Engender response to the Scottish Government consultation on a new Mental Health and Wellbeing strategy

September 2022

1. INTRODUCTION

Women and men experience mental health in vastly different ways. Women and girls are diagnosed with depression and anxiety disorders in greater numbers, and experience difference in diagnosis and treatment, and access to health and support services. The experiences and specialist needs of minoritised groups of women, including Black and minority ethnic women (BME), disabled women, LGBT women and victim-survivors of violence against women are distinct, but are underexplored and understood. Scottish public services are not equipped to meet the mental health needs of women and girls.

Evidence also shows that poor mental health is on the rise among women and girls, and that this trend precedes the pandemic.[1] Depression and anxiety in women is significantly higher among the hundreds of thousands of women who hold caring roles in Scotland, young women, lone parents, low-income women, LGBT women, victim-survivors of gender-based violence, and women in the criminal justice system. Though data is lacking for BME and disabled women at Scottish level, there is evidence that Black women experience 'common mental disorders' at higher rates than white women elsewhere in the UK,[2] and non-disaggregated statistics indicating poorer mental health for disabled people suggest that disabled women experience worse outcomes than non-disabled women. Both anxiety disorders and depression are likely to be exacerbated by uncertainty, fear and long periods of isolation, which continue to be experienced by women and girls throughout the country. The impacts of the Covid-19 pandemic on mental health, were and are experienced disproportionately by women, with particularly acute impacts experienced by disabled and

[1] UK Government and Agenda (2018) The Women's Mental Health Taskforce: Final report. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf

[2] NHS Digital (2014) Adult psychiatric morbidity study: Available at: https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf

young women.[3] As a significant majority of frontline key workers, women providing care in home and clinical settings have been exposed to trauma and the risk of reduced mental health and wellbeing during the height of the crisis and beyond.

This is now compounded by the cost of living crisis. Women's mental health is and will be disproportionately impacted, as a result of economic insecurity, constrained opportunities and choices, and reduced autonomy in relation to domestic abuse and coercive control.[4] Within this, Black women and women from certain ethnic minority communities, disabled women, lone parents, unpaid carers and women with insecure immigration status are particularly disadvantaged.[5] This is the result of existing economic inequality that repeatedly sees women, and especially minoritised groups of women, at the sharp end of economic and other crises. It is likely that young women, older women, trans women and others facing multiple forms of discrimination will also experience disproportionate impacts of spiralling inflation, due to existing economic and social marginalisation.

Engender welcomes this opportunity to comment on the revised Mental Health and Wellbeing Strategy for Scotland. This response draws on previous research, including a roundtable focussed on women's equality and mental health, a NACWG[6] Circle event co-hosted with The ALLIANCE and See Me, engagement with development of the current mental health strategy and the mental health transition and recovery plan, membership of Scottish Government's mental health equalities forum, and our 'Women and Covid-19' project which gathered women's experiences of the pandemic.

However, the evidence that we reference should not be considered as a comprehensive or detailed assessment of issues relating to gender and mental health. Nor does it reflect the full picture of women's mental health in Scotland in 2022, in part because of evidence gaps at Scottish level - particularly with regard to intersectionality - and a lack of gender-sensitive data. Engender is not an expert in mental health by any means and we have not undertaken the systematic and detailed work necessary to provide the information that Scottish Government needs to develop an adequate Mental Health and Wellbeing Strategy that meets women's needs.

The current Mental Health Strategy is virtually gender-blind and demonstrates no understanding that inequality and violence contribute to poor mental wellbeing by constraining opportunities, restricting financial resources, diminishing the importance of

[3] Engender (2021) Joint briefing on the impact of Covid-19 on women's wellbeing, mental health, and financial security. Available at: https://www.closethegap.org.uk/content/resources/Close-the-Gap-and-Engender-Joint-briefing-on-the-impact-of-COVID-19-on-womens-wellbeing-mental-health-and-financial-security.pdf

[4] Engender (2022) Parliamentary briefing: the cost of living crisis. Available at: https://www.engender.org.uk/content/publications/Engender-briefing-cost-of-living-crisis.pdf

[5] Women's Budget Group (2022) The gendered impact of the cost of living crisis. Available at: https://wbg.org.uk/wp-content/uploads/2022/03/The-gendered-impact-of-the-cost-of-living-crisis.pdf.

[6] The First Minister's National Advisory Council for Women and Girls

women's social roles and leaving them responsible for unpaid care.[7] Nor does it identify women's highly gendered experiences of mental health and wellbeing or address women's needs. Despite progress within the Mental Health Transition and Recovery Plan,[8] we remain concerned by a persistent lack of rigorous gender analysis within Scottish Government's mental health policy development and by the lack of quality gender-sensitive sex-disaggregated data gathered on mental health in Scotland. We urge Scottish Government to ensure that the process of developing the new Strategy mainstreams gender, gender equality and intersectionality throughout, and robustly considers the mental health needs of women and girls by gathering evidence in a systematic and participatory way.

BACKGROUND

Women and men experience poor mental health or wellbeing at broadly similar rates but in very different ways,[9] and poor mental health for women and girls is on the rise. However, the experience and presentation of mental health conditions are highly gendered. Research from England suggests that women are more likely to have a common mental disorder than men,[10] with around one in five women in the UK affected.[11] Data shows that women are twice as likely to be affected by "depressive disorders" and men by "behavioural disorders" and substance abuse.[12] Twice as many women are diagnosed with anxiety disorders.[13] Yet, the latest Scottish Health Survey found little difference in rates of self-reported symptoms of depression between men and women,[14] and an 8% gender difference in terms of self-reported anxiety. This may point to gendered norms around seeking help and sexist biases in diagnosis.

Depression and anxiety in women is significantly increased amongst those with caring roles,[15] including unpaid carers and single parents, and those in the criminal justice system. Young women are noted as a key risk group in international and UK research, experiencing

[7] Scottish Government (2020) Mental Health Strategy 2017-2027. Available at: https://www.gov.scot/publications/mental-health-strategy-2017-2027/
[8] Scottish Government (2020) Mental Health – Scotland's Transition and Recovery. Available at: https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/
[9] Mind 'Mental health facts and statistics.' Available at: https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/
[10] NHS Digital (2014) Mental Health and Wellbeing in England Adult Psychiatric Morbidity Survey 2014. Available at:https://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf/
[11] The Mental Health Foundation 'Women and Mental Health.' Available at: https://www.mentalhealth.org.uk/a-to-z/w/women-andmental-health
[12] WHO (2001) The World Health Report 2001. Available at https://www.who.int/whr/2001/en/whr01_en.pdf
[13] Mental Health Foundation 'Mental health statistics: anxiety'. Available at: https://www.mentalhealth.org.uk/explore-mental-health/mental-health-statistics/anxiety-statistics
[14] Scottish Government (2020) Scottish Health Survey 2019 - volume 1: main report. Available at: https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/
[15] Carers Scotland (2022) State of Caring 2021 in Scotland. Available at: https://www.carersuk.org/about-us/36-for-professionals/policy-eng/report/6958-state-of-caring-2021-report?gclid=EAIaIQobChMIja3Usu6v-gIVhLHtCh3iXwtwEAAYASAAEgLWkPD_BwE

high rates of eating disorders, self-harm, depression and anxiety compared to other groups. There are high correlations between various forms of gender-based violence and poor mental health outcomes. Women experiencing domestic abuse are more likely to experience poor mental health, while women with mental health issues are also more likely to experience domestic abuse.

Gendered norms, inequalities and discrimination also impact the extent to which people seek and access support, as well as the treatment and diagnoses they receive. For instance, women are more likely to have physical symptoms misdiagnosed as mental health conditions, delaying much-needed treatment and care, and building mistrust in medical professionals.

Statistics relevant to a gender analysis of mental health and wellbeing include:

- Women are about twice as likely as men to develop depression during their lifetime[16] and to be diagnosed with anxiety disorders.[17]
- Unipolar depression, predicted to be the second leading cause of global disability by 2020, is twice as common in women.[18]
- Women are around 60% of those with phobias or obsessive compulsive disorder. Phobias affect about 22 in 1,000 women in the UK, compared with 13 in 1,000 men.[19]
- One in five (19.1%) women experience Common Mental Disorder symptoms, compared with one in eight men (12.2%) [20]
- Women report higher rates of work-related stress than men.[21] Women are the majority of frontline key workers that have been exposed to trauma and risk of depression and reduced wellbeing throughout the pandemic.
- Eating disorders are gendered. Women are ten times more likely to experience anorexia and around 8% of women have bulimia at some stage in their life.[22]

[16] C. Kuehner (2016) Why is depression more common among women than among men? Available at <https://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(16)30263-2.pdf>
[17] Mental Health Foundation 'Mental health statistics: anxiety'. Available at: https://www.mentalhealth.org.uk/explore-mental-health/mental-health-statistics/anxiety-statistics
[18] WHO 'Gender and women's mental health' Available at: https://www.who.int/teams/mental-health-and-substance-use/gender-and-women-s-mental-health
[19] Recovery in Mental Health 'Mental Health Statistics: Men and Women'. Available at: https://ramh.org/guide/women-mental-health/
[20] Mental Health Foundation. 'Mental health statistics: men and women.' Available at: https://www.mentalhealth.org.uk/statistics/mental-health-statistics-men-and-women
[21] Health and Safety Executive (2020) Work-related stress, anxiety or depression statistics in Great Britain, 2020. Available at: https://www.hse.gov.uk/statistics/causdis/stress.pdf
[22] Anorexia and Bulimia Care 'Statistics.' Available at: https://www.anorexiabulimiacare.org.uk/about/statistics

