Consultation response: long term conditions framework 20/07/25

About See Me
See Me is Scotland's national programme to end mental health stigma and discrimination. Our vision is for a fair and inclusive Scotland, free from mental health stigma and discrimination. See Me is hosted by SAMH and the Mental Health Foundation. More: www.seemescotland.org

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?

We broadly agree with this approach, provided the driver for the framework is to address stigma and discrimination as an underlying cause of the significant health inequalities for people living with a long and enduring mental health diagnosis and improving physical and mental health outcomes for this group. We would also add that physical and mental health cannot be seen separately.

"Stigma meets all of the criteria to be considered a fundamental cause of health inequalities[1]."We therefore recommend that anti-stigma measures are embedded into the framework.

The mortality gap inequality

"Statistically, I'm way beyond the time I should have died. I am really conscious of that. I know that people like me die so much earlier than the rest of the population[2]."

The population average age is increasing[3] but not for people with a long-term mental illness. The result is that the mortality gap is persistent and widening[4].

It should be considered a national shame that people with long term mental illness have a life expectancy of between 15 and 20 years lower than the average

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[1] Stigma as a fundamental cause of population health inequalities https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2012.301069
[2] Graham Morgan MBE Holyrood Inside Politics | Scots suffering from severe mental illness die two decades earlier
[3] Scottish Government Mental Health and Wellbeing Strategy https://www.gov.scot/publications/mental-health-wellbeing-strategy/pages/16/
[4] https://www.gov.scot/publications/scottish-health-survey-2021-volume-1-main-report/pages/7/

population. This mortality gap is persistent and widening with 95% of early deaths caused by a physical illness; and 5% by suicide. Therefore, to address this devastating inequality, measures to address mental health stigma from an intersectional lens must be embedded into the framework. Only this will achieve the vision of the Scottish Government's Mental Health and Wellbeing Strategy which acknowledges that "Health inequalities are the unjust and avoidable differences in people's health across the population and between different population groups[5]."

This mortality gap has been described as an "entrenched disparity" needing systemic change:

"the life expectancy gap in people with SMI persisted or widened from 2000 to 2019[6].

Addressing this entrenched disparity requires equitable social, economic and health policies, healthcare re-structure and improved resourcing, and investment in interventions for primary and secondary prevention of SMI and associated comorbidities[7]."

The gap remains disproportionately high:

- People with severe mental illness (SMI) living in Scotland have a life expectancy 15-20 years less than the general population.
- 2 in 3 of these deaths are from preventable causes - by conditions such as cancer, respiratory, cardiovascular and liver disease.
- **5% of deaths from SMI are from suicide - 95% are due to other causes.**
- The mortality gap continues to widen - despite the fact that overall life expectancy in Scotland has increased over the past 20 years.

Recent research from Edinburgh University also shows that the mortality gap is increasing for people living with schizophrenia, and has remained persistent for other serious diagnoses over the last 20 years:

"It's now well established that people with schizophrenia, bipolar disorder and depression have a lower life expectancy than people without such illnesses. What's most disappointing about our findings is the lack of progress in closing this gap over the last 20 years, and a possible widening of the gap for people with schizophrenia.

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[5] Inquiry into health inequalities - Scottish Parliament - Citizen Space

[6] The University of Edinburgh May 2025 https://www.ed.ac.uk/news/life-expectancy-gap-widening-for-scots-with-schizophrenia?utm_source=linkedin&utm_medium=organic_post&utm_campaign=cam_research_comms&utm_term=&utm_content=smi_life_expectancy

[7] Time trends in life expectancy of people with severe mental illness in Scotland, 2000-2019: population-based study - PubMed

Addressing this entrenched disparity requires equitable social and health policies to prevent and treat poor physical health amongst people with mental illness[8]."

It's important to recognise that the majority of these deaths are from co-morbid physical health conditions. When compared with the population not living with mental illness, this shows a fundamental inequality.

Stigma as a fundamental cause of inequality
There is evidence to show that these poorer outcomes can be attributed to discrimination in healthcare settings as noted in the statistics from The Scottish Mental Illness Stigma Study (SMISS)[9] where people experienced:

- systemic marginalisation within all levels in the system
- persistent judgement, shame, fear - often preventing them from accessing and benefiting from a range of public services.
- an imbalance of power in relationships when disclosing or making decisions about care and support; not being listen to and not taken seriously.
- having physical health conditions overlooked, misdiagnosed or inappropriately treated.

SMISS shows that stigma and discrimination within healthcare and mental healthcare settings is a significant barrier to accessing care and treatment for people living with serious mental illness (SMI): "stigma was linked to particularly high levels of withdrawal from asking for help from healthcare professionals (87%)

- asking for help for physical health problems (85%).
- Eight in ten (81%) agreed that they had avoided discussion of their mental health needs and experiences when accessing help from healthcare professionals for a physical health problem. Of note, over half of respondents endorsed statements that they had withdrawn early from health care services
- (55%), had stopped themselves obtaining prescriptions or taking medication for physical health problems (52%)
- and had avoided calling an ambulance or attending A&E for their physical health (51%).

[8] The University of Edinburgh - life expectancy gap widening for Scots with schizophrenia https://www.ed.ac.uk/news/life-expectancy-gap-widening-for-scots-with-schizophrenia?utm_source=linkedin&utm_medium=organic_post&utm_campaign=cam_research_comms&utm_term=&utm_content=smi_life_expectancy

[9] The Scottish Mental Illness Stigma Study (SMISS) https://www.seemescotland.org/media/11118/see-me-scottish-mental-illness-stigma-study-final-report-sep-2022.pdf

- Close to half (49%) also agreed with the statement that they had stopped themselves attending general health check-ups (e.g. vaccinations, breast screening or prostate screening)[10]."

The SMISS report says, "possible contributory factors include: smoking, 'poorer access to physical healthcare and diagnostic overshadowing (where physical problems are undertreated or wrongly attributed to mental health issues), inadequate diet, lack of exercise, the effects of long-term use of psychiatric medication, higher rates of suicide (compared to the general population), and accidental and violent deaths. Public health is failing this population[11]'."

SMISS highlights that when people experience repeated stigma and discrimination in healthcare settings, they withdraw. This is recognised in further evidence that these traumatic experiences can cause people to withdraw from care and support causing a "missingness" from healthcare for people living with mental illness:

"...a lifetime's worth of experiences of stigma, hostility, trauma, and difficult relationships with care may act as a deterrent against accessing care[12]."

This underlines the case for sustained and properly resourced anti-stigma activity across healthcare and mental healthcare settings.

The LTC framework aligns to the ambitions contained in the recently published Population Health Framework which we welcome, in particular the focus on health inequalities. This has the potential to address the significant stigma and discrimination people with mental illness experience in health and mental healthcare settings. We welcome the mention of racism and other social determinants in both frameworks. We would encourage an intersectional approach to the LTC framework in addressing health inequalities.

Removing stigma and discrimination is foundational to good outcomes for people. The Scottish Mental Illness Stigma Study (SMISS)[13] revealed that respondents ranked healthcare settings as one of the areas where people had experienced stigma, and/or discrimination most frequently. SMISS also showed that when people experience stigma and, or discrimination in health settings, they withdraw which means that they don't get equal access to the care and support.

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[10] The Scottish Mental Illness Stigma Study see-me-scottish-mental-illness-stigma-study-final-report-sep-2022.pdf

[11] The Mental Health and Wellbeing Strategy https://www.gov.scot/publications/mental-health-strategy-2017-2027/

[12] Applying a missingness lens to healthcare https://www.enlighten.scot/nhs2048/applying-a-missingness-lens-to-healthcare-andrea-williamson/

[13] The Scottish Mental Illness Stigma Study see-me-scottish-mental-illness-stigma-study-final-report-sep-2022.pdf

We do however note that:

- It's disappointing that the consultation largely overlooks mental health and its impacts. Although there is mention of mental health, this is in the context mainly of someone's mental health being impacted as a result of managing a physical health condition.
- We acknowledge the impact on someone's mental health of managing a long term physical health condition, however, we would ask that the framework specifically recognises the evidence to show the fundamental inequality of poorer physical outcomes for people living with serious mental illness.
- It's disappointing and surprising that there is no mention of SMI or severe and enduring mental illness especially in the context of poorer outcomes for this group of people who are more likely to die earlier and have co-morbid physical health conditions as detailed in the foregoing. An estimated two thirds of these deaths are preventable[14].
- A condition-specific approach, while valuable for certain high-burden conditions, fails to recognise the common challenges faced by people living with multiple conditions and the shared social determinants that impact health outcomes. Cross-cutting policies enable more efficient use of resources, better coordination of care, and the ability to address underlying issues such as poverty, isolation, stigma and discrimination, all of which disproportionately affect people with mental health conditions.
- This strategic shift aligns closely with See Me Scotland's priorities in several ways:
    - It reinforces a person-centred approach that sees the individual, not the diagnosis.
    - It provides opportunities to tackle stigma and discrimination systemically, rather than in isolated clinical contexts.
    - It promotes equity by enabling resources to be allocated based on need, not historical condition-specific lobbying or visibility.
    - It creates the conditions for embedding trauma-informed, rights-based, and inclusive service models.
- To be successful, the approach must be adequately resourced and supported by a governance structure that includes people with lived experience, especially those affected by mental health stigma and discrimination.
- We would ask that measures to tackle mental health stigma and discrimination are embedded through the core of the framework

[14] Wellbeing and mental health: Applying All Our Health - GOV.UK

- we would take this opportunity to remind the Scottish Government that mental illness is protected under the Public Sector Equality Duty (PSED) and therefore the public sector is obligated to:
    - ensure fair access to services for people with protected characteristics
    - Identify and remove barriers to care
    - Advance equality of opportunity, which includes taking positive steps to meet the different needs of different patient groups.
    - create good relations between groups—for example, through inclusive communication or reducing stigma around mental illness.
- We would also note that the national equality outcomes include one which says: “we respect, protect and fulfil human rights and live free from discrimination”

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?

Through our targeted engagement we know that, care and support should be recovery focussed, and outcomes and strengths based. Lived experience participation should not only inform and shape service design and delivery, but should occupy leadership roles to drive forward anti-stigma approaches.

Partnership working between the third sector and statutory services provide valuable non-clinical models of support that fulfil the Scottish Government’s visions for Time Space Compassion and realistic medicine. This does not replace clinical care, but rather should complement clinical/medical care.

Having lived experience input is central to all work to tackle stigma and discrimination, not simply in respect of challenging attitudes, prejudice and inequality but also providing insight and expertise in what works and what needs to change.

It's vital that lived experience is central to designing, co-creating and delivering services to ensure that services and systems are inclusive. Action on stigma and discrimination could be strengthened through current approaches driven by the Scottish Government and COSLA, such as the community engagement and participation guidance within the health and social care branch[15].

[15] Part 1 – Planning with People - Health and social care - Planning with People: community engagement and participation guidance - updated 2024 - gov.scot

A number of improvements in mental health and community-based models of care have shown strong potential for adaptation and scaling across all LTCs:

- Peer-led support models: Peer-led initiatives in mental health services have created supportive environments that reduce isolation, improve self-efficacy, and build resilience. These models should be considered a key component of supported self-management in all LTCs.
- Psychosocial interventions: Mental health services have increasingly adopted holistic approaches that recognise the importance of income security, housing stability, and community connection in health outcomes. These social model principles can be applied across LTC services to reduce avoidable deterioration and hospitalisation.
    - Digital wellbeing platforms: Innovations such as digital CBT and mobile apps for anxiety and depression provide tools for self-monitoring and self-management. With appropriate adaptation, these could help people with other LTCs manage fatigue, pain, sleep and emotional regulation[16].
    - Third sector collaborations: Co-produced care models involving voluntary organisations have led to more trusted, accessible care for mental health service users. This inclusive, localised approach should inform wider LTC strategies.
    - These examples underscore the need for integrated, relational and person-led approaches to become the norm across all LTC responses. They align strongly with See Me Scotland's vision for stigma-free, equitable, and empowering care systems.

A specific example of cross sector multi-disciplinary working is Milestone in Edinburgh. Milestone[17] is a short-term residential step down facility. It supports people living with alcohol related brain damage (ARBD) and is designed to support people as they leave hospital. It is a multi-disciplinary service run in partnership with the health and social care partnership and mental health charity, Penumbra. The focus on recovery is critical in improving outcomes for people living with this highly stigmatised condition. Crucially, residents at Milestone are involved in every part of their care and decision making. When residents are ready to move on after this period of cognitive recovery and building confidence and living skills, partnership working with social work means appropriate tenancies are provided, designed to gradually help people back into the community with more independent living.

[16] Self-guided Cognitive Behavioral Therapy Apps for Depression: Systematic Assessment of Features, Functionality, and Congruence With Evidence - PMC
[17] Alcohol Related Brain Damage – NHS Lothian | Our Services

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.

Condition specific work should be data driven looking at outcomes and taking into account the biggest inequalities gap. The work should be intersectional in its nature and data collection should consider social determinants. Both mental health and physical health outcomes are interlinked and cannot be addressed as separate issues.

The framework must address the stark inequalities and poorer outcomes for people living with a severe and enduring mental illness as previously outlined in relation to the mortality gap.

We would also add that in addressing stigma and discrimination as a fundamental cause of health inequality, the framework should consider how services can establish baseline data around mental health stigma and discrimination experienced by people, and to consider how best to track change over the duration of these strategies.

This data should come from both national and local sources, including health board and local authority level data. It should gather disaggregated data on protected characteristics to allow for intersectional analyses and contribute towards tackling stigma experienced by communities. It should include perspectives of lived experience as well as looking at attitudes and levels of comfort in being close to someone who identifies as having a mental health problem. We note that there is mention of data collection in the Population Health Framework which we welcome. We suggest that any framework for long term conditions should align to the ambition on tracking stigma and discrimination- using indicators that can be tracked and monitored over time to deliver interventions.

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

It is of course necessary to have easy access to information and sign-posting, however, it is also essential to remember that people will withdraw from accessing support when they experience stigma and discrimination. This question makes the assumption that people simply do not know what services are out there. We would argue that in the case of medical care, people may not always access support or may even withdraw due to stigmatising experiences within first access points, including being dismissed because of their mental health diagnosis.

In addition we would add the following:

- Ensure information is accessible in community languages, mirroring NHS Inform. Ensure easy read versions are available and are distributed in the locations communities actually use.

- When considering this we need to think about adequate commissioning and consideration of planning – for example, strategic equalities organisations, grassroots partners and individuals with diverse lived experience and clinicians should be involved in the design, delivery and implementation.

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

A “no wrong door” approach. For example if there are frequent appointments with cardio etc, they should be able to refer for mental health support as a holistic practice.Furthermore, an option for self-referral to mental health services. Previous engagement with See Me volunteers they have flagged that they have been denied access to secondary mental healthcare support due to waiting list lengths and GP’s concluding that they do not require mental health support. Respondents emphasised that some people struggle to find the words to express how they feel due to internalised self- stigma and anticipated experiences of stigma and discrimination, which can result in assessments not providing a clear overview of how they feel.

From our engagement with grassroots organisations working with diverse groups, we understand that there is a need for cultural understanding. For example, a gypsy traveller community member who experienced multiple health problems expressing that a GP asked them to stay in one place to get better help but travelling is core to their identity;

“I said the house is killing me, but they could not understand how I feel that way about living in a house.[18]”

Digital literacy and skills development needs also play an important role, so information must be available in alternative formats for people to access.

We know comorbidities of long-term illnesses are a contributing to poor mental health and suicidal ideation (Jackson et al, 2021) and that demands the need for intersectional interventions for access and appropriate support. This can be seen as

[18] .Blog: Amplifying voices: Highlighting health inequalities in the Gypsy/Traveller community | End Mental Health Stigma and Discrimination

hybrid models of service design and delivery via using platforms preferred by communities. Services should support community connection, peer support and safe spaces which consistently involves people meaningfully in service design, as needs of people change over time with renumeration built in to promote fair inclusion (Trevena,2022). In order to efficiently cater to the needs of people, representation in services is crucial.

Some good practice examples look like:

- Training of community members as point of contact for the needs of the community:
    - Saheliya's Champions of Wellbeing programme (2017-2019) trained approximately 20 women per year in mental health awareness, encouraging talking and help-seeking. The groups have continued post-funding on a smaller basis and the women continue to help others in their community with signposting and information sharing.
    - Similarly, the African Women's Network trained 20 women in basic mental health awareness in 2020.

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

See Me would suggest embedding shared unified systems with patients receiving a printed copy to provide to healthcare professionals to ensure that each healthcare professional is receiving the same information – Transitions and sharing information between services have the potential to make people feel secure in their care, by knowing that they don't have to reshare their story and difficult experiences numerous times. Forcing people to constantly re-tell distressing experiences is a form of structural discrimination that can be ended by good connections. This is supported by VOX and The Alliance who emphasised that re-telling stories can result in misinterpretation of information, this could ultimately impact the services that people are referred to meaning they may not receive the right care at the right time.

In terms of creation of care plans, we would question the specific professionals that will be involved in this standard and creation of the care plan, especially if this was to take a multidisciplinary approach. See Me and MHF's perinatal mental health standards uncovers this theme further evidencing barriers such as intersectional stigma and its impact when creating collaborative care plans. This showed that women from minority ethnic backgrounds reported experiences of prejudice and discrimination in community healthcare service settings, with their needs and preferences not always considered. For example, requests for female practitioners

and interpreters. Creation of an agreed care plan must be followed with relevant scrutiny and accountability processes in place to ensure that person centred appropriate care is delivered[19].

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.

People living with mental illness and other long term conditions require ongoing medical care throughout their lives. This can be complemented with non-medical community support. The third sector provides over a third of all social care support across Scotland. However, the care and support available should not and cannot be one or the other. People managing a long term condition(s) should be able to access recovery focussed mental health and wider social care support in and around their community that can work in tandem with any medical support. This type of community support is well placed to deliver the Scottish Government's commitment to Time Space Compassion, realistic medicine and improve outcomes for people.

For example:

- When leaving hospital, recovery focussed supported accommodation and, or support in the home should be made available which focuses on self-management by supporting the person to gain the confidence and skills to move onto their own tenancy, back to their own home, or to maintain their tenancy. Opportunities for collaborating with council departments (ie housing, social work and homelessness).
- Peer groups and peer support – much work has been done in establishing mental health peer working models particularly across the third sector. Much of this is patchy and we would encourage a national piece of work to map out where there are gaps in order to develop networks that can support people with a diagnosis and can offer support to parents, carers and family members. There are many good examples of mental health peer working happening across Scotland, but there is no framework that sets out a national vision. We would support such a move and would highlight the work of the Scottish Recovery Network.
- Community link workers – we note that the National CLW Advisory Group is evaluating the effectiveness of CLWs, but we also note that the Scottish Government is currently sustaining current numbers rather than looking to

[19] literature-review-report-pnimh_final_31_07_23.docx

increase the number of CLWs. We would champion for an increase in the number of CLW to support this. [20]

- Any community support should be specialised for long term mental illness – e.g., peer spaces created by Lothian Bipolar Group[21].

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

We would take this opportunity to share our concern that community services and support are geographically inconsistent, and awareness of those services among health and social care professions also remains patchy, reducing the opportunities for signposting into non-medical community support.

The patchy nature of non-medical services and support could be attributed to the complex and confusing way local services are commissioned. While government policy strategically supports third sector commissioned services, commissioning on the ground is often short term and confusing, leading to issues around recruitment and long term sustainability of services.

Community mental health services are largely provided by the third sector and commissioned at the local level by health and social care partnerships. This means availability across the country varies. Although ALISS was hoped to be the directory for all community services across Scotland, this has proved not to be the case. People are therefore reliant on what information they can get from their GP or primary care team, what information they can find online, or from local knowledge. There is no central place where people can find information.

The iThrive Partnership in Edinburgh is an example of where local partners can come together to provide community services alongside a digital database of what's available as an easy to use resource. This model was hailed as a best practice example of excellence in commissioning only a few years ago, but since that time many of the services within it are under threat because of funding cuts from the health and social care partnership. This is yet another example where what happens at policy level is not reflected in communities. In the case of iThrive, the smaller charities and providers will struggle to absorb cuts and will have to close – this will affect the most marginalised communities, with their specific support services likely to be cut because of this lack of accountability at local commissioning level. This is despite the known likelihood of negative consequences..

It should not be assumed that GPs and primary care teams know what community services are available. GPs are under immense pressure and cannot be expected to

[20] Examples of best practice: Digital Front End | i-THRIVE

[21] Lothian Bipolar Group Bipolar Edinburgh | Peer Support for Bipolar Disorder

alwyas be up to date on fragmented community provision, especially when short term funding decision could see community provision disappear. Many third sector support services are commissioned on a pilot basis adding another layer of reluctance from primary care teams to signpost because of uncertainty of the future of the service.

We note that the government is soon to publish the "Target Operating Model" for mental health services. We hope this framework will look at where resources are and where they need to be in order to get people the quality support they need. We also hope that it will look at commissioning and procurement, particularly ethical commissioning. We would argue that it's not just about provision of community services, but also quality of support. The existing commissioning process is such that health and social care partnerships will try to push down the cost of contracts and this inevitably has an impact on the quality of care providers are able to offer. We would also encourage the model to consider in tandem the health inequalities faced by people with SMI also living with a physical health condition.

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

Co-morbid mental health issues and long term physical healthcare conditions are very closely linked with a cyclical relationship between long term pain and mental illness. We would draw your attention to this lived experience account[22] of the reality of looking after your physical health from Graham Morgan MBE. Mr Morgan is a mental health advocate and lives with paranoid schizophrenia:

> Morgan, who is in his early 60s, is acutely aware of the danger – yet he still struggles with maintaining good physical health. The antipsychotics he takes for his schizophrenia make him put on weight and, while he goes on regular walks with his dog, Dash, he finds it difficult to find the motivation for any more strenuous exercise. His diet, he says, is relatively healthy. "I know I should go along and get checked up, but I can't make myself. I think there's something more complicated than saying I'm just being lazy. There's something about motivation.
>
> "And also, my internal vision of myself is that I'm just horrendous and loathsome and not someone anyone wants to be near. To be honest, a lot of my life is thinking I should be dead, and I should either kill myself or someone

[22] Graham Morgan MBE Holyrood Inside Politics | Scots suffering from severe mental illness die two decades earlier

should kill me. Luckily, I have the most wonderful family keeping me from doing that sort of thing. But it is hard to treasure my body and my life."

But he admits he drinks more than he should. "Sometimes I use alcohol not to think some of the thoughts I have. I find it easier if I'm not thinking, especially in the evening, which is a really bad way to use alcohol, but it's what some of us do," he says.

The following example also shows the tiring reality of diagnostic overshadowing, where people's physical health problems or symptoms are dismissed because of the stigmatising attitudes of healthcare providers and includes specific examples from Bipolar Scotland research:

"When you're unwell, unfortunately it is common to neglect yourself. People say it's more difficult to actually summon the energy to go to the doctor or to want to take care of yourself. The other thing about stigma and discrimination is that if people have had those negative reactions from health professionals in the past or that judgement that people experience, that can also put them off seeking help and support. All of this puts the onus on the person who's not well to have to have the motivation, the patience, the perseverance" to advocate for their own healthcare. "And oftentimes people don't. And so then they fall through the gaps."

One Bipolar Scotland survey respondent had suffered from endometriosis for years, but it was not picked up because of her bipolar diagnosis. "I eventually had a hysterectomy, and the surgeon said I had the worst case of undiagnosed endometriosis she had seen. I had all the classic symptoms for years but just wasn't taken seriously".

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

People should be provided with a copy of care plan and notes to ensure that no misinformation is within the clinical summaries and ensuring transparency and shared decision making - A common theme when speaking to PWLE (people with lived experience) is feeling disempowered when decisions are made about the nature and type of support they require. With power imbalance reported as a common theme when accessing healthcare. We would emphasise the need for shared decision making, use of advocacy and advance statements in care.

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

In terms of resources, we would champion for ongoing sustained, multi-year funding for peer support groups. SRN emphasised that peer support is a driver of cultural change through normalising mental health conversations and challenging stigma. Future work should recognise peer support as a profession with long term sustained funding from the Scottish Government to maximise this resource[23]. Stigma in relationships was cited as have the most damaging impact within the SMISS. Participants stated that due to stigma around their illness, people are left with little hope of happy connections, with eight in ten assuming people will not want to be their friends, and more than three quarters thinking that people would not want to start a relationship with them. Beyond sharing stories and experiences, joining a peer support group can help empower people and challenge self stigma[24].

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

Medical practitioners need to listen to people when they present with physical symptoms. We've outlined in this response examples of diagnostic overshadowing for people living with SMI when their physical symptoms are ignored or dismissed. This amounts to discrimination.

Furthermore, the appropriateness of the assessment and the tone in which it is written should be considered. Language, tone of assessment tools and unconscious bias from practitioners can play a role in how assessments are carried out, affecting the outcomes for individuals. If there is not the right training in place for practitioners to be able to accurately assess someone, this will fall short. This would require an anti-racist approach, cultural humility, as well as a broader acknowledgment and understanding of marginalisation and systems of power. We would suggest engagement with a diverse range of lived experience to ensure the assessment tools and the training that practitioners receive are inclusive.

This should also include further training on issues relating to equality and diversity, whilst also underlining that mental health is a protected characteristic under disability. This training should acknowledge on the inequalities and marginalisations are created by society. This training should highlight that it is not identity that creates inequality – it is how society treats people based on stigmatised identities. This training should focus on the historic roots of stigma, wider social determinants and

[23] Growing peer support in Scotland Community roundtable summary report May 2025

[24] Reducing Stigma, Emphasising Humanity

ensuring parity of esteem within their clinical practice. This is in conjunction with the British Psychological Society's calls to action to achieve parity of esteem and ensure that momentum is not lost following the 25-26 Programme for Government[25].

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

We fundamentally object to the idea of "making healthy decisions" as a root cause of preventing or slowing progress. This comes with judgement, blame and assumptions about the person living with a long term condition that they are somehow at fault. It puts the onus on the person living with a long term condition to take better care of themselves. We would argue that choice is very subjective and can be determined by a number of factors outside the person's control especially in the case of people living with mental illness.

People experiencing mental illness often have their physical symptoms ignored as exampled in this extract from SMISS:

"Patients with severe and enduring mental health distress and comorbid physical conditions often receive lower levels of assessment and treatment than those without"[26]. 'The current healthcare system is not designed to support an integrated approach to meeting the mental and physical health needs of the population. In addition, the continued stigma associated with mental health and diagnostic overshadowing means that those with mental health problems, particularly long-term mental health problems, do not always receive the same quality of care for physical health problems. For example, despite higher rates of cardiovascular disease and related health issues among people with a diagnosis of schizophrenia, there is evidence of under-recognition and treatment of these conditions[27].

[25] BPS cautions against losing momentum on crucial areas missing from Scotland's policy priorities | BPS

[26] Langan, J., Stewart, Mercer ,S. and Smith, D. (2013). Multimorbidity and Mental Health: Can Psychiatry Rise to the Challenge? The British Journal of Psychiatry, 202, 391–393.

[27] NHS Health Scotland 2017, p7/8 NHS Health Scotland (2017). Inequality Briefing 10. Mental Health. Nov. 2017. Accessed on 21/2/2022 from http://www.healthscotland.scot/media/1626/ inequalities-briefing-10_mental-health_english_ nov_2017.pdf

We would also argue that even when someone needs medical attention for a physical health problem, mental illness and symptoms can be unpredictable and can prevent people from being able to fit into the expectations to turn up for inflexible appointments or to arrange/ access more.

We would argue further that living with a mental illness can be debilitating for the person in trying to take care of basic needs and wellbeing as explained by Graham Morgan, mental health campaigner and advocate who lives with schizophrenia[28].

All of this considered, we would advocate that measures to address mental health stigma and discrimination should be embedded in the framework in order to address these inequalities in being able to achieve equity of care, treatment and support.

In relation to poor physical health outcomes for people, SMISS told us, "possible contributory factors include: smoking, 'poorer access to physical healthcare and diagnostic overshadowing (where physical problems are undertreated or wrongly attributed to mental health issues), inadequate diet, lack of exercise, the effects of long-term use of psychiatric medication, higher rates of suicide (compared to the general population), and accidental and violent deaths. Public health is failing this population[29]'."

SMISS told us that when people experience repeated stigma and discrimination in healthcare settings, they withdraw. This is recognised in further evidence that these traumatic experiences can cause people to withdraw from care and support:

"...a lifetime's worth of experiences of stigma, hostility, trauma, and difficult relationships with care may act as a deterrent against accessing care." [30]

The result is that the mortality gap is persistent and widening. Recent research from Edinburgh University shows that the mortality gap is increasing for people living with schizophrenia, and remains persistent for other serious diagnoses over the last 20 years:

"It's now well established that people with schizophrenia, bipolar disorder and depression have a lower life expectancy than people without such illnesses. What's most disappointing about our findings is the lack of progress in closing this gap over the last 20 years, and a possible widening of the gap for people with schizophrenia.

[28] Inequalities and people with complex mental health problems

[29] The Mental Health and Wellbeing Strategy https://www.gov.scot/publications/mental-health-strategy-2017-2027/

[30] Applying a missingness lens to healthcare https://www.enlighten.scot/nhs2048/applying-a-missingness-lens-to-healthcare-andrea-williamson/

Addressing this entrenched disparity requires equitable social and health policies to prevent and treat poor physical health amongst people with mental illness" [31].

This underlines the case for sustained and properly resourced anti-stigma activity.

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

It is key that the Scottish Government uses targeted methods embedding an intersectional approach. This should involve actively seeking diverse perspectives and experiences of individuals who hold multiple, intersecting identities (such as race, gender, class, sexual orientation, etc.) within a specific community or group. The consultation process should embed the guidelines and toolkit created by the UN targeted at taking intersectional approaches[32]. Within this process it is key to also engage with leaders from racialised backgrounds, those with severe and enduring mental illness and those from socioeconomically deprived areas. A key suggestion further includes engagement with diverse lived experience, prioritising remuneration and working closely with grassroots community organisations and strategic equalities organisations.

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?

Yes. We would encourage adopting an intersectional lens to understand the nuances of communities and the intersection of identity. Intersectional stigma describes how social identities and structural inequities shape and influence each other (Sievwright et al., 2022). This means we cannot understand any one stigma (more often discussed in terms of associated prejudices when related to protected characteristics) in isolation from another, which might simultaneously be at play, compounding negative experiences, e.g. of services as well as health outcomes.

Therefore, to understand and address public health inequities [we need to] deliberately integrate an intersectional approach into interventions (Sievwright et al., 2022). Intersectional approaches to understanding and designing interventions,

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[31] The University of Edinburgh - life expectancy gap widening for Scots with schizophrenia https://www.ed.ac.uk/news/life-expectancy-gap-widening-for-scots-with-schizophrenia?utm_source=linkedin&utm_medium=organic_post&utm_campaign=cam_research_comms&utm_term=&utm_content=smi_life_expectancy

[32] INTERSECTIONALITY RESOURCE GUIDE AND TOOLKIT

which take account of every form of discrimination (e.g., racism, homophobia, mentalism) individuals and groups face, are therefore recommended to improve health outcomes (Turan et al., 2019). See Me suggests scoping should be undertaken focusing on how to better understand the issues of intersectional stigma in all communities. Following this it is key to- publish data, including data gaps, to identify where more evidence is needed, and commission future research. We would also suggest aligning work that looks to measure intersectional stigma and to create an impact assessment and produce an intersectional framework to understand stigma locally and nationally. This should be co-produced with communities and monitored and evaluated simultaneously.

A focus on severe and enduring mental illness is key when examining intersections across protected characteristics. The SMISS examined experiences of those with severe and enduring mental illness in Scotland. The results of this showed a clear pattern indicating that those who experience stigma in services then further anticipate experiencing stigma in future. This then leads to withdrawal from services with many disengaging completely. Updated training co-produced and co-delivered with people with lived experience should be embedded into the mandatory training for all healthcare practitioners to prevent stigma within services.

In regards to rural communities there is a higher risk of stigma, specifically related to mental illness. This can occur due to the risk of someone knowing their healthcare professional personally, as there is a small population in these communities. This often means people do not disclose their mental illness for fear of people finding out. We would encourage engagement with the Rural Mental Health Forum chaired by Change Mental Health to embed the needs of rural communities[33].

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

See Me supports the key asks in the Coalition for Race Equality and Rights 2026 Manifesto[34]. Particularly in regards to culturally safe early intervention services for those from racialised backgrounds. On designing these services we would also encourage implementation of the following points;

Competencies to address structural stigma (allocation of resources, access to care and quality of care)

[33] National Rural and Islands Mental Health Forum
[34] Manifesto for an Anti-Racist Scotland 2026 — CRER

Leadership requires the competencies to recognise and prevent intersectional mental health stigma and discrimination to address the allocation of resources access to care, and quality of care[35].

Leaders should have:

- An understanding of evidence-based intersectional MH S&D, social determinants of health inequity and human rights
- Commitment to cultural humility and critical thinking[36].

Commitment to person-centred care and tailored support
Leaders should be committed to person-centred care. Person-centred care results in higher trust in the service, help-seeking and treatment engagement[37].

Collaborative leadership
Collaborative leadership with workforce, patients, carers: community input influences strategic decision making (resource allocation, policy, practice and process).

Stigma and discrimination monitoring systems for accountability

- Equity Data influences strategic decision making (resource allocation, policy, practice and process).
- Implement safe reporting systems and monitor reports of stigma and discrimination
- Monitor workforce attitudinal change

Workforce (cultural norms and resource allocation)

- Attend to cultural competencies in the workforce by allocating appropriate, on-going training and self-reflective practice - to attend to negative attitudes, and adverse interactions.
- Monitor attitudinal change
- Allocate appropriate resources to attend to staffing shortages

We welcome that this is being addressed in this consultation. An intersectional approach to tackling mental health stigma and discrimination is needed to achieve the systems change that will reduce the devastating health inequalities people living

[35] Co-Leadership | RANZCP
[36] Mental Health Providers' Attitudes, Norms, and Beliefs About Cultural Humility in Service Delivery | The Journal of Behavioral Health Services & Research
[37] How Stigma and Discrimination Influences Nursing Care of Persons Diagnosed with Mental Illness: A Systematic Review - PubMed

with mental illness experiences as recognised in the Mental Health and Wellbeing Strategy.

Those commissioning, designing, and delivering programmes and interventions should prioritise community led work to tackle stigma and discrimination over universal approaches and acknowledge this will decrease scale but focus on depth of understanding and support community led solutions.

Governance structures such as the Mental Health and Wellbeing Leadership Board need to centre intersectional, anti-racist approaches. This includes prioritising and meaningfully engaging with concerns around systemic marginalisation and ensuring relevant expertise is included in decision making spaces to co-produce solutions – this would include organisations with anti-racist expertise, for example.

Embed a focus on intersectional approaches to addressing mental health stigma and discrimination as a work stream within the Anti-Racist Observatory for Scotland, this should also be part of the repository of anti-racism practice across Scotland as it forms.

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

We would question further information regarding accountability and scrutiny around this new approach to conditions. We would encourage upskilling and diverse voices are included in any future plans to embed this.

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