Response ID ANON-A39A-RJE5-4

Submitted to Health: Long Term Conditions Framework
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Questions - part 1 of 2

1 Do you agree that Scottish Government should move from a condition-specific policy approach to one that has a balance of cross-cutting improvement work for long term conditions alongside condition-specific work?

Yes

Please explain your answer below.:

We are extremely concerned by the framing and scope of the long term conditions framework and the omission of mental health conditions and/or mental illnesses as long term conditions within themselves. The framework is almost entirely framed around physical health, despite the fact that long term mental health conditions are prevalent in Scotland and contribute to a major proportion of the workload of mental health services.

According to the 2022 Scottish Census, the percentage of people reporting a mental health condition increased from 4.4% in 2011 to 11.3% in 2022. This was the largest increase across all condition types. The rise was especially pronounced among younger people, with a six-fold increase. In 2022, 15.4% of 16 to 24 year olds reported a mental health condition, up from 2.5% in 2011.

Mental illnesses and conditions, especially severe mental illnesses (such as schizophrenia, bipolar disorder, or major depressive disorder) are long term conditions which are persistent and have major impacts on a person's life – often affecting mood, thinking, behaviour, and commonly resulting in long-term functional impairment. Because of the long term and complex nature of some mental illnesses and conditions, there is a need for fully funded specialised health and social services to care for and support individuals to manage the persistent and disabling nature of their illness and enable meaningful recovery wherever possible. It is a major oversight of this framework to exclude this vast and extremely vulnerable population group from the scope of the framework.

Despite the definition at the outset of the framework, mental health and/or illness is only referred to throughout this framework as a byproduct of a long term physical health conditions – or as a comorbidity. Whilst it is true that mental health conditions and impacts can and do arise as a result of the effects of dealing with a long term physical condition, it is absolutely essential that this framework acknowledges mental illnesses and mental health conditions as a standalone set of long term conditions (i.e. not just a byproduct of physical conditions).

The converse is also true, that mental health conditions can have major physical health impacts – which the document does not acknowledge. There is a shocking and persistent mortality gap for those with severe mental illness (SMI) in Scotland. Individuals with SMI have a life expectancy 15-20 years less than those without a mental illness. 5% of these deaths are from suicide – however 95% are due to other causes: predominantly preventable physical illnesses such as cancer and liver, cardiovascular and respiratory diseases. It is estimated that 2 in 3 of these deaths could be prevented. Individuals with SMI are less likely to access physical health services: annual health checks for those with SMI would help with prevention/early intervention and would be an important step in reducing the mortality gap.

There is also no mention in the framework of individuals learning disabilities. This is a major oversight, as individuals with learning disability are at a much greater risk of developing a long term physical health condition: a study in Glasgow found that 98.7% of adults with learning disabilities had multiple physical health conditions, with an average of 11 physical health conditions per person. The mortality gap for people with learning disabilities is around 15-20 years, with a greater proportion of deaths being preventable than in the general population. This mortality gap is even higher for people with more severe learning disabilities, and for people who are also autistic.

The SMI mortality gap is widening over time, despite the fact that life expectancy of the general population is increasing. It is therefore vital that any long term conditions framework gives equal weighting to both physical and mental health long term conditions – and acknowledges the interactions between these condition groups, in order to achieve the goals as set out in the framework. This framework should seek to address the fact that individuals with mental illness and learning disability experience major barriers in accessing physical health care and should have an overarching goal of reducing the persistent mortality gap.

We would also urge the consideration of dementia in any long term conditions framework – both as a long term condition in itself and also due to the range of comorbid long term conditions associated with dementia. This must be included in the next iteration of the framework.

In order to reflect the true entirety of the range of long term conditions and their morbidity and mortality within Scotland, the framework – and any associated policy – must have an equitable focus on mental conditions.

We are also concerned by the omission of addictions as long term conditions in the framework. Addictions are long term, often chronic conditions which required tailored treatment and support on a long term basis. Scotland is widely regarded as one of the countries most severely affected by addiction-related harms globally. It has some of the highest rates of alcohol and drug-related deaths in Europe, with alcohol-specific deaths reaching a 15-year high in 2023. Despite significant government investment in tackling drug and alcohol misuse, alcohol and drug harm continues to claim more lives, highlighting a deep-rooted public health crisis. We urge that the next iteration of the framework includes a section on addictions.

RCPsychiS want to ensure that our patients are served and reflected in this framework, and query how this framework sits alongside, or intersects with, the Scottish Government Mental Health and Wellbeing strategy. This must be clarified. We do agree that a general framework (for long term conditions) – which sets out the general principles and strategy is helpful, as we acknowledge that there are too many specific conditions for each to have their own framework. However, for the reasons as discussed above, we would not be able to support the framework in its current form - due to the exclusion of

those with long term mental health conditions and/or learning disability.

2 Are there any improvements in prevention, care or support you have seen in a long term condition you have, or provide care and support for, that would benefit people with other long term conditions?

Please answer below.:

There are well established models of delivering mental health care – for example community mental health teams. However, these have been persistently under-resourced and often overlooked. RCPsychiS recommend that when looking to who could deliver the aspirations of this framework, interventions which take a holistic, whole-person approach (which views the patient as a complete individual, considering not just their physical condition but also their psychological and social well-being) is prioritised.

Unfortunately, many examples of best practice in mental health care have historically been overlooked. They are often heavily dependent on resources and, as a result, have not been prioritised or scaled up - despite their proven value.

A persistent lack of parity of esteem and parity of action prevails in Scottish healthcare in relation to mental health. This is apparent when we look to improvements in the ability of our health and social care sector to provide care and support for patients with long term mental health conditions. The mental health sector in Scotland is chronically under-prioritised and under-resourced and this framework must seek to remedy this, rather than further silo mental health away from the rest of healthcare (and thus further entrench the lack of parity).

We also feel that there should be increased focus on social inequalities and associated factors which make individuals in Scotland at much higher risk of developing long term conditions. We must address the drivers of poor health, in order to truly achieve prevention and early intervention.

In our previous answer we have discussed the need to consider mental health conditions as long term conditions in themselves – in addition to physical health conditions. However, the framework must also address the fact that many people experience comorbid physical and mental health conditions, where the combined impact is more than just the sum of each condition. This case is similar for individuals with learning disabilities. In these cases, it is essential for integrated and co-located physical and mental health conditions to be available, resourced, and equitably accessible – ideally with a high level of specialisation – in order to ensure effective outcomes for all aspects of health.

3 Do you have any thoughts about how areas for condition-specific work should be selected? This means work which is very specific to a health condition or group of health conditions, rather than across conditions.

Please answer below.:

The percentage of people reporting a mental health condition more than doubled between the 2011 and 2022 Scottish Census, and increased 6-fold in children and young people (aged 16-24). This was the highest increase amongst all health condition types in the Census. It is for this reason, as well as the stark mortality gap (as outlined in previous answers), that long term mental health conditions and associated impacts must be a key area of focus for this framework.

As an overarching comment, we feel that groups that need assertive outreach (such as individuals with severe psychosis and complex needs), young people with complex co-morbidities, and those where the interventions are very niche and require specialist skills and expertise should be given further consideration as part of the framework.
Additionally, an area of condition-specific work requiring urgent attention is neurodevelopmental conditions.
Neurodevelopmental conditions (NDCs) are conditions that affect brain function and disrupt typical neurological development, leading to challenges in social, cognitive, and emotional functioning. Autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD) are the most common examples of NDCs.

Neurodevelopmental conditions significantly affect many aspects of people's lives – with major emotional, social, and health impacts and risks. It is therefore essential that people with NDCs have access to prompt diagnosis and support – and in some cases medication. It is estimated that NDCs affect around 15% of the Scottish population. However, NDCs are significantly underdiagnosed in Scotland.