- More women are affected by PTSD than men. The risk of developing PTSD after any traumatic event is 20.4% for women and 8.1% for men.[23]
- The experience of gender-based violence, including domestic abuse, sexual violence and FGM, is highly correlated with depression, anxiety and PTSD.
- One study found reported lifetime prevalence of severe domestic violence among psychiatric in-patients ranged from 30% to 60%.[24]
- Women are more likely to self-harm than men across all age groups. This gender gap is most pronounced for young people; 22% of young women report self-harming.[25]
- Young women in Scotland experience anxiety at twice the rate of young men (54% vs. 27%) and depression at almost twice the rate (32% vs 17%). Young women score significantly higher than women in all other age groups for both conditions.
- Young women also experience high rates of post-traumatic stress disorder and bipolar disorders.[26]
- Girls aged 11 are 30% more likely to experience poor mental health than boys, with girls of 18 more 50% as likely to be affected. The pandemic has seen a huge increase in internalised control in girls.[27]
- FGM, forced marriage and honour-based violence affects the mental health and wellbeing of women in certain BME communities, and especially young women.[28]
- Black women are more likely than white women to experience common mental health disorders.[29]

[23] Recovery Across Mental Health 'Gender differences in Mental Health'. Available at: https://ramh.org/guide/gender-differences-in-mental-health/
[24] Howard et al (2010) Domestic violence and severe psychiatric disorders: prevalence and interventions. Available at: https://pubmed.ncbi.nlm.nih.gov/19891808/
[25] SPiCE (2022) Mental health of young adults (18-24) in Scotland. Available at: https://spice-spotlight.scot/2022/06/10/mental-health-of-young-adults-18-24-in-scotland/#:~:text=The%20mental%20health%20of%20Scotland's%20young%20adults&text=In%202019%2C%2023%25%20of%2016,high%20scores%20of%20young%20women.
[26] BBC (2016) 'Young women at 'highest mental health risk''. Available at: https://www.bbc.co.uk/news/entertainment-arts-37504679
[27] Steer Education (2022) Young people's health in the UK: How the pandemic has affected young people's ability to self-regulate socially and emotionally. Available at: https://steer.education/wp-content/uploads/2022/02/Young-Peoples-Mental-Health-in-the-UK-STEER-Report-Feb-2022.pdf
[28] Adzajlic (2022) Mental health and wellbeing of black and minority ethnic children and young People in Glasgow. Available at: https://www.stor.scot.nhs.uk/bitstream/handle/11289/580329/Mental%20health%20and%20wellbeing%20black%20and%20minority%20ethnic.pdf?sequence=1&isAllowed=y
[29] This data refers to England, there is an evidence gap regarding BME women's mental health in Scotland. NHS Digital (2014) Adult psychiatric morbidity study: Available at: https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf

- Women from Black and Asian communities are less likely to receive treatment.[30] Black women are half as likely as white women to seek care.[31]
- LGBT women are at high risk of poor mental health. 61% of bisexual women, 59% of trans women and 40% of lesbian women report depression, anxiety or stress.[32]
- Disabled people in Scotland have poorer mental health than non-disabled people,[33] but evidence is lacking for disabled women and existing data is not gender-sensitive.
- An estimated 40% of older people living in care homes experience depression. The majority of this cohort are women. Those over 85 are at particular risk.[34]
- It is very common for people with dementia to develop depression, and it can be hard to diagnose.[35] Women are two thirds of those with dementia in the UK.
- Research shows 61% of female prisoners have anxiety and 65% depression (vs. 33% and 37% of men). 44% of women on remand have attempted suicide at some point[36]
- The suicide rate is higher for men than for women. Attempted suicide (parasuicide) is commonly higher for women than for men. Little examination of the parasuicide rate has been undertaken.[37]

Mental health issues and women's reproductive health

An estimated 1 in 4 women experience mental health problems during pregnancy, with depression and anxiety the most commonly reported disorders.[38] Post-natal depression is

[30] ibid
[31] Richards (2021) The State of Mental Health of Black Women: Clinical Considerations. Available at: https://www.psychiatrictimes.com/view/the-state-of-mental-health-of-black-women-clinical-considerations
[32] By comparison, 30% of women in the latest Scottish Health Survey report symptoms of anxiety, and 22% symptoms of depression. Leven (2022) Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people. Available at: https://www.stor.scot.nhs.uk/bitstream/handle/11289/580332/Final%20Report%20%2831%20May%202022%29.pdf?sequence=1&isAllowed=y
[33] Scottish Government (2019) Analysis of the National Performance Framework (NPF) outcome indicators from the perspective of disability. Available at: https://www.gov.scot/publications/scotlands-wellbeing-measuring-national-outcomes-disabled-people/pages/10/
[34] Recovery Across Mental Health. 'Gender differences in Mental Health.' Available at https://ramh.org/guide/gender-differences-in-mental-health/
[35] Alzheimer's Association "Depression". Available at: https://www.alz.org/help-support/caregiving/stages-behaviors/depression
[36] UN House Scotland "Women's mental health and the justice system". Available at https://www.unhscotland.org.uk/post/2019/09/25/womens-mental-health-and-the-justice-system
[37] Scottish Government (2018) Scottish Health Survey 2017 - volume one: main report. Available at https://www.gov.scot/publications/scottish-health-survey-2017-volume-1-main-report/
[38] Kings College London "1 in 4 pregnant women have mental health problems". Available at: https://www.kcl.ac.uk/archive/news/ioppn/records/2018/january/1-in-4-pregnant-women-have-mental-health-problems#:~:text=They%20found%20that%20when%20interviewed,bipolar%20disorder%20and%20other%20disorders

believed to affect between 10-15% of women.[39] Women also report that the fear of negative consequences frequently act as a barrier to mothers reporting their symptoms to healthcare professionals. This may delay or prevent diagnosis for some women.

Shocking disparities in maternal health outcomes for Black and minority ethnic women persist in the UK. Black women are four times more likely to die in pregnancy and childbirth than white women, and maternal mortality is twice as high for mixed race women and almost twice as high for Asian women.[40] This is partly attributed to institutional and systemic racism. This context provides a backdrop to BME women's family planning, pregnancies and experiences of childbirth in Scotland, with clear implications for mental wellbeing. Research found the Black women continue to experience long-term mental health issues due to poor care received during labour, including PTSD and severe anxiety. Midwives and other practitioners were found to be lacking in provision of information, advice and support related to mental health.[41]

Disabled women's access to reproductive and sexual health services is undermined by lack of knowledge and inclusivity. Health and social care workers in Scotland often perpetuate negative stereotypes, and view disabled women and girls solely through the lens of their impairments. Disabled women describe infantalising treatment based on their gender, assumptions by practitioners about their fertility, capacity and desire to parent, and negative comments regarding pregnancy and maternity. Disabled women continue to experience forced sterilisation, and lack of autonomy in accessing abortion and contraception. These issues have clear and egregious impacts on disabled women's mental health and wellbeing.[42]

Women's mental health experiences may be impacted by other aspects of reproductive health including use of hormonal contraceptives, puberty, pregnancy, menstruation and menopause.[43] A survey undertaken by Engender in 2019 found that most respondents reported negative physical and mental impacts of menopause that affected their wellbeing and ability to engage in economic and social activities.[44]

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[39] Anokye (2018) Prevalence of postpartum depression and interventions utilized for its management. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5941764/

[40] MBRRACE-UK (2021) Saving Lives, Improving Mothers' Care. Available at: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

[41] Five X More (2022) The Black maternity experiences survey: A nationwide survey of Black women's experiences of maternity services in the United Kingdom. Available at: https://static1.squarespace.com/static/5ee11f70fe99d54ddeb9ed4a/t/628a8756365828292ccb7712/1653245787911/The+Black+Maternity+Experience+Report.pdf

[42] Engender (2018) Our bodies, our rights: Identifying and removing barriers to disabled women's reproductive rights in Scotland. Available at: https://www.engender.org.uk/files/our-bodies,-our-rights-identifying-and-removing-barriers-to-disabled-womens-reproductive-rights-in-scoltand.pdf

[43] L. Dennerstein et al (1993) Psychosocial and Mental Health Aspects of Women's Health. Available at <https://apps.who.int/iris/bitstream/handle/10665/61376/WHO_FHE_MNH_93.1.pdf>

[44] Engender (2020) Engender Briefing to the Women's Health Plan: What Do Women

The focus on perinatal mental health that is identified in the current Mental Health Strategy 2017-2027 is welcome and should be retained. However, the revised Strategy must take an intersectional approach to maternal health, and broaden the scope to include reproductive and sexual health more broadly. Whilst perinatal mental health is the only gendered aspect of the current strategy, the full spectrum of mental health concerns for women and girls must also be reflected in the revised edition.

Women's mental health and systemic gender inequality

Women's social, economic, cultural and political inequality with men undermines good mental health and wellbeing in a wide range of ways. Unpaid caring roles, low-paid work, inadequate social security, pension poverty, endemic violence against women, physical health inequalities, lesser access to power and decision-making, gender stereotyping in culture, education and the media, gendered housing insecurity and homelessness, constrained use of public space, sexist and misogynist bullying, and the continuous navigation of sexism that pervades daily life for women and girls have a cumulative and egregious impact on wellbeing.

Little research has been done at Government level to understand the gendered differences in mental health diagnoses and to unpick where interventions are targeted. However, this will be vital in order to mitigate and respond to ongoing harm experienced as a result of the pandemic, and emerging mental health and wellbeing impacts related to the cost of living crisis. Gender blind policy making poses a high risk of entrenching inequality in service design and access, especially when it informs national spending priorities.

Systemic inequalities that affect women's mental health include:

- Women disproportionately provide unpaid care for children, disabled people and older people, with impacts on emotional health, social life and finances.
- Women are even more likely to provide intensive care, sandwich care for older people and children, and are twice as likely to give up paid work in order to care.
- Women often juggle multiple roles including paid work, childcare, care for others and greater provisions of domestic work.
- Women are overrepresented in underpaid, undervalued jobs, precarious and part-time work and are more likely to live in poverty than men.

Experiencing the Menopause in Scotland Need? Available at: https://www.engender.org.uk/content/publications/Engender-Briefing-to-the-Womens-Health-Plan-What-Do-Women-Experiencing-the-Menopause-in-Scotland-Need.pdf

- Women are twice as reliant on social security as men[45] and more vulnerable to economic shock or downturn, and to public spending cuts.
- Men's violence against women and girls, including domestic abuse, sexual violence and sexual harassment, is endemic.
- Over half of women have experienced sexual harassment at work.[46]
- Research found 97% of 18-24 year old women had been sexually harassed in public places,[47] and 80% of girls aged 13-18 did not feel safe going outside on their own.[48]
- Time use studies show that women in opposite sex couples in Scotland undertake 68% of household labour[49] and have less leisure time than men.
- Women tend to undertake household management and budgeting, including with regards to spending on children, which is particularly stressful in times of crisis.
- Gendered inequalities across medicine and healthcare, including mismanagement of women's pain, have an impact on mental health.
- Older women, unpaid carers, mothers of young children, and people with insecure immigration status are particularly exposed to isolation.
- Gender stereotyping throughout early years, education, employment, politics, caring expectations, media and many other aspects of public life fuels gender inequality.
- Sexist bullying and misogynist behaviours are highly prevalent in education settings in Scotland.[50] 75% of girls and young women report that anxiety about sexual harassment affects their lives.[51]

[45] Engender (2015) Securing Women's Futures. Available at: https://www.engender.org.uk/content/publications/Securing-Womens-Futures---using-Scotlands-new-social-security-powers-to-close-the-gender-equality-gap.pdf
[46] TUC (2016) Still just a bit of banter? Sexual harassment in the workplace. Available at: https://www.tuc.org.uk/sites/default/files/SexualHarassmentreport2016.pdf
[47] UN Women UK "Public spaces need to be safe and inclusive. Now." Available at: https://www.unwomenuk.org/safe-spaces-now
[48] Girlguiding "New research reveals 80% of girls don't feel safe outside. Available at: https://www.girlguiding.org.uk/about-us/press-releases/80-of-girls-dont-feel-safe-outside-alone-with-over-half-receiving-unwanted-sexual-comments-and-attention-reveals-girlguiding-research/
[49] Scottish Government (2019) Centre for Time Use Research Time Use Survey 2014-15: Results for Scotland. Scottish Government. Available at: https://www.gov.scot/publications/centre-time-use-research-time-use-survey-2014-15-results-scotland/pages/5/
[50] Educational Institute of Scotland (2016) Get it Right for Girls. Available at: https://www.eis.org.uk/Content/images/equality/Gender/Get%20it%20Right%20for%20Girls%202016%20WEB.pdf
[51] Girlguiding UK (2015) Girls' Attitudes Survey 2015. Available at: https://www.girlguiding.org.uk/globalassets/docs-and-resources/research-and-campaigns/girls-attitudes-survey-2015.pdf

- Housing insecurity is gendered, with women more likely to rent than men.[52] Women are at risk of homelessness once the short-term evictions ban and rent freeze expire.
- Experiences of sexism, racism, ablism, homophobia and other forms of oppression and their intersections are harmful to women's mental health and wellbeing
- Young women aged 16-30 who report experiencing sexist behaviour are over 5 times more likely to have clinical depression.[53]
- Representation of women in the media, including sexualisation, stereotyping, lack of diversity and sexist standards around body image drives poor mental wellbeing.

Sexism in healthcare

Structural sexism across medical and healthcare institutions must also be considered in a gender analysis of mental health. This is linked to power dynamics between those delivering and receiving healthcare, including the simple fact that men are over-represented in senior positions. For Black and minority ethnic women, disabled women, LGBT women, younger and older women, women with insecure immigration status, and other minoritised groups, gendered discrimination and unconscious bias are overlaid with racism, ableism, transphobia, homophobia, ageism and other prejudices.

Women are more likely to have physical symptoms ascribed to mental health issues, an inequality that exists alongside the fact that mental and physical health are interlinked. Engender's engagement work revealed that many women feel "gaslit" by medical professionals who do not take their concerns seriously. One participant described issues with male psychiatrists understanding issues from a female perspective, and underestimating or disregarding concerns. Lack of focussed research on issues primarily experienced by women plays into this. For instance, chronic fatigue syndrome is around four times more likely to occur in women,[54] and is routinely misdiagnosed as related to mental health. Evidence suggests that that women with complex trauma may be given other diagnoses, including borderline personality disorder, potentially leading to increased stigma and them not receiving the most appropriate treatment.[55]

These inadequate and harmful responses can create or compound mental health issues for women.

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[52] Engender (2020) Gender, Housing and Homelessness: A Literature Review. Available at https://www.engender.org.uk/content/publications/GENDER-HOUSING-AND-HOMELESSNESS---A-LITERATURE-REVIEW.pdf

[53] Young Women's Trust (2019) Impact of Sexism on Young Women's Mental Health. Available at: https://www.youngwomenstrust.org/research/impact-sexism-young-womens-mental-health/

[54] ME Research (2015) ME/CFS in women and men. ME Research Available at: https://www.meresearch.org.uk/sex-differences-in-mecfs/.

[55] UK Government and Agenda (2018) The Women's Mental Health Taskforce. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf

3. QUESTIONS

1. Definitions

1.1 Do you agree with this description of "mental health"? [Y/N]

We would add the following amendment.

> "Mental Health" Everyone has mental health. This is how we think and feel about ourselves and the world around us, and can change at different stages of our lives. Our mental health is affected, both positively and negatively, by lots of factors, such as our own life circumstances, our environment, our relationships with others, our past experiences, plus our genetic make-up. ***Our mental health is also impacted by gender, race, disability, sexual orientation, gender identity, age, pregnancy and maternity, class and other identities, particularly when forms of inequality intersect.*** Being mentally healthy is about having good mental health, as well as addressing mental health problems. Having good mental health means we can realise our full potential, feel safe and secure, and thrive in everyday life as well as to cope with life's challenges.

1.2 If you answered no, what would you change about this description and why?

As set out in the background to this paper, mental health is profoundly gendered.

This is reflected in Scottish Government's Mental Health Transition and Recovery Plan, which commits to making "women and girls' mental health a priority", recognizing the ongoing gendered impacts of the pandemic on mental health and highlighting some of the key issues set out above. This consultation states "we want the Strategy to be equality and human-rights based." Yet no reference to women, girls or gender is made in the consultation document. We were taken aback by this omission.

Given what we know about gendered inequalities in the experience of and response to poor mental health and mental illness, the listed factors that affect mental health should include gender. Other social hierarchies, including race/ racism, gender identity/ homophobia and transphobia and disability/ ableism, also have profound impacts on mental health. Intersectionality is where people experience more than one of these forms of inequality and discrimination, such that (for instance) disabled women, Black and minority women or LGBT women, can have particularly acute mental health issues and/or specific access needs. This is reflected in our suggested amendment.

1.3 Do you agree with this description of "mental wellbeing"?

No

> "Mental wellbeing" Mental wellbeing affects, and is affected by, mental health. It includes subjective wellbeing (such as life satisfaction) and psychological wellbeing

(such as our sense of purpose in life, our sense of belonging, and our positive relationships with others). We can look after our mental wellbeing in the same way as we do our mental health – and having good mental wellbeing can stop our mental health getting worse. The Royal College of Psychiatrists defines wellbeing as: 'A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment'.

1.4 If you answered no, what would you change about this description and why?

Engender recommends shifting the framing of mental wellbeing in this description away from the implication that control of mental wellbeing is within the gift of the individual. Structural social and economic inequality have an enormous impact on mental wellbeing. The suggestion that "we can look after our mental wellbeing in the same way as we do our mental health" to a woman with complex trauma as a result of rape, a woman skipping meals to make the family budget stretch further due to spiralling costs and inadequate social security, or a woman denied access to paid work due to insecure immigration status, is likely to compound stress and poor mental wellbeing. The onus to achieve positive mental wellbeing should not be put on women and other minoritised and low-income groups.

We suggest that this line is removed or else reference to the impacts of structural inequality and other external issues is included.

1.5 Do you agree with this description of "mental health conditions" and "mental illness"?

We would add the following amendment.

> "Mental health conditions are where the criteria has been met for a clinical diagnosis of mental illness. This means that a diagnosis of a mental illness has been given by a professional. Mental health conditions can greatly impact day to day life, and can be potentially enduring. These include depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD), as well as bipolar disorder, schizophrenia, and other psychosis, among many more. ***Women and men different experience mental health conditions to different extents.*** How mental illness affects someone can change from day to day. The professional treatment and support that each individual needs can change too. Someone may have an acute mental health problem or mental health condition that has not yet been diagnosed, but they can still be unwell. Their diagnosis may also change over time."

1.6 If you answered no, what would you change about this description and why?

The experience and diagnosis of mental illness is highly gendered. Women are diagnosed with depression, anxiety, phobias, OCD and bipolar disorder at notably higher rates compared with men (as set out in detail on p. 4-6), and gendered discrimination shapes their experience of diagnosis and care within the health system. We therefore recommend

that this is reflected in the description. This information is not widely known, nor well integrated through healthcare responses or high-level policy framing. It may be helpful, however, for women experiencing symptoms or coping with diagnoses to understand the gendered context of their condition. Embedding gender analysis within strategic frameworks also helps to ensure that women's experiences and needs are mainstreamed throughout policy and service provision.

2. Draft vision and outcomes

Our Overall Vision

2.1 On page 8, we have identified a draft vision for the Mental Health and Wellbeing Strategy: "Better mental health and wellbeing for all". Do you agree with the proposed vision?

2.2 If not, what do you think the vision should be?

Our experience is that stating a vision or a policy is "for all" becomes meaningless in practice unless marginalised groups and those with particular needs are specified. We recommend that the vision is expanded to specify what is meant by "for all", by adding ***"regardless of gender, race, disability, sexual orientation, gender identity, age, class, religion and belief, pregnancy and maternity, immigration status, or any other inequality".***

2.3 If we achieve our vision, what do you think success would look like?

Policy to advance women's equality

Better mental health and wellbeing for women and girls is linked to systemic gender inequality. Success will therefore hinge on the provision of targeted support, including financial support, for those most exposed to mental health risks, including women in low-paid employment, unpaid carers, single mothers, women experiencing domestic abuse and other gendered violence, women living with poor physical health, young women, older women, pregnant women, women with insecure immigration status, women in the criminal justice system, BME women, disabled women and LGBT women.

In policy terms this means that outcomes of mental health policy rest on stronger cross-governmental working, including significant advances in mainstreaming gender and equality more broadly across government,[56] implementation of the National Advisory Council on Women and Girls recommendations and policy frameworks related to women's equality,[57] and new commitments to mitigate impacts of the pandemic and cost of living crisis on women's mental health. Support for women and girls on low incomes and in precarious

[56] In turn this is contingent on the Scottish Government's forthcoming Equality and Human Rights mainstreaming strategy being prioritised and well-resourced

[57] Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls, and A Fairer Scotland for women: Gender pay gap action plan

situations that would prevent poor mental health and wellbeing, and that should be prioritised by Scottish Government include:

- Delivery of automatic individual payments of Universal Credit, as first committed to in 2017[58]
- Doubling the Carers Allowance Supplement and creating a Carers Hardship Fund
- Increasing the Scottish Child Payment to £40 per week and doubling bridging payments for eligible school aged children
- Creating a new entitlement, potentially through the Scottish Welfare Fund, to support women experiencing domestic abuse to leave an abusive partner
- Uprating social security entitlements in line with inflation
- Expansion of funded childcare to 50 hours of universal, flexible, accessible and culturally competent childcare per week[59]

More broadly, Scottish Government can prevent poor mental health for women and girls and create favourable conditions for improved wellbeing by:

- Implementing and expanding the Women's Health Plan, including improvements to abortion care services and access, and decriminalisation of abortion
- Committing to sustained funding for the Equal Media and Culture Centre, to ensure sustainable scrutiny of the Scottish media, and cultural content and production
- Reviewing the Scottish anti-bullying strategy to ensure it adequately tackles sexist and misogynist bullying in schools
- Ensuring all work on mental health for women and girls takes a rigorously intersectional approach, including through vastly improved data collection and use
- Plugging gaps in the law with a new Bill that criminalises misogynistic conduct[60]
- Fulfilling commitments to enhance protection of women's rights by incorporating CEDAW directly into Scots law within the proposed Human Rights Bill
- Developing a high-level intersectional strategy to tackle workplace sexual harassment.

[58] For information on this issue see Engender (2016) Gender matters in social security: Individual payments of Universal Credit. Available at: https://www.engender.org.uk/content/publications/Gender-matters-in-social-security---individual-payments-of-universal-credit.pdf

[59] This is in line with the Scottish Government's response to the First Minister's National Advisory Council on Women and Girls report 2018.

[60] As recommended by the Working Group on Misogyny and Criminal Justice, see the Scottish Government's response here: https://www.gov.scot/publications/misogyny-and-criminal-justice-working-group-recommendations-scottish-government-response/

A wide spectrum of reserved policy calls, such as granting the right to work to asylum seekers, scrapping the benefit cap and two child limit, and uplifting Universal Credit payments would also have a hugely positive impact on women and girls' mental health and wellbeing.

Success in progressing this vision therefore rests squarely on gendered policy development across government and Scottish Government must develop a cross-government approach to mental health. For instance, with regards to the acute risks of poor mental health for young women and girls, the Strategy should include substantive read across to policy areas that explain root causes. These include sexualised and sexist bullying in education, gender stereotyping in media and culture, and negative portrayals of body image. Success would entail reducing these inequalities for Scotland's young women and girls.

Access to services

Equality of access to services is absolutely crucial if mental health and wellbeing is to be improved for all in Scotland. Gendered barriers to mental health services relate to sexist assumptions and misdiagnoses, women's unpaid caring roles, gendered power dynamics, and the lack of a widespread trauma-informed approach, amongst other issues. Linguistic barriers continue to impact on some BME women, refugee, asylum-seeking and migrant women, and others with insecure immigration status.

However, there is a critical difficulty in assessing which and how barriers to services manifest. There is little gender-sensitive sex-disaggregated data on mental health gathered in Scotland (see detail on p.16) and the Mental Health Strategy 2017 - 2027 contains almost no gender analysis. Significant gaps in knowledge about gendered mental health inequalities also mitigate against women accessing the support that they need. This must be systematically addressed, through the Equality Evidence Strategy and by improved intersectional equality data practices throughout health and social care. Publishing this data is an important part of the picture, helping to build knowledge and enabling equality advocates to scrutinise progress.

Equal access to services will also entail significant investment in specialist services that are equipped to support lesbian and bisexual women, trans women, disabled women, including Deaf women and learning-disabled women, victim-survivors of violence against women, Black and minoritised women, women from minority faith communities, neurodivergent women, and women in or on the edges of the criminal justice system.

For instance, LGBT women tend to present later to health and support services, possibly due to negative experiences and/or expectations of dealing with healthcare practitioners who are not knowledgeable and affirmative of LGBT identities. Trans women express symptoms of poor mental health to LGBT+ organisations, but show an unwillingness to seek health and support interventions in case this disrupts their transition or because of expectations of

dealing with professionals who are not knowledgeable and affirmative of their gender identity.

The Mental Welfare Commission Scotland has stated that "the Scottish Government's mental health strategy must place a greater focus on women offenders".[61] The needs of women and girls in prisons and Young Offender Institutions require specific consideration given the nature and pattern of women's offending, the propensity of women to receive short term sentences, and the high rates of depression, anxiety and self-harm among women in the criminal justice system.

Geographical coverage, including throughout rural and remote areas, and proportionally across areas of deprivation in line with the scale of need, also forms a critical part of this picture. Where emerging digital solutions are proposed, it is vital that digital exclusion is accounted for and mitigated. Increased use of virtual healthcare provision may have significant impacts for women, particularly for older women, BME women and disabled women. Women are less likely to have access to personal ICT and are more likely than men to be internet non-users. Issues of privacy need to be considered, including for women who live with an abusive partner or parent, or women who are at home with children and have no childcare support. Availability of remote appointments may however be of benefit to unpaid carers or disabled women who may encounter physical or financial barriers to in person support.[62]

Comprehensive mapping to establish the nature and extent of need for specialist mental health services in Scotland is sorely lacking. This must include intersectional assessment of women's mental health experiences and needs.

Data

Linked to such a needs assessment are issues with data. Any measurement framework for success regarding mental health must include indicators regarding intersectional equality. For this to be achieved the collection, collation and use of equality data, including intersectional gender-sensitive and sex-disaggregated data, must be built into the system. However, this is not currently the case in Scotland. We are aware of very little gender disaggregation and intersectional analysis available to develop responses to women's mental health and wellbeing needs. For instance, very little data regarding Black and minority ethnic (BME) women's mental health in Scotland is evident, despite BME women's disproportionate exposure to stressors including poverty and the significant impact of stigma within some communities. Similarly, evidence around disabled women's mental health needs are lacking, despite the manifest need for specialist services relating to a broad

[61] Mental Wefare Commission for Scotland (2019) Mental health of women detained by the criminal courts. Available at: https://www.mwcscot.org.uk/sites/default/files/2019-06/women_offenders_final_report.pdf

[62] Engender (2020) Engender response to the Scottish Government Consultation on the Digital Strategy for Scotland. Available at <https://www.engender.org.uk/content/publications/Engender-response-to-the-Scottish-Government-Consultation-on-the-Digital-Strategy-for-Scotland.pdf>

range of impairments, and deep social and economic inequalities – including higher rates of violence against women and un/underemployment – faced by disabled women.

Engender advocates for a set of principles for 'gender data', including those enumerated by the UN and European Institute of Gender Equality, to be operationalised in Scotland as the default.[63] This means going beyond disaggregation by sex through the design and collection of 'gender-sensitive data' – in this case gathering evidence related to gendered mental health and wellbeing issues that is built on a gender analysis, and reflects the diverse realities of women's lives.

Sexism and intersectional discrimination

Sexist assumptions and discrimination also act as a barrier to women accessing mental healthcare. Women consistently raise their experiences of being not listened to, taken seriously or actively involved in treatment planning or prescription choices. They wait longer for pain medication than men, wait longer to be diagnosed, are more likely to have their physical symptoms ascribed to mental health issues, are more likely to have their heart disease misdiagnosed, and are more likely to suffer from illnesses ignored or largely denied by the medical profession. Women's physical pain and discomfort is routinely disbelieved or underplayed, and gender-based biases influence treatment.[64]

Evidence that doctors downplay women's health concerns suggests both that this risk exists with regards to mental health symptoms, and an increased risk of stress and anxiety associated with delays to diagnosis and treatment of physical health issues.[65] Meanwhile, the extent to which gendered differences in diagnosis of depression and anxiety relate to gendered biases and assumptions, or to gendered responses to similar risk factors is unclear. Gendering research will improve our understanding of these differentials and ensure that women and men receive accurate diagnoses.

Interplay with systemic racism must also be considered. Issues regarding BME women's maternal mortality and impacts on mental wellbeing are described on p.7. One further example relates to application of the Mental Health Act in Scotland. Grounds on which detention is justified has a racialised and gendered dimension, with the biggest gap for those perceived as a risk towards 'self and others' seen between Black women and white

[63] Engender (2021) Engender response to "sex and gender in data: collection and publication"; guidance from the Chief Statistician to Scottish Public Bodies. Available at: Engender-response-to-Chief-Statistician-working-group-consultation-on-sex-and-gender-and-data-FINAL.pdf

[64] L. Kiesel (2017) Women and pain: Disparities in experience and treatment. Available at: https://www.health.harvard.edu/blog/women-and-pain-disparities-in-experience-and-treatment-2017100912562

[65] C. Noe Pagan (2018) When Doctors Downplay Women's Health Concerns. New York Times. Available at: https://www.nytimes.com/2018/05/03/well/live/when-doctors-downplay-womens-health-concerns.html

Scottish women.[66] All categories of white people were more often perceived only as a risk to themselves.

Such systemic issues across mental healthcare must be mapped and addressed. The revised Strategy should include short and medium term actions related to discrimination in mental health, including sexism, racism and ableism. Steps towards plugging evidence gaps regarding intersecting forms of structural inequality in healthcare should also be developed and included.

3. Key areas of focus

3.1 On page 9, we have identified four key areas that we think we need to focus on. Those were:

• Promoting and supporting the conditions for good mental health and mental wellbeing at population level ***for all groups***.

• Providing accessible ***and inclusive*** signposting to help, advice and support.

• Providing a rapid, and easily accessible response to those in distress ***that is gender sensitive, trauma informed, inclusive and culturally competent***.

• Ensuring safe, effective treatment and care of ***all*** people living with mental illness.

Do you agree with these four areas? [Y/N]

Engender is not in a position to comment on whether these areas of focus are appropriate and comprehensive.

In terms of the areas identified, we recommend some elaboration to embed and clarify the Strategy's vision of better mental health for all. This means that creating conditions, signposting, response and treatment must be developed in line with best practice on gender competence, trauma, cultural competence and LGBTI inclusion, as well as full accessibility for disabled people and neurodivergent people.

3.2 If not, what else do you think we should concentrate on as a key area of focus?

All of these key areas are highly gendered. As set out in our answer to question 2.3, promoting and supporting conditions for good mental health and wellbeing must involve targeted measures to ensure women and other marginalised groups are able to enjoy the full breadth of their human rights, have access to adequate incomes, are supported to leave abusive partners, are protected against misogyny and discrimination in the law, are able to

[66] Mental Welfare Commission for Scotland (2021) Racial inequality and mental health in Scotland: A call to action. Available at: https://www.mwcscot.org.uk/sites/default/files/2021-09/Racial-Inequality-Scotland_Report_Sep2021.pdf

enjoy good health and wellbeing on an equal basis with men, and have equality of access to quality abortion care at the point of need in Scotland.

Accessible signposting to help, advice and support should be developed in collaboration with disabled people's organisations, race equality organisations and organisations supporting migrants and those with insecure immigration status. The women's, equalities and anti-poverty sectors, including those working with and for particular cohorts of women should also be consulted to ensure that hidden and/or vulnerable groups are considered and attempts to signpost comprehensively are maximised. These include:

- Violence against women organisations such as Scottish Women's Aid, Shakti Women's Aid and Rape Crisis Scotland
- Organisations that support BME and Muslim women such as Saheliya and Amina
- The Young Women's Movement
- Women and work organisations such as Close the Gap and Women's Enterprise Scotland
- Single parent family organisations such as One Parent Family Scotland and Fife Gingerbread
- Housing organisations such as Crisis Scotland and Homeless Network Scotland
- Groups that support women in or on the edges of the criminal justice system such as the Willow Service and Tomorrow's Women Glasgow
- Wider equalities organisations such as Equality Network, Scottish Trans and Age Scotland.

Providing a rapid and easily accessible response to those in distress relies upon nuanced intersectional knowledge and understanding the nature of distress that women may be experiencing. Responding to and treating the complex needs of a Muslim woman with PTSD or a learning disabled woman with an anxiety disorder cannot be done safely and effectively without adequate gendered, culturally competent and inclusive training. Ensuring that the care that women ultimately receive is appropriate, safe and effective relies on a solid understanding of issues upstream in the system - throughout prevention, signposting and referral – and therefore must be mainstreamed throughout the Mental Health and Wellbeing Strategy.

4. Outcomes

As with the vision and the areas of key focus, gender must be mainstreamed throughout the outcomes. It has been outwith the scope of this response to analyse the outcomes in full, however we offer the following comments that are indicative of a gender analysis.

Under 4.1:

- We fully support the objective of addressing underlying inequalities across policy areas. In order to see change for women and girls, however, this would need to be targeted at

gender equality and specify that this and other inequalities (rather than 'social factors') are the focus for influence. Our experience is that aims/ visions/ outcomes/ policy intentions to 'reduce inequality' in a broad and undefined sense are not adequately specific to hold meaning for women, and tend to be interpreted as socioeconomic inequality.

Under 4.2:

- Factors that impact on people's health and wellbeing should not be confined to the individual level, but also highlight that structural social injustice and inequality have a significant bearing.

- Whilst we advocate for cross-governmental working and the need for the mental health strategy to be linked with and calling for policies to reduce financial precarity and improve social security, it is important that the Strategy doesn't over-promise. The outcome "people have the material […] resources to enable them to cope during times of stress, or challenging life circumstances" risks doing this – particularly in the context of the current costs crisis – unless there are clear steps to this end set out in the Strategy and there is coherent read across with wider and **new** Scottish Government policy.

- Likewise, outcomes that people feel safe, secure, valued, are able to maintain healthy, nurturing relationships, and are empowered to make decisions about their healthcare and lives are profoundly gendered. These outcomes will not be achieved for women and girls unless gender analysis is embedded throughout implementation planning and monitoring and evaluation.

Under 4.3:

- Participation in community engagement and decision-making is highly gendered and must be undertaken in line with emerging best practice on gender sensitivity, trauma, cultural competence, accessibility and inclusion.

- We agree that communities are often a source of support during difficult times but reiterate concerns that the onus for solutions to poor mental health and wellbeing must not be disproportionately skewed towards individuals or communities, as opposed to systemic approaches.

Under 4.4:

- In line with comments above, the outcome "We live in a fair and compassionate society that is free from discrimination and stigma" is outwith the reach of this strategy. Discrimination and stigma in Scotland are extremely wide ranging and intersectional, impacting on large numbers of minoritised and oppressed groups, some of which are largely invisible in mainstream policymaking and political discourse. Stigma and discrimination stem from deeply entrenched inequalities and abuses of human rights, and cover hugely diverse sets of issues.

To take but one example, stigma attached to abortion denies women fundamental choices that alter the course of their lives and is deeply rooted in misogyny and sexist inequality. The Mental Health and Wellbeing Strategy should make links between issues with abortion care and good mental health for women and girls, and advocate for better reproductive health services and action to address stigma. It cannot however set a course to eradicate stigma surrounding abortion.

- The following outcome "We have reduced inequalities in mental health and wellbeing and mental health conditions" is realistic and essential. It must be accompanied by an **intersectional** measurement framework to assess progress in terms of gender, race, disability, LGBTI issues, class, age, immigration status and other social inequalities.

- The third outcome "We have created the social conditions for people to grow up, learn, live, work and play, which support and enable people and communities to flourish and achieve the highest attainable mental health and wellbeing across the life-course" is extremely broad, lacks a clear focus, and overlaps with the first two in this section. As such it is hard to see how progress against this will be monitored and understood.

Under 4.5:
- An increased focus on lived experience and co-production must systematically seek to adopt emerging best practice standards around participation,[67] and balance forms of learned expertise, including equalities input, and lived expertise.[68] It must take care not to conflate participatory processes with the comprehensive data collection that is needed, or to provide false assurance that relevant evidence has been gathered.

- We agree that when people seek help the response they receive should be person-centred and flexible. In our experience, however, stipulating that a policy or programme is person-centred in an all-encompassing way does not automatically lead to better outcomes for women and girls. Regardless of the circumstances that an individual presents with, responses should be gender-sensitive, trauma-informed, inclusive, culturally competent and accessible in a systemic and overarching way.

- Likewise, the following outcome on equality of access must include a structural focus, including with regard to intersectional gendered inequalities. As currently presented, systemic equality issues are not captured for monitoring and evaluation purposes.

Under 4.6:

[67] Poverty and Inequality Commission (2020) Guidance for the Poverty and Inequality Commission: Involving experts by experience. Available at: https://povertyinequality.scot/wp-content/uploads/2020/10/Guidance-on-involving-experts-by-experience-PIC-Guidance.pdf

[68] For fuller discussion of this, including gendered parameters, please see pp. 8-9 of Engender's evidence to the EHRCJ committee's pre-budget scrutiny. Available at: https://www.engender.org.uk/content/publications/?cat=2

- The outcome around improved data use is essential. We would recommend expanding this to include a focus on intersectional equalities data, and to stipulate that data is gathered, collated and published, as well as used. Existing datasets are not adequate to capture the breadth of information that is needed, and gender sensitive design of new data collection is essential. Data must be collated such that intersectional analysis is possible. Data should be published to allow for greater understanding and scrutiny of mental health and wellbeing.

5. Creating the conditions for good mental health and wellbeing

Questions 5.1 – 5.4 on "the main things in day-to-day life that currently have the biggest positive / negative impacts on mental health and wellbeing"

Cost of living crisis

The cost of living crisis is at the forefront of concerns for many women in Scotland at present. Women are already feeling impacts that will affect their mental health and wellbeing, as the majority of low-paid and precarious workers, as unpaid carers and lone parents with low incomes and high energy needs, as women financially unable to leave abusive partners, and as 'poverty managers' responsible for stretched household budgets and spending on children.[69] One Parent Family Scotland report that 86% of single parents (92% of whom are women) have struggled with their mental health over the last year, with 56% feeling this way "most of the time".[70]

The fear, anxiety and uncertainty around spiralling costs, including energy bills, and the impacts that **may** emerge also have an impact on mental health in the present. Statistics from the ONS show that 81% of women (compared with 73% of men) are "very or somewhat worried about the rising costs of living". Only 3% of women said they were "not at all worried" about the cost of living crisis in the two weeks prior to interview.[71] Disabled people were more likely to express worry than non-disabled people (82% compared with 75%), suggesting that figures for disabled women may be higher yet. However intersectional data has not been published.

Pandemic

The disastrous forecast for the rate of inflation cannot be divorced from the egregious impact of the Covid-19 pandemic on equality, which has already placed women at greater risk of economic insecurity and poor mental health.[72] A rollback on women's rights and

[69] Engender (2022) Parliamentary Briefing on the Cost of Living Crisis. Available at: https://www.engender.org.uk/content/publications/Engender-briefing-cost-of-living-crisis.pdf

[70] One Parent Family Scotland (2022) Living without a lifeline: Single parents and the cost of living crisis Available at: https://opfs.org.uk/wp-content/uploads/2022/09/Living-without-a-lifeline-full-report.pdf

[71] ONS (2022) Worries about the rising cost of living, Great Britain: April to May 2022. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/worriesabouttherisingcostsofliving greatbritain/apriltomay2022

[72] Engender and Close the Gap (2020) Gender and economic recovery. Available at: https://www.engender.org.uk/content/publications/Gender--Economic-Recovery---Engender-and-Close-the-Gap.pdf; Engender (2020) Women and unpaid work: the impact of Covid-19 on women's caring roles. Available

equality is widely recognised,[73] with specific issues and their ongoing implications manifesting for Black and minority ethnic women, young women, disabled women, unpaid carers, mothers, pregnant women, LGBT women, and women with insecure immigration status, amongst other groups. Against this baseline, the current cost of living crisis will further exacerbate women's economic inequality, pushing many into poverty. The harm this will cause to women's security and wellbeing will resound throughout the course of women's lives and those of their children.

Poor mental health and wellbeing related to the pandemic is ongoing for unpaid carers with whom Engender engages. 72% of carers reported that their mental health had deteriorated since the start of the pandemic.[74] Many carers continue to self-isolate or shield to varying degrees due to clinical vulnerabilities of those for whom they provide care. This undermines women's ability to access paid work, education, social activities and other leisure time. Some of our members have spoken powerfully of feeling abandoned by Scottish Government, with policy approaches and political discourses suggesting that we are living in a post-pandemic Scotland. Many carers, disabled people and older people – the majority of all of whom are women – are gearing up for a stressful winter, living in fear of Covid.

Global evidence shows higher negative mental health trends for women since the start of the pandemic as compared with men.[75] In the UK, women experienced the largest spikes in poor mental health with increased depression and anxiety across all age groups, but particularly for young women.[76] During the pandemic, 78% of carers reported providing more care than they were prior to the coronavirus outbreak,[77] with clear implications on time available for other activities and the prevention of poor mental health outcomes. The extent to which these impacts are ongoing is unclear in Scotland. Other impacts of the pandemic, including the removal of support systems, on single parents, parents of young children, and parents providing home schooling - mostly mothers – are still being felt. New mothers isolated from support networks were a particularly vulnerable group during

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at: https://www.engender.org.uk/content/publications/1594974358_Gender--unpaid-work---the-impact-of-Covid-19-on-womens-caring-roles.pdf.

[73] See Engender and Close the Gap websites for reports and briefings on COVID-19 and different aspects of women's equality, e.g. https://www.engender.org.uk/content/publications/1594974358_Gender--unpaid-work---the-impact-of-Covid-19-on-womens-caring-roles.pdf; https://www.engender.org.uk/content/publications/Gender--Economic-Recovery---Engender-and-Close-the-Gap.pdf.

[74] Carers Scotland (2021) State of Caring 2021 in Scotland. Available at: https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-2021-report

[75] F. Thibaut et. al. (2020) Women's Mental Health in the Time of Covid-19 Pandemic. Available at https://www.frontiersin.org/articles/10.3389/fgwh.2020.588372/full ; S. T. Lindau, et al. (2021) Change in Health-Related Socioeconomic Risk Factors and Mental Health During the Early Phase of the COVID-19 Pandemic: A National Survey of U.S. Women. Journal of Women's Health. Available at https://doi.org/10.1089/jwh.2020.8879.

[76] Mental health during lockdown: evidence from four generations Initial findings from the COVID-19 Survey in Five National Longitudinal Studies. Available at <https://cls.ucl.ac.uk/covid-19-survey/findings/>

[77] Carers UK (2020) Carers Week 2020 Research Report. Available at < https://www.carersuk.org/images/CarersWeek2020/CW_2020_Research_Report_WEB.pdf>

respective lockdowns. The extent to which poor mental health and wellbeing amongst these different groups of women have become entrenched, and the ongoing ramifications of these highly stressful and isolating circumstances should be explored in the process of developing a new Strategy. It is likely that research and further evidence gathering will need to be mandated and this should include an intersectional equality focus.

Poverty and austerity

These crises have exposed the faultlines, deepening existing economic inequality for women in Scotland. Women continue to live with the impacts of a decade of austerity, in terms of insufficient social security and cuts to public services that influence their daily lives.

Women are twice as likely as men to rely on a social security system that fuels economic hardship and inequality. The levels at which entitlements are set are wholly inadequate, and the design and delivery of much of the system generates insecurity and financial precarity rather than the provision of a safety net that so many need during periods of economic volatility.[78] Nor are these inadequate entitlements being uprated in line with the Retail Price Index, effectively amounting to yet more cuts to benefits. Analysis from the House of Commons Library found that up to 86 per cent of net 'savings' carved from social security payments and public services between 2010 and 2020 will have come from women's incomes.[79] This gendered decimation of social security in the UK leaves disabled, Black and minority ethnic and refugee women, lone parents and unpaid carers at even greater risk of poverty and destitution. The threat of these risks becoming reality is a spectre in many women's lives, with clear implications for mental health and wellbeing.

Crucial elements of this for women include the 'two child limit' within Universal Credit, the benefit cap – which predominantly affects single parents, 92 per cent of whom are women – the five week wait, and the household payment of Universal Credit. This single household payment undermines women's access to an independent income and has been widely condemned as a regression to a 'male breadwinner model'. In 2018, it was described as misogynistic by the UN's Special Rapporteur on extreme poverty and human rights.[80] Scottish Government is committed to providing individual payments of Universal Credit within flexibilities devolved under the Scotland Act 2016, however, this has yet to be delivered.

Questions 5.5 – 5.9

[78] Engender (2016) Securing women's futures: using Scotland's social security system to close the gender equality gap. Available at: https://www.engender.org.uk/content/publications/Securing-Womens-Futures---using-Scotlands-new-social-security-powers-to-close-the-gender-equality-gap.pdf.
[79] Women's Budget Group (2016) The impact on women of the 2016 budget: Women paying for the chancellor's tax cuts. Available at: https://wbg.org.uk/wp-content/uploads/2016/11/WBG_2016Budget_FINAL_Apr16-1.pdf.
[80] Ward, V (2018) "UK's welfare system is cruel and misogynistic", says UN expert after damning report on poverty. The Telegraph. Available at: https://www.telegraph.co.uk/news/2018/11/16/welfare-system-cruel-misogynistic-un-expert-warns-damning-report/.

There are things we can all do day-to-day to support our own, or others', mental health and wellbeing and stop mental health issues arising or recurring. In what ways do you actively look after your own mental health and wellbeing? o Exercise o Sleep o Community groups o Cultural activities o Time in nature o Time with family and friends o Mindfulness/meditation practice o Hobbies/practical work o None of the above o Other

Referring to your last answers, what stops you doing more of these activities? This might include not having enough time, financial barriers, location etc.

Gendered barriers

Time-use surveys show that women spend more time on domestic labour and have less time for leisure than men in the UK. Latest figures for Scotland show that women in opposite sex couples undertake 68% of household labour and 68% of childcare.[81] This has a major impact on health and wellbeing. Many unpaid carers of disabled and older people are extremely time-poor, particularly those with multiple caring roles and those caring for people with complex needs. Finding time to exercise, to spend time with family and friends, or to attend community groups is all but impossible for many. Unpaid caring also undermines women's financial security and the likelihood of disposable income to spend on things like cultural activities, hobbies and access to nature.

Violence against women, including lower-level harassment such as cat-calling, shapes how women and girls navigate public space and acts as a barrier to accessing community groups, exercise, cultural activities and time with family and friends. Women experiencing coercive control may not be able to regularly spend time on hobbies or practical work, attend community groups or meet with family and friends.

Single parents are most often very constrained in the amount of time they are able to take for themselves and are amongst those at the sharpest end of the cost of living crisis. Other groups of low-income women are excluded from many of the measures, such as those set out above, that are often recommended to promote good mental health and wellbeing.

The majority of older people in Scotland are women, many of whom are isolated due to ill health, mobility issues, limited social networks and financial precarity. Women have less savings and access to occupational pensions than men, with clear and cyclical implications for opportunities that impact on mental health and wellbeing throughout their lives. Older women have faced a six percent rise in pension poverty over the last decade, with 20% of women of pensionable age now "living below the breadline".[82] This shocking figure is even more acute for Black and minoritised women, one in three of whom experiences pension

[81] Scottish Government (2019) Centre for Time Use Research Time Use Survey 2014-15: Results for Scotland. Scottish Government. Available at: https://www.gov.scot/publications/centre-time-use-research-time-use-survey-2014-15-results-scotland/pages/5/

[82] Age UK (2021) New Age UK analysis finds one in five UK women pensioners now living in poverty. Available at: https://www.ageuk.org.uk/latest-press/articles/2021/new-age-uk-analysis-finds-one-in-five-uk-women-pensioners-now-living-in-poverty/.

poverty. Financial barriers therefore limit action that older women are able to take to promote good mental health. Older women's use of public space is also constrained by lack of public toilets, an issue that also manifests for pregnant women, disabled women (and therefore their carers), mothers of young children, and menstruating women.

Disabled women's access to public space is constrained by venues, public transport and pavements that are not accessible. For BME women, women from minority faiths, and refugee and migrant women, access to many of the activities outlined above is constrained by a lack of cultural competence. Poor public transport, which is disproportionately used be women, undermines access to cultural activities, community groups and other public events for women in both rural and urban areas.

Sleep is cited as a method of looking after mental health and wellbeing, but this is outwith the control of many groups of women. It is common for women going through the menopause and perimenopause to encounter significant or acute issues with sleep. A survey undertaken by Engender in 2019 found that most respondents reported negative physical and mental impacts of menopause that affected their wellbeing and ability to engage in economic and social activities.[83] Mothers of small children often have limited access to routine and prolonged sleep. Unpaid carers for disabled people often raise broken sleep as an issue that undermines their health. Older women are at higher risk of sleep problems, including insomnia,[84] a range of health conditions experienced by disabled women are associated with long-term difficulties with sleep,[85] and there is a high prevalence of sleep disorders amongst people with learning disabilities.[86]

Finally, meditation and mindfulness activities have become increasingly accessible along with digital access. However, digital exclusion is gendered; women are the majority of non-internet users.[87] Internet usage is markedly lower for disabled people[88] and it is likely that women are more affected than men within this. BME women may also be particularly affected by digital inequality.[89]

<u>Prevention</u>

[83] Engender (2020) Engender Briefing to the Women's Health Plan: What Do Women Experiencing the Menopause in Scotland Need?. Available at: https://www.engender.org.uk/content/publications/Engender-Briefing-to-the-Womens-Health-Plan-What-Do-Women-Experiencing-the-Menopause-in-Scotland-Need.pdf

[84] Office on Women's Health "Insomnia". Available at: https://www.womenshealth.gov/a-z-topics/insomnia

[85] Healthy Aging RRTC (2015) How to sleep better. Available at: https://agerrtc.washington.edu/sites/agerrtc/files/files/Aging_Sleep_2015.pdf

[86] Shanahan et al (2022) The prevalence of sleep disorders in adults with learning disabilities: A systematic review. Available at: https://onlinelibrary.wiley.com/doi/10.1111/bld.12480?af=R

[87] ONS (2019) Exploring the UK's digital divide. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/articles/exploringtheuksdigitaldivide/2019-03-04

[88] ibid

[89] Women and Equalities Committee (2020) Unequal impact? Coronavirus and BAME people. Available at: https://committees.parliament.uk/publications/3965/documents/39887/default/

It is vital that onus and responsibility for supporting mental health and wellbeing is not projected on to women and others that are at risk of poor health and may already be coping with mental illness. As outlined, there are myriad barriers that prevent different groups of women from undertaking the commonly suggested activities to promote good mental health. Indeed, the suggestion to get some exercise or sleep, or to visit friends or attend a cultural activity when this is simply not possible, may aggravate various mental health conditions or prompt poorer mental wellbeing.

The Mental Health and Wellbeing Strategy must focus on structural issues, including tackling economic and social inequality for women, in order to **prevent** poor mental health and wellbeing in the first place.

5.10 We know that money worries and debt can have an impact on mental health and that this is being made worse by the recent rise in the cost of living. In what way do concerns about money impact on your mental health?

5.11 What type of support do you think would address these money-related worries?

Please see comments on the cost of living crisis and the impact on women's mental health on p.21 of this paper, and recommendations to reduce financial precarity on p.14.

6. Access to advice and support for mental wellbeing

As we are answering as a women's equality organisation, our comments regarding access do not respond to the questions targeted at individuals.

Rather, we reiterate the issues set out in response to question 2.3 on what success in achieving better mental health and wellbeing for all would look like.

Gendered barriers to mental wellbeing are intimately linked with women's lower access to income, power, security and safety. These inequalities are further entrenched for minoritised groups of women, including young women, BME women, disabled women, LGBT women, and women with insecure immigration status. Isolation is a major cause of poor mental wellbeing for unpaid carers, single mothers, older women, rural women. Victim survivors of violence against women, women in the criminal justice system, and low-income women, including those in precarious employment, all have specific access needs. Trauma-informed approaches are crucial.

Issues that should be taken into account in an intersectional gender analysis of barriers to advice and support include:

- LGBT women express anxiety about interacting with health professionals who may make assumptions about identities, or services which are not perceived to be inclusive.
- Participants at our 2019 mental health roundtable felt that potential 'perceived consequences' are a strong barrier in seeking help and support – fear of children

being removed, fear of transition processes being paused or stopped, and fear of losing jobs were all raised.

- BME women seem acutely at risk of community and cultural factors acting as a barrier to health and support interventions. A well gendered study on the mental health and wellbeing of BME young people and children in Glasgow found that:
    - Stigma surrounding mental health in some BME communities leads to high levels of non-disclosure, including in the context of arranged marriage.
    - Poor mental health can be associated with "bad blood", "and "blamed on the women and her line."
    - "Many women were unaware of trauma and general mental health issues as the concept of looking after themselves are often non-existent in their communities."
    - British Pakistani women have high levels of social support but high levels of mental health stigma within these.
    - Many women want to access a practitioner from their own community but fear risking disclosure.
    - "Discussing mental health without cultural sensitivity can lead to associations with "madness", witchcraft, sprits, curses and black magic, which can prevent engagement with services."
    - The use of male interpreters can act as a barrier to BME women seeking support, particularly in relation to gender-based violence. [90]
- Women with insecure immigration status may be unaware of rights to emergency healthcare or unwilling to share personal information with statutory services.
- Health services do not flexibly take account of unpaid care roles or that women are more likely to rely on public transport, i.e. with a shortage of flexible appointments.
- Reliance on interpreters for BME, refugee and migrant women, and others who may not speak English acts as barrier to communicating symptoms, especially where informal translation is provided by a relative.
- Domestic abuse may also prevent access to healthcare and support. Pregnant women are at very increased risk of domestic abuse and perinatal services should be aware of risks.

[90] Adzajlic (2022) Mental health and wellbeing of black and minority ethnic children and young People in Glasgow. Available at: https://www.stor.scot.nhs.uk/bitstream/handle/11289/580329/Mental%20health%20and%20wellbeing%20black%20and%20minority%20ethnic.pdf?sequence=1&isAllowed=y

- Travel and transport are a barrier for people experiencing poor mental health, and women are more likely to rely on public transport than men.
- Disclosure of mental health symptoms may act as a barrier for women in rural and remote areas, as well as good, reliable and affordable public transport options.
- Only 2 of the 3 medium security units in Scotland accommodate women and there are few low secure hospital options for women, meaning women are frequently accommodated outside their own health board.[91]
- Mixed sex wards are still in use, and 1/4 women have expressed concerns about their safety on mental health wards.[92]
- Participants at our roundtable expressed concern that CAMHS was not accessible for ethnic minority young women and for LGBT young women.
- Diagnosis and resulting support for eating disorders appears linked to BMI, meaning that women and girls must wait until their illness is 'severe' to access support.
- Increased use of virtual healthcare provision may have significant impacts for women, particularly for older women, BME women and disabled women.[93]

This is an indicative rather than comprehensive list of issues. Ensuring equal access to advice and support must fundamentally take stock of gendered barriers, by building the evidence base and applying intersectional gender analysis to the design and provision of services. Specialist services and/or support are needed for various groups of women including LGBT women, disabled women, some BME women, victim-survivors of violence against women, neurodivergent women, and women in the criminal justice system. As the most at-risk demographic in Scotland barriers for young women must be identified and removed.

7. Improving services

7. 1 We have asked about the factors that influence your mental health and wellbeing, about your own experiences of this and what has helped or hindered you in accessing support. Reflecting on your answers, do you have any specific suggestions of how to improve the types and availability of mental health and wellbeing support in future?

Please see our response to questions 2.3 and 6 in relation to gendered issues that must be considered across the design and delivery of services. It is vital that an intersectional

[91] Mental Welfare Commission (2017) Medium and Low Secure Forensic Wards. Available at: https://www.mwcscot.org.uk/media/385624/medium_and_low_secure_forensic_wards.pdf
[92] Mental Welfare Commission (2017) Scotland's adult acute mental health wards - improvements in care, but patients express fear over safety. Available at <https://www.mwcscot.org.uk/about-us/latest-news/scotlands-adult-acute-mental-health-wards-improvements-in-care,-but-patients-express-fear-over-safety/>
[93] Engender (2020) Engender response to the Scottish Government Consultation on the Digital Strategy for Scotland. Available at <https://www.engender.org.uk/content/publications/Engender-response-to-the-Scottish-Government-Consultation-on-the-Digital-Strategy-for-Scotland.pdf>

approach to improving services is adopted, and that specialist support is developed where needed.

8. The role of difficult or traumatic life experiences

8.1 For some people, mental health issues can arise following traumatic or very difficult life experiences in childhood and/or adulthood. What kind of support is most helpful to support recovery from previous traumatic experiences?

8.2 What things can get in the way of recovery from such experiences?

Women are more than twice as likely to experience post-traumatic stress disorder than men, and tend to experience symptoms for significantly longer than men before diagnosis and treatment.[94] This is intimately connected with the endemic nature of men's violence against women.

Gendered approaches that are intersectional, culturally competent, LGBTI inclusive, accessible, and fully trauma-informed are therefore essential. The lack of rigorous gender competence throughout support and treatment can compound trauma, delaying recovery and causing women harm.

9. Children, young people's and families mental health

We draw attention here to the egregiously disproportionate incidence of poor mental health amongst young women that is indicated throughout this paper. Latest figures from the Scottish Health Survey include deeply concerning figures from the General Health Questionnaire 12 (GHQ-12), in which a score of 4+ indicates a possible psychiatric disorder. Results show that 27% of young women aged 16-24 are included in this category, are twice as likely to experience anxiety as young men, and almost twice as likely to experience depression.

A large-scale study from Steer Education, published in February 2022, found that the mental health of girls (aged 11-18) is "at a precipice" with the pandemic leading to a "growing gulf" between girls and boys.[95] Data showed girls aged 11 are now 30% more likely to experience poor mental health than boys, and girls of 18 more than twice as likely as boys of their own age. Girls are more likely to hide distress, both compared with boys and in comparison with data prior to the pandemic. Girls are also more likely to be adversely affected by internalised control, such as controlling eating, perfectionism, self harm, and obsessive patterns of thinking. The report states that "Strong signals indicate that the specific long-

[94] Olff (2017) Sex and gender differences in post-traumatic stress disorder: an update. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5632782/

[95] Steer Education "Girls' mental health "at a precipice" and increasingly worse than boys', data shows". Available at: https://steer.education/girls-mental-health-at-a-precipice-and-increasingly-worse-than-boys-data shows/#:~:text=The%20findings%2C%20part%20of%20STEER's,the%20UK%20report%2C%20reveal%20that&te xt=Increasing%20numbers%20of%20girls%20now,to%20identify%20and%20help%20them.

term psychological risk from the pandemic will be pathologies driven by internalised control, particularly in girls aged 14-18" and that mental health in young people is unlikely to shift back to pre-pandemic levels in the coming years.[96]

It is **vital** that this Strategy and programmes of support for young people are comprehensively gendered and developed in collaboration in with external gender experts.

10. Your experience of mental health services

N/A

11. Equalities

We are aware that existing inequalities in society put some groups of people at a higher risk of poor mental health. We also know that not being able to access mental health support and services can increase that risk. The previous questions provided an opportunity to comment on the factors that influence our mental health and wellbeing and our experiences of services.

11.1 Do you have any further comments on what could be done to address mental health inequalities for a particular group of people? If so, what are they?

The current Mental Health Strategy is staggeringly ungendered. It references women four times, once in a footnote regarding CEDAW, twice in reference to the action on perinatal mental health, and once in a quote describing the gender breakdown of the onset of psychosis. This latter point is not accompanied by a gender analysis or a gendered response. We hope that given the context and analysis set out in this paper, it is clear why we view this to be unacceptable. Engender has previously engaged with Scottish Government over the EQIA that was published with the strategy for 2017-27, and critiqued it as insufficient. This lack of robust equalities mainstreaming from the outset of the process explains to some extent the gender incompetence of the strategy. It also means the Scottish Government has not been compliant with its obligations under the public sector equality duty, in advancing equality and non-discrimination in mental health.

The Scottish Government's Mental Health Transition and Recovery Plan improves on this, following increased awareness of gendered mental health concerns throughout the pandemic. It contains a section on women and girls and commits to "make women and girls' mental health a priority."[97] However, reference to the root causes of mental health – different forms of women's social and economic inequality – is limited, as is integration of intersectional issues. Aside from the page dedicated to women and girls, women are included in terms of perinatal mental health and referenced in a gender breakdown of the

[96] Steer Education (2022) Navigating the road of adolescence: Young people's mental health in the UK. Available at: https://steer.education/wp-content/uploads/2022/02/Young-Peoples-Mental-Health-in-the-UK-STEER-Report-Feb-2022.pdf

[97] Scottish Government (2020) Mental Health – Scotland's Transition and Recovery. Available at: https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/

incidence of suicide in Scotland, which disproportionately impacts men. Higher rates of parasuicide amongst women is not recognised. Gender inequality is not integrated in other elements of the plan, though many of these are highly gendered (for instance, employment, socio-economic inequalities, relationships, and older people). The next Strategy must mainstream gender analysis throughout, rather than treating women and girls as an add-on. This would lend itself to more coherent policymaking.

We also acknowledge and welcome the work to establish the Mental Health Equality and Human Rights Forum, which has allowed for structured feedback and engagement on the Transition and Recovery Plan. We reiterate, however, concerns with the process of engaging with equalities organisations and their networks. With regard to any future engagement to gather equalities evidence, the following statement from our Forum Feedback Pack remains relevant:

> "We are concerned about the inadequacy of this approach to contribute to meaningful outcomes for women and girls. Engender cannot realistically develop rigorous, or even competent, consultation with women and women's organisations – who have not agreed to commit their time or resources to this work – within four weeks and with the questions provided, which are broadly requests for evidence, much of which is not systematically collected in Scotland. [Such approaches] may provide false assurance that the relevant evidence has been gathered. This is particularly likely to prove harmful to groups of women who are marginalised within existing research and data."

The EQIA that is undertaken for the new Mental Health and Wellbeing Strategy must be developed at the outset of the process, with adequate time to inform the content built in, and to ensure that intersectional equality analysis is embedded throughout. We can anticipate that targeted interventions will be needed for young women, unpaid carers, single parents, and other groups of low-income women. However, evidence at the Scottish level is lacking and it is the EQIA's function to clearly map this, so that the Strategy can include commitments to close qualitative and quantitative data gaps. We know already that research on BME, disabled and LGBT women's mental health at the Scottish level is lacking. An intersectional focus in the EQIA will be vital to build a bigger picture of what is needed to create an approach to mental health and wellbeing that works for all women and girls in Scotland.

12. Funding

12.1 Do you think funding for mental health and wellbeing supports and services could be better used in your area?

Procurement should be used to ensure that mental health and welling supports and services are gender competent. Public procurement that takes account of gender equality considerations has significant scope to leverage public spending to buy gender-sensitive

goods and services and mandate gender-sensitive employment practice. Our recommended draft regulations and response to the Scottish Government's consultation on the public sector equality duty include a requirement for listed authorities to follow a set of 'equality' steps in procurement processes.

General support and services should be designed, delivered and procured in line with guidelines that are gender-sensitive, trauma-informed, culturally competent, accessible and inclusive. Specialist services should be procured in line with a more rigorous set of standards.

13-17. Our mental health and wellbeing workforce

Any discussion of the mental health and wellbeing workforce must take stock of gender and women's equality. Women form a large or overwhelming majority of various roles set out regarding the scope of the mental health and wellbeing workforce on p. 47 of the consultation document. Women are:

- 85% of the NHSScotland psychology workforce[98]
- 86% of the Child and Adolescent Mental Health Services (CAMHS) workforce[99]
- 73% of Mental Health Officers (risen from 69% in 2017)[100]
- 83% of the social services workforce[101]
- 79% of staff at NHSScotland.[102]

This means that mental health workers face gendered barriers to their own mental health and wellbeing, including as unpaid carers, mothers, victim-survivors of violence against women, and insecure, undervalued and underpaid workers. Reflecting broader trends, women working in mental health are more likely to work part-time than men (for instance, 58% of women in the NHS psychology workforce in Scotland work part-time, compared with 29% for men), and are particularly over-represented in low-paid insecure work, including as social care staff in care homes. Studies show that frontline health and social care workers, predominantly women, experienced occupational stress and burnout during the pandemic,[103] with ongoing impacts of this unknown.

[98] NES (2020) Psychology services workforce in NHSScotland. Available at: https://turasdata.nes.nhs.scot/media/aemja1z5/2020-06-02-psychology-workforce-report.pdf
[99] NES (2021) CAMHS workforce in NHSScotland. Available at: https://turasdata.nes.nhs.scot/media/2qtphqzz/2021-06-01-camhs-workforce-report.pdf
[100] SSSC (2022) Mental Health Officers (Scotland) Report 2021. Available at: https://data.sssc.uk.com/images/MHO/MHO2021/Mental_Health_Officers_Scotland_Report_2021.pdf
[101] SSSC (2022) Scottish Social Service Sector: Report on 2021 workforce data: Available at: https://data.sssc.uk.com/images/WDR/WDR2021.pdf
[102] Scottish Government (2022) Health and social care staff experience report 2021. Available at: https://www.gov.scot/publications/health-social-care-staff-experience-report-2021/documents/
[103] Sriharan et al (2021) Women in healthcare experiencing occupational stress and burnout during COVID-19: a rapid review. Available at: https://bmjopen.bmj.com/content/11/4/e048861

We have not been able to consider the questions set out in this section of the consultation in any detail. However, in response to the draft ambitions and outcomes, we make the following observations that will be essential in developing a "detailed Workforce Plan".

- An intersectional gender analysis must be applied if the following goal is to be delivered.

> "To deliver our ambitions, it is essential that we understand the shape of the current mental health and wellbeing workforce in Scotland, and what the future needs of the workforce are."

- To achieve the vision of a workforce that is valued, huge political and financial investment in professional care sectors and the broader care economy is needed. This includes pay rises for the lowest paid (mostly women), as well as the use of social security powers to target income support at unpaid carers.

- To improve recruitment and retention of staff, pay and conditions for social care staff amongst others must be addressed. Chronic issues with recruitment and high turnover of staff in the social care sector[104] testify to the clear need for gender-sensitive investment in the workforce.

- Fair Work practices identified must include gender-sensitive employment practices such as flexible working, carers leave and other carer-friendly approaches, and best practice regarding sexual harassment in the workplace.[105]

- Improved and consistent training standards must include gender competence, intersectionality and other equalities approaches (e.g. LGBTI inclusion) as well as trauma-informed practice and cultural competency.

- Improved diversity must include a focus on the vertical segregation that sees men significantly over-represented in leadership as per the overall gender split of the workforce.

- Data and management information should be gathered and collated such that it is disaggregated by sex, gender-sensitive and allows intersectional analysis. Workforce data should be published.

4.CONCLUSION

Outcomes for women and girls across most aspects of mental health are poorer than those for men and boys.[106] The new Mental Health and Wellbeing Strategy should therefore be

[104] Scottish Care (2018) The 4Rs: the open doors of recruitment and retention in social care. Available at: https://scottishcare.org/wp-content/uploads/2019/11/The-4Rs-The-Open-Doors-of-Recruitment-Retention-inSocial-Care.pdf

[105] Engender (2022) Enough is enough: tackling workplace sexual harassment in Scotland. Available at: https://www.engender.org.uk/content/publications/Enough-is-Enough---tackling-workplace-sexual-harassment-policy-in-Scotland.pdf

[106] Scottish Government (2020) Mental Health – Scotland's Transition and Recovery. Available at: https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/

well gendered as a matter of course. This means embedding gender equality at the strategic and visionary level, applying an intersectional gender analysis to policy development, and stipulating that the commitments and actions set out must be designed and delivered in line with best practice on gender-sensitivity, trauma-informed practice, cultural competence, accessibility and LGBTI inclusion.

There are many gaps in the evidence base regarding mental health and wellbeing for women and girls, in particular for minoritised groups. This is particularly problematic in light of the disproportionate impact of the pandemic on women's mental health, and emerging implications of the cost of living crisis. The Strategy must mandate research and evidence gathering to ascertain the 'state of play' for all groups of women referenced in this paper, along with others that may have specific experiences and needs related to mental health and wellbeing.

Where data does exist, signalling for instance deeply alarming rates of depression, anxiety and other mental health conditions in young women and girls, this has not led to a targeted focus on tackling underlying issues or providing support. The Strategy must commit to developing solutions to address the different ways in which women and girls experience poor mental health, to investment in specialist services where needed, to improving the gender-sensitivity of services, and to ensuring equality of access to support. It must also take a cross-governmental approach, highlight policy areas that undermine or support good mental health for women and girls, and advocate for policy that reduces women's inequality.

The issues that we set out in this response are indicative rather than comprehensive, and Engender is not an expert in mental health by any means. Development of the strategy should be undertaken in collaboration with gender experts in mental health, ensuring that intersectional expertise is fully integrated, as well as with experts in other equalities areas.

FOR FURTHER INFORMATION

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ABOUT US

Engender is Scotland's feminist policy and advocacy organisation, working to increase women's social, political and economic equality, enable women's rights, and make visible the impact of sexism on women and wider society. We work at Scottish, UK and international level to produce research, analysis, and recommendations for intersectional feminist legislation and programmes.