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YOUNG PEOPLE AND HEALTH, WELL-BEING AND SOCIAL EXCLUSION

MARY ISSITT

Editorial

Debates about how to promote young people's health inevitably reflect wider tensions between the oft quoted ideal of 'a state of complete, mental, physical and social well-being, and not merely the absence of disease or infirmity' (World Health Organisation, 1946), and the more pragmatic 'end -focused and purposive action' (Buchanan, 1995: 222), which is geared towards the achievement of specific goals for health improvement. Current government policy aims

- *to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness*
- *to improve the health of the worst off in society and to narrow the health gap (Department of Health [DoH], 1998:55).*

For young people the strategy is both generic - to enhance their overall health, and specific - to target particular groups and behaviours which are regarded as damaging or 'risky'. Health is closely associated with well being and in all of this

> *education is one of the most important ways of giving children and young people a healthy start in life. This is not just about learning how the body works and how behaviour can affect health. It is also about whether we are able to equip ourselves with the skills and knowledge to make the most of the opportunities life presents*
> *(Department of Health, 1998:49).*

Thus the health promoting schools programme and the inclusion of personal, social and health education (PSHE) within the national curriculum together with on-line initiatives such as 'Wired for Health' (Department of Health, 1998) are presented as ways of enabling young people to learn how to be healthy and avoid 'negative' health choices such as the use of illegal substances, alcohol, drugs and early pregnancy.

Within current policy initiatives a further link is made between health, well-being and social exclusion. Tony Blair has defined social exclusion as 'covering those people who do not have the means, material or otherwise, to participate in social, economic, political and cultural life (Hansard, 39th October 1997, col. 859), and young people are an important focus. The Social Exclusion Unit (SEU) refers to them in general publications and two of its earliest reports were specifically concerned with issues affecting young people. These dealt with teenage pregnancy and the lack of involvement of some sixteen to eighteen year olds in either education, training or the labour market (SEU, 1999a and b). The launching of Connexions followed

(DfEE, 1999), aimed at the 16-18 age group, 'joining up services to provide coherence to young people's lives' (Weinstock, 2000:5). The Connexions service is to prioritise those who are most at risk, seeking to provide a 'ladder out of social exclusion' (DfEE, 1999:14), noting that 16-18year olds who are not in employment, education or training are more likely than their peers to be 'unemployed, unqualified, on a low income, a parent, and at risk of depression and poor physical health' (ibid:14).

The articles in this edition of *'Youth and Policy'* all deal with a number of different facets of social exclusion and the impact on the health and well-being of young people. All adopt a broader view than the current emphasis of social inclusion inevitably being about participation in education, training and employment. Kate Philip draws upon a research study using participatory rapid appraisal techniques informed by youth work methods with young people living in the north east of Scotland. Whilst many felt that rural lifestyles were more healthy, their location and lack of transport facilities meant that they were unable to gain access to services or participate in leisure facilities available to other young people. Boredom could then lead to the kind of 'negative' health choices that the government wishes young people to avoid such as smoking and drinking. A number of initiatives have emerged following the research which are attempting to tackle some of the needs identified.

Joy Trotter's article considers the way young gays and lesbians are excluded in sex education and service provision with a negative impact on their emotional health. The young people in her research reported how they were rendered 'invisible' with gay and lesbian sexuality not being dealt with positively either through sex education programmes or when they were insulted and bullied as a result of actual or suspected sexual orientation as gay or lesbian. This raises a number of cautionary notes for more inclusive approaches to sex education, and if the abolition of section 28 promised by Jack Straw goes ahead (*The Guardian*, 31st March 2001) will require considerable refocusing and re-orientation of teaching and service provision.

Emma Wincup's and Rhiannon Bayliss's piece reports on the early stages of a research project into problematic substance abuse and young homeless people. They review a range of relevant literature to identify the links between homeless young people, their health practices and the way being without housing prevents them from accessing health services. The literature they cite shows how young homeless people are more likely to have prolonged illnesses due to the inaccessibility of services, and the psychological effects of homelessness may contribute to a lifestyle more prone to substance abuse. They argue for a multi-agency, multi-faceted approach, and note the problems there have been in developing strategies to overcome the complexity of factors and service barriers for young homeless people who need health care in relation both to general needs and specific problems related to substance misuse.

Keith Green presents a detailed account of the processes involved in an eighteen month group project undertaken within 42nd Street, a young people's mental health agency. 42nd Street has been cited as an example of good practice by the government's Policy Action Team (PAT, 2000), and the values and dilemmas faced by the organisation have recently been reviewed by Bernard Davies (2000) in conjunction with staff and service users. Green focuses on a new aspect of the agency's work which provides an alternative to therapeutic, counselling oriented youth work in order to sustain a social action approach with young people who self harm. The article reflects upon the range of complex, sensitive issues involved for the young people, the group workers and their managers. It goes on to suggest how this way of working may be extended in the future.

Mental health is one of a range of factors considered by Sarah Ansell in relation to the health and well-being of young people who may be prioritised by the Connexions service (Department for Education and Employment [DfEE], 2000). She argues that a holistic approach to the promotion of young people's health is required, based upon personal social and health education. She uses her own research to argue for a young person-centred co-ordinated approach across the range of services involved in Connexions. The issues she raises have implications for the training of different professionals involved who may be used to a more 'expert-led' approach to combating what are perceived in policy as young people's negative health practices and behaviours. The approach advocated by Ansell has much in common with youth work which has over the years used informal education to develop inter-agency projects to promote young people's health (see for example, Bloxham, 1998). The difference is that whereas youth workers work through open, voluntary relationships with young people, Connexions is tied into specific objectives geared towards involvement in employment, education and training.

Emphasising this focus as the passport for inclusion within society, doesn't adequately address the problems of poverty faced by many young people and may be ignoring important and meaningful involvements (Levitas, 1996) that are central to young people's health and well being. Thus some employment or government sponsored training schemes will be a less positive option than activities with friends or in local communities (Jeffs and Spence, 1999). In discussions about health and social exclusion that focus on 'negative behaviours', it is easy to lose sight of the fact that young people are the most healthy group within society, consulting proportionately less with GPs than the population at large. However, young people in general may have health needs that are not being met and experience difficulties in terms of embarrassment or feeling they would get an unsympathetic response from medical staff (Coleman, 1997). Alternative provision based on more informal youth work with young people (Robertson, 2001) and some PSHE approaches, together with

making sure all services are better publicised and more young person 'friendly' would go a long way to promoting young people's health and well being, and overcoming the exclusion they experience.

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YOUNG PEOPLE'S HEALTH NEEDS IN A RURAL AREA:

Lessons from a Participatory Rapid Appraisal Study

KATE PHILIP

This article critically reports on recent research which set out to elicit the views of young people on health within a community context. It formed one element of a study of how people living and working within a rural area perceived their health needs. A participatory rapid appraisal approach was adopted. The paper considers the advantages of such an approach within a collaborative partnership between a health authority and a local authority. It is argued that this can be useful particularly if it takes a community development approach that recognises the expertise and experience within communities themselves. The paper also explores potential disadvantages which require attention if the benefits of the approach are to be realised.

The paper draws on data from a recent participatory appraisal undertaken by the author and others in the North East of Scotland which sought to elicit the perspectives on health held by people living in five rural settlements. It was commissioned by the Moray Health Strategy steering group, a partnership between the local authority and the health board. The project was funded from a variety of sources including Grampian Health Board, Moray, Badenoch and Strathspey Enterprise and was supported, in kind, by the Moray Council. Approaches which allowed young people to 'tell their stories' and to reflect on and participate in the analysis of the findings underpinned the methodology of the study which set out to engage with groups of young people whose voices often remain unheard within rural communities. It was envisaged that the findings would offer insights into the processes underlying health actions and enable the partnership effectively to target interventions to improve health. It was also designed to assist the creation of an active and sustained dialogue between different groups within the community and between these groups and service providers.

Assessing community health needs - the new agenda

The current UK government has set an ambitious agenda for health with the stated aim of eradicating health inequalities (Scottish Office, 1999, Department of Health, 1999). This agenda is based on a renewed acceptance of the persistence and deepening of inequalities in health in the U.K. and recognition of how these interact with other forms of inequality (Acheson Report, 1999). In turn, this has demonstrated a need for evidence of the underlying processes and mechanisms at work (Graham, 2000). In particular it highlights the need for better understanding of the role of psycho-social factors and the ways in which experiences of health inequalities interact with feelings of isolation, fragmented social networks and

depression (Wilkinson, 1996). Improved understanding of how childhood and youth are key stages in the life course, and evidence that child poverty has increased substantially in the U.K in recent years, has refocused attention on young people as targets for social and health policy (Berney, Blane, Davey-Smith, and Holland, 2000).

It is well recognised that appropriate methods for assessing community health needs generally remain undeveloped and that the range of methodologies needs to be extended (World Health Organisation, 1995). Too often health needs assessments have been viewed as straightforward technical exercises in which professionals go out and survey 'the community' without taking account of the complexities and nuances of community life. Until recently, little attempt has been made to gauge how local communities and communities of interest may identify health needs (Labonte, 1999). A demand now exists for more reflexive approaches and a move towards recognition of the key role of lay understandings of health. For example, Wallerstein and Freudenberg (1998) have suggested,

> *By not listening to community needs and issues, professionals may impose their values, believing that the community is misinformed or misguided. On the other hand, health professionals may glamourise communities, overlooking homophobia, sexism, racism or xenophobia. Communities are not monolithic but subject to a dynamic process of competing values (p54).*

Health promotion has been identified as having a key role in improving the evidence base for health interventions (Scottish Office, 1999). The principles outlined within the Ottawa Charter (World Health Organisation, 1986) and in particular the emphasis on community development and associated themes of empowerment have been around for some time but have only recently assumed a central role in UK health policy (Acheson Report, 1999). Labonte (1999) however, criticises much existing community based health promotion for failing to reach the disadvantaged or to engage their active participation in planning, implementation and evaluation. He calls for a shift from health policy preoccupation with *content* to *context* and for such endeavour to root itself in activist politics. His argument is that community development can inform effective interventions through a set of principles and practices which underline the importance of shifts in structural conditions as well as individual and collective behaviours.

Health and young people

Arguably, some sections of the youth population within the U.K. are excluded groups *per se* with few opportunities to relay their views to policy makers or mechanisms

available to assist them in claiming their rights (National Youth Agency, 1999; Alderson, 1999). A strong body of research has demonstrated that many young people are now dependent on their parents for longer, face difficulty in setting up home, experience poor employment prospects and have scant opportunity to make their 'voices' heard (Jones, 1995; Williamson and Butler, 1995, France, 1998). In fact research has consistently shown that young people form a diversity of communities and that their experiences continue to be mediated by structural factors such as race, gender and social class (Coles, 1995).

It is only recently that the perspectives of young people themselves have been identified as being worthy of attention in debates about their health (Brannen, Dodd, Oakley and Storey, 1994). This lack of interest in young people is also evident in social and educational policy making arenas which have traditionally excluded young people from decision making processes or restricted such activity to relatively tokenistic efforts (Milburn, 2000).

Equally, the health of young people has been the focus of academic research for a considerable time but it is only recently that their own accounts have been viewed as worthy of attention (Brannen et al,1994; Hendry, Shucksmith and Philip 1995).

A number of recent studies have drawn on the new sociology of childhood which frames children and young people as active agents whose perceptions of their social networks and strategies are important in their own right (James and Prout, 1990; Backett and Alexander1991). A considerable body of work (Brannen et al, 1994; Shucksmith and Hendry, 1998) has also shown how young people's concerns about health are frequently linked to issues relating to future employment, housing and transitions to adulthood.

This interest has led to the development of participatory approaches to working with young people on health, many of which have drawn heavily on youth work practices (Aggleton et al, 1990, Bloxham, 1998). More recently studies in which young people themselves give their own accounts on citizenship have become popular with policy makers (NYA/Home Office, 2000, Forrest and Wood, 1999). Small scale and localised studies have yielded important insights into current issues but many have lacked a theoretical analysis. Youth work practices lend themselves to such research since they are essentially voluntary sets of relationships between young people and adults in which participants actively choose to be involved and which are based on negotiation (Jeffs and Smith, 1990). Secondly, youth work settings can interact with friendship groups and peer groups and interventions often address the individual young person within existing social networks. In this way groups that are deemed to be 'hard to reach' through conventional channels may

be in contact with youth workers. For these reasons, such settings often form the backcloth for health promotion interventions, with youth workers acting as 'honest brokers' with both groups over how the intervention will operate. These often delicate and subtle processes are all too often neglected in the reporting of such initiatives other than to acknowledge the gatekeeping function of youth workers (Bloxham, 1998).

However it is often unclear just how participatory such research endeavour has been, since few studies give information about how power imbalances between researchers and young people have influenced the enquiry. Researchers may neglect to explore how their own assumptions and opinions have influenced the participation of young people. Furthermore these approaches may fail to engage with the underlying sets of beliefs which underpin the accounts given by young people. In addition, ethical issues demand careful consideration which goes beyond securing informed consent to participate (Wood and Forrest, 2000).

Rural youth and health

Despite the increasing interest in participatory research, the distinctive experiences of young people in rural areas have been neglected. A recent review of work on social exclusion in the countryside makes little explicit mention of health but nevertheless raises a number of important questions about related issues of housing, employment and education (Shucksmith, 2000). Shucksmith, Chapman, Clark, Black and Conway (1996) earlier showed how people living in rural communities may experience a complex array of inequalities. They pointed out that existing indicators of poverty have a strong urban bias which can distort important aspects of rural inequalities.

Existing work on young people's health in rural areas has tended to focus on problematic activities of young people. Thus drug and alcohol misuse and teenage sexuality have been accorded a high priority (Anderson, K. Plant, M. Baillie, R. Nevison, K. Plant, M. and Ritson, B 1997; Henderson, 2000; Galt, 2000). Exceptions to this include a study of youth lifestyles, health and health concerns in rural areas undertaken by Hendry, Glendinning, Wood and Reid (1998), a study by Tyrell for save the Children, which explored young people's views on transport in rural areas (Save the Children, 2000) and a study of social exclusion in rural Scotland undertaken by Platt, Pavis, and Hubbard (2000). However few studies have set out to examine the views of young people and to relate their views to that of other members of the community. Existing work in this field has also excluded young people from the analysis of findings, a process in which their views may have particular resonance. Fewer still have taken an action research approach. Participatory rapid appraisals may offer a means of addressing this gap.

A participatory rapid appraisal approach

Rapid appraisal has its roots in community development and became a key intervention in health work in developing countries as it became clear that top down approaches offered a limited means of assessing needs and carrying out action (Dudley, 1996). It is a qualitative approach often adopting a diversity of methods and drawing its conceptual framework from agriculture, forestry, gender studies, community development and adult education. However, in the absence of an explicit conceptual framework, rapid appraisal can frequently be simply a more sophisticated mechanism for professionals to glean information with little involvement by the community itself (Murray, 1999).

Participatory rapid appraisal aims to 'generate information which can shape resource allocation and which supports community participation' (Ong and Humphries, 1994). It is most accurately described as a mix of methods, employing qualitative approaches 'with an underlying philosophy that data collection is valued as a process of learning in an iterative and systematic way in and of itself, not merely an activity for the product of information' (Rifkin, 1996: 513). This has resonance with Freire's (1976) work on literacy using 'generative themes' as part of a collaborative educational process. A Freirean approach emphasises how communities themselves undertake a 'naming' process in which the problem is defined in their own terms. By drawing on accounts from different sections of the community and by using this to build up a textured picture of health and inequalities, the range of perspectives and experiences within communities can be highlighted. Within this professional definitions are just one of a range of discourses. Such a process of 'naming the problem' has the potential to reach out to those who traditionally are excluded from more quantitative approaches. The emerging data can go beyond existing 'official' accounts and engage with localised issues, subjective meanings and lay beliefs. It can also take account of differences of opinion, conflicts of interest and power imbalances between different interests and groups. This approach, importantly, has the potential to empower communities by recognising and building on their views and experiences in planning for health. Thus community groups can develop skills to critically reflect on what is going on, and to develop action based on this reflection in the tradition of Freire's (1985) concept of liberatory education. Such critical reflection can contribute to a more egalitarian relationship between groups and service providers by revealing the wider social, economic and political constraints and how power is held, negotiated and understood by the different partners. A key element of this process is in raising questions about structural as well as individual concerns.

Problems with this approach are also evident: in the absence of a theoretical framework, an illusion of democracy can mask the reinforcement of existing power relationships. It can also be used to enhance community involvement rather than community development and in so doing, increase the surveillance and marginalisation of groups. Murray (1999) has warned against rapid appraisal being used 'to collect poor information for supporting decisions already made'. In common with other research methods, it could be reduced to a set of technical data gathering tools for services which neglect any element of genuine participation and dialogue. The use of the term rapid may also be misleading since although the data gathering itself may be swift, the processes of planning and analysis of the data demands a more lengthy and sustained commitment.

The Strathisla study

The study took place in 5 five settlements within a rural area of North East Scotland. Accepting that 'rural' is itself a contested term (Shucksmith et al, 1996), these areas fell within the Scottish Office definition of rural. While not the poorest areas, they included pockets of deprivation according to available statistics (Moray Council, 1998).

The research attempted to capitalise on the strengths of the approach through four key mechanisms outlined below

- *A collaborative approach*
- *A community development focus, agreed by all participants, including service providers*
- *A commitment to action*
- *A four stage approach which enabled the analysis of the findings by policy makers, research team and the participants.*

A collaborative approach.

The need for the study had been identified by the health strategy steering group out of a concern about the lack of information about the health needs of rural areas. In this respect the study was a 'top down' approach instigated by the council and partner agencies. As a group they felt that local expertise and views could better inform the strategy and that there was a need to go beyond the existing and rather meagre statistical information. The multi-disciplinary nature of the steering group enabled the research team to have access to official documents and services, use of buildings for meetings and permission to interview through, for example, the mobile library van. Rural Environmental Action Project (REAP), a local community development organisation also provided valuable help with the co-ordinator undertaking a range of tasks within the study. His experience of participatory

appraisals and knowledge of local networks also eased access to community organisations. It was important, however, for the research team to remain at a distance from both the local authority and the health board since a widespread disillusionment with both these bodies was evident from the outset.

A community development approach.

The strategy group agreed at an early stage that the study would be viewed as a starting point for developing a more sustained dialogue between service providers and communities themselves rather than as providing a definitive profile. The ten month timescale of the study militated against a genuine community development strategy so where possible, the researchers worked with existing networks and relationships. Within this a youth work approach emphasised the role of young people as collaborators and key informants whose views were central to the study. Youth workers in the area supported the work in a variety of ways and thus were an important resource in establishing and maintaining rapport. All the researchers had youth work or community development skills and experience which was an important asset.

An action focus

This aspect of the study enabled a link between the critical reflection and attempts to address immediate concerns. The advisory group was made up of key decision makers from health promotion and the local authority. It was envisaged that they could act on issues raised in the course of the study and that this would make a link between research and action. An example of this was the initiation of an interdepartmental group to review the council transport fleet by the director of community services in response to issues raised in the initial interviews. At the first meeting of this group, a list of issues raised in community meetings was tabled. This led to the development of a joint planning process with community groups to develop a rural transport initiative with and for young people.

Sampling

The sample was recruited through schools, youth clubs, voluntary organisations, hostels for the young homeless, gay and lesbian groups, youth training schemes and youth organisations and day centres. It included a broad spectrum of young people. Fieldwork was also carried out in pubs, street corners, chip shops and known meeting points. 'Snowballing' techniques whereby participants recruited members of their friendship groups extended the sample to include 'hard to reach' individuals and groups. Considerable time was spent searching out young people who did not attend existing youth groups. This often led to opportunistic interviewing in village halls, and at local services such as post offices, chip shops and garages. The researchers also attended discos and party nights in the local town since these

attracted considerable numbers from the area. This had the benefit of allowing further rapport to be built up with those who had already participated, affording the opportunity for researchers to be introduced to other social networks.

This diversity of approaches was felt necessary in order to reach out to those who did not take part in formal youth provision and to ensure that a broad cross-section of young people took part. Few young people declined to participate and there was general enthusiasm for the activities involved. 60 young people participated in the group discussions, youth club sessions and pub quizzes. A further 20 were interviewed individually and 39 took part in the day event. These were in the 12-18 age group. Within the primary schools, a further 50 children participated in class group and individual interviews.

Contact was also made with Gay and Lesbian Switchboard, an alternative to care project, training initiatives and day centres for young people with disabilities as well as mental health services. The numbers involved from these projects were very low but this itself offered important insights. Most young people contacted through these mechanisms were reluctant to take part in the day seminar but contributed their own views through further individual and paired discussions with researchers.

A wide variety of methods were used in order both to extend the sample to include a broad range of experience and to sustain the interest of the participants. Games were devised in conjunction with the young people and were introduced in feedback sessions with other groups. Quizzes based on health promotion interventions enabled researchers to stimulate interest among young people in settings like discos where group work was likely to be disrupted by lack of quiet space for interviews. Graffiti boards provided a useful means of gleaning comments and questions with a minimum of threat to anonymity. Mapping exercises enabled connections to be made between health and other issues salient to the participants.

Data Gathering and Analysis

As is common with much qualitative research, analysis took place throughout the project. All interviews and group discussions were recorded. Where possible, tape recording was carried out with the permission of the participants and supplemented notes taken during the sessions. All transcriptions were typed up, themes identified and categorised and brought to team meetings. Excerpts from transcripts were discussed with steering group members. Themes were then investigated at steering group meetings and in feedback sessions with professionals. These findings were triangulated through the checking of transcripts and discussion within the team, in conjunction with the steering group and at the feedback sessions. The review of emerging themes took place with participants, in either group discussions or individual and paired interviews. In these reviews, new themes emerged, others

were discarded and on occasions previously discarded themes were reintroduced. The two final seminars at which service providers and agencies met with community groups also provided a further opportunity to critically analyse these themes and to set out a strategy for dealing with them. In both the data gathering and analysis processes, considerable care was taken to safeguard the anonymity of participants.

The Process

The study took place over four stages.

Stage 1: information gathering

Key community networks and a wide range of professional and local contacts provided a wealth of 'unofficial information' which covered a wide range of issues including anecdotal evidence about high levels of alcohol use and changing patterns of relationship within communities. A statistical profile drew together routinely available figures including census information, healthcare statistics, housing provision, take up of schools meals/clothing grants, housing benefit.

Stage 2: interviews

Information gleaned from stage 1 formed the basis for planning the first round of group and individual interviews. Group interviews provided a useful means of alerting people to the aims of the study, of tapping into collective concerns and group norms and of identifying and testing out emerging themes. Where group interviews were inappropriate or unrealistic individual or paired interviews took place. A sub-sample of individual interviews also allowed issues to be discussed that were not amenable to group discussion. In addition to work with young people, interviews were undertaken with adults and professionals working in the areas.

These interviews generated a large number of themes which were then recorded and collated. These were whittled down through a process of progressive focusing, in which the research team categorised issues and concerns and further refined these in discussion with the advisory group.

Stage 3: feedback

This involved working with youth groups, firstly to report on progress and secondly to draw them into refinement of findings and the development of local agendas. The team agreed that this had to be done in a light-hearted way and the sessions were 'sold' as social events, rather than public meetings, in which findings were to be investigated to ensure that the themes selected would reflect community interests. The sessions took place in youth settings and some in pubs with older teenagers. A game was devised whereby statements were drawn on cards, and these were then discussed in depth within small groups. The opportunity was given to challenge themes and to add to these. The final stage of these sessions focused on prioritising the issues for the group or the area.

Feedback to professional groups was also undertaken at this stage through group discussions. An interim report was then presented to both the Grampian Health Board and the Moray Council to ensure support was maintained for the next stage of the study and this led to the initiation of some interim action by agencies in the areas.

Key Issues Emerging from stages 1-3

The key issues which formed the basis of the final discussions overlapped to a large extent but were divided into the following:

- *Transport*
- *Communication, isolation and well being*
- *Access to services*
- *Work and economic development*

Stage 4: priorities for action

Representatives from the relevant agencies and authorities were invited to participate alongside the communities in two seminars to explore how to take forward the findings. Young people were invited to both seminars but one had its main focus on the needs of young people.

The young people's day was organised around a series of outdoor activities and a barbecue and was seen as a means of not only enabling further discussion but acknowledging the time and commitment given to the study by the participants. It was planned in conjunction with young people themselves, some of whom had expressed frustration at the lack of facilities in the area and about 'boring meetings'. A video was made of the proceedings; photographs taken by participants and conclusions from the discussions were exhibited at the second seminar. Transport was arranged to transport participants to and from the event which was judged a success with highly positive feedback and requests for further events.

At these final sessions, key priorities for action were identified: although some were viewed as long term, it was clear there was some potential for action and for linking into other initiatives. Some issues were identified as clearly the responsibility of service providers, others were shared between the providers and the community and finally some issues were viewed as most effectively tackled within communities themselves.

Findings

The young people in this study identified themselves as relatively healthy. Overall they claimed to be happier and healthier than their peers who lived in urban settings. A crime free environment, pleasant surroundings and fresh air were frequently mentioned as contributing to a sense of well being. However underneath this rather rosy picture a more complex set of processes were described.

The disadvantages of living in a rural community in relation to health were most strongly voiced in relation to well-being, access to services and an absence of supportive adults. Poor access to decent, affordable facilities often used to illustrate a disregard for young people and an absence of 'champions' to advocate on their behalf.

A local lifestyle study recently suggested that alcohol misuse was an increasing issue in the area and this was strongly reinforced by the views of young people in this study (Grampian Health Board, 1998). While young people in the study were almost unanimous in their perception of alcohol and smoking as considerable problems for some young people, they were more likely to attribute this to a lack of alternatives for social activity rather than to a lack of knowledge about the consequences. Although some claimed that illicit drugs circulated in the area, these appeared to play little part in the social lives of those interviewed. Poor diet was agreed to be a major problem in the area but most claimed to eat healthy food themselves.

To a large extent many of the issues overlapped but for clarity of discussion it will be useful to separate these out.

Transport

Unsurprisingly the absence of accessible, affordable transport underpinned many of the issues raised. The importance of social networks for promoting resilience among young people has been well recognised but specific difficulties remain in rural settings at a practical level which may hold serious implications for well being. In relation to health, themes of loneliness and isolation were closely linked to being excluded from participation in social activities,

> *There is less chance to meet friends out of school, as we need to rely on parents and transport to get to anything so it can get isolated.*

There were mixed feelings about the high level of dependency on the good will and ability of parents to transport young people to activities. Young people in the study felt they were subject to more surveillance than those in urban settings and this limited their activities. It was also clear that young people who did not have access to parental 'taxi' services were further disadvantaged and this often had an economic basis.

Public transport was viewed as poor: the timing was wrong for both reaching facilities and for getting home, it was very expensive and it could mean a car journey to the bus stop, since many of the young people lived in remote settlements off public transport routes. Although some of the distances are not enormous, the climate means that cycling, or even walking, is not practical in the winter months.

One young man who had organised a highly complex set of arrangements for getting to work pointed out, there had been a spate of accidents involving cars and

cyclists in the area as a whole, 'I could cycle to work but it is dangerous'. Young people who attended day centres were even more constrained: taxis were expensive and there was only one which was wheelchair accessible and it was based in the major town for the district so costs were prohibitive.

Overall young people appeared to feel they had little power to influence transport in the area. For some groups who sought to develop an 'alternative' identity transport was both a means of escape and a means of restricting their movement. In important respects, young people who were already disadvantaged were further marginalised by having few options open to them. For some, getting and keeping a driving licence was an important milestone in signalling autonomy.

Communication, Isolation and Well Being

It's ok if you already have friends that aren't too far away but it is difficult to make new friends.

Mention has already been made about how some young people felt they were more subject to surveillance and supervision by parents than their peers in urban settings. A number of young people resented this and some preferred to remain at home rather than justify their actions.

Dependence on a small group of friends within the area was viewed by some as highly positive, sometimes providing support within the school setting. For others it sometime imposed a degree of conformity on the one hand which some interpreted as isolating them from other networks. However some young people were reluctant to talk about this issue other than saying that it existed.

Families were viewed as important sources of support and information on some health issues. However the family setting was also one in which problems of communication caused stress to both parents and young people. Some young people were keenly aware of parental problems and of stressful factors affecting other members of the family. For some young people, their status as members of a family of 'incomers' to the areas sometimes reinforced feelings of loneliness and dislocation. A number of young people saw themselves as sources of support to others within the family and that this promoted more equal relationships with a parent. Often this related to helping with livestock or with childcare while a parent was at work.

References were also made within one group to a number of recent suicides within the local farming community - the figures were not reflected in existing health statistics but appeared to be a form of localised knowledge which was reinforced by a range of people in the adult and professional groups. Some young people suggested that this was more of a problem for the 'older generation' of farmers

who were described as highly resistant to the notion of discussing problems. Despite the discussions about lack of social support, they viewed themselves as less likely to feel pressured than their parents since they could call on resources within their friendship networks to help them in dealing with stressful situations.

As with other studies many young men were reluctant to explore these issues other than through anonymous comments on graffiti boards or cards while young women were more forthcoming about their views, especially in relation to sexual matters.

Access to facilities.

Issues of confidentiality and anonymity often inhibited the use of health services for sensitive issues. This reinforces findings from other studies of teenage health but perhaps highlights the need for innovative policy development in designing services for rural areas. Being visible within the community held serious implications for some groups such as young women and young gay men and was strongly related to feelings about identity and reputation. Issues of timing, access, confidentiality and anonymity in relation to services were therefore recurring themes.

More surprisingly perhaps, the benefits from access to 'supportive' adults who would respect desires for confidentiality arose in both individual and group discussions. Such adults were viewed as potentially easing the path, acting as advocate or as a source of advice. Conversely, in one mixed group, anecdotes about a GP in a nearby area who was highly judgmental about teenage sexual activity, was used to rationalise decisions to avoid local health services. Awareness of outlets where condoms were sold in the area was high among young women but this was not linked to an intention to use this service. For some this related to views that this was the responsibility of boys rather than girls.

By contrast, some young women were clear that they viewed the disadvantages of being visible as outweighed by fears of pregnancy:

> *You have to ask (for contraceptives)..it's hard to do but I'd sooner ask than have a bairn.*
> *(Young woman)*

The young gay men who participated were more knowledgeable about unsafe sex and about where to access free condoms, but their openness on this topic lay in sharp contrast to their fears about family and peers discovering their sexuality. The existence of a local Gay Switchboard was seen as an important potential source of support to these young people although they were more likely to attend activities in the nearest city, than locally.

The lack of comfortable settings to meet was a key issue in all the groups. It was not just facilities that were referred to here - a recurring theme was a perceived

reluctance on the part of some adults to take the social needs of young people seriously. In two settlements, examples were given of youth clubs being excluded from use of the local village hall. A belief that the adults responsible for managing these facilities were hostile to young people, and that no one would advocate successfully on their behalf led some to look outside the area for social contact. Lack of transport then became an important constraint.

Young people in the study expressed feelings of mixed messages and exclusion from some sections of the community. For one group that had been involved in trying to get the use of a hall to meet, this comment summed up their disgruntlement,

> *The old folk just make trouble for us. They didn't want us to get use of the hall. It took ages and the least thing and they'd put us out at the first thing.*

Another group had taken part in a village clean up but this had not given them any more access to facilities. However such situations were seen as simply examples of adult/young person conflicts,

> *Youth clubs that cater for everyone are no use. We need space to meet with a pool table or a jukebox and we don't always want youth workers around.*

The inadequacy of local facilities was well recorded and reinforced by teachers, parents and health visitors,

> *The fitness centre is a joke - you have to travel to it and it is more or less a cupboard.*

> *They have reduced the hours of the swimming pool and there is no primary school use.*

For some young people, this lack of access meant there was little incentive to adopt so called 'healthy behaviours', and these examples were often given to illustrate the mixed messages they received about health and fitness. For one young woman, it provided a justification for describing herself as 'a couch potato',

> *We're stuck in the house all night because there's nothing to do, eating and smoking away...you do smoke more when you're bored*

Economic Development and work

Many young people felt that they had low expectations of remaining in the area since few jobs would be available and little opportunities existed for further education. Many in the sample felt it was not a problem for them although they anticipated it might be in the future. For some the lack of local opportunities provided, 'an excuse to get away from here'. The jobs that did exist locally were described as low paid and likely to involve costly travel. Some young women had worked in

a fish processing plant some distance away and transport had been provided. However this was seasonal, poorly paid and unlikely to offer long term employment. Generally young people were fatalistic about employment opportunities locally although some young people expressed a desire to remain in the area anyway while others viewed themselves as likely to return to live there at some point. This reinforces the findings of a recent Scottish study of social exclusion undertaken by Platt et al, 2000.

Actions following the study.

In response to the findings of the study a number of measures were introduced by the local council and the health board.

- *The development of a community led rural transport initiative to enable young people to travel cheaply into the main centre of population, timed with cinema and leisure centre openings.*
- *Financial support to a newsletter to improve communication within one settlement. This has strong representation from a small friendship group of young people*
- *Two young people from the area have been involved with others on a study tour of community food initiatives in rural areas across Scotland and plan to work on this locally..*
- *The development of a mobile health information bus targeted at young people in rural areas. The bus spends 7 weeks in each area, works in conjunction with youth workers and local agencies and aims to provide a broad range of information and advice.*
- *The preparation of a toolkit for community groups to enable them to research their own communities and to build up their own case for better facilities.*
- *The introduction of two community agents to work with community groups in the area, including youth groups.*
- *The review of the transport fleet does not appear to have made any progress. Social work and education minibuses still chase each other round the area often with only one passenger.*
- *The successful social inclusion bid for the area includes a health promotion worker with a remit to work with young people in rural settings.*

At a wider level, one school has been closed down, there has been no increase in the youth work provision and a further closure of a major employer in the nearest town has further weakened the local economy. No clear mechanisms for continuing the dialogue with young people have been established and the reality appears to be that the onus remains on them to lever resources into the area.

Discussion

In this section the benefits and disadvantages of the approach taken are explored in relation to the long term gains for young people. It is argued that the approach has great potential but that important limitations exist. These need to be addressed in research designs and in a commitment to continuing the process.

Benefits and Disadvantages of this Approach

Participatory rapid appraisal is in some danger of becoming the latest fashion victim as health promoters strive to work with the concept of community development. In order to ensure that the approach does offer a useful addition to the armoury of those working with young people in rural communities, it is important that both the benefits and limitations are better understood.

Rapid appraisal has emerged from a community development perspective and it has been used in developing countries in response to disillusionment with 'top down' approaches to assessing health needs. The study discussed above was an initiative of a new partnership between a health board, a local authority and supported by the local enterprise company in which the community was invited to participate. This approach opened many doors in terms of access: researchers were permitted to travel on the mobile library, could use council buildings, information and other health and council resources. However it was important that the research project was viewed as independent of both authorities. Nevertheless, communities themselves were clearly experiencing 'consultation' fatigue and some cynicism about the study at the outset. As a result the advisory group was concerned that the study should lead to some form of short term action, if only to promote goodwill and as a precursor to longer term interventions.

As a result, several immediate actions were taken by the local authority and the health board in response to the findings. These were largely 'technical issues' which required the tweaking of services or the allocation of some resources to the area. These interventions included the inception of a mobile health information bus, involvement in the development of a rural transport initiative for young people and the employment of community agents. On the face of it these appear to be significant investments in the small population of the settlements. Closer scrutiny shows that many were pilot projects which have as yet to prove their worth and which are highly dependent on 'positive' responses from communities themselves. It remains to be seen whether these developments will be followed by more integrated mainstream measures addressing the needs of young people within rural areas. Nevertheless because groups themselves had some involvement in requesting services, potential exists for future pressure to be exerted on the authorities to maintain these. At the same time however, communities themselves appear to have little say in the management of these projects or in evaluations of their effectiveness from a local or young people's

perspective. The absence of a mechanism for communities themselves to monitor these developments perhaps demonstrates an important weakness of the study and illustrates the relative powerlessness of the community groups in relation to decision making.

A major problem within the study was in establishing contact with young people. This demonstrates the often invisible role played by existing services in underpinning rapid appraisal approaches. Youth workers and informal community contacts provided valuable support and were effective 'gatekeepers'in this phase but since the area has a low level of youth provision: few youth workers were on the ground, they often worked in a voluntary capacity, largely on their own and with little power to influence policy. However one result of the study is that youth workers have taken part in training on health issues and in supporting the work of the mobile bus. In this way they will remain as a resource in the area beyond the life of the study. Another advantage from the study has been the links forged between youth workers, health visitors and other professionals across the area as a result of the professional workshops.

During the study, young people viewed the feedback sessions very positively but this also provoked tensions since these were not to be continued beyond the life of the study. At the consultations, care was taken to prioritise issues identified by young people into three sections: those which could be undertaken by service providers, those which should be the responsibility of communities and those which could be tackled jointly by communities and service providers. The demise of the joint health strategy group has unfortunately meant that there have been no recall days or other means of measuring progress. Again this indicates the need for some in-built mechanism to support communities themselves in these activities.

A serious weakness of the approach is that it may only offer a more sophisticated 'hit and run' strategy with professionals simply canvassing the views of communities and incorporating these into their own agendas. Thus it could be of benefit to the planners and policy makers by enhancing their knowledge of local issues and using the community without recognising their commitment in terms of time, skills and effort. Young people were invited to help shape the agenda for action from this research study but this was limited since the overarching theme of health had already been agreed. Arguably the concept of health allowed scope for a flexible interpretation which was agreed by the participants. However one safeguard would be the inclusion of local people on the advisory group and the health strategy group. To make such involvement effective it would have to go beyond the often tokenistic inclusion of one unsupported individual sitting among a group of professionals.

A strength of this approach is that it can take account of health as a holistic concept, it can highlight how health inequalities overlap and interlink with other forms of inequality as demonstrated by the focus on transport as underpinning health and

well-being in the study. It can shed light on links between social determinants of health and lifestyle issues. It also has the potential to generate knowledge and information about the specific health related needs of an area by tapping into local experience and expertise. Such information can provide valuable signposts to the value of interventions and insights into how new developments are likely to be received.

This study perhaps says little new about young people and their perceptions of health. However it does reflect how young people understood health within the context of their day to day lives and the links with other concerns about well-being, inclusion and social networks. It also gives a picture of young people as active agents concerned about both the issues that impinge on their lives and potential obstacles to good health.

Unlike in many other appraisals young people did not carry out interviews. However they were involved in recruiting others, in planning the feedback sessions and seminars, in communicating findings to the 'adult' seminar, in agenda setting and in various activities that developed from the findings of the study as well as 'key informants'. Most importantly they were drawn into and contributed to the processes of analysis.

By setting the findings from work with young people alongside those from other groups, it was also possible to build up a textured picture of health needs in the five rural settlements which went beyond existing 'official' sources of information and went some way to filling gaps in understanding.

What was the impact on young people of this study?

In important respects this study raised some questions with young people about the role of health in their lives. It also enabled them to link health to other concerns in their lives. It certainly drew attention to the ways in which many young people felt they were excluded from community events and resources. Within some of the settlements, this has led to reconsideration of access by youth groups to school buildings and village halls out of school hours. But the absence of supportive adults with whom they could explore issues in confidence was another resource which was raised by different groups of young people. It proved to be difficult to probe too far beneath the surface within the confines of a 'rapid' appraisal as the aim of developing shared priorities among groups relied on a consensus model. More time was required to move beyond these rather generalised issues. Nevertheless the approach allowed some groups of young people who seldom participate in surveys and who are often marginalised within rural settings, to voice concerns, identify and prioritise issues and discuss these with decision-makers. At the outset the study was seen as initiating a longer term dialogue within communities and between communities and providers. It is perhaps in this respect that any further benefits of the study will be seen.

One criticism of a rapid appraisal approach is that it is a form of 'community development on the cheap'. Clearly there are dangers that this becomes the case if it is substituted for planned and resourced work. However it has significant potential if it is used as one element of a community development strategy in helping communities to identify their needs, reflecting on the processes at work and seeking ways of meeting such needs. While the fieldwork can be undertaken quickly, the analysis involves a much more demanding and long term set of processes on the part of authorities and communities.

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CHALLENGING ASSUMPTIONS AROUND SEXUALITY:
Services for Young People

JOY TROTTER

This article is concerned with the health of young people, especially young lesbian, gay and bisexual people, and considers some of the supports and services, as well as some of the risks and problems in this regard.[1] Focusing mainly on the experiences of 11-16 year olds in secondary schools, and referring to a small study undertaken in the North East of England, professional practices are examined and discussed. The relevance and importance of invisibility is highlighted as a key issue (particularly for heterosexual professionals) for improving services and promoting the health of all young people. It begins by suggesting that young people are obliged to negotiate and rehearse their sexual identities and behaviours against a background of shifting beliefs and behaviours, policies and prohibitions, with little or no help from the professionals around them.

Sexuality, as an expression of a person's sexual identity, orientation and behaviour, has been shifting into the foreground in Britain in recent years. This is partly in response to the growing strength of the lesbian and gay movements and as art, fashion, music and other purveyors of modern culture have expanded, watered-down and popularised sexuality in the media. Terms which were unknown only a few years ago such as 'bisexual', 'closet', and 'homophobia' are now common parlance. Cultural and political movements have strengthened the position of sexuality as a powerful and tangible social phenomenon. Rather than constituting a 'natural' and 'private' matter, sexual practices, desires, and patterns of intimacy are 'socially made and organized' (Adkins and Merchant, 1996:1). However, despite these moves towards greater consideration and familiarity, away from censure and unease, many difficulties remain.

Like most other adults, many professionals find it especially difficult to deal with sexual matters around children and young people. Those who are concerned with the lives of young people only seem able to offer limited services, and young people seem unable to understand them. Professionals are often caught in a web of conflicting pressures from state controls, press 'scandals', parental concerns and ideological notions of equalities and rights. This seems to be especially so in Britain where arguments persist about morality in education, sexuality in schools and homosexuality in the curriculum. These arguments are accessible to and involve a broad cross-section of people, including young people themselves (Becker, 2000; Trotter, 2000a).

Arguments seem destined to continue as adults increasingly attempt to prohibit and constrain the sexual behaviours, sexual inquisitiveness and sexual identities of all young people in a string of ineffective and contradictory policies. In 1994 the Criminal Justice and Public Order Act lowered the legal age for consensual gay male sex from twenty-one to eighteen - still two years older than the age of consent for heterosexual acts. Yet gay male sexual activity continued to attract a disproportionate amount of the criminal justice system's time and effort and much of this activity was still defined as criminal (Cosis Brown, 1998; Field, 1995). In 1998 the House of Commons voted in favour of lowering the homosexual, in line with the heterosexual, age of consent to sixteen, and the law was recently amended.

Policies relating to heterosexual relationships have been no more logical. In 1984, for example, the Appeal Court ruled in favour of Victoria Gillick stating that a girl under sixteen 'could not give valid consent to the provision of contraception and parents had rights over their children that a doctor must not infringe' (Durham, 1991:45). Almost two decades later, Britain's relatively high rate of unplanned pregnancy influenced the promotion of specific sex related education in the government's white paper, *Health of the Nation*. Yet in only two years the Health Education Council's promotion of safer sex and condoms was banned as unacceptable, and the distribution of condoms in schools was left to 'professional judgement' (Lees, 1997).

Young people are not only constrained in their sexual activities and relationships by laws and policies; social institutions add to the prohibitions. Schools, where large numbers of people regularly gather together, are one of the only places in society where most of those people are outlawed from sexual relationships. And yet we know that a lot of young people are sexually active (Ryan, 2000), and at some time or another the great majority of them *talk* about sexual activity. It is apparent that for most young people today, unless their families can provide or 'allow' some privacy at home, there is nowhere private for them. However, research suggests that home is not a likely place for many young people to learn about or even to freely discuss sex, sexuality or any related matters. Oinas (1998) demonstrated that even periphery issues such as menstruation are difficult to discuss or to find information about, and the young women in her study turned to health advice columns for medical images and terms to find standards and security rather than asking at home. Bearing in mind that their letters, which were littered with notions of shame, anxiety and taboo, were about a universal female experience, it is difficult to conceive how much is hidden or avoided in families. Many of these anxieties around sexual matters are associated with mental health problems, especially those linked with heterosexuality and lesbian and gay issues.

In April 1997 the British Medical Association produced a report which advocated abolishing Section 28[2], and introducing teaching about homosexuality to the National Curriculum. Its position was based on the belief that young lesbian, gay or bisexual people may be exposed to mental or physical health problems as a result of social isolation, bullying or lack of self esteem (Fletcher, 1997). Others have catalogued health risks for young gay men, bisexuals and lesbians. Stonewall (Mason and Palmer, 1996) report that forty-eight per cent of young lesbians and gay men have experienced a violent attack, and another study found that thirty per cent of gay and bisexual adolescent men attempt suicide at least once (Ramafedi, 1987). Others have pointed to the health risks for young heterosexual people as they witness or are involved in the harassment and bullying of others, or are themselves targeted (and 'mistakenly' identified) as lesbian or gay (Duncan, 1999). In their analyses, all of these studies highlighted the role of professionals to some extent or another.

One of the reasons for many professionals overlooking or mistreating young people around sexual issues is because they are like the rest of adult society, and want to regard children and young people as 'pre-sexual' or 'non-sexual' 'innocents'. Many health and social care services only treat young people in the context of 'family' (Burton, Nesmith and Badten, 1997; Pearce and Thompson, 1998) and sexual issues are then usually allocated to the realm of the adults/parents. For example, a recent publication about social work (Adams, Dominelli and Payne, 1998) makes reference to sexuality, heterosexism and homophobia in relation to social policies, work with adults, anti-oppressive practice, the law, social work organisations and groupwork. The chapter about work with children and families (Waterhouse and McGhee, 1998) does not refer to young people's relationships, nor to lesbian or gay sexualities at all. However, in a brief section entitled 'changing family patterns' (p276) marriage, divorce, step-parenting and other (adult) heterosexual arrangements are discussed. Not only does this omission deny lesbian, gay or bisexual relationships, it also obliterates any data about young people's sexual relationships–they are categorised as 'children' (and deemed to have none).

Other reasons why professionals and the services they work for fail to meet young people's sexual needs, particularly young lesbian, gay and bisexual people's, are political and financial. One health promotion project, when faced with limiting resources, decided (on the basis of 'effectiveness') to axe the young lesbian's group in favour of work with young men. It was clear that 'effectiveness' was measured differently according to professional background (youth workers emphasised process, participation and reaching marginalised groups; health workers preferred to assess their effectiveness numerically - numbers of condoms distributed). In this instance the health service (who provided the funding) influenced the decision and,

according to Batsleer 'the social policy aims of the Health of the Nation initiative and of "the control culture" are established' (Batsleer, 1997:85).

Ryan and Futterman (1998) provide a comprehensive analysis of the health and mental health experiences and needs of American lesbian and gay young people and outline their unique vulnerabilities, stressors and health problems (largely arising from stigma and discrimination). They also emphasise that provision of services should be presented within the context of care provided for all young people and argue that it is important to consider separately the circumstances and needs of particular groups of young people (including bisexual and transgendered adolescents). Ryan and Futterman also made the important point that although it was recognised that young people were at increasing risk from HIV infection, relatively few had access to HIV counselling or testing. Similar revelations were made in Britain earlier in the decade where most publicly funded projects had not targeted young people and most of the services were inaccessible to them (Bremner and Hillin, 1994). Despite a range of documentary evidence about increased health risks for lesbian and gay young people (Treadway and Yoakam, 1992; Ryland and Kruesi, 1993; Black, 1994; Rivers, 1995; Berger and Purchin, 1995; Gochros and Bidwell, 1996; Saulnier, 1998), most of the literature about health promotion and health services for this age group omits any discussion of sexuality (Young Minds, 1996; Hendry, Shucksmith and Philip, 1995; de Winter, Baerveldt and Kooistra, 1999).

Focusing on health problems, as opposed to health and well-being, when discussing lesbian and gay young people, may wrongly imply their lives are destined to disease and distress. Even worse, concentrating on discussions about HIV and AIDS may add to incorrect assumptions by implying feckless and selfish behaviour. It must be remembered that many young people (over five million children world-wide) are infected with HIV without any sexual experience (Lwin and Duggan, 1996) and considerable numbers of heterosexual young people are engaging in sexual behaviours that carry some risk of HIV infection (Breakwell and Fife-Schaw, 1992; Prasad, 2000). Furthermore, it must also not be forgotten that most lesbian and gay young people do not attempt suicide, suffer depression, contract HIV or any other such illnesses or diseases.

Sexuality in Secondary Schools in Britain

Considerable research into sexuality in schools has begun recently in Britain. Many of the researchers refer to an early study by Trenchard and Warren (1984) which provided important statistics at a time when little evidence was available (see table one). In the section about school they found that only eleven per cent of young lesbian and gay people remembered homosexuality being mentioned in class.

> *242 people (60%) said that the topic of homosexuality was not mentioned in any lesson at school. Of those who said that the topic was talked about, 80% said they did not find it helpful*
> (Trenchard and Warren, 1984:56).

Problems at school were also recorded (Table One).

Table One: Problems at school.

Problem	Female	Male	Overall Frequency
Isolation/nothing in common with classmates	10 (27%)	28 (24%)	38 (25%)
Verbal abuse	3 (7.7%)	29 (25%)	32 (21%)
Teasing	5 (13%)	15 (13%)	20 (13%)
Beaten up	1 (2.6%)	18 (16%)	19 (12%)
Ostracised	4 (10%)	7 (6.1%)	11 (7.1%)
Pressure to conform	6 (15%)	5 (4.3%)	11 (7.1%)
Other	10 (26%)	13 (11%)	23 (15%)
Total	**39 (100%)**	**115 (100%)**	**154 (100%)**

(Trenchard and Warren, 1984:59 [Table 4.2])

Although incidences of verbal abuse, and to a lesser extent physical abuse, were significant, isolation was overwhelmingly the most commonly experienced problem from the young person's perspective.

A more recent, retrospective study of over a hundred lesbian, gay and bisexual adults' experiences of anti-lesbian and anti-gay abuse at school (Rivers, 2000a), found that bullying was linked to academic attainment and absenteeism as well as to sexuality. All participants in this crucial study had reported victimisation linked to their actual or perceived sexuality, and seventy-two per cent of them had either played truant or feigned illness to avoid the anti-lesbian or anti-gay abuse. Significant correlation was found between particular types of bullying and absenteeism, and these were not the same as the most frequently experienced ones in the Trenchard and Warren study. Having belongings stolen, being ridiculed in front of others and being frightened by a look or stare were more likely to result in absenteeism than name calling, being ostracised or actual assaults. Rivers also found that although there was no difference between absentees and non-absentees with regard to their CSE/GCE O-level/GCSE passes, there was significant difference at A level when non-absentees gained more passes. Later research (Rivers, 2000b) revealed that this result was not likely to be linked to ability or intelligence as greater numbers of lesbian and gay men return to education later in life and achieve proportionally more degrees and higher degrees than the rest of the population. One other important result from Rivers' work was that just over one quarter of participants recalled being bullied by a teacher because of their actual or perceived sexuality.

Not all the experiences in British schools are so negative. Indeed, Rivers (2000b) found that fifty per cent of teachers were reported to intervene when needed, and others acknowledge that anti-lesbian and anti-gay bullying is at last being recognised and condemned (Brant and Too, 1994; Whitney, 1996). Moreover the experiences of young people and professionals in the two schools in this study were not all negative, although responses were very varied and often conflicted.

Professional responses in NE England

How are professionals managing the conflicting messages and how are they responding to sexuality issues? In order to answer these questions, results were used from some qualitative research which examined the experiences and opinions of three groups of people (young people, teachers and other professionals) in north-east England. The research involved small questionnaires and in-depth interviews with 11 teachers, 3 education social workers, 2 youth workers and a school nurse as well as group interviews with 19 young people aged 12 to 25.

Indications from the study suggested that professionals would ignore and avoid sexuality issues in their work with young people. Results indicated that professionals underestimated the extent and implications of anti-gay harassment, and frequently denied the existence of lesbian and gay young people in their schools. Some of the implications for young people will be discussed, and important issues for professionals and their young clients will be identified by illustrating some of the understandings and misunderstandings which often result in young people being denied services.

1) Young People

The first group were young people. In total, nineteen young people were involved in three group interviews. Two groups, aged 12 to 13 and 16 to 18 respectively, of mixed gender and non-defined sexualities were made up from members of a youth centre, which was attached to a rural comprehensive school. The third was a young gay men's group that met regularly in the local town. On the whole, unlike the adults, all three groups, and almost all of the individual young people in those groups, were eager to talk about sex and sexuality and were enthusiastic about using words that the adults had avoided. According to the second group, it was a regular feature of their conversations.

- *We were all that close we knew who'd had sex and who hadn't. And who they'd had sex with and how they did it, and when, and how, and ...*

[How did you know?][3]

- *'Cause we all asked*
- *Everyone discussed it*
- *Gossip*

(Group 2).

Much of the language used was colloquial and often derogatory, and frequently was inept or confused. The second group confirmed that this derisive language was widely used by young people in school.

- *They'd call each other 'puff'.*
- *'Gay boy', yeah.*

[How often did you hear the word 'heterosexual' in school?]

- *Not very often.*
- *No.*
- *I think I said it about four times.*
- *I can't remember hearing it.*
- *But that was to be clever when one of the lads said 'hey you're lesbian' I'd say 'no actually I'm heterosexual' and they'd be thinking 'what's it mean?'*
- *It wasn't really used that much, that I can remember.*
- *I can't remember a teacher ever saying it*

(Group 2).

This young woman referred to using the word 'heterosexual' as a kind of intellectual put-down and believed that most of her contemporaries would not understand what it meant. This was born out by Group 1 who clearly demonstrated a great deal of confusion and misunderstanding about a number of words.

- *You talk, no, we say like transvestite and all that.*
- *Yeah.*
- *And transsexual and all that.*
- *Trannies.*

[How often do you hear the word 'heterosexual'?]

- *What's that?*
- *Don't know what it is.*
- *Is it one of them people what dress up as a bi.*
- *Prostitute.*
- *What do you call 'em?*
- *Like Lily Savage?*
- *Yeah, like Lily Savage?*
- *Men, dressed up as men?*
- *Oh like lemons?*

- *Like men dressed up as women.*
- *Yeah, like Hayley and Roy.*
- *Oh I know. It's like a transsexual and a ..., change into a woman and then a bloke knows that.*
- *Like Hayley and Roy out of Coronation Street?*

(Group 1).

Most of these exchanges seemed to refer to communications amongst themselves, there were few references to which words were used by, with or in front of adults. Communication about sex and sexuality did not seem to be equally or evenly distributed between adults and young people. There was no mention whatsoever of parents, or other professionals or governors, and almost entirely negative references to the communications with teachers. One group felt that teachers were especially bad at communicating about sexuality, despite having information available.

- *Yeah, so if they said 'oh, if you think you are gay - here's some facts'*

(Group 3).

One young man from this group described a particular incident at his VI form college and realised that the staff played a crucial role in how the issue was dealt with.

- *At college where the library is, there's like the whole library was packed, and as I was walking out the door I got called a shit-stabber and a queer and a puff and all this. And we've got three librarians stood there, and two other teachers stood there and they didn't say anything. That really did annoy me. I went to my tutor and I told her what happened, and I said why didn't they do anything? 'Well, we are a Catholic college and we don't want to be ...'. So I have to put up with, everyday, every time I go to college I have to put up with a lot of names, sometimes the Principal's stood there or the Vice-Principal or my tutor.*

(Group 3).

The other two groups admitted their involvement in bullying on the grounds of sexuality. Initially they were assured that things were only humorous, but as they recounted the implications on particular individuals, they conceded the seriousness of such behaviour.

The young people were asked what they thought should be taught about sex and sexuality, and what their ideas were about how and where it should be positioned in the curriculum.

- *It would be better, you know, sex education, if it was just like a short assembly for boys, different for girls, you know, and it's talked about, you know, being gay or lesbian or summat like that. And also straight, even if it was an assembly where you had three speakers, one after another, you know.*
- *It doesn't necessarily have to be in the curriculum, but it could be mentioned. I've never heard anyone mention it.*
- *Different genders, something like that.*
- *In years to come we might hope that gay male and gay female sex is in the curriculum*

(Group 3).

The other two groups were less specific about what they thought should be taught in school, though generally they agreed that it should be fairly comprehensive.

[What ... should people be taught in school about sexuality?]

- *Well every aspect.*

[Every aspect?]

- *Every aspect*
- *But I definitely think you should be taught everything at school. I mean they don't have to show you a video of two men having sex ...*

(Group 2).

These were not the only young women to express some reservations about being too explicit, the last speaker in the next extract expressed her distaste quite strongly.

[What do you think schools should teach you or other young people?]

- *Everything.*
- *Everything you have to ...*
- *Showing you real, real videos.*
- *Yeah, real, real videos.*
- *Get two people talking about sex and then show the proper one, what they do.*
- *Show us real ...*
- *Yeah, and point things out, like a person.*
- *Eurgh!*

(Group 1).

Although there was some confusion about exactly what was taught and when, the young people did remember a great deal about the sex education they had

received at school. They also were able to suggest what might improve things, and were intensely sceptical in one particular respect: the partiality of the sex education teaching. The third group had a great deal to say about the emphasis on reproduction.

- *It was all, it was very heterosexual, anything like that. Very heterosexual.*
- *Yeah, specially if it was like you know, biology or anything like that. It was always referred to the heterosexual, it was never the homosexual or nothing like that.*
- *Always heterosexual.*
- *Unless it was slightly homophobic.*
- *If it was about sex it was heterosexual.*
- *Heterosexual, yeah*

(Group 3).

The second group also acknowledged that the sex education that was offered was limited and focussed on reproduction.

- *When you're just on about straightforward sex ... when they're just on about straightforward sex when you're fifteen, not on about anything you can catch*

[What does 'straightforward sex' mean?]

- *'This is how you do it.'*
- *Well, more, more the reproductive system. Sexual intercourse is ...*
- *'When a man puts his penis up a vagina and his sperm then it goes to the ovary'. That's just like all it was wasn't it?*
- *Yeah. It shows like how you're baby gets made.*
- *They always brought sex over, sex was always brought over as how to make a baby, it was never brought over as an enjoyment.*
- *Mmmm.*
- *It was never brought over as two men have sex or two women have sex, it was always 'sex is to make a baby' and it was always from that angle, always from that angle.*
- *Yeah.*
- *Never from the enjoyment angle, never the gay angle, lesbian angle, it was just from the angle of the sperm and the egg wasn't it?*
- *Yeah, definitely*

(Group 2).

Although there seemed to be no, or at least very few, visible lesbian or gay young people in school, there was a great deal of graffiti which suggested the opposite. The second group were asked about this and about what they thought would happen if young people were able to be more open.

- *It'd be the teachers who'd have the biggest grudge, if, I think, the teachers'd make the biggest and longest issue of it any two girls or any two boys were inclined that way with each other.*

[So what do they do? What do the lesbian and gay young people in your school do?]

- *I don't know any lesbians or gay lads.*
- *We never knew.*
- *You wouldn't have found out. They'd keep it to themselves, I would, I never knew of any*

(Group 2).

These young people found it difficult to imagine any options other than to keep things hidden and although they initially suspected that teachers would react negatively, they had not been encouraged to expect anything different or attempt any real examination of the issues. Such insignificance and indifference were reported as common responses from teachers when confronted with anti-gay or anti-lesbian harassment.

- *Staff sometimes turn a blind eye. You go and say 'they're picking on me' and 'it's playground banter' you know, 'go away, stop telling tales' and all that.*
- *They've been there ten, fifteen years they've heard it all and just don't care anymore.*
- *Yeah, they just don't care.*
- *It's usual.*
- *They turn a blind eye to it, you know, 'life's life, you'll get used to it' but you shouldn't have to get used to it*

(Group 3).

The reasons for this indifference, and for the general invisibility of lesbian and gay people in schools, were not generally discussed in the groups. Intolerance, which was clearly indicated in the language, bullying and graffiti reported by the young people, probably played a large part. The very limited level of tolerance expressed by some of the young people themselves may also have been a factor.

- *As long as they don't try it on me, then you're not bothered.*
- *Yeah.*
- *That's same with me*

(Group 2).

2) Teachers

The second group of people in the study were teachers. There were contradictions in what the teachers reported about their schools. One found that young people were uninterested or rarely mentioned lesbian and gay issues.

> *But the gender thing tends to be between boys and girls as opposed to sexuality. It doesn't really get in-depth into lesbian or gays, but it's mentioned in the terms of if they have hassle about it. I can't remember any specific things, but I'm sure it's there, because I can remember kids talking about it. (T4)*

Another teacher felt that it was a crucial element of her classes, and realised the implications for young lesbian and gay people.

> *I was horrified by their attitudes basically.*
>
> ***[Why did you try to discuss it [homophobia] with them?]***
>
> *Because we were doing sexual relationships, so it was one of the things that lead on to it, and was absolutely stunned by the venom against homosexuality. It was just horrifying and I just couldn't bring them round at all, and I just thought if there is a child in this school going through this, they have got no-one to discuss it with. They've got nothing they can do. (T6/T7).*

One teacher felt that the young people knew about homophobia and knew that it was unacceptable - at least in class.

> *Homophobia has [come up]. All the classes I've had know about it. It's never been a big issue that they are always very tolerant and rational. What they may say very privately ... you know in their own sort of peer group may be quite different but they know it wouldn't be acceptable to come out with those sort of prejudices and they don't. (T4)*

The teaching staff themselves responded in different ways, some were eager to discuss the subject of sexuality, and even seemed relieved that they could. Others, however were more reluctant, and in many ways found it quite difficult.

> *Em ... yeah ...well, interesting. There are obviously things that we tackle all of the time, and are looking at and discussing all the time. Some of them I find a bit hard .... without any sort of evidence base. (T4).*

One member of staff acknowledged the likelihood of anti-lesbian and anti-gay bullying, but didn't know what effect this had.

> *That's bound to happen that people would be ribbed or accused or taunted by their friends and teachers don't know about it and we don't know the affect it has on them. (T1)*

More than one teacher felt that sexuality, or at least lesbian and gay sexuality, did not 'emerge' until after young people left school.

> *I think perhaps it something that comes up more once they leave school maybe. I think post 16 or year 11 and beyond it becomes more of an issue. I mean it will have been personally to them. But I'm not aware of any great problems about it. But then I wouldn't expect there to be either, unless they were experiencing hassle about it, I wouldn't expect to know. Why should I? (T4)*

According to most of the interviewees, the apparent absence of lesbian and gay young people, and lesbian and gay staff, from the two schools had not been discussed prior to this research being undertaken. Many of the teaching staff were unaware of any lesbian or gay colleagues, and some seemed not to have considered this before. When asked how many lesbian or gay staff there might be, one teacher admitted she had no idea.

> *I can't honestly answer that. I don't know.*
>
> ***[Yet it's likely that there are gay staff and children, why aren't they out?]***
>
> *I can't answer that.*
>
> ***[Does it matter?]***
>
> *No I don't think so. (T4)*

In many interviews it appeared that heterosexuality had been assumed.

> *Yes, you get the courtship rituals of course, like any adolescents, you get the em ... I do Assemblies on instinctive and animal behaviour in humans and stuff like that, and mock them, you know, the skirmishing that goes on between males when girls are around. (HT2)*

Some teachers were aware of shifts in society's expectations about relationships between men and women, though these perceived changes were linked to work rather than sexuality issues.

> *With girls it's changing. Girls were previously expected to grow up, get married, have a family. Now they're looking to have careers and things. (T4)*

Other teachers did acknowledge that there were lesbian and gay young people in their schools, although they were managing to hide their sexualities. They also

acknowledged that bullying and name-calling occurred quite regularly, and that many of these lesbian and gay young people would be experiencing difficulties. However, most of the staff failed to think about these issues.

[Do you think any of the lower school children know what sexuality they are? Do you think they know whether they are lesbian or gay or straight even?]

I've never asked them. (T1)

Overall, staff seemed to have overlooked or avoided this sensitive and difficult subject in their day-to-day work and there is little doubt that the invisibility of lesbian and gay staff and young people contributed to this position.

Although not widely discussed or acknowledged by the interviewees as an important issue, visibility, or rather - invisibility - was one of the key themes that emerged from the data. Teaching staff were beginning to develop an awareness of this, but some had not made connections between their inattention to the issues and continued invisibility.

It didn't exhibit itself as a school problem until he started to truant and then it was a school problem and then he didn't come along and say 'I need help'...

[So you said you weren't aware of it until he started disappearing? Why weren't you aware that he was having problems?]

Because he didn't exhibit them in school.

[So why did he not come, if there was no problem, why didn't he just keep coming?]

Why, because we didn't know the problems which he was facing were because of his sexuality. (T1)

A few of the staff talked about 'normal' young people, unaware of their implied exclusion of lesbian and gay (and other minority group) young people. Given the ambiguity about sexuality in schools, it was difficult to interpret this euphemism as anything other than heterosexism.

I mean it was normal fourteen or fifteen year olds who were on a dance floor, holding each other tightly, and enjoying that close contact. (HT1)

Some of the staff were aware of the pressures to remain invisible, and referred to this when discussing the experiences of young people.

I think there is a social culture that almost forces people down a narrowing road towards common acceptability almost of the normal stereotype heterosexual male/female and it takes a little while to step off that track. (T2)

Most of the eleven teaching staff however did not make any connection between their own disregarding attitudes and practices, and the experiences relating to sexuality in their own schools. As one teacher put it:

> *their own personal sexuality, we don't discuss that. We don't have a programme for that. (T1)*

3) Social Workers, Youth Workers and a School Nurse

In order to get some more precise information from the other professionals, a very brief questionnaire was sent in advance of the next set of interviews. The first question ('how many people [of secondary school age] do you think are lesbian or gay?') revealed a great deal of uncertainty. Two people thought that less than five per cent of young people in school were lesbian or gay, one person thought there was between six and ten per cent, one person thought there was between eleven and thirty per cent and one person didn't know at all. Further discussion revealed some of the thinking behind their answers.

[11-30%?].

> *I've ticked that because I think it's far more and I wanted to err on the 'more', because I think there are far more gay and lesbian young people than we would think there were ... and, in certain circumstances, than we would hope there were. (YW2).*

This youth worker implied that some professionals would prefer not to have to work with young lesbians and gay men and so tended to assume that there were very few (or none) of them in schools. Her colleague, guessing at a much smaller percentage, felt that geography had some part to play, though it's not clear whether she was referring to the North East of England, to the inner-city setting of the school, or to some other specific aspect of location.

> *I went for 1-5% because I know it's very small, I would certainly say we don't have none, I'm not sure that we would have 6-10% in an area like this. I might be totally wrong, all I judge it by is I do year-ten sex education in school. (YW1)*

The education social worker quoted below seemed to be opting for the lowest category above zero, perhaps implying some reluctance at overcoming the logic of his own judgement about the inevitability of at least some lesbian and gay young people in schools.

> *It was just a guess basically. I mean, what I was saying was, I don't believe there isn't any gay and lesbian youngsters in school, so there's got to be a percentage point somewhere. I think it's a small amount of people who are gay or lesbian within schools. (ESW1)*

His colleague was more shocked at her failure to 'meet' any lesbian or gay young people when she realised the large numbers.

[So how many lesbian and gay children do you think there are at ...?]

I don't think it's nil ... I don't know the proportion, I don't know. ... I would say ... it would be the same as the general population. ...

[So, possibly talking about one hundred or more lesbian and gay young people here.]

And I haven't come across any! (ESW3)

The third education social worker revealed her uncertainties about sexuality, suggesting that she was 'waiting' for the young people themselves to say something and implying that she would never ask.

I haven't, as far as I'm aware I haven't, I mean I have children I'm unsure of, but they've never actually come out and said. (ESW2)

The questionnaire also asked about contact with or experience of working with young lesbian and gay people; three of them had no experience at all and none of them felt very competent. Once again, further discussion suggested a variety of opinions and hypotheses.

I've been an education social worker now for seven years ... I've never had any experience of it... it's something ... I'm not very used to at all. (ESW3)

It wasn't only the education social workers who had no experience at all, the school nurse also said she had never discussed such issues, although she was confident that at least some of the young people were gay.

I have worked around sexuality a lot, because I mean I do a lot of the sex education in the school, I also work in the local family planning clinic so I see pupils with all sorts of sexual problems, but, ... there's been a few who I've been totally sure that they were probably gay, but they've never, ever come out and said it. (SN)

Understandings, misunderstandings and implications

Although some of the young people in this study seemed uncertain about the meaning of terms and the implications of their words and actions, they agreed with the literature about the experiences of young gay men and lesbians in school. Their stories about name-calling, teasing and isolation mirrored the results from a study nearly a quarter of a century earlier (Table one). The young people were also virtually unanimous in their assessment of teachers' inability to talk about sex and

sexuality. They were not asked about other professionals' abilities in this area, and further research needs to be done to discover this. However, it may be conjectured that they would be perceived as doing little better than the teachers.

The two most important results from the interviews with teachers were that, on the whole, they greatly underestimated the probable numbers of young lesbians and gay men in their schools and many overlooked or were unaware of the extent of sexual bullying and harassment. These factors are crucial when considering health issues, and particularly sobering as the interviewees were not intolerant or homophobic. Indeed, they seemed to be intelligent and caring individuals (they had volunteered to be interviewed, unlike most of their teaching colleagues), and presented themselves as liberal and fair-minded people. The other professionals were more aware of these factors and had a greater understanding of sexuality generally. Yet, on the whole, they had almost no experience of addressing these issues, of working with lesbian or gay young people, nor with sexual harassment and bullying generally.

Whilst this very small study may not represent the situation in all other schools in England, it is likely that some of the findings will be of relevance to others. What may be one of the most crucial findings for professionals is that although their awareness and understanding of lesbian and gay issues in schools is reasonable, they are offering no advice and providing no services. They have no comprehension of the health risks involved for young lesbian, gay and bisexual people, and also for young heterosexual people who experience and /or fear harassment and bullying. Considering that young people seem to have no other workers to turn to, this situation is contemptible.

Supporting the invisible

Given the heterosexist nature of society, the process a person goes through in deciding that they are lesbian or gay is often lengthy and sometimes traumatic; the extent to which negative messages and stereotyped images are internalised by the individual impinge on this process. For most lesbians and gay men, becoming open about their sexuality is also a long process, often cautious and sometimes life-long. Professionals need to give consideration to the effects on young people of being open about lesbian and gay sexualities, not only relating to bullying and harassment at school, but also to very real possibilities of ill health and social isolation, and the potential loss of home and family. Pressures and problems are hardly any different for lesbian and gay teachers, with additional fears about careers and even jobs, very few are open about their sexuality at work. It is likely therefore, that there are as many lesbian and gay people in schools as there are in wider society, and arguably there are similar proportions of lesbian and gay young people as there are lesbian and gay adults. However, understandably, most of them remain invisible.

It is clear that professionals working with young people in schools cannot wait for the invisible to become visible before taking any action, nor can they rely on or attempt to persuade their lesbian and gay clients or colleagues to lead the way. Professionals need to devise strategies and interventions that refer to, acknowledge and include sexualities other than heterosexuality. They must be clear about the diversity of lifestyles and avoid relying on stereotypes (Karban and Horrocks, 2000). In order to approach their work appropriately, workers must understand the oppression of and discrimination against lesbians and gay men (Karban, 1999) and remember that this may be relevant to colleagues and parents, as well as to their young clients (Trotter, 2000b). Professional education and (re)training must be familiar with changing attitudes to sexuality and incorporate lesbian and gay scholarship and research (Logan et al, 1996). In particular, heterosexual professionals must place lesbian and gay issues at the top of their agendas in order to provide services for young people which promote, not prohibit, health.

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Notes

(1) This article is based on a paper by Joy Trotter and Kate Karban which was presented at the Second International Conference on Child & Adolescent Mental Health in Kuala Lumpur, 6 - 10 June 2000.

(2) Section 28 (Local Government Act 1988) bans the 'promotion' of homosexuality by local authorities - though they have not been directly responsible for sex education in schools since 1986. It has undoubtedly contributed to an atmosphere of intimidation, and campaigns for its repeal continue.

(3) Interviewer's words indicated by bold print in square brackets.

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PROBLEMATIC SUBSTANCE USE AND THE YOUNG HOMELESS:

Implications for Health and Well-Being

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In October 2000, the homeless once again received widespread media coverage. The homelessness 'tsar', Louise Casey, claimed that giving cash to beggars was misplaced goodwill. In a controversial campaign, a £240,000 advertising blitz urged people not to give to the homeless on the streets but instead to donate to recognised charities at collection points in pubs and shops. One of the driving forces behind the campaign was that the homeless may spend money on drugs or alcohol. Unsurprisingly, this campaign was severely criticised by some, although not all, of the agencies who work with the homeless as a simplistic and offensive campaign. Dissenting agencies highlighted the many problems homeless drug users face in accessing appropriate support, suggesting that the political focus should be on addressing these problems and distinguishing between the 'deserving' and 'undeserving', would ultimately disadvantage all homeless people (Shelter 2000a). The debate was largely grounded in professional experience about the lived realities of working with the young homeless rather than rigorous research. Whilst the panoply of health and social needs of the homeless have been identified in a number of studies, few studies have explored in detail the links between substance use and homelessness (Fitzpatrick and Klinker, 2000). In this article, we explore available research on the nature and extent of substance misuse amongst the homeless, explanations for such use and its impact on health. We consider some of the barriers faced by the young homeless in accessing specialist and health care resources, and explore the implications of the research findings for policy and practice in terms of prevention and treatment. This is set against a backdrop of relevant policies which have emerged since 1998.

Before progressing we need to define our boundaries. We have concentrated on the young homeless, defined as those under 25. This literature review forms part of the work for a Home Office funded project on problematic substance use amongst the young homeless. The emphasis on the under 25s is in keeping with the UK drugs strategy (to be discussed later in this article). We have chosen to focus our research on substance use, in other words the use of alcohol, illegal drugs, and illicit use of prescribed medication, over-the counter remedies and solvents, rather than drugs. We recognise the need for distinctions to be made but would argue that similar factors may lead to the misuse of different substances; that there is some overlap in the responses to those who misuse different substances; that the physical, psychological and social problems stemming from misuse can be similar,

and that individuals frequently misuse a combination of substances. However, current policy and research focuses largely on illegal drugs and neglects the use of other substances. This article follows in this tradition and we are mindful of this gap in our knowledge and policy.

The homeless population is a heterogeneous group with diverse social, economic and health needs, and the homelessness literature has begun to reflect this by examining homelessness as not just a housing problem. The homeless are those who do not have access to homes which are affordable, of adequate size and design, in good repair, safe, secure and with support if required (Shelter, 2000b). Included in the homeless population are rough sleepers, hostel, night shelter and bed and breakfast residents, those living in squats and the hidden homeless who are staying temporarily with friends or relatives. It has been estimated that there are 2 million homeless in Britain (Wade and Barnett, 1999); 2,500 of whom are rough sleepers. The number of households living in temporary accommodation such as bed and breakfast establishments and hostels is at a record level of 66,030 (Hart, 2000) and these households will include, and may be headed by, young people under 25(Smith and Gilford, 1998; Smith, 1999). In recent years, the average age of the homeless population has fallen due to a growth in the number of homeless people under 25, who according to recent estimates occupy one-third of hostel places (Wrate and Blair, 1999). The reasons why young people become homeless are diverse but may include eviction, relationship breakdown, domestic violence and other forms of abuse, leaving care, parental divorce, family alcohol or drug problems and unemployment (see Blackman, 1998).