In recent years, there has been an unprecedented rise in referrals for neurodevelopmental condition assessment and support in Scotland. Referrals for ADHD assessment alone increased by 500%-800% across health boards between 2019 and 2021. This is driven by several factors: increased societal awareness and understanding, unmet historical needs, population growth and social change, and the impact of the COVID-19 pandemic. However, there is currently no dedicated, national standard NDC referral, treatment or support pathway for adults in Scotland. This is leading to critical issues within the mental health sector.

Without a nationally agreed pathway in place for NDCs, the rapidly rising scale of need has had a critical impact on service capacity within secondary care mental health services. This has led to unprecedented pressures in the mental health sector and lengthy waits for assessment and treatment across all health board areas in Scotland - which is posing an existential threat to the mental health system.

The rising demand for NDC assessment and care is placing immense pressure on Scotland's mental health services, leading to several critical challenges:

• Mental health services are overwhelmed by the volume of referrals for NDC assessment and support.
• This has created lengthy waiting lists – extending to multiple years in some areas. At the same time, the number of people requesting assessments continues to rise, far exceeding the capacity of the staff available to provide these. Projections indicate that, without major systemic change, waiting times could exceed 10 years within the next couple of years.
• The lack of dedicated pathways for NDCs means that general services are absorbing all NDC cases, significantly reducing their capacity to address other cases.
• Because NDC cases are being absorbed by general psychiatry (which is also responsible for managing acute crises and severe and high-risk mental

health cases), NDC assessments and treatment are often deprioritised.
General psychiatry staff are struggling to handle the overwhelming demand for NDC assessment and support, while also managing their existing workloads. This dual burden has led to multiple major negative consequences. If staff are diverted away from managing the most severe and high-risk patients, there will ultimately be adverse outcomes. At the same time, requiring clinicians to try and meet unattainable demands leads to an inevitable sense of moral injury, burnout and departure of clinicians from psychiatry. Recent years have seen an exceptional number of psychiatrists leaving general adult psychiatry for just this reason.

Secondary care services are designed for complex mental health conditions such as schizophrenia (which affects about 1 in 100 of the population), and bipolar disorder (which affects 2-3 in 100 of the population). These services were never designed to meet the needs of people with NDC (which affect about 1-2 in 10 of the population). As a result, mental health services are being overwhelmed with referrals for NDC assessments, which would be handled more appropriately through specialised assessment and care pathways. Without structured pathways, the current approach is fragmented and reactive, straining the system and leading to inefficiencies.

Absorbing NDC cases into general psychiatry is problematic, because NDCs require distinct assessment and support approaches. Placing NDC cases on the same waiting lists as those for mental illnesses overwhelms services, delaying care for both groups and deprioritising urgent mental health crises. This lack of separation is unfair as:

1) Individuals with NDCs endure lengthy waits without appropriate support.
2) People with mental illnesses risk worsening outcomes due to delayed access to priority services.

Dedicated pathways for NDC are essential to ensure tailored, timely, and equitable care for all.

The RCPsychiS has developed a fully-costed 4-tiered proposal for a national pathway for NDC, which can be accessed here:
https://www.rcpsych.ac.uk/docs/default-source/members/devolved-nations/rcpsych-in-scotland/rcpsychis---ndc-pathways-proposal-final---january-2025.pdf?Status
We urge this to be considered as part of any long term conditions strategies or frameworks.

4 What would help people with a long term condition find relevant information and services more easily?

Please answer below.:

Before we discuss accessibility and visibility of services, we require for these services to actually exist. We must establish sustainable, fully resourced (both financially and in workforce) services in an equitable manner before going on to discuss information sharing etc.

The enactment of the vision and mission of the framework as a whole, is underpinned by the need for sufficient, and successfully targeted funding and resourcing – which must be equitably directed in itself. Our members have provided the feedback that one of the biggest barriers to enacting the vision, objectives, and addressing the drivers as outlined in the framework is the resource-constrained and understaffed environment that they find themselves working within. These constraints are amongst the biggest perceived barriers to ensuring that patients realise their rights to the fullest potential.

