Early Years Network Meeting, 4 May 2023

The Educational Institute for Scotland

EIS Response to the Scottish Government's 'Consultation – a Mental Health and Wellbeing Strategy for Scotland'

Introduction

The EIS, as the largest education union in Scotland, with more than sixty thousand members, welcomes the opportunity to comment on the Scottish Government's 'Consultation – a Mental Health and Wellbeing Strategy for Scotland'.

Now more than ever, there clearly is a need to adopt a comprehensive Mental Health and Wellbeing Strategy for Scotland, designed to meet needs and deliver timeous, positive outcomes for children, young people and adults, on an equitable basis, irrespective of geographical location or social background.

Everyone has been affected by the pandemic in some way. Confinement, restricted social interaction, illness, bereavement, unemployment, poverty, and food insecurity, financial worries, have all made their mark to varying degrees on individuals, families and communities.

Whilst some may have begun the process of recovery, others are still suffering the harsh consequences of Coronavirus on their physical and emotional health, family life, finances and employment status. And it may be some time before we are fully aware of the extent of the impact which the last two and half years has had on the mental health and wellbeing of all.

The evidence to date is that this impact has been most heavily felt by children, young people and families who are most disadvantaged by societal inequality, this having been well documented by researchers, press and media, and in the data published in the National Improvement Framework Interactive Evidence Report. Statistics gathered over the pandemic have shown that death rates for COVID-19 have been twice as high for people living in the poorest communities compared to those living in the 20% least deprived areas[1]. This is a clear marker of pre-existing health inequalities and an indicator of the greater likelihood of trauma and bereavement among children and young people from these communities. With this in mind, we are of the firm view that the needs of these children, young people and families must be evident in and prioritised through, the strategy, and as part of an holistic response to deliver support as we work towards recovery.

COVID-19 has also had a disproportionately high impact on people from BAME backgrounds to varying extents in different parts of the UK, both in terms of the likelihood of infection and in death rates. It is essential, therefore, that support to address the associated higher levels of distress and trauma for children and young people from BAME backgrounds and their families features strongly in the strategy developed.

The need for a shared vision and clear outcomes to improve and support mental health and wellbeing is even more acute now, as we face the enormity of the challenges which the cost-of-living emergency brings. With rising levels of stress

[1] Covid+and+Inequalities+Final+Report+For+Publication+-+PDF.pdf (www.gov.scot)

and anxiety, we cannot underestimate the collective and individual trauma which families face as they wrestle with the dilemma of heating their homes or eating.

We welcome the opportunity through this consultation process to help shape the Mental Health and Wellbeing Strategy. What is developed must be responsive to existing needs; provide a framework of the intensive support which children, young people and families require to allow them to move forward positively with their lives, contributing effectively to the communities in which they live; and must be agile enough to be able to support mental health and wellbeing with the requisite emphasis upon early intervention strategies, moving forward.

However, a strategy alone will not deliver the support and changes needed to realise the policy ambition and the outcomes referenced. The Scottish Government must also commit to the allocation of sufficient staffing, time and resources to allow this work to develop, and for all agencies in this sphere to work together to promote and support mental health and wellbeing in practice, strengthening the delivery of appropriate interventions that are targeted to address the holistic needs of children, young people and adults in Scotland.

Part 1

1.1 Do you agree with this description of 'mental health'? (Y/N)

1.2 If you answered no, what would you change about this description and why?

The Institute welcomes the holistic approach adopted in drafting the definition of 'mental health' and broadly agrees with its terms. The definition recognises that mental health is not static, can change at different stages of people's lives and be influenced by a wide range of factors. However, we would recommend that the definition is extended to reflect the impact of societal factors. The environment in which people live, poverty, the associated stigma, and the worry which the current cost of living emergency brings can all impact negatively on mental health. We would recommend that this is reflected in the definition given.

We would also suggest that further consideration is given to the statement '*having good mental health means we can realise our full potential, feel safe and secure, and thrive in everyday life as well as cope with life's challenges*.' This statement fails to recognise the range of factors which can impinge on a person's ability to reach their potential (and it must be understood, also, that potential is not fixed) and thrive in everyday life. Having good mental health is an important contributory factor but it is not the only one and this should be reflected in the definition.

1.3 Do you agree with this description of 'mental wellbeing'? (Y/N)

(1.4 If you answered no, what would you change about this description and why?)

Yes. However, we would also recommend that the definition is extended to reflect the fact that people's experiences of discrimination and disadvantage arising from holding protected characteristics can also impact on their wellbeing.

1.5 Do you agree with this description of 'mental health conditions' and 'mental illness'? (Y/N)

1.6 If you answered no, what would you change about this description and why?

No, the definition of 'mental health condition' appears to depend on the need for a clinical diagnosis. As is recognised in the document, however, a person may have a 'mental health condition' or 'mental illness' which has yet to be diagnosed for a variety of reasons.

We know from the data published in the Public Health Scotland report, 'Child and Adolescent Mental Health Services in Scotland Waiting Times', for example, that children and young people may wait lengthy periods of time before they are seen by a health care professional. The most recent report highlights that only 68.4% of children and young people were seen within eighteen weeks of referral, falling far below the Scottish Government standard which provides that 90% of children and young people should *start treatment* within eighteen weeks of referral to CAMHS.

The fact that a person has not been diagnosed does not mean that they do not have a 'mental health condition' or 'mental illness'. Children and young people, and their families, are living with the impact of the mental health condition or mental illness, pending diagnosis. Similarly, reports from our members suggest that it is teachers and other school staff who are often left to bridge the gap, striving to provide support, during this period.

To restrict the definition in the way proposed, detracts from the real and lived experiences of the children and young people, and their families, who through no fault of their own cannot access the early diagnosis needed to advance their care and ensure that appropriate supports are in place.

Part 2 – Our Draft Vision and Outcomes

2.1 On page 8, 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? (Y/N)

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

The reference to 'better' mental health and wellbeing for all does not, in our view, go far enough, since it does not take account of existing mental health inequalities or the social inequalities that could give rise to poor mental health. We would suggest that the commitment should be to 'good' mental health and wellbeing for all. The strategy must be responsive to need and ensure that there is equity of outcome for all. The draft vision does not reflect the urgent need for restorative action, as part of the Recovery agenda, to address current inequalities in this sphere.

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

We believe that success would see early intervention strategies being adopted on a multi-agency basis, with practitioners having sufficient time and resource to

embed trauma informed practice, respond timeously to need and adopt interventions designed to support mental health and wellbeing. This provision would be available consistently, sustainedly and sustainably across Scotland, with equity of access and ring-fenced funding to ensure that there is certainty that on-going need can be met.

Part 3 – Our Key Areas of Focus

3.1 On page 9, we have identified four key areas that we think we need to focus on. Those were:

- **Promoting and supporting the conditions for good mental health and mental wellbeing at population level.**
- **Providing accessible signposting to help, advice and support.**
- **Providing a rapid and easily accessible response to those in distress.**
- **Ensuring safe, effective treatment and care of people living with mental illness.**

Do you agree with these four areas? (Y/N)

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

The Institute believes that rather than focusing on accessible signposting to help, advice and support, there needs to be a greater emphasis placed on facilitating early access to appropriate face-to-face provision and specialist support. Consideration should be given to streamlining processes and reducing bureaucracy to ensure that such support can be accessed as early as possible. Reliance on and promotion of signposting alone can mean that early intervention opportunities are missed, with the potential that the support accessed may not meet the needs of the individual referred.

We also believe that early and effective intervention measures should be referenced in the areas of focus. It is axiomatic that access to effective support at an early stage will promote mental health and wellbeing whilst preventing the deterioration of any mental illness. Investment in these measures will reap benefits for the individual and for wider society. Early intervention can mean that the individual receiving the support is able to continue to contribute to society whilst also resulting in cost savings associated with the provision of more acute care and intervention.

The key areas of focus also fail to acknowledge the yawning gap between policy and practice in supporting mental health and wellbeing in our schools, both for pupils and for staff. The consultation document states that 'we will not achieve our ambitions unless we focus on new ways of doing things, and new ways of responding to different types of need.' The EIS would challenge this. If services, such as health, social work and education were adequately resourced and the rising levels of poverty addressed, then the ambition could be met.

In Scotland, we have the legislative and policy frameworks to promote a rights-based approach to delivery of the support need to ensure that everyone can reach

their potential and the mental health and wellbeing of the children and young people in our schools is supported. Curriculum for Excellence, with its commitment to social justice, equity and equality, is the bedrock of comprehensive education. The four capacities, supported by Getting It Right for Every Child ('GIRFEC'), promote the holistic development of all learners and their right to be supported to achieve their potential. The UNCRC (Incorporation) (Scotland) Act builds on this approach and together with the plethora of relevant legislation[2], puts Scotland in prime position to deliver the policy ambition.

However, it is clear that need is outstripping resource. Evidence highlights that access to services for children and young people is inconsistent across Local Authority and Health Board areas and that many have to wait lengthy periods before receiving an appointment with the professionals involved. It is clear that there is a wide gap between policy and practice. Capacity is not meeting demand, not only in terms of CAMHS but in other services designed to support the mental health and wellbeing of children and young people. Increasingly the onus is resting upon teachers and an expectation growing that they will train as Mental Health First Aiders in lieu of proper specialist support being available for those who need it. Whilst the EIS is supportive of mental health awareness training for teachers, we can see risk both for the 'First Aiders' and for those who require their intervention, in relaying on this kind of approach. There is a need for urgent action to ensure equity of provision and access to timely support to meet the needs of the children and young people in our society. This should feature in the key area of focus.

We would also suggest that there is a need for further education around mental health in society, with a shift away from individualistic approaches to one which places a greater emphasis on societal and institutional responsibilities. Despite a growing awareness of the importance of mental health and wellbeing in society, reports from our members still suggest that there is a stigma associated with seeking mental health support in the workplace. If there is to be meaningful and sustained change, steps must be taken to remove this stigma, promote truly inclusive attitudes and supportive responses from employers, institutions and society more widely.

Employers owe a duty of care to keep staff safe and the development of good employment practices which prioritise the mental health and wellbeing of staff would be helpful in bringing about this change. We are aware of an increasing number of violent incidents, occurring in schools and yet support for teachers and pupil support workers is often overlooked. Since the pandemic, our members have reported an increase in the number and severity of such incidents, arising from distressed behaviour, most notably in younger children who traditionally have been less likely to exhibit violent behaviour. Despite this, teachers are often left to manage the behaviour of the pupil who is distressed and to support the children in the class, who may have witnessed the incident, without intervention or support from others. Provision should be made to ensure that the teacher or member of

[2] The Education (Additional Support for Learning)(Scotland) Act 2004, the Standards in Scotland's Schools etc Act 2000, the Equality Act 2010 and the Child Poverty (Scotland) Act 2017

staff who has witnessed this behaviour is given time outwith the class to recover and appropriate support in terms of their mental health and wellbeing.

Part 4 – Outcomes

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

- **Through actions across policy areas, we have influenced the social factors that affect mental health and wellbeing, to improve people's lives and reduce inequalities.**

Strongly agree but policy alone will not deliver the outcomes. The policy must be backed by adequate resources to ensure that the policy objectives can be implemented in full, delivering the intended impact on the social factors which affect mental health and wellbeing.

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

- **People have a shared language and understanding of mental health and wellbeing and mental health conditions** – Rather than adopting an individualistic approach, we would recommend that society should have a shared language and understanding of mental health and wellbeing and mental health conditions. Only then, will truly inclusive practice and attitudes be evident at a societal and institutional level.
- **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 but the important thing will be putting these attributes into practice and actually treating people with tolerance and compassion, rather than simply having an understanding of the importance of this.
- **People understand that it is natural for everyday setbacks and challenging life events to affect how they feel –** Agree. However, this is much easier if the person is in good mental health. Having this perspective is much more difficult when people are stressed, under pressure or living in poverty, wondering how they are going to be able to feed themselves and their families.
- **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 –** Whilst the strategy might promote this information, the impact on outcomes will only be evident if people are supported to access the help needed at an early stage. Someone with a mental health condition or mental health illness might be aware of how to access support but the impact of the condition or illness might prevent that person from doing so.
- **People have the material, social and emotional resources to enable them to cope during times of stress, or challenging life circumstances –** Strongly agree. However, the strategy alone will not be

able to deliver this outcome. This will require to be underpinned by the allocation of adequate resources.

- **People feel safe, secure, settled and supported –** Strongly agree. However, the strategy alone will not be able to deliver this outcome. This will require to be underpinned by the allocation of adequate resources.
- **People feel a sense of hope, purpose and meaning –** Strongly agree.
- **People feel valued, respected, included and accepted –** Strongly agree.
- **People feel a sense of belonging and connectedness with their communities and recognise them as a source of support –** Strongly agree.
- **People know that it is okay to ask for help and that they have someone to talk to and listen to them –** Strongly agree.
- **People have the foundations that enable them to develop and maintain healthy, nurturing, supportive relationships throughout their lives –** Strongly agree.
- **People are supported and feel able to engage with and participate in their communities - –** Strongly agree. However, it must be recognised that community-based services will need to be adequately resources to enable the full participation and engagement envisaged in this outcome, particularly in rural communities.

  People with mental health conditions are supported and able to achieve what they want to achieve in their daily lives – Strongly agree. However, this outcome must also be supported by an underpinning economic strategy to ensure that financial barriers and affordability do not impact negatively on an individual's ability to achieve what they want to in their daily life.

- **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.
- **People living with physical health conditions have as good mental health and wellbeing as possible –** Strongly agree.
- **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 –** Whilst we agree with this as an outcome, we would suggest that the words 'where appropriate and helpful' are removed from the brackets and given more prominence in the statement. The level of support required and the ability to self-manage care will vary from individual to individual and be dependant on a range of factors, including age and stage and the severity of the mental illness.
- **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?

Whilst this is good in theory, the implementation of the strategy to facilitate realisation of the outcomes will require significant and sustained resourcing. There is an interface between mental health and wellbeing and physical and emotional health and wellbeing. The outcomes must be considered through an holistic lens and efforts made to support all aspects of health and wellbeing, as one will inevitably impinge on the other.

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

This includes geographic communities, communities of interest and communities of shared characteristics.

- **Communities are engaged with, involved in, and able to influence decisions that affect their lives and support mental wellbeing**
- **Communities value and respect diversity, so that people, including people with mental health conditions, are able to live free from stigma and discrimination**
- **Communities are a source of support that help people cope with challenging life events and everyday knocks to wellbeing**
- **Communities have equitable access to a range of activities and opportunities for enjoyment, learning, participating and connecting with others.**

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

The Mental Health and Wellbeing Strategy alone will not be capable of delivering these outcomes. These outcomes can only be realised if they are underpinned by resources allocated in an overarching economic strategy. The Mental Health and Wellbeing Strategy should then be closely aligned with the economic strategy to ensure cohesion of approach. The economic strategy must reflect, inter alia, the challenges faced by the significant number of people in Scotland who live in poverty and/or who otherwise experiences the sharp end of social inequality, and by rural communities in terms of poverty and isolation.

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

- **We live in a fair and compassionate society that is free from discrimination and stigma**
- **We have reduced inequalities in mental health and wellbeing and mental health conditions**
- **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**

- **People living with mental health conditions experience improved quality and length of life.**

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

The Mental Health and Wellbeing Strategy will not be able to achieve these outcomes for populations unless it is underpinned by resources, clearly ring-fenced in economic strategy. The strategy should also be responsive to the specific needs of different communities, reflecting the distinct challenges which each may face.

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

- **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**
- **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**
- **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**
- **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;**
- **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**
- **People are able to easily access and move between appropriate, effective, compassionate, high quality services and support (clinical and non-clinical)**
- **Services and support focus on early intervention, as well as treatment, to avoid worsening of individual's mental health and wellbeing.**

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

The EIS would strongly support these outcomes but if they are to be effectively implemented, they will require to be underpinned by sufficient and sustained resourcing. We have highlighted above the gulf between policy and practice in supporting children and young people in terms of their mental health and wellbeing. If these outcomes are to be achieved, then the waiting lists which currently exist must be eradicated

and additional resources ring-fenced to address the trauma, arising from the pandemic and the mental health and wellbeing pressures arising as a direct result of poverty and now the cost of living emergency.

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

- **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.**

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

Strongly agree.

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 <u>positive</u> impact on the mental health and wellbeing of you, or of the people you know?

Good working conditions and a manageable workload are key factors which *could* significantly improve our members' mental health and wellbeing.

Collegiality, professional agency and empowerment are key components of a supportive culture in the workplace. If teachers feel valued in the exercise of their professional judgment and can share their ideas openly, then this promotes engagement, builds confidence in the collective endeavour, and reduces feelings of isolation and the damaging effects of a culture of managerialism which negatively impact on mental health and wellbeing.

Adequate time and resources to enable teachers to deliver high quality teaching and learning to meet the needs of all learners are also key to promotion of good mental health and wellbeing for our members. If teachers were given the time and resources to be able to engage with pupils, parents and partner organisations, then this would greatly alleviate the current pressures on their mental health and wellbeing. Smaller class sizes and reduced class contact time, in line with the EIS's 20:20 campaign, and sufficient specialist support for the growing numbers of children and young people with additional support needs, including of a mental health-related nature, would be instrumental in delivering these objectives.

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

Poor working conditions, excessive workload, insecure employment, systemic under-resourcing, including of additional support needs provision,

and top-down managerialism set in a culture of over-scrutiny and criticism have the biggest negative impact on the mental health and wellbeing of teachers.

Poor working conditions and insecure employment mean that teachers on precarious contracts cannot plan for their future or even, have certainty around whether they will have an income from one month to the next. The stress and anxiety of this situation in the context of the current cost of living emergency only adds to the pressures which these teachers are experiencing. Far too many teachers on temporary contracts or on supply lists are not experiencing Fair Work.

Furthermore, the number of staff on temporary contracts or seconded to different positions without backfill, particularly in an ASN context, increases the pressures on those staff who are employed on a permanent basis. This brings uncertainty about the future, increases workload and impacts negatively on planning for delivery of quality learning and teaching experiences. Security of tenure is key to providing the stability which schools need to deliver positive outcomes for children and young people but also in supporting good mental health and wellbeing for all staff.

The past 30 months have undoubtedly put a significant strain on teachers and our education system as a whole. However, even before the pandemic, teachers in Scotland had raised the alarm on high levels of stress, unsustainable levels of workload and poor wellbeing within the profession.

Working during a global pandemic has further compounded the longstanding issues around teacher workload. The views highlighted within a survey of our members conducted in November 2021 demonstrate the urgency needed to tackle teacher workload. When asked how many extra hours a week outside of their contracted hours they carried out, almost half of respondents indicated that they work more than 8 extra hours per week. This would equate to more than an extra day of work, every week, for a considerable number of our members. 26% of those working part-time said that they worked more than 5 extra hours and a further 25% said that they worked more than 8 extra hours per week.

Our members report feeling worn down and exhausted by the lack of trust in their professional judgment and the relentless bureaucracy which they are required to produce but which has no impact on outcomes for children and young people. This coupled with a lack of time to engage with colleagues, families and other professionals, and a lack of additional expert support for children and young people only compounds the stress which they feel, impacting negatively on morale.

Reports from a recent meeting of the EIS ASN Network highlight that teachers are now having to use break and lunch times to liaise with colleagues and other professionals about planning and support for children and young people with additional support needs. There is no time or capacity to manage the workload demands. And yet GIRFEC policy is based on principles of joint working in a culture of co-operation and

communication between professionals, working in partnership with children, young people and their families. For this approach to operate effectively, teachers and practitioners must be given time to develop relationships, to engage in meaningful planning and reflective practice and to assess the impact of interventions. They should not have to use essential breaks from work to plug this gap.

Teachers need to feel valued as professionals and be given the dedicated time which they need to support children and young people in their settings. Teachers, too, need pastoral support and protected time for supervision, in the same way as social workers and those providing family support. Only if the mental health and wellbeing of teachers is supported will they be able to provide the support which children and young people in their settings require.

This list should also reflect the structural barriers that impact our mental health. For example, disabled, LGBT and BAME people, as well as women, experience structural inequalities that cause additional stressors and pressures in our lives and exacerbate the risk of ill mental health. Furthermore, it is well documented that the trauma of racism has long-lasting effects. Aligned with this, solutions must not only place the onus on the individual, but on society, to address the factors which cause our ill health in the first place.

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**
- **none of the above other**

Collegiality is missing from this list and a key factor in supporting mental health and wellbeing in the workplace.

Safe spaces with others – for minoritised groups such as BAME, LGBT, women and disabled people, connecting with others who may share some of their experiences can be important for good mental health and wellbeing. Related to this, the importance of Effective Voice is a dimension of the Fair Work Framework, intrinsically linked to wellbeing.

5.8 Referring to your last answers, what stops you doing more of these activities? This might include not having enough time, financial barriers, location, etc..

Our members have been clear that excessive workload is the biggest barrier to participation in activities which might help to reduce stress and improve mental health and wellbeing. The comments we have made above in this regard are relevant here.

Our members, the majority of whom are women, also report the impact which bearing the burden of unpaid and caring work has on their ability to access activities, which might improve mental health and wellbeing. Indeed, the additional pressures of bearing the brunt of unpaid domestic and care work, as well as emotional labour, exacerbates the risk for ill mental health in the first place. For many, there is simply insufficient time to do thereafter engage or they are simply too exhausted at the end of the working day to engage meaningfully, in any mental health initiatives.

During the pandemic, we conducted a survey to capture the experiences of women members in relation to their health, homelife, paid and unpaid work at that time. The EIS's findings from the One Thousand Women's Voices questionnaire speak loud and clear and demonstrate the barriers in place, rooted in gender inequality and the opportunities for change.

There is no doubt that the additional pressures experienced at that time have, and continue to have, an adverse impact on women's mental health and wellbeing. The relentlessness of juggling multiple responsibilities leaves women with little to no time to reset, recover or engage in the activities referred to above.

This is even more worrying when we consider that 93.5% of respondents said that they had experienced increased stress, anxiety, low mood or depression.

It is crucial therefore that planning around the Mental Health and Wellbeing Strategy takes full account of these barriers and addresses the gender inequality arising from unpaid and caring work.

Financial barriers and affordability are also factors which will influence participation. Faced with the cost of living emergency, members are concerned about their ability to heat their homes and feed their families, meaning that there is little left over for participation in these activities.

Members who are underrepresented in the profession, such as BAME, LGBT and disabled members, may experience professional isolation which adds to risk of ill mental health. It is therefore important that colleagues and leadership are supportive, and create affirming whole-school environments where people are able to bring their full selves to work.

Part 6 – Access to Advice and Support for Mental Wellbeing

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

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, young people, their parents and families?

The issues relating to accessing support for the mental health and wellbeing of children and young people must be seen in the context of under-resourcing and increasing level and complexity of need. It is not always possible to access the most appropriate support when required. Information we have gathered suggests that there is a significant backlog to access specialist support from CAMHS but also, as demand increases, on access to support for perceived 'routine interventions' which might otherwise support children and young people.

As was highlighted above, the Scottish Government sets a standard for the NHS in Scotland to deliver a maximum wait of 18 weeks from a patient's referral to treatment from specialist CAMHS and determined that this standard should be met for at least 90% of patients.

Figures in relation to these waiting times are published quarterly by Public Health Scotland. The 'Child and Adolescent Mental Health Services in Scotland Waiting Times' sets out the data on CAMHS waiting times as at 30th June 2022.

The high-level outcomes for that period show that:

- 68.4% of children and young people were seen within 18 weeks from referral, a decrease of 4.8% from the previous quarter (73.2%) and also of 4.1% from the quarter ending June 2021 (72.5%)
- 9,729 children and young people were referred to CAMHS in Scotland for the quarter ending June 2022. This compares to 10,346 for the previous quarter and 11,714 for the quarter ending June 2022

It is clear from the statistics that as we emerge from the pandemic, there has been a greater number of referrals and that capacity is not meeting demand.

On 31 August 2021, Audit Scotland published a blog, raising concerns about the waiting times'. Using the data available in August 2021, the blog highlighted some concerning facts:

- More children and young people are waiting more than 18 weeks to access CAMHS from the point of referral in 2020/21 than in 2017/18, with figures sitting at 33% in 2020/21, an increase of 7% from 2017/18 figures

- Those waiting more than a year for treatment had trebled in the year prior to publication of the report – up from 6% in March 2020 to 18% in March 2021
- Almost 1 in 4 (23.5%) of referrals to specialist CAMHS were rejected in 2020/21 but without national data, it is unknown whether these children and young people accessed alternative services and if so, what difference this made.

Following publication of the blog, the Public Audit Committee of the Scottish Parliament launched an inquiry into the issues raised and took evidence from a range of stakeholders about waiting times for CAMHS, the impact of this on children, young people and their families and what action was being taken to address these issues.

The evidence taken highlighted the variability in access to CAMHS across the country with some NHS Boards ensuring that arrangements were in place for children and young people to meet with primary care mental health workers within 2 weeks (NHS Fife) whilst others reported waiting times in excess of a year.

Evidence also considered the number of rejected referrals and the impact of these decisions on children, young people and their families.

Relating to this issue, Dr Catriona Morton, Deputy Chair (Policy) of the Royal College of General told the Committee:

'The feeling is that the bar for referrals is very high. Some of the feedback was that GPs…will think three or four times before even considering a referral, and we have high levels of referral rejections.'

She went on to say:

'We know how damaging it can sometimes be to the person referred and their family if they get a rejection, because they will have tried lots of other things before they get to us.'

Witnesses discussed the importance of everyone having a clear understanding of the criteria for access to CAMHS and of early intervention strategies. Consideration was given to a number of multi-agency initiatives which are being developed, including an online resource which has been developed by the Mental Health in Schools Working Group. In referencing this resource, it was, however, acknowledged that both school staff and GPS are already under extreme pressure in terms of their workload and that even setting aside time for training could be a challenge.

Referring to the issues around gaps in data collection, the witnesses highlighted that there is a lack of information about what supports are in place whilst children and young people are waiting to access services and also, following a rejection from CAMHS.

Commenting on this, Dr Morton placed a sharp focus on the personal impact of current provision and the potential impact for the future:

'I see children and young people not getting help at a point where some of what they are suffering could be improved or reversed earlier. The result is that they struggle on themselves or with facilities that cannot match the severity of their condition. This is just building up difficulties for the future for our national health boards and for the young people concerned, who will take those mental health problems into adulthood.'

Our members also report the need for a drastic increase in support for CAMHS, expressing a collective dismay about the current situation.

We know that some schools are electing to use Scottish Attainment Challenge ('SAC') funding, and in particular, Pupil Equity Funding ('PEF') to secure support, such as inhouse counselling and play therapy, to meet the needs of the children and young people in their school communities.

Whilst this funding is welcome, it is no substitute for the provision of sustained and significant core funding, needed to ensure that there is equity of provision across Local Authority areas and that key policy ambitions around closing the poverty related attainment and achievement gap and GIRFEC are being met.

Anecdotal evidence from members also highlights the additional pressures which wider services across Education, Health and Social Work are facing, as a result of health and wellbeing needs arising from the pandemic but also as a result of the lengthy waiting times for CAMHS.

There is a perception that schools are stepping in, to bridge gaps and support children, despite the excessive workloads which they face.

These issues in terms of resourcing and addressing the backlog of children and young people waiting to access appropriate support must be considered and addressed when setting priorities to support the mental health and wellbeing of children, young people and their families.

Part 12 – Funding

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

As highlighted above, there is a need for additionality of resource. It is not a question of using funding better. There is an urgent need for significant and sustained additional funding to address the need which we are currently seeing in society, as we begin to work towards Recovery and as we face the challenges of the cost of living emergency.

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?

The EIS would recommend that there is a specialist mental health contact for each school to ensure that there can be meaningful discussion at an early stage and appropriate identification of early intervention strategies.

We would also recommend that supports should be available for the families of children and young people requiring mental health support.

The removal of GTCS registered teachers from nurseries is a further barrier to early identification of need. With a 52% reduction in the number of teachers in ELC settings over the last ten years, implementation of early intervention strategies will be negatively impacted.