

Youth Work and the Power of ‘Giving Voice’: a reframing of mental health services for young people

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There is no such thing as the voiceless, there are only the silenced and the deliberately misheard.
(Arundhati Roy, 2004)

THIS ARTICLE draws on research undertaken within a rural youth work project in the south west of England which supports young people experiencing difficulties with their mental health. The project is part of a larger voluntary sector youth work organisation and adopts a youth work approach to engage young people in one – to – one and small group work support, with youth workers who are ‘non-medical’ professional staff. In particular the project offers informal peer support groups, and more formal youth participation activities in the form of a Young People’s CAMHS Board (CYPB), as well as individual support. The Young People’s CAMHS board is commissioned by the local clinical commissioning group (CCG) to work alongside the Children and Young People’s Emotional Well-being and Mental Health Partnership Board. It represents the voice of young people in Child and Adolescent Mental Health Services (CAMHS) in the county. The project works with young people who have enduring mental health problems and extensive contact with health and social care services, as well as those experiencing early symptoms of mental distress. Young people are referred by schools, CAMHS staff, GPs, youth workers, parents or can self-refer.

This article examines the potential role of youth work in reformulating mental health support in ways which might better meet the needs of young people (MHF, 2007; 2004; Fraser and Blisshen, 2007). It suggests that youth work approaches can effectively strengthen mental health and promote well-being and resilience. It also explores ways in which a values-based, anti-oppressive practice, working out of ‘a vision of social justice’ (Batsleer, 2010: 164), might work to counteract some of the exclusion and discrimination encountered by young people experiencing mental distress within a society and political climate increasingly seeking to problematise, scapegoat, control, and contain young people (Batsleer, 2010; Davies, 2010; de St Croix, 2010; Giroux, 2003). It frames mental illness within a ‘social model’ (Tew, 2005; Tregaskis, 2002) and argues that giving young people a voice and position of influence can have an empowering and rejuvenating effect on the lives of those experiencing mental ill health. It also suggests that youth work can provide opportunities to develop shared understanding and work towards collective well-being, thereby opening up possibilities for development and change.

Context: young people and mental health

We're expected to be good daughters/sons, good siblings, very good students, thin and beautiful, talented, and good friends. Constantly these expectations are far too high for teenagers to meet, and so we come to think it's our own fault, and gradually begin to hate ourselves for not being able to meet society's expectations (Young person, cited in Brophy, 2006).

Research data suggests that in the UK one in ten children and young people has a clinically recognisable mental health disorder, while as many as 20-30 percent experience lower level symptoms of mental distress (Green et al, 2005; MHF, 2007a; Joy et al, 2008; DH, 2011). Self-harming is now thought to affect at least one in 12 children and young people and over the past ten years in-patient admissions for young people who self-harm have risen by 68% (Young Minds and Cello, 2013). Adolescence and young adulthood is described as a time of particularly high risk for developing problems with mental health (MHF, 2007a; MHF, 2007b; Joy et al, 2008), '... possibly the highest at any stage in the life course' (Maughan et al, 2004 cited in Joy et al, 2008). One report suggests that as many as one in five young people aged 16-24 has a mental health disorder (Joy et al, 2008, citing Clutton and Thomas 2008).

Reported rates of mental health problems and conduct disorders among young people have risen significantly in recent years. The Mental Health Foundation (MHF) describes a 70% increase in rates of anxiety and depression (MHF, 2007a; MHF, 2005) while research cited in a report for New Philanthropy Capital (Joy et al, 2008) notes a steady increase in rates of a range of emotional problems among adolescents, with a doubling since the early 1990s. This includes a dramatic increase in reported incidences of self-harm between the 1950s and 1980s and although these figures have now stabilised the rates remain very high (ibid). This growth in poor mental health and well-being is not matched in other developed countries (Joy et al, 2008; Margo et al, 2006). A recent UNICEF inquiry found that out of 21 developed countries involved in the study 'the UK received the lowest score for child well-being' (UNICEF, 2007). Of the six measures of well-being examined, the UK was ranked bottom on 'young people's behaviour and risks' and on 'subjective well-being' and 'family and peer relationships' (ibid). In addition, the 2006 'Truth Hurts' inquiry suggested that rates of self-harm in young people are higher than anywhere else in Europe (Brophy, 2006).

A range of individual and environmental factors have been shown to increase the risk of mental health problems and perhaps go some way to accounting for the UK's figures. These include learning disabilities, poor physical health, social isolation, lack of family support, poverty, parental ill health, being in care or being in a young offenders institution (MHF, 1999; Newman, 2004; WHO, 2005 and 2007, cited in MHF and Paul Hamlyn, 2008; Coulston, 2010; Nuffield Foundation, 2012). Joy et al assert that 'there is strong evidence associating mental health problems with almost

every form of persistent disadvantage in society' (2008: 18). Studies from the MHF (2004) and Young Minds (2006), confirm that certain socio-economic factors increase young people's risk of experiencing mental health problems, but also note that causal and risk factors are likely to involve a 'subtle and complex interplay of many different factors' (Young Minds, 2006) which might include 'academic pressure, alcohol and drug misuse, junk food, sedentary lifestyles and media influences' (MHF, 2007a: 10).

In addition, several more recent publications link current increases in mental ill health, particularly among young people, to increasing economic inequality and materialism and changing social values in many developed and developing countries, in particular the US and the UK (Layard and Dunn, 2009; Wilkinson and Pickett, 2010; Dorling, 2011). Both Wilkinson and Pickett (2010), and Dorling (2011), find direct correlation between the prevalence of mental health problems – particularly anxiety, 'diseases of despair' (Dorling, 2011: 269), conduct disorders and substance abuse/addiction and levels of inequality. Dorling notes: 'The injustices and inequalities which underlie most rich countries are having a "dose-response" effect on the mental wellbeing of populations; the greater the dose of inequality, the higher the response in terms of poor mental health' (2011: 269). Wilkinson and Pickett (2010), link this, in turn, to chronic problems and inequalities in physical health, noting that our psychological well-being has a direct impact on our health, as do our relationships and social networks while Dorling also sees the drive to individualisation in developed countries as a significant factor, suggesting that being deprived of social connection and value 'makes us mentally ill' (2011: 270). Evans and Prilleltensky (2007) confirm this, noting that personal, relational, and collective or community well-being are highly interdependent and that in recent years a focus on promoting personal well-being has paradoxically undermined this by not acknowledging or supporting the environmental and social infrastructure that enhances well-being.

The 'Good Childhood' report, an inquiry commissioned by the Children's Society (Layard and Dunn, 2009), finds that modern society's values and lifestyle choices, especially the promotion of consumerism, aggression and unhealthy living, together with pressure to grow up too quickly and the stresses of the modern education system are contributing significantly to the difficulties faced by young people in the UK (2009). This is also supported by findings from Girl Guiding UK (2008), Young Minds (2013, 2006) and the Nuffield Foundation (2012). There is also a considerable body of evidence to suggest that poor mental health may have a significant and lasting impact on young people, with mental health problems associated with educational failure, family disruption, antisocial behaviour, substance abuse, physical disability and ill health, homelessness, and unemployment (DH, 2004; MHF, 2007a; Joy et al, 2008; Coulston, 2010). There is also growing evidence showing a strong correlation between childhood mental health issues and long term mental health problems in adults (MHF, 2007a; Joy et al, 2008; MHF and Paul Hamlyn, 2008; Layard, 2012). Studies in the US and New Zealand reveal that half of all long term problems start by the mid-teens and three quarters by early adulthood (DH, 2011; Kessler et al, 2005 and Kim-

Cohen et al, 2003, both cited in MHF and Paul Hamlyn, 2008). Joy et al note that far from being the 'normal growing pains of childhood and adolescence' (2008: 11), 'the emotional well-being of a young person age 16 is a strong predictor of his/her mental health and life chances age 30' (2008:20).

Left unresolved, this increasingly widespread mental distress in young people is likely to result in huge economic, social and emotional cost (MHF, 2007b; Layard, 2012). Purcell et al confirm this, suggesting that mental ill health in early adulthood that prevents young people reaching their potential is 'a social and economic calamity' (Purcell et al, 2011: 74). A significant increase in youth mental ill health since the 1970s is likely to be compounded by the impact of UK youth unemployment and cuts to youth services (Coulston, 2010, CYP Now, 2012) as well as to CAMHS services (Young Minds, 2012b; Layard, 2012), resulting from current austerity policies. The need therefore to address these problems and strengthen positive mental health in young people has never been more pressing. However, there is also evidence to suggest that effective interventions, particularly at early and low level stages of mental distress can prevent escalation into long term problems (Kim-Cohen et al, 2003, cited in MHF and Paul Hamlyn, 2008).

The strengthening of protective factors and the building of resilience can also significantly reduce the impact of risk factors (Jenkins et al, 2002 and DfES, 2007, both cited in MHF and Paul Hamlyn, 2008; Coulston, 2010). Identified protective factors for mental well-being in young people include empowerment, positive interpersonal interactions and social cohesion (WHO, 2007, cited in MHF and Paul Hamlyn, 2008), as well as strong social support networks; participation in a range of extra-curricular activities; the opportunity to 'make a difference' by helping others; a sense of mastery; exposure to situations that provide opportunities to develop coping skills; a committed mentor from outside the family and the ability and willingness to seek help (Newman, 2004).

The 'problem' of young people's mental health services

Despite the recognition that adolescence and early adulthood are a period of unparalleled vulnerability (Joy et al, 2008), it has been suggested that statutory mental health services are 'arguably at their weakest' in supporting those aged 16-25 (ibid: 16; Purcell et al, 2011). The MHF's 'Youth Crisis Project' (2004), concluded that 'current mental health services for 16-25 year olds are failing to meet their needs' (ibid: 4) arguing that oversubscribed services, long waiting lists, medical professionals who are unsympathetic or insensitive to their needs, and variable – often unsuccessful – transitions from CAMHS to adult mental health services, are letting young people down, deterring them from accessing services or allowing them to slip through the net altogether. This has been confirmed by subsequent research and further consultations (MHF, 2007a; MHF, 2007b; DH, 2008; Joy et al, 2008; Purcell et al, 2011, Young Minds, 2012a).

Purcell et al note that 'the number of young people accessing care services declines substantially

between 18 and 24, precisely when it is needed most' (2011: 75). The MHF finds that between 2003 and 2006 only 25% of children with a diagnosed mental health disorder were accessing specialist services (MHF, 2007b); Lord Layard's very recent report reveals no change in this, stating that of the 700,000 children and young people experiencing mental health problems in the UK today three quarters are receiving no treatment at all, and noting that children's services are being disproportionately affected by current NHS budget cuts (2012). Despite the rhetoric of early intervention, those with low level problems are least likely to receive support, although there is widespread agreement that problems are 'best tackled in their initial stages' (Joy et al, 2008: 25; Coulston 2010; Purcell et al, 2011). Young people are left feeling 'extremely isolated' (MHF, 2004: 5) and this has prompted calls for a 'radical rethink of ... services for 16 – 25 year olds' (ibid: 3; Purcell et al, 2011; Young Minds, 2006). The MHF argues that any new forms of support 'need to be provided through universal services and located in the settings young people will access' (MHF, 2007b: 6). Their 'Listen Up!' report identifies an explicit role for youth work in this delivery, arguing that what young people want is informal support 'staffed by skilled youth workers with knowledge of mental health issues' (MHF, 2007a: 11), someone to talk to who will listen to them, give advice and support, and be non-judgemental (Brophy, 2006; MHF, 2007a). This is borne out within the project we researched, where the trusting relationships youth workers form with young people mean they are often in the front line and are the first adult some young people turn to when seeking support. This highlights the need for workers to have confidence and understanding when faced with mental health issues. Supporting this, Coulston's (2010) report highlights the ways in which youth work processes can promote positive mental health and well-being, as well as suggesting a move towards addressing this in future youth work training and development. Coulston notes that:

Poor mental health is likely to have a significant impact on the life of a young person; including adverse effects on their educational achievement and relationships with family and friends, and an increased risk of them becoming unemployed, developing physical health problems and mental health problems during adulthood (p.7).

He suggests that youth work is well placed to promote the aforementioned protective factors and build the emotional and social capabilities associated with increased resilience by focusing on relationship building and providing support that is accessible, community based, and destigmatising.

Young people's experiences of mental health services

Research into mental health and primary care services for young people presents a complex picture of frequently negative and alienating encounters with health care services and welfare professionals, and widespread experiences of stigma and exclusion that impede recovery and prevent help – seeking (Brophy, 2006; MHF, 2007a). The Listen Up! consultation (MHF, 2007a)

found that 'young people frequently felt they were not respected or treated as individuals by professionals within statutory services' (ibid: 24); reporting that they felt devalued, unable to build relationships with staff, and intimidated by the formal arrangements and time pressured services. The Truth Hurts inquiry also noted that 'over and over again, the young people we heard from told us that their experience of asking for help made their situation worse. Many have been met with ridicule and hostility from the professionals they have turned to' (Brophy, 2006: 3):

I had to see a children's psychiatrist, who every week I saw him would tell me I had cut myself for the attention, and asked me why I had wanted the attention. And every week I would tell him why I had really done it and he would never listen. This lack of understanding was so frustrating and patronising, it was supposed to help me stop wanting to cut (Young Person, cited in Brophy, 2006, p. 27).

Our research revealed similar negative experiences. Discussions with both workers and young people gave specific insights into the ways in which poor mental health impacts on the lives of young people, resulting in experiences of isolation and discrimination, as well as revealing the nature of their interactions with specialist mental health services, particularly post-18, mainstream health, education, criminal justice and other welfare systems. While some have found specialist services helpful and supportive, the majority described feeling 'patronised and treated like we're idiots' and 'misunderstood'. Many also reported feeling anxious and afraid of what may happen to them if they disclosed feelings of distress to professionals. Those that did felt that they were treated as 'an illness rather than a person' and were uninvolved and without control in decisions affecting their care. One young person stated, 'it's horrible in there ... you're just there and they drug you and you wait for them to let you out' (Young Person, 2012).

These problems are particularly acute after transition to adult services at 18 (Young Minds, 2012a) and also for those who self-harm or have eating disorders. These young people describe a lack of compassion and understanding of their needs within adult services, and professionals so stretched they don't have time to listen or to build trusting relationships. This results in a fear of professionals and a reluctance to engage with services or ask for support when they need it:

I feel like they are judging me or think I am lying, I hate the language they use about me, I always get really scared when I see their letters come ... I just want someone to talk to, but they're always in a rush, it just feels like they don't care ... (Young Person, 2012).

In addition, many young people reported they are frequently driven to crisis and serious self-harm before they are taken seriously or receive the support they need, potentially impacting on their recovery. Perhaps most concerning have been the stories recounted of young people being met with outright hostility, coercion or discrimination at the hands of other health and welfare services,

particularly A and E staff and police officers, as well as their families or local communities. This includes being handcuffed and physically restrained, made to feel like a criminal, humiliated, or told they were wasting valuable time and resources. For example one young person reported that:

Some of the nurses are really understanding ... but some of them are really rude to you and like 'we've got better things to do than treat people like you' ... they've got no right to speak to anyone like that, let alone when you're in a bad way, cos then you're just going to feel worse and struggle more (Young Person, 2011).

Again these experiences are echoed in the findings of the *Truth Hurts* inquiry:

A and E isn't usually a positive experience. The last time I had a blood transfusion the consultant said that I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked whether I was proud of what I'd done ... The consultants I do see there act as if to say 'Not you again' ... when I go to A and E I just want appropriate medical care ... (Young Person, cited in Brophy, 2006).

My doctor looked at me differently once I told her why I was there. It was as if I were being annoying and wasting her time (Young Person, cited in Brophy, 2006).

It is evident that in many cases young people's experiences of services designed to give help and support are actually exacerbating feelings of emotional distress and compounding the exclusion experienced by those with mental ill health. It is argued that if services are to be genuinely supportive and beneficial, issues of power and powerlessness must be addressed. There is considerable merit therefore in considering a critique of services from an anti-oppressive perspective.

Anti-oppressive practice and mental health

Dalrymple and Burke (2006) note that anti-oppressive practice is founded within a commitment to social justice, a belief that practice should make a difference and focuses primarily on working towards transformational change. This will mean working alongside young people to develop shared understanding of the ways that power, oppression and inequality determine personal and structural relations and impact on their lives (Dalrymple and Burke, 2006); rather than seeing individuals from a perspective of deficit – as either entirely responsible for their problems, or as passive victims. As a result we might begin to transform and challenge the common sense assumptions, stigma and fear that surround mental ill-health, which contribute to exclusion and negatively impact on well-being.

Our research revealed that as a result of prejudice and stigma young people regularly encounter negative experiences of power and powerlessness at the hands of health and welfare professionals.

As one young woman described her experience of being admitted to A and E:

I didn't want to go, but I had overdosed and cut myself, so the police were called and I ended up being handcuffed, and they took me in, in a police van, so everybody looked at me and just automatically thinks 'oh you've broken the law, you've done something wrong' ... and I was handcuffed to the bed and that made me struggle and cause myself more injuries ... and when the police went I had security guards by my bed ... (Young Person, 2012).

For some these repeated experiences and resultant battles have come to shape their daily lives, and have become an integral part of their identities. Internalising the constant negative experiences results in a loss of self-esteem and self-worth, and can manifest in disruptive and exaggerated behaviours. Tew (2005) notes that experiences of, and responses to mental distress are often bound up with and shaped by such issues of power and powerlessness. These incidences and the attitudes described by the young people reflect what Newman and Yeates (2008, cited in Lister, 2010) describe as 'entanglements' between social welfare and crime control policies, in which 'welfare' contains a shifting balance of both 'care' and 'control'. This is enacted through coercive practices legitimised through a narrative of 'protection', framed in the best interests of that young person and the wider community but which does little to positively impact on the young person.

The *Truth Hurts* inquiry reminds us that to work effectively with distressed young people in ways that do not perpetuate harm or compound exclusion, professionals must 're-connect to their core professional skills and values: empathy, understanding, non-judgemental listening, and respect for individuals ... young people [in distress] are entitled to a response based on practice of the core skills and values of the caring professions' (Brophy, 2006: 16). Only then can we, 'pave the way for forms of intervention that are more humane, less stigmatising and divisive, and above all work better' (Weare, 2006: 124). Youth Work with its commitment to developing anti-oppressive practice which seeks to ensure that interventions are empowering and young person centred (Ord, 2007), could explicitly counteract the agenda of control and containment of these young people, and begin to provide the support necessary to overcome and challenge discrimination.

Keeping in mind Thompson's (2006) suggestion that to work anti-oppressively it is necessary to 'move beyond the personal' in terms of understanding and tackling discrimination (2006: 30), it is argued that in order to begin this process we must first understand these young people's experiences within a wider structural and cultural context, in which young people are increasingly represented in terms of 'risk' and 'deficit', as 'youth in crisis' and 'youth at risk' (Cullen and Bradford, 2012). As a result of this they are subject both to problematisation, surveillance and containment within a rhetoric of protection from harm, and to prevention of harm (Batsleer, 2010; de St Croix, 2010). This scenario is also played out in the context of the dominant bio/medical model of mental health, which is 'incongruent' with anti-oppressive approaches to practice (Larson, 2008).

From this perspective mental health problems can be separated from their social and political context, to individualise and pathologise mental distress as symptoms of illness, disorder or deficiency, 'without social causation' (Tew, 2005: 84). On this basis expertise, and therefore power is assigned to medical and social care professionals, legitimating controlling responses to 'deviance' and 'non-conformity' through a narrative of 'risk management'. This ultimately serves to maintain a dominant power structure in which such behaviours are seen as a threat to social order (Tew, 2005; Szasz, 1962).

Our research suggests that in order for youth work interventions to effectively address mental health needs and promote emotional well-being, our practice must seek to challenge these dominant discourses. Only then might we begin to mitigate the exclusion, stigma and harm that young people experience as a result.

A social justice orientated, anti-oppressive approach to practice seeks to re-politicise mental health, acknowledging the social and structural circumstances in which young people live their lives, linking their personal experiences to wider political contexts (Dalrymple and Burke, 2006: Thompson, 2006). It is premised on a recognition of young people as individuals in their own right and values them as such. It engages them in activities that promote experiential learning which help them to challenge negative assumptions, rather than focussing on correcting, containing or 'treating' them and their 'symptoms'

Defining how this anti-oppressive practice might look 'in practice', necessitates a consideration of the 'social models' developed in resistance to the dominant medical construction of mental health and disability (Tew, 2005; Tregaskis, 2002). It also requires further exploration of the nature of power, particularly in terms of Foucault's concepts of bio-power and disciplinary power. From this perspective young people's experiences are seen within a context in which power is diffuse, pervasive, ordinary, 'devolved to an army of professionals' (Tew, 2005: 84), and not seen as a monolithic 'thing' 'to be possessed', but rather 'exercised' as a 'social relation between people' (ibid: 73). Power is therefore seen as fluid and shifting, and crucially this acknowledges the possibility of counter agency, and of the possibility of contesting oppressive uses of power with the production of counter narrative and the telling of a different story...

As Foucault notes, 'there are no relations of power without resistances ... like power resistance is multiple' (1980, cited in Dalrymple and Burke, 2006). It is important then that we do not view young people simply as victims 'lacking any possibility of exercising power for themselves' (Tew, 2005: 73). Tew suggests conversely that people experiencing oppression very often do 'develop strategies for survival and influence that involve the creative deployment of a variety of forms of power' (2005: 73), becoming 'adept at resisting or subverting the expectations that may be made of them' (ibid). Moreover, while these 'manoeuvres' are sometimes construed as being 'difficult' or 'manipulative', they 'may represent some people's most realistic strategies for having any influence

over their lives' (Tew, 2005: 74). Anti-oppressive practice requires us to seek to understand young people's situations from their perspective and to see their possibilities for resistance from within this context (Dalrymple and Burke, 2006).

From this perspective, our research suggests that what might initially (and perhaps most often) be perceived as young people's 'difficult', withdrawn or disruptive behaviour, can begin to be seen as strategies of resistance, of complex and legitimate expressions of their anger and disappointment, attempts to regain some control, or even as counter-narratives to challenge those imposed upon them. Baker Miller (1983, cited in Tew, 2005) notes that, 'people in subordinated power positions ... may be denied any opportunity to express their hurt and anger' (2005: 81). If practice is to be anti-oppressive and 'take account of the experiences and views of oppressed people ...' (Dalrymple and Burke, 2006: 19) it is therefore important to provide young people with opportunities to articulate their stories as they see them.

This prompts a reframing and re-evaluation of assumptions around mental health and illness, and the ways in which these are influenced by discourses of risk, deficiency and deviance that serve to maintain the status quo so that (within this context) a youth worker's role might not be to 'challenge' or 'manage' young people, but rather to connect with core values and to build relationships based on 'regard' and 'recognition' (Nzira and Williams, 2009; Belton, 2010), as a result developing a genuine understanding of what is really going on for these young people. Importantly our research indicates that what is of value to the young people is for someone to hear what they say, to acknowledge and accept their feelings. They want someone to take their concerns seriously and to find ways to respond that do not invalidate feelings or see actions as 'symptomatic' of mental health problems rather than as legitimate expressions of pain, resentment, fear or anger. This was experienced by young people to be of benefit and in itself can promote positive well-being:

Being able to connect with people who understand is really helpful, instead of people who talk out of a text book at us (Young person, 2013).

This does not mean that youth workers within the project had stopped 'managing' behaviour, or that they absolved young people of responsibility for their actions and did not offer appropriate challenges or introduce opportunities for learning, but rather in becoming more aware of the origins of feelings and behaviours, from within the wider context of power relations, they emphasised listening and dialogue, opening up space to ensure everyone had opportunities to speak and be heard. They focused on channelling rather than challenging feelings of anger and injustice, naming these and recognising them as legitimate and as potential sources of creativity, protest and as an impetus for change, for example through the making of short films which highlight young people's experiences of stigma and bullying, or through the development of training activities for professionals, which communicate their negative experiences of services.

Batsleer reminds us that 'dissatisfaction and discontent are invaluable allies of the practitioner' (2008: 72). Newman suggests that educators 'can help people develop, articulate and explore their anger', a process through which they 'seek to release and at the same time focus the passion and creativity of a potentially wayward emotion' (2006: 55-56). Anti-oppressive youth work practice can find ways of enabling young people to exercise power productively and 'speak back' constructively, opening up possibilities for change.

Re-framing of mental health services and the youth work response

The aforementioned consultations (MHF, 2004; MHF, 2007a) highlight young people's desire for a change to systems of mental health support. They reveal an awareness of the limitations of current approaches, implicitly critiquing or even rejecting the medical model. This is reinforced by young people's continued reluctance to access services (Brophy, 2006). It also suggests that they have a very clear sense of the models of support that will work for them. This research echoes these earlier consultations and young people stressed that they want person centred services that are commissioned across the age range – ie. 16 – 24yrs, and importantly see them as 'individuals and not a collection of symptoms' (MHF, 2007a: 26). In instances where young people do want access to psychological therapies and emotional support, they prefer this to be delivered through community based services that are informal, flexible, accessible, confidential and non-stigmatising. They talk about opportunities to build friendships and gain support from peers who have had similar experiences and they stress the importance of fun and creative group activities. They also emphasise the value of building trusting long term relationships with non-judgemental and accepting workers who support them with care and empathy (Brophy, 2006; MHF, 2007a; Joy et al, 2008):

I want workers to be more concerned about me, genuinely, than to be only thinking about risks (Young Person, cited in Brophy, 2006).

They state that they want choice over both who they work with and how the work develops, expressing a desire to be involved in professional training and recruitment, and argue the case for a holistic or multi-disciplinary approach that addresses other factors which impact on their mental health such as housing, employment, relationships, drugs and alcohol (MHF, 2004; MHF, 2007a, Joy et al, 2008). This is reaffirmed by workers who were also consulted and identified that:

It is important that young people are able to have a part of their life that focuses on them as a person rather than just what is wrong with them (Youth Mental Health Worker, cited in MHF, 2007a).

They want ... a service that isn't just about mental unwellness ... they don't want to sit in an office and talk about what's gone wrong and come away with an appointment for three weeks

time (Youth Mental Health Worker, cited in Joy et al, 2008).

Coulston's report confirms that 'young people have said that specialist mental health support is not always what they need, and what they have found helpful is support from informal, community services' (2010: 13) and that 'naturally occurring opportunities in daily living may ultimately prove more therapeutic than ones which are specially contrived or engineered' (Gilligan 2000, cited in Coulston, 2010: 13).

As noted, any shift in approach to meet the needs of young people and 'rethink' services, as part of a positive re-framing of mental health, will entail greater emphasis on support provided in non-mental health settings (MHF, 2007b). It is argued that youth work in many ways is uniquely placed to support a re-framing of mental health in line with social models (Tregaskis, 2002; Thompson, 2006) and with young people's expressed needs and desires, and can work alongside therapy – based approaches if necessary. It is a practice which is not only characterised by flexible approaches and accessible settings, but equally importantly by commitments to respect and mutuality in the relationships between adults and young people (Ord, 2007), an emphasis on conversation and dialogue (Smith, 2001; that Jeffs and Smith, 2005), aims to tip the balance of power in young people's favour and to start where young people are at (Davies, 2005), and to foster participative and associative processes that work from a strengths-based rather than a deficit model of young people (Davies, 2005; Jeffs and Smith 2005; Cooper, 2011).

As a practice youth work has potential to genuinely empower young people (Cooper, 2011), supporting those experiencing poor mental health to develop coping strategies, improve emotional well-being and find ways to challenge the exclusion they have experienced. In addition, as Coulston (2010) notes, youth workers and youth projects are able to provide many of the factors identified as important for strengthening resilience (see Newman, 2004; MHF, 2004, 2007a and Paul Hamlyn, 2008). Our research suggests that such youth work practices, when delivered as part of a project for young people experiencing mental ill health, can considerably promote young people's emotional well-being. It is argued that the most significant factors in this transformational work are the potential of 'developmental group work' and 'giving voice' through innovative approaches to genuine youth participation. [HERE](#)

Group Work

Drawing on evidence from the aforementioned studies, and through ongoing discussion, and consultation with young people, this project aimed to develop a service that is accessible, relevant, non-stigmatising and attempts to meet their needs through a positive approach to mental health. It was based on core youth work principles outlined above and was in sharp contrast to the deficit perspectives associated with the 'medical model' and much of the dominant policy discourse and the popular representation of young people with mental health issues. As such, the group work

offered through the project does not offer traditional forms of 'talking therapy' but is activity and conversation based, and focused on experiential learning, inclusion, association and developing positive, trusting and supportive relationships.

Group activities are varied and range from music, arts and film making, preparing healthy food or learning yoga and relaxation, to more structured learning around mental health. All the activities are used as tools to build resilience, promote well-being and reduce isolation. They offer young people a 'safe space' in which they can share stories and experiences and build friendships, as well as challenge themselves and try out new activities. The young people are given the opportunity to increase their understanding of mental health and emotional well-being and learn about 'self-care' and are, as a result, enabled to develop strategies for positive mental health. This is often achieved through the articulation and expression of their feelings through creative and/or physical activities. In addition young people have opportunities to take part in consultations, formal discussion events and campaigns that help them to understand the 'bigger picture' – the social context of mental health – and the resulting impact of stigma and discrimination on young people with mental health difficulties. These provide empowering opportunities for them to 'have their say'.

The groups are run by two JNC professionally qualified and experienced youth workers, who have undertaken some additional (non-medical) training to enhance their understanding of youth mental health, such as suicide prevention, self-harm, resilience, adolescent brain development and mental health stigma.

Groups are small, up to 10 young people, and accessed only via referral to ensure they feel safe. They are attended by young people experiencing low to moderate mental health difficulties, and by those who have more enduring and significant problems, as well as by some who have additional learning difficulties or autism/Asperger syndrome. Some who attend are in mainstream education, while others are educated through 'cyber-school', short stay schools, or are out of education/employment. Young people are referred in to the project by schools, parents, GPs, CAMHS workers, social workers and other youth professionals. They can also refer themselves. Often the young people do not meet the eligibility thresholds for specialist CAMHS (Tier 3/4) services, although for some who do, they often choose to attend the groups alongside their individual treatment from CAMHS or adult community mental health teams (CMHTs), or as part of their transition out of specialist (Tier 3) or sometimes inpatient (Tier 4) services.

Some who attend a group also receive one to one support from the project workers. This consists of ongoing sessions based on listening, emotional support, developing understanding of mental health and positive coping strategies and also involves making and supporting referrals into specialist CAMHS or CMHTs or other local services such as drug/alcohol services, family support, housing or employment support. Workers also work as part of multi-agency teams to support young people through local Common Assessment Framework and Team Around the Child (CAF/TAC) processes

or Care Programme Approaches (CPAs). This individual work is important in supporting young people to access the groups and to encourage them into specialist services if necessary.

Systematic analysis of project outcomes data was not available at the time of writing, although the project has now improved its evaluation and monitoring processes, including introducing the 'Youth Star' outcomes tool (Triangle Consulting Social Enterprise Limited 2009-2012). Further research is planned which can both identify significant outcomes of the projects as well as identifying some of the causal factors in their production. However, our initial findings based on observations and feedback from young people, indicate that involvement in the groups has a positive impact on their well-being, promoting understanding and normalising of mental health. Involvement also promoted feelings of acceptance, belonging and being part of something, building confidence, forming positive relationships and sharing experiences. These can all begin to counter experiences of exclusion, bullying, stigma and isolation that many of these young people have encountered.

What's best about the groups is being able to share your experiences with other people who have been through something similar, so you don't feel you're alone with it anymore (Young person, 2013).

I don't really go out with other young people, so [the project] gets me socialising and doing things and meeting people which makes me feel better (Young person, 2013).

Fuller et al note that 'young people with mental illnesses largely remain on society's fringe' (1998 in Dadich, 2010: 106), the very nature of mental distress isolating them from school, employment, family and friendship groups. This is compounded by popular rhetoric and policy, as well as by health care approaches that largely construct them as vulnerable and dependent recipients, often excluding them from decisions and processes affecting their lives. This unfortunately often leads to 'cynicism, fatalistic attitudes and a sense of hopelessness' (ibid). Our research demonstrated the value of developmental group work processes and the potential of group membership to counter this exclusion by including and empowering these young people, bringing them back in from the periphery. Tew notes that, 'for many, everyday survival may depend on networks of mutual support and co-operation ... offering mutual forms of understanding and emotional support' (2005: 73).

Attending groups alongside others who have shared or similar experiences can offer young people opportunities to construct productive, 'co-operative' experiences of 'power together' (Dominelli, 2002) enabling them to see their personal experiences as part of wider shared experiences, linked to social, political and economic processes (Dalrymple and Burke, 2006; Thompson, 2006). For the young people involved, simply realising they are 'not the only one' is very powerful. Dominelli emphasises the empowering potential of group work, stating, 'oppression individualises people in ways that isolate them and fragments their experience ... coming together in groups is a major way of reversing this fragmentation' (2002: 109).

I've got a lot more confident since coming here. When I first came I wouldn't even say hello ... I think it's because I felt welcome here, I didn't feel pushed out or I didn't feel weird here. I knew other people were going through the same thing and I wasn't the only one ... I found it helpful knowing I wasn't the only one. I didn't feel on my own or like an outsider (Young Person, 2012).

In addition, Dadich finds that 'opportunities to both give and receive assistance were helpful' (ibid: 107). This is confirmed by Coulston who suggests that 'one of the most important coping strategies that young people can use is to seek support from others' (2010: 14). Similarly the Truth Hurts enquiry found that young people generally prefer to seek help from peers who have had similar experiences when they have a problem with mental health (Brophy, 2006).

Our research indicated that young people who regularly attend the groups benefit as much from the relationships they develop with one another as from the support they receive from workers, with some going on to take mentoring roles with younger members. In this way, through peer support and reciprocal learning, group membership changes power dynamics, enabling young people to become providers of support to others, allowing them to experience 'an altered understanding of their abilities and of their valuable role within the group' (Dadich, 2010: 107). This paves the way for a 'strengthened self-perception' (ibid), and helps build positive mental health and resilience (Joy et al, 2008), as well as self-confidence and emotional development (Brophy, 2006).

Importantly, as these groups are facilitated by experienced workers, peer support is delivered in a safe and supportive manner, with clear boundaries and supervision, ensuring young people are not overwhelmed by taking on responsibility for another's distress.

We do support each other, especially when we know each other quite well ... it's really good to have people to talk to who understand and know what you're going through (Young Person, 2012).

Coming to the group is the first time I have actually felt 'normal' in a really long time (Young Person, 2013).

These groups can be seen as powerful examples of the anti-oppressive perspective in practice. Dadich describes such groups as an 'environmental antidote' to social isolation and exclusion which offer possibilities for counter narratives to social constructions [whereby young people] challenge and change constructions they had of themselves and reframe their self-identity, giving rise to different self-understanding' (2010: 106-108).

These insights reinforce the value of youth work's historic commitment to association and informal social education through developmental group work, working with the 'collectivities' and networks

to which young people are attached (Smith, 2001; Davies, 2005; Ord, 2007). It also highlights the opportunities for empowerment and recovery that can be missed through the individualistic focus of many mental health services and psychological therapies. Our research also counters the increasing emphasis on individualised one to one interventions and formalised case work approaches in current youth policies, which are in danger of undermining such successes (Davies, 2010; Jeffs and Smith, 2002; Smith, 2003). As Dorling notes 'learning to live better with each other is beginning to be seen as the key to learning to live better within our own minds' (2011: 270).

Participation and empowerment

Central to anti-oppressive youth work practice is the process of youth participation (Davies, 2005; Ord, 2007). This is seen as a 'transformative' process, and is 'the antithesis of isolation, marginalisation, exclusion, powerlessness and alienation' (Ledwith and Springett, 2010: 57). It is premised on inclusion, trust and a belief that young people have a valuable contribution to make; it is also an important factor in enhancing well-being (Evans and Prilleltensky, 2007; Cooper, 2011).

Since the 1980s there has been increasing recognition of the rights of children and young people to have their 'voice' heard within institutions, as well as be more involved in the decision making processes that affect their lives (Young Minds, 2005; MHF and Paul Hamlyn, 2008). This is reflected in a range of legislation and policy documents that attempt to ensure that young people's active participation is no longer an optional add on but is a central principle underpinning the delivery of services: for example, the Children Act, 1989, the United Nations Convention on the Rights of the Child (UNCRC, ratified 1991), and Every Child Matters, (2003). More recently, the updated NHS Constitution, 2013, and Coalition Government policy (DH, 2013a; DH, 2010) have emphasised clear commitments to the involvement of children and young people in health services, including the planning, commissioning, development, and evaluation of services. The participation of young people in service development is important as it helps to ensure that provision is relevant, accessible, and is meeting their needs. Importantly these participatory processes also potentially build many of the protective factors described earlier (MHF and Paul Hamlyn, 2008; Newman, 2004) and thereby promote positive mental health and resilience.

Participation and youth voice therefore form a central thread running throughout the project and the trajectory towards genuinely enhanced participation is an important part of the pathway the project seeks to open up for young people. Much of this activity is led by or carried out through the CAMHS Young People's Board (CYBP) described earlier, although those involved in social groups also take part in consultations and creative participation activities, and many go on to become members of the CYPB as they build confidence.

Members of the CYPB come from a variety of backgrounds, some are project participants and/or CAMHS service users, others are carers for parents or friends and some simply have an interest in

young people's mental health. The board is commissioned by the local clinical commissioning group (CCG) and members regularly attend meetings with health professionals, including commissioners and senior service managers. The board is involved in a wide range of activity; they are regularly consulted and have recently contributed to a local CAMHS needs assessment and the development of a new mental health strategy for young people. They also carry out consultations and 'peer research' with other young people locally, in order to represent their views. They have worked alongside CAMHS staff to organise and facilitate conferences and training for local professionals working with young people, have been involved in the recruitment and induction of CAMHS staff, and receive their own small commissioning budget through which they are able to develop resources to meet identified 'gaps'. This has included film-making, organising events, developing a local youth mental health website, and designing leaflets and information resources for young people. More recently they have been invited to support the national CYP IAPT (Children and Young People Increasing Access to Psychological Therapies) programme which aims to transform delivery of specialist CAMHS across many parts of England. They have also been working with the newly established local Healthwatch. Members receive training and are informed and supported by the project workers to ensure they are able to participate fully.

No participative process is guaranteed; young people and workers will be faced with challenges (Baker, 1996; Ord, 2007) and the tension between empowerment and control at the heart of the participative process needs to be navigated (Barber, 2007). For example young people may express initial resistance and need to be encouraged, or be anxious in dealing with other professionals and need to be supported. They may also be wary of tokenism. Similarly the participative process within this project was not always smooth. For example at times young people needed to cope with their anxiety in dealing with other professionals who lacked understanding and at times workers met with resistance. However the participative opportunities developed within the project provided genuine involvement, which allowed young people to 'speak back' and have their voices heard, to use personal narrative to offer powerful insights into their experiences. It also enabled young people to describe the discrimination and stigma they have been subject to, to highlight the impact of cuts to services, to question or challenge professionals and to ensure young people's concerns are on the agenda. As such, they enable invaluable experiences of empowerment and provoke a 'shift' in relationships with professionals. Even if this was momentary, young people are still able to speak as 'experts' in their own lives, through what Tew describes as 'dialogue across difference' (2005: 79). Such difference is viewed 'as an opportunity rather than a threat' (ibid: 78), and may provide the impetus for learning and change. Such opportunities allow the young people to feel that they have some control and are able to make a difference and influence change, as is powerfully expressed by one young person on the project:

Going to the conferences and meetings is quite hard, because it's hard not to be angry with the professionals, because of your experiences, but then they have made the effort to come and learn more and try to understand it a bit more ... and having a chance to speak to them

makes me feel better because I know I can be the better person ... we just want to make things better for people who come after us (Young Person, 2012).

Participation is essential to an anti-oppressive youth work that seeks to promote well-being and positive mental health because it attempts to change the narrative – challenging discourses and policy making based on assumptions of risk and deficit – by empowering young people. It supports them to achieve change and become actors rather than recipients of care, transforming their individual experiences into collective concerns, giving them responsibility and valuing their input.

Several reports (Oliver et al, 2006; MHF, 2007a; Joy et al, 2008; MHF and Paul Hamlyn, 2008; Coulston, 2010; Cooper, 2011) similarly conclude that being involved in such participatory processes supports young people to understand the socio-economic and cultural factors that impact on their lives and their mental well-being, enabling them to feel in control and connected to their community. It also helps young people to develop trust and important decision making, communication and relationship building skills. Such processes are essential to building resilience and promoting positive mental health, as well as enabling young people to develop a sense of optimism, purpose and hope, and to challenge stigma, (MHF, 2007a; Joy et al, 2008). Young people's participation must be seen as more than 'making individual decisions about health care' or 'identifying areas for service improvement and developing wish lists', but rather as an empowering, anti-oppressive and emancipatory model of practice (Cooper, 2011).

Conclusion

It is argued that youth work is well placed to meet a number of the challenges facing mental health services for young people. The work developed within this project promotes protective factors which are important to recovery and resilience. The groupwork and participation practices employed by this project provide a vehicle for including and engaging the voices of excluded or marginalised young people with mental health difficulties and: 'reconstruct views of participants as active ... in improving their own situations ... able to actively engage in reflecting on and transforming their own marginalisation' (Dadich, 2010: 108) thereby 'challenging the status quo by contesting and transforming self-identity and the dependency implicit in prevailing models of mental health care responses' (ibid: 109). Whilst there is evidence of a slight shift in focus among some mental health researchers and practitioners, in some parts of UK government policy (Brophy, 2006; DH, 2009; DH, 2011), whereby 'child and adolescent mental health work is starting to take a more holistic and preventive approach' (Weare, 2005: 119) moving from a 'pathogenic' or medical model to a 'salutogenic' or wellness model (ibid), there is clearly still much more work to be done. This paper proposes that youth work is well placed to deliver projects involving developmental group work and participative practices, underpinned by anti-oppressive principles which enable the voice of young people experiencing mental health problems to be genuinely heard, enabling young people to develop agency in helping to shape the services they receive which in turn significantly enhances their own and others' mental health.

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Note

1. This is an online alternative provision for young people with health problems and whose mental health stops them attending school in the county.