Mental health remains to be a majorly under-resourced area of the frontline NHS spend, despite an exponential rise in demand for mental health services. Mental health services in Scotland are under unprecedented pressure, with demand vastly surpassing resourcing. The 2022 Scottish Census found that the number of people reporting a mental health condition in Scotland has more than doubled since 2011, rising from 4.4% to 11.3% of the population. This upsurge was the largest increase across all health condition types in the Census. Young people are particularly affected, with reports of mental health conditions among respondents aged 16-24 increasing sixfold between 2011 and 2022. It is therefore vital that this is prioritised.

Adequate funding is critical in addressing this rising demand, alongside tackling workforce shortages and ensuring timely, equitable access to high quality treatment and care.

The Royal College of Psychiatrists in Scotland is calling for increased funding to address Scotland's national crisis with mental health. In their 2021 election manifesto, the SNP committed to 'ensure that, by the end of the parliament, 10% of our frontline NHS budget will be invested in mental health.' This commitment was then reiterated in the Scottish Government and Scottish Green Party's shared policy programme. Unfortunately, every year since the 10% budget allocation commitment was made (2021), NHS frontline spend has moved away, not toward, the Government's spending commitments. In 2011/2012, 9.12% of NHS spending went towards mental health, over a decade later (and since the commitment to 10% has been made), the share of overall NHS funding has decreased to 8.53% in 2022/23.

In 2022/23, no health board achieved the 10% spending target set by the Scottish Government to achieve over this parliamentary term and only one board hit the target to invest at least 1% of its funding into CAMHS. NHS Territorial Boards were allocated £14.387bn in the 2025-26 Budget. Despite the Scottish Government commitment to dedicate 10% of this spend to mental health, there is still no mechanism in place to ensure that this target is met.

Government representatives have explained to us that the onus is on individual Boards to enact the division of NHS funding, but our own Managers in the Boards tell us they have no basis to insist on their share of funding, and are often expected to enact disproportionate cuts to mental health services. We require a mechanism to cut this cycle.

RCPyschiS is calling for the implementation of a legislative mechanism to ringfence this budget – recognising the importance of protecting and delivering investment in mental health (akin to measures in place in England and Wales). This would mean the mandatory spending of at least 10% of allocated budgets to mental health by each health board and 1% on CAMHS, alongside the mandatory reporting of this.

Taking 2022/23 as an example, NHS health boards would need to have invested an extra £238.5m into mental health services in order for the 10% pledge to have been fulfilled. This funding gap could cover the cost of*:

• 1775 more consultant psychiatrists (based on consultant pay scales, pay points 4-8 – including national insurance).
• 5,400 more mental health nurses (based on the 2024/25 band 6 A4C pay, pay point 1 – including national insurance).
• 55, 827 more patients treated by Community Mental Health Teams. - 3,272 more patients treated through crisis resolution.
• 17, 112 patients treated through assertive outreach services.
• 1084 additional adult acute beds.

*The above was calculated by RCPsych based on the NHS Staff Pay 2024 to 2025 and NHS Benchmarking Network, Adult and Older People's Mental Health Services 2024 report. This is calculated for each item, and is either or.

We are calling for:
• Delivery of the Scottish Government's committed allocation of 10% of NHS frontline spend to mental health and 1% to CAMHS.
• The implementation of a legislative mechanism to ringfence this spend.
• Mandated reporting from health boards confirming this spending target has been met.

Additionally, Scotland is facing a psychiatric workforce crisis. The workforce is not growing sufficiently to keep pace with the well-documented rising scale of demand for services. As such, our workforce is overwhelmed and stretched to its absolute limit. Clinicians are increasingly finding themselves having to work in untenable conditions. As a result of this, we are experiencing a critical loss of our substantive (permanent) psychiatric workforce, jeopardising the ability of our services to provide safe care and treatment to patients.

There is a major shortfall in psychiatrists able to fill roles in Scotland, and vacancy rates for consultant psychiatry roles are as high as 46% in some parts of the country. These workforce gaps have led to the widespread recruitment of locum psychiatrists as a temporary solution. An average of 1 in 4 consultant psychiatry positions are estimated to be vacant or filled by a locum across Scotland. Between September 2014 and September 2024, we lost a staggering 22% of our permanent psychiatric workforce.

Major systems changes are required in order to rebuild our workforce and ensure that there are enough qualified substantive consultant psychiatrists in Scotland to provide the high-quality mental health care which our society requires and deserves.

5 What would help people to access care and support for long term conditions more easily?

Please answer below.:

See answer to Q4.

We also feel that the framework should give further consideration to the equity of access of services across the country – the geographic areas and areas of higher need. The framework should seek to address barriers to care and support.

In relation to neurodevelopmental conditions – the RCPsychiS proposes the following tiers to help people access care and support:
• Level 1: National public health approach
• Level 2: National self-help resources
• Level 3: Specialist third sector commissioning for a NDC approach
• Level 4: Adult neurodevelopmental teams
Detail on each of these tiers can be found in our full proposal - linked in previous answer.

6 How could the sharing of health information/data between medical professionals be improved?

Please answer below.:

RCPsychiS members have fed back that fragmentation and gaps between services are exacerbated by the use of different IT systems across and between services and boards. A standardised system would improve ease of sharing information and data between medical professionals.

Members have also had feedback from patients around the perceived value of patient-held records. Patients appreciate the transparency and autonomy of having access to their medical records and information. This would also improve information sharing between medical professionals, as patients would have access to all of the relevant information to share with their medical professionals – which they could be able to share themselves in a meaningful way.

7 What services outside of medical care do you think are helpful in managing long term condition(s)? You may wish to comment on how these services prevent condition(s) from getting worse.

Please answer below.:

Non-NHS services would include social work, social care, peer support, third sector partners and supported living services. NHS would include allied health professionals. Services need to be available in the first instance and adequately staffed and resourced (see answer to Q4).

8 What barriers, if any, do you think people face accessing these (non-medical) services?

Please answer below.:

Again, service availability and capacity must be highlighted: lack of sustainable resourcing is also relevant here – see answer to Q4.

People with long term mental health conditions and/or learning disabilities experience a range of significant barriers when trying to access non-medical

services. These barriers can be personal, systemic, or due to a variety of social determinants. The result of these barriers relates back to our answers on the mortality gap previously in this consultation – see answer to Q1.

Stigma is one of the most common barriers to accessing support for individuals with long term mental health conditions. Perceived negative societal attitudes discourage people from seeking help.

Transport and accessibility are also major barriers – especially in rural and underserved areas.

Services are also often not physically accessible for individuals with mobility issues or accessibility needs associated with sensory issues. Digital exclusion should also be given consideration.

A digital-first agenda has been promoted and, in some instances, as seen during the Covid pandemic, fully adopted by health and social care services without addressing the digital exclusion that some individuals face. Any digitalisation of health and social care services must incorporate ways to mitigate and prevent digital exclusion.

Barriers experienced by minority communities further the persistent inequalities experienced by these groups and should be given particular focus in the framework.
Long waiting times and inadequate pathways are major barriers in accessing services in both medical and non-medical settings also.

9 What should we know about the challenges of managing one or more long term conditions?

Please answer below.:

Each additional co-morbid long-term condition exponentially adds more morbidity and complexity and poorer outcomes via a compound effect. One long-term condition (e.g. schizophrenia) can make it harder to access care and services for another long-term condition (e.g. diabetes).

10 What would strengthen good communication and relationships between professionals who provide care and support and people with long-term condition(s)?

Please answer below.:

We reiterate the perceived value of the transparency and autonomy of patients having access to their own medical records and information – see answer to Q6.

