensitivities around language may further help to reduce reluctance amongst Gypsy/Travellers to seek help for mental health conditions. Targeted promotion of mental health resources such as Breathing Space may also be needed [282].

Trust between Gypsy/Traveller community and health care services is highlighted as a key barrier to accessing services generally, including mental health services. A 2018 review of research into how to improve trust and engagement between Gypsy/Travellers and health services further stressed the importance of involving Gypsy/Travellers in service delivery and design in order to make these services accessible [275]. This review concluded with suggestions and proposals for policy and practice, including for example: sustain investment in initiatives to promote trust between Gypsy/Travellers and health services; promote collaborative working between health services and individuals and organisations who already have positive and trusted relationships with Gypsy/Traveller communities; develop minimum standards of courtesy for health service staff; simplify registration processes with health services such as GPs; introduce literacy supports throughout the NHS and provide alternatives to written information; improve health literacy among Gypsy/Travellers; and provide more flexible health services [275].

Impacts of the COVID-19 pandemic

The impacts of COVID-19 on Gypsy/Traveller communities are somewhat unclear, particularly in relation to mental health, though they are thought likely to be exacerbated by existing underlying health and social inequalities and by the impact of COVID-19 measures on the ability of communities to practice cultural norms, including community meetings and travelling [283].

Refugees and asylum seekers

Existing mental health inequalities

It is difficult to accurately assess the prevalence of mental health needs amongst asylum seekers and refugee populations. Reviews of international evidence have produced a wide range of estimates [284]. There is also a diversity of experience relating to asylum seekers and refugees. However, research undertaken in Scotland has highlighted mental health concerns as one of the biggest issues for asylum seekers and refugees [255], [285], [286].

Trauma

Asylum seekers and refugees are at risk of developing mental health concerns both due to their exposure to trauma in the home countries from which they have fled, and from a range of post-displacement stressors, including social isolation, poverty, lack of access to resources and discrimination [287]. Asylum seekers and refugees are more likely to experience poor mental health than the local population, including higher rates of depression, post-traumatic stress disorder (PTSD) and other anxiety disorders. Similarly, one meta-analysis reported that common mental disorders (anxiety and depression) are twice as prevalent among asylum seekers and refugees as among non-asylum seeking or refugee migrants [288]. Research with newly arrived asylum seeking women in Glasgow found that 57% of interviewees showed symptoms of PTSD [249] and 45% of separated children accessing Scottish Guardianship Services in 2011 reported mental health difficulties [250].

Stress integrating and navigating asylum system

Peer research undertaken by British Red Cross highlights the difficulties faced by asylum seekers particularly in their first six months of living the UK, which include: difficulties arising from factors such as delays in receiving asylum support; lack of knowledge about the asylum system and their rights within it; language and cultural barriers; not knowing how to access support, advocacy and advice; being repeatedly moved within asylum accommodation; and, consequently, being unable to establish and maintain social connections and support networks [289]. This presents challenges for everyday life and makes people more vulnerable to destitution, which are compounded by stress and frustrating interactions with complex Home Office processes. The report highlights interviewees citing having had suicidal thoughts or wanting to die as a result of feeling they had no other way out of the difficulties they faced [289].

The Red Cross report highlights factors which could improve the wellbeing of asylum seekers, including good quality advice and advocacy, including interpreters and legal support, as well as support from the voluntary and community sector in helping people meet their essential needs and build social connections and support networks [289].

Discrimination

A study carried out by researchers at the University of Strathclyde in 2012 explored the views of asylum seekers and refugees in Scotland on mental health, stigma and discrimination [285]. It found that migration can have adverse effects on mental health and wellbeing due to racism and the asylum process, which are worsened by stigma and discrimination. This stigma is influenced by both social and cultural causal factors, including fear, past trauma, isolation, racism and the stress of the asylum process coupled with negative cultural beliefs about mental health conditions [285]. Unemployment, enforced economic inactivity and consequential dependence on state and charity support for long lengths of time, as well as barriers to access employment are also key causes of poor or worsening mental health among asylum seekers and refugees [286].

Inequity experienced in accessing services and support

A systematic review of asylum seekers' and refugees' utilisation of mental health and psychosocial support services in European Union countries found that the use of these services was relatively low, despite the often higher burden of psychiatric illness among these populations [290]. Barriers were identified for asylum seekers and refugees accessing mental health services, including: lack of availability of timely and joined-up services; low acceptability of services and lack of trust in health care staff; low awareness of services, and; stigma and reluctance to seek help, in part due to cultural differences in how mental health needs are understood and appropriate coping methods [290].

In relation to seeking help, the 2012 University of Strathclyde study found that people would first speak to friends or family about their mental health issues, although some would seek help outside their community to avoid stigma and the potential for gossip [285]. In general, asylum seekers and refugees were more likely to seek help from local organisations rather than governmental/'official' sources. Barriers to seeking help included existing attitudes within communities and language barriers. This has been echoed in other research, which also highlights the need for culturally sensitive approaches and more specialised services [291].

Impacts of the COVID-19 pandemic

A survey undertaken by the Scottish Refugee Council in 2020 provides insight into the experiences of refugees, asylum seekers and supporting organisations during the pandemic [292]. In the study, 30% of women and 33% of men stated that their mental health had been poor or very poor in the period preceding the survey. For respondents without secure immigration status, there were indicators that uncertainty over their future was a major stressor. The COVID-19 pandemic caused anxiety and isolation, where the research indicated that those with insecure immigration status were less confident in accessing help, as well as reporting feelings of loneliness and isolation which contributed to their poor mental health. Isolation was a prominent concern relating to poor mental health, with 30% of people with secure immigration status and 37% of those with insecure status having had phone or in-person contact with friends and family only a few times a month or less [292].

According to the research undertaken as part of the University of Glasgow's 'Scotland in Lockdown' study, the experiences of asylum seekers during lockdowns were also influenced by challenges in accessing a disrupted welfare system and access to voluntary sector support, inappropriate accommodation, lack of translated information and increased social isolation [293]. Delays to legal processes also influenced asylum seekers' wellbeing. The British Red Cross highlight the mental health deterioration seen by their support services across the UK between 2020 and 2021, with an increase in complex safeguarding concerns, often connected to suicidal thoughts and attempts, blamed on prolonged use of isolated, temporary accommodation and poor resolution of complaints, isolation and barriers in accessing healthcare [294].

Research from Change Mental Health highlighted the geographical variation in experiences of the pandemic, with refugees and asylum seekers living in rural Scotland saying that the pandemic created opportunities for time outdoors, which was conducive to improved mental helath and wellbeing [158]. The research also highlights issues with barriers to local support, reduced language learning opportunities and challenges for integration within local communities [158].

8. Faith and Belief

Key points

Existing mental health inequalities	• There is mixed evidence around the relationship between religion and mental health. Religion is associated with greater hope, optimism and life satisfaction [295], less depression and fast remission of depression [296], lower rates of suicide [297], and reduced prevalence of drug and alcohol abuse [298]. However, there are also indications of higher anxiety levels in more religious people, as well as contradictory evidence which suggests weak correlations between religiousness and depressive symptoms [299].
Social determinants	• There are significant experiences of discrimination and hate crime experienced by some religious groups in Scotland, which can negatively impact mental health such as depression, heightened levels of anxiety and suicidal thoughts. This includes Islamophobia and antisemitism [300], [301], [302]. • Research also reports within some religious communities, gendered expectations of fulfilling certain behaviours can cause strain on mental health, such as taking on both domestic and work commitments [268]. • There are positive aspects of faith-based organisations in providing a protective role in mental health through the provision of communities of support and cultural centres, as well as spaces to provide support services [303]. • Faith can also play a positive role in supporting mental wellbeing. More than half of the young Muslim respondents in a 2021 report said they are likely to turn to faith when experiencing mental health struggles [304].
Inequity experienced in accessing services and support	• The role of discrimination against religious minorities is highlighted as a barrier to being aware of the help that is available [300]. Sources also note language barriers can also be an issue which could restrict access to services to people from some religious groups [268].
Experiences of services and support	• There is a need for culturally aware support services for some religious groups, including outreach services, the ability to navigate language barriers and provide sensitive and appropriate support [268]. • Training to actively counter discrimination, including Islamophobia and its impacts, is noted as being an important provision for mental health professionals and organisations [304].

Data and evidence gaps	Key data gaps include a systematic understanding of mental health across different faith groups. Additional qualitative evidence focusing on access to and experience of using mental health services would also be valuable.

Introduction

While there is a lack of evidence relating to faith and belief and mental health in Scotland, there is evidence that being part of a community of support and guidance can be a positive impact on mental health. Faith-based organisations can play a key role in providing community support, as seen in the pandemic. There is, however, discrimination and exclusion experienced by members of some religious groups in Scotland which can have a strong negative impact on mental health.

There are significant intersections between religion and minority ethnic communities. For example, approximately 1.45% of Scotland's population are Muslim (based on the 2011 census), of whom approximately 65% are South Asian, 9.8% are Arab, 7.8% are White and 7% are Black [305]. This means that many of the inequalities around religion and belief are likely to overlap with those who are from minority ethnic groups (see race section).

Existing inequalities & mental health disparities

Existing mental health inequalities

There are minimal overall figures available for Scotland which provide a full picture of mental health and religion. The 2017 Scottish Core Questions Survey indicated that the wellbeing of Roman Catholic and Other Christian groups were slightly higher than the no religion reference groups (SWEMWBS scores of 24.5 for Roman Catholics and 24.7 for Other Christian compared to 24.1 for no religion), however, there were no other statistically significant differences [183].

Internationally there is mixed academic research about mental health and faith and belief. These findings are also potentially context-specific, involve complexities in understanding how 'religiosity' is measured and also what aspects of religion and wider spirituality impact mental health [306]. However, there is some evidence which demonstrates that those who are religious may have better mental health. Religion is associated with greater hope, optimism and life satisfaction [295], less depression and fast remission of depression [296], lower rates of suicide [297] and reduced prevalence of drug and alcohol abuse [298]. However, there are also indications that anxiety levels may be heightened in more religious people, as well as contradictory evidence which suggests weak correlations between religiousness and depressive symptoms [299]. Literature extending beyond Christianity also indicates that religious beliefs impact differently on mental health according to the faith group of the subjects [306]. Often being a member of a faith or belief group can be both a protective factor for mental health as well as risk factor, often due to societal factors such as discrimination.

Social determinants of mental health

Community & support

Several sources highlight the role of faith-based organisations in providing a protective role in mental health through the provision of communities of support and cultural centres, as well as spaces to provide support services.

The ‘House of Good’ report from the National Churches Trust highlighted the economic and social value of church buildings in the UK, noting the role of churches in hosting community support, including food banks, youth groups, drug and alcohol support clinics and mental health services, in some cases [303]. Anecdotal evidence included in the report noted churches’ roles in providing social spaces for people to connect.

Source of support

A 2021 report, ‘Hidden survivors: uncovering the mental health struggles of young British Muslims’ highlights that while survey respondents reported high levels of mental health struggles (in the form of anxiety, depression and stress), they also reported that faith played a positive role in supporting mental wellbeing [304]. More than half of the young Muslim respondents said they are likely to turn to faith when experiencing mental health struggles. Actions such as prayer were seen as a key supportive instrument to help support mental health during difficult periods.

Discrimination

Faith and beliefs can be factors which influence experiences of discrimination and experiences of hate crime, which can negatively impact mental health and affect different groups in a variety of ways [307].

The Cross Party Group on Tackling Islamophobia report ‘Scotland’s Islamophobia’ highlights the significant experiences and impacts of Islamophobia on Muslims in Scotland [300]. It emphasises the severity of Islamophobia in Scotland, where, of those Muslims who completed the survey, 83% had experienced Islamophobia directly, in the form of verbal abuse, abuse on social media, damage to buildings or property and physical assault [300]. Participants in the research highlighted not only physical and verbal abuse but also a fear of being increasingly restricted from practising their religion and having their rights curtailed [300]. Participants described the consequences of severe Islamophobia and social exclusion in the onset or worsening of mental health conditions that they or their friends and family members experience, including depression and suicidal thoughts [300].

The Scottish Council of Jewish Communities highlight concerns around antisemitism in their reports ‘Being Jewish in Scotland’ (2013) and ‘What’s changed about being Jewish in Scotland’ (2015). These reports describe heightened levels of anxiety, discomfort and vulnerability felt in the Jewish community following an increased number of antisemitic incidents in the summer of 2014 [301], [302].

The Sikh Sanjog report ‘Sikh Women Speak’, which consisted of research based on a survey and in-person workshops with Sikh women in Scotland, also highlighted discrimination and racism experienced in Scotland today [268].

Additionally, the ‘Pagan Discrimination Survey’, undertaken with a member of the Pagan Faith Community, found that over 40% of respondents stated that they had been directly discriminated against because they were pagans and that over 40% have also felt anxious or depressed because of other people’s attitudes towards their faith [308].

There are also potential issues around discrimination within religious communities. The ‘Sikh Women Speak’ report, highlighted division within the Sikh community along caste lines. Caste discrimination was noted by many of the survey respondents with 70% saying they felt that Scotland’s Sikh communities are divided [268].

Gender

The ‘Sikh Women Speak’, report also highlighted discrimination challenges specifically facing Sikh women both within the community and in the workplace [268]. They highlighted the gendered expectations of fulfilling certain behaviours, such as taking on both domestic and work commitments, which cause strain on mental health. Respondents highlighted low self-esteem in their own abilities and knowledge in the workplace, often attributed to being out of work for long periods of time (due to having children or other family commitments), which they said had a knock-on effect on their mental and emotional health [268].

Inequity experienced in accessing services and support

Awareness

The ‘Scotland’s Islamophobia’ report highlights the role of discrimination against religious minorities as a barrier to being aware of the help that is available [300]. Sources also note language barriers as also being issues which could restrict access to services [268].

Discrimination

There is evidence that discrimination towards religious minorities can have an impact on accessing healthcare services. As part of the research for the ‘Scotland’s Islamophobia’ report, the organisation TellMAMA provided evidence of discrimination affecting the ability of Muslims and other religious minorities in accessing medical treatment, including evidence of Muslim women being unable to access mental health support for their children [300].

Experiences of services and support

Lack of cultural awareness

Issues were highlighted in the ‘Sikh Women Speak’ report around the cultural awareness of mental health services, as well as difficulties in navigating the system [268]. Women interviewed said that they were forced to turn to private mental health care, as the NHS system was too stressful and fragmented. The additional language barrier challenges faced by some were also noted.

The lack of prenatal and postnatal care given to new Sikh mums was particularly highlighted [268]. This was also related to a lack of cultural awareness, for instance, within multi-generational families.

Evidence from the ‘Hidden Survivors’ report showed that nearly two in five Muslims said they would prefer to see a Muslim counsellor or therapist, a number which rises to 55% amongst those with experience of counselling [304]. Respondents also said that they would prefer for mental health services to show cultural/faith sensitivity.

The Sikh Women Speak report highlighted a lack of appropriate and culturally aware mental health services [268]. Many reported that they are not fully understood by therapists and counsellors in the current system. This was highlighted particularly by the lack of therapists with lived experience of the South Asian community. This means many feel unable to share their experiences due to fear of judgement and lack of understanding.

Training needs within services to counter discrimination

Beyond culturally aware services, training to actively counter discrimination, including Islamophobia and its impacts, is noted as a recommendation in the ‘Scotland’s Islamophobia’ report, as being an important provision for mental health professionals and organisations [300].

COVID-19 pandemic impacts

Role of the places of worship and faith-based organisations on wellbeing

Faith-based organisations, including churches and other places of worship, played a key role throughout the pandemic in providing both material and emotional support.

The ‘Keeping the Faith’ report from the UK government highlighted the role of partnerships between faith groups and local authorities since the beginning of the pandemic [309]. It notes that 67% of local authorities in the UK reported an increase in partnerships working with faith groups, with 60% of local authorities involving food banks operated by faith groups or faith-based organisations as part of their response to the pandemic [309]. These partnerships particularly focused on food poverty (such as food banks, pantries and food parcel deliveries) and mental health and wellbeing (such as fitness initiatives and counselling) [309].

Data and evidence gaps

There is currently a lack of overall evidence around how faith and belief impact mental health inequalities. In population-level surveys it is often challenging to gather large enough sample sizes to establish statistically significant findings and also where faith and beliefs are not recorded.

9. Sex

Key points

Existing mental health inequalities	• There are gendered components to how mental health conditions present, as well as societal gender roles and expectations which may have an impact on how mental health is experienced and reported by men and women. • 2021 SHeS data reports average mental wellbeing (WEMWEBS) scores were 49.0 for men and 48.3 for women, with no statistically significant variation [310]. Both figures fell from the 2019 reported scores (49.9 for men and 49.7 for women [37]), but fell by more for women. As in previous years, women were more likely than men to record a GHQ-12 score of 4 or more (indicative of a possible psychiatric disorder) in 2021 (24% compared to 19% respectively), both men and women had an increase from 2019 [310]. • In the 2021 SHeS survey, there were no significant differences between men and women displaying two or more symptoms of depression (12% and 10% respectively) [310]. This has, however, risen significantly for men from previous years (from 7% in 2010/2011 to 12% in 2021), while remaining in a similar range for women [310]. Women are consistently more likely than men to record two or more symptoms of anxiety [310]. • There are also indications from other data sources in Scotland and the rest of the UK that women are more likely to experience mental health concerns than men [32]. • Women are at higher risk of eating disorders [311], and post-traumatic stress disorder (PTSD) compared to men, with an estimated lifetime prevalence rate of 10-12% for women and 5-6% for men [312]. • While women are more likely to have ever attempted suicide than men [32], men are at much higher risk of dying by suicide. During the period 2011-2017, men accounted for 73% of the probable suicide deaths recorded in Scotland [313]. • Academic evidence shows that generally women more often experience mental illnesses with internalising symptoms, such as low self-esteem and anxiety [314], whereas men are more likely to be diagnosed with behavioural disorders and substance abuse [315], [316].
Social determinants	• Factors which can put women at greater risk of poorer mental health than men include a higher likelihood of living in poverty (especially for single mothers) [317], greater caring responsibilities [318], the impacts of cultural influences with respect to body image and comparison through social media [319] and experiences of living with domestic violence, abuse, coercive control and toxic masculinity [320]. Life events and hormonal changes can also impact women's mental health, including during pregnancy, menstruation, menopause and using some types of contraceptives [321]. There are also periods of loneliness which can impact women,

	including women with young children and older women living alone [310]. - Women are thought to be more comfortable talking about their mental health than men and have stronger social networks, which can help to protect their mental health [141]. Men are at greater risk of social isolation than women [141]. - Men in mid-life are at higher risk of suicide compared to younger and older men [322]. Risk factors associated with men's suicide include living in a deprived area, living in lower quality housing, earning a lower income, low levels of education and being in poor quality or low employment [322].
Inequity experienced in accessing services and support	- In the UK, men are less likely to access psychological therapies than women: only 36% of referrals to NHS talking therapies in England are for men [323]. Men are more likely to be compulsorily detained or 'sectioned' for treatment than women [324]. The 2014 England APMS showed that men with a common mental health disorder were less likely than women to be receiving treatment at the time of the survey, even after accounting for differences in symptom severity [32]. Data from ScotSID show that a lower percentage of men who died by suicide between 2011-2017 had been in contact with health services (including mental health services) in the period before death than women (65% and 86%, respectively) [313]. - Mental health stigma acts as a barrier to accessing services for both women and men [325], [326].For women, the impacts of experiencing violence against women and girls can also act as a barrier [327].
Experiences of services and support	- Women highlighted concerns around building trust in services and being taken seriously [328]. - Evidence highlights the importance of trauma-informed approaches for women who have experienced trauma [329], [327].
Data and evidence gaps	Key evidence gaps include: - Intersectional understandings of the experiences of minority ethnic men and women in Scotland. - Qualitative evidence around men's mental health and experience of using mental health services across different ages. - Understanding of the impacts of self-reported mental health, which may be impacted by gendered norms and stigma.

Introduction

This section looks at the mental health inequalities around sex. It primarily uses the language around sex as a protected characteristic under the Equality Act (which defines sex as a man or a woman [1]). The evidence presented, particularly around underlying inequalities, also relates to societal gender roles, stereotypes and expectations.

The current evidence around sex inequalities in mental health paints a complex picture of how sex and gender impact on both experiences of mental health and mental illness and in help seeking behaviours. In Scotland, wellbeing and acute mental illness generally appears to be experienced at broadly comparative rates by men and women but in very different ways. Women experience greater levels of common mental disorders, eating disorders and PTSD, whereas men are consistently found to be at a much higher risk of suicide and are more likely to be using mental health inpatient services. Women experience a large number of social and economic inequalities which contribute to worsened mental health. However, they are more likely to seek support for mental health needs compared to men and have stronger social networks, which can help to protect their mental health. There are significant barriers which prevent men from seeking mental health support, which is believed to contribute to the higher levels of suicide among men.

While this section looks broadly at the sex inequalities relating to mental health, there is significant intersectionality across different age groups and specific experiences for women and men with disabilities and those from minority ethnic backgrounds, though elements of these lack adequate research.

Existing inequalities & mental health disparities

Existing mental health inequalities

Comparisons between men and women in common mental disorders and wellbeing

Population surveys on mental health and wellbeing show mixed evidence relating to the gendered inequalities around mental health and wellbeing. This highlights the complexity of understanding how gender/sex relates to mental health. There are differences in how women and men experience poor mental health and wellbeing, as well as potential disparities in self-reporting and across different measurement tools.

The 2021 SHeS reported that average mental wellbeing (WEMWBS) scores for were 49.0 men and 48.3 women, with no statistically significant variation [310]. Both figures fell from the 2019 reported scores (49.9 for men and 49.7 for women), but fell by more for women [37]. As in previous years, women were more likely than men to record a GHQ-12 score of 4 or more (indicative of a possible psychiatric disorder) in 2021 (24% compared to 19% respectively), both men and women had an increase from 2019 [310].

In the 2021 SHeS survey, there were no significant differences between men and women displaying two or more symptoms of depression (12% and 10% respectively) [310]. This has, however, risen significantly for men from previous years (from 7% in 2010/2011 to 12% in 2021), while remaining in a similar range for women [310].

From compiled SHeS analyses from 2008/2009 to 2021, women are consistently more likely than men to record two or more symptoms of anxiety [310]. In the 2021 SHeS, a difference of 8% was recorded, the highest over the time series, with 18% of women reporting two or more symptoms of anxiety compared with 10% of men [310].

There are also indications from other data sources in Scotland and the rest of the UK that women are more likely to experience mental health concerns than men. In the most recent 2014 APMS for England, a higher percentage of women reported symptoms of a common mental disorder (19%) than men (12%) [32]. Symptoms of common mental disorders were further found to have steadily increased among women between 1993 to 2014 although a similar trend among men is less apparent [330]. APMS evidence further highlights young women as a group who are particularly at risk of poor mental health, and shows how the mental health gap between young men and women has grown in recent years: in 1993, 16-24 year old women were twice as likely as 16-24 year old men to report symptoms of a common mental disorder, however by 2014 young women were three times more likely to report symptoms of a common mental disorder than young men [330].

Other mental illness

Women are at higher risk of eating disorders [8], accounting for around three quarters of cases in the UK [311], with this disproportionately impacting young people [331]. There is evidence of a higher risk of women developing PTSD compared to men, with an estimated lifetime prevalence rate of 10-12% for women and 5-6% for men [312]. The risk of developing PTSD after a traumatic event is 20% for women compared with 8% for men [332].

The 2022 Mental Health & Learning Disability Inpatient Census showed 59% of all patients occupying a mental health, addiction or learning disability bed in NHS Scotland were male, which increased to 68% for those aged 18-39 [260]. In the census, 16% of patients were receiving Forensic Services, of whom 96% were male, mostly of working age. This is an increase of 7% since 2019. Of the patients aged under 18, 87% were female. Female patients were more likely to express suicidal ideation on admission and were more likely to have been self-harming in the week prior to admission [260].

Differences in presentation of mental health conditions

The presentation of mental health conditions is seen to be gendered in the UK and internationally. Academic evidence shows that, generally, women more often experience mental illnesses with internalising symptoms, such as low self-esteem and anxiety [314], whereas men are more likely to be diagnosed with behavioural disorders and substance abuse [315], [316]. These differences are often linked to perceived gender expectations of masculinity and femininity, such as men often being discouraged from showing emotion [333]. The role of societal gender roles and expectations may also influence self-reported measures of wellbeing and mental health [334].

Mental health inequalities amongst children and young people

Amongst children, the 2019 SHeS showed that there was a significant variation in the WEMWBS wellbeing scores recorded by sex in 2016-2019, with a higher mean score of 52.0 recorded among boys compared to 49.9 among girls. These figures are the same as those recorded in the previous four-year period [37]. During the period 2016-2019, a higher proportion of boys than girls aged 4-12 had borderline or abnormal scores on the Strengths and Difficulties Questionnaire (SDQ) (which indicates emotional wellbeing and behavioural issues for children) including on conduct disorder dimension (23% compared to 18%), peer problems (22% compared to 17%), hyperactivity (25% compared to 15%) and pro-social behaviour dimension (10% compared to 5%) [37].

Long-term health conditions and disability

Having a disability, impairment or long-term physical health condition significantly affects mental health [335]. Patients diagnosed with a long-term condition experience higher rates of mental health conditions, including anxiety and depression, compared with those without a long-term condition. There is a growing gender disparity between the proportion of men and women in the population self-identifying as having a disability, impairment or long-term health condition [336]. As of 2020/2021, 20% of men were disabled in the UK compared to 24% of women [337]. While much of the gender-related disparity in prevalence rates can be explained due to women having longer life expectancies, there is also a significant disparity in gender-related prevalence rates of disability between ages 30 and 64 [338]. Disabled women are also seen to be at greater risk of developing mental health issues than disabled men and non-disabled women [339].

Suicide and attempted suicide

APMS evidence shows that women are more likely to have ever attempted suicide than men (9% compared to 6% of) [32]. However, men are consistently found to be at higher risk of dying by suicide in Scotland and internationally. Analysis of the ScotSID shows that men accounted for 73% of the probable suicide deaths recorded during the period 2011-2017 [313]. Men aged 40 to 49 have the highest suicide rates in the UK and have lower levels of life satisfaction according to some wellbeing surveys [340].

Social determinants of mental health: gendered risks

There are numerous underlying inequalities and experiences which contribute to the gendered risks around mental health. While many social and economic factors can put women at greater risk of poorer mental health than men, women often find it easier to talk about their feelings and have stronger social networks, which can help to protect their mental health.

Gender roles & stereotypes

Both existing literature and contributions from stakeholders to the MHEHRF highlight the potential impact of gender stereotyping on the wellbeing and mental health of men and women. While these are shaped by cultural expectations with nuances across different groups and backgrounds, they commonly include ideas that women and girls are more “emotionally giving” and more able to take on caring roles [328].

Contrastingly, men and boys are often encouraged not to show their emotions, which can be influenced by societal expectations through schooling, interactions with peers and family and wider gender expectations [341]. For example, the pressures that can be placed on men to provide materially for others are seen to increase self-harm amongst men during periods of economic hardship [342]. The expectations on men and boys to hide their emotions can also be seen in the experiences and outcomes of mental illness, with higher levels of substance use and anger management issues [341].

Social determinants of mental health: Women and girls

Caring roles

Generational and gendered perceptions of women’s roles and responsibilities at home and within communities have an impact on mental health. In the UK, women are more likely than men to be caregivers at all ages [318]. Women who are carers are more likely to experience depression or anxiety than women in the general population [318]. Most single-parent families are headed by women, with a higher likelihood of experiencing poverty than couple-parent families [343]. This can contribute to financial stress and feelings of isolation, depression and anxiety, alongside managing the stigma associated with being a single parents [343].

Poverty

Women and girls are disproportionately impacted by poverty and dependence on social security [344], with single women with children having the highest poverty rates in Scotland (though at lower rates that in the past) [317]. Women are overrepresented in underpaid, undervalued jobs, precarious and part-time work [345]. Living in poverty can lead to social isolation, anxiety, depression and stress. Agenda's report, 'Joining the dots: the combined burden of violence, abuse and poverty in the lives of women', which uses data from the 2014 English APMS, notes that 29% of women in poverty experience common mental health disorders compared to 16% of women not in poverty [345]. Women in poverty who have experienced abuse are even more likely to experience poor mental health [345].

Contributions from the Scottish Women's Convention in the MHEHRF highlighted the impact of poverty on women's mental health, particularly because of the cost of living crisis, where stress and anxiety over the cost of food and essentials has negatively impacted the mental wellbeing of the people they engage with.

A report from the Centre for Ageing Better, 'Inequalities in later life*',* highlights inequalities amongst older adults, with evidence that older women are more vulnerable to financial difficulties than older men, often due to their fragmented employment history and family circumstances impacting pension income and abilities to save [346].

Health

Trauma due to life events and physical and biological factors can impact women's mental health, including pregnancy, miscarriage, health problems linked to reproductive health, menstruation, menopause and the impacts of using contraceptives [316].

Perinatal mental health conditions affect up to 20% of women during pregnancy and in the first year after the birth of a child [210], with suicide being the leading cause of overall maternal deaths in the first year [209]. Factors which influence the prevalence of mental health concerns include histories of psychiatric illness, life stress and lack of social support [225].

There are linkages between the menstrual cycle and mental health. Premenstrual syndrome (PMS) impacts between 50% and 90% of women and includes a range of psychological symptoms including depression, anxiety, irritability, loss of confidence and mood swings [347]. There is evidence that these can impact more negatively on women with learning disabilities. Conditions such as premenstrual dysphoric disorder (PMDD) (a very severe form of PMS, which causes a range of emotional and physical symptoms), and endometriosis can have severe mental health implications, including feelings of anxiety, hopelessness and suicidal thoughts [348], [349].

There are indications of mental health side effects on women from using hormonal contraceptives, including higher rates of depression, anxiety and fatigue [350], [351]. Going through menopause can also have significant mental health implications [352]. A 2019 survey undertaken by Engender highlighted that most respondents had experienced physical and mental health symptoms and nearly 60% said they had not felt supported by medical professionals [353]. The study highlights that women can often feel isolated and unsupported during peri- and post-menopause.

Violence against women and girls

Violence against women and girls (VAWG) includes: physical, sexual and psychological violence in the family, general community or institutions, including domestic abuse, rape, incest and child sexual assault; sexual harassment and intimidation at work and in public; commercial sexual exploitation including prostitution, pornography and trafficking; and so-called 'honour based' violence (a term used to describe abuse carried out by a family or community member to defend their perceived honour [329]), including dowry related violence, female genital mutilation, forced and child marriages and 'honour' crimes [354]. This is committed primarily, though not exclusively, against women by men [355].

The mental health impacts of VAWG include disproportionate rates of PTSD, suicidal thoughts and attempts, isolation, anxiety and depression [356], [357], [327]. Agenda's report 'Hidden hurt: violence, abuse and disadvantage in the lives of women', which is based on the 2014 APMS, highlights that: 53% of women who have mental health needs have experienced abuse; 36% of women who have faced extensive physical and sexual violence in both childhood and adulthood have attempted suicide; and 22% have self-harmed [358].

Women with mental health conditions are thought to be more at risk of domestic abuse, with 30-60% of women with a mental health condition having experienced domestic violence [359]. Evidence shows that disabled women are between two and three times more likely to experience domestic abuse compared to non-disabled women [320]. This includes honour-based abuse, financial abuse, physical and psychological abuse, contributing to feelings of worthlessness, isolation and low self-esteem.

Stakeholders in the MHEHRF highlighted concerns around the impact of domestic violence and mental health needs, with the Scottish Women Convention noting the long term impact of VAWG on women and children even after they have left the situation, which requires consistent mental health support. Stakeholders also highlighted the specific concerns around the mental health of minority ethnic women due to oppression through the power structures relating to both race and gender, with varying experiences for women from different minority ethnic backgrounds. There are also potential contributing factors around the disproportionate experiences of poverty and deprivation amongst minority ethnic communities.

Body image

The 2019 'Status of Young Women in Scotland' report focused on body image and the impact of negative body image on young women, based on an online survey and focus groups [319]. The survey indicated that half of the respondents had negative feelings about their bodies, with 80% of respondents saying that body image had stopped them from doing something or negatively impacted their confidence and limited their life choices [319]. This included participation in sports and exercise activities, engagement in social activities, relationships and education and career development. Focus group respondents highlighted that issues often became present at a young age, with mental health impacts including anxiety and disordered eating [319]. The role of social media in perpetuating body or beauty standards that young women are pressured into conforming to was also noted [319].

Loneliness

According the 2019 SheS, 12% of women reported feeling lonely 'often' or 'all of the time' in the previous two weeks, a significantly higher proportion than men (9%) [37]. Women were also significantly more likely than men to have reported feeling lonely 'sometimes' (21% compared with 17%) while men were more likely than women to have reported feeling lonely 'rarely' or 'never' in the previous two weeks (75% and 68% respectively) [37]. This is echoed in the 2023 ONS 'State of Loneliness' report, which found that while both women and men became more lonely between 2020 and 2022, women were significantly more likely to be chronically lonely than me (7.7% of women were chronically lonely on average across 2020-2022, compared to 6.4% of men) [38]. There are specific life stages when women may be at greater risk of loneliness, such as women with young children or babies [360].

Social determinants of mental health: Men and boys

Male suicides

The reasons why men are more likely to die by suicide are complex and span a wide range of individual-level and broader social factors, which also impact the likelihood of men seeking help for their mental health needs [361]. The Samaritans' report, 'Suicide risk factors for middle-aged men', highlights the key factors associated with male suicides [322]. These include how men living in the most deprived areas are up to ten times more likely to end their lives by suicide than those from the most affluent areas, while those with living in lower quality housing, earning a lower income, having less education and in poor quality or no employment are at most risk of suicide. Men in mid-life are at higher risk of suicide compared to younger and older men [322].

The Samaritans' report also showed that while a history of psychiatric illness, particularly depression, underlies many suicides, only a minority of those who have wider diagnosed mental health conditions take their own life [322]. Some personality traits and mindsets are thought to contribute to the development of suicidal thoughts, including perfectionism, self-criticism, brooding and having no positive thoughts about the future. Failing to meet perceived expectations for masculinity (such as a perceived role of providing materially for others) contribute to feelings of shame and defeat, which may propel some men towards suicide and as a way of regaining control. Marriage breakdowns are more likely to lead men, rather than women, to suicide. It is thought this is because many men rely on their partners for emotional support. Connected to which, divorced or separated men are twice as likely as divorced or separated women to have suicidal thoughts or to have planned suicides as a result of men having fewer supportive peer relationships than women, particularly over the age of 30. A culture of reluctance to talk about emotions can mean men do not recognise or deal with their distress until a point of crisis [322].

Homelessness

Mental health needs have frequently been identified as a contributory factor for homelessness. UK estimates indicate that common mental health conditions are twice as high amongst homeless people compared to the general population, with psychosis being 15 times as high [362]. UK ONS data indicates that men are more likely to be rough sleeping than women, at a ratio of around six to one [363]. In Scotland, 70% of the homelessness applications made to councils over the period of 2020-2021 were single households, and primarily single men [364].

Social isolation

While evidence shows higher percentages of women reporting loneliness, evidence also demonstrates that men, particularly those over 50, appear to be more vulnerable to social isolation than women [141]. Evidence from the European Social Survey shows that men report increasingly higher levels of loneliness over the age of 75 [365]. In Scotland, survey data shows that men are less likely to report high levels of social support or frequent social contact [141]. These gender patterns vary with age; as women get older their levels of social support tend to remain relatively stable while the proportion of men with limited social support increases [141].

Inequity experienced in accessing services and support

There are differences in the routes to and types of treatments for mental health conditions experienced by men and women. In the UK, men are less likely to access psychological therapies than women: only 36% of referrals to NHS talking therapies in England are for men [323]. Data on mental health prescribing from PHS shows that, for four out of the five groups of mental health medicines, substantially more medicines are dispensed to women than men [366]. In 2019/2020, for example. 65% of patients who received antidepressant treatment were female, while 35% were male [366]. The exception to this is ADHD, where almost 80% of dispensing is to men [366].

Men are more likely to be compulsorily detained or ‘sectioned’ for treatment than women [324]. The 2014 APMS showed that men with a common mental health disorder were less likely than women to be receiving treatment at the time of the survey, even after accounting for differences in symptom severity [32]. Data from ScotSID show that a lower percentage of men who died by suicide between 2011-2017 had been in contact with health services (including mental health services) in the period before death than women (65% and 86%, respectively) [313].

Women and girls

Stigma

Respondents to the National Advisory Council on Women and Girls (NACWG) Satellite Wee Circle event highlighted that in some cases women and girls’ mental health concerns are dismissed as being overdramatic or reduced to being blamed on hormones [328]. Self-stigma was discussed at the event and was thought to prevent women and girls from seeking support over concerns of not “being worthy” of receiving help, feeling ashamed and worried about others’ perceptions if they are struggling, and feeling guilty that they are not coping [328]. Comparing themselves to social media and popular culture images of women portrayed as having fun, coping and leading fulfilled lives was also a barrier to seeking support [328]. Evidence from the UK Women’s Mental Health Taskforce highlights concerns from mothers reluctant to seek mental health support due to fear of their child being taken away from them as a result of the stigma around mental health issues, such as being seen as an unfit parent [326].

Violence against women and girls

Experience of gender-based violence can be a barrier to accessing mental health support and services. Responses from survivors of abuse/violence highlighted in the 2021 IS report, ‘Understanding the mental health needs of women and girls experiencing gender-based violence’, noted the need for free, easy-to-access therapeutic options to meet their mental health needs without feeling ‘bounced around’, which is currently lacking according to the report [327]. Recommendations to overcome this include women-only spaces, childcare provision and information tailored to different languages and cultures [327]. The report advocated for more joined-up services which provide holistic pathways to support [327]. Partnerships between services and organisations working on local and national levels were seen as central to this [327].

Men and boys

Stigma

Mental health stigma amongst men remains a key barrier when engaging with mental health services. Stigma has also been associated with wider concepts of male masculinity, pride, and self-reliance in managing physical and mental illness [367]. Men who subscribe to stereotypes associated with masculinity are seen to be less likely to engage in health positive behaviours and can be reluctant to seek physical or mental health assistance from professionals [368]. Research also shows that men are less likely to share their feelings with friends, families and medical professionals due to fear of mistreatment or losing agency [369].

Research undertaken by the Men's Health Forum found that over a third of men wait two or more years before disclosing a mental health problem [325]. Men were found to be too embarrassed or ashamed to take time off work for mental illness, however they were more likely to take time off for physical ailments. The research also found that much of the language used around mental health can impact men's engagement with services, disclosure of mental illness and diagnosis [325]. For instance, the term 'mental health' was seen by respondents as being indicative of a 'failure to cope'. It was suggested that the use of fewer clinical terms and more socially and colloquially acceptable language would be effective in engaging with men on mental health issues [325].

Evidence shows that Black and minority ethnic men are less likely to access mental health support services than other groups, particularly White British men [245]. There is nuance across different groups in terms of where men might seek support with their mental health. For example, research amongst Muslim men found that they preferred to seek help at their mosque [325].

Experiences of services

Women and girls

The 2022-2023 'Status of Young Women in Scotland' report explored experiences of accessing healthcare, including mental health services [370]. Respondents described feeling not heard or taken seriously, and being frustrated by long waiting times and lack of continuity of care, with some deciding to look for private mental health care, despite the significant financial burden of this [370]. When accessing care, respondents described being told by healthcare professionals that physical and mental health symptoms were attributable to hormonal or menstrual issues and were not offered space or time to explore other potential causes. Some also described experiences of having physical symptoms dismissed as being due stress or anxiety and being told that their mental health symptoms were not severe enough to warrant a referral to mental health services [370]. Many respondents attributed their experiences to being young women and, in some cases, being women of colour. Academic literature based on research in Southeast England highlights these issues, particularly for women from minority ethnic backgrounds [245]. Evidence gathered by organisations at the NACWG Satellite Wee Circle on gender equality and mental health echoes the experiences highlighted in the 'Status of Young Women in Scotland' report, and emphasised that women feeling ignored by medical professionals, who did note take their symptoms seriously, can, in turn, negatively impact their mental health [328]. This was also echoed in Scottish Government research into women's experiences of discrimination and the impact on health, where young women described struggling to be taken seriously and the mental health impacts of this [351].

Respondents to the UK Women's Mental Health Taskforce described women experiencing problems developing trusting and rapport-based relationships with mental health care staff. Respondents also described how they needed to feel safe and supported, particularly in the context of opening up about past experiences of abuse or trauma [326]. Issues around care continuity were particularly highlighted, as were experiences of feeling discriminated against and marginalised, which was re-traumatising in some circumstances [326]. A lack of choice or control over where care was received, who they received it from and how they received it contributed to feelings of powerlessness among respondents [326]. Minority ethnic women specifically spoke about the perceived imbalance of power and authority between service users and providers, alongside cultural naivety, insensitivity and discrimination [326].

Training needs within services

Research and stakeholders in the MHEHRF highlight the need for trauma-informed approaches to help reduce the barriers to accessing support, increase the likelihood of women seeking further support and reduce potential for re-traumatisation [371]. This also supports the mental health workforce in understanding the impacts of vicarious and secondary trauma [371]. IYS highlighted in the MHEHRF that for minority ethnic women and girls particularly, there is a need for counsellors, therapists and other mental health professionals to have awareness of racial trauma and who are culturally appropriate, accessible and inclusive [266].

Men and boys

There is a general lack of evidence about men's experiences of using of mental health services. Qualitative research from a collaboration between Men's Health Forum and Mind in 2010 provides some insight into men's underuse of mental health services [372]. Alongside barriers associated with stigma and difficulty in recognising mental health conditions, respondents also perceived that many services were more focused on the needs of women, without adequate specific focus on men's mental health and a lack of male mental health practitioners [372]. Respondents also highlighted the lack of services for specific communities, including minority ethnic groups and LGBTI+ men. The Men's Health forum research found that how interventions on men's mental health are delivered, including who delivers them, is important. The use of online services to engage men and provide positive support for mental health was thought to be helpful [372].

Impacts of the COVID-19 pandemic

Findings from University College London (UCL) research on COVID-19 surveys found that young women were most likely to have experienced high levels of depression, anxiety and loneliness in lockdowns and showed the biggest increase in mental health needs [373]. The research also found that women were more likely than men to experience mental health concerns. The British Academy report 'The Covid decade: understanding the long-term societal impacts of COVID-19' collated research on the mental health impacts of the pandemic and noted gender disparities [374]. It highlights that women were among the groups already experiencing lower levels of mental wellbeing before the pandemic and have continued to be disproportionately affected compared to men [374].

Research demonstrates a correlation between lower levels of mental health in women and periods of lockdown [97]. Studies note a greater proportion of women reporting feeling lonely sometimes or often compared with men during the pandemic, a decline in the number of friends and a higher level of loneliness over time amongst women, potentially impacted by women generally having wider social circles pre-pandemic [375]. The Ipsos MORI report, 'The impact of COVID-19 on wellbeing in Scotland', notes that while most people had regular social contact during the pandemic, women were more likely than men to feel cut off and find restrictions on socialising hard (50% compared to 43%) [376].

Care roles during Covid

It was highlighted by several organisations in response to the MHEHRF that the emotional labour of caring for others often fell on women during the pandemic. This included, for example, supporting children with home learning and caring for others, including those shielding and those whose existing care support had been disrupted [377]. International evidence indicates that parents and caregivers who were home-schooling during the pandemic experienced significantly higher levels of psychological distress and work/home impairment compared to those who were not home-schooling or who had no school-aged children [378]. Disabled women disproportionately took on increased care work to cope with the disruption of care support [379]. Existing self-management approaches, such as talking to support networks, were made more challenging by lockdown measures.

Employment & poverty

Women are more likely to be employed in health and social care jobs in the UK [380] and therefore often held key worker roles during the pandemic [381]. There is evidence that women providing care in domestic and clinical settings during Covid were greater risk of developing trauma, depression and poor wellbeing [382].

People living in the most deprived areas on low incomes were least likely to be managing well financially before the pandemic, and women, especially single women and those who are lone parents, had a higher likelihood of being in poverty [383]. This is thought to have worsened over the course of the pandemic [383]. There is evidence which shows that female employment fell faster than male employment in much of the world [384], with those working in sector that were heavily impacted by lockdowns, such as hospitality, were already twice as likely to be in poverty [383]. Evidence from the Fawcett Society found that 43% of working women in the UK and 50% of BAME women were worried about jobs or promotions as a result of the pandemic [385].

Disabilities

Given the higher proportion of women who are disabled than men, many of the impacts of the pandemic on disabled people had a disproportionate impact on women, as well as specific impacts for disabled women and those with multiple intersectionalites. A survey conducted by Glasgow Disability Alliance (GDA) found that 90% of respondents had been worried about their physical and mental health during the pandemic [114]. Their report, ‘Triple whammy: disabled women’s lived experiences of COVID-19’, highlights the specific challenges faced by disabled women [137]. Alongside lack of access to health and social care, they highlight poverty and financial struggles (including access to food, money, social security and resources such as sanitary and continence provisions) [137]. Many disabled women remained on legacy benefits and were therefore unable to access the £20 uplift award to those on Universal Credit [137]. In addition, lack of employment and discrimination in the workplace, including pressure to return to face to face working and challenges with access to work affected many disabled women in particular [137].

Violence against women and girls

A major concern throughout the pandemic and particularly during periods of lockdown was the impact on domestic violence. Numerous sources highlight that all forms of VAWG were exacerbated by the pandemic, as was difficulty in accessing justice [386], [387].

Research undertaken by the Scottish Government on domestic abuse and other forms of violence against women and girls during the pandemic highlights that VAWG services consistently reported victims experiencing significant mental ill health due to the impact of

COVID-19 [387]. Organisations reported victims citing the combined consequences of isolation, lack of safe childcare options, managing the risk of domestic abuse and the risk of the virus as having a severe impact on their mental health and resilience [387]. Some victims of domestic abuse reported their lack of options for ‘emotional safety-planning’ (attending safe spaces such as churches and/or sporting, parenting or community groups) impacted negatively on their mental health [387]. The impact was also particularly acute for women involved in prostitution/commercial sexual exploitation due to the unknown end date and financial and economic impacts of the COVID-19 restrictions [387].

Many organisations observed increases in crisis work with victims of VAWG, with many people experiencing suicidal ideation, depression and anxiety, increasing substance misuse as a coping mechanism, and/or increased levels of fear, both of the perpetrator and the virus [387]. Organisations observed that victims required increased support, with many contacting services several times a week and requiring extended support calls [387]. A number of services reported that low mood and trauma triggers appear to be a recurring feature for the most isolated women. Particularly during Phases 1 and 2 of Scotland’s Route Map out of the COVID-19 crisis (May-August 2020), there were reports of victims with addictions lapsing or relapsing during lockdown, and services and clients attributing relapse to increased isolation, lack of support and the increased pressures of having children at home [387].

In terms of accessing support, the main barrier for services engaging with victims of VAWG was mitigating the risks of contacting those who they reside with and/or are monitored by their perpetrator [387]. Some victims were reported to be digitally excluded by not having a smart device, poor telephone signal in their area or lacking a good Wi-Fi connection, making it more difficult to access support [387]. Women fleeing abuse who were housed in temporary accommodation were also affected by this [387]. In some cases, services supporting victims of VAWG highlighted issues such as limited spaces in childcare hubs, mothers’ roles as key workers, absence of family support and reduced provision of mainstream support services as compounding factors in providing support [387].

The SafeLives ‘Safe at home: mental health stakeholders’ roundtable report also highlights the increase in mental health service needs for domestic abuse survivors, it identifies gaps during the pandemic such as: limited access to GPs; intensification of an existing lack of mental health provision; reduced face-to-face contact, impacting victims’ feeling of connectedness; and anxiety caused by remote appointments [388].

Prior to the pandemic, disabled women were at twice the risk of domestic and financial abuse compared to non-disabled women, indicating a particular risk of worsening through the pandemic, particularly within the wider context of the pandemic’s impact on disabled people [389].

Data and evidence gaps

Much of the high level survey and service usage data is collected with disaggregation by sex and so there is a substantial body of evidence from mental health statistical surveys. Key remaining evidence gaps include:

- Experiences of minority ethnic men and women in Scotland
- Qualitative evidence around men’s mental health across different ages
- Understanding of the impacts of self-reported mental health, which may be impacted by gendered norms and stigma

10. Poverty and low-income

Key points

Existing mental health inequalities	• Based on SHeS, there continues to be clear differences in WEMWBS wellbeing mean scores by areas of deprivation. There is a linear decrease from a mean of 51.5 among adults in the least deprived quintile to a significantly lower mean of 46.9 in the most deprived quintile [37]. • Compared to adults living in the least deprived quintile, adults living in the most deprived quintiles are more likely to report two or more symptoms of depression (21% compared to 8%) and have higher rates of self-reported self-harm (13% compared to 5-7%) [37].
Social determinants	• Social determinants which make people living in poverty more vulnerable to having mental health needs are: stress associated with living on low income and with debt, insecure and low quality employment [330], [390], [391] increased likelihood of having experienced psychological trauma and adverse childhood experiences (ACEs) [392], discrimination and stigma attached to being in poverty [393], [394], and low quality physical environments [395]. • People in receipt of housing benefits have been shown to be twice as likely to have a common mental health condition as those not in receipt [32].
Inequity experienced in accessing services and support	• International evidence suggests that mental health stigma, lack of signposting and access to information, long waiting times and geographical inequalities in access (such as affordability of transport) contribute to inequalities experienced in accessing support and services [396].
Experiences of services and support	• International evidence highlights that the power and class dynamics between those living in poverty accessing services and those, often middle class, providing services can act as a barrier in understanding the practical realities of mental health concerns caused by or exacerbated by living in poverty [397]. • Trials integrating money advice in general practices within the most deprived areas of Glasgow showed benefits including improved mental health outcomes [398].
Data and evidence gaps	Key evidence gaps include: • More recent and updated evidence from Scotland about experiences of using mental health services for people living in poverty and in low-income and deprived areas.

	• Evidence relating to the current cost of living crisis and its impact on the mental health of people with protected characteristics.

Introduction

Estimates suggest that around one million people are living in poverty in Scotland. After housing costs, 21% of people in Scotland are living in relative poverty and 17% are living in absolute poverty [399]. Evidence shows that people living in poverty are disproportionately affected by poor mental health. Living with mental health needs can increase the risk of poverty and living in poverty can have a negative impact on mental health outcomes.

The current cost of living has had an impact on the number of people experiencing various types of poverty, including fuel poverty and food poverty. There are indications that this has caused and exacerbate existing mental health needs by causing stress and anxiety [400], particularly for people on low incomes. Based on a Royal College of Physicians survey in April/May of 2022, over half of the people surveyed in the UK said the crisis had a negative impact on their mental health [401]. Furthermore, 16% said that they had been told by a doctor or health professional in the past year that stress caused by rising living costs had worsened their health [401]. Data from ONS Opinions and Lifestyle Surveys in January 2023 in the UK indicated that around three-quarters (73%) of adults reported being very or somewhat worried about rising costs of living in the past two weeks [402].

Existing inequalities & mental health disparities

Existing mental health inequalities

There is a substantial body of literature evidence indicating that poverty and deprivation correlate with lower wellbeing and increased mental ill health.

Based on the 2019 SHeS, there continues to be clear differences in WEMWBS wellbeing mean scores by areas of deprivation [37], including:

- A linear decrease from a mean of 51.5 among adults in the least deprived quintile to a significantly lower mean of 46.9 in the most deprived quintile [37].
- Adults living in the most deprived quintile were more than twice as likely to report two or more symptoms of depression as those living in the least deprived quintile (21% compared to 8%) [37].
- The likelihood of reporting two or more symptoms of anxiety was 24% amongst those living in the most deprived areas compared to 11-14% for those living in other, less deprived areas [37].
- Adults living in the most deprived areas were around two to four times as likely as those living in less deprived areas to report having ever attempted suicide (15% compared with 4-8%) [37].
- Rates of self-reported self-harm also varied significantly with area deprivation, with the highest prevalence recorded among those living in the most deprived quintile (13% compared with 5-7% among those living in less deprived quintiles) [37].
- Those living in the most deprived areas were more likely than those in the least deprived areas to experience loneliness (17% of those living in the most deprived

quintile reported having felt lonely ''often/all of the time'' compared with 6% of those living in the least deprived quintile) [37].

ScotSID data over the period from 2011 to 2019 indicates that suicide deaths are approximately three times more likely among those living in the most deprived areas compared to those living in the least deprived areas [11].

There are also iinequalities in levels of mental wellbeing, where adults living in the most deprived areas of Scotland report lower levels of wellbeing than those in the least deprived [310].

Social determinants of mental health

The link between deprivation and poorer mental health is thought to result from the level, frequency and duration of stressful experiences people have and the extent to which social and individual resources, and sources of support reduce their impact [403]. These experiences include poverty, poor housing, family conflict, unemployment, childhood adversity and chronic health problems which all contribute to a greater risk of mental health concerns, particularly if several occur together and without protective factors, such as strong support networks, to offset their negative impacts [403].

Income and debt

Low and insecure income and problem debt (debt where people are unable to afford repayments) are associated with an increase in the risk of mental health conditions [390], [404]. Different types of intersecting poverty, including food and fuel poverty, as well as housing insecurity, can contribute to poor mental health through stress and anxiety [405]. In the 2014 APMS, people in receipt of housing benefits in England were more than twice as likely to have a common mental health condition as those not in receipt [32].

Academic evidence from the UK shows that the more debts people have, the more likely they are to have some form of mental disorder, even after adjustment for income and other sociodemographic variables [390]. The relationship between problem debt and mental health needs is likely to be two-way. Around one-quarter of people with mental health needs report being in serious debt [34]. Having mental health problems can also can affect someone’s ability to manage financial commitments and trigger problem debt, as well as affect their ability to regain financial control, thus contributing to a cycle of deprivation [390]. The Money and Mental Health Policy Institute highlight that, in the UK, people with mental health problems are three times more likely to be behind on at least one key payment (such as credit cards, rent or energy bills) compared to people without mental health problems [406]. They also note that people with mental health concerns are nearly three times more likely to have felt anxious, unable to cope or dread about receiving communications about overdue payments in the past three months, highlighting the day to day impacts of experiencing poverty and poor mental health [406].

Work and employment

Employment status is linked to mental health outcomes, with those who are unemployed or economically inactive having higher rates of common mental health conditions than those who are employed. The 2014 English APMS found a greater prevalence of common mental disorders amongst adults who are not in employment [330]. This has varying implications at different stages of life and with various intersecting characteristics. Of particular concern are young people with few qualifications who find it difficult to enter the labour market and those with mental health needs who are often excluded from the workforce [407]. Older adults who lose their jobs are less likely to find new ones, or ones at a similar level compared with other age groups [407], and may be more likely to be unemployed for a longer period of time [408]. It is important to support people to move into sustainable, secure, paid employment which lifts them out of poverty and protects their mental wellbeing.

While employment is generally seen to be beneficial for mental health, the mental health benefits of employment depend on the quality of work; work that is low-paid, insecure or poses health risks can be damaging to mental health [391]. For those in poor-quality employment, there are significant financial stresses, with 68% of children in Scotland in poverty living in working households [399]. In-work poverty particularly impacts women, young people and people from minority ethnic backgrounds across Scotland [399].

Adverse childhood experiences (ACEs) & trauma

Inequalities in mental health by deprivation emerge early in childhood and persist into adolescence and adulthood. At age 3, for example, 20% of children living in the most deprived areas display high levels of emotional and behavioural difficulties compared to just 7% of children in the most affluent areas [409]. Evidence indicates that 20% of adults living in the most deprived areas of Scotland have experienced four or more ACEs, such as abuse, neglect, community violence, homelessness or growing up in a household where adults are experiencing mental health issues or harmful alcohol or drug use, compared with 11% from the least deprived areas [392].

Analysis of data from ‘Growing Up in Scotland’, a longitudinal survey looking at the experiences of children and families, also finds significant associations between family poverty and higher ACE counts when children in the study cohort were eight years old. 24% of the children who lived in households below the poverty line had experienced three or more ACEs, compared with 5% of those with incomes above the threshold [410]. ACEs and trauma can have a significant negative experience on people’s lives [411], with those who have experienced four or more ACEs having a WEMWBS wellbeing mean score of 46.0 compared to 52.0 for the wider population [392]. A Welsh study found that those with four or more ACEs were six times more likely to have received treatment for mental illness than those with none [412].

Discrimination & stigma

Qualitative evidence highlights the impact of stigma and discrimination of poverty in Scotland and the implications for self-esteem, the internalisation of negative attitudes and emotional responses to stigma [393], [413]. The impacts of this have effects on people living in poverty in numerous ways, including through media representations of poverty; negative encounters with social security systems, which are perceived as being deliberately difficult and hostile to deter people from claiming benefits; and perceived public attitudes regarding poverty, including where poverty is attributed to laziness or a personal failing. Evidence from Age Scotland highlights evidence from their engagements that older adults, for instance, are regularly too embarrassed or too proud to claim the financial support they are entitled to, with feelings of shame associated to accessing social security or concerns they have “failed” in life [394].

Physical environments

Aspects of physical environments can have a negative effect on mental health. There is considerable evidence indicating linkages between poor quality housing and mental ill health [414]. Homes which are warm, dry and energy efficient contribute to better mental health, whereas cold, damp housing has been associated with poor physical health as well as poor mental health and wellbeing [395]. People who spend a high proportion of time at home, including older people, children, people who are disabled or have long-term conditions and people who are socially isolated can be disproportionately affected [395]. Unaffordable housing can also contribute to negative impacts on mental health through anxiety and stress related to rent or mortgage payments [414].

Environmental factors such as access to green space are also seen to have an impact on mental health. However, green space is unevenly distributed, with those living in areas of the greatest socioeconomic deprivation less likely to live within walking distance of green space and are less likely to be satisfied with that green space [415].

Homelessness

Research has established that the prevalence of mental health disorders, as well as drug and alcohol disorders, is markedly higher amongst homeless people than in the general population [416]. Analysis of health records data from over 1.3 million people living in Scotland during the period 2001 – 2016 has further shown that there is a considerably higher burden of mental ill health amongst those who have ever been homeless or at risk of homelessness, including a higher prevalence of comorbid drug and alcohol problems [417], [362]. For example, 6% of individuals who had ever been homeless showed evidence of experiencing a mental health, drug-related and alcohol-related condition over the study period – though not necessarily at the same time – compared to only 1% and 0.2% of those living in the most and least deprived areas of Scotland, respectively [362]. This figure rose to 16% among those who had experienced repeated homelessness [362].

Disability and physical health problems

There is a significant relationship between disability and poverty in Scotland. Families with at least one disabled member are more likely to live in poverty after housing costs, compared to families without a disabled person (31% compared to 19%) and 44% of disabled young adults (aged 16-24) are in poverty, along with 66% of single disabled people living alone [418]. This means that the impacts of poverty on mental health are likely to disproportionately impact disabled people [419].

People living in the most deprived areas of Scotland develop multi-morbidity 10 to 15 years earlier than those in more affluent areas which impacts their quality of life, social and psychological wellbeing [420] and makes their health problems more complex to diagnose and treat [421].

Minority ethnic communities

Experiences of poverty and deprivation intersect significantly with racial inequalities in Scotland and the wider UK. In Scotland between 2015-2020, people from non-white minority ethnic groups were more likely to be in relative poverty after housing costs compared to those from White-British and White-Other groups [399]. The poverty rate was 41% for the 'Asian or Asian British' ethnic groups (50,000 people each year), and 43% for 'Mixed, Black or Black British and Other' ethnic groups (no population estimate available due to the small sample). The poverty rate amongst the 'White - Other' group was 24% (80,000 people) and that of the 'White - British' group was 18% (860,000 people).

Minority ethnic people fare worse in the labour market than White counterparts in terms of pay, economic activity, in-work poverty and security of contracts, and are disproportionately represented in the private rented sector [422]. While there is a lack of evidence on the intersection of poverty, minority ethnic communities and mental health, this indicates a disproportionate impact of social determinants of mental health on minority ethnic groups.

Inequity experienced in accessing services and support

There is currently limited evidence in the differences in accessing services and support and mental health outcomes within low-income areas in Scotland and the UK, with a particular lack of qualitative research based on lived experiences. International evidence suggests that many of the wider barriers to accessing mental health services apply to people living on low incomes and are often exacerbated [396]. These include mental health stigma, lack of signposting and access to information, long waiting times and geographical inequality in access. People living on low incomes are less likely to be able to access private mental health services, due to the economic barriers these present [396].

Analysis of mental health prescribing and referrals to CAMHS in NHS Grampian between 2015 and 2021 found a clear social gradient in prescribing by home area socioeconomic deprivation [423]. Average annual rates of mental health prescription for children living in the most deprived 10% of neighbourhoods was double that of the least deprived (34 prescriptions per 100 children compared to 17 per 100 in the least deprived). The average annual proportion of mental health prescription in the most deprived 10% of neighbourhoods was 4% of the population, double the proportion in the least deprived decile at 2%. Likewise, rates of referrals to CAMHS were 1.9 times higher in the most deprived areas compared to the least deprived areas, with the most deprived areas seeing between 2 and 2.5 additional referrals per 100 children each year. The mean age at which children in the most deprived areas are first referred to specialist CAMHS services is over a year younger than the average in the least deprived areas (10 years and 5 months compared to 11 years and 8 months).

Based on engagement at the National Rural Mental Health Forum highlighted by Change Mental Health through the MHEHRF forum, some aspects of the cost of living crisis were highlighted as barriers to mental health services in rural areas. These particularly included worries over the cost of public transport links to get to in-person services, which echoes concerns over the affordability of transport becoming a barrier to access proper care to manage mental health conditions [115]. This potentially also has implications for those in urban areas, though to a lesser degree.

Experiences of services and support

While there is a lack of evidence relating to the Scottish and UK context, there is more international evidence about the experiences of low-income individuals accessing mental health support [424]. These frequently flag issues around class dynamics between low-income service users and often middle class counsellors and other mental health workforce members. This highlighted the power dynamics between different groups, as well as barriers to mutual understanding around the practical realities of mental health concerns caused by or exacerbated by living in poverty [397].

Service approaches

There is a potential role for poverty-aware practices within healthcare as a means to tackle both poverty and mental health [425]. The Glasgow Centre for Population Health highlight approaches to integrating money advice in general practice and trialled this in general practices working in the most deprived areas of Glasgow [398]. Benefits included improved mental health outcomes, which could be expanded to reduce mental health inequalities by boosting household incomes [398]. Other approaches to 'social prescribing' enable GPs, nurses and other health and care professionals to refer people to a range of local, non-clinical services which can support both mental health and poverty alleviation [426].

Impacts of the COVID-19 pandemic

While the mental health impacts of the pandemic were experienced by people across the socio-economic spectrum, there is evidence that they disproportionately impacted those living on low incomes [427]. Adults who have, or expect to, experience negative financial impacts from the pandemic experience higher levels of anxiety, lower levels of happiness and other negative mental health impacts [383]. Analysis of the Covid Mental Health Tracker found that those from 'lower' socio-economic groupings were consistently reporting higher rates of depressive symptoms and suicidal thoughts compared to those from other groups [170].

Evidence collected by the Poverty Alliance as part of the Get Heard Scotland programme highlights the views of community-based organisations who reported that they had witnessed a steep rise in the numbers of people they support experiencing mental health issues, with some reporting a rise in suicidal ideation among the people they work with, as well as a rise in alcohol and substance misuse [428]. The key drivers noted include worries about financial difficulties, increased cost of food and energy, extended waiting times for healthcare, the ongoing impact of social isolation and the additional stress on parents looking after children, including the pressures of online learning [428]. Organisations noted that even before the pandemic, mental health provision was difficult to access, with long waiting times and alternative private mental health services being unaffordable to those on low incomes [428]. Lone parents and carers were particularly impacted, made worse by having no access to day-care centres or respite care [428].

Income

The impact of reductions in income as a result of unemployment due to COVID-19 were significant and disproportionately felt by women (particularly those with children and who are lone parents), people from minority ethnic backgrounds and young people [429]. While support through furlough schemes cushioned against the initial economic shocks of the pandemic, it did not overcome the pressures that exist with a precarious financial position and low-paid people were still vulnerable to the same financial stresses and consequent risks to mental health as they were in work [429].

Based on evidence from Ipsos MORI surveys undertaken during the pandemic, those with lower incomes were more likely to have lost their jobs or been made redundant [376]. These people were more likely to be unable to work from home, which may have caused significant stress and anxiety [376]. Younger people, those on lower incomes or in deprived areas, those renting accommodation, and people with limiting conditions were all more likely than others to report difficulties accessing or paying for essentials, like fuel bills or food [376]. There were varied impacts of schemes such as the Government furlough scheme, where older workers were more than twice as likely to be on furlough [430].

Housing

Evidence shows that poor quality housing during the pandemic had a significant impact on wellbeing. Research from The Health Foundation in the UK highlights an existing correlation between overcrowding and psychological distress, which was exacerbated during the pandemic [431]. Between 2017/18 and April 2020, there was a bigger increase in the share of people indicating psychological distress for those living in overcrowded households (15% rise) than those living in non-overcrowded housing (9% rise) [431]. Poor mental health also seemed to have lasted longer for those in overcrowded households, with those living in overcrowded households remaining 6% above pre-pandemic levels of psychological distress in June 2020, compared to 4% of those living in non-overcrowded housing [431].

Digital access

As services increasingly shifted online, digital access became essential over the pandemic in accessing a range of services (including mental health support), this presented a barrier for many low-income households and individuals [428], [146]. Lack of money to buy or run digital devices or a lack of digital skills meant that many were excluded once services were moved online and with the closure of services like local libraries, which had previously provided many people with internet access [428]. Larger families are said to have especially struggled, with devices having to be shared between children in order to carry out schoolwork online [428].

Data and evidence gaps

Overall, there is a strong evidence base around the linkages between poverty, deprivation and socio-economic inequality and mental health, with consistent recording of data on deprivation. Key evidence gaps which remain include:

- More recent and updated evidence from Scotland or the UK about experiences of using mental health services for people living in poverty and in low-income and deprived areas
- Continued expansion of the evidence base on the current cost of living crisis and its impact on the mental health of people with protected characteristics

11. Geographical location

Key points

Existing mental health inequalities	- There are varied levels of wellbeing across Scotland, with a tendency for higher wellbeing and lower mental illness in more rural areas outside the Central Belt [310], [432]. - International evidence [433], including research conducted within the UK, suggests that mental health needs are more prevalent amongst people who live in urban areas, relative to rural populations [434].
Social determinants	- Social determinants influencing regional disparities in mental health and wellbeing include regional variations in poverty and deprivation, which is experienced differently in different areas, but tends to be more concentrated in urban areas [435]. - Higher rates of crime [436] and differences in physical environments – including access to green space and levels of noise and air pollution can have impacts on mental health in urban areas [437]. - Experiences of isolation and loneliness are seen to have impacts on mental health in remote and rural areas [115], particularly for certain communities, such as LGBTI+ people [192]
Inequity experienced in accessing services and support	- Accessibility of mental health services can be a challenge in rural areas, the 2017 Scottish Rural Mental Health Survey indicated that challenges with public transport were worsened for those self-reporting suicidal thoughts and feelings and self-harming behaviour, which could lead to a 'layering' of isolation factors [115]. - Stigmatising attitudes to mental health can act as a barrier to accessing support in some areas, with perceptions that close communities can also result in lack of privacy and confidentiality concerns for people experiencing mental health conditions [115].
Experiences of services and support	- Issues which already impact minority ethnic communities, like language barriers, can be worse in rural areas [246].
Data and evidence gaps	While there is a growing evidence base around mental health and mental health services in rural areas, the remaining evidence gaps include: - Lack of directly comparative evidence and analysis around rurality and mental health, including intersections with poverty and deprivation - Recent and updated evidence about mental health experiences in urban areas from the Scottish context.

	• Insight into regional variations in the experience of accessing and using mental health services and support.

Introduction

While much of Scotland's land is rural, the majority of people live in urban areas. Rural areas make up 98% of Scotland's land, with 17% of the population living there [438]. Health and wellbeing are influenced by a wide range of factors which differ across different regions and between rural and urban areas. These include population demographics, the availability of housing and employment, physical environments, social networks and levels of crime and safety. These factors are also experienced differently by people from different backgrounds and with various intersecting identities and characteristics. While there are challenges in making geographical generalisations around mental health due to the heterogeneity of people living in different areas, some broad trends can be observed. Along with the social determinants of mental health in different locations, there are also important variations in the support available and the barriers to accessing this.

The population of rural Scotland is growing at a faster rate than the rest of Scotland, driven by the increase in accessible rural areas, mainly due to inward migration. In recent years there has been an increased focus on mental health within rural areas of Scotland, as there are unique challenges in these areas which have previously been under-researched.

Existing inequalities and mental health disparities

Existing mental health inequalities

Evidence from SHeS over the period from 2016 to 2019 shows that the mean WEMWBS score indicating wellbeing was lowest for the health board areas of Lanarkshire (48.7) and Greater Glasgow and Clyde (49.2), compared to a Scottish overall mean score of 49.7. The highest mean scores were found in Western Isles (51.5), Shetland (51.1), Highland (50.7), Grampian (50.6) and Lothian (50.3) [37]. The percentage of those scoring 4 or more in the GHQ-12 questionnaire (indicative of a potential psychiatric disorder) was found to be significantly higher in the Greater Glasgow and Clyde health board area (20%) and significantly lower in Grampian (14%), compared to a Scottish average of 17% [37]. This demonstrates the varied levels of wellbeing across the country and the tendency for higher wellbeing and lower mental illness in more rural areas outside of the Central Belt.

International evidence, including research conducted within the UK, suggests that mental health needs are more prevalent amongst people who live in urban areas, relative to rural populations [433], [434]. In Scotland, prescription rates for psychiatric medications targeting depression, anxiety and depression have been found to be higher in Scotland’s urban areas relative to rural areas [439]. Levels of mental wellbeing have also been found to be higher among rural populations in Scotland than in urban populations [440].

Rates of suicide also vary across geographical regions. Based on analysis of ScotSID data, suicide rates are around 12.8 per 100,000 population in areas categorised as accessible rural areas compared to 19.7 per 100,000 in very remote small towns [11]. Lower rates of suicide are seen in accessible rural areas and remote small towns, with higher rates in large and urban areas, as with very remote small towns [11], [441]. However, there is a risk of over-interpreting these urban/rural differences, given the overlapping confidence intervals between the different area types [441].

Social determinants of mental health

Poverty & deprivation

The negative impact of poverty and deprivation on wellbeing and mental health is well established. Reasons for this include financial stress associated with low income and debt, higher levels of unemployment and poor-quality employment, discrimination and stigma and higher risks of adverse childhood experiences found in the most deprived areas (see poverty and low income section).

While pockets of deprivation exist across Scotland, deprivation is experienced differently in rural and urban settings and is more concentrated around urban areas [435]. Approximately 1.95 million people in urban areas live in the 20% of most deprived areas, with 810,000 in income poverty. In rural areas, approximately 30,000 people living in rural areas live in the most deprived parts of Scotland, and around 15,000 people live in income poverty [442], [399].

It should be acknowledged, however, that the Index of Multiple Deprivation used to locate disadvantaged communities has limitations in its ability to identify all those living in deprivation [432]. In addition to deprivation seen in towns and cities, there is also significant deprivation in rural and remote Scotland, with additional barriers around access to employment opportunities, with fewer large employers than in urban areas, which presents a barrier to social and economic participation [443]. This has been highlighted as being particularly impactful for equality groups, including disabled people and minority ethnic people [443].

Crime

There is international evidence which links negative mental health to high crime rates, which tend to be higher in non-rural and particularly deprived areas [444]. This is caused by the heightened risk of personal victimisation and witnessing crime and the stress and fear of crime. There is evidence in Scotland and across the UK that urban areas tend to have higher levels of crime and violence and have been associated with aggregations of both psychiatric and physical health conditions [436]. A study based on the Scottish Longitudinal Study showed that an increase in crime was possibly associated with self-reported mental illness and antidepressant prescriptions [436].

Physical environments

International evidence indicates that physical environments impact mental health and that living in urban areas can cause an increase in rates of mental ill health, due to a range of factors which include reduced access to green space and high levels of noise and air pollution [437]. These factors vary widely in different areas of Scotland and while many urban areas have good access to green space, there are potential environmental factors in urban areas which could influence mental health. However, it should be noted that just because someone has access to green space, does not equate them to having good mental health [437].

Isolation

Findings from the 2017 Scottish Rural Mental Health Survey highlight the potential role of isolation and loneliness in remote areas on mental health [115]. The report also describes the close sense of community and support for some, but respondents noted difficulties accessing public transport to be able to socialise, as well as challenges in meeting new friends and support networks [115]. People with poorer mental health found that transport was more of an issue than those with less severe mental health conditions [115].

Occupations

Research from both NHS Grampian and Scotland’s Rural College (SRUC) highlights the disproportionately higher rates of depression amongst agricultural communities, with suicide rates amongst farmers among the highest of any occupational group [445], [446]. Four out of five farmers in Scotland under the age of 40 consider mental health to be the biggest problem facing the agricultural community [447]. Mental health issues within farming are thought to be caused by a number of factors which can be hazardous to mental health, including social isolation and loneliness, long hours and poor worklife balance, stress associated with farm management and external pressures and uncertainty and financial stress, with variable incomes due to circumstances outside of their control [447]. Depression in farmers increases with age and is more associated with men, who may also be less likely to reach out for mental health support [447].

LGBTI+ people

While overall wellbeing is often better in rural areas, for some groups, there are additional stressors which can impact mental health. The ‘Further Out: the Scottish LGBT Rural Equality’ report, by the Equality Network and Change Mental Health, highlights some of the key challenges for LGBTI+ people living in rural areas of Scotland which have an impact on their mental health [192]. These include factors such as: perceived socially conservative communities and experiences of prejudice, combined with more traditional gender roles and misogyny; lack of anonymity within close-knit communities and pressure to suppress one’s ‘true self’; lack of visibility, representation and positive role models; lack of LGBTI+ awareness; and isolation [192].

From the survey included in the ‘Further Out: the Scottish LGBT Rual Equality’ report, 62% of LGBTI+ respondents felt that people living outside of Scotland’s cities face more inequality than those living in them. Of respondents, 70% felt that more needed to be done to tackle inequality experienced by LGBTI+ people living outside of Scotland’s cities [192]. The report also highlighted a lack of safe spaces and lack of access to explicitly LGBTI+ or LGBTI+-friendly services. 66% of respondents believed that social provision (such as pubs and social spaces) in rural areas, which tend to have a positive impact on the mental wellbeing and levels of isolation experienced by LGBTI+ people, did not meet the needs of LGBTI+ [192].

Inequity experienced in accessing services and support

Accessibility

While there is evidence of better overall mental health in rural areas, there are specific challenges in addressing the mental health issues which exist in rural areas, particularly in terms of barriers to accessing services and adapting specific approaches to rural contexts.

Evidence highlights the barriers to accessing mental health services and support in rural areas of Scotland. These include reduced access to GP surgeries and other healthcare facilities (including mental health services), as well as other key services such as shops, post offices, cash machines and banking services, due to travel distances and costs [115]. A lack of access to public transport is also a factor in rural areas [115]. These challenges also have the potential to exacerbate feelings of isolation, particularly for older adults and disabled people. The 2017 Scottish Rural Mental Health Survey indicated that the challenges with public transport were worsened for those self-reporting suicidal thoughts and feelings and self-harming behaviour, which could lead to a ‘layering’ of isolation factors [115].

Stigma

Mental health stigma in rural Scotland was a theme in the Scottish Rural Mental Health Survey [115]. Survey respondents highlighted that while communities can help people stay well, there are also stigmatising attitudes to mental health which can harm people [115]. Respondents also shared perceptions that in close communities there can be a lack of privacy and confidentiality and a level of judgement from the surrounding community, which can be a barrier to seeking support and accessing help [115]. The survey findings indicated that those with lived experience of poor mental health often wished to be supported pre-crisis in a non-clinical setting in their community, such as a workplace or interest group, which may help to address stigma [115].

Experiences of services and support

While there is little evidence of perceptions of mental health services that are specific to certain geographical areas, reduced availability of services and adaptation to support specific equalities groups has been highlighted elsewhere in the report. This includes language barriers affecting some minority ethnic people, which are especially difficult in rural and remote areas of Scotland [246]. There is also regional variation of CAMHS and perinatal mental health services [79], [218].

Impacts of COVID-19 pandemic

There is evidence from over the course of the pandemic that mental health and access to services varied by geographic region and across rural and urban areas. A study based on the Ipsos Mori COVID-19 Health & Adherence Research in Scotland (CHARIS) survey indicated that people living in urban areas had worse psychological distress compared to people living in rural areas, but that this varied by mental health condition [376].

Urban experiences during the pandemic

The wellbeing of people living in urban areas during the pandemic, and particularly during lockdowns, was influenced by urban environments, including access to outdoor green space and overcrowding in houses. Studies have shown that mental health was worse during the pandemic for people in overcrowded housing (based on the number of rooms versus number of people) [431]. Based on evidence from Shelter Scotland, households who lived in rural areas had below average national overcrowding rates [448].

Analysis by ONS suggests that 13% of households in Scotland have no access to a private or shared garden, exaggerating some of the inequalities in access to outdoor space, which was more likely in urban areas [449]. Through lockdowns, parks and greenspaces were particularly valuable but less likely to be available in deprived areas [450].

Marginalised communities in rural areas

The 2021 National Rural Mental Health Forum and Change Mental Health ‘Marginalised rural communities report’ focuses specifically on the mental health of people from marginalised communities (particularly LGBTI+ people, young carers and refugees and asylum seekers) living in rural Scotland. It highlights that 93% of respondents believe that the pandemic had an impact on their mental health and wellbeing [158]. Among the key issues are the loss of face-to-face contact and lack of access to local support. Long-standing challenges experienced by marginalised communities, including lack of digital connectivity, transport and isolation have worsened during the pandemic [451].

Rural infrastructure

Organisations in the MHEHRF highlighted digital connectivity as an issue for some people living in rural areas during the pandemic, as services and opportunities to stay connected moved online. While for some the shift online reduced or negated long travel times, many felt excluded from online activities due to their lack of connectivity, citing poor infrastructure and high cost barriers. In particular, internet speeds in rural areas are insufficientto use video calling applications [451].

Isolation and community

The National Rural Mental Health Forum and Change Mental Health report also said that while respondents generally considered living in rural areas a benefit during the pandemic, with a chance to connect with nature, people felt cut off from their nearby communities [158]. It also reported people experiencing nervousness in re-joining their communities after restrictions were eased and the loss of community social spaces, including churches, local befriending groups and council-organised activities, was a common theme [158].

Access to services

Disruption to services including GPs, community and specialist services, had specific geographical implications, where there was reported inconsistency in how delivery took place. This was highlighted in rural areas in the MHEHRF.

Conversely, however, as mental health services were moved online, this offered the potential to be more inclusive for people living in rural or remote areas, at least in places with reliable digital connectivity [450]. Particularly for those who are unable or prefer not to travel long distances, this could have a positive impact on the delivery of mental health services, though this is type of service likely not to be preferred by everyone [450].

Data and evidence gaps

While there is a growing evidence base around mental health and mental health services in rural and urban areas, remaining evidence gaps include:

- Lack of directly comparative evidence and analysis around rurality and mental health, including intersections with poverty and deprivation
- Recent and updated evidence about mental health experiences in urban areas from the Scottish context.
- Insight into regional variations in the experience of accessing and using mental health services and support.

12. Carers

Key points

Existing mental health inequalities	- While caring can be a fulfilling experience, carers widely report stress, anxiety and depression driven by the pressures of their caring role [452]. This is particularly the case for carers providing more than 35 hours of care a week [453]. - Carers Scotland found that nearly two-thirds of carers report not getting enough sleep [452].
Social determinants	- In the UK, an estimated 44% of working age adults who provide unpaid care for more than 35 hours a week are in poverty [454]. - Carers report having breaks from caring as being important to their wellbeing. However, for many this is not possible, survey results showed that more than 50% of those who were struggling financially had not had a break in the previous 12 months and 43% of older carers had not had breaks in the previous 12 months [452].
Inequity experienced in accessing services and support	- There is evidence that carers may be less able to look after their own health to ensure the wellbeing of the cared for person, with some carers treating their own health as secondary to that of the care recipients [453]. - Research also highlights challenges for carers in accessing primary and community health care generally, including issues such as long waiting times for referrals and a lack of flexibility in accessing appointments and services [452]. - Research also highlights lack of signposting for mental health and support services specifically catering to carers, making services difficult to navigate [168].
Experiences of services and support	- The State of Care Scotland report also highlighted negative experiences of accessing support through Adult Carer Support Plans and Young Carer Statements, where 58% of respondents said that their assessment for the support plan did not consider their health and wellbeing properly or at all [452].
Data and evidence gaps	Key evidence gaps which exist include understanding carers' experiences of accessing and using services and support.

Introduction

There are estimated to be between 700,000 and 800,000 carers in Scotland, including around 30,000 young carers [455]. An estimated 171,000 carers aged 16+ provide care for 35 hours a week or more [453]. Analysis of the 2016-2019 Scottish Health Survey showed that for people aged 16 and over, 17% of women and 12% of men are carers [455].

People are more likely to be providing unpaid care in their later working years, particularly women [456]. In 2016-2019, 26% of women aged 45-54 and 23% aged 55-64 provided unpaid care [455].

There are intersectional factors which influence who is most likely to be a carer and which shape their wider experiences, as well as having a potential impact on their mental health. Overall, 59% of carers are women, with the most common age group being 55-64, with working age women being much more likely to be carers than men [453]. Carers UK found that minority ethnic carers were less likely to receive financial and practical support, thought to be through lack of culturally appropriate information and lack of engagement [457]. Carers are also significantly more likely than non-carers to have a long term condition, disability or illness [458].

Caring is not a one-dimensional experience, and can have both positive and negative aspects simultaneously [459]. While caring can be a positive and rewarding experience and have a positive impact on wellbeing, there is also evidence that caring is associated with poor psychological wellbeing and physical health [453]. Factors which influence this include the stresses related to caring, isolation and lack of social support, which was particularly prominent during the pandemic, and an increased likelihood of living in poverty or deprivation. Research highlights the importance of breaks from caring and access to tailored support as being critical to carer wellbeing.

Existing inequalities and mental health disparities

Existing mental health inequalities

Research finds there are some mental health and wellbeing related benefits to caring, including stronger relationships and increased resilience [453]. However, unpaid caring can be a significant predictor of poor mental wellbeing and the presence of possible psychiatric disorders, particularly when caring for a high number of hours per week.

Analysis of previous years' SHeS results undertaken in 2015 showed that, when controlled for age, among carers who provide support for more than 35 hours per week, WEMWBS scores (46.4) were considerably lower than among non-carers (49.9) [453]. However, carers who provide a small amount of care, in particular those who provide up to 4 hours per week, showed a higher mean WEMWBS score (51.5) than non-carers, indicating a higher level of mental wellbeing [453]. Carers who provide more than 35 hours per week (35%) were significantly more likely to exhibit signs of the presence of a possible psychiatric disorder than non-carers (15%), carers who provide 0-4 hours (10%) or carers who provide 5-34 hours (17%) of care per week [453]. The difference in the proportion exhibiting signs of the presence of a possible psychiatric disorder, comparing carers providing up to 4 hours per week compared to non-carers, was statistically significant. Women who carry out 35 or more hours of unpaid care were significantly more likely to have a low WEMWBS score compared to those who did not provide unpaid care, though there were no significant differences for men who were carers [453].

Other sources also highlight the large proportion of carers reporting mental health concerns. Survey research undertaken by Carers Scotland found that 27% of respondents reported bad or very bad mental health [452]. This rose to 31% among those caring for 35 hours or more and amongst those who have been carers for 10 or more years [452]. Over a quarter (26%) of respondents to the survey said they often or always felt lonely, and a further 47% said they felt lonely sometimes [452].

Young carers have also been found to report higher levels of behavioural and emotional difficulties [460], [461], and lower levels of wellbeing, than their peers who do not provide care [461]. The SALSUS survey in Scottish schools found that pupils who were young carers were considerably more likely to have a borderline or abnormal SDQ score and lower WEMWBS wellbeing scores than pupils without caregiving responsibilities [461].

A survey of older adult unpaid carers undertaken by Carers Trust Scotland found that 87% of respondents said that their mental halth and wellbeing had been affected by their caring role [65]. Analysis indicated that the likelihood of experiencing a negative impact on mental health due to the caring role may increase with age, with those of 80 reporting the highest levels of having been greatly affected [65].

Social determinants of mental health

Stresses related to caring

Carer Scotland research showed that carers widely report the stress, anxiety and depression driven by pressures of their caring role [452]. Respondents to their research highlighted the lack of ability to benefit from leisure activities which might support their mental health, as well as lack of time to see family and friends. Many carers report difficulty maintaining regular and adequate sleep schedules. The survey found that nearly two-thirds were worried about not getting enough sleep [452].

For carers who are also working, there are particular challenges of juggling work and care, with respondents to the Carers Scotland research citing worry and tiredness at work because of their caring responsibilities [452]. Carers said that they were feeling increasingly burnt out and struggling with their mental wellbeing [452].

Need for respite

Research highlights the importance of breaks from caring, with the Carers Scotland survey highlighting that both mental health and physical health were improved amongst carers who had had a break from caring within the last 12 months [452]. Respondents report the ability to recharge their batteries and do things for themselves. However, for many this had not been possible. More than 50% of those who were struggling financially had not had a break in the previous 12 months and 43% of older carers had not had breaks in the previous 12 months [452].

Poverty and deprivation

Carers Scotland report, ‘State of Caring in Scotland 2022’ highlights the financial impact of caring, particularly during the cost of living crisis, noting that unpaid carers are one of the groups hardest hit [452]. Evidence from the Joseph Rowntree Foundation estimates that in the UK, 44% of working age adults who provide unpaid care for more than 35 hours a week are in poverty [454]. As well as higher essential costs because of their caring role (including costs to power essential equipment, heat homes well enough for those they care for, and additional transportation costs), cares often have to give up paid work or reduce their working hours to provide care [452]. Around one quarter (26%) of respondents to the ‘State of Caring’ report said that they were struggling to make ends meet, with nearly two thirds (64%) saying that cost of living worries were having a negative impact on their health [452]. Of those struggling financially, 48% reported their mental health as being bad or very bad [452]. Respondents described the inescapable stress, anxiety fear and feelings of hopelessness around their financial situation.

Inequity experienced in accessing services and support

There is limited research to understand experiences of accessing of services and support for carers themselves, with more evidence focusing on the experiences of carers in accessing mental health services for those that they care for [168]. However, research by VOCAL and Thrive Edinbrugh highlights lack of signposting for mental health and support services specifically catering to carers, with respondents saying that many find systems difficult to navigate, and would appreciate opportunities for referral to such services [168]. Respondents also highlighted the challenges in being taken seriously by healthcare professionals, and the subsequent lack of referrals to tailored support services [168].

There is also evidence that carers may be less able to look after their own health to ensure the wellbeing of the cared for person, with some carers treating their own health as secondary to that of the care recipients [453]. Research from Carers Scotland also highlights the challenges for carers in accessing primary and community health care generally, including issues such as long waiting times for referrals and a lack of flexibility in accessing appointments and services [452]. This is compounded by the stress and anxieties of being unable to provide adequate care for those being cared for due to being unable to access services and care themselves.

Experiences of services and support

There is a lack of research into carers’ experiences of using mental health services, where, again, research primarily focuses on carers’ experiences of using mental services with or on behalf of those they care for. Research does highlight the often detrimental impact of these processes on the mental health of carers, particularly in terms of the lack of involvement and support for carers, and the feelings of frustration and isolation [168].

The ‘State of Caring in Scotland’ report also highlighted negative experiences of accessing support through Adult Carer Support Plans and Young Carer Statements, where 58% of respondents said that their assessment for the support plan did not consider their health and wellbeing properly or at all [452].

Impacts of COVID-19 pandemic

The mental health impacts of the pandemic and pandemic measures on carers, and especially young carers, has been widely highlighted. Unpaid carers reported many of the practical and emotional challenges to providing care during lockdown, and considerable distress that often accompanied these [180]. A survey by Carers Trust Scotland indicated that 50% of unpaid carers surveyed described their mental health as “worse than before the pandemic”, and 34% described it as “much worse than before the pandemic”, with many experiencing more stress and loneliness [379].

Pandemic risks

Fear of COVID-19 was and still is heightened for those with long-term health conditions and for those caring for them. Both during lockdowns and since restrictions have been eased, carers are continuing to practice prevention measures, such as limiting social contact with family and friends, which has a long term impact on mental wellbeing [178].

Disruption to support services

Research undertaken by ALLIANCE with young disabled people, and their parents and carers highlighted the stresses of navigating health and social care systems to access services and support for disabled young people and those with complex needs [180]. This was made particularly challenging with the widespread disruption during the pandemic, and had a negative impact on the wellbeing of those with caring responsibilities. The lack of access to day care services and respite have been highlighted by numerous sources as a factor which impacted carer wellbeing, reducing the ability for carers to take breaks which are essential to their wellbeing [180].

Data and evidence gaps

It is difficult to identify people who are carers, because they may not self-identify as a carer, “caring” may not be seen as a distinct role (especially for women) or because caring often commences at a low level and includes invisible tasks such as emotional support which are less recognised as caring tasks. These means the current data collected is not necessarily representative of everyone who has caring responsibilities.

Key evidence gaps which exist include understanding carers’ experiences of accessing and using services and support.

Appendix A- Membership list of Mental Health Equalities and Human Rights Forum

Age Scotland
Scottish Youth Parliament
Inclusion Scotland
Glasgow Disability Alliance
Equality Network
LGBT Health and Wellbeing
BEMIS
Intercultural Youth Scotland
Scottish Refugee Council
Engender
Scottish Women’s Convention
Poverty Alliance
National Rural Mental Health Forum
Scottish Human Rights Commission
VOX
Change Mental Health
Mental Health Foundation
See me Scotland
Samaritans
Alliance Scotland
NRS Scotland
COSLA

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