The context within which all of the subsequent points are made is one where provision needs to be recognised as patchy and fragmented. This unevenness is especially apparent in certain areas, particularly rural ones. By its very nature adolescent mental health requires specialist, often intensive support which is often sadly lacking.

Identification takes place in a number of ways: classroom teachers reporting a change in attitude or behaviour; pupil support or pastoral care staff detecting a problem during their regular monitoring interviews or contact is made by social work or other agencies. In addition, pupils self refer and parents ask for help too.

In terms of prevention, a wide array of approaches are used. Some schools have professional counsellors who can support children through bereavement and other issues. This initiative has been highly praised but needs much greater resourcing for all schools to access this service. Through social education, pupils are made aware of the issues via programmes like “Problem, no problem” and there are activities dealing with stress, exam pressures and other factors. Some areas have drop-in health clinics and advice centres targeting young people in the local community. There are also many school based schemes – Buddying to support vulnerable new pupils or Peacemakers, an anti-bullying initiative offering peer conflict resolution, for example – as well as the positive impact of a wide range of extra-curricular clubs and activities.

Furthermore, there has been the growth of nurture groups in the primaries, now spreading to the secondaries which can fill the gap created by a lack of parental involvement. Indeed all of the Integrated Children’s Services, in particular Home / School Partnership workers, Family Support workers, Attendance Officers, P6 / S2 Co-ordinators, all have a very significant part to play in detection and prevention. In practical terms, the involvement of school psychologist and nurse is often crucial.

The major obstacle is still the social stigma attached to mental illness which prevents pupils and parents from talking about it in any way. Often the issue is hidden by the child or the parent because they cannot face the anticipated consequences. Ironically, the sharing information protocols may make this even harder since a young person can refuse involvement at any stage. The continuation of the excellent Government publicity campaign is essential – it needs to be sustained and highlight adolescent mental health in particular. Depression and self-harming are probably the biggest problems schools face and require a great deal of patience and often intensive one-to-one support.

Early intervention has been shown to be effective by the nurture group development, schemes like the school counsellor pilot and the various efforts to raise awareness. We need to reach the point where mental illness is treated the same way as any other illness.

More local services are required with a big investment in community facilities, like the co-location in medical centres or drop-in clinics. The whole approach needs to be better coordinated and more consistent in response.
The transition to adult services is extremely uneven and this example of the postcode lottery could only be changed by improved services which would require considerable funding. There has been little co-ordinated action in this field but rather, sporadic responses to need and a pick-list approach where for many areas the list is pitifully short.

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