Response ID ANON-A5H7-36XU-B

Submitted to A new Mental Health and Wellbeing Strategy - consultation
Submitted on 2022-09-07 16:52:06

Part 2 - Our overall vision

2.1 In the 'Draft Outcomes' section we have identified a draft vision for the Mental Health and Wellbeing Strategy: 'Better mental health and wellbeing for all'. Do you agree with the proposed vision?

Yes

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

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

Please add your response in the text box:

A successful system would be fair, accessible, responsive, and culturally inclusive, ensuring that the entire population has access to high-quality person-centred mental health support and services, free of inequality, coercion, and discrimination. Where possible, well-resourced preventative support and mental wellbeing infrastructure would be made available within people's geographical communities. As part of this person-centred practice, culturally responsive services that meet the needs of people from specific ethnic or cultural backgrounds should be available as standard, with targeted services where there is evidence of need. Beyond this, formal services and infrastructure within the sector must embrace and utilise a greater range of approaches and points of access in line with the complexity and elasticity of mental health, employing a diverse workforce to better address BME mental health needs, and prioritising accountable, nuanced and rights-based practice over a one-size-fits-all approach.

Part 3 - Our key areas of focus

3.1 In the 'Draft Outcomes' section, we have identified four key areas that we think we need to focus on. Do you agree with these four areas?

No

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

While the four key areas of focus represent essential priorities for improving mental health services and mental wellbeing in Scotland, recent equalities evidence has revealed patterns of disparate service access and use of coercive and compulsive treatment affecting Black and minority ethnic groups, amongst other inequalities within the sector. In line with Scottish Government commitments to tackling racial inequalities and health inequalities more generally, a greater focus is needed on quantifying, mitigating, and tackling these inequalities at a structural level. This should be reflected in the list of key areas of focus.
Further, as this consultation mentions improved and expanded community-based services and support infrastructure throughout its contents, a commitment to achieving this should be listed as a key area of focus. Whilst signposting is an essential part of improving service accessibility, it will have an insignificant effect on service uptake if delivery methods and points of access remain the same – there must be a specific commitment to improving the availability and accessibility of well-resourced and prevention-focused community-based services.
As such, an additional key area of focus could be 'Preventing mental health problems population-wide, with a particular emphasis on improving mental health outcomes for those groups of people more at-risk of experiencing poor mental health.'

Part 4.1 - Outcomes: addressing the underlying social factors

4.1 Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcome to address underlying social factors?

social factors - likert - Through actions across policy areas, we will have influenced the social factors that affect mental health and wellbeing, to improve people's lives and reduce inequalities:
Strongly agree

Part 4.2 - Outcomes: individuals

4.2 Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for people?

individuals-likert - People have a shared language and understanding of mental health and wellbeing and mental health conditions:
Agree

individuals-likert - People understand the things that can affect their own and other's mental health and wellbeing, including the importance of tolerance and compassion:
Strongly agree

individuals-likert - People recognise that it is natural for everyday setbacks and challenging life events to affect how they feel:
Strongly agree

individuals-likert - People know what they can do to look after their own and other's mental health and wellbeing, how to access help and what to expect:
Strongly agree

individuals-likert - People have the material, social and emotional resources to enable them to cope during times of stress, or challenging life circumstances:
Strongly agree

individuals-likert - People feel safe, secure, settled and supported:
Strongly agree

individuals-likert - People feel a sense of hope, purpose and meaning:
Strongly agree

individuals-likert - People feel valued, respected, included and accepted:
Strongly agree

individuals-likert - People feel a sense of belonging and connectedness with their communities and recognise them as a source of support:
Strongly agree

individuals-likert - People know that it is okay to ask for help and that they have someone to talk to and listen to them:
Strongly agree

individuals-likert - People have the foundations that enable them to develop and maintain healthy, nurturing, supportive relationships throughout their lives:
Strongly agree

individuals-likert - People are supported and feel able to engage with and participate in their communities:
Strongly agree

individuals-likert - People with mental health conditions are supported and able to achieve what they want to achieve in their daily lives:
Strongly agree

individuals-likert - People with mental health conditions, including those with other health conditions or harmful drug and alcohol use, are supported to have as good physical health as possible:
Strongly agree

individuals-likert - People living with physical health conditions have as good mental health and wellbeing as possible:
Strongly agree

individuals-likert - People experiencing long term mental health conditions are supported to self-manage their care (where appropriate and helpful) to help them maintain their recovery and prevent relapse:
Strongly agree

individuals-likert - People feel and are empowered to be involved as much as is possible in the decisions that affect their health, treatment and lives. Even where there may be limits on the decisions they can make (due to the setting, incapacity or illness), people feel that they are supported to make choices, and their views and rights will be respected:
Strongly agree

4.2.1 Do you have any comments you would like to add on the above outcomes?

Please add your response to the text box:

Whilst having a shared language and understanding is important, an over-emphasis on reaching uniform understanding may contribute to over-simplification or the adoption of one-size-fits-all approaches which neglect the complexity and intersectional nature of mental health needs in a diverse and multicultural population. For instance, Black and minority ethnic populations have specific mental health needs and often encounter challenges specific to them, however, the mental health sector largely embraces an understanding of mental health heavily skewed towards white Western standards and experiences. As such, the care provided within traditional services is often less effective and responsive to BME people's needs, reflecting wider issues regarding the absence of anti-racist and inclusive service design and provision throughout Scottish public sector services. There is no one way to support the mental health and wellbeing of a diverse and multicultural population, and a successful person-focused strategy must actively embrace the full range of understandings, languages, points of access and methods of service delivery to improve mental health population-wide and actively reduce inequalities. For example, a service better tailored to BME people's needs would make use of truly anti-racist and intersectional spaces, would be delivered by practitioners who either have the lived experience of racialisation or adequate anti-racist training and knowledge and would be made available in the primary language of the service user – when this cannot be achieved, specifically trained interpreters should be used. This must also accompany a shift in services to better recognise and account for the structural influences and drivers of mental health, such as housing, education, finances, employment, and associated experiences of racialisation, such that, mental health services can better direct users to the most appropriate supports for their experiences and circumstances.
To ensure that someone feels valued, respected, included and accepted, special measures must be taken to build the capacity and spaces needed to facilitate new conversations on mental health issues. There must be a systems-level recognition of the complexity and nuance of mental fitness, and adequate services must be rebuilt from the ground up with communities and lived experience at the heart of the process to ensure that diverse and culturally specific needs are heard and addressed. A mental health and wellbeing system built without specific consideration of BME communities will never be able to effectively mitigate and treat the specific mental health needs within these communities and would likely entrench racial disparities in

mental health outcomes.
Further, to ensure that people feel a sense of belonging and connectedness with their communities and recognise them as a source of support, there must be a systems overhaul of how community-led organisations and initiatives secure and receive resources, funding and training. Past funding provision systems are often ineffective and inconsistent, leaving essential preventative infrastructure (such as informal community groups, peer support networks, and services working beyond mainstream services, such as outdoors and nature groups) under-resourced and their potential underutilised. With secure funding and improved resource and training accessibility, community support systems can better address mental health needs within their communities and ensure that people feel a sense of belonging and connectedness.

Part 4.3 - Outcomes: communities

4.3 Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for communities?

communities-likert - Communities are engaged with, involved in, and able to influence decisions that affect their lives and support mental wellbeing:
Strongly agree

communities-likert - Communities value and respect diversity, so that people, including people with mental health conditions, are able to live free from stigma and discrimination:
Strongly agree

communities-likert - Communities are a source of support that help people cope with challenging life events and everyday knocks to wellbeing:
Strongly agree

communities-likert - Communities have equitable access to a range of activities and opportunities for enjoyment, learning, participating and connecting with others.:
Strongly agree

4.3.1 Do you have any comments you would like to add on the above outcomes?

Please add your response to the text box:

When challenging the stigma surrounding mental health, further attention and targeted strategy are required to effectively reach all groups. Existing and past anti-stigma campaigns, such as See Me, have largely failed to effectively impact and engage with BME communities, as they often fail to be culturally appropriate, utilise the most effective media channels, or provide clear or translated materials. New strategies must embrace intersectional community engagement and co-production to maximise their effectiveness and ability to address the full complexity of mental health stigmatisation.
Further, ensuring that communities have equitable access to a range of activities and opportunities is an absolutely essential part of preventing poor mental health and establishing structures of peer support. However, with widespread evidence detailing the numerous barriers preventing some BME groups from engaging in the full range of leisure and community activities accessible to others, Scottish Government must make improving access to sports and leisure opportunities at a national level a priority. Policymakers may wish to refer to the recommendations presented by the Scottish Parliament's Health, Social Care and Sport committee within their 'Wellbeing of Children and Young People' report.

Part 4.4 - Outcomes: population

4.4 Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for populations?

Population - likert - We live in a fair and compassionate society that is free from discrimination and stigma:
Strongly agree

Population - likert - We have reduced inequalities in mental health and wellbeing and mental health conditions:
Strongly agree

Population - likert - We have created the social conditions for people to grow up, learn, live, work and play, which support and enable people and communities to flourish and achieve the highest attainable mental health and wellbeing across the life-course:
Strongly agree

Population - likert - People living with mental health conditions experience improved quality and length of life:
Strongly agree

4.4.1 Do you have any comments you would like to add on the above outcomes?

Please add your response to the text box:

While the scope and sentiment of these outcomes represent positive and necessary goals, specific and explicitly stated equalities targets are needed to effectively tackle inequalities, discrimination and stigma surrounding mental health and wellbeing. An over-reliance on general equalities commitments can create and widen gaps within policy, as a lack of specifically framed actionable targets can allow some groups and the inequalities affecting them to become overlooked and neglected during decision-making. For example, mental health and wellbeing policy cannot effectively deliver Outcome 3 for Scotland's BME communities without specific policy attention given to tackling structural racism, recognising it as a significant influence on social conditions for BME populations. Ideally, any inequalities mentioned within Scottish policy should be directly tied to named protected characteristics*, with specific recognition of the structural factors contributing to them and the influence of intersectionality**. This provides more clarity to policy direction and allows for commitments to be tied to action plans linked with measurable targets, enabling more effective progress checking and policy evaluation.
For detailed recommendations on building effective anti-racist policy, policymakers may wish to refer to CRER's guidelines within our 'Anti-Racist Policy

Making: Lessons from the first 20 years of Scottish devolution' report.
As such, we believe Outcome 2 could be rephrased as 'We have reduced inequalities associated with mental health and wellbeing and people's access to and experiences within mental health services across all protected characteristics covered by the Equality Act 2010.' Additionally, Outcome 3 may be improved by including equality targets within its remit, perhaps through the specific mention of tackling structural barriers and disadvantages.
Further, an additional outcome could be added to ensure that the strategy addresses historic shortcomings and injustices related to existing and previous mental health systems, policies and legislation. While new and revised goals may improve mental health and associated treatment for current and future service users, it is important to work towards reparative justice and provide new opportunities for support for those failed by past systems. This is particularly important for older groups and past BME service users, who bear the brunt impact of shortcomings in service design. By seeking to mitigate the impact of ineffective and exclusionary systems of the past, services can help break intergenerational cycles of trauma and poor mental health, ensuring that mental health and wellbeing are improved for all.

*For reference: the characteristics protected by the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.
** Intersectionality refers to how people are impacted by the combination of protected characteristics they have.

Part 4.5 - Outcomes: services and support

4.5 Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for services and support?

Services&Support likert - A strengthened community-focussed approach, which includes the third sector and community-based services and support for mental health and wellbeing, is supported by commissioning processes and adequate, sustainable funding:
Strongly agree

Services&Support likert - Lived experience is genuinely valued and integrated in all parts of our mental health care, treatment and support services, and co-production is the way of working from service design through to delivery:
Strongly agree

Services&Support likert - When people seek help for their mental health and wellbeing they experience a response that is person-centred and flexible, supporting them to achieve their personal outcomes and recovery goals:
Strongly agree

Services&Support likert - We have a service and support system that ensures there is no wrong door, with points of access and clear referral pathways that people and the workforce understand and can use:
Strongly agree

Services&Support likert - Everyone has equitable access to support and services in the right place, at the right time wherever they are in Scotland, delivered in a way that best suits the person and their needs:
Strongly agree

Services&Support likert - People are able to easily access and move between appropriate, effective, compassionate, high quality services and support (clinical and non-clinical):
Strongly agree

Services&Support likert - Services and support focus on early intervention and prevention, as well as treatment, to avoid worsening of individual's mental health and wellbeing:
Strongly agree

4.5.1 Do you have any comments you would like to add on the above outcomes?

Please add your response to the text box:

To achieve a strengthened community-focussed approach, current community-based and third-sector services, e.g., peer support networks and community wellbeing hubs, must be expanded upon and presented with improved access to financial and training resources – this must also include the increased availability of seed money for new initiatives capable of addressing intersectional needs. This will likely require increased flexibility within the sector to better recognise informal peer support networks and community services (such as outdoor leisure groups) as potential extensions of their services. Co-production with community groups and communities themselves will not only ensure that services address local and culturally-specific priorities and needs but also present new opportunities for shared learning and collaboration in the long term. An example of effective co-production within policy settings is the collaborative work organised by the Mental Health Foundation as part of the Mental Health and Wellbeing Strategy consultation process, wherein a diverse range of grassroots organisations and stakeholders came together to share knowledge and produce agreed recommendations and rationale. Scaling up this model and embedding it in everyday Government practice should be a priority area on a cross-departmental basis.
Ensuring that people can easily access and move between appropriate, effective, compassionate, and high-quality services and support requires substantial systemic change. For BME groups, this may take the form of building a demographically representative and culturally competent workforce, ensuring that service users have access to care and services from practitioners with shared and similar lived experiences, cultural backgrounds, and understandings of mental health.

Part 4.6 - Outcomes: information, data and evidence

4.6 Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcome for data and evidence?

Information, data & evidence - likert - People who make decisions about support, services and funding use high quality evidence, research and data to improve mental health and wellbeing and to reduce inequalities. They have access to infrastructure and analysis that support this:
Strongly agree

4.6.1 Do you have any comments you would like to add on the above outcome?

Please add your response to the text box:

A good evidence base is crucial for decision making, policy evaluation and equalities monitoring. However, the Strategy must explicitly recognise the significant data scarcity issues currently affecting the mental health and wellbeing sector and reducing the quality and effectiveness of its services. This outcome must be expanded upon to aim for improved and regulated standards for data, research and evidence relating to mental health care settings. From a race equality standpoint, this should include improved reporting of ethnicity throughout the sector, ensuring that all published datasets can be disaggregated by ethnicity to identify systemic inequalities and shortcomings. In cases where ethnicity data disaggregation is impractical due to sample sizes and associated issues with anonymity, methods such as data pooling of multiple time periods should be encouraged and utilised. This work must link closely to the concurrent development of the Equality Evidence Strategy and equalities focuses within the Health and Social Care Data Strategy. However, it must be emphasised that the presence of ongoing equalities data work within the wider sector does not negate the need for dedicated equalities data commitments within the Mental Health and Wellbeing Strategy.

Part 4.7 - Outcomes: other

4.7 Are there any other outcomes we should be working towards? Please specify.

Please add your response to the text box:

In addition to aiming for equitable access to support and services geographically, there should be a greater emphasis on challenging wider inequalities contributing to poor mental health and affecting the accessibility of care, such as those caused by structural racism and cultural barriers to community participation. As many of the barriers to treatment and negative impacts on mental health stemming from inequality are named within this consultation, the outcomes should better recognise the goal of eliminating them. Ideally, commitments should take the form of specifically framed sub-strategies and intervention plans which attempt to quantify inequalities linked to protected characteristics, identify their causative components within and beyond the sector, and include action delivery plans complete with performance indicators, measurable targets and timescales for evaluation and completion.

Part 5 - Creating the conditions for good mental health and wellbeing

5.1 What are the main things in day-to-day life that currently have the biggest positive impact on the mental health and wellbeing of you, or of people you know?

Please add your response to the text box:

While the mental health of BME groups cannot be treated as collective or uniform, commonly reported positive influences on mental health include cultural inclusivity, access to community infrastructure and peer support (especially beyond a place of worship), and actions which make both individuals and groups feel valued, positively visible, and safe. This also extends to language, such as the opportunity to be understood in your primary language. However, it should be noted that recent mental health dialogue within BME communities has conveyed a range of influences relating to language. For instance, some individuals find comfort in speaking about their mental health and wellbeing in their primary language as it can be easier to communicate personal feelings and the complexities of their mental health. However, given the intense stigmatisation of mental health within some communities, some groups have expressed that speaking English can provide a positive distance between their perception of their mental health and wider cultural perceptions. Ideally, there should be systems in place to treat both perspectives as valid to ensure that people have access to the forms of communication that best serve them and their unique mental health needs.

5.2 Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Please add your response to the text box:

5.3 What are the main things in day-to-day life that currently have the biggest negative impact on the mental health and wellbeing of yourself, or the people you know?

Please add your response to the text box:

The potentially negative impacts on mental health for Scotland's BME communities are diverse and multi-faceted, however, there are several commonly reported areas considered uniquely detrimental to BME people's mental health.
Community Stigma:
Within some BME communities, there are significant and intense stigmas surrounding mental health and its treatment, often deriving from varied cultural understandings of mental health and wellbeing, associations of all mental health problems with acute mental illness, and societal and professional standards of 'good mental health' being heavily skewed towards a Westernised understanding. This can contribute to significant intergenerational trauma, as mental duress and poor ways of managing one's mental health can become embedded in cultural practice. Without open conversations about mental health or suitable platforms and safe spaces in which BME people can discuss their mental health issues, needs and concerns, those with poor mental health are less likely to seek help and treatment, potentially exacerbating their mental health struggles. Unfortunately, previous drives to tackle the stigma of mental illness and poor mental health in Scotland, such as the See Me campaign, have proven ineffective at challenging the unique forms of stigmatisation within BME communities. Improving visibility and representation within the existing conversation and better targeting BME groups through targeted campaigns is crucial to minimising poor mental health and reducing ethnic inequalities in mental health and its treatment.

Interpersonal Discrimination:
Being exposed to and being a victim of interpersonal acts of discrimination are closely linked to poor mental health and wellbeing. Further, those who have experienced racism in the past, particularly within public sector institutions, are often less likely to expect fair treatment from public sector services and are, therefore, less likely to seek formal mental health support for themselves or their dependents.
Evidence suggests that this is particularly prevalent amongst younger groups and those exposed to discrimination due to other protected characteristics, who bear the brunt of hate crimes and incidents of discrimination. However, without a clinical definition of racial trauma within the NHS, there is little opportunity for shared understanding amongst practitioners of how racial discrimination affects mental health, meaning many BME people feel unable to discuss these specific issues out of fear of not being understood. Ultimately, mental health practitioners and other professionals within the sector must receive more complete training to understand the influence of discrimination on mental health and how intersectionality affects this.

Adverse Life Experiences:
Exposure to adverse life experiences has a well-documented impact on mental health and wellbeing, and in Scotland, those from Black and Minority Ethnic backgrounds are more likely to experience negative influences on their mental health due to racism and structural inequalities linked to poverty, employment, and housing. For example, the rate of relative poverty in Scotland is more than double for those from BME groups compared to the majority White Scottish/British group, and data suggests that around half of children in BME families are living in relative poverty, meaning that BME populations are more likely to experience poor mental health.
Therefore, policy strategies serious about improving mental health on a population level must campaign for significant structural changes to reduce the prevalence of adverse life experiences and inequalities at a societal scale. Further information, evidence and possible action points on these disparities can be found within CRER's publications, such as 'Poverty and Ethnicity in Scotland', 'Minority Ethnic Communities and Housing – Room for Improvement?' and 'The State of the Nation: Employment'.

Barriers to Accessibility:
There are numerous barriers to accessing and utilising mental health support and treatment which can negatively impact the mental health of BME individuals. A recurring theme among BME mental health discussions is language, particularly among older groups and some recent migrant communities, as language barriers impede the ability to explain problems and understand advice from professionals. Further, there are significant problems relating to the awareness of services, as some groups, such as young BME people and children and those recently arriving in the UK, struggle with limited knowledge of the health system and don't know what services are available or how they are accessed. There must significant improvements to mental health service signposting and a drive to provide multi-language mental health support (ideally, avoiding the use of interpreters by diversifying the workforce) to effectively tackle these barriers.

Institutional Racism:
Like in many aspects of Scotland's public sector, institutional racism within the mental health care sector can reduce the quality of support and care provided to BME service users. Some mental health advocacy groups have linked this to the fact that current mental health services have not been built with BME people in mind, and thus, some BME service users do not have their particular needs understood or met, receive inadequate or insensitive services, or receive pushback when unable to engage and progress well with support not tailored to their needs. To alleviate this, there must be sector-wide anti-racist training and a complete system overhaul to improve accountability and equality throughout mental health services.

5.4 Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Please add your response to the text box:

5.5 There are things we can all do day-to-day to support our own, or others', mental health and wellbeing and stop mental health issues arising or recurring. In what ways do you actively look after your own mental health and wellbeing?

Exercise, Sleep, Community groups, Cultural activities, Time in nature, Time with family and friends, Mindfulness/meditation practice, Hobbies/practical work

5.6. If you answered 'other', can you describe the ways in which you look after your own mental health and wellbeing, or the mental health and wellbeing of others?:

5.7 Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Please add your response to the text box:

5.8 Referring to your last answers, what stops you doing more of these activities?

Please add your response to the text box:

There are many widely reported barriers reducing BME people's access to the range of practices and activities that can improve and maintain mental health and wellbeing.
First, structural racism within the UK has contributed to BME people being disproportionately represented in insecure, precarious, and lower-paid employment, meaning that a significant number of BME people work for more hours in lower-paid sectors than the White British population, preventing them from accessing some of these activities due to time and money constraints. This is particularly significant when considering leisure activities with higher participation costs, such as equipment and training-reliant sports and location-specific activities with associated transport costs.
Second, many BME people are less likely to engage with some local community and leisure activities to avoid potential mistreatment and discrimination, particularly in spaces which are disproportionately white, both culturally and demographically. For instance, a survey conducted by the Mental Health Foundation found that 23% of BME respondents felt that racism limited their ability to enjoy nature as they wished. When paired with the heightened barriers to participation in many outdoor and nature-based activities, BME populations often have reduced engagement with the outdoors, minimising the effects of its positive influence on mental health. The increased use of link workers within the health and wellbeing sector could help promote BME engagement with these activities, as link workers with a dedicated outreach function can highlight their positive influences on mental health and refer

patients to support programmes and grassroots/third-sector organisations operating within their communities.
This impeded engagement with outdoors and nature-based activities is partially representative of wider barriers impacting BME people's mental health, largely in relation to the accessibility of green spaces. Green space and nature are widely cited positive influences on both physical and mental health, however, Scottish Household Survey data reveals that just 45.6% of BME people in Scotland live within 5 minutes' walk of their nearest green space compared to 66.1% of white individuals, and where there is green space, it tends to be of poor quality. This reduced access is further compounded by financial status, with Ramblers' research revealing that just 46% of people with an income below £15,000 live in proximity to green space, compared to 63% of those earning above £35,000, meaning that BME people of lower economic status are likely to be particularly cut off from green space. Thus, significant parts of the population miss out on the benefits of local high-quality green space due to structural inequalities relating to housing, urban planning, and employment.

5.9 Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Please add your response to the text box:

Given the recognition of the broad and diverse positive influences on mental health, the mental health sector must incorporate improving access to these activities as part of its service and expand opportunities for shared learning with informal mental health support services and initiatives. This may be particularly effective for tackling racial and ethnic disparities in mental health, as initiatives like BME outdoor activity and nature groups (these are often framed as 'stress-busting' activity groups, which do not mention mental health by name due to its intense stigmatisation) often serve as early and effective points of mental health support, making them vital preventative and peer support resources within the informal sector. Given the Strategy's focus on preventative measures and infrastructure, it must push for significant investment to improve the availability of resources, training, and seed funding to help address ethnic inequalities and improve mental health at a population level.

5.10 In what way do concerns about money impact on your mental health?

Please add your response to the text box:

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

Please add your response to the text box:

Money-related worries largely stem from significant structural failures and cannot be effectively addressed without significant overhauls to many aspects of society. However, some issues relating to disproportionate BME poverty (BME groups in Scotland experience more than double the poverty rate as the majority population) can be partly tackled through measures within the employment sphere, specifically those seeking to improve employment, job security, and wages for Scotland's BME groups. Such measures must be paired with an anti-racist evaluation and improvement of financial support services, including the implementation of anti-racist training and capacity-building programmes for Social Security Scotland staff and policy change that better understands and reflects the needs of BME communities.
Additionally, finance-related mental health strains may be partly improved by the delivery of outreach and signposting programmes to ensure those with money-related worries are made fully aware of the support available from their local authorities and the voluntary sector. Furthermore, special attention must be given to eliminating child poverty and its effects, as evidence suggests a significant linkage between childhood poverty and poor mental health in adulthood, such that, to achieve long-term improvement, multi-generational support is needed.
Policymakers may wish to refer to the guidelines and recommendations published within CRER's 'Poverty and Ethnicity in Scotland' report.

Part 6 - Access to advice and support for mental wellbeing

6.1 If you wanted to improve your mental health and wellbeing, where would you go first for advice and support?

Not Answered

If you selected 'other', please specify:

6.2 If you answered 'online support' could you specify which online support?:

6.3 Is there anywhere else you would go to for advice and support with your mental health and wellbeing?

6.4 If you answered 'online support' could you specify which online support?:

6.5 If you answered 'local community group', could you specify which type of group/activity/organisation?:

6.6 Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?:

6.7 Please use this space to tell us the positive experiences you have had in accessing advice and support for your mental health or wellbeing.

Please add your response to the text box:

In many cases, BME service users have reported that their experience with mental health advice and support services was improved by the presence of BME practitioners or those with a similar cultural background as this increased the likelihood of shared values and gaining a mutual understanding when discussing their mental health needs and concerns. BME mental health advocacy groups and literature suggest that this is particularly beneficial for BME service users opening up about experiences of race, racism and culturally specific grievances as they feel as though they are more likely to be understood. Given the lack of a clinical definition of racial trauma and associated knowledge gaps amongst ethnic majority practitioners, an increasingly diverse workforce alongside measures to improve racial literacy and cultural responsiveness amongst the frontline staff can help address related concerns for BME service users.

These positive experiences will likely fuel further engagement with mental health services, encouraging more BME individuals to seek and access support as they know that there are professionals who understand racism and cultural nuance. Thus, to help improve BME access to and engagement with mental health services, significant investment and targeted strategy are needed to increase the number of BME practitioners and implement anti-racist training programmes for all professionals in the sector.

6.8 Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?:

6.9 We also want to hear about any negative experiences of accessing mental health and wellbeing advice and support so we can address these.If you have experienced barriers to accessing support, what have they been?

Lack of awareness of support available, Time to access support, Travel costs, Not the right kind of support, Support not available near me, Lack of understanding of issues, Not a good relationship with the person offering support, Having to retell my story to different people, Long waits for assessment or treatment, Stigma, Discrimination

6.10 If you selected 'other', could you tell us what those barriers were?:

6.11 Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?:

Existing and past mental health care systems have not been designed with BME people's needs, concerns, and desires in mind, contributing to many BME people being prevented from, or having negative experiences when accessing formal mental health services and support.
One major barrier which reduces engagement with mental health services is the prevalence of systemic racism within the mental healthcare sector and how this contributes to the disparate use, type and length of detentions under the Mental Health Act, which have been disproportionately used against Scotland's BME populations. For instance, SHELS data reveals that psychiatric admission of BME individuals was 4.8x more likely to use compulsion than the admission of White Scottish individuals, and over the past 10 years, 2.1% of Community Treatment Order detainees have been Black, despite only being 1% of the national population. Therefore, some BME individuals are significantly discouraged from accessing mental health services out of fear of coercive and compulsive treatment, as they are often treated as a greater risk to themselves and others than their White British counterparts. Such that, a lack of trust in the mental healthcare sector can serve as a significant barrier to accessing support.
Additional barriers to accessing support include a lack of awareness of available support (and how to access it) due to insufficient and ineffective signposting, a lack of local and physically accessible services, unavailability of the right support, long waiting lists for assessment and treatment, fear of discrimination by service providers, language barriers, and the trauma of having to retell experiences to every point of contact within the system. For instance, some BME service users have reported that having to re-explain their circumstances and justify their lifestyle, cultural attitudes, and unique positionality to unresponsive or insensitive practitioners can worsen their mental health and compound trauma.
Additionally, BME children and young people experience unique barriers to accessing support and engaging with mental health services. These often relate to the overt and covert dynamics of structural racism in the mental health sector, the alienation and marginalisation of BME children and young people and the dismissal of their mental health needs. Furthermore, research reveals that the acute stigmatisation of mental health within some BME communities has a particularly profound impact on younger people, who feel as though they cannot access services or support out of fear of families and wider community members finding out. There are not enough alternative delivery methods and points of access to effectively care for BME youth mental health needs. The Mental Health and Wellbeing Sector must work closely with youth groups and school communities to better support children and young people at a greater risk of poor mental health and ensure that those facing racism have access to culturally responsive support and, where needed, counselling.

Part 7 - Improving services

7.1 Reflecting on your answers, do you have any specific suggestions of how to improve the types and availability of mental health and wellbeing support in future?In particular, do you have any thoughts on how the new National Care Service can create opportunities to improve mental health services?

Please add your response to the text box:

As a whole, the mental health and wellbeing sector must better recognise that there is no one way to support the mental health and wellbeing of a diverse and multicultural population and that an adequate person-centred approach requires offering a wide range of services, points of access, and methods of service delivery.
First, the mental healthcare sector must work to better integrate traditional services with those offered by the third sector and volunteer-run community support groups, viewing their work as a crucial preventative and early intervention resource. By entering and maintaining sustainable and meaningful partnerships with these organisations, the sector can expand its service to provide a greater range of accessible, specialised, and intersectional mental health support at a community level and begin to co-produce support schemes suited to unique local and cultural needs. However, such a shift towards co-production necessitates significant community engagement to ensure that the voices and lived experiences of intersectional stakeholders are centred within decision-making processes and that new or expanded services adequately and holistically meet diverse community needs. This is an essential step towards tackling racial inequalities within the sector, as it demonstrates a shift away from ineffective 'colourblind' approaches and can help ensure that services are culturally competent and sufficiently specialised for addressing BME mental health needs and concerns.
Minimising the barriers that prevent some groups from effectively accessing and engaging with support will significantly improve the quality and user experience of Scotland's mental health services and likely improve mental health for all. As BME groups are often those most impacted by barriers to service accessibility, their elimination will help significantly reduce racial inequalities associated with mental health and its treatment. To reduce these barriers, the sector must expand the variety of channels for service access, ensuring that all groups and locales have access to face-to-face, phone-based, and virtual service provision both within clinical settings and their communities, and increase the flexibility of care pathways to accommodate varying degrees of commitment in line with the elasticity of mental fitness. New approaches to tackling stigma are also required to encourage service engagement, with the sector commissioning the development of improved, culturally competent anti-stigma campaigns focused on intersectional issues and mental health concerns specific to BME communities.
Furthermore, significant intervention is required to ensure that mental health services are culturally competent and free of discrimination, as this will improve the experience of service users and those within the workforce, reducing mental health inequalities stemming from within the sector. This

necessitates expanded equalities and specific anti-racist training for practitioners to ensure that they understand the barriers and challenges affecting BME populations in Scotland, better respect their lived experience within clinical settings, and offer the most effective and appropriate support for their unique needs (even if this requires referring patients to BME professionals who may better understand and assist with their needs). However, in line with the recommendations co-produced by CRER and the Mental Health Foundation, anti-racist training and development programmes for frontline public service workers must occur throughout their training and careers and should be tailored to organisational needs to maximise their effectiveness. In addition to the recommendations collaboratively produced by CRER and the Mental Health Foundation, policymakers may wish to refer to CRER's 'Race Equality Training in Scotland's Public Sector' publication for further information on the development of effective training programmes. The delivery of such training would reduce the prevalence of discrimination within the sector, improve the experience and retention of BME practitioners, and better support the needs of BME service users, reducing racial mental health inequalities across Scotland.

Part 8 - The role of difficult or traumatic life experiences

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

Please add your response to the text box:

Studies reveal that the emotional and psychological effects of racism are consistent with traumatic stress, and many of those receiving support for racial trauma and similar mental health conditions have noted improved care experiences when engaging with BME practitioners, as they feel as though there's a greater possibility for shared understanding and for their concerns to be taken seriously and appropriately addressed. Such that, in addition to delivering anti-racist training and development programmes for existing practitioners, there should be a dedicated effort to diversify the workforce and enhance the recruitment of BME mental health professionals to better equip the sector for dealing with racial trauma and other conditions more prevalent within BME groups. However, the sector must also focus on providing trauma support beyond clinical settings, facilitating partnerships with community groups and third-sector organisations to improve the accessibility and flexibility of care, so that services may be accessed where and when they work best for users. In terms of racial trauma, this requires establishing and maintaining effective and bilateral partnerships with BME community groups and organisations focused on BME mental health to ensure that service users have access to a network of trauma-informed and culturally appropriate support in the places they are most comfortable.

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

Please add your response to the text box:

Instances where trauma victims are made to repeat their experiences (e.g., at the first point of healthcare contact and within subsequent referrals) or justify how experiences have impacted them (e.g., due to practitioners not understanding how racism can cause traumatic stress) can significantly impede recovery and, in some cases, worsen mental distress. Systems must be in place to improve the sharing of patient information within the sector to reduce the likelihood of trauma victims having to relive and retell their experiences, thus enabling practitioners to be better equipped for delivering trauma-informed support and effectively assisting in service users' recoveries.

8.3 Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation?

Please add your response to the text box:

In line with Scottish Government commitments to tackle racial inequalities throughout society and within healthcare settings, it is essential that public health services in collaboration with those with lived experience work towards a clinical definition of racial trauma to ensure that practitioners are equally informed about how the issue impacts BME individuals and communities and are best equipped to respond to it sensitively and appropriately. Services cannot claim to be person-focused or trauma-informed until they embed understandings of racial trauma into their practice.

Part 9 - Children, young people and families' mental health

9.1 What should our priorities be when supporting the mental health and wellbeing of children and young people, their parents and families?

Please add your response to the text box:

Half of all mental health problems are established by age 14, and untreated mental health problems and trauma in early years are likely to have repercussions across the life course. However, BME children and young people face many unique challenges to their mental health and are over-represented in Children and Young People Mental Health Service (CYPMHS) caseloads, indicating disproportionate service need and significant risk of long-term mental health problems among BME communities. For instance, in 2021, the Mental Welfare Commission revealed that, despite the numerous barriers to BME service uptake, 10% of CPYMHS caseloads were from BME groups whilst just 6% of children and young people in Scotland come from BME backgrounds. However, issues specific to BME groups are often an afterthought within mental health service design and the mainstream discourse on mental health in Scotland. The Mental Health and Wellbeing Sector must prioritise designing and implementing targeted BME youth services which tackle mental health stigma in a culturally competent and representative manner and deliver services specifically tailored to BME youth needs. In line with the recommendations made by BME youth mental health experts, this requires moving away from services skewed towards Western standards of mental health and youth development, better-utilising school counselling services as early-intervention resources, and working collaboratively with community groups and informal support assets to better identify and address BME mental health needs, thus ensuring that sensitive, responsive, and actively person-focused support is available and easily accessible to BME children and young people.
However, as with many health and wellbeing inequalities in Scotland, there are significant issues of data scarcity surrounding children and young people's mental health regarding ethnicity. For instance, despite issues concerning inadequate data collection for BME groups being identified at an early stage of the COVID-19 Early Years Resilience and Impact Survey (CEYRIS), significant data gaps prevent the effective disaggregation of results by ethnicity. With a well-maintained and robust evidence base being crucial to the development of effective policy and intervention, the Mental Health and Wellbeing Strategy

must also prioritise establishing and maintaining high standards for ethnicity data collection and equalities monitoring throughout the sector to better support the wellbeing of children, young people, and families.
Furthermore, to adequately improve mental health for families, policy intervention must work towards improving mental health services for parents and older people as well as children, as shortcomings within pre-existing mental health systems have likely contributed to intergenerational cycles of poor mental health, trauma and associated stigmatisation, particularly for those from BME groups. By creating spaces for both existing and future generations, service providers can begin to effectively address mental health needs in a multi-generational manner and significantly reducing poor mental health throughout Scotland.

9.2 Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation?:

9.3 What things do you feel have the biggest impact on children and young people's mental health?

Please add your response to the text box:

Extensive literature suggests that BME children and young people's mental health are significantly impacted by structural inequalities and their influence on adverse life experiences, community pressures and stigmatisation, and exposure to racial discrimination.
For instance, child poverty has been strongly linked with poor mental health and wellbeing in both childhood and adulthood. With almost half of Scottish BME children living in poverty, major structural changes are needed to eliminate structural racism and poverty in Scotland, which would ultimately reduce the prevalence and likelihood of poor mental health across BME youth groups and at a population level.
Further, due to these structural inequalities and certain cultural practices, some BME groups are impacted by heightened pressures on mental health and deeply entrenched mental health stigma, meaning that BME children and young people often experience unique challenges to their mental health and encounter barriers when accessing support within their communities. This can worsen mental distress for BME youth and reduce the likelihood of accessing formal mental health services as they may not know how or where to access the available support or worry about how their use of these services will be received by family members and wider communities due to intense stigmatisation. Targeted intervention is needed to provide safe and accessible spaces to establish and maintain conversations on mental health issues specific to BME groups, ensuring that they are no longer excluded from the mainstream discourse or treated as an afterthought in service design.
Beyond this, BME learners are highly exposed to racist abuse within school settings, with nearly 1200 racially motivated bullying incidents reported across Scottish schools in 2020/21*. Such exposure to discrimination has a well-evidenced impact on the mental health of its victims, contributing to anxiety, chronic and repeated stress, high blood pressure, and racial trauma, among other physical and mental conditions with long-lasting effects. However, despite the severe impact of racism on mental health, young victims of racist abuse often encounter significant barriers when seeking support from psychological services, as their concerns are either not taken seriously due to poor racial literacy among educational psychologists and counsellors, or due to the prioritisation of white young people's needs by practitioners, sometimes resulting in the cancellation of appointments linked with racial trauma. It is clear that much more needs to be done to better recognise the mental health needs and concerns of BME children and young people and safeguard them against the impacts of racial discrimination.

*These figures likely do not paint the full picture of racism within Scotland's schools due to significant issues of under-reporting regarding racist incidents and varied uptake of the SEEMiS Bullying and Equalities module.

9.4 Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation?:

Part 11 - Equalities

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

Please add your response to the text box:

As shown by previous comments within this response, significant structural and systemic changes are needed to tackle racial inequalities associated with the prevalence and treatment of mental health conditions. Both past and present systems have not been designed or maintained with Black and minority ethnic people and their needs in mind, and thus, often fail to effectively improve mental health within BME communities. To remedy this, a complete system overhaul is required, ensuring that policymakers actively follow anti-racist practice, the tackling of inequality is explicitly centred within the proposed strategy, and experiences are improved for BME people on both the providing and receiving ends of mental healthcare services. New policy directives must ensure that BME perspectives are centred within service design processes through consultation and co-production and that the sector is more willing to engage with approaches beyond the current Eurocentric standards for mental health support to better address BME mental health needs and concerns. Therefore, equalities work within the Mental Health and Wellbeing Sector can be improved through increased and more appropriate engagement with lived experience and expert NGOs, and the use of cross-departmental approaches that better address the structural nature of mental health inequalities (e.g., strategies that aim to improve mental health inequalities by directly tackling the effects of structural racism and discrimination).
To improve the experiences of service users and reduce the prevalence of discrimination in the short term, the sector must expand equalities training schemes, establish anti-racist training programmes for all new and existing staff, and ensure that equalities training occurs throughout all stages of career development, rather than delivered as a one-off exercise. These training programmes must be linked explicitly to wider work on improvements in services, policies and practices. Ultimately, this will improve BME service users' experiences within the sector, encouraging future service uptake and improving practitioners' ability to address specific BME mental health needs and concerns. Similarly, anti-racist training across the workforce will likely improve BME service providers' experiences of working within the sector, reducing some of the barriers that prevent BME people from entering and progressing through the Mental Health and Wellbeing Sector and improving staff retention.

If so, what are they?:

Part 12 - Funding

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

Yes

12.2 Please explain the reason for your response above.:

While resource constraints within public mental health and wellbeing supports and services have a marked impact on the quality of help received by service users, some BME communities are most affected by funding limitations and barriers within the informal sector. Currently, funding opportunities for community groups and third-sector organisations are often reliant on impractical systems that can impede groups' ability to deliver consistent and high-quality services and plan for the future. For example, the majority of local grant funding can only be secured for limited periods of time, without any certainty of renewal, and a lack of effective signposting can make applying for seed money difficult for emerging community support groups – this particularly impacts informal services with an intersectional focus, which often work on small scales and encounter additional disadvantages and barriers. Additional and proactive support must be provided to reduce barriers to the creation of new community groups and ensure that pre-existing groups can access secure funding opportunities and are supported in delivering their essential informal services. Until a proactive approach is taken for community mental health and wellbeing support funding, mental health inequalities will persist and possibly widen.

12.3 Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation?

Please add your response to the text box:

Part 14 - Our vision and outcomes for the mental health and wellbeing workforce

14.1 Do you agree that these are the right short term (1-2 years) outcomes for our mental health and wellbeing workforce?

Short term workforce outcomes - Plan: Improved evidence base for workforce planning including population needs assessment for mental health and wellbeing:
Strongly agree

Short term workforce outcomes - Plan: Improved workforce data for different mental health staff groups:
Strongly agree

Short term workforce outcomes - Plan: Improved local and national workforce planning capacity and capability:
Strongly agree

Short term workforce outcomes - Plan: Improved capacity for service improvement and redesign:
Strongly agree

Short term workforce outcomes - Plan: User centred and system wide service (re)design:
Strongly agree

Short term workforce outcomes - Plan: Peer support and peer worker roles are a mainstream part of mental health services:
Strongly agree

Short term workforce outcomes - Attract: Improved national and international recruitment and retention approaches/mechanisms:
Strongly agree

Short term workforce outcomes - Attract: Increased fair work practices such as appropriate channels for effective voice, create a more diverse and inclusive workplace:
Strongly agree

Short term workforce outcomes - Attract: Increased awareness of careers in mental health:
Strongly agree

14.2 Do you agree that these are the right short term (1-2 years) outcomes for our mental health and wellbeing workforce?

short term outcomes: train - Train: Long term workforce planning goals are reflected in and supported by training programmes provided by universities, colleges and apprenticeships:
Strongly agree

short term outcomes: train - Train: Increased student intake through traditional routes into mental health professions:
Strongly agree

short term outcomes: train - Train: Create alternative routes into mental health professions:
Strongly agree

short term outcomes: train - Train: Create new mental health roles:
Strongly agree

short term outcomes: train - Train: Improved and consistent training standards across Scotland, including trauma informed practice and cultural competency:
Strongly agree

short term outcomes: train - Train: Our workforce feel more knowledgeable about other Services in their local area and how to link others in to them:
Strongly agree

short term outcomes: train - Train: Our workforce is informed and confident in supporting self-care and recommending digital mental health resources:
Strongly agree

short term outcomes: train - Train: Develop and roll out mental health literacy training for the health and care workforce, to provide more seamless support for physical and mental health:
Strongly agree

short term outcomes: train - Train: Improved leadership training:
Strongly agree

short term outcomes: train - Train: Improved Continuing Professional Development (CPD) and careers progression pathways:
Strongly agree

14.3 Do you agree that these are the right short term (1-2 years) outcomes for our mental health and wellbeing workforce?

short term workforce outcomes: employ - Employ: Consistent employer policies:
Strongly agree

short term workforce outcomes: employ - Employ: Refreshed returners programme:
Strongly agree

short term workforce outcomes: employ - Employ: Improved diversity of the mental health workforce and leadership:
Strongly agree

short term workforce outcomes: employ - Nurture: Co-produced quality standard and safety standards for mental health services:
Strongly agree

short term workforce outcomes: employ - Nurture: Safe working appropriate staffing levels and manageable workloads:
Strongly agree

short term workforce outcomes: employ - Nurture: Effective partnership working between staff and partner organisations:
Strongly agree

short term workforce outcomes: employ - Nurture: Improved understanding of staff engagement, experience and wellbeing:
Strongly agree

short term workforce outcomes: employ - Nurture: Improved staff access to wellbeing support:
Strongly agree

short term workforce outcomes: employ - Nurture: Improved access to professional supervision:
Strongly agree

14.4 Do you have any comments you would like to add on the above outcomes?

Please add your response to the text box:

While improving workforce diversity has been recognised as a much-needed outcome, specific, measurable targets should be set where possible. Such as, improving workforce diversity so that it is representational of Scotland's population within a given timeframe, or through specific goals relating to positive action. Action towards improving workforce diversity also necessitates improvements within primary, secondary and tertiary education settings to ensure courses are more accessible and appropriate for BME learners, and better encourage BME uptake within subjects associated with mental healthcare careers.
Literature has also highlighted the prevalence of discrimination within the mental health sector, with one-third of mental health staff reporting that either they or their colleagues have been racially abused. It is vital that additional supports are provided for BME staff and that all staff receive anti-racist training upon recruitment and throughout their career. This should be reflected in the outcomes under the 'Train' and 'Nurture' headings.

14.5 Do you agree that these are the right medium term (3-4 years) outcomes for our mental health and wellbeing workforce?

Medium-term workforce outcomes - Comprehensive data and management information on the Mental Health and wellbeing workforce:
Strongly agree

Medium-term workforce outcomes - Effective workforce planning tools:
Strongly agree

Medium-term workforce outcomes - Good understanding of the gaps in workforce capacity and supply:
Strongly agree

Medium-term workforce outcomes - Improved governance and accountability mechanisms around workforce planning:
Strongly agree

Medium-term workforce outcomes - User centred and responsive services geared towards improving population mental health outcomes:
Strongly agree

Medium-term workforce outcomes - Staff feel supported to deliver high quality and compassionate care:
Strongly agree

Medium-term workforce outcomes - Leaders are able to deliver change and support the needs of the workforce:
Strongly agree

Medium-term workforce outcomes - Staff are able to respond well to change:
Strongly agree

14.6 Do you have any comments you would like to add on the above outcomes?

Please add your response to the text box:

14.7 Are there any other short and medium term outcomes we should be working towards?

Please add your response to the text box:

Part 17 - Our immediate actions

17.1 In addition to developing our workforce vision and outcomes, we are also seeking views on what our immediate short-term actions (in the next year) should be for the mental health and wellbeing workforce.

Develop targeted national and international recruitment campaigns for the mental health workforce, Scope alternative pathways to careers within the workforce, beyond traditional university and college routes, such as apprenticeship pathways into mental health nursing, Improve capacity in the mental health services to supervise student placements to support the growth of our workforce, Take steps to increase the diversity of the mental health workforce, so it is reflective of the population that it cares for, Work with NHS Education Scotland (NES) to improve workforce data, including equalities data, for mental health services in the NHS, by the end of 2023, Undertake an evaluation of our Mental Health Strategy 2017 commitment to fund 800 additional mental health workers in key settings, including A&Es, GP practices, police station custody suite and prisons, to ensure that the lessons learnt inform future recruitment.

17.2 Do you think there are any other immediate actions we should take to support the workforce? Please specify.

Please add your response to the text box:

Following the Mental Welfare Commission's Racial Inequality report and other emerging evidence of systemic racism within Scotland's Mental Health and Wellbeing Sector, immediate action and interventions are crucial. Policymakers must better understand the scale and nature of these racial inequalities through an anti-racist evaluation of services and current practice, with key stakeholders commissioning the delivery of anti-racist training and capacity-building programmes throughout the sector to ensure that all staff receive specialist training upon recruitment and throughout all stages of career development. Ultimately, the sector must work towards measurable changes in practice, BME staff experiences, and the quality of care delivered to BME service users, ensuring that all stakeholders within the sector have improved outcomes and experience fewer mental health inequalities linked to racism. Given the systemic inequalities within the sector, policymakers should not take steps to increase the diversity of the workforce without simultaneously developing improved infrastructure and practice to better support BME staff by increasing resource availability for BME staff groups and networks and embedding anti-racist practices in the workplace.

17.3 Do you have any further comments or reflections on how to best support the workforce to promote mental health and wellbeing for people in Scotland? Please specify.

Please add your response to the text box:

17.4 Do you have any examples of different ways of working, best practice or case studies that would help support better workforce planning?

Please add your response to the text box:

Part 18 - Final thoughts

18.1 Is there anything else you'd like to tell us?

Please add your response to the text box:

The scope and ambition of this strategy demonstrate a strong commitment to expanding, improving, and diversifying Scotland's mental health and wellbeing services and workforce, and CRER commends the shift towards responsive, person-centred and, where possible, community-based support. However, in line with wider Scottish Government and public health commitments to tackling racial inequality, this strategy can do more to centre race equality and anti-racist practice within its remit. To avoid the shortcomings of existing and previous systems, any new mental health and wellbeing services and infrastructure must be designed with BME people's needs and mental health concerns in mind, and this must be reflected within the underlying policy. For further information on the design of effective anti-racist policy, policymakers may wish to refer to CRER's 'Anti-Racist Policy Making: Lessons from the first 20 years of Scottish devolution' report.
Please note, the various statistics, reports, and academic studies referenced throughout this report have not been included as footnotes due to

formatting constraints within this questionnaire. Further sources of evidence and full references of cited documents can be supplied upon request.

About you

What was your age last birthday?

Add your answer in the box below:
22

Do you have a physical or mental health condition or illness lasting or expected to last 12 months or more?

Yes

If you answered 'Yes' to the above question, does this condition or illness affect you in any of the following areas?

Mental health

If you selected 'Other', please write your response here:

If you answered ‘Yes’ to the above question, does your condition or illness reduce your ability to carry-out day-to-day activities?

Not at all

What is your sex?

Male

Do you consider yourself to be trans, or have a trans history?

No

If you would like to, please describe your trans status in the box (for example non-binary, trans man, trans woman): :

What is your ethnic group?

Black, Black Scottish or Black British

If you selected 'Other', please write your response here:

Which of the options best describes how you think of yourself?

Bisexual

If you selected 'Other', please write your response here:

What religion, religious denomination or body do you belong to?

None

If you selected 'Other', please write your response here:

About you continued

What is your name?

Name:
Lucien Staddon Foster

What is your email address?

Email:
Lucien@crer.org.uk

Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
Coalition for Racial Equality and Rights (CRER)

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

Publish response with name

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Yes

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?:
Slightly satisfied

Please enter comments here.:

It was great to see a number of engagement roundtable sessions for this consultation, and the document itself demonstrated a positive and ambitious stance toward mental health. However, this consultation should have paid more attention to equalities issues.

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

Please enter comments here.: