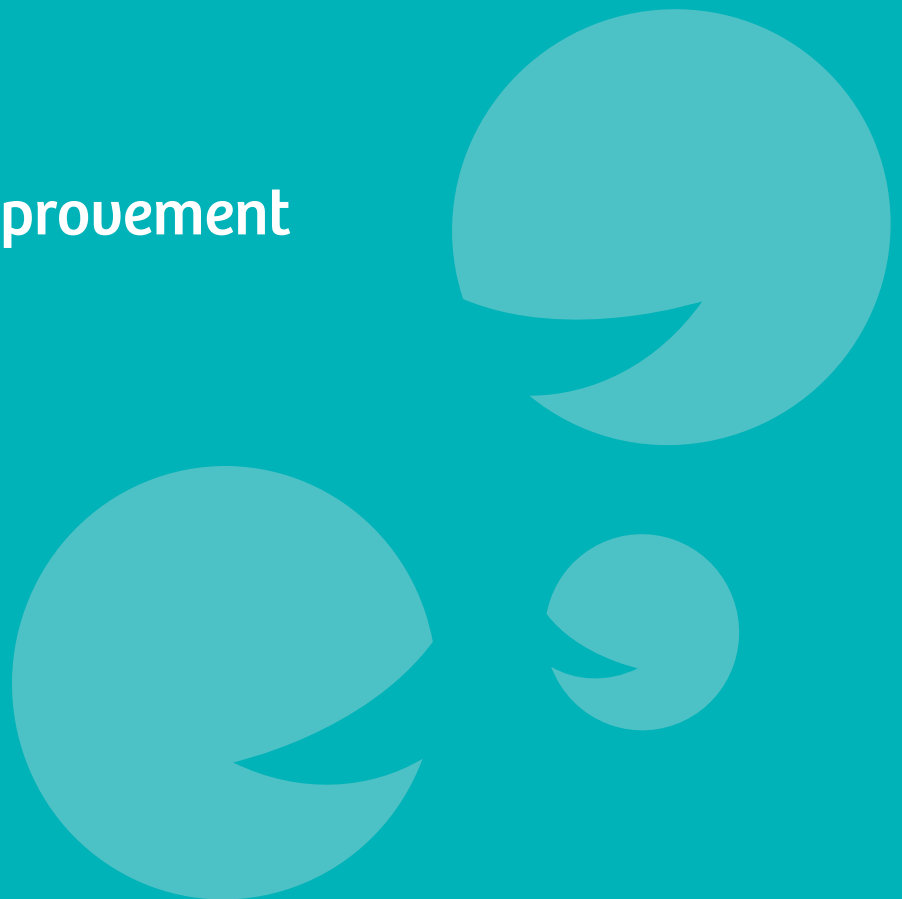


Reducing Mental Health Stigma and Discrimination in Mental Health Services

Diagnostic and Improvement
Framework



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About See Me

See Me is Scotland's national programme working to reduce mental health stigma and discrimination. These persistent injustices create stark inequity in people's lives.

See Me work alongside people with diverse lived experience. We bring together and support communities, organisations and decision-makers to understand where stigma and discrimination exist. We are guided by evidence and research to change the attitudes, behaviours, cultures, policies, practices and systems that allow them to persist.

We build the knowledge, confidence, skills and connections needed to sustain action across Scotland. Together, we are working towards a fair and inclusive society where no one is denied their rights, opportunities or the quality of life they deserve because of mental health stigma or discrimination.

Why we exist

Mental health stigma and discrimination are persistent injustices that create stark inequity in people's lives. They deny people opportunities, access to support and the ability to exercise their rights and live the quality of life they deserve.

Greater openness about mental health does not mean stigma and discrimination have disappeared. They continue to affect people's rights, life chances and outcomes, making sustained national action essential.

What we do and how we create change

Guided by evidence and research, we work alongside people with diverse lived experience of mental health illness and problems and those around them to understand where stigma and discrimination exist and what needs to change.

We lead and connect people and communities with organisations and decision-makers across Scotland – including educators, employers and public services – to challenge discriminatory attitudes and behaviours and influence cultures, policies, practices and systems.

We build and share the knowledge, confidence, skills and connections people and organisations need to take effective action and sustain change.



How we approach the work

We take an intersectional approach because mental health stigma and discrimination are not experienced equally. People's experiences can be shaped by different and interacting forms of prejudice and structural inequity, which must be accounted for in the solutions.

We locate the causes of injustice in how people are perceived and treated, and in the cultures, institutions and systems around them – not in their identities, circumstances or experiences of mental health.

The Scotland we are working towards

Our long-term vision is a fair and inclusive Scotland, free from mental health stigma and discrimination.

Achieving that vision requires collective action across government, public services, employers, educators, communities, organisations and individuals. See Me provides national leadership, connects lived experience with evidence and action, and enables others to create and sustain change.

Together, we are working towards a fair and inclusive Scotland where no one is denied their rights, opportunities or the quality of life they deserve because of mental health stigma and discrimination.

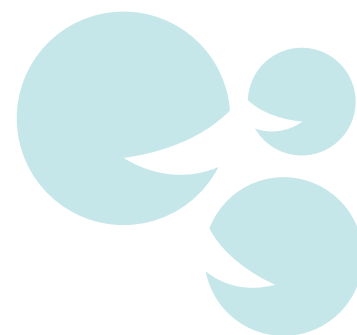
See Me support for mental health services

See Me provide leadership, support and guidance to build national and local capacity. We work with mental health service leaders, improvement teams, in strategic partnership with the third sector, and with people with lived experience of mental health stigma and discrimination.

See Me:

- ✓ Provide tools to support services to identify where stigma and discrimination are in the service.
- ✓ Offer understanding, language and tools to help teams stay focused on need and what matters most to people experiencing mental health stigma and discrimination.
- ✓ Support services to ask the right questions about stigma and discrimination improvement.
- ✓ Support services to position national priorities for anti-stigma at different levels in the service.
- ✓ Provide tools, methods and actions to co-design services with people experiencing mental health stigma and discrimination.
- ✓ Provide tools and evidence for action planning, improvement and evaluation.

Glossary



Mental health problems

These include a range of symptoms that may or may not meet the criteria for clinical diagnosis. Examples include depression and anxiety. The term is often used interchangeably with mental health, mental ill health, and mental distress.

Mental illness

Mental illness refers to a wide range of mental health conditions that affect our mood, thinking, and behaviour. These are diagnosed conditions that can significantly impact daily functioning and quality of life. Mental illness can vary in severity and duration.

Mental health stigma

Mental health stigma is created and reinforced at multiple levels in our society. It marks out, stereotypes and devalues people with mental health problems or illness. Mental health stigma operates through negative attitudes and assumptions and through cultures, institutions and systems. It can affect people who experience mental health problems or illness.

Stigma limits people's choices, opportunities and ability to exercise their rights and participate fully in society. It can be internalised, affecting how people see themselves and what they believe is possible for themselves.

Mental health discrimination

Mental health discrimination is the unfair or inequitable treatment of people with mental health problems or illness. Discrimination is a key part of stigma and is enacted through societal and organisational behaviours and cultures, policies, practices and systems that disadvantage or exclude people. It can be intentional or unintentional, explicit or implicit, and interpersonal or structural.

Intersectionality

A theory and practice that recognises that people experience multiple and overlapping forms of inequity and discrimination across their gender, race, sexuality, age, socio-economic status, ethnicity, citizenship status etc. This approach supports the identification of the structural causes of mental health stigma and discrimination.

Lived experience

All aspects of what a person has undergone and learned based on their history, perspective and identity.

Pathologising

People's mental health conditions are categorised medically as psychological abnormalities attributed to their race, gender, sexuality, class, socio-economic status, disability, neurodivergence, and/or ethnicity.

Marginalised

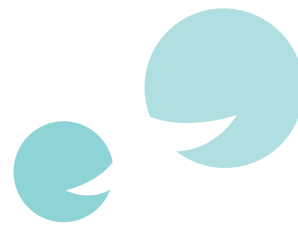
A process of social exclusion in which individuals or groups are relegated to the fringes of a society, being denied economic, political, and/or symbolic power and pushed towards being 'outsiders'.

Peer support

A mutual relationship where people with shared lived experiences support each other particularly as they move through challenging times.

Peer workers

People with lived experience of mental health challenges and recovery who are trained and employed (paid or unpaid) to use their lived experience intentionally to support others in their recovery journey.



Diagnostic and Improvement Framework

Shared goal

To create mental health services where everyone is treated with dignity, and experiences equitable access and outcomes

About the framework



See Me's Diagnostic and Improvement Framework is designed to help mental health services to identify, understand, and reduce mental health stigma and discrimination experienced by people with mental health problems and illness.

It looks beyond individual attitudes to examine how stigma and discrimination are embedded in the structures cultures, systems, and practices that shape how services are designed, delivered and experienced.

Key improvement areas



See Me identified key areas that centre prevention and early intervention, and target embedded structural stigma and discrimination in:

- Equity evidence, system design, resource allocation, accountability and workforce conditions.
- Anti-stigma and -discrimination practice.
- Service policies, pathways and practices.
- Lived experience leadership, power sharing, and co-design.

The framework



We address stigma and discrimination across four interconnected areas:

- **Structural**
Leadership, governance.
- **Cultural**
Beliefs, values, assumptions and norms.
- **Institutional**
Policies, pathways and organisational practices.
- **Personal**
Lived and living experience of people who use the service.

All four areas are interconnected and influence each other.

Who is it for?



The framework is for anyone involved in the design, leadership, delivery or improvement of mental health services.

- Senior leaders and decision-makers.
- Service managers and improvement leads.
- Practitioners and Multi Disciplinary Teams.
- Equality, human rights, quality, and workforce teams.
- People with lived and living experience.
- Communities, partners and organisations.

It's a shared process, not a checklist, and can be used at any stage in your journey.

How to use the framework

The framework follows a two-stage improvement process, with ongoing learning and action.



1 Diagnose

Identify, locate and analyse where stigma and discrimination may be operating in the service.

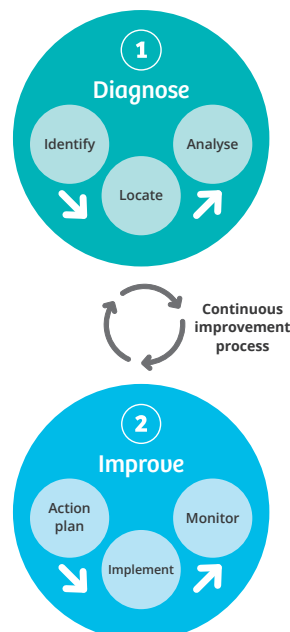
This involves examining evidence from across the Structural, Cultural, Institutional and Personal dimensions of the service. It supports services to look beyond individual attitudes to critically examine the ways that leadership, governance, service design, workplace culture, policies, pathways, and everyday experiences may create, reinforce, or challenge stigma and discrimination.

2 Improve

Use what has been discovered through the diagnostic process to prioritise and implement action.

This involves working collaboratively to develop improvement actions, identify responsibilities, monitor progress, and learn from the impact of change.

The process is continuous



What the framework helps services to do

- Make stigma and discrimination visible in the service.
- Identify what's working and where change is needed.
- Prioritise actions that address structural and systemic barriers.
- Involve people in meaningful ways.
- Build fairer, more inclusive and more effective services.



Scottish Government
Riaghaltas na h-Alba



Penumbra
Mental Health

Overview

About the framework

See Me's Diagnostic and Improvement Framework is designed to support mental health services to identify, understand and reduce mental health stigma and discrimination experienced by people with mental health problems and illness.

The framework is a whole system approach that recognises that stigma and discrimination are not only found in individual attitudes and behaviours; they are also embedded in the institutional structures, cultures, systems, policies and practices that determine how services are designed, delivered and experienced.

Key evidence-based improvement areas centre prevention and early intervention, and target the root causes of structural mental health stigma and discrimination across:

- equity evidence, system design, resource allocation, accountability, workforce conditions,
- anti-stigma and -discrimination practice,
- service policies and pathways,
- lived experience leadership, power sharing, and co-design.

The framework addresses a gap between ambitions set out across Scottish Government strategies and plans and practical implementation within mental health services. The framework provides a structured process for translating commitments to prevention, equity, and reducing stigma into improvement practice. The framework provides mental health services with the clarity to:

1. examine how stigma and discrimination operates across key improvement areas,
2. identify where stigma and discrimination contribute to inequitable experiences and outcomes,
3. plan and implement practical, measurable improvement.

At its core, the framework recognises that reducing stigma and discrimination is not an additional or separate activity. It is fundamental to providing safe, equitable, person-centred mental health care.

Who is the framework for?

The Diagnostic and Improvement Framework is intended for anyone involved in the design, leadership, delivery or improvement of mental health services.

This may include:

- Senior leaders and decision-makers;
- Service managers and improvement leads;
- Mental health practitioners and multi-disciplinary teams;
- People and teams with responsibility for equality, human rights, quality improvement or workforce development;
- People with lived and living experience of mental health problems and illness;
- Peer workers;
- Communities, partners and organisations involved in the design or delivery of mental health support.

The framework is designed to support collaborative improvement. It is not designed to be completed by one person or used as an external assessment of whether the service is 'good' or 'bad'.

Instead, it creates a shared process for asking:

- Where does stigma and discrimination occur in the service?
- Who is affected?
- How does it operate?
- What evidence do we have?
- What will we do differently?
- How will we know if we've made a difference?

Services can use this framework whether they are beginning to consider mental health stigma and discrimination or if they already have anti-stigma activity underway. It can help teams identify gaps, strengthen existing work, and ensure action addresses the personal, structural and systemic conditions that can reproduce stigma and discrimination.

How to use the framework

The framework supports a two-stage improvement process:

1

Diagnose

Identify, locate and analyse where stigma and discrimination may be operating in the service.

This involves examining evidence from across the Structural, Cultural, Institutional and Personal dimensions of the service. It supports services to look beyond individual attitudes to critically examine the ways that leadership, governance, service design, workplace culture, policies, pathways, and everyday experiences may create, reinforce, or challenge stigma and discrimination.

2

Improve

Use what has been discovered through the diagnostic process to prioritise and implement action.

This involves working collaboratively to develop improvement actions, identify responsibilities, monitor progress, and learn from the impact of change.

The framework is not a checklist with a single correct answer. Services will begin in different places, and face different challenges. The purpose is to support meaningful enquiry, reflection and action that can be adapted in local contexts. At every stage, people with lived and living experience should play a meaningful role in identifying problems, interpreting evidence, shaping priorities, and designing solutions.

The framework should be used as a continuous improvement process (Figure 1):

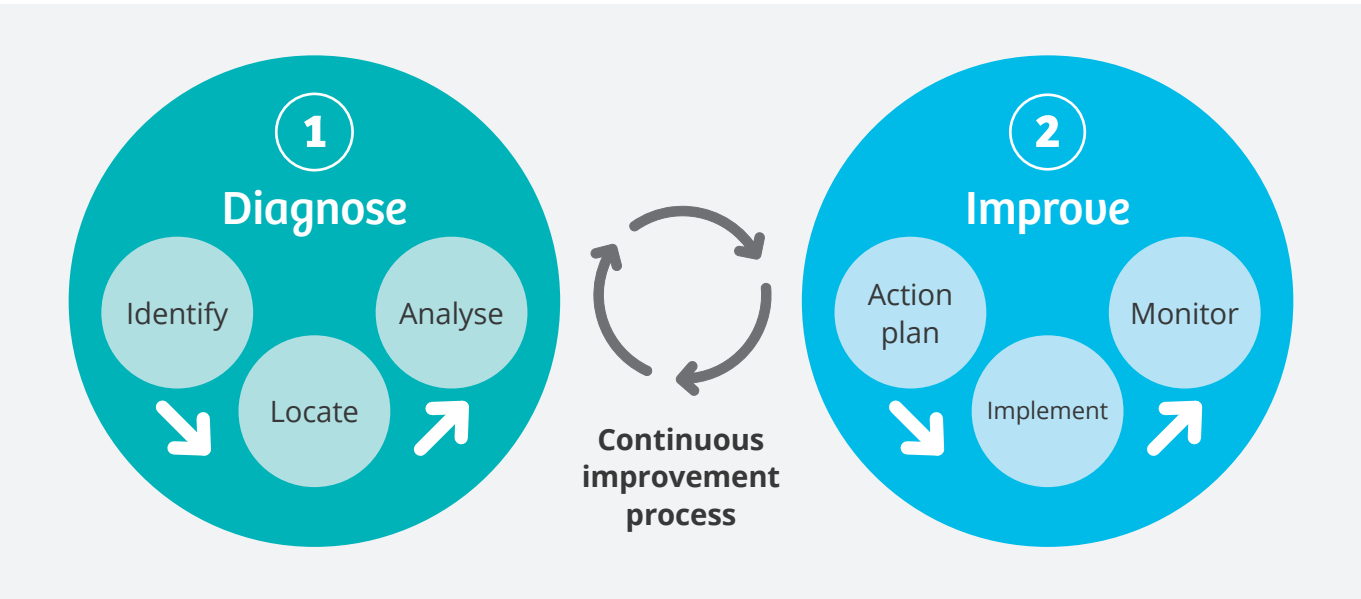


Figure 1. The diagnostic and improvement process

The framework supports services to make stigma and discrimination visible within the systems and practices of mental health services. It aims to support sustained action towards services where people are treated with dignity and experience equitable access and outcomes.

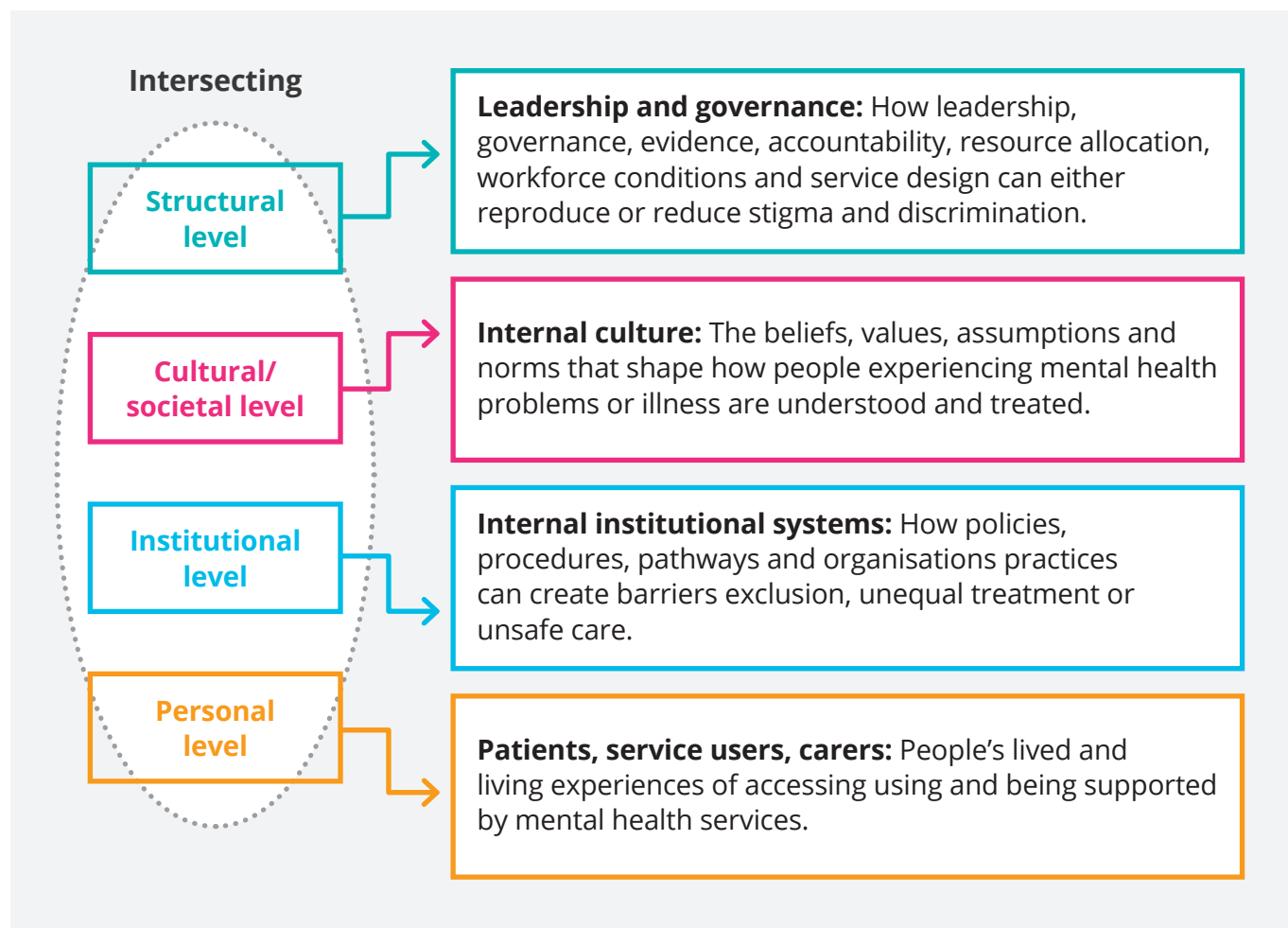


Figure 2. Locating stigma and discrimination across four levels¹

It supports services to explore stigma and discrimination across four connected levels (Figure 2). Improvement in one level is unlikely to be sufficient if stigma and discrimination continue to be reproduced elsewhere. For this reason, the framework encourages services to move beyond a sole focus on interpersonal stigma to ask:

- How might our systems, cultures, structures and practices be producing or reinforcing stigma and discrimination?
- What needs to change?

The diagnostic and improvement process

1

'Diagnose' (identify, locate, analyse)

a. Identify: Establish the nature, scale and impact of mental health stigma and discrimination.

- How do we know if people are experiencing mental health stigma and discrimination?
- Who is experiencing mental health stigma and discrimination?
- Who is experiencing poorer access, quality, safety or outcomes?
- Whose experiences are missing from our evidence?
- How do experiences differ across groups of people?

b. Locate: Identify where mental health stigma and discrimination is occurring and embedded in the service.

- **Structural:** Are leadership and governance processes creating or dismantling the conditions for mental health stigma and discrimination?
- **Cultural:** How do service beliefs, norms, and attitudes normalise or challenge mental health stigma and discrimination?
- **Institutional:** How do service policies, pathways and everyday practices reproduce or reduce mental health stigma and discrimination?
- **Personal:** How do people's experience of the service demonstrate the presence or absence of mental health stigma and discrimination? How do their experiences demonstrate access, engagement, and recovery?

c. Analyse: Understand root causes and identify priorities for improvement.

- What patterns of mental health stigma and discrimination are emerging?
- Which groups of people experience the greatest inequities?
- What structural, cultural or institutional factors contribute to these experiences?
- Are experiences of mental health stigma and discrimination caused by service processes, the service culture, or wider systems?
- What needs to change?

2

Improve (action plan, implement and monitor)**a. Action plan: Develop targeted improvements**

Structural: Are leadership and governance processes creating or dismantling the conditions for mental health stigma and discrimination?

- Strengthen leadership accountability.
- Improve equity monitoring.
- Align resources with need.
- Embed lived experience in governance.
- Address fair working conditions.

Cultural: How do service beliefs, norms, and attitudes normalise or challenge mental health stigma and discrimination?

- Develop anti-stigma and –discrimination capability.
- Strengthen person-centred, recovery-oriented, trauma-responsive, rights-based, intersectional practice.
- Identify, challenge, and address mental health stigma and discrimination.

Institutional: How do service policies, pathways and everyday practices reproduce or reduce mental health stigma and discrimination?

- Review and co-design policies and pathways.
- Improve assessment, referral and care planning processes.
- Strengthen cultural safety.

Personal: How do people's experience of the service demonstrate the presence or absence of mental health stigma and discrimination? How do their experiences demonstrate access, engagement, and recovery?

- Improve experiences of safety, dignity, choice and inclusion.
- Use feedback to design and adapt services.

b. Implement targeted improvements

- Who is accountable for the improvement process?
- Who will coordinate, lead and support the improvement actions?
- What are the timescales?

c. Monitor: Determine if improvements are reducing mental health stigma and discrimination and improving equitable care.

- Are fewer people reporting experiences of mental health stigma and discrimination?
- Are inequities in access, quality, and outcomes reducing?
- Do people experience services as safer, more respectful, and more inclusive?
- Are engagement, recovery and wellbeing outcomes improving?
- **What have we learned that needs further action?**

1

Part 1: Mental Health Stigma and Discrimination



Definition and impact

Lived and living experiences of mental health stigma and discrimination

People who experience mental health problems and illness are at risk of experiencing mental health stigma and discrimination. It shows up as issues of access to and quality of care from mental health services. Equitable access means that people can obtain the mental healthcare they need, when they need it. Good quality care is safe, effective and respectful.²

Mental health stigma and discrimination are not experienced equally by all people or across all problems or conditions. The 2025 Scottish Social Attitudes Study³ reported that people with severe and enduring mental illness continue to be at heightened risk of discriminatory public attitudes. In the wider context, stigma related to mental illness is recognised as one of the most significant challenges in global mental health.⁴

People who experience mental illness may face poorer quality of life⁵ and can die 15 to 20 years earlier⁶ than people who don't experience it. Stigma and discrimination play a significant part in those inequities. Conditions like schizophrenia, bipolar disorder, or borderline personality disorder are often deeply stigmatised⁷ resulting in inequitable access to care and compromised quality of care.

People who experience mental health problems *and* illness and severe, multiple disadvantage are at heightened risk of experiencing mental health stigma and discrimination. Deeply stigmatised mental illnesses often link to discrimination against people with marginalised identities.⁸

Multiple forms of stigma and discrimination mutually shape the lived experiences and opportunities⁹ of people who are marginalised. This creates distinct disadvantages. These lived experiences cannot be understood in isolation from one another.¹⁰

Mental health stigma and discrimination is experienced by most people who identify as living with mental illness, and disproportionately affect people with:

- Protected Characteristics,
- marginalised identities (across gender, race, sexuality, disability and neurodivergence, ethnicity, age, citizenship status etc.).

And people who have experience of, or are experiencing:

- adverse living conditions (e.g. poverty and homelessness),
- adverse lived experiences (e.g. trauma, violence, ACEs¹¹ and GBV¹²),
- and stigmatised responses to distress (suicidality, self-harm, and substance use).

Mental health stigma and discrimination exacerbate existing health inequalities for people within these populations.

What is mental health stigma and discrimination?

Mental health stigma and discrimination is both interpersonal and structural. It includes explicit and implicit¹³ prejudicial attitudes, beliefs, and values and discriminatory behaviour, practice, and policies.¹⁴ Current community-based and academic evidence advocates for a shift away from solely addressing interpersonal stigma to address stigma and discrimination in policy advocacy and change, system redesign, resource allocation, and lived experience evidence.¹⁵

Mental health stigma and discrimination is a form of ableism that is based in systems of power and privilege. It intersects with other forms of stigmatisation and discrimination including misogyny, racism, homophobia, transphobia, classism, ageism and xenophobia. This results in compounded and cumulative harms, including intensified barriers to accessing services and negative engagement with services.

Mental health stigma and discrimination have a long historical legacy dating back centuries ([Appendix 2](#)). This legacy is embedded in our society, cultures, institutions, and communities. Mental health stigma has three functions¹⁶ which cause and perpetuate inequality, discrimination, and social exclusion:

- norm enforcement (keeping people in),
- domination (keeping people down),
- and 'disease' avoidance (keeping people away).

Mental health stigma and discrimination:

- Result in exclusion and isolation.¹⁷
- Increase health, social, and economic inequality.¹⁸
- Worsen people's quality of life.¹⁹
- Worsen people's mental and physical health outcomes.²⁰
- Have profoundly negative impacts on recovery.²¹
- Lower people's life span by up to 20 years.²²
- And are consistently associated with adverse outcomes across life domains (including employment, education, health care, and active participation in the community).²³

The impacts of mental health stigma and discrimination

Internalised stigma and anticipating stigma²⁴ from mental health services are significant barriers to help-seeking and contribute to worsening mental health. Mental health stigma and discrimination cause people to internalise negative societal views of their mental health problems and themselves.²⁵ This is coupled with lived experience of structural stigma and discrimination in mental health and wider services, including poor access, stigmatising attitudes, pathologising, diagnostic overshadowing of physical health issues, and unmet need.

Internalised stigma and anticipating stigma from mental health services result in:²⁶

- reduced help-seeking,
- people hiding or 'masking' their mental health condition,
- reduced adherence to treatment,
- reduced openness to therapeutic interventions,
- and reduced efficacy of some treatments.

'Stigma by association' or 'associative stigma' is applied to and experienced by the families and carers.²⁷ Among other impacts, this can lead to barriers to seeking care for a relative.²⁸ Mental health professionals are also subject to stigma by association.²⁹ A recent study by See Me³⁰ on stigma and mental health nurses in Scotland reported a range of negative impacts³¹ including trauma, stress, and demotivation, job dissatisfaction, low resilience, and professional burnout. This contributes to critical staff shortages in the sector.



Mental health stigma and discrimination in mental healthcare

Mental health stigma and discrimination is present in organisational cultures of care³² at multiple levels. It is embedded structurally in complex social and systemic processes in:³³

- how services are commissioned, designed, delivered and experienced,
- how people are treated (clinically and interpersonally),
- how clinical environments, structures and pathways are maintained.

Equitable access to care³⁴

Structural stigma and discrimination surfaces when policies and practices produce inequitable access to health care for people living with mental health problems and illness.

Access is compromised in several ways:

- inequitable distribution of resources (services and treatment),
- under identification and treatment of health problems,
- withholding of services,
- inflexible pathways and access criteria,
- fragmented care.

Equitable quality of care³⁵

Structural stigma and discrimination are expressed when people systematically receive a lower quality of care.

The serious issues impinging on quality of care include:

- prejudicial attitudes and poor practices among healthcare and other practitioners;
- judgement and biased assessment of capability and agency, particularly for people with complex mental illness;
- adverse health-care decisions, interactions and experiences;
- the overuse of coercive or paternalistic approaches.

People living with mental health problems and illnesses can be subject to a wide range of inequalities in mental health services.

These include:³⁶

- Imbalances of power in relationships when disclosing or making decisions about care and support. People often describe not being listened to, not being taken seriously, and being judged.
- Failure in the provision of appropriate, personalised services or support that is responsive and sensitive to individual needs and circumstances.
- Stigmatising myths and stereotypes that are reinforced through political rhetoric, in the media, in communities, and by family members and carers.

These factors can prevent people from accessing the information, support, and resources they need, creating mistrust and further exclusion.³⁷





Part 2: The Diagnostic and Improvement Framework

Leadership, Governance, Service Design and Resource Allocation

Key question

Who experiences poorer access to care and poorer quality of care?

Diagnostic Area 1: Equity Evidence³⁸

- How do we collect, analyse, and monitor engagement and experiences of groups most at risk³⁹ of experiencing mental health stigma and discrimination?
- How do we use the evidence to ensure equitable access⁴⁰ to care and good quality care⁴¹ when people receive it?

Diagnostic and Improvement Questions

What do we know about our approach to equity evidence?

- How do our approaches to equity evidence (collection, analysis, action and monitoring) challenge or reproduce structural mental health stigma and discrimination?
- In what ways are our systems capable of seeing mental health stigma and discrimination?
- Who might experience mental health stigma and discrimination because of how our equity evidence is collected, interpreted, or used? How?

What do we know about inequitable patterns in the service?

- Who is not accessing or benefiting from services?
- Who says that they have experienced mental health stigma and discrimination?
- Who says that they have experienced poorer access, and quality of service?
- When we aggregate people's experiences what patterns of inequity are revealed?
- How are resources unaligned with need?
- Are we monitoring delays, waiting lists, care opinion, complaints and tribunals for indications of discriminatory distribution of resources?

What do we know about service equity differentials in the service?

- Within our service who is most at risk of experiencing mental health stigma and discrimination?
- Who is experiencing higher rates of detention?
- Who is most at risk of waiting longer?
- Who is most likely to be discharged?
- Who is most at risk of being excluded from treatment?

Diagnostic and Improvement Questions (continued)

What do we know about equity in outcomes?

- How do we monitor outcomes?
- How are outcomes monitored by gender, race, ethnicity, sexuality, migration status, language and other Protected Characteristics?
- How do we collect disaggregated, intersectional rather than single-category evidence?

Good Practice Improvement Aims		Actions
1	Our equity evidence collection, analysis, action, and monitoring and Accountability align with Scotland’s programme of public services reform; National Priorities; and Approaches.	Embed mental health stigma and discrimination in existing governance, equality, and improvement systems.
2	We collect and analyse multiple sources of equity evidence.	Establish routine collection and intersectional analysis of lived experience, access, outcome and quality data.
3	We identify outcomes, inequitable patterns, and service differentials.	Use evidence to identify patterns of poor access, quality and outcomes and where mental health stigma and discrimination is embedded.
4	We use the equity evidence to action plan for improvement.	Translate evidence into co-designed, accountable improvement plans.
5	We monitor equity evidence for improvement impact.	Track whether changes reduce mental health stigma and discrimination and improve equitable care.
6	There is clear and structured accountability in mental health stigma and discrimination detection, action, and monitoring processes.	Define leadership responsibility, reporting structures and oversight mechanisms.

Sources of Guidance

- Scotland’s Equality Evidence Strategy 2023-2025
- Public Health Scotland, Evidence for improving equalities data collection, 2024
- Voices of Experience (VOX), Collective Lived Experience Advocacy
- Equality and Human Rights Impact Assessment (EQHRIA)
- WHO Transforming mental health through lived experience: Roadmap for integrating lived and living experience practitioners into policy, services and community, 2025

Leadership, Governance, Service Design and Resource Allocation

Key question

Who experiences poorer access to care and poorer quality of care?

Diagnostic Area 2: Accountability

- How are we accountable for identifying, addressing and monitoring mental health stigma and discrimination within mental health services?

Diagnostic and Improvement Questions

What do we know about our approach to accountability?

- How are we accountable for identifying, taking action to reduce, and monitoring mental health stigma and discrimination?

Leadership and governance

- How can mental health stigma and discrimination be explicitly identified and monitored?
- How can mental health stigma and discrimination be discussed at Senior and/or Board level?

Action and improvement

- What are the accountability and action processes where stigma and discrimination are identified?
- Who is responsible for responding to identified inequities?
- How are inequitable experiences and outcomes reviewed and acted upon?
- How can actions be assigned clear ownership, resources, timescales, and measures of impact?
- How can people with lived experience be involved in interpreting findings and shaping responses?

External accountability

- What and who are services accountable to in identifying and addressing mental health stigma and discrimination?
 - Public Sector Equality Duty
 - Legislation
 - Rights frameworks⁴²
 - Professional standards
 - Mental Welfare Commission
 - Communities and people with lived experience.

Good Practice Improvement Aims		Actions
1	Our accountability processes align with Scotland’s programme of public services reform; National Priorities; and Approaches.	• Embed mental health stigma and discrimination within governance and quality improvement processes. • Establish mechanisms to identify and monitor mental health stigma and discrimination through equity evidence. • Inequitable experiences and outcomes trigger review, action and improvement. • Define leadership responsibility for responding to mental health stigma and discrimination. • Report on progress and impact through senior leadership and Board structures. • Define and ensure accountability to legislation, rights frameworks, regulators, communities and people with lived experience.
2	There is clear accountability for identifying, addressing and monitoring mental health stigma and discrimination within mental health services.	

Sources of Guidance

- Scottish Government, Clinical and Care Governance Framework 2015
- NHS Scotland – blueprint for good governance 2022
- Health & Social Care Service Renewal Framework 2025-2035
- Integration Joint Board – roles, responsibilities and membership: guidance and advice 2025
- Equality and Human Rights Impact Assessment (EQHRIA)



Leadership, Governance, Service Design and Resource Allocation

Key question

Who experiences poorer access to care and poorer quality of care?

Diagnostic Area 3: Service Design

- Do our service design processes create equitable, accessible, non-stigmatising services?

Diagnostic and Improvement Questions

What do we know about approach to service design?

- How do our approaches to service design challenge or reproduce mental health stigma and discrimination?
- Who experiences stigma and discrimination due to our service design processes? How do we know? What do they experience?
- Who is included or excluded from the service design decisions? Who has the power to define and solutions?

Collaborative Leadership and Governance

- Does the way we design services redistribute power towards people with lived experience (PWLE)?
- How do we understand PWLE of mental health stigma and discrimination as having agency and expertise to contribute to service design improvement?
- How do we recognise PWLE of mental health stigma and discrimination in the service from a strengths-based perspective?
- How do we understand people with lived and living experience of mental health stigma and discrimination, carers, and frontline staff as experts in how the service is experienced?
- How is collaborative leadership operationalised at the strategic, service, and improvement levels?
- When are PWLE consulted about service design decisions?
- Are structures, resources and support in place to enable meaningful participation?

Co-design

- How does lived experience guide service design, delivery, and service evaluation?
- In what ways are PWLE involved from the start of the process?
- How do we ensure that co-design includes the people most affected by mental health stigma and discrimination?
- How do we know that co-design has influenced decisions and outcomes?
- What methodologies of co-design do we follow?
- Does participation increase people's influence, agency and control over decisions?

Diagnostic and Improvement Questions *(continued)*

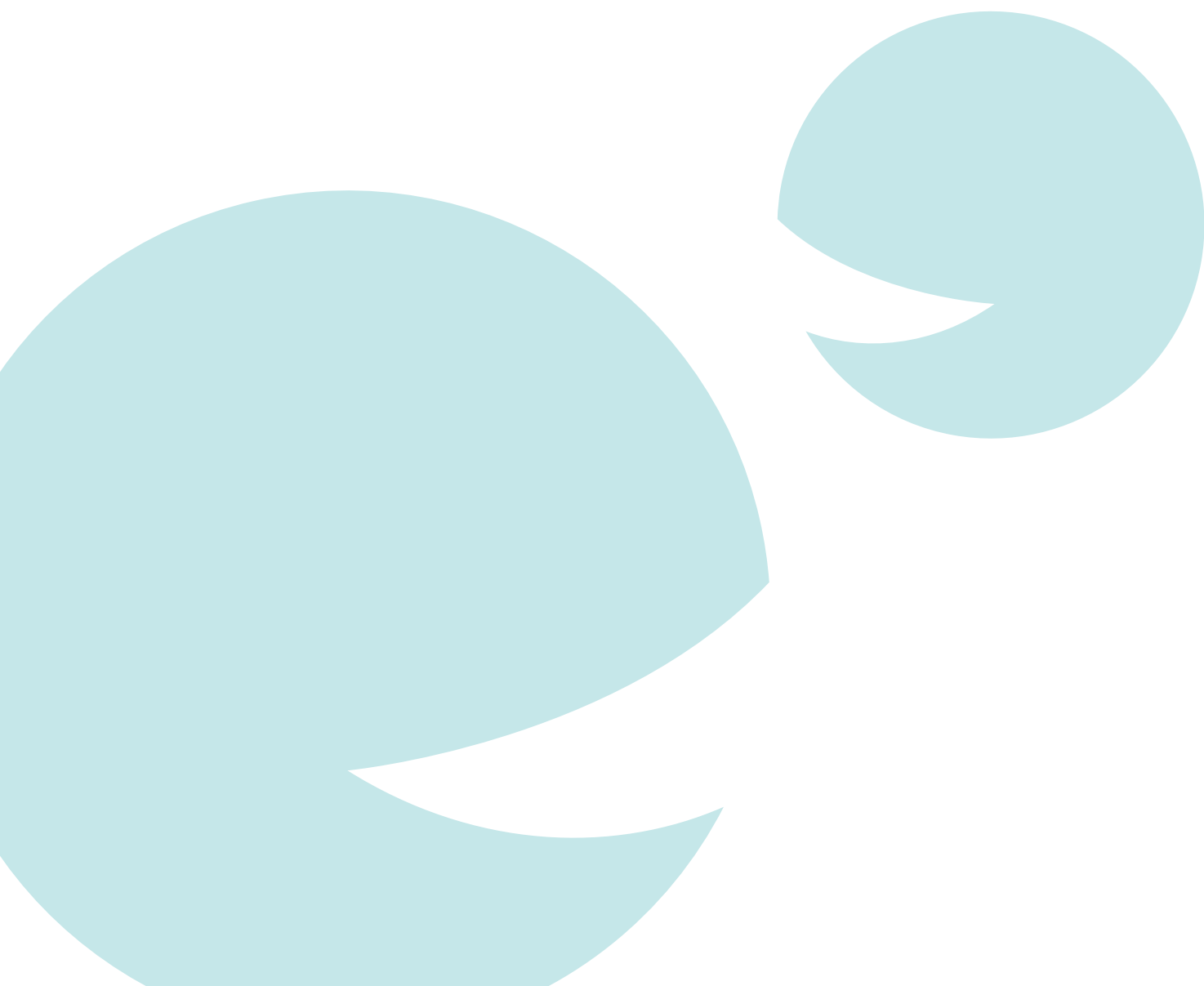
Peer Involvement

- Where peer involvement exists, how do we monitor and evaluate it for impact on mental health stigma and discrimination?
- In what ways are peer involvement roles valued as expertise?
- How are peer workers supported, included and treated equitably in the workforce?
- How do our peer involvement opportunities reach people most affected by mental health stigma and discrimination?
- How are barriers to training and employment for marginalised groups identified and addressed?
- What are the career progression pathways for peer roles?

Good Practice Improvement Aims		Actions
1	Our service is designed to align with Scotland’s programme of public services reform; National Priorities; and Approaches.	• Review existing service design processes for exclusion, assumptions, and unequal power relationships; identify who is missing or underrepresented. • Embed an ethical collaborative leadership model. • Embed a strategic, resourced, and sustainable collaborative service co-design programme. • Monitor and evaluate collaborative service co-design processes for impact on mental health stigma and discrimination.
2	Service design processes actively challenge mental health stigma and discrimination by embedding lived experience and shared decision making.	
3	Collaborative leadership structures recognise PWLE of mental health stigma and discrimination as experts, partners and leaders in service improvement.	
4	Co-design approaches ensure that the people most affected by mental health stigma and discrimination shape service design, delivery, and evaluation.	
5	Peer involvement is valued as expertise and contributes to reducing mental health stigma and discrimination	• Develop and sustain accessible, equitable, fair working peer roles within services, with career progression paths. • Monitor and evaluate peer involvement for impact on mental health stigma and discrimination.

Sources of Guidance

- The Scottish Approach to Service Design, How to design services with people, 2026
- See Me, Creating Space: Arts based approaches to tackling mental health stigma, 2025
- WHO Mosaic toolkit to end stigma and discrimination in mental health, 2024
- Mental Health Foundation, Diverse Experiences Advisory Panel
- King's Fund, The practice of collaborative leadership across health and care services, 2023
- Scottish Co-production Network, The Co-production Guide, 2026
- Scottish Recovery Network: Peer support in Scotland – Insight Report 1
- WHO Transforming mental health through lived experience, 2025



Leadership, Governance, Service Design and Resource Allocation

Key question

Who experiences poorer access to care and poorer quality of care?

Diagnostic Area 4: Resource Allocation

- How does resource allocation ensure equitable access to care and good quality care when people receive it?

Diagnostic and Improvement Questions

What do we know about approach to resource allocation?

- How do our approaches to resource allocation challenge or reproduce mental health stigma and discrimination?
- How do we know that our resource allocation decisions are equitable?
- Who might experience mental health stigma and discrimination because of how and where our resources are prioritised, distributed, or accessed? How and why?

Equity evidence

- How are resources allocated according to existing service models and demand?
- How are resources transparently allocated according to population need and evidence of inequity?
- How does equity evidence and co-design expertise inform our resource allocation processes?
- How are resources allocated according to prevention, early intervention, and community-based support?

Inequitable access and outcomes

- Which groups of people are waiting to access services?
- Which groups of people have the longest waiting times?
- How long are they waiting?
- What is the impact on their health and wellbeing?
- Which groups of people experience the poorest outcomes?
- Which groups of people are the least likely to access support?
- Which groups of people experience barriers to our service? What are the barriers?

Good Practice Improvement Aims		Actions
1	Our resources are allocated in alignment with Scotland’s programme of public services reform; National Priorities; and Approaches.	• Identify unmet need and inequitable access using equality evidence and co-design expertise. • Identify where resource allocations contributing to unequal outcomes. • Investment is prioritised where the evidence demonstrates poorer access, outcomes, greatest barriers, experiences of mental health stigma and discrimination. • Investment prioritises prevention, early intervention, and community-based approaches. • Resource allocation decisions are monitored, evaluated, and routinely reviewed to track whether changes reduce mental health stigma and discrimination and improve equitable care.
2	Resource allocation is informed by equity evidence and co-design expertise to reduce mental health stigma and discrimination and improve equitable access, quality, and outcomes.	

Sources of Guidance

- Public Health Scotland, Health Impact Assessments (HIA)
- Assessment (EQHRIA)
- WHO Transforming mental health through lived experience, 2025



Leadership, Governance, Service Design and Resource Allocation

Key question

Who experiences poorer access to care and poorer quality of care?

Diagnostic Area 5: Workforce Conditions

- How do we understand how workforce conditions influence practitioners' ability to provide non-stigmatising, equitable, rights-based care?
- How do workforce conditions enable compassionate, reflective, and equitable practice?
- How do we understand that the organisational culture and workforce conditions are determined at Structural Level and operationalised at Cultural Level?

Diagnostic and Improvement Questions

What do we know about our approach to workforce conditions?

- How do workforce conditions challenge or reproduce mental health stigma and discrimination?
- Who experiences mental health stigma and discrimination due to workforce conditions (pressures or organisational constraints)? How?

Conditions

- In what way do staffing levels impact mental health and wellbeing?
- How do staff report burnout?
- How is mental health and wellbeing addressed in supervision?
- What training do staff have access to
- How is reflexive practice embedded in the service?
- Which groups of staff are disproportionately affected by their working conditions? How might this influence experiences of care?

Accountability and responsibility

- In what ways do leaders demonstrate accountability and responsibility for the workforce conditions that enable staff to provide non-stigmatising, equitable, rights-based care?

Good Practice Improvement Aims	Actions
1 Our workforce conditions align with Scotland's programme of public services reform; National Priorities; and Approaches.	Embed person-centred, recovery-oriented, trauma-responsive, equality and human rights-based, intersectional practice as a cultural foundation for reducing mental health stigma and discrimination.
2 Workforce conditions enable staff to provide non-stigmatising, equitable, rights-based care.	Review workforce capacity and pressures that affect relational care.
3 Workforce planning matches the needs of person-centred, recovery-orientated, right-based, trauma-responsive, culturally safe care models.	• Resources allocation is based on requirements for person-centred, recovery-orientated, right-based, trauma-responsive, and culturally safe service design. • Embed workforce wellbeing as an enabler of equitable care. • Ensure that workforce conditions support staff have knowledge, confidence, and support to practice equitable care and to challenge mental health stigma and discrimination. • Services routinely undertake and monitor Staff surveys; Focus groups; Reflective practice sessions; Training evaluations, and Service user-narratives. • Leaders routinely monitor staff feedback, and complaints by PWLE, families, and carers.

Sources of Guidance

- Fair Work Convention
- Equality and Human Rights Impact Assessment (EQHRIA)
- WHO Transforming mental health through lived experience, 2025

Service Beliefs, Values, Norms, and Attitudes

Key question

What assumptions about mental distress, diagnoses, and identity are embedded within the organisation?

Diagnostic Area 1: Beliefs, Values, Norms, and Attitudes

- What beliefs, values, assumptions and norms shape how people are understood, treated and valued in the service?
- How do we use this information to ensure equitable access to care and good quality care when people receive it?

Diagnostic and Improvement Questions

What do we know about our approach to our service's culture?

- How do our beliefs, values, norms, and attitudes challenge or reproduce mental health stigma and discrimination?
- In what way does practitioner prejudice and bias produce stigmatising and discriminatory practice in the service?
- Who might experience mental health stigma and discrimination because of our institutional culture? How and why?
- How does our current workforce knowledge and training offer challenge or reproduce mental health stigma and discrimination?

Attitudinal risks

Are there beliefs or attitudes that create different experiences of care for groups most at risk of experiencing mental health stigma and discrimination?

- How are cultural safety and multiple disadvantages understood?
- How do staff understand the relationship between mental distress and experiences of discrimination, trauma and exclusion?
- In what ways are some diagnoses viewed more negatively than others?
- What practice is in place to ensure:
 - people with histories of trauma are understood and treated fairly?
 - people who self-harm are understood and treated fairly?
 - people who use substances understood and treated fairly?
- To what extent are people from some groups understood through pathologising, deficit-based or stereotypical narratives?
- How do assumptions about risk, credibility, motivation, or responsibility influence care?

Diagnostic and Improvement Questions *(continued)*

National change approaches

Person-centred, recovery-oriented practice

- How do we see people beyond their distress and/or diagnoses?
- How do we support dignity, choice, hope and agency?
- How are people understood holistically?
- How do we understand people's identities, relationships, strengths, cultures and communities?
- How do we understand people's wider social circumstances and experiences of exclusion?
- How is lived experience believed and valued and viewed as expertise?
- To what extent are power dynamics between PWLE and professionals recognised, understood and addressed?
- To what extent are people treated as active partners in their recovery?

Trauma-responsive practice

- How do we understand distress in context and avoid creating further harm?
- How are we curious about what happened to people (over what is 'wrong' with people)?
- How do we avoid practices, language, or interactions that may recreate experiences of powerless, fear or shame?
- How are PWLE's responses to the service understood as meaningful adaptations to trauma?
How is risk understood?

Equalities and human rights-based practice

Fairness and equity

- How do we uphold dignity, equality, autonomy and participation and challenge discrimination?
- How do we recognise and address unequal experiences, access and outcomes?
- How do we identify groups experiencing mental health stigma and discrimination and examine why these inequities exist?
- How are bias, prejudice, and discriminatory assumptions actively challenged?

Respect and dignity

- How are people treated with compassion, dignity and respect?
- How do people feel safe, included, and respected within services?
- How are people protected from degrading, dismissive, or discriminatory experiences?

Autonomy

- How are people supported to make decisions about their care?
- How are shared decision-making and choice embedded within relationships and practice?
- What opportunities do people have to meaningfully influence over what happens to them?

Diagnostic and Improvement Questions (continued)

Participation and empowerment

- How are people with lived experience active partners in shaping services?
- How are people supported to challenge decisions or discrimination when it occurs?
- What opportunities do people have to influence improvement and change?

Intersectional practice

- How do we recognise that stigma and discrimination are compounded by multiple, interconnected inequalities that impact people across identity, circumstances, and experiences?
- How do we recognise and name the structural inequities and systems of power⁴³ that shape people’s experiences of distress, stigma, and access to care?
- How do we understand the impact of ableism, racism, sexism, socio-economic disadvantage, classism, misogyny, homophobia, transphobia, and xenophobia on people’s experiences?

Good Practice Improvement Aims		Actions
1	Our organisational cultural aligns with Scotland’s programme of public services reform; National Priorities; and Approaches.	• Embed person-centred, recovery-oriented, trauma-responsive, equality and human rights-based, intersectional practice as a cultural foundation for reducing mental health stigma and discrimination. • Embedded workforce training, supervision, reflective practice, and support in person-centred, recovery-oriented, trauma-responsive, equality and human rights-based, intersectional practice.

Sources of Guidance

- Learning from Person-Centred Approaches, 2023
- WHO Quality Rights module on transforming services & promoting rights
- An Expanded Definition of Intersectional Stigma for Public Health Research and Praxis, 2022
- A Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland, 2023
- Trauma-informed approaches to supporting people experiencing multiple disadvantage, 2023
- See Me, Evidence to Action: System-Wide Intersectional Approach to Tackle Mental Health Stigma and Discrimination
- See Me, Challenging Mental Health Stigma & Discrimination Through an Intersectional Approach
- Health Service Executive Ireland, National framework for recovery in mental health 2024–2028

Service Beliefs, Values, Norms, and Attitudes

Key question

What assumptions about mental distress, diagnoses, and identity are embedded within the organisation?

Diagnostic Area 2: Identifying, challenging, and addressing mental health stigma and discrimination

- What beliefs, values, assumptions and norms shape how people are understood, treated and valued in the service?
- How do we use this information to ensure equitable access to care and good quality care when people receive it?

Diagnostic and Improvement Questions

What do we know about our approach to leadership accountability and responsibility?

- How are leaders responsible for creating a culture that prevents and addresses mental health stigma and discrimination?
- How are leaders visibly accountable for identifying, addressing and monitoring mental health stigma and discrimination?
- What are the procedures for identifying, addressing and monitoring mental health stigma and discrimination?
- Who is responsible for identifying, addressing, and monitoring mental health stigma and discrimination?
- How are reports and complaints analysed for patterns of mental health stigma and discrimination?
- How are reports from the workforce and complaints from PWLE, families and carers used as learning opportunities to improve the culture?

Workforce

- How are workforce supported and expected to challenge colleagues, systems or practices that may contribute to mental health stigma and discrimination?
- How accessible, safe, and easy to navigate are reporting procedures for the workforce?

Diagnostic and Improvement Questions *(continued)*

PWLE, families and carers

- How accessible, safe, and easy to navigate are complaints procedures for PWLE, their families and carers?
- Do PWLE, their families and carers know to raise concerns?
- How is advocacy used to support PWLE, their families and carers to make complaints?
- How do PWLE, their families and carers see that concerns and complaints about mental health stigma and discrimination are taken seriously and lead to action?

Good Practice Improvement Aims		Actions
1	Our organisational cultural aligns with Scotland’s programme of public services reform; National Priorities; and Approaches.	• Define leadership responsibility, reporting structures and oversight mechanisms. • Leaders ensure workforce safety to challenge and report mental health stigma and discrimination. • Leaders ensure that there are independent advocacy and complaints mechanisms that are easily accessible and well-publicised. • Routine equity evidence collection, analysis, action and monitoring including analysing reports, complaints and audits of lived experience, case-notes, and care plans.
2	There is clear and structured accountability in mental health stigma and discrimination detection, action, and monitoring processes.	

Sources of Guidance

- Voices of Experience (VOX), Collective Lived Experience Advocacy
- Scottish Government, Clinical and Care Governance Framework 2015
- NHS Scotland – blueprint for good governance 2022
- Health & Social Care Service Renewal Framework 2025-2035
- Integration Joint Board – roles, responsibilities and membership: guidance and advice 2025
- Equality and Human Rights Impact Assessment (EQHRIA)

Policies, pathways and practices

Key question

How do service values, policies, and pathways translate into day-to-day practice?

Diagnostic Area 1: Policies, pathways, and everyday practices

- How do we understand how and where our policies, pathways and practices contribute to mental health stigma and discrimination?
- How do we use this information to ensure equitable access to care and good quality care when people receive it?

Diagnostic and Improvement Questions

What do we know about our approach to policies, pathways, and everyday practices?

- How do our policies, pathways, and workforce practices to challenge or reproduce mental health stigma and discrimination
- Who experiences mental health stigma and discrimination due to our service policies, pathways, and practices?
- How do we design service processes around people's needs and realities?

Access, eligibility, and inclusion

- How do eligibility criteria, thresholds, and service models influence equitable access? How do we know they do not exclude people from some groups?
- In what ways do our current policies, pathways and practices prioritise prevention, early intervention, and community-based approaches?
- How do we understand who is currently included and excluded? How do we know?
- How do our diagnostic thresholds challenge or reproduce mental health stigma and discrimination?
- Are some diagnoses excluded from treatment?
- Are there distress, risk, diagnoses, or complexity thresholds?
- Are people excluded from treatment due to substance use, trauma histories, neurodivergence, disability, age, migration status, communication needs?

Diagnostic and Improvement Questions (continued)***Attendance***

- What are our attendance policies? Do they create barriers for specific groups? How do we know?
- How accessible are our appointment systems? Who for?
- How flexible and accessible are our service hours?
- How accessible are our buildings?
- Do we understand non-attendance as potential communication of unmet need?

Referrals

- What are our referral criteria? Are they transparent and accessible?
- Do our referral criteria exclude some groups? Who? How do we know?
- What are our referral routes?
- How are referral decisions made? Do they challenge or reproduce mental health stigma and discrimination?

Cultural safety

- How are our services culturally safe and appropriate?
- How are communication needs identified and supported?
- Do we provide clarity about how information is shared with other systems like immigration, child protection, safeguarding processes?
- Do service processes recognise experiences of discrimination and exclusion?

Assessment and diagnostics

- Does diagnostic overshadowing occur? How do we know? Who for?
- Are physical health concerns taken seriously? How do we know? Who for?
- How are risks interpreted differently for different groups?
- How are diagnoses influenced by assumptions about gender, race, sexuality, disability, trauma, self-harm or substance use?
- How do diagnostic biases and processes cause disparities in health outcomes for groups most at risk of experiencing mental health stigma and discrimination?

Care Planning

- How is shared decision making consistently practised?
- How do people have meaningful influence over their care?
- Is advocacy routinely offered?
- How are family, friends and chosen support networks included where appropriate?
- How are people's goals, values, and priorities reflected?
- How are care plans based on people's strengths and aspirations as well as mental health needs?
- How are people's identities, cultures, and circumstances considered?

Diagnostic and Improvement Questions *(continued)****Transitions***

- Which people experience poorer transitions between services? Who? How do we know?
- Who experiences gaps in care?
- How are people discharged due to readiness?
- How are people discharged with appropriate support and follow-up?
- How are transitions planned collaboratively?
- How are people at increased risk of exclusion when they move between services, when they reach age thresholds, when there are changes in their eligibility, when they are discharged?



Good Practice Improvement Aims		Actions
1	Our policies, pathways and everyday practices align with Scotland’s programme of public services reform; National Priorities; and Approaches.	• Conduct a collaborative, systematic review of exclusionary criteria with PWLE. • Identify where eligibility criteria, thresholds or processes create exclusion. • Co-design pathways based on lived experience. • Routine use of EQHRIAs in collaboration with PWLE to conduct reviews of policy, referral pathways, and eligibility criteria to identify and remove discriminatory barriers.
2	Policies and pathways are designed to reduce mental health stigma and discrimination and promote equitable access, inclusion and outcomes.	
3	Assessment, diagnoses, and care practices are safe, equitable, and free from discriminatory bias.	• Embed trauma-responsive and culturally safe approaches. • Advocacy and communication supports are routinely available. • Equity evidence is monitored to identify and act on differences in diagnoses, treatment, and outcomes between groups.
4	Service processes enable people to remain engaged and to experience continuity of care, dignity and recovery.	• Review attendance and engagement policies. • Embed a strengths-based approach that supports shared decision making and autonomy in care planning. • Embed collaborative transition planning. • Embed transition processes that support inclusion, continuity, and better outcomes for people.

Sources of Guidance

- Core Mental Health Standards 2023
- WHO Transforming mental health through lived experience, 2025
- WHO, Guidance on mental health policy and strategic action plans 2025
- Equality and Human Rights Impact Assessment (EQHRIA)

Lived Experience and Outcome Expertise

Key questions

How do people experience mental health services as accessible, safe, inclusive, and effective?

How do people's experiences and outcomes demonstrate the presence or reduction of mental health stigma and discrimination?

Diagnostic Area 1 & 2: Lived experience of the service and Outcome Expertise

Lived Experience and Outcomes Expertise

- How do we understand lived experience of stigmatising and discriminatory mental health care as a source of evidence that inform improvement at multiple levels (SCIP).⁴⁴
- How do we use this information to ensure equitable access to care and good quality care when people receive it?

Diagnostic and Improvement Questions

What do we know about our approach to lived experience and outcomes expertise?

- What mechanisms are in place to understand people's experiences and outcomes?
- How do we measure and learn from people's experiences and outcomes to determine if improvements are reducing mental health stigma and discrimination, and improving equitable care?

Lived experience of access, inclusion and quality

- How do we understand people's experiences of accessing and receiving mental healthcare?
- How can we be sure people experience our service as welcoming, safe, inclusive, and culturally responsive?
- How do we know:
 - people feel listened to, believed and respected?
 - people experience dignity, choice and autonomy in their care?
- Who experiences poorer access, poorer quality of care, or exclusion from services?
- Whose experiences are missing from our evidence?

Lived experience of engagement and recovery

- How do we know:
 - people experience care as supporting engagement, hope and recovery?
 - people are participating in decisions about their care?
 - people feel supported to remain engaged with the service?
 - people feel improvements in their wellbeing and quality of life?
- In what way are there differences in engagement and recovery outcomes between people and groups?
- How do experiences of mental health stigma and discrimination influence help-seeking, trust in services, engagement, treatment, and recovery?

Good Practice Improvement Aims		Actions
1	Our understanding of lived experience evidence aligns with Scotland's programme of public services reform; National Priorities; and Approaches.	• Embed the use of inclusive We have a robust inclusion approach to ensure that seldom-heard groups can participate. • Embed the use of lived experience measures. • Collect feedback at multiple points across the care pathway.
2	We understand people's experiences and outcomes of mental health services through inclusive and meaningful lived experience evidence.	
3	Lived experience evidence informs improvement activity to reduce mental health stigma and discrimination and improve equitable care.	• Embed mechanisms at the Structural Level to collect, analyse, action, and monitor lived experience evidence of access, inclusion, engagement, and recovery. • Embed PWLE as partners in improvement work. • Establish processes to translate lived experience into improvement priorities. • Embed the use of lived experience evidence to identify inequities, understand causes, prioritise actions, co-design solutions.
4	We evaluate whether improvements are reducing mental health stigma and discrimination and improving people's experiences and outcomes.	• At the Structural Level we measure the impact of improvement actions using lived experience expertise; We monitor change in experiences of mental health stigma and discrimination; We identify learning and adapt services accordingly.

Sources of Guidance

- Mental Health Commission of Canada, Stigma Cultures in Health Care Scale, 2025
- Stuart and Knaak, 2025, Client experiences of structural stigma in mental healthcare settings
- WHO Transforming mental health through lived experience: Roadmap for integrating lived and living experience practitioners into policy, services and community, 2025
- HIS Ethical Commissioning Research Report, 2024
- The National Care Service Charter of Rights 2026

Appendix 1: See Me Evidence-base

What is good anti-stigma practice in mental health services?

Between 2025 and 2026 See Me collated a robust evidence-base to define good anti-stigma practice in mental health services. This evidence informs our *Good Anti-Stigma Practice Principles* and grounds our *Diagnostic and Improvement Framework for Reducing Mental Health Stigma and Discrimination in Mental Health Services*. We continue to develop this evidence-base, ensuring that it reflects up-to-date multi-disciplinary research.

Overview

We conducted a thematic analysis of primary and secondary research. We collated evidence from a range of sources. This included:

- 1. UN Sustainable Development Goals, Mental Health Legislation, and Scottish Government strategies, frameworks and guidance.
- 2. Global good practice in mental health strategies and frameworks from mental health commissions and directorates.
- 3. Lived experience research with See Me volunteers, our Community and Priority Group Programme, and wider communities across Scotland.
- 4. Mental health practitioners.
- 5. Mental Welfare Commission Scotland.
- 6. Academic literature.

UN Sustainable Development Goals, Legislation and Scottish Government strategies, frameworks and guidance

Document Title	Author/Publisher	Date
Measurement of Wellbeing Framework	The Organisation for Economic Co-operation and Development (OECD)	2011
National Performance Framework	Scottish Government	2026
Scottish Mental Health Law Review	McKay, C. et al., Scottish Government	2022
Patient Rights (Scotland) Act 2011	Scottish Government	2011
Public Services Reform Strategy	Scottish Government	2025
Scottish Approach to Service Design	Scottish Government	2026

UN Sustainable Development Goals, Legislation and Scottish Government strategies, frameworks and guidance

Document Title	Author/Publisher	Date
Scotland's Population Health Framework	Scottish Government	2025
Health & Social Care Service Renewal Framework	Scottish Government	2025
Mental Health and Wellbeing Strategy, Delivery Plan, and Workforce Action Plan	Scottish Government	2023
Self-Harm Strategy and Action Plan 2023 to 2027	Scottish Government	2023
Creating Hope Together Scotland's Suicide Prevention Strategy 2022-2032	Scottish Government	2022
Distress Brief Intervention (DBI)	Scottish Government	
Multi-Agency Partnership Approach to Distress Framework for Collaboration	Scottish Government	
Core Mental Health Standards	Scottish Government	2023
Health and Social Care Standards	Scottish Government	2017
Realistic Medicine & Value-Based Care	NHS Scotland	2022
GIRFE	Scottish Government	2025
What Matters to You?	Health Improvement Scotland	2017
A Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland	National Trauma Transformation Programme (NTPP)	2023
Women's Health Plan	Scottish Government	2021
Women's Health Plan Phase Two	Scottish Government	2026
Women's Experiences of Discrimination and the Impact on Health	Scottish Government	2023
Race Equality Framework for Scotland	Scottish Government	2016
Anti-Racism Delivery Plan	Scottish Government	2026
Non-Binary Equality Action Plan	Scottish Government	2023
National Mission on Drug Deaths: Plan	Scottish Government	2022
Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan	Scottish Government	2026
The National Mental Health and Substance Use Protocol	Health Improvement Scotland	2024
Equality and Human Rights Mainstreaming Action Plan	Scottish Government	2025
Public Health Scotland Together we can: Our 10-year strategy to 2035	Public Health Scotland	2025
Using intersectionality to understand structural inequality in Scotland: evidence synthesis, 2022	Scottish Government	2022

Global good practice in mental health frameworks and reports from mental health commissions and directorates

Document Title	Author/Publisher	Date
Structural stigma in health-care contexts for people with mental health and substance use issues: A literature review	Livingston, J.D., Mental Health Commission of Canada	2020
The Chief Public Health Officer’s Report on the State of Public Health in Canada: Addressing Stigma – Towards a More Inclusive Health System	Mental Health Commission of Canada	2019
Public Health Canada Action Framework for Building an Inclusive Health System	Mental Health Commission of Canada	2019
Public Health Canada Stigma Cultures in Health Care Scale (SCHCS)	Mental Health Commission of Canada	2024
Public Health Canada Structural Stigma Measures Case Study	Mental Health Commission of Canada	2025
National framework for recovery in mental health 2024–2028	Health Service Executive (HSE) Ireland	2024
WHO Mosaic toolkit to end stigma and discrimination in mental health	WHO	2024
Guidance on mental health policy and strategic action plans	WHO	2025
Victorian Psychiatrist Leadership Framework Competencies: Co-leadership	The Royal Australian and New Zealand College of Psychiatrists	2024

See Me Lived experience evidence, research and reports

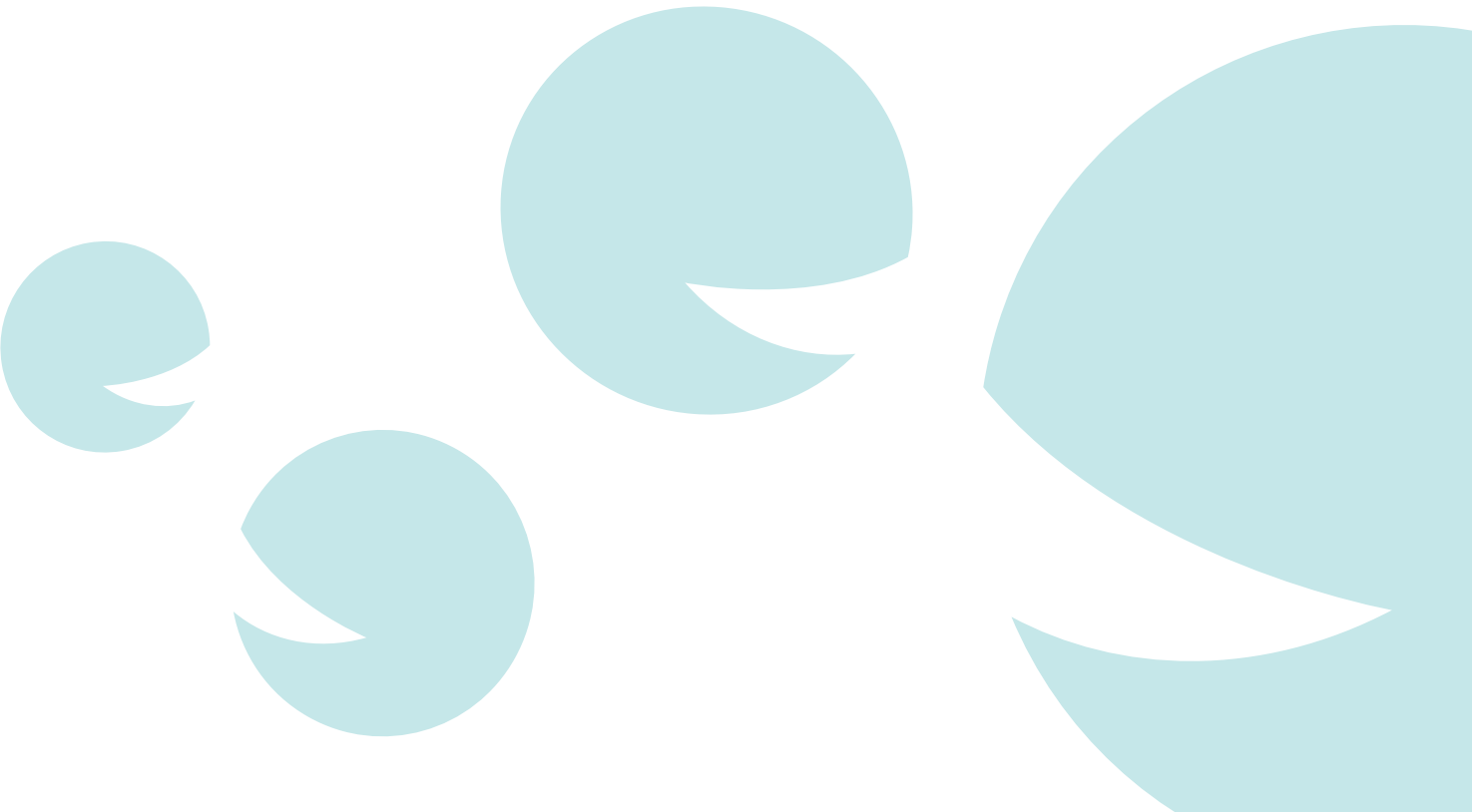
Document Title	Author/Publisher	Date
Scottish Mental Illness Stigma Study	See Me	2022
Reducing Mental Health Stigma and Discrimination, Expert Group Report	See Me [Internal document]	2024
See Me Communities and Priorities Groups: Intersectional Evidence Report	See Me [Internal document]	2025
Evidence to Action: System-Wide Intersectional Approach to Tackle Mental Health Stigma and Discrimination	See Me	2025
Challenging Mental Health Stigma & Discrimination Through an Intersectional Approach	See Me	2025
Creating Space: Arts based approaches to tackling mental health stigma	See Me	2025

Mental health practitioners

Document Title	Author/Publisher	Date
Workshop with Robert Gordon University, Mental health nursing undergraduates from See Me’s Educating for Change Programme	See Me [Internal document]	2025
Interviews with Scottish community-based mental health models of good practice including Hillcrest Futures: The Beacon , Penumbra: Hope Point , Anchor House: The Neuk	See Me [Internal document]	2025
The Stigma by Association in Mental Health Nursing: Final Report	Rudd, B., Nguyen, V., and Scott-Pearce, M.; See Me, Mental Health Foundation, University of Abertay	2025

Regulator evidence

Document Title	Author/Publisher	Date
Desk-based analysis of Mental Welfare Commission 2024-2025 Visit Reports and Recommendations.	See Me [Internal document]	2025



Academic public health evidence in mental health stigma and discrimination reduction

- Abubakar, I. et al. (2022). Confronting the consequences of racism, xenophobia, and discrimination on health and health-care systems. *The Lancet*, Volume 400, Issue 10368, 2137 – 2146. doi: [10.1016/S0140-6736\(22\)01989-4](https://doi.org/10.1016/S0140-6736(22)01989-4)
- Adu J., et al. (2024). Negotiating familial mental illness stigma: The role of family members of persons living with mental illnesses. *PLoS ONE* 19(9): e0311170. <https://doi.org/10.1371/journal.pone.0311170>
- Adu, J., et.al. (2023). Experiences of familial stigma among individuals living with mental illnesses: A meta-synthesis of qualitative literature from high-income countries. *Journal of Psychiatric and Mental Health Nursing*, 30, 208–233. <https://doi.org/10.1111/jpm.12869>
- Blair Irvine, A., et al. (2012). Mental Illness Training for Licensed Staff in Long-Term Care. *Issues in Mental Health Nursing*, 33(3), 181–194. <https://doi.org/10.3109/01612840.2011.639482>
- Blume, L. (2002). Stigma and Social Control. Reihe Ökonomie / Economics Series No. 119, Institute for Advanced Studies (IHS), Vienna. <https://hdl.handle.net/10419/71207>
- Boardman, J. and Dave, S. (2020). Person-centred care and psychiatry: some key perspectives. *BJPsych International*;17(3):65-68. doi:[10.1192/bji.2020.21](https://doi.org/10.1192/bji.2020.21)
- Bourdieu, P. (1991). *Language and Symbolic Power*. Harvard University Press.
- Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity*, New York, Routledge.
- Carrara, B.S. et al. (2019). Stigma in health professionals towards people with mental illness: An integrative review. *Archive of Psychiatric Nursing*;33(4):311-318. doi: [10.1016/j.apnu.2019.01.006](https://doi.org/10.1016/j.apnu.2019.01.006). Epub 2019 Jan 26.
- Chan, J.K.N. et al. (2023). Life expectancy and years of potential life lost in people with mental disorders: a systematic review and meta-analysis, *eClinicalMedicine*, Volume 65, 102294.
- Chandra, A. et al. (2022) Equity as a guiding principle for the public health data system. *Big Data* 10:S1, 3–8, <https://www.liebertpub.com/doi/full/10.1089/big.2022.0204>
- Chin, J. L. (Ed.). (2010). *The psychology of prejudice and discrimination* (A revised and condensed edition). Praeger/ABC-CLIO.
- Clement, S. et al. (2012), Filmed v. live social contact interventions to reduce stigma: randomised controlled trial. *Br J Psychiatry*;201(1):57-64. doi: [10.1192/bjp.bp.111.093120](https://doi.org/10.1192/bjp.bp.111.093120). Epub 2011 Dec 8. PMID: 22157800.
- Cohen, A. K. and Syme, S. L. (2013). Socioeconomic status and health: A review of the literature. *The Social Determinants of Health, 2nd edition*, 105-123. doi: [10.1037/0003-066x.49.1.15](https://doi.org/10.1037/0003-066x.49.1.15)
- Collins, P.H. (1990). Black feminist thought in the matrix of domination. *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*, 138(1990), 221-238.
- Commons Treloar A.J. and Lewis A.J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality disorder. *Aust N Z J Psychiatry*;42(7):578-84. doi: [10.1080/00048670802119796](https://doi.org/10.1080/00048670802119796).
- Corrigan, P.W. et al. (2004), Structural levels of mental illness stigma and discrimination. *Schizophr Bull.* 2004;30(3):481-91. doi: [10.1093/oxfordjournals.schbul.a007096](https://doi.org/10.1093/oxfordjournals.schbul.a007096). PMID: 15631241.
- Crenshaw, K. (1989). [Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique](https://doi.org/10.1215/00141801-1989-001)

of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum, (1), 139–167.

Crocker, J., Major, B. and Steele, C.M. (1998). Social Stigma. In Gilbert, D.T., Fiske S.T., and Lindzey, G. (Eds.), *The Handbook of Social Psychology* (pp. 504–553). Boston: McGraw-Hill.

Dinur, R. (2022). Intentional and Unintentional Discrimination: What Are They and What Makes Them Morally Different. *Journal of Moral Philosophy*, vol. 19, no. 2, 2022, pp. 111–134. <https://doi.org/10.1163/17455243-20213430>

Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences*, 5(4), 565-575. [doi:10.3390/bs5040565](https://doi.org/10.3390/bs5040565)

Eschliman, E.L. et al., (2024). The use and operationalization of “structural stigma” in health-related research: A scoping review. *BMC Public Health* 24, 3614. <https://doi.org/10.1186/s12889-024-21171-8>

Fanon, F. (2001). *The wretched of the earth* (C. Farrington, Trans.). Penguin Classics. (Originally published in 1961)

Frazer-Carroll, M. (2023). *Mad World: The Politics of Mental Health*. First edition. London, England: Pluto Press.

Goffman, E. (1963). 1922-1982. *Stigma; Notes on the Management of Spoiled Identity*. Englewood Cliffs, N.J. Prentice-Hall.

Greig, I. et al. (2024). [Experiences of poverty stigma and mental health in the UK](#). Mental Health Foundation.

Gronholm, P.C. et al. (2017). Interventions to reduce discrimination and stigma: the state of the art. *Soc Psychiatry Psychiatr Epidemiol* 52, 249–258. <https://doi.org/10.1007/s00127-017-1341-9>.

Gronholm, P.C. et al. (2023). Toward a multi-level strategy to reduce stigma in global mental health: overview protocol of the Indigo Partnership to develop and test interventions in lowand middle-income countries. *Int J Ment Health Syst* 17, 2 <https://doi.org/10.1186/s13033-022-00564-5>

Gov.uk. Detentions under the Mental Health Act, Published 16 August 2024 [Detentions under the Mental Health Act – GOV.UK Ethnicity facts and figures](#)

Gupta, S. et al. (2024). [Mental health stigma and its relationship with mental health professionals – A narrative review and practice implications](#). *Indian J Psychiatry*;66(4):336-346.

Hanisch, S.E. et al. (2016). [The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review](#). *BMC Psychiatry*; 6;16:1.

Hatzenbuehler M.L., Phelan J.C., and Link B.G., (2013), Stigma as a fundamental cause of population health inequities. *Am J Public Health* DOI: 2013;103:813-21.

Hatzenbuehler M.L., Phelan J.C., and Link B.G., (2014), Introduction to the special issue on structural stigma and health, *Social Science & Medicine*, Volume 103, Pages 1-6. <https://doi.org/10.1016/j.socscimed.2013.12.017>.

Hemeida, S. and Goldberg, D. (2022). Dismantling structural addiction stigma in law: Policies for systematic change. *Families, Systems, & Health*, 40(2), 288–290. <https://doi.org/10.1037/fsh0000714>

Hempeler, C. et al. (2024) [Intersectional Discrimination in Mental Health Care: A Systematic Review With Qualitative Evidence Synthesis](#). *Psychiatr Serv*; 1;75(11):1125-1143. Epub 2024 June.

Hughes, K. et al. (2017) [The effect of multiple adverse childhood experiences on health: a systematic](#)

review and meta-analysis. *The Lancet Public Health*, Volume 2, Issue 8, e356 – e366

Ilyas, A., Chesney, E., and Patel, R. (2017). Improving life expectancy in people with serious mental illness: should we place more emphasis on primary prevention? *Br J Psychiatry*;211(4):194-197. Epub 2017 Sep 7.

Kågström, A., et al. (2025). Mental health stigma and its consequences: a systematic scoping review of pathways to discrimination and adverse outcomes, *eClinicalMedicine*, Volume 89, 103588, <https://www.sciencedirect.com/science/article/pii/S2589537025005218>

Lima J. et al. (2025). Intersectionality and mental health in university students: a jeopardy index approach. *Rev. Saude Publica*;59:e3. <https://doi.org/10.11606/s1518-8787.2025059006197>

Link, B.G. and Phelan, J.C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, 27(1), 363–385. <https://www.jstor.org/stable/2678626>

Livingston, J.D. (2020). *Structural stigma in health-care contexts for people with mental health and substance use issues: A literature review*. Ottawa: Mental Health Commission of Canada.

Lowther-Payne, H.J. et al. (2023). Understanding inequalities in access to adult mental health services in the UK: a systematic mapping review. *BMC Health Serv Res* 23, 1042. <https://doi.org/10.1186/s12913-023-10030-8>

Maternal Mental Health Alliance (2025), MBRRACE 2025: *Mental health still the leading cause of late maternal death*

Mehta, N. and Thornicroft, G. (2013). 'Stigma, Discrimination, and Promoting Human Rights', in Patel, V. and others (eds), *Global Mental Health: Principles and Practice*, New York; online edn, Oxford Academic, 1 Feb. 2014), <https://doi.org/10.1093/med/9780199920181.003.0018>.

Mental Health Foundation (2023), *Evidence Review: How do education-based anti-stigma interventions impact mental health stigma and discrimination among qualified and pre-qualifying healthcare professionals?* [Internal document].

Metzl, J.M., (2009). *The protest psychosis: How schizophrenia became a black disease*. Beacon Press.

NHS England, *Improving the physical health of people living with severe mental illness*, Published 10 January 2024.

Ng Y.P., Rashid A., and O'Brien F. (2017). Determining the effectiveness of a video-based contact intervention in improving attitudes of Penang primary care nurses towards people with mental illness. *PLoS One*;12(11):e0187861. doi: 10.1371/journal.pone.0187861.

Njaka, S., et al., (2023). A systematic review on prevalence and perceived impacts of associative stigma on mental health professionals, *International Journal of Africa Nursing Sciences*, Volume 18, <https://doi.org/10.1016/j.ijans.2023.100533>.

Ordover, N. (2003) *American Eugenics: Race, Queer Anatomy, and the Science of Nationalism*. University of Minnesota Press.

Parker, R. and Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science & Medicine*;57:13–24. doi: 10.1016/s0277-9536(02)00304-0

Phelan, J.C., Link, B.G. and Dovidio, J.F., (2008). Stigma and Prejudice: One Animal or Two? *Social Science & Medicine*, 67(3), 358-367. doi: 10.1016/j.socscimed.2008.03.022

Rao, D., et al. (2019). A systematic review of multi-level stigma interventions: state of the science and future directions. *BMC Med* 17, 41. <https://doi.org/10.1186/s12916-018-1244-y>

Rojas Vistorte, A.O. et al. (2018). Clinical decisions and stigmatizing attitudes towards mental health problems in primary care physicians from Latin American countries. *PLoS One*;13(11):e0206440. doi: [10.1371/journal.pone.0206440](https://doi.org/10.1371/journal.pone.0206440)

Sap, K. and Stupak, R., (2026). Dignity in mental health care: the conceptual connections between sense of dignity, stigma and self-stigma among people with mental disorder diagnoses. *Front. Psychiatry* 17:1600777. doi: [10.3389/fpsy.2026.1600777](https://doi.org/10.3389/fpsy.2026.1600777)

See Me (2022), [The Scottish Mental Illness Stigma Study](#).

Sievwright, K.M. et al. (2022). An Expanded Definition of Intersectional Stigma for Public Health Research and Praxis *American Journal of Public Health* 112, S356_S361, <https://doi.org/10.2105/AJPH.2022.306718>

Stuart, H. and Knaak, S. (2025). Client experiences of structural stigma in mental healthcare settings. *PLOS Ment Health* 2(12): e0000493. <https://doi.org/10.1371/journal.pmen.0000493>

Tajfel, H. and Turner, J.C. (1986). The Social Identity Theory of Intergroup Behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of Intergroup Relations* (pp. 7-24). Chicago: Nelson-Hall. <https://doi.org/10.4324/9780203505984-16>

Tajfel, H. and Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The Social Psychology of Intergroup Relations* (pp. 33-47). Brooks/Cole.

Tasca, C. et al. (2012). Women and hysteria in the history of mental health. Clinical practice and epidemiology in mental health: CP & EMH. 8. doi: [10.2174/1745017901208010110](https://doi.org/10.2174/1745017901208010110)

Thornicroft, G., et al. (2022). [The Lancet Commission on ending stigma and discrimination in mental health](#). *The Lancet*, Volume 400, Issue 10361, 1438 – 1480.

Thornicroft G. et al. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *Lancet*;387(10023):1123-1132. doi: [10.1016/S0140-6736\(15\)00298-6](https://doi.org/10.1016/S0140-6736(15)00298-6). Epub 2015 Sep 22.

Turan J.M. et al. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Med*. 2019 Feb 15;17(1):7. doi: [10.1186/s12916-018-1246-9](https://doi.org/10.1186/s12916-018-1246-9).

Tyerman J., Patovirta A.L. and Celestini A. (2021). How Stigma and Discrimination Influences Nursing Care of Persons Diagnosed with Mental Illness: A Systematic Review. *Issues Ment Health Nurs*;42(2):153-163. doi: [10.1080/01612840.2020.1789788](https://doi.org/10.1080/01612840.2020.1789788). Epub 2020 Aug 7.

World Health Organization, (2018). [Health inequities and their causes](#).

Winkler P. et al. (2017). Short video interventions to reduce mental health stigma: a multi-centre randomised controlled trial in nursing high schools. *Soc Psychiatry Psychiatr Epidemiol*;52(12):1549-1557. doi: [10.1007/s00127-017-1449-y](https://doi.org/10.1007/s00127-017-1449-y). Epub 2017 Nov 3.

Yildiz, I. (2021), [Hysteria, Foucault and Feminism. Resistance in Psychiatric Power and Phallogocentric Discourse](#), *Literary Yard E-Journal*.

Appendix 2: Historical Legacies of Mental Health Stigma and Discrimination

Mental health stigma and discrimination have deep historical roots.⁴⁵ Familiarising ourselves with these histories is important because they reveal the enduring beliefs that impact our current understandings of and approaches to supporting people with mental health problems and illness.

Historical assumptions are embedded in our institutions, cultures, and everyday thinking. They are often invisible to us as they have been normalised over time.⁴⁶ When embedded assumptions go unrecognised, they can continue to influence professional knowledge, organisational cultures, policies and practices, and everyday interactions.

Understandings of mental distress have been shaped by historical ideas about madness, normality, and difference,⁴⁷ and by wider systems of power.⁴⁸ These ideas and systems determined whose lives were seen as valuable and useful, whose behaviour was acceptable, and who was seen as capable to participate equally in society.

Perceptions of mental illness are entangled with systems of power and harmful ideologies⁴⁹ about race, gender, sexuality, class, poverty, and disability. In some cases, experiences of distress⁵⁰ due to discrimination and inequity⁵¹, or behaviours that challenged social expectations⁵² were interpreted as evidence of mental illness. Historical research documents how social judgements about difference⁵³ were legitimised in medical professional knowledge, classifications, diagnoses, and systems of 'care'.⁵⁴ 'Madness' became a condition that was pathologised, rooted in biology and diagnosed as inherent, hereditary, and permanent.⁵⁵

Histories of mental health stigma and discrimination demonstrate that it has three functions,⁵⁶ norm enforcement (keeping people in), domination (keeping people down), and "disease" avoidance (keeping people away).

Mental health stigma and discrimination have been sustained through common processes that:

- classify people,
- pathologise difference,
- position mental illness as weakness or deviance,
- dehumanise,
- attribute blame for mental distress on the individual,
- segregate, police, and coerce people,
- silence lived experience in favour of professional authority,
- discriminate and reduce human rights and opportunities,
- induce internalised self-blame and shame.

These processes became embedded in our legislation and government, social institutions, and cultural norms, and influence how people experience mental health services today.

However, this is not just a history of abuse of power, control and harm. It is also a history of resistance. For decades movements of people with lived experience of mental health stigma and discrimination have organised in psychiatric survivor and **Mad Movements** in coalition and solidarity with anti-racist, feminist, LGBTQI+, and disability rights activists. These grassroots communities have challenged assumptions, practices and power structures to influence change in legislation, policies, and attitudes.

The global mental health climate⁵⁷, lived experience evidence, and wider research on impact⁵⁸ demonstrate the urgent need for continued work to tackle and reduce mental health stigma and discrimination. Evidence specifies the importance of professionals people with lived experience and communities working in collaboration to lead and affect a better future for people who experience mental health problems and illness. This requires transformative institutional change.

Further Reading

- [Oor Mad History Ten Years On](#)
- [Mad World: The Politics of Mental Health, Micha Frazer-Carroll](#)
- [The Protest Psychosis: How Schizophrenia Became a Black Disease, Jonathan M. Metz](#)
- [Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in DSM and ICD, Jack Drescher](#)
- [On eugenics, disability, and dignity, Marius Turda](#)
- [Madness and Civilization, Michel Foucault](#)
- [Women and hysteria in the history of mental health, Cecilia Tasca et al.](#)
- [The Stigma Surrounding Mental Health: Historical Context And Current Challenges – Klarity Health Library](#)
- [Deconstructing madness: Foucault's revolutionary vision of mental illness – Neuro & Psycho](#)
- [A history of stigma | BPS](#)
- [When Did the Stigma of Mental Illness Begin? – ScienceInsights](#)

Appendix 3: Approaching Anti-stigma and Discrimination in Mental Health Services

Supporting Scotland's National Priorities and Approaches to Reducing Mental Health Stigma and Discrimination

See Me's Diagnostic and Improvement Framework translates national priorities and approaches to prevention, equity, and reducing stigma into practical improvement actions across key improvement areas.

Supporting National Priorities

Reducing mental health stigma and discrimination supports the delivery of the service reform agenda in Scotland. See Me's approach aligns with the [Public Services Reform Strategy 2025's](#) focus on prevention, outcomes, and reducing systemic barriers to public services; [Scotland's Population Health Framework 2025-2035's](#) commitment to reducing health inequalities and addressing wider determinants of health; and the [Health & Social Care Service Renewal Framework 2025-2035's](#) vision of high-quality, equitable, person-led services.

Our approach aligns with recommendations from the [Scottish Mental Health Law Review 2022](#), and supports national priorities including the [Core Mental Health Standards, Mental Health and Wellbeing Strategy and Delivery Plan](#); and related strategies including [Self-Harm Strategy and Action Plan 2023 to 2027](#); [Creating Hope Together Scotland's Suicide Prevention Strategy 2022-2032](#); and [Distress Brief Intervention \(DBI\)](#).

Aligning with Marmot's⁵⁹ proportionate universalism approach, See Me take action to address mental health stigma and discrimination across the whole system. We take additional and proportionate action where people experience greater disadvantage, exclusion and exposure to stigma. Our approach addresses disproportionate experiences of mental health stigma and discrimination at the intersections of Protected Characteristics and marginalised identities, adverse living conditions and lived experiences, and stigmatised responses to distress. Our approach aligns with mental health cross-policy recommendations in:

- [Race Equality Framework for Scotland 2016 to 2030](#); [Anti-Racism Delivery Plan 2026-2030](#); [Women's Health Plan Phase Two 2026-2029](#); [Disability Equality Plan 2025](#); [Non-Binary Equality Action Plan 2023-2028](#); [New Scots Refugee Integration Strategy 2024](#); [Ending Destitution Together Strategy Phase 2 Delivery Plan 2026-2029](#); [Improving the Lives of Scotland's Gypsy/ Travellers 2 Action Plan 2024-2026](#)
- [National Trauma Transformation Programme \(NTTP\)](#); [Together we can: our 10-year strategy to 2035](#)
- [National Justice Plan 2023/24 to 2025/26](#)
- [National Mission on Drug Deaths: Plan 2022-2026](#); [Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan 2026-2025](#); [The National Mental Health and Substance Use Protocol 2024](#).

Key Improvement Areas

We strategically address mental health stigma and discrimination in key, evidence-based, improvement areas in alignment with Scotland's National Priorities.

Key Improvement Area	National Priorities	Focus
Equity evidence	Mental Health and Wellbeing Strategy and Delivery Plan; Self-Harm Strategy and Action Plan 2023 to 2027; Scotland's Population Health Framework 2025-2035; Anti-Racism Delivery Plan 2026-2030; Disability Equality Plan 2025; Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan 2026-2025.	Move from monitoring inequalities to using equity evidence to diagnose the systems, practices and conditions contributing to them.
System design	Public Services Reform Strategy 2025; Scotland's Population Health Framework 2025-2035; Health & Social Care Service Renewal Framework 2025-2035; Mental Health and Wellbeing Strategy and Delivery Plan; New Scots Refugee Integration Strategy 2024; Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan 2026-2025.	Design systems around preventing the causes of inequitable mental health outcomes, stigma and discrimination.
Resource allocation	Mental Health and Wellbeing Strategy; Scotland's Population Health Framework 2025-2035; Anti-Racism Delivery Plan 2026-2030; Disability Equality Plan 2025.	Resource allocation reflects the scale and complexity of disadvantage and exposure to stigma, discrimination and exclusion.
Accountability	Public Services Reform Strategy 2025; Mental Health and Wellbeing Strategy and Delivery Plan; Scotland's Population Health Framework 2025-2035; Anti-Racism Delivery Plan 2026-2030.	Move to clear accountability for identifying, addressing and demonstrating improvement in mental health stigma and discrimination.
Workforce conditions	Health & Social Care Service Renewal Framework 2025-2035; Mental Health and Wellbeing Strategy and Delivery Plan; Anti-Racism Delivery Plan 2026-2030; Disability Equality Plan 2025; Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan 2026-2025.	Address how workforce conditions and organisational culture enable or constrain equitable, person-centred and anti-discriminatory practice.

Key Improvement Area	National Priorities	Focus
Anti-stigma and discrimination practice	Mental Health and Wellbeing Strategy and Delivery Plan; Self-Harm Strategy and Action Plan 2023 to 2027; Anti-Racism Delivery Plan 2026–2030; Disability Equality Plan 2025; Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan 2026-2025.	Address the structural, cultural, institutional, and interpersonal stigma and discrimination.
Service policies, pathways and practices	Public Services Reform Strategy 2025; Health & Social Care Service Renewal Framework 2025-2035; Mental Health and Wellbeing Strategy and Delivery Plan; Self-Harm Strategy and Action Plan 2023 to 2027; Anti-Racism Delivery Plan 2026–2030; Disability Equality Plan 2025; New Scots Refugee Integration Strategy 2024; Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan 2026-2025.	Examine service policies and pathways to address who is excluded, disadvantaged, or required to overcome additional barriers to access and benefit from care.
Lived experience leadership, power sharing, and co-design	Public Services Reform Strategy 2025; Health & Social Care Service Renewal Framework 2025-2035; Mental Health and Wellbeing Strategy and Delivery Plan; Self-Harm Strategy and Action Plan 2023 to 2027; Anti-Racism Delivery Plan 2026–2030; Disability Equality Plan 2025; New Scots Refugee Integration Strategy 2024; Preventing Harm, Promoting Recovery: Scotland's Alcohol and Drugs Strategic Plan 2026-2025.	Support lived experience as a form of leadership and expertise with genuine power sharing in problem definition, priorities, service design, decisions and improvement.

Taking action in these key areas is a whole system improvement process.

- Equity evidence helps identify where inequities are and why.
- System design and resource allocation shape the conditions and opportunities available to people.
- Accountability and workforce conditions determine whether services are able and willing to address the root causes of stigma and discrimination and to change.
- Anti-stigma and discrimination practice shape how stigma and discrimination are understood and addressed.
- Service policies, pathways and practices influence people's experience of access and care.
- Lived experience leadership, power sharing and co-design shift who has the authority to define problems, set priorities, and shape solutions.

Supporting National Improvement Approaches

See Me’s approach to improvement⁶⁰ compliments Scotland’s health and social care renewal agenda and the [Scottish Approach to Change](#). Tackling mental health stigma and discrimination through the [Scottish Approach to Service Design](#) is fundamental to achieving the ambitions of these national approaches.

We support services to embed anti-stigma and discrimination practice within person-centred, recovery-oriented, trauma-responsive and informed, equality and human rights, and intersectional approaches.

Person-centred and recovery-orientated

National Change Approach	Anti-Stigma and –Discrimination Work
- Public Services Reform Strategy 2025 - Scottish Approach to Service Design - Scottish Mental Health Law Review 2022 - Mental health and wellbeing strategy 2023-2025 - Core Mental Health Standards - Race equality framework for Scotland 2016 to 2030 - Women’s Health Plan Phase Two 2026-2029 - Disability Equality Plan 2025 - Non-Binary Equality Action Plan 2023-2028 - Ending Destitution Together Strategy Phase 2 Delivery Plan 2026-2029 - The National Mental Health and Substance Use Protocol 2024 - Public Health Scotland Together we can: Our 10-year strategy to 2035 - Realistic Medicine & Value-Based Care - GIRFE - What Matters to You?	- Addresses stigma and discrimination in attitudes, behaviours and systems. - Recognises the person beyond their distress or diagnosis. - Values lived experience as expertise. - Promotes service co-design. - Promotes dignity and choice. - Attends to unequal power relationships. - Builds trusting relationships that support inclusion and recovery. - Addresses people’s wider social circumstances including adverse lived experiences and circumstances, discrimination and exclusion.

Trauma-responsive

National Change Approach	Anti-Stigma and –Discrimination Work
• Scottish Mental Health Law Review 2022 • National Trauma Transformation Programme (NTTP) • Mental health and wellbeing strategy: delivery plan 2023-2025 • Core Mental Health Standards • Anti-Racism Delivery Plan 2026–2030 • Women’s Health Plan Phase Two 2026–2029 • Non-Binary Equality Action Plan 2023–2028 • New Scots Refugee Integration Strategy 2024 • Ending Destitution Together Strategy Phase 2 Delivery Plan 2026–2029 • The National Mental Health and Substance Use Protocol 2024	• Challenges prejudice, stereotypes and discrimination. • Promotes dignity, inclusion and equity. • Prevents exclusion and discriminatory or harmful experiences. • Focuses on respectful, non-judgemental care. • Addresses structural, organisational and interpersonal stigma.



Equality and Human Rights-based

National Change Approach	Anti-Stigma and –Discrimination Work
• Scottish Approach to Service Design • Mental health and wellbeing strategy 2023–2025 • Scottish Mental Health Law Review 2022 • Public Services Reform Strategy 2025 • Race equality framework for Scotland 2016 to 2030 • Anti-Racism Delivery Plan 2026–2030 • Women’s Health Plan Phase Two 2026-2029 • Disability Equality Plan 2025 • New Scots Refugee Integration Strategy 2024 • Ending Destitution Together Strategy Phase 2 Delivery Plan 2026–2029 • Improving the Lives of Scotland’s Gypsy/ Travellers 2 Action Plan 2024-2026 • Equality and Human Rights Mainstreaming Action Plan 2025	FREDA Principles • Fairness: Addresses unequal outcomes; challenges bias; and supports individualised service provision. • Respect: People are treated with dignity, compassion, and as an individual (not a diagnoses or label). • Equality: Addresses both direct discrimination and structural inequalities that disproportionately affect people experiencing mental health problems, particularly those experiencing multiple intersecting forms of disadvantage. • Dignity: People feel safe, valued and inherently valuable; Services promote hope, autonomy, recovery, and as equal partners in their care. • Autonomy: Supports shared decision-making, values lived experience expertise, values and supports people’s agency and capacity. PANEL Principles • Participation: People with lived experience are active participants in designing, delivering, and evaluating policies, services, and improvement work. • Accountability: Leaders take responsibility for preventing stigma and discrimination, monitor progress and act when rights are not upheld. • Non-[Anti-] discrimination: Right to fair treatment and equal access to healthcare are intentionally actioned and upheld; Interpersonal and structural stigma are addressed. • Empowerment: People have the knowledge, confidence, and opportunities to exercise choice, decision-making, and to challenge discrimination when it happens. • Legality: Decisions and practice are grounded in human rights law and standards.

Intersectionality

National Change Approach	Anti-Stigma and –Discrimination Work
• Scottish Approach to Service Design • Mental health and wellbeing strategy 2023–2025 • Core Mental Health Standards • Multi-Agency Partnership Approach to Distress Framework for Collaboration • Race Equality Framework for Scotland 2016 to 2030 • Anti-Racism Delivery Plan 2026–2030 • Women’s Health Plan Phase Two 2026–2029 • Disability Equality Plan 2025 • New Scots Refugee Integration Strategy 2024 • Non-Binary Equality Action Plan 2023–2028 • Equality and Human Rights Mainstreaming Action Plan 2025	• Recognises multiple and overlapping forms of stigma and discrimination. • Supports responses that are tailored to people’s realities, cultures, and circumstances. • Identifies structural causes of mental health stigma and discrimination. • Centres lived experience and expertise. • Promotes equity. • Supports inclusion and belonging. • Strengthens FREDA Principles.

Person-centred approach

Person-centred practice depends on both practitioner behaviour and system conditions. The core attributes of person-centred approaches include a holistic understanding of the whole person, their circumstances, relationships, and wider determinants of health. It has an ethical grounding in dignity, respect, human rights, compassion, and equity.

It is an assets-based approach that builds on people’s strengths, capabilities, lived experience, and community networks. It recognises the need for relational trust and respect, and the redistribution of power between service users and professionals. Person-centred services are co-designed based on people’s needs, and recognition that they are experts in their own lives.⁶¹

Trauma Informed and Responsive Practice

Trauma Informed and Responsive Practice understand people’s behaviours or distress in the context of their adverse lived experiences of trauma. It recognises and reduces barriers created by the impact of trauma. It supports people’s recovery and resists re-traumatisation.⁶² A trauma-responsive approach considers cultural, historical and marginalisation contexts. And addresses power imbalances through collaboration between stakeholders at all levels.⁶³

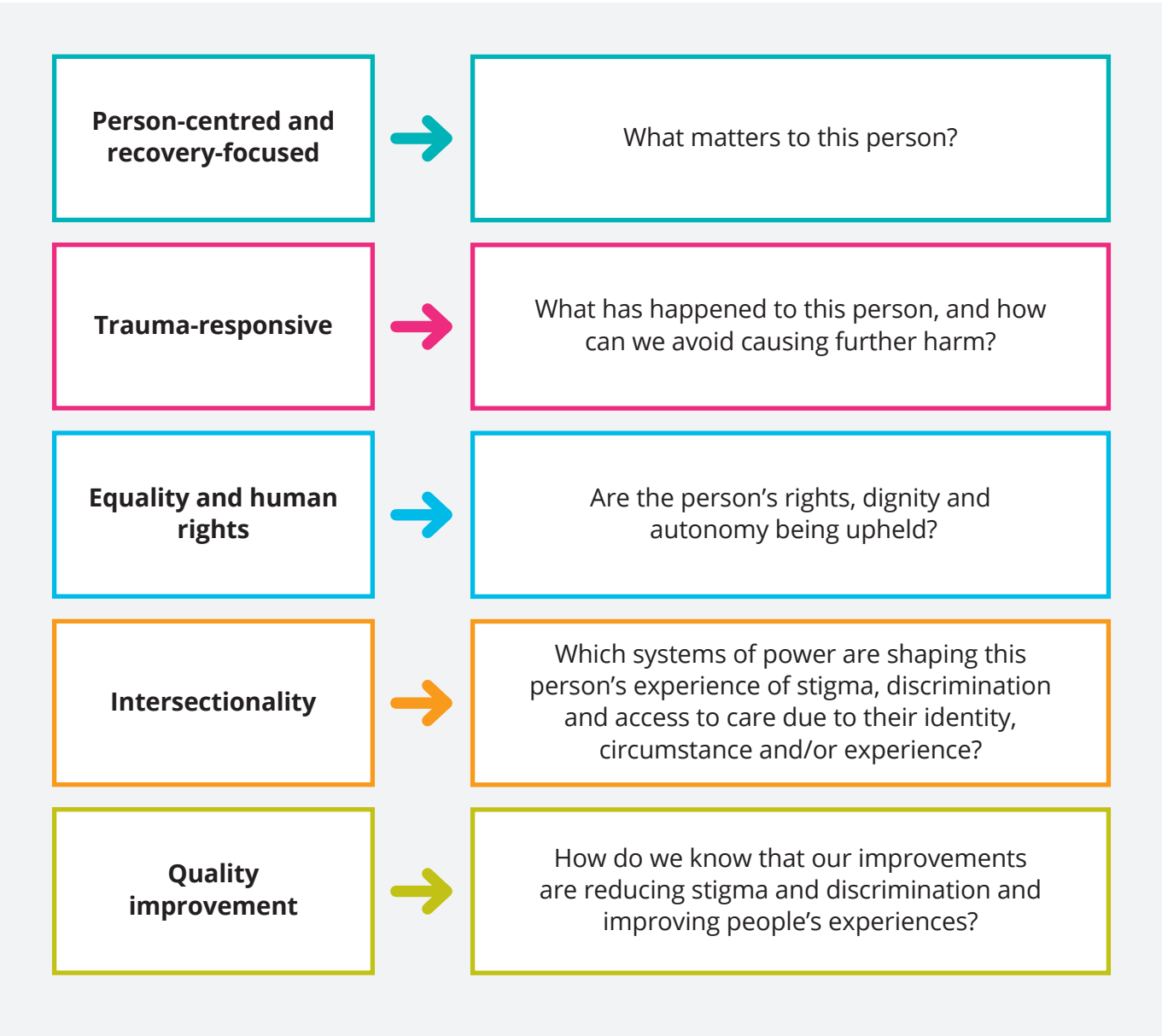
Equality and Human Rights-Based Practice

An equality and human rights approach views people as active, rights-holders, and services as duty bearers. Success is measured by improvements in equity, inclusion, access, participation and outcomes. The FREDA and PANEL principles provide a framework for co-creating cultures, services, and relationships where people experiencing mental health conditions and illnesses are supported to exercise choice and control over their lives and care.

Intersectionality

An intersectional approach recognises that stigma and discrimination are compounded by multiple, interconnected inequities that impact people across identity, circumstances, and experiences.⁶⁴ The approach addresses stigma and discrimination in attitudes and behaviours and wider social, cultural, and structural factors. An intersectional approach centres lived experience, challenges unequal power relationships, and dismantles unequal systems.

See Me support mental health services to ask:



See Me's Systems Change Improvement Approach: Creating the Framework

See Me's approach to reducing mental health stigma and discrimination in mental health services is:

1. **Grounded** in our evidence-based (Appendix 1), Good Anti-Stigma Practice Principles.
2. **Structured** in our whole system approach (Appendix 3).
3. **Actioned** through a step-by-step process to address specific issues in services.

Grounding the systems change improvement approach

A robust evidence-base informs See Me's **Good Anti-Stigma Practice Principles** and grounds our key improvement areas.

1

Principle 1: Resource allocation and Sustainable investment

Rationale: Resource allocation shapes who can access support and can either reinforce or reduce structural stigma and discrimination.

- Investment aligns with the values of person-centred, trauma-responsive, and equitable care.
- Funding models prioritise prevention, early intervention, and community-based support.
- Resources are transparently distributed based on population need and demand, and intersectional social determinants of health.

2

Principle 2: Person-centred, rights-based, trauma-responsive care

Rationale: Care that respects autonomy, dignity and identity can challenge stigma, discrimination and power imbalances.

- Care is person-centred, individualised, co-produced, and strengths-based.
- Trauma-responsive, culturally safe, and rights-based approaches are foundational.
- Interventions are recovery-oriented and centre respect, autonomy, identity, and lived experiences.

3 Principle 3: Anti-stigma and inclusion

Rationale: How services understand stigma and discrimination can reinforce or reduce stigma and discrimination

- Mental health services actively dismantle stigma, discrimination, and systemic bias.
- Services are safe and non-judgmental, especially for people with marginalised identities, and stigmatised living conditions, lived experiences, and distress responses.

4 Principle 4: Intersectionality and Cultural Safety

Rationale: How services recognise difference and inequity shape experiences of stigma and discrimination

- Mental health care addresses intersectional stigma and discrimination towards people with marginalised identities, and stigmatised living conditions, lived experiences, and distress responses.
- Services are culturally safe and responsive to people's diverse lived realities.
- Equity monitoring and culturally safe care are built into practice.
- Evidence-informed equity planning guides resource allocation and service design.
- Language is respectful, empowering, and recovery oriented.

5a Principle 5a: Co-Production, Peer Involvement, and Empowerment

Rationale: Sharing power and valuing lived experience can challenge stigma and discrimination

- Lived experience guides service design, delivery, and evaluation.
- Peer support, co-produced care plans, and shared decision-making are embedded.
- Power-sharing to rebuild trust and accountability.

5b Principle 5b: Collaborative Leadership and Governance

Rationale: Who holds power in decision-making shapes accountability for stigma and discrimination

- Decision-making involves patients, carers, frontline staff, and communities.
- Collaboration at clinical and strategic levels (e.g. MDTs⁶⁵, IJBs⁶⁶, Boards).
- Accountability and transparency built into governance structures.

6**Principle 6: Access, Equity, and Service Improvement**

Rationale: Service accessibility and flexibility can reduce structural barriers and discrimination

- Services are accessible, timely, and responsive to need.
- Services are not limited by funding models or rigid eligibility.
- Barriers to access (language, location, fear of consequences) are removed.
- Data-informed equity planning guides resource allocation and service design.

7**Principle 7: Holistic, Medical and Non-Medical Care Options, and Community-Based Approaches**

Rationale: The range of support offered can challenge narrow and stigmatising understandings of mental health

- Care is holistic (e.g. Talking and somatic therapies, social prescribing, creative therapies).
- Care addresses emotional, social, spiritual, and cultural aspects of distress.
- Community connection, collective and community healing, belonging, and support networks are part of effective mental health care.

8**Principle 8: Workforce Capacity, Training, and Support**

Rationale: Workforce conditions, knowledge and attitudes shape experiences of stigma and discrimination

- Leadership and workforce are trained in cultural safety, trauma-informed care, and anti-stigma practices.
- Supervision, reflective practice, and fair work conditions support sustainability and empathy.
- Workforce planning matches the needs of inclusive care models (e.g. Safer Spaces, peer-led services).

Structuring the systems change improvement approach

See Me made the complexity of mental health stigma and discrimination visible by drawing from and adapting whole system approaches in sociology and public health research:

1. The SCIP Analysis⁶⁷ (Social, Cultural, Institutional, and Psychological) provides understanding of prejudicial and discriminatory social processes and their impact on individuals and groups.
2. A socio-ecological model of stigma⁶⁸ provides understanding of how stigma operates and how it can be addressed.⁶⁹

Locating stigma and discrimination in our wider society

We produced the *See Me SCIP Framework 1* (Figure 1). This model supports us to locate mental health stigma and discrimination at four levels across our society. It allows us to identify the roots of mental health stigma and discrimination and interactions across wider governmental policy, legislation, political rhetoric; within our culture (media, family, friends and communities); in our wider institutions (healthcare, education, employment, housing, justice etc.); and in personal experiences.

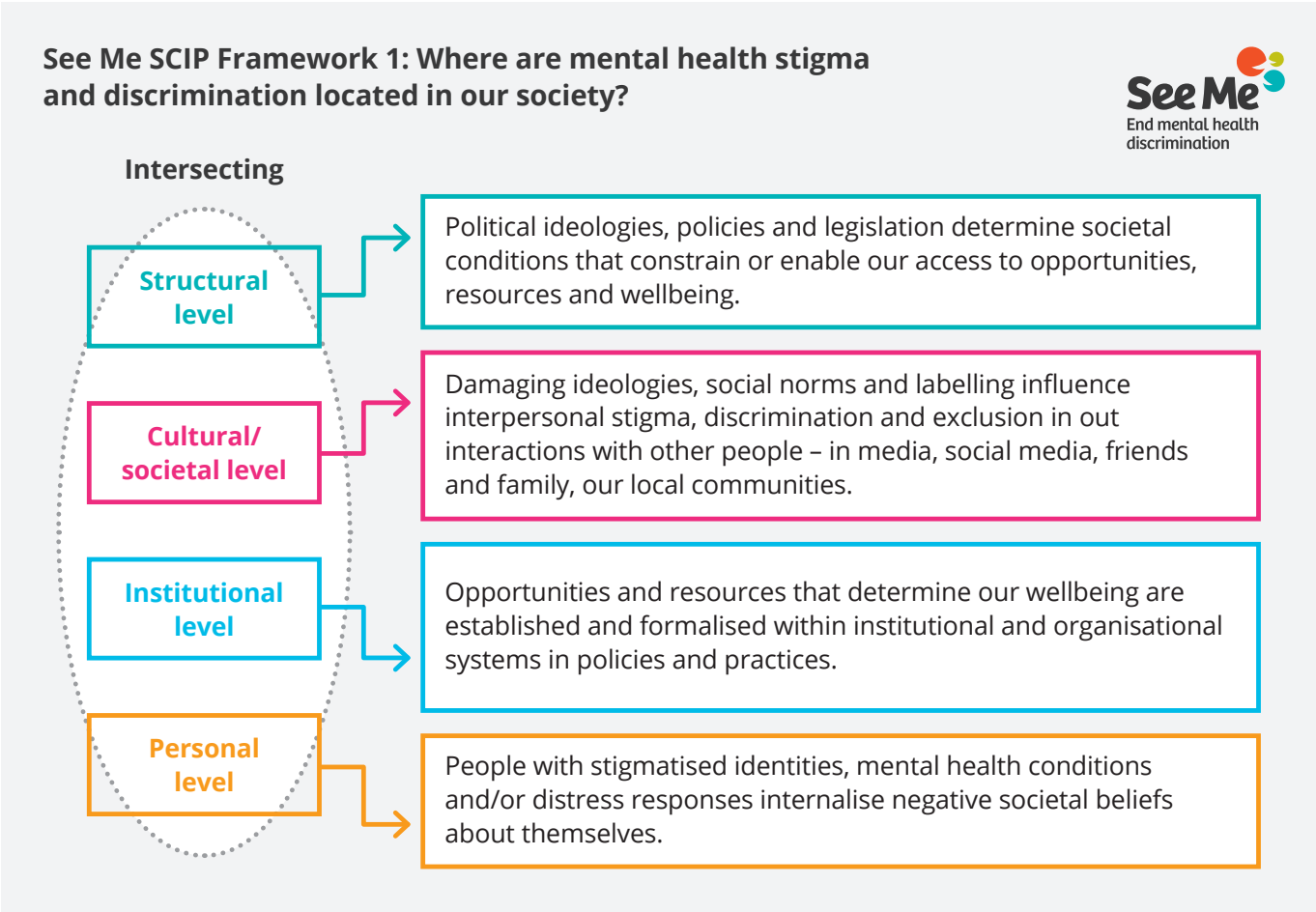


Figure 1. See’s Me’s adapted SCIP Model: Framework 1, 2025

Locating stigma and discrimination inside Mental Health Services

The *SCIP Framework 2* (Figure 2) demonstrates where mental health stigma and discrimination are located at four levels *within* mental health services. Our improvement approach is structured by this model. It allows for targeted interventions at multiple strategic points.

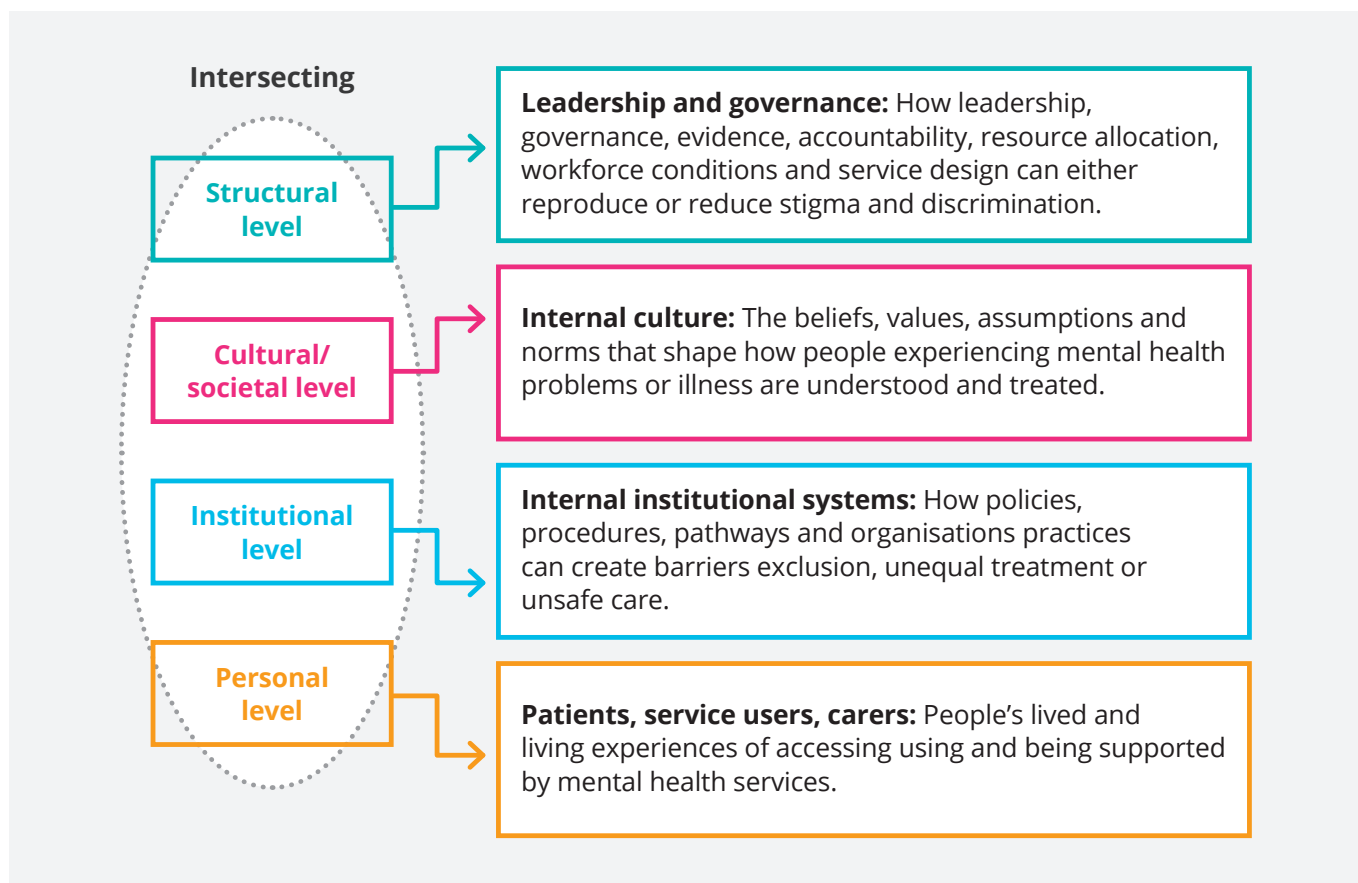


Figure 2. See's Me's adapted SCIP Model: Framework 2, 2025

Key strategic improvement areas

We located the evidence-based *Good Anti-Stigma Practice Principles* in the *SCIP Framework 2* across four levels of mental health services and asserted key improvement areas (Figure 3).

The improvement areas centre prevention and early intervention, and target embedded structural stigma and discrimination in:

- equity evidence, system design, resource allocation, accountability, workforce conditions,
- anti-stigma and -discrimination practice,
- service policies and pathways,
- lived experience leadership, power sharing, and co-design.



Where is mental health stigma and discrimination located in the service?

Evidence-based improvement areas

Structural

Leadership and governance

- 1 → Equity evidence
- 2 → Accountability
- 3 → Service design
- 4 → Resource allocation
- 5 → Workforce conditions

Cultural

Service beliefs, norms and attitudes

- 1 → Person-centred, recovery-orientated, trauma-responsive, rights-based, intersectional practice
- 2 → Identifying, challenging and addressing mental health stigma and discrimination

Institutional

Service policies, pathways and practices

- 1 → Access, eligibility and inclusion; attendance; referrals; cultural safety; assessment and diagnostics; care planning; transitions

Personal

Lived experience of the service

- 1 → Lived experience of access, inclusion and quality
- 2 → Lived experience of engagement and recovery

Figure 3. Structuring the key improvement areas in the SCIP model.

Endnotes and References

- ¹ Adapted from Portilla, K. (2016); White Hughto, J.M. et al. (2015); Cook J.E. et al. (2014); Rao, D. et al. (2019).
- ² Livingston, J. D. (2020). *Structural stigma in health-care contexts for people with mental health and substance use issues: A literature review*. Ottawa: Mental Health Commission of Canada.
- ³ Hinchcliffe, S. et al. (2025). *The Scottish Social Attitudes Study 2025: Attitudes to Discrimination and Positive Action*, Scottish Government.
- ⁴ Kågström, A. et al. (2025). Mental health stigma and its consequences: a systematic scoping review of pathways to discrimination and adverse outcomes, *eClinicalMedicine*, Volume 89, 2025, <https://doi.org/10.1016/j.eclinm.2025.103588>. "There is no country, society or culture where people with mental illness have the same societal value as people without mental illness". Rössler, W. (2016). The stigma of mental disorders. *EMBO Rep* 17, 6. <https://doi.org/10.15252/embr.201643041>
- ⁵ Mental Health Foundation, 2021. *Stigma and discrimination*.
- ⁶ Chan, J.K.N. et al. (2023). *Life expectancy and years of potential life lost in people with mental disorders: a systematic review and meta-analysis*, *eClinicalMedicine*, Volume 65, 102294; Ilyas A. et al. (2017). Improving life expectancy in people with serious mental illness: should we place more emphasis on primary prevention? *Br J Psychiatry*;211(4):194-197. Epub 2017 Sep 7.
- ⁷ Sap, K. and Stupak, R. (2026). Dignity in mental health care: the conceptual connections between sense of dignity, stigma and self-stigma among people with mental disorder diagnoses. *Front. Psychiatry* 17:1600777. doi: 10.3389/fpsyt.2026.1600777
- ⁸ Gov.uk, (2024). *Detentions under the Mental Health Act – GOV.UK Ethnicity facts and figures*; Maternal Mental Health Alliance [n.d.], Black Maternal Health; Lowther-Payne, H.J. et al. (2023). Understanding inequalities in access to adult mental health services in the UK: a systematic mapping review. *BMC Health Serv Res* 23, 1042. <https://doi.org/10.1186/s12913-023-10030-8>
- ⁹ Opportunities to access care and to experience good quality of care.
- ¹⁰ Sievwright, K.M. et al. (2022). An Expanded Definition of Intersectional Stigma for Public Health Research and Praxis *American Journal of Public Health* 112, S356_S361, <https://doi.org/10.2105/AJPH.2022.306718>
- ¹¹ Adverse Childhood Experiences (and Trauma).
- ¹² Gender-Based Violence.
- ¹³ West (2025) defines explicit bias as "biases that people are consciously aware of and fine admitting in public" [p44], and implicit bias as "biases that people are less aware of and less likely to admit to others, (or sometimes even to themselves)" [p45], West, K. (2025). *The Science of Racism: Everything you need to know but probably don't—yet*. Pan Macmillan.
- ¹⁴ Turan J.M. et al. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Med*. 2019 Feb 15;17(1):7. doi: 10.1186/s12916-018-1246-9; Kågström, A. et al. 2025.
- ¹⁵ Corrigan, P.W., et al. (2004). Structural levels of mental illness stigma and discrimination. *Schizophr Bull*;30(3):481-91. doi: 10.1093/oxfordjournals.schbul.a007096; Eschliman, E.L., et al. (2024). The use and operationalization of "structural stigma" in health-related research: A scoping review. *BMC Public Health* 24, 3614. <https://doi.org/10.1186/s12889-024-21171-8>; Hatzenbuehler M.L. (2016). Structural stigma: Research evidence and implications for psychological science. *Am Psychol*;71(8):742-751. doi: 10.1037/amp0000068.; Hatzenbuehler M.L., Phelan J.C., and Link B.G. (2014). Introduction to the special issue on structural stigma and health, *Social Science & Medicine*, Volume 103, Pages 1-6. <https://doi.org/10.1016/j.socscimed.2013.12.017>.; Hemeida, S., and Goldberg, D. (2022). Dismantling structural addiction stigma in law: Policies for systematic change. *Families, Systems, & Health*, 40(2), 288–290. <https://doi.org/10.1037/fsh0000714>; Rao, D., et al. (2019). A systematic review of multi-level stigma interventions: state of the science and future directions. *BMC Med* 17, 41. <https://doi.org/10.1186/s12916-018-1244-y>; Stuart, H., and Knaak, S. (2025). Client experiences of structural stigma in mental healthcare settings. *PLOS Ment Health* 2(12): e0000493. <https://doi.org/10.1371/journal.pmen.0000493>; See Me, (2024). Reducing Mental Health Stigma and Discrimination, Expert Group Report (Internal document).

16. Phelan, J.C., Link, B.G., and Dovidio, J.F. (2008). Stigma and Prejudice: One Animal or Two? *Social Science & Medicine*, 67(3), 358-367. doi: [10.1016/j.socscimed.2008.03.022](https://doi.org/10.1016/j.socscimed.2008.03.022)
17. See Me, (2022). [The Scottish Mental Illness Stigma Study](#).
18. Mehta, N., and Thornicroft, G. (2013). 'Stigma, Discrimination, and Promoting Human Rights', in Patel, V. and others (eds), *Global Mental Health: Principles and Practice*, New York; online edn, Oxford Academic, 1 Feb. 2014, <https://doi.org/10.1093/med/9780199920181.003.0018>.
19. [Mental Health Foundation \(2021\)](#).
20. [Livingston \(2020\)](#).
21. WHO, (2024). [Mosaic toolkit to end stigma and discrimination in mental health](#).
22. Lifespan inequalities including a poorer quality of life and life expectancy at 15–20 years shorter than that of the general population. [Chan et al. \(2023\)](#); [Ilyas et al. \(2017\)](#). This disparity is largely due to preventable physical illnesses. NHS England, [Improving the physical health of people living with severe mental illness](#), Published 10 January 2024.; WHO (2024).
23. Thornicroft, G., et al. (2022). [The Lancet Commission on ending stigma and discrimination in mental health](#). *The Lancet*, Volume 400, Issue 10361, 1438–1480.
24. There are clear links between people's repeated experience of stigma and discrimination, their anticipation of stigmatising and judgemental treatment, and disengagement from services. Clement, S. et al. (2012). Filmed v. live social contact interventions to reduce stigma: randomised controlled trial. *Br J Psychiatry*;201(1):57-64. doi: [10.1192/bjp.bp.111.093120](https://doi.org/10.1192/bjp.bp.111.093120). Epub 2011 Dec 8. PMID: 22157800; Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiol Psychiatr Soc*.;17(1):14-9. doi: [10.1017/s1121189x00002621](https://doi.org/10.1017/s1121189x00002621). See Me, 2022.
25. Sap, K. and Stupak, R. (2026). Dignity in mental health care: the conceptual connections between sense of dignity, stigma and self-stigma among people with mental disorder diagnoses. *Front. Psychiatry* 17:1600777. doi: [10.3389/fpsyt.2026.1600777](https://doi.org/10.3389/fpsyt.2026.1600777)
26. OECD (2021). A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health, OECD Health Policy Studies, OECD Publishing, Paris, <https://doi.org/10.1787/4ed890f6-en>; Sap and Stupak, 2026.
27. Adu, J., et.al. (2023). Experiences of familial stigma among individuals living with mental illnesses: A meta-synthesis of qualitative literature from high-income countries. *Journal of Psychiatric and Mental Health Nursing*, 30, 208–233. <https://doi.org/10.1111/jpm.12869>; Adu J., et al. (2024). Negotiating familial mental illness stigma: The role of family members of persons living with mental illnesses. *PLoS ONE* 19(9): e0311170. <https://doi.org/10.1371/journal.pone.0311170>
28. Jankowski, S.E. et al. (2023). Reducing Public Stigma Towards Psychosis: A Conceptual Framework for Understanding the Effects of Social Contact Based Brief Video Interventions, *Schizophrenia Bulletin*, Volume 49, Issue 1, Pages 99-107, <https://doi.org/10.1093/schbul/sbac143>; Corrigan, P.W. et al. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. *Psychological Science in the Public Interest*, 15(2), 37-70. <https://doi.org/10.1177/1529100614531398>
29. Njaka, S., et al. (2023). A systematic review on prevalence and perceived impacts of associative stigma on mental health professionals, *International Journal of Africa Nursing Sciences*, Volume 18, <https://doi.org/10.1016/j.ijans.2023.100533>.
30. Rudd, B., Nguyen, V., and Scott-Pearce, M. (2025). [The Stigma by Association in Mental Health Nursing: Final Report, 2025](#), Commissioned and published by See Me, Mental Health Foundation, and the University of Abertay.
31. Mental health nurses described encountering stigmatising comments based on the belief that mental health patients are dangerous or difficult to work with. This stigma extends more acutely to specific areas of practice, such as forensic services and substance use, where patients are highly stigmatised. [Rudd, Nguyen, and Scott-Pearce \(2025\) \[page 8\]](#).
32. This includes pathways to care, clinical practices, shared ways of thinking, patterns of communications, and patterns of interaction. [Stuart and Knaak \(2025\)](#).
33. [Livingston \(2020\)](#).
34. *ibid*.

35. *ibid.*
36. See Me (2022). *The Scottish Mental Illness Stigma Study*; See Me (2024). Reducing Mental Health Stigma and Discrimination, Expert Group Report (Internal document); See Me (2025). Community and Priority Groups Lived Experience Evidence (Internal document).
37. Scottish Government (2025). *Multi-Agency Partnership Approach to Distress Framework for Collaboration*.
38. We use the term 'equity evidence' over 'data' to recognise data as one aspect of the multiple sources of evidence needed to inform the improvement. Equity evidence includes access data; outcomes data; equity data; and quality of care measures.
39. People experiencing severe, multiple disadvantage are at heightened risk of experiencing mental health stigma and discrimination. This reflects the compounded effects of inequality and exclusion. Mental health stigma and discrimination disproportionately affect people with Protected Characteristics, marginalised identities (e.g. gender, race, sexuality, disability, ethnicity, citizenship, age). And people who have or are experiencing adverse living conditions (e.g. poverty and homelessness), adverse lived experiences (e.g. trauma, violence, ACEs, GBV), and stigmatised distress responses (e.g. suicidality, self-harm, and substance use).
40. Access: People can obtain the mental healthcare they need, when they need it.
41. Quality: Clinical care is safe, effective and respectful.
42. And forthcoming Human Rights Bill Compliance Duty.
43. Patriarchy, white 'supremacy' and capitalism.
44. **Structural:** Equity evidence informs the structure of the service: governance, accountability, service design, and resource allocation. **Cultural:** Experience evidence supports us to understand the culture. **Institutional:** Experience evidence supports us to understand the institutional processes that are producing stigma and discrimination.
45. Rössler, W. (2016). The stigma of mental disorders. *EMBO Rep* 17, 6. <https://doi.org/10.15252/embr.201643041>
46. Hill Collins, P. (2000). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (2nd ed.). Routledge. <https://doi.org/10.4324/9780203900055>; Bourdieu P. (1977). *Outline of a Theory of Practice*. Nice R, trans. Cambridge University Press.
47. O'Reilly, M., and Lester, J.N. (2017). History of Mental Health and Mental Illness. In: *Examining Mental Health through Social Constructionism. The Language of Mental Health*. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-319-60095-6_2
48. Drescher, J. (2015). Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in DSM and ICD. *International Review of Psychiatry*, 27(5), 386–395, <https://doi.org/10.3109/09540261.2015.1053847>; Foucault, M., (1971). *Madness and Civilization* (1st ed.). Routledge. <https://doi.org/10.4324/9780203164693>; Frazer-Carroll, M. (2023). *Mad World: The Politics of Mental Health*. First edition. London, England: Pluto Press; Metzl, J.M. (2009). *The protest psychosis: How schizophrenia became a black disease*. Beacon Press; Turdas, M. (2025). *On eugenics, disability, and dignity*. Volume 405, Issue 10474 189-190.
49. Racism, imperialism, colonialism, capitalism, and patriarchy; Butler explains that systems of power established certain groups as inherently 'inferior' to the dominant social norm. Dominant social norms serve as a benchmark for evaluating people and groups as 'normal' and/or 'acceptable'. Perceived deviation from these norms can lead to stigmatisation, social exclusion, and marginalisation for groups of people who fall outside of the idea of who the 'default', 'normal' human being is. hooks and Messa-Bains state that these systems of power interact and reinforce one another to maintain social hierarchies and inequality. Butler, J. (2006). *Gender Trouble: Feminism and the Subversion of Identity* (1st ed.). Routledge; hooks, B. and Mesa-Bains, A., (2017). *Homegrown: Engaged Cultural Criticism* (1st ed.). Routledge.
50. and anger, grief, and resistance.
51. The diagnoses of 'drapetomania' Frazer-Carroll (2023); 'protest psychosis' Metzl (2009); 'hysteria' Tasca (2012); enforced heterosexuality Drescher (2015); enforced productivity Foucault (2006). Tasca, C. et al. 2012. Women and hysteria in the history of mental health. *Clin Pract Epidemiol Ment Health*;8:110-9. doi: 10.2174/1745017901208010110

52. Socially deviating from good mental health, race, gender, sexuality, and socio-economic productivity norms by having a mental illness, being a person of colour, being a woman, being LGBT+, being poor, not being able to work.
53. from dominant social norms.
54. [Frazer-Carroll \(2023\)](#); [Metzl \(2009\)](#); [Drescher \(2015\)](#); [Turdas \(2025\)](#); [Foucault \(2006\)](#).
55. Science Insights (2026). [When Did the Stigma of Mental Illness Begin?](#)
56. [Phelan, Link, Bruce, and Dovidio \(2008\)](#).
57. Sisti, D.A. (2026). [Trump's Homelessness Order Sparks Fears of a Return to the Asylum Era](#). Penn Leonard Davis Institute of Health Economics. Blogpost.
58. See Me (2022). [The Scottish Mental Illness Stigma Study](#); [See Me \(2024\)](#). Reducing Mental Health Stigma and Discrimination, Expert Group Report [Internal document]; See Me (2025). Community and Priority Groups Lived Experience Evidence [Internal document].
59. Marmot, M., Goldblatt, P., Allen, J. et al. (2010). [Fair Society, Healthy Lives](#), The Marmot Review; Marmot, M. et al., (2020). [Health Equity in England: The Marmot Review 10 Years On](#).
60. Specifically in leadership, culture, capability, policies, pathways and practice, lived experience evidence and co-design.
61. Robertson, M. (2023). [Learning from Person-Centred Approaches](#), Office of the Chief Social Policy Adviser, Scottish Government.
62. The National Trauma Transformation Programme (NTP) (2023), [A Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland](#), Scottish Government.
63. Revolving Doors (2023). [Trauma-informed approaches to supporting people experiencing multiple disadvantage A Rapid Evidence Assessment](#), Department for Levelling Up, Housing and Communities.
64. Protected Characteristics; marginalised identities (across gender, race, sexuality, disability and neurodivergence, ethnicity, age, citizenship etc.); adverse living conditions (e.g. poverty and homelessness); adverse lived experiences (e.g. trauma, violence, ACEs, and GBV); and stigmatised distress responses (e.g. suicidality, self-harm, and substance use).
65. Multi-Disciplinary Teams.
66. Integrated Joint Boards.
67. Portilla, K. (2016). Redressing Everyday Discrimination: The Weakness and Potential of Anti-Discrimination Law (1st ed.). Routledge. <https://doi.org/10.4324/9781315688534>
68. Which can also be termed a 'multi-level ecological' approach.
68. White Hughto, J.M. et al. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions, *Social Science & Medicine*, Volume 147, <https://doi.org/10.1016/j.socscimed.2015.11.010>; Cook J.E. et al. (2014). Intervening within and across levels: a multilevel approach to stigma and public health. *Soc Sci Med*. 2014 Feb;103:101-109. doi: [10.1016/j.socscimed.2013.09.023](https://doi.org/10.1016/j.socscimed.2013.09.023). Epub 2013 Oct 3; [Rao, D. et al. \(2019\)](#).

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