Continuity of care is also absolutely essential in achieving good communications and optimum patient outcomes – particularly in mental health care. Health boards are becoming increasingly reliant on the appointment of locums to fill vacant posts – this is having impacts on continuity and quality of care and patient outcomes. Continuity of care is essential in psychiatry: continuity strengthens therapeutic relationships, and this is associated with improved quality of care and patient outcomes.

This was recently highlighted through the VOX Scotland report (Your Views: Psychiatrists in Scotland' on lived experience of locum psychiatry). RCPsychiS also carried out our own survey on locum psychiatry in November 2024 – which can be accessed here:
rcpsych-in-scotland---locum-survey-report-2024.pdf. This report also highlighted the essential nature of permanent staff in delivering continuity of care. The report outlines our recommendations to strengthen the permanent psychiatric workforce and reduce the reliance on temporary locum staff.

The framework should seek to improve current gaps in information sharing between healthcare professionals and social work also.

Questions - part 2 of 2

11 What digital tools or resources provide support to people with long term conditions?

Please answer below.:

We are optimistic about the potential of new digital tools and technologies, but with the caveat of some concerns about the ability of these to integrate with patient generated information. The framework must consider the unintended consequences associated with advances in digital technologies in terms of digital exclusion, and the risk of further entrenching existing inequalities.

It is paramount that any adoption of digital tools and resources has a co-existing action framework that ensures that those unable to access digital options are not excluded.

12 What new digital tools or resources do you think are needed to support people with long term conditions?

Please answer below.:

As above in answer to Q11.

The framework should consider how digital tools could be utilised to address the gaps in provision of support for individuals with long term mental health conditions – particularly those in rural and underserved communities, or those who find it challenging to receive in person support.

We also refer back to the RCPsychiS proposal for a 4-tiered national approach to neurodiversity. Tier 2 refers to the development of a centralised, national digital platform to provide comprehensive self-help resources for individuals with neurodevelopmental conditions.

13 How do you think long term conditions can be detected earlier more easily?

Please answer below.:

Individuals with long term severe mental health conditions are at much higher risk of developing long term physical conditions – hence the mortality gap referred to throughout this response. People with SMI have a life expectancy 15-20 years shorter than the general population, and two thirds of these deaths are from preventable causes – predominantly physical illnesses that could be tackled through early detection and intervention. For example, people with SMI experience a 6.6 times increased risk of respiratory disease, 4.1 times increased risk of cardiovascular disease, and 6.5 times increased risk of liver disease.

In England, a comprehensive plan to address this inequality has been implemented, but no such plan exists in Scotland.

RCPsychiS are calling for the urgent implementation of a fully funded national strategy to reduce the mortality gap. More on this can be found in the RCPsychiS manifesto for the 2026 Scottish Parliament election. One of the key pillars of this would be the establishment of a comprehensive healthcare monitoring system for people with SMI, to ensure that they receive regular physical health checks and interventions. For example, annual health checks via assertive outreach. Annual health checks are already being rolled out for people with learning disabilities - and people with SMI would benefit from the development of a similar programme. Both groups require active interventions to reduce the mortality gap.

Bolstering the functionality, capacity, and resourcing of – as well as accessibility to – GPs is essential in ensuring early detection of both physical and mental health conditions.

14 What barriers do people face making healthy decisions in preventing or slowing the progress of long term condition(s)?

Please answer below.:

People living with mental health conditions often encounter distinct and overlapping barriers that make it more difficult to make healthy lifestyle choices aimed at preventing or managing long-term physical health conditions. Similarly, individuals with learning disabilities may face multiple, though differently shaped, challenges that can also hinder their ability to engage with health-promoting behaviours.

The presence and diagnosis of a mental health condition can make partaking in daily activities which protect against developing physical health conditions extremely difficult – often intervening with, for example, people's ability to exercise, cook healthy meals, and to rest properly and/or have appropriate sleep hygiene. Additionally, mental health conditions also increase the likelihood of behaviours that can increase physical health risks, for example: poor diet and smoking and/or substance use. Additionally, the use of some psychiatric medications can increase physical health risks, such as increased risk of diabetes or cardiovascular disease.

As outlined throughout this response, a major barrier to preventing or slowing the progression of long-term physical health conditions for people with mental health conditions is their reduced likelihood of accessing healthcare services and support. While there has been some recognition of this issue for people with learning disabilities - reflected in initiatives like annual health checks and liaison nurse roles - these measures, though valuable, remain insufficient to close the significant mortality gap or address persistent disparities in service access. Both individuals with SMI and LD continue to face unacceptable inequalities. The framework must explicitly acknowledge and address this as a matter of urgency, with clear recommendations for service adjustments, adequate resourcing, and proactive outreach to ensure equitable care for all.

Certain subgroups of society are at a higher risk of developing a mental health condition due to social determinants such as poverty, poor housing, and limited access to education, but the converse is also true: mental health conditions can exacerbate these challenges - creating a cycle whereby social disadvantage and mental illness can reinforce one another. Population-wide interventions which target these determinants across the life course provide not only the opportunity to improve population mental health, but also to reduce the risk of those with mental health conditions from being disproportionately affected by negative social determinants.

15 Is there anything currently working well within your community to prevent or slow progression of long term conditions?

Please answer below.:

As above.

16 How can the Scottish Government involve communities in preventing or slowing the progress of long term conditions?

Please answer below.:

Communities can be better involved in preventing or slowing the progress of long-term conditions with a wide range of groups and through active outreach to underrepresented voices – especially underrepresented voices within marginalised groups and communities themselves. Outreach should be targeted further than just those traditionally engaged with – recognising that barriers differ between communities and groups. It's vital that we don't rely solely on self-appointed leaders, but to actively outreach to engage with new and diverse voices. This is necessary for coproduction and to ensure that services truly are accessible, inclusive, and appropriately tailored.

17 Are there additional important considerations for people with long term conditions? For example people who; live in deprived areas and rural and/or island areas, have protected characteristics e.g. race, disability, who are in inclusion health groups e.g. homelessness, or who experience stigma due to perceptions of their long term condition e.g. people with dementia?

Please answer below.:

Consideration of the intersectionality of mental health alongside other factors which act as barriers to good health is absolutely essential in this framework. For example, different forms of discrimination – such as racism, sexism, ageism, ableism, etc interact and compound the experiences of those with long term mental health conditions.

For example, for people from marginalised groups who also live with a long term mental health condition, stigma (and self-stigma) is often compounded and intensified. People from marginalised communities commonly face pre-existing societal and self-stigma. When these individuals also experience long term mental health conditions, the effects of this are compounding. This commonly becomes a significant barrier to accessing and trusting healthcare systems and can result in worsened health outcomes. Multiple factors affect how, when, and if a diagnosis is made and thus the treatment and support provided. The framework does not currently address this, and the RCPsychiS advise that this must be included.

18 Given that racism and discrimination are key drivers of inequalities, what specific actions are necessary to address racism and discrimination in healthcare?

Please answer below.:

19 Is there anything else you would like to raise that was not covered elsewhere in the consultation paper?

Please answer below.:

About you

What is your name?

Name:
Jane Gordon

Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
Royal College of Psychiatrists in Scotland (RCPsychiS)

Further information about your organisation's response

Please add any additional context:

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

Publish response with name

Do you consent to Scottish Government contacting you again in relation to this consultation exercise?

Yes

What is your email address?

Email:
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I confirm that I have read the privacy policy and consent to the data I provide being used as set out in the policy.

I consent

Evaluation

Please help us improve our consultations by answering the questions below. (Responses to the evaluation will not be published.)

Matrix 1 - How satisfied were you with this consultation?:

Please enter comments here.:

Matrix 1 - How would you rate your satisfaction with using this platform (Citizen Space) to respond to this consultation?:

Please enter comments here.: