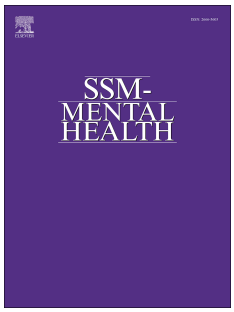

Intersectional discrimination, exclusion and the socio-political economy of global mental health: A Systematic Scoping Review of the Literature

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PII: S2666-5603(24)00087-2

DOI: https://doi.org/10.1016/j.ssmmh.2024.100382

Reference: SSMMH 100382

To appear in: *SSM - Mental Health*

Received Date: 4 June 2024

Revised Date: 12 December 2024

Accepted Date: 16 December 2024

Please cite this article as: Burgess R.A., Chobhthaigh S.N., Biswal B., Ceccolini D., Fadipe B., Khan D., Aggarwal N., Pabla I., Solis C., Pillutla R., Sarkar P., Frasco E., Iemmi V., Pathare S. & Lund C., Intersectional discrimination, exclusion and the socio-political economy of global mental health: A Systematic Scoping Review of the Literature, *SSM - Mental Health*, https://doi.org/10.1016/j.ssmmh.2024.100382.

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Intersectional discrimination, exclusion and the socio-political economy of global mental health: A Systematic Scoping Review of the Literature

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Abstract

Social determinants literature has reinforced the importance of social landscapes to poor mental health. However, such frameworks face critique linked to their limited acknowledgement of structural determinants and complex social processes which establish the patterns of disease. In this scoping review, we explore the extent to which the current mental health evidence base acknowledges the impact of structural determinants of mental health outcomes, via the mechanism of discrimination - linked to a range of commonly underexplored socio-political and economic factors (Protocol registrationDOI:10.17605/OSF.IO/CGJQH).

We included nine social phenomena widely acknowledged in social theory as contributing to the patterning of social determinants : (1) Political Dynamics, (2) Racism, Caste & Xenophobia, (3) Gender & Sexuality, (4) Neighbourhood Dynamics, (5) Class & Working conditions, (6) Colonialism, (7) Indigeneity, (8) Religious & Spiritual Identities (9) Age & Disability. We explored these factors intersectionally, including studies with two or more factors in their analyses. Findings are reported using the PRISMA extension for Scoping Reviews Checklist. We screened 27,003 records with 118 papers meeting inclusion criteria.

We found no papers exploring caste-based discrimination in relation to the factors in our framework and very few exploring discrimination linked to indigeneity, colonialism, religious institutions, and language. The majority of studies focused on racism and its intersections with sexuality, gender and working conditions. We found a near balance in qualitative and quantitative approaches to exploring intersectoral discrimination. Common mental disorders were the most explored across all studies. Based on our findings the field appears to still be in its infancy in terms of engaging with intersecting forms of discrimination as a key mechanism driving the mental health consequences of many social and structural determinants. We articulate critical implications for research noting the necessity of research that explicitly names structural factors and acknowledges their intersections in people's lives, and frameworks that support this.

Keywords

Socio-political economy; global mental health; intersectionality; discrimination; social determinants of mental health

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If you don't ask, you don't know, and if you don't know, you can't act.

Nancy Krieger, 1992

1 Introduction: Social *and* structural determinants of mental health

In recent decades, an increased understanding of the causal pathways from social inequities to mental ill-health and recognition of the contextual realities experienced by people with mental health conditions has driven an interest in global advancement of policy responses addressing social determinants of mental health. It is increasingly common to encounter interventions which seek to take seriously the longstanding calls among people living with mental health conditions to engage with the wider social and structural dimensions of their lives, to make good mental health possible (Lund et al, 2018). This is crucial, given that many of the social and structural conditions that precipitate poor mental health conditions are unequally and unfairly distributed. For example, multi-dimensional poverty (MDP) – linked to low quality housing, poor access to educational opportunities, poor social infrastructure and access to social welfare has widely accepted relationships with poor mental health (Ridley et al., 2020). Unsurprisingly, MDP is highest in, for example, Central African countries, where burden of disease from mental disorders is simultaneously extremely high (UNDP, 2023; GBD 2019 Mental Disorders Collaborators, 2022). In high income settings such as Canada, MDP is highest among traditionally excluded populations (such as racialised or indigenous populations (Employment and Social Development Canada, 2021) - groups which also face high levels of burden of mental ill health (Nelson & Wilson, 2017).

However, evidence suggests that efforts to implement the necessary changes in services to address these complexities remain insufficient. Mental health inequalities continue to widen within and across countries. While up to 75% of people in the world living with major depressive disorder live in low- and middle-income country (LMIC) settings, approximately 8% receive any treatment (Moitra et al., 2022). In high-income settings, only one third of people living with depression receive any treatment, which is likely to be unequally distributed (WHO, 2021; Kirkbride et al., 2024). Beyond this, access to care continues to face challenges in meeting demand, as reflected in the gap between available treatments and their ability to recognise, let alone address, the social and structural challenges in people's lives (Roberts et al., 2022; Burgess et al, 2021). In the face of this maldistribution, further attention needs to be given to the processes through which mental health inequalities manifest, both within the progressive deterioration of mental health and in the content of our efforts to intervene. The limited attention to the contributions of discrimination and exclusion in determining mental health outcomes potentially sets up interventions for failure – as approaches which ignore these wider factors can have limited benefits to those whose suffering is anchored in complex interactive systems of oppression (Roberts et al., 2022).

A recent Lancet commentary argues that the principles of social justice – typically defined as attention to the unequal patterning of access to resources and opportunities for a better life – remain under-appreciated within mental health (Pathare, Burgess & Collins, 2021). The 2022 World Mental Health Report (WHO, 2022) acknowledged the importance of social justice as critical to changing the mental health landscape, acknowledging the need to end discrimination and address wider structural challenges such as climate change and humanitarian crises. However, to take this call seriously, further work is needed to draw attention to – particularly among researchers - the highly political and structurally determined nature of

poor mental health outcomes. Existing work in the landscape of social determinants has advanced attention to particular social factors in necessary but insufficient ways, often limited by the paternalistic nature of the applications of the framework, as well as the individualisation of impacts of complex social phenomenon use (see Frank et al., 2020).

In this scoping review, we explore the extent to which the current mental health evidence base acknowledges the impact of social *and* structural determinants on mental health outcomes, linked to a range of socio-political and economic factors that mark our current social, political and economic order. We use a Socio-Political Economy of Global Mental Health framework to explore the current state of research that seeks to engage with intersectional forms of oppression – namely discrimination and exclusion – on mental health. We hope our approach will move the field forward in two key ways: First, pushing us to acknowledge the role that intersectional structural factors play in poor mental health outcomes. Second, pushing our focus in relation to oppression and exclusion and mental health beyond our current emphasis on stigma, by prompting the field to consider more closely and conceptualise more explicitly the specific dynamics of experience being explored.

2 Background

2.1 Examining the intersectional socio-political drivers of poor mental health: broadening our conceptual frameworks for global mental health

In recent years, efforts have turned to a problematising of the social as it relates to global mental health. Bemme and Béhague's (2024) recent series on theorising the social, highlights that mental health needs to be understood in the contexts of social systems which configure material, and psychological relationships that drive not only lived experiences, but also mental health realities. Work by Kirmayer (2024) argues that interdisciplinary approaches are needed to simultaneously consider social psychological, psychosociological and socio-phsyiological processes that mediate impacts of environments, the interactional nature of social systems, and crucially the positive impacts of agency and subjectivity. Recent work has emphasized the need to acknowledge structural determination as it relates to mental health (Burgess, 2023), particularly in the context of racism and discrimination. This move beyond the more commonly used social determinants framework is necessary to spotlight the contextual circumstances that enable, and disable, good health for individuals and communities over time (Devakumar et al., 2022). In the absence of adequate recognition of structural factors, individual-level interventions may not only detract from addressing social and structural drivers but also risk perpetuating shaming narratives and replicating harmful power dynamics between those who have access to good mental health, and those who do not. It is increasingly important in mental health landscapes, to understand who, or what, is determining the social determinants of mental health. This requires closer engagement with the mechanisms that work to predispose certain populations to the perpetual and compounded experience of various harmful social determinants. A socio-political economy approach offers a paradigm which acknowledges the interplay of multiple social, political and economic forces that shape and sustain the distribution of power and resources in society. It spotlights the mechanisms through which many common social determinants come to impact some groups of people within societies, such as discrimination, marginalisation, and oppression (Kreiger 2001). It presents a conceptualization of health that views the causes of disease in the context of their social, political, and economic framings, as well as the contemporary and historical forces that produce the patterns of living and social conditions through which people's health is determined (Kreiger et al.,1997; Schrecker, 2019; Glasgow & Schrecker, 2016). Such an approach is critical, as it views the factors which place health at risk as active dynamic processes that reproduce patterns of poor health within and across generations.

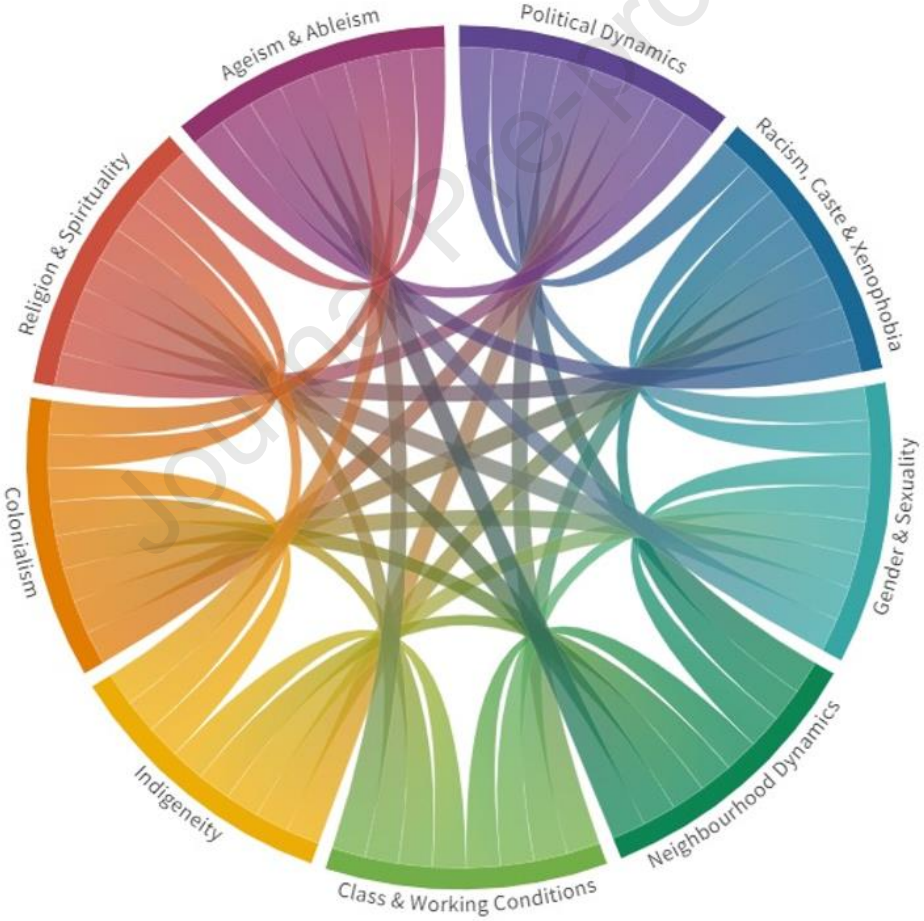
To advance and expand current debates on the role of the social in mental health (Bemme & Béhague, 2024), particularly within the social determinants literature, we propose a novel framework: the socio-political economy for global mental health (Burgess, 2024). This framework offers a perspective on social determination for poor mental health which extends beyond the current social determinants literature in this area by drawing attention to the dynamic interplay of structural conditions that precipitate, shape and reinforce common social determinants in people's everyday lives.

Our starting point was to extend domains presented in a 2018 systematic review of reviews published by one of the authors on social determinants of mental health and sustainable development goals (Lund et al., 2018), by identifying the structural drivers which establish them. Domains align with recent work by UNPRPD and UN Women (2022). The resulting Socio-Political Economy of Global Mental Health framework includes nine defined domains: (1) Political Dynamics, (2) Racism, Caste & Xenophobia, (3) Gender & Sexuality, (4) Neighbourhood Dynamics, (5) Class & Working Conditions, (6) Colonialism, (7) Indigeneity (8) Religious & Spiritual Identities, and (9) Age & Disability. The framework is represented in Figure 1 and domains and factors are provisionally defined in supplementary Tables 1 and 2. Fundamentally, these domains will be rooted to unique socio-political-historical contexts, the salience and impact of particular domains, and additional domains that have not been recognised by the field, will vary depending on the framework's application to particular contexts, questions and time. Furthermore, we do not imagine these domains as exhaustive, in recognition of the active and ever-evolving nature of these factors, and processes of exclusion they illuminate. This is represented as a category of 'Other' in our search, to capture other factors that may be missed.

It is important to note our grouping of these social factors differ from what is seen in existing literature, to expand on how many of these concepts are currently approached. For example, we opted to include a separate domain for neighbourhood dynamics, to better capture how issues such as green spaces, food deserts, and differential investment and resource allocation in communities contribute to exposure to poor mental health (Compton & Ku, 2023; Pearson et al., 2023; Xian et al., 2024). We grouped class and working conditions, to account for the common association seen with these factors within literature. That is, blue-collar, or informal labour (such as gig-economy, or zero-hour contracts continually associated with unsafe working conditions (Jaramillo et al., 2022; Wilson & McDaid, 2022) while higher class jobs (i.e defined as white collar or permanent roles) often have safer work environments. While we acknowledge that indigeneity and colonialism are related processes, we highlight the need for their differentiation in order to capture the reality of experiences. While colonialism ensures we capture processes of extraction– such as resources or culture - and individual experiences of internalisation, indigeneity allows us to capture the impacts of erasure – of traditional knowledge and practices - with both mechanisms operating at individual, organisational and structural levels. On closer examination, colonialism as a structural antecedent of social location, predisposes certain groups to greater risk for poor mental health outcomes. For example, it establishes patterns of thinking within both majority and minority populations, that contributes to driving poor mental health. For example, the pathologisation of quests for freedom during Slavery in the 17th century (see Faber et al, 2023 discussion of Drapetomania) was rooted in a colonial mindset that worked to maintain colonial systems and satisfied a normative ideal that slaves agreed with their enslavement. In contemporary societies, research has also articulated how colonial ideals are internalised among formerly colonised peoples, such as internalised inferiority towards old colonial powers or externalised superiority, i.e. colonial mentality in Filipinos (Ferrera, 2011) or mother country narrative within Black Caribbean communities (Krieger, 1992). In both instances, the mechanism through which these ideals are internalised, is through the idealisation of the colonial power structure, often delivered through education systems designed to shape a belief in the validity of colonial powers, which continues to impact on wellbeing of minority people today (Stein & Shankely, 2021). Further, the mechanism of colonialism is differentiated

from political dynamics and discrimination based on Indigenous status, as exemplified by the experiences of Indigenous communities in Canada, who are affected by the failure to action the Truth and Reconciliation Act which seeks to repair relations between the state and Indigenous communities (political dynamics), lack of access to safe drinking water on First Nation reserves (Colonialism), and discrimination based on Indigenous status (Indigeneity).

We also added a domain of political dynamics, to acknowledge the specific role that policy landscapes and political discourse plays in establishment of poor mental health outcomes globally. We note political dynamics, can act at a structural level (e.g. healthcare access), but can also be experienced at the individual or interpersonal level, such as how a healthcare provider's political allegiance may influence their interactions with individuals; or internalised, as doubts in their knowledge about their own health, in the validity of their embodied experience, or a belief that they are unable to change their health outcomes, making efforts feel futile.



Burgess, R. A., Ní Chobhthaigh, S., Lee, S., Pathare, S., Iemmi, V., & Lund, C. (2022, June 24). Scoping Review Protocol: Establishing a Socio-Political Economy of Global Mental Health. Retrieved from osf.io/e68un

Figure 1. Socio-Political Economy of Global Mental Health

A key aim of this framework is to prompt the user (i.e. researchers or providers) to consider the specific factors driving discrimination within society that they are seeking to understand, measure or change. Any framework, even a socio-political economic one, can also fall short, given the politicised manner in which research itself is conducted (Kreiger 1992; Frank et al, 2020). As a result, these platforms may inadvertently contribute to the erasure of complex experiences, particularly those shaped by the compounded effects of exposure to multiple factors of discrimination. Labelling factors is a critical first step in actioning social justice-oriented responses to the mental health consequences of social and structural determinants. As such, by specifically labelling our domains, we are prompting users to be more specific in terms of identifying and detailing the forms of discrimination at work in peoples' lives. This framework is not intended to reduce experiences to fixed or stable categories, but to explicitly draw attention to domains often overlooked and under addressed in the field. We view these domains as dynamic, interactive and ever-evolving across individual, interpersonal, societal and structural levels. We encourage the use of alternative, adapted and locally meaningful definitions of domains to ensure the framework is adapted to the context in which is it being applied. Crucially, we seek to emphasise the role of these dynamics, highlighting that identities themselves are not risk factors, but rather, it is the discrimination, exclusion and oppression based on those identities, tied to socio-political-historical contexts, that drive inequalities in mental health outcomes. We focus on mental health explicitly within our framework, to balance a history of inequity in relationship to physical health and to acknowledge that while the factors that drive oppression and shape poor physical and mental health may be similar, the *processes* through which they operate are not, and as such, various health domains benefit from explicit focus and attention.

Critically, our framework integrates socio-political economy with the concept of intersectionality – defined as the interconnected, relational and cumulative nature of social categories and locations (Collins, 2019). Intersectionality provides a lens to understand the specific and varied experiences and harms faced by marginalised and excluded communities, which sharpens our focus on how the combinations of determinants produce specific experiences and outcomes for communities beyond a simple additive effect (Collins & Bilge, 2016; Collins, 2000). While eco-social theory such as Kreiger's work (see Krieger 1999) highlights how health inequalities and oppression are produced and reproduced through social structures, in the absence of sufficient specificity, this alone may unintentionally overlook or erase the lived experience of those most vulnerable to and affected by oppression, due to a less explicit acknowledgement of power and interplay between social systems driving oppression (Merz et al., 2021). Thus, theoretical expansion is needed so the complexity of structural factors of oppression and related experiences can be fully understood, primarily through bottom-up theorising and close attention to the specific social locations shaped by compounded exposures to specific factors of discrimination (Collins, 2000, 2019). By articulating an intersectional approach to socio-political economy, we seek to direct actors to hold onto the complexity of people's experiences, to enable awareness of, and conversations across differing levels of power (i.e. the interpersonal, structural, disciplinary and hegemonic domains) at work in people's lives. As such, our framework depicts how *structural* determinants work as factors of oppression creating continual interactions, amplifying and creating unique experiences of risk of poor mental health among individuals and communities. Or more simply put, promoting the understanding that acknowledging that risk is everywhere, is not the same as understanding the risks that factors pose for communities.

While much debate has circulated around a definitive definition of intersectionality, we apply Patricia Hill Collins' conceptualization, which centres the workings of power and oppression as structural determinants of the lives of typically marginalised and excluded communities. Crucially, within her framework, power is seen to work within and across levels, creating interlocking webs of oppression, and drawing our attention

to the fact that bodies are the sites where intersectionality of the various forms of oppression work (Collins et al, 2021). Such a framing maps perfectly along our choice to identify specific domains of exclusion and discrimination in our socio-political economic framework and ensures that we attune to the ways these factors actually work in people's lives.

Our application of intersectionality theory aligns with the arguments of Cho and colleagues (2013) who suggest that intersectionality is best viewed as an analytic sensibility – and what makes an analysis intersectional is its adoption of an intersectional way of considering issues of similarity and difference and how they are framed by power. Such an approach allows us to illuminate the importance of social justice beyond distributive paradigms that advocate for a more just distribution of resources, forcing our attention instead towards the acknowledgement of power dynamics across a range of social domains and their impacts on the possibility for good mental health. By power dynamics, we mean the importance of acknowledging power at work at macro, meso, and family and kin levels, while acknowledging that these relationships are themselves shaped by historical and contemporary structural and political realities (Burgess, 2024).

Furthermore, the value of an intersectional analysis also resides in its ability to contribute to the achievement of health equity (Nash, 2018). Intersectional analyses can help us identify what is needed to achieve health equity – without it, we will perpetuate inequalities through the development of partial or incomplete responses (Cho et al., 2013). Efforts must acknowledge the need to prioritise those who are furthest behind equity, which is often those who experience the most compounded effects of socio-political determinants. This supports efforts to drive mental health practice more in line with critical praxis, which promotes action within domains that are often positioned as beyond the boundary of psychological and psychiatric practice. Further details on the theory behind the framework are discussed in an additional manuscript (See Burgess et al, Forthcoming).

2.2 Discrimination and exclusion as factors of poor mental health

In this work, we focus on two main processes through which oppression works to shape poor mental health: discrimination and exclusion. Although we acknowledge the presence of other factors, in this initial scoping review, we focus on discrimination and exclusion as key mechanisms by which social and structural determinants yield negative mental health outcomes. The processes of discrimination and exclusion are often acknowledged, yet further work is needed to understand the diversity and complexity of these mechanisms and how they contribute to poor mental health. Explorations around these processes within the mental health landscape often emphasise relationships to the experience of mental illness itself; stigma (Thornicroft et al., 2022) and social exclusion (Kienzler, 2023) of people living with mental health conditions. Although this has driven waves of positive action, supporting increased awareness and positive public perspectives towards mental health treatment globally (Iemmi, 2022), the emphasis has also resulted in an underappreciation of the intersectionality of different experiences of exclusion as they relate to the development and experience of mental health conditions. We purposefully draw attention to and assign equal weighting to less considered factors that manifest risk.

We applied a purposefully broad definition of discrimination as systemic unfair treatment (Kreiger, 1999), created through a process of ‘othering’ - to capture the multiplicity of factors that drive the experience of discrimination and its ultimate relationship to poorer mental health outcomes. For example, how othering manifests in the most minute interpersonal interactions, to macro structural organisations of society – an interpersonal and structural mechanism through which oppression becomes manifest within social realities. We were interested in four broad levels of discrimination: *interpersonal discrimination* (defined as discriminatory interactions between individuals across different power levels); *Institutional/organisational*

discrimination (defined as discriminatory policies or practices carried out by states or organisations) and *structural discrimination* (defined as the totality of ways that societies enable discrimination) (Kriger, 1999). Finally, Internalised discrimination (oppression) where members of excluded groups——internalize the negative views held about them by dominant groups, and as a result accept their subordinate status and exclusion in society as "deserved" (Krieger,1999)

In addition, we understand exclusion as both active and passive processes linked to discrimination. The active form includes mechanisms that decide who is granted access to legal status, resources, or social services, which reflect active inclusion or exclusion policies. The passive form, reflects on mechanisms that through inaction help to perpetuate the status quo in a range of settings including workplace settings (e.g., absence of anti-racist policies), service provision (e.g.., rape support services creating protected spaces to meet the needs of the majority group who experience rape - women - but not of other groups such as men or transgender people), and wider society (e.g., public transport sensory overload, crowding, and unpredictable disruptions or detours creating inaccessible environments for neurodiverse individuals).

We have opted to complete a scoping review of these two processes in order to understand to what extent the current literature reflects the complexity of forms of discrimination linked to structural drivers of oppression and its relationships to mental health outcomes. We believe our approach will move the field forward in two keyways: First, pushing us to acknowledge the role that structural factors play in poor mental health outcomes. Second, pushing our focus in relation to oppression and exclusion as it relates to mental health beyond the current emphasis on stigma.

3. Methods

We conducted a systematic scoping review, following the Joanna Briggs Institute Methodology for Scoping Reviews (Peters et al., 2020) and Peters and colleagues' (2015) 'Guidance for conducting systematic scoping reviews.' We reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) extension for Scoping Reviews Checklist (Tricco et al., 2018). The review protocol was published on the Open Science Framework June 2022, registration DOI: 10.17605/OSF.IO/CGJQH (Burgess et al, 2022).

3.1 Review questions

In line with our protocol, the scoping review centred on understanding the scope of available evidence on experiences of discrimination and exclusion and their mental health consequences, in the context of intersectionality. Additionally, we expanded the review with a series of sub questions, to delve deeper into the distribution of attention to experiences of discrimination and exclusion within mental health research. Our review considers the following key questions:

1. *Scope*: In what ways does the current literature examine the impact of intersectional forms of oppression – through processes of discrimination and exclusion– on mental health?
    a. What factors of discrimination and exclusion appear most frequently?
    b. What factors of discrimination and exclusion appear most neglected?
    c. What intersections of socio-political factors appear most frequently?
    d. What mental health conditions are examined?
2. *Intersectionality*: What are the shared themes among those papers with explicit reference to intersectionality theory?
3. *Global*: How much are these themes explored within research in LMIC settings? What are the shared themes among those papers conducted in LMIC settings?

For a detailed description of the socio-political factors, see Supplementary Table 1.

3.2 Eligibility criteria

Studies were included if:

1. They examined the *intersection* between two or more factors of discrimination or exclusion on mental health outcomes. Studies that only examined the additive impact, *without* considering the interaction or synergistic effects of these factors on mental health, did not meet criteria. For example, in quantitative studies, the intersection may be represented by an interaction term or measure of intersectional experience (e.g., discrimination based on the interaction of disability and age), reflecting how the combined effect of two or more factors is uniquely different from, and potentially greater than, the sum of the individual effects of the factors. Similarly, in qualitative studies, the intersection may be represented by an analysis of or themes reflecting the synergistic effect of two or more factors on mental health (e.g. accounts of experiences of discrimination based on both disability and age in the context of mental health difficulties).

2. They explicitly mentioned the mechanism of discrimination or exclusion. Studies that examined oppressed identities but did not measure the processes of discrimination or exclusion did not meet criteria.

3. They reported on experiences of discrimination or exclusion. Experiences of discrimination or exclusion were organised according to the nine domains of the Socio-Political Economy of Global Mental Health framework (see Figure 1 and supplementary Tables 1). Instances where a study measured more than one factor but only examined one combined exposure on mental health, for example, they merged racism and sexism into one combined measure of 'discrimination', did not meet criteria.

4. They reported the effects of intersectional discrimination or exclusion on mental health outcomes. Mental health outcomes included mental health conditions, psychological distress, suicide and self-harm, as well as substance-related disorders. Recognising differential measurement and conceptualisation of mental health outcomes between quantitative and qualitative research, quantitative studies were included if they used standardised measures of mental health, substance-use disorders, or psychological distress as well as measures of self-harm, or suicidal behaviour. Qualitative studies were included if they included discussions of mental ill-health, but excluding discourse focused only on positive mental health. All population groups across the life-course were eligible. We excluded studies which measured only quality of life, stress, burnout, psychological wellbeing, or self-esteem as these outcomes did not meet the specified criteria to be categorized as mental ill-health outcomes.

5. They included a broad range of study designs. All papers that conducted primary data analyses, as well as papers that conducted secondary data analyses on administrative data were included. Research papers of any design and methodology (including quantitative and qualitative evaluative design) as well as policy reports with data analyses were eligible. Literature reviews, commentaries, editorials, and evaluations that did not include quantitative or qualitative analysis were excluded.

6. They were published in English with no limitation on publication date. Papers which were not available in English were excluded.

3.3 Search strategy

Six medical and social science databases were searched between 26th May and 25th August 2022: PubMed, Global Health, Web of Science, PsycINFO, PAIS International and ProQuest's Social Science Premium Collection (includes International Bibliography of the Social Sciences, Sociological Abstracts, and Applied Social Sciences Index and Abstracts). In an effort to reduce publication bias, grey literature sources were searched: WHO, World Bank and IMF websites.

Searches included key terms for (1) mental health (2) "discrimination" or "exclusion" and (3) factors of discrimination that we defined in our framework for a Socio-Political Economy of Global Mental Health (see Figure 1) which serve as the basis for discriminatory practices and experiences (see Supplementary Table 2 for Search Concepts and Terms). Culture and/or country-specific terms (e.g., two-spirit, honour killings, Maori, Janajatis) were not included in the search. Our aim was to provide a starting point for future analyses giving broad overviews rather than specific explorations into cultural processes we argue should be led by those who are closest to those experiences, in line with decolonial principles (Smith, 2021) . We did not include terms with pejorative and negative connotations (e.g., Indian) which can be replaced with other terminology that will allow us to identify relevant papers (e.g., Indigenous/Native/Aboriginal/First Peoples).

3.4 Study selection & data charting

Search results were compiled, duplicates removed and inputted into Rayyan. Reviewers independently screened paper titles and abstracts for potentially eligible studies using Rayyan. Ten percent of paper titles and abstracts were double screened to ensure consistency. Potentially eligible papers progressed to full-text review. Given the complexity of the inclusion criteria, full-text screening was combined with a stepped data extraction procedure. Core data from all potentially eligible papers was entered into a data extraction table, including the paper citation, key analysis, key mechanisms of discrimination and exclusion and mental health outcome, and a breakdown of each of the factors examined (including what, how, and the level it was measured). Papers deemed eligible for further review underwent full extraction, including methodology, population, setting, process and outcome measures, as well as reference to intersectionality framework, prior to final decision.

The data extraction process was piloted by the study co-ordinator (S.N.C.), and one reviewer (B.B.), with oversight from the lead senior author (R.A.B.), then refined in consultation with the wider review team. Reviewers received initial training in screening and extraction and continued to meet for team workshops throughout the full-text review and data extraction process. Twenty percent of results were double-screened at the title and abstract stage. Additionally, twenty percent of papers were double extracted by two independent reviewers, 80% of reviewers' decisions at full-text were cross-checked by S.N.C. Where reviewers were unable to make a confident decision, either at title/abstract stage or full-text stage, the paper was first reviewed by S.N.C., if questions remained outstanding, conflicts were resolved by a senior member of the team (R.A.B., S.P., V.I., C.L.). Twenty-six papers required resolution by a senior member of the team at full-text stage, representing an inter-rater reliability for inclusion of 94%.

3.5 Data analysis

All included studies were assessed relative to the key outcome indicators and descriptive statistics were calculated to summarise the results of the core review question on scope. We also explored two subsets of studies that 1) explicitly referenced 'intersectionality' and 2) were conducted in LMIC settings.. In these sub-analyses, we present a synthesis of key themes relating to our main research questions.

3.6 Team expertise and public involvement

The team included a range of mental health experts, across countries and disciplines and career levels. We did not have any public involvement within this review.

4. Results

4.1 Search results

The literature search yielded 27003 articles after duplicates were removed (Figure 2). After carrying out a title and abstract screening, 436 articles were identified as potentially eligible. The full-text was obtained for 431. The five remaining records were unavailable through the University College London, London School of Hygiene & Tropical Medicine, or Kings College London libraries, and there was no response to efforts to contact authors. 118 studies were deemed eligible and included in the analyses (see Figure 2. PRISMA diagram; Supplementary Table 3).

4.2 Scope

A total of 118 studies were found that explored the impact of two or more factors of discrimination or exclusion on mental health. Of these 118, 48 (41%) utilised a qualitative methodology, 60 (51%) a quantitative methodology, and 10 (8%) a mixed-methods methodology. Publication dates ranged from 1997 to 2023, with more than half of the included articles (53%) having publication dates between 2019 and 2023, and less than 5% having publication dates prior to 2009.

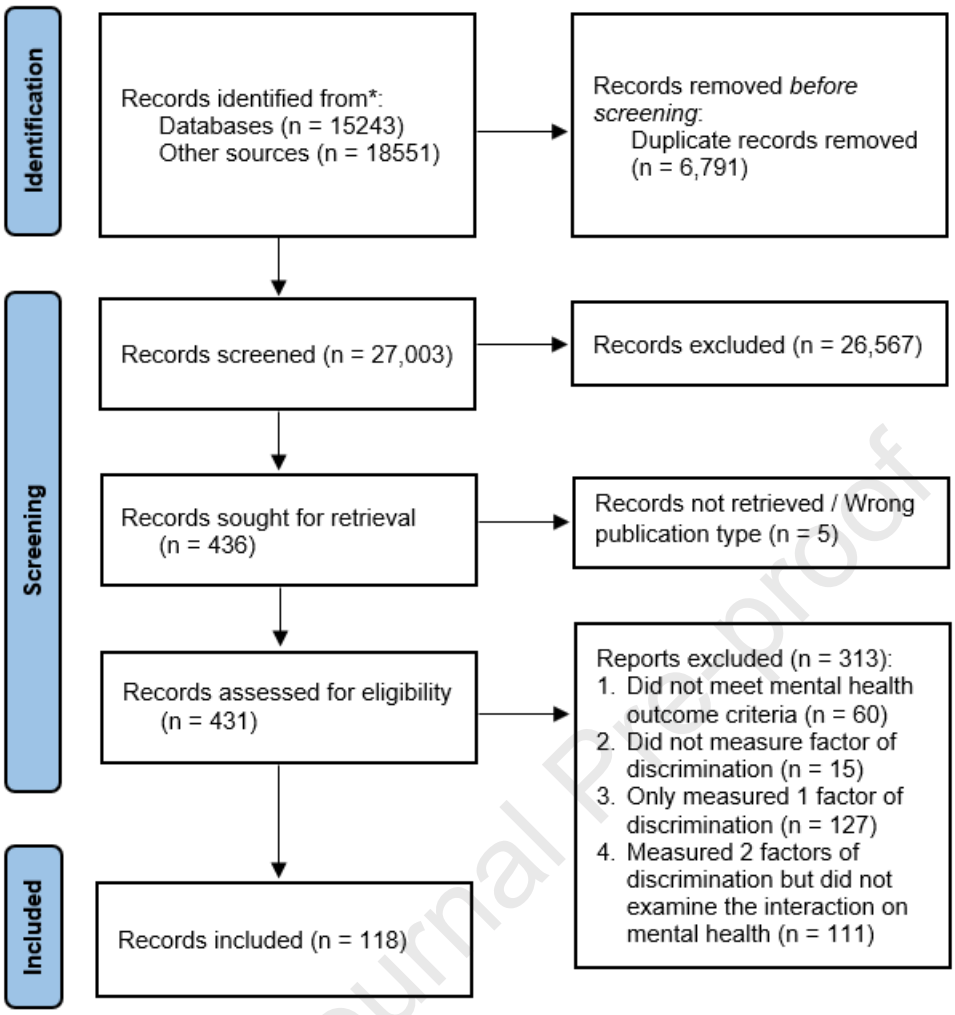


Figure 2. PRISMA Diagram

Factors of discrimination and exclusion

Our results show that certain factors of discrimination and exclusion were systematically explored more or less frequently than others in the analysed literature (see Figure 3 below). As there were no studies examining the intersectional impact of caste-based discrimination, we have omitted the category 'Caste' from our aggregated label for the purpose of our results. Overall, across all study types (quantitative, qualitative and mixed methods), Racism & Xenophobia (71%) and Gender Identity & Sexuality (71%) emerged as the most frequently examined factors. Among the quantitative studies, Racism & Xenophobia (82%) and Gender Identity and Sexuality (78%) received the greatest attention. In contrast, qualitative studies explored Political Dynamics (85%) far more frequently than in quantitative studies (30%), though Racism & Xenophobia (58%) and Gender Identity & Sexuality (63%) remained common. Mixed-methods studies included a balanced focus across Political Dynamics (70%), Racism & Xenophobia (70%) and Gender & Sexuality (70%). Additionally, Class & Working conditions were explored in approximately half of the qualitative (52%) and mixed method (50%) studies, but less often in quantitative studies (22%).

Conversely, Indigeneity (2%) and Colonialism (3%) were the least frequently examined factors across all study types. Indigeneity was not explored in any quantitative or mixed-methods studies, and only 4% of qualitative studies addressed it. Colonialism appeared in just one quantitative (2%), one qualitative (2%)

and one mixed-methods study (10%). Additionally, attention given to Ageism & Ableism varied across study types; absent from mixed method studies, 17% of quantitative and 29% of qualitative studies. Similarly, Neighbourhood Dynamics was examined less in mixed-method (10%) and quantitative studies (10%), while qualitative studies gave it moderate attention (35%). Furthermore, 11% of all studies examined 'other' factors, which included language-based discrimination and parent/family dynamics, with less focus in quantitative studies (3%) compared to qualitative (17%) and mixed methods (30%). Finally, religious & spiritual related discrimination varied by method type, being examined in 14% of studies overall, with 10% in quantitative, 19% in qualitative, and 20% in mixed methods.

When we break these aggregated factors down into the specific disaggregated factors, Race (53%) and Gender Identity (53%) were the most frequently examined across all study types, followed by Sexuality (42%). A similar trend was observed in quantitative studies, where d Race (68%), Gender Identity (53%), and Sexuality (48%) were most commonly studied. However, among qualitative studies, the focus shifted slightly, mirroring the aggregated results, with Gender (48%) and Working Conditions (44%) leading, closely followed by Borders (40%), Health & Social Care (38%) and Policy (35%). Among mixed-methods studies, Gender (70%), Race (50%), and Working conditions (50%) received the most attention.

Conversely, discrimination based on welfare dependency (1%), accent (1%), and minority/majority context (1%) were among the least examined factors across all methodologies. Quantitative studies did not address discrimination related to welfare dependency, accent, legal/refugee status, parent/family dynamics or discrimination by religious institution. In contrast, qualitative studies did explore these areas, albeit minimally: welfare dependency (2%), accent (2%), legal/refugee status (19%), parent/family dynamics (6%), and religious institutions (6%); no qualitative studies examined minority/majority context. Given the small number of mixed method studies, several disaggregated factors were not explored, including discrimination related to parent/family dynamics, welfare dependency, class/social status, neighbourhood, accent, legal/refugee status, minority/majority context and as noted under the aggregated factors, ageism or ableism.

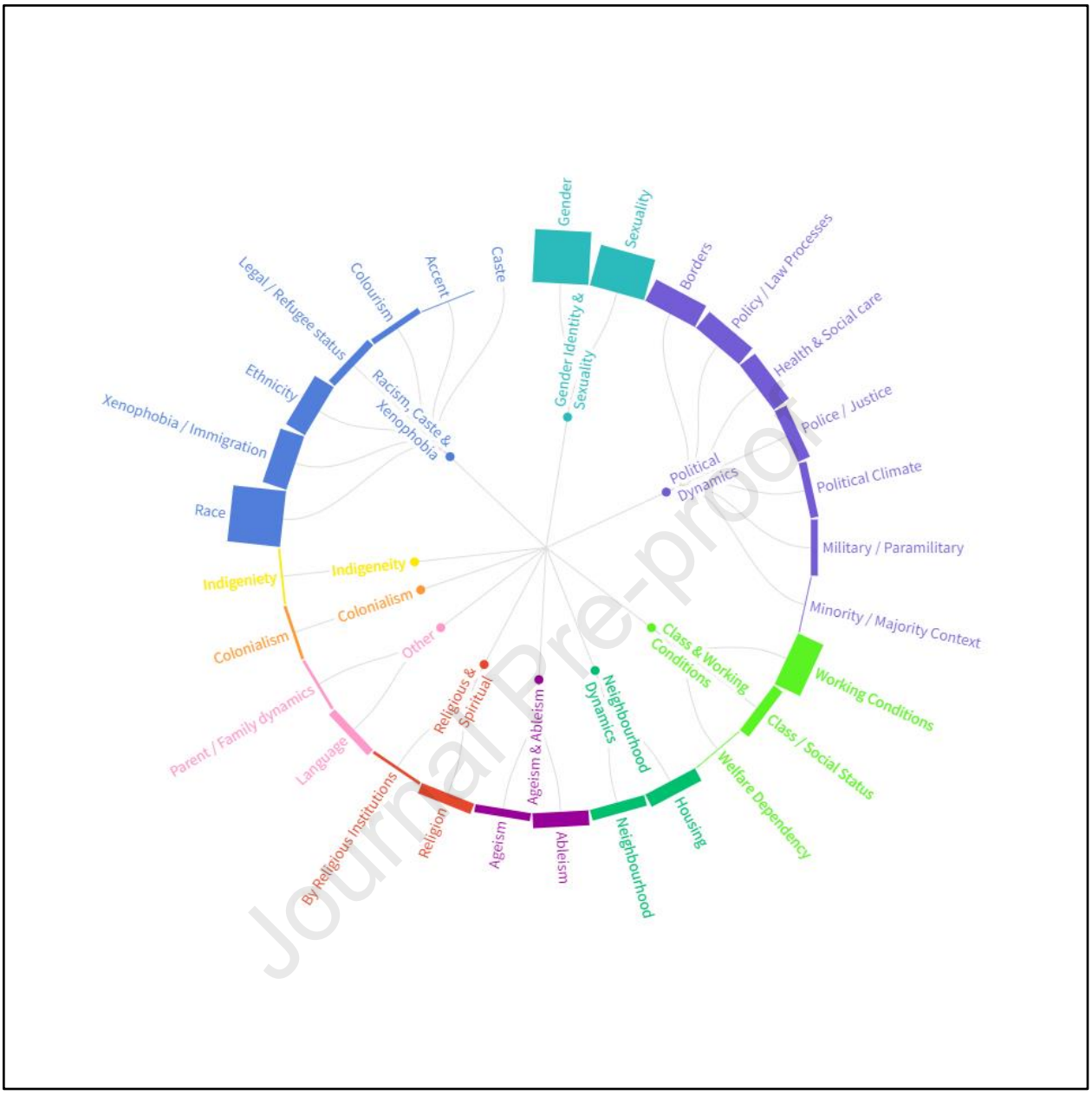


Figure 3. Frequency of the factors of discrimination reported in the literature

Levels of discrimination

Within our sample, distinguishing between different levels of discrimination was challenging, due to overlaps, interactions within the processes and a lack of reporting on conceptual frameworks. Across all study types, greatest attention was given to interpersonal discrimination (65% overall; 63% quantitative, 65% qualitative, 80% mixed-methods) and organisational/structural discrimination (62% overall; 37% quantitative, 92% qualitative, 70% mixed-methods), while internalised discrimination was examined in isolation in 26% of studies (37% quantitative, 19% qualitative, 0% mixed-methods). Despite an initial interest in four discrete types of discrimination, we found many studies reported discrimination acting across more than one level such that it was not possible to determine the effects of each (e.g., a measure of experiences of discrimination that includes both interpersonal and workplace discrimination). A

combination of interpersonal and organisational/structural discrimination was explored in 44% of all included studies (35% quantitative, 54% qualitative, 50% mixed-methods). To a lesser extent, a combination of internalised and interpersonal discrimination was examined in 5% quantitative, 4% qualitative, and 10% mixed-methods (6% overall). A combination of all three levels – internalised, interpersonal and organisational/structural - was explored in a handful of studies (3% overall; 3% quantitative, 4% qualitative, 0% mixed-methods).

Intersections

Our results show that certain intersections between factors were systematically explored more frequently than others (see Figure 4). Notably, some studies examined intersections involving more than two factors. Across all methods, the most frequently studied intersection was between Racism & Xenophobia and Gender & Sexuality (46% overall), followed by intersections of Political Dynamics with Racism & Xenophobia (32%), Gender & Sexuality (32%), and Class & Working Conditions (29%). Among quantitative studies, Racism & Xenophobia and Gender Identity & Sexuality were explored the most (62%), while Racism & Xenophobia and Political Dynamics as well as Gender & Sexuality and Political Dynamics were each examined by 17%.

This pattern differed among qualitative studies with the most frequent examined intersections being Political Dynamics with Racism & Xenophobia (50%) Gender & Sexuality (48%) or Class &Working Conditions (48%), in line with our results showing Political Dynamics was the most studied factor among qualitative studies. The intersection of Racism, & Xenophobia with Gender Identity & Sexuality was studied less often (27%), on par with Political Dynamics and Ageism & Ableism (27%) but behind other combinations like Political Dynamics and Neighbourhood Dynamics (33%), and Class & Working Conditions with Racism & Xenophobia (31%) or with Gender Identity & Sexuality (31%). Mixed methods studies most frequently examined the intersection between Gender & Sexuality and Political Dynamics (50%), along with Political Dynamics and Racism & Xenophobia (40%), and Racism & Xenophobia and Gender Identity & Sexuality (40%).

In contrast, intersections involving Indigeneity or Colonialism were the least examined. No studies examined the intersections between Colonialism and Neighbourhood Dynamics, Indigeneity or Other (i.e. Language or Parent/Family Dynamics). The only quantitative study that examined Colonialism, analysed the intersection with Racism & Xenophobia (2%) (see Nikalje & Çiftçi, 2023). The only qualitative study that explored Colonialism explored intersections with Ageism & Ableism, Political Dynamics, Racism & Xenophobia and Class & Working Conditions (see Takagi, 2006). The two qualitative studies on Indigeneity explored intersections with Political Dynamics, Gender Identity & Sexuality, Neighbourhood Dynamics, and Class & Working Conditions. The first of these studies also included intersections with Ageism & Ableism, Racism & Xenophobia, as well as Language and Parent/Family Dynamics (categorised as Other) (see Benbow, Forchuk & Ray, 2011) while the second included intersections with Religious & Spirituality (see Ecker et al., 2019).

At the disaggregated level, many intersections were only examined by 1 or 2 studies. Across methodologies, the intersections most frequently analysed were Gender Identity with Race (30%), Gender Identity with Sexuality (22%), and Sexuality with Race (20%). The trends varied somewhat between study types; qualitative studies examined a wider range of intersections, with the most frequently examined being Borders with Race (21%), Borders with Xenophobia/Immigration (21%) Gender Identity with Working Conditions (21%), Race with Xenophobia/Immigration (21%), and Policy with Health & Social Care (21%). In contrast, quantitative studies focused heavily on the intersections of Race with Gender Identity (37%), and Race with Sexuality (33%),followed by Gender Identity with Sexuality (23%). In mixed-methods

studies, five examined the intersection of Gender Identity with Working Conditions (63%), while four explored Gender Identity with Race (50%).

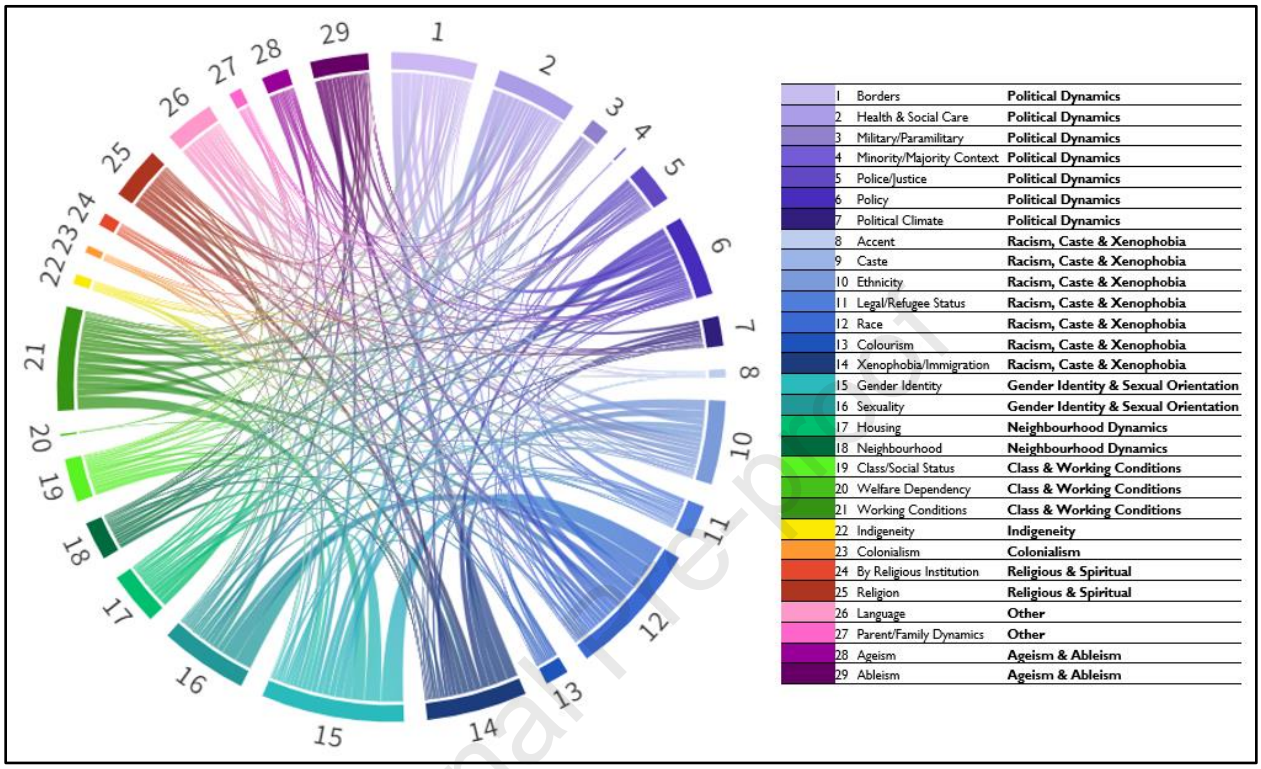


Figure 4. Intersections of factors of discrimination captured in the literature

Mental Health Outcomes

Overall, the included studies examined the effects of intersections between factors of discrimination and exclusion on several mental health outcomes, including depression (62%), anxiety (34%), unspecified mental ill-health (29%), suicide or suicidal ideation (14%), psychological distress (14%), substance-related disorders (13%), and post-traumatic stress disorder (13%). Only two included studies measured self-harm (2%; one qualitative, one quantitative), while eating disorders (1%; mixed-methods), bipolar disorder (1%; quantitative) and common mental disorders (1%; quantitative) were each examined by a single study. Notably, no included study investigated mental health outcomes such as psychosis. This focus varied across methodologies, with qualitative studies more likely to examine unspecified mental ill-health (32%), giving less attention to depression (26%), anxiety (18%), and suicide or suicidal ideation (11%). In contrast, quantitative studies focused primarily on depression (68%), followed by anxiety (30%) and psychological distress (20%).

Unspecified discrimination

Overall, 20% of the included papers examined the effect of two or more factors of discrimination on mental health, meeting our inclusion criteria, with one factor being an unspecified form of discrimination. For example, some studies measured “discrimination” utilizing the Everyday Discrimination Scale (EDS;

Williams et al., 1997), which measures everyday experiences of discrimination but does not explicitly address what factor of discrimination these experiences were due to. Only 4% of papers using a qualitative methodology did not specify what factor of oppression they were measuring, compared to 30% and 40% of papers using a quantitative and mixed methodology respectively.

4.3 Intersectionality

Less than half (41%) of included papers, explicitly referred to intersectionality. Among these studies explicitly using an intersectional lens, the majority were quantitative (65%), followed by qualitative (31%) with only two mixed-methods studies (4%). Half of included quantitative papers explicitly mentioned intersectionality, while just 31% of qualitative, and 20% of mixed-methods did so. Only one study using an intersectionality framework was based in a LMIC (Dominican Republic, see Childers, 2017). The factors of discrimination and exclusion most frequently explored were Racism & Xenophobia (88%) and Gender Identity & Sexuality (85%), with 73% of these studies exploring the intersection between these two factors. Discrimination was explored at the interpersonal level (alone or combined with another level) in 63% of studies explicitly engaging with intersectionality frameworks.

4.4 Geographical distribution of studies

Only seven percent (N=8) of our included papers were based in LMIC settings, including, Brazil, China, Dominican Republic, India, Macedonia, Nigeria, Rwanda, and Tajikistan. Half of these studies were qualitative (N=4), the other half mixed (N=4) methodologies. LMIC papers explored a range of mental health conditions, with depression (63%) and anxiety (63%) most commonly mentioned, followed by suicide or suicidal ideation (50%). The impact of Political Dynamics was examined in all LMIC papers (100%), most frequently at the intersections with Gender Identity & Sexuality (60%) and Class & Working Conditions (63%).

5. Discussion

Scope of literature on intersecting forms of discrimination on mental health

Based on our findings the field appears to still be in its infancy in terms of engaging with intersecting forms of discrimination as a key mechanism driving the mental health consequences of many socio-structural determinants. We identified 118 studies that examined the impact of intersecting factors of discrimination and exclusion on mental health outcomes. These studies included quantitative designs, such as longitudinal and cross-sectional studies, as well as qualitative designs, including interviews, focus groups, and ethnographies, and mixed-methods studies. Our review featured a near equal number of qualitative and quantitative approaches to understanding these intersectional effects of discrimination and exclusion on mental health. Qualitative studies gave more attention to Working Conditions and Political Dynamics domains, while other factors, such as Racism & Xenophobia and Gender Identity & Sexuality, were examined across qualitative, quantitative and mixed-methods studies. While the qualitative studies included in our review were more likely to examine complex intersections across more than two factors of discrimination and exclusion, we found a substantial proportion of quantitative studies that analysed intersectional impacts. With the advancement of recent statistical techniques (e.g. Intersectional MAIHDA) our findings suggest a growing potential for quantitative approaches to handle complexity, challenging long-held beliefs that qualitative approaches are inherently better suited for this task. In reality, what matters most is not the method itself, but the orientation, framing and conceptualisation applied by researchers that enables a nuanced understanding and interpretation of complexity within their analyses. As an orientation, political economies and intersectional approaches are oriented towards understanding ‘wicked’ problems (Schrecker, 2018), and advancing social justice principles by advocating for their

solution (Merz et al., 2021). But even these approaches can lead to narrow interpretation and applications within research and policy landscapes. As noted by Mertens (2007) and others (Burgess, 2024) it is the ontological, epistemological and axiological positioning of researchers that drive researchers to stay with complexity. However, the combination of these two frameworks in our work provides a platform that makes explicit a new 'how' for staying with complexity; that appears to be relevant to both meaningfully to qualitative and quantitative designs.

Our work also highlights the importance of attending to silences in the field. Within our included studies, we found no papers exploring intersections with caste-based discrimination and very minimal engagement exploring intersecting forms of discrimination linked to Indigeneity, Colonialism, Religion & Spirituality, and Language. Such absences speak to the ways in which we often fail to recognise the significant contributions these factors play in shaping mental health experiences, particularly when intersecting with categories more commonly explored. Alternatively, these forms of discrimination may have been articulated in locally meaningful concepts, or examined in conjunction with locally specific factors not explicitly captured in our search criteria. This underscores the importance of the flexibility within the framework, enabling it to capture critical dimensions and intersections specific to particular local contexts.

In contrast, the majority of included studies focused on Racism and its intersections with factors including Sexuality, Gender Identity and Working Conditions. This is potentially a reflection of the dominance of high-income countries like the United States, where research into the effects of racism on mental health is longstanding and extensive (Williams & Williams Morris, 2000; Pieterse et al., 2012; Okazaki, 2009). In keeping with previous findings on social determinants of mental health, only a small proportion of included studies were in LMIC settings. It is worth noting that funding priorities also shape the nature of bodies of literature. Our findings align with trends which witnessed an increase in funding priorities around gender in the last two decades, with Overseas Development Assistance with a focus on gender rising from 5% in 2002, to 42% in 2020 (George & Gulrajani, 2023), alongside a rising emphasis in exploring racial inequalities in high income countries like the US and UK. Extensive bodies of literature articulate the importance of structural factors like political landscapes (Jadhav et al., 2015) working conditions (Gakii et al., 2023) and religion (George & Bartlett, 2024; Moreira-Almeida et al., 2006) to mental health in many of these regions. However, there is limited evidence exploring how these issues are likely to be compounded, and impact on mental health experiences globally. Our findings also point to the value in widening our social determinants approaches to also explore intersectional structural drivers of discrimination as it relates to mental health. We found that our selected socio-political and economic factors known to be the foundations of discrimination and exclusion, are relevant to the mental health landscape. However, the substantial weighting and attention in the focus of these studies on the most visible and commonly acknowledged factors of discrimination (race and gender), remind us that there is a value in articulating a range of structural factors – as we do in our framework - to overcome the visibility and legacy which drives work in particular directions.

Considerations & Critiques

While our searches indicated a moderate literature base examining the impact of discrimination on mental health outcomes, there was large variation in approaches and recognition of the impact of *intersecting forms of discrimination*. Our exclusion process shows that within the current literature base, the focus remains on identity, without acknowledging that identities are merely a proxy for the lived experience of marginalization and exclusion. It is important to acknowledge that identity, in and of itself, should not be considered a risk factor. Instead, the critical factor associated with mental health outcomes is the *discrimination* associated with these identities. For example, it is not being a sexual minority that should be considered a risk factor, but the potential experiences of homophobia associated with being a sexual

minority that might be a risk factor for negative mental health. There is a need for improved specificity when examining concepts, for example, is the intention to examine racial identity, or identity as a proxy to understand the lived realities of racialisation. As such, much of the literature raises awareness of relationships, instead of critically understanding processes driving these relationships. Similarly, findings also highlighted lack of clarity on the form of discrimination, including poor definitions of core concepts driving the experience of participants. Often it was not clear what form of discrimination researchers were trying to capture. Our analyses highlighted the blurring of discrimination based on race, ethnicity or nationhood or ethnicity and race within the context of nationality or immigration status as well as instances where racism was used to refer to discrimination based on indigenous status, historical trauma, or colonialism (e.g. Janzen et al., 2017). While these domains are related, they are not the same, and more careful exploration of how such processes drive mental health outcomes across place and space is needed. In addition, multiple forms of discrimination were often merged, overlooking the differential impact that distinct types of discrimination have on people's lives.

In most excluded papers, discrimination was mentioned 'implicitly' and not explicitly defined or labelled. This mirrors a potential process of silencing, placing the burden on individuals, instead of creating space to acknowledge the structural processes responsible for perpetuating inequalities that drive poor mental health outcomes, and access to services (Burgess, 2023). There is a need for research in this area to more intimately engage with discrimination as a mechanism beyond experiences of stigma that are common within mental health spaces, and to acknowledge and operationalise the complexity and diversity of its workings. It is through naming these processes that we begin to uncover opportunities to interrupt their impact in people's lives. We also excluded a large number of studies that examined the impact of a single factor of discrimination on mental health (N = 127), a subset of which analysed the impact of group (identity) differences on mental health. In these instances, although these papers may be exploring the effect of an intersection of *identities*, they were not specifically exploring the intersection between two or more forms of discrimination or exclusion.

Although many studies measured multiple factors, they failed to examine specifically the intersection between these factors as the creation of a new social landscape of experience. For example, we excluded 67 papers that measured multiple factors as a single category of experience, (i.e., discrimination). We considered this as measuring only one factor, since collapsing them into a single category inherently erases the diversity of experiences. Similarly, we found other studies (N = 41) which examined differences based on group identity on the impact of two separate factors of discrimination or exclusion on mental health without delving into the interaction between the factors. These studies fail to acknowledge that the interaction between the factors contribute to a distinct experience. For example, studies examined gender differences in the impact of racism and homophobia separately, without examining how the interaction between racism and homophobia impacts mental health. In total, 111 papers were excluded because they did not examine the interaction between, and as such, the *intersectional* experiences of two or more forms of discrimination on mental health. For example, quantitative papers that reported a regression analysis, without an interaction term, examined the additive but not the combined effect. This highlights the need for researchers to carefully consider what their analyses do and do not capture to analyse the combined impact of multiple forms of discrimination adopting appropriate statistical methods used in mental health (Alghamdi et al, 2023) and beyond (Harari and Lee, 2021)

Among the included papers which explicitly applied intersectional frameworks (i.e., anchored to definition of the theory and terms), the emphasis was around interpersonal forms of discrimination. This confirms the need to expand research acknowledging the role that structural, rather than individual acts play in determining mental health outcomes – given that structural realities create risky environments that foster

interpersonal and internalised experiences of oppression. There was also inconsistency in how intersectionality was applied across studies. Scholars have articulated the dangers of a non-specific application of intersectionality theory, with much debate within Black feminist scholarship around the importance of clear articulations and applications of its use (see Mcall, 2005; Nash, 2018) By linking socio-political economic domains with intersectional approaches, this scoping review highlights the crucial role that intersectional approaches play in illuminating how structures work to define identity experiences (Cho, Crenshaw & Mcall, 2013). Our work highlights that while mapping identity positions is necessary, it is not sufficient to understand the types of discrimination that shape mental health outcomes globally. Furthermore, our findings also point towards a need for what has been described by Hancock Alfaro (2020) as stewardship in relation to the application of intersectionality within mental health spaces: one that orients those who apply the theory to acknowledge its historical roots in social justice interests, alongside the important work of expanding its global reach to further our understandings of experiences of oppression and discrimination in the field.

Included studies explored a wide range of mental health outcomes. However, the emphasis remained on conditions within the umbrella of common mental disorders, such as depression and anxiety. Studies engaging with more complex, long-term conditions such as psychosis were absent, despite evidence indicating various forms of racialised and other discriminations associated with diagnosis and treatment for severe mental illness. For example, work by Morgan and colleagues (2017; Schofield et al., 2023) reveals that Black African and Black Caribbean patients with psychotic disorders in the United Kingdom experienced worse social, clinical, and service use outcomes than their white counterparts, suggesting that previous experiences of structural social disadvantage contributed in part to differences in outcomes. Such realities occur alongside pathways to care for minoritised individuals that are more likely to include criminal justice services (Bhui et al., 2015) and higher rates of use of restraint among Black patients (The Observer, 2024)

Implications & Recommendations

Our scoping review highlights that the mental health field is still in its infancy when it comes to acknowledging the complexity of intersecting forms of discrimination and exclusion and the relationship to poor mental health. This suggests that research needs to engage in practices that are more specific in two key ways. First, we need to be explicit in the labelling of forms of discrimination. This will be a crucial step to understanding the pathways through which distress manifests in people's lives. Second, discrimination and oppression need to be considered through an intersectional lens, which allows us to capture the reality of these factors; that they rarely work in isolation. Third, it illuminates the need for studies to push beyond the social determinants discourse, to highlight the structural and political landscapes which establish them.

We acknowledge that a framework combining a socio-political economy and intersectionality is very complex. As a result, dimensions of the framework may feel at times as inseparable, which makes quantitatively exploring interactions between them complicated. However, this can be done as illustrated in the included studies. In instances where explanatory variables - factors - are correlated, perhaps we need to explore and assess specific intersectional experiences e.g. racism, ableism and sexism experienced by Black disabled women, compared to ableism and sexism experienced by White disabled women.

However, we caution that the point of the framework is *not* to compare the impact of different forms of discrimination, or to justify ‘oppression Olympics’, but to highlight the cumulative impact of multiple forms of oppression. We emphasize that discrimination and exclusion should be considered the driving forces behind mental health inequalities; and their resultant group differences - rather than any inherent aspects of identity. Additionally, it is crucial to acknowledge that the intersection of two or more factors compounds

these effects; as such treating these factors separately is neither useful nor appropriate. The combined impact of multiple forms of discrimination and exclusion must be considered when developing interventions to ensure they are effective.

Our hope is to make it clearer that researchers, policymakers and practitioners must recognise the ripple effects of structural drivers and understand discrimination and exclusion as mechanisms or risk factors for mental health inequalities. Where the intersection of two or more factors of discrimination exist and amplifies impact, failing to recognise this makes our efforts at support ineffective and potentiality unsafe. While some may argue that attending to complexity makes practical response to intersecting challenges more difficult, however, the reality is that interventions designed to respond to the most complex issues remain relevant to simpler ones. For instance, a program developed to address multiple forms of oppression can also benefit those experiencing a single form. In this way, by focusing on those most affected, we create solutions that help many, even with limited resources to hand.

It is crucial that concepts are labelled thoughtfully and explicitly to increase understanding of the impact of experiences of discrimination and exclusion on mental health. Further, we encourage the use of alternative, adapted and locally relevant definitions of concepts to ensure the framework is appropriately tailored to the context in which it is applied. This also helps identify when studies are not truly measuring what they claim, particularly when they fail to capture intersectional experiences. When concepts aren't clearly defined, they risk being overlooked or dismissed, perpetuating vagueness and maintaining the status quo.

Strengths & Limitations

There are limitations to our work. First, we note that at the time of publication, our searches are two years old, and as such the upward trend we noted in increased publications in this space may have continued with new evidence produced. Due to the complexity of our screening and analysis procedures, we opted not to re-run searches at this time. However, we outline a methodology that could be replicable by others who seek to explore our model in future studies. The exclusion of culture and/or country-specific terms from our searches may have influenced the results. While this was necessary due to the broad scope and our aim to provide a broad overview, future reviews with a narrower, context-specific focus could incorporate more locally meaningful terms, and we welcome the adaptation of the framework to ensure relevance and meaningfulness for the local context. Given the complexity of the review, we also acknowledge the risk that reviewers may have interpreted inclusion criteria differently, however, we mitigated this risk through rigorous cross-checking at the title and abstract stage, as well as during full-text review. Furthermore, our presentation of findings remains within the descriptive domain, as is typical of scoping reviews. However, given the depth of studies identified in our review, we present deeper analytical engagement with findings in a subsequent paper, which centres the value of the framework to policy and practice spaces (see Burgess et al, forthcoming). We acknowledge that including papers available in English only may have replicated an exclusionary practice similar to those we are critiquing, yet it was not feasible to include non-English sources due to the large number of papers screened. However, our main objective – to explore the extent to which the current literature base engages with complexities of social and political factors impacting mental health outcomes via the mechanisms of discrimination and exclusion, specifically, the intersection of these experiences – still provides a key contribution to our field. We argue that our proposed framework offers a lens through which to structure mental health research, in ways that acknowledge the multiple forms of discrimination that should be considered within the mental health landscape, as part of the wider social determinants approaches.

Conclusion

Our scoping review captures the ways in which the current literature base acknowledges the impact of intersectional discrimination and exclusion linked to socio-political factors on mental health. While our findings indicate a growing engagement with intersectional structural factors as drivers of poor mental health attention has predominantly been focused on a few, more visible factors of oppression, particularly those with longer-standing legacies of advocacy and public engagement, leaving other largely neglected from an intersectional perspective. To overcome this partial seeing and simplification of human experience, researchers must engage in more explicit definition of variables, improve transparency in reporting the assumptions and conceptual framings of research. Crucially, our review highlights it is not the method that dictates whether one can capture this complexity, but rather the orientation, framing and conceptualisation that researchers apply in their approach to understanding the drivers of poor mental health. Application of conceptual frameworks with built in explicit dynamics, will help to support acknowledgment of the compounded and complex experience oppression that is at the heart of many mental health challenges globally.

Supplementary files

1. Detailed description of socio-political economic factors
2. Search concepts and terms
3. List all included papers

Funding – There is no funding associated with this work.

Author Contributions

The paper was conceptualized by RAB, SP, CL, VI and SNC. The manuscript was drafted by RAB and SNC, with considerable input from DC, and reviewed by all authors. The review process was coordinated and led by SNC, supervised by RAB. BB assisted with the data extraction piloting and contributed extensively to screening, data extraction and verification. Alongside SNC and BB, screening was completed by RAB, DC, BF, CS, RP, CL, VI; data extraction and verification completed by DC, BF, DK, CS, NA, IP, EF, in order of input; and DC, DK, NA, RP, PS assisted in the analyses breakdown and compilation of results. The final manuscript was agreed by all authors.

Declaration of competing interests

Acknowledgements

We would like to thank Diana Rebeca Acosta Focil, and Suna Lee for their assistance with initial screening as well as Vanessa Eastick for supporting the creation of data visualisations. We are thankful to reviewers for their thoughtful comments which strengthened this manuscript.

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Intersectional discrimination, exclusion and the socio-political economy of global mental health: A Systematic Scoping Review of the Literature

Research highlights

- Continuing high levels of burden from mental health conditions globally signals further attention needs is needed to address mental health inequalities.
- There is Limited attention to how societal drivers of discrimination and exclusion in determining mental health outcomes globally, with significant impacts for those whose suffering is anchored to complex systems of oppression.
- Our novel Socio-Political Economy of Global Mental Health framework provides an opportunity to systematically explore how intersecting socio-structural determinants yield mental health outcomes, through experiences of discrimination and exclusion,
- The current evidence base is limited by attention to only a handful of vectors of discrimination and exclusion: racism, gender and workplace and political environments, and underappreciation of intersectionality of discrimination drivers.
- Findings suggests the need for new logics of mental health care which encapsulate the social, structural and political determinants that shape our lives

Intersectional discrimination, exclusion and the socio-political economy of global mental health: A Systematic Scoping Review of the Literature

Funding, Author contribution, competing interests and acknowledgement statements

Funding: RAB was funded by a UKRI/ESRC UKRI/ESRC Newton Award, grant number ES/V013211 during the completion of this award, which supports her work on mental health systems and service improvement. No other funding supported the completion of this work.

Author Contributions

The paper was conceptualized by RAB, SP, CL, VI and SNC. The manuscript was drafted by RAB and SNC, with considerable input from DC, and reviewed by all authors. The review process was coordinated and led by SNC, supervised by RAB. BB assisted with the data extraction piloting and contributed extensively to screening, data extraction and verification. Alongside SNC and BB, screening was completed by RAB, DC, BF, CS, RP, CL, VI; data extraction and verification completed by DC, BF, DK, CS, NA, IP, EF, in order of input; and DC, DK, NA, RP, PS assisted in the analyses breakdown and compilation of results. The final manuscript was agreed by all authors.

Declaration of competing interests

We have no competing interests

Acknowledgements

We would like to thank Diana Rebeca Acosta Focil, and Suna Lee for their assistance with initial screening as well as Vanessa Eastick for supporting the creation of data visualisations.

Declaration of interests

☐ The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

☒ The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

Rochelle A. Burgess reports financial support was provided by Economic and Social Research Council. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.