Policy Context

A plethora of policies have been launched between 1998 and 2000 in England and Wales which are relevant to our analysis of the young homeless, health and substance use. They are broad in scope and many relate to promoting health and social inclusion. Some of these policies can potentially overcome some of the difficulties experienced by the young homeless which will be discussed later in this paper. Others may prove detrimental to the well-being of this particularly vulnerable group. Examples here might include recent announcements that hostel accommodation is to be conditional upon joining education and training schemes (Hinsliff, 2000); the zero tolerance approach to begging which might lead to offending (Vasager and Scott, 2000) and the Alcohol Action Plan (Home Office, 2000). The latter focuses on under-age drinking, public drunkenness and the prevention of alcohol-related crime. The high visibility of young homeless drinkers may mean that they are targeted by the police and susceptible to being arrested. Given the complexity of substance misuse and youth homeless, many policies are relevant. In the review below, we focus on the most significant strategies.

In April 1998, *Tackling Drugs to Build a Better Britain* (President of the Council, 1998) was launched. This is the Government's 10 Year Strategy for tackling drug misuse. Despite its title, the focus of this strategy is on England, but the UK Anti-Drugs Co-ordinator, Keith Hellawell, asked all other parts of the UK to reflect on the implications for their existing strategies. In Wales, a review process took place which welcomed the general vision of the UK strategy but chose to continue with a focus on substance misuse rather than solely drug misuse. *Tackling Substance Misuse in Wales* (National Assembly for Wales, 2000) was launched in May 2000. Both strategies identify the homeless as one group at particular risk of developing patterns of problematic substance use. Both focus also on the young (i.e. the under 25s) and dedicate one of their four aims to helping young people resist substance misuse to achieve their full potential in society. Action promised which may impact on the young homeless includes appropriate and specific prevention interventions for at risk groups; improvements to the range and quality of treatment services for the under 25s and promoting access to specific support services for young people.

Health strategies have also been recently launched in England and Wales; *Saving Lives: Our Healthier Nation* (Department of Health, 1998) and *Better Health, Better Wales* (Welsh Office, now National Assembly for Wales, 1998). The former aims to tackle poor health and to improve the health of everyone, but particularly the worst off. It focuses on tackling cancer, coronary heart disease and stroke, accidents and mental health. Of particular importance to the young homeless is the recognition that social, economic and environmental factors (including housing) are potent in determining health and a recognition that inequalities in health prevail. In a similar vein, the Welsh health strategy focusing on inequalities, aims to bring the level of those with the poorest health up to the level of those with the best health. Both strategies also outline action which will tackle drug and alcohol misuse but this is largely a cross-reference to more specific strategies. Finding local solutions to localised health problems is central to both strategies. Local health policies should be tackling substance misuse but the London Health Strategy has already been criticised by campaigners for its lack of specific reference to the homeless (Health Action for Homeless People, 2000).

In 1999, the Rough Sleepers Unit was established and published a national strategy for reducing the number of rough sleepers, *Coming in from the Cold* (Rough Sleepers Unit, 1999). The strategy promised a radical new approach to helping vulnerable rough sleepers off the street, rebuilding the lives of former rough sleepers and preventing new rough sleepers of tomorrow. It was recognised that young people by virtue of their age were vulnerable and included specific proposals to help them, for example the provision of emergency accommodation and family mediation. Those who misuse drugs and alcohol were defined as a vulnerable group and the

need for appropriate support and help for this group emphasised. Initiatives flowing from this include specialist workers, funding for extra services and the creation of a Homelessness and Drugs Unit within Drugscope (on a short-term basis). The strategy also recognised that rough sleepers with physical or mental health problems have traditionally had poor access to health care and measures to address this have included audits of primary care provision, some additional resources and training for frontline voluntary sector staff around mental health issues.

All the strategies referred to above have performance targets, and achievements will be measured against them. It is too early to evaluate any real impact that they may have had on substance misuse, health inequalities or rough sleeping, and some may take issue with the focus purely on quantitative outcome measures as opposed to qualitative aspects of progress. However, at this stage we can raise a number of concerns about these policies and their potential impact on the young homeless and their health.

First of all, we can question whether the strategies are backed up by sufficient resources to make a difference. As we will discuss later in this article, the barriers to accessing appropriate health care by the young homeless are multiple and will take considerable resources to address. Secondly, we can take issue with the focus on rough sleepers. Whilst this group are most exposed to health risks, to focus solely on this group is extremely limited. It draws our attention and resources towards the 'visible' homeless and therefore excludes the 'hidden' homeless (see Fitzpatrick, 1998 for a discussion of these concepts). This approach has also been described as an extremely gendered policy and as ethnically exclusive because rough sleepers are most likely to be young, white males (Smith and Gilford, 1998). It also results in resources being concentrated in London and other major cities with high numbers of rough sleepers. The policy focus mirrors the focus in the homelessness literature on the visible homeless. If not addressed, this will prove to be at the expense of responding adequately, if at all, to the plight of the hidden homeless. As Blackman (1998:49) has commented, policy interventions which remove the homeless from the streets '... makes the condition of homelessness both more comfortable and more invisible'. The Housing Green Paper, *Quality and Choice: A Decent Home for All* (DETR, 2000), is a welcome step because, amongst other things, it highlights the need to prevent homelessness amongst vulnerable young people. However, its success is governed by the availability of public housing, both permanent and temporary, for young people. Thirdly, many concerns have been expressed about the UK drugs strategy and the extent to which it constitutes a 'war on drug users' as well as 'war on drugs' (Buchanan and Young, 2000). It fails to recognise a distinction between drug users; in other words to recognise the differences between recreational and problem users and thus glosses over the value of harm

reduction approaches in favour of treatment, coerced in the case of offenders who misuse drugs. Fourthly, we can raise concerns about the deficits in alcohol policy which are clearly illustrated by the failure to devise any kind of national strategy (except in Wales), despite promises of successive governments over the past twenty years.

The Health of the Young Homeless

It is widely accepted that homelessness can have an adverse impact on physical and mental health, although as Grenier (1996) notes, it is much harder to establish the nature of the relationship. Whilst most studies have focused on the impact of homelessness on health, others have also highlighted that health problems, particularly mental health problems, may begin before the first episode of homelessness (Craig, Hodson, Woodward and Richardson, 1996). Grenier's (1996) detailed study of rough sleepers found that they had a reduced life expectancy, an increased risk of suicide, higher rates of mortality and were more likely than housed individuals to die from unnatural causes including drug and alcohol poisoning. Physical health difficulties to which they are susceptible include respiratory, muscular and joint, digestive and dental problems, wounds, skin ulcers and other skin complaints (see Balazs 1993; Bines, 1994). They are at particular risk because of their exposure to severe weather on the streets, contact with diseases which spread easily in over-crowded and poorly ventilated hostels and shelters, poor nutrition, irregular meals and lack of access to hygiene facilities (Shelter, 2000b). Their ability to recuperate from illnesses, even minor ones, is constrained compared to housed individuals (see Boulton, 1993). Hence, many of the factors which serve to cause physical illness also exacerbate them. Despite serious health problems rough sleepers are unlikely to seek help until their condition becomes acute or severe. Those who are homeless are also unlikely to have the resources to purchase over-the-counter remedies to treat minor ailments. The centrality of survival means that the search for food and warmth is prioritised and health care is frequently neglected (Grenier, 1996). As Boulton (1993: 143) notes 'young people with nowhere to live are often overwhelmed by the difficulty of surviving'. Their lifestyle may not be conducive to taking prescribed medication, which is at risk of being lost or stolen. They may find it difficult to take medication at the required intervals, or to observe other rules such as taking medication with meals.

Mental health problems are also common although one difficulty here is the lack of an agreed definition of what is included. Some researchers use comprehensive definitions to include depression and anxiety through to schizophrenia and psy-chopathy, and others adopt more exclusive ones. Bines (1994) found that rough sleepers are eleven times more likely to have mental health problems compared to housed individuals. Grenier (1996) notes that some people would argue mental

illnesses go with the territory, almost as if to say that to adapt to being homeless is to develop a mental health problem. The manifestations of these problems may include suicidal thoughts and tendencies and forms of self-harm, including substance abuse. Mental health problems can impact on an individual's access to care and as we will discuss later in the article, accessing services is very problematic for the young homeless who misuse substances and are also experiencing mental health problems.

Klee and Reid's (1998) recent work specifically on drugs and the young homeless elucidates many of the issues explored above. All their respondents reported episodes of poor physical health and more persistent psychological symptoms that they attributed to their lifestyle. Stressors include poor living conditions, leading commonly to colds, influenza and general aches and pains; and loneliness and isolation, sometimes leading to depression, aggression, anxiety, paranoid delusions and suicide attempts. A major finding was that illegal drugs were used as a means of self-medication, particularly for depression, aches and pains and insomnia.

Problematic Substance Misuse and the Young Homeless

Frequent difficulties in the histories of young homeless people include deprived family backgrounds, family discord, abuse, periods in care or custody, problems at school and mental health issues (Social Exclusion Unit, 1998; Safe on the Streets Research Team, 1999). These are all linked to problematic substance use, highlighting the inter-connectedness of risk factors (Lloyd, 1998). As Utting (1998) notes, the commonality of risk factors for social problems such as drug misuse, juvenile crime, teenage pregnancy, school failure and adolescent psychiatric problems suggest that strategies designed to reduce risk and enhance the protection of young people could hit a number of prevention targets.

Seddon (1998) notes that the research evidence on the nature and extent of drug use amongst the young homeless is scarce and equivocal. Some studies have found extremely high prevalence rates (Carlen, 1996; Flemen, 1997; Hammersley and Pearl, 1997; Klee and Reid 1998), whilst others have suggested that their levels of use are pretty much the same as for comparable groups (Randall, 1988; Craig, Hodson, Woodward and Richardson, 1996). Whether prevalence rates are higher amongst the young homeless is a moot point but certainly the young homeless have higher rates of consumption (Seddon, 1998), greater exposure to drugs (Carlen, 1996) and engage in riskier drug-related behaviours which impinge on their health (to be discussed later). They are also depicted negatively as dangerous or demonic due to their consumption of alcohol and drugs (Blackman, 1998). The young homeless are more likely to become problem drug misuers. A useful definition of problem drug misuse is offered by Edmunds, May, Hearnden and Hough (1998) as involving dependency, regular excessive use, or use which creates serious health risks. This group of misusers typically consume large amounts of heroin,

crack or amphetamine, usually as part of a pattern of poly drug misuse. This poses a risk to themselves and communities, and can lead to drug-related crime. Problem misusers need to be distinguished from 'recreational' users (Edmunds et al, 1998; Hough, 1996) to allow the development of interventions appropriate to the needs and circumstances of each group. This is not to suggest that 'recreational' use is unproblematic because it can expose young people to health risks.

The changing patterns of drug use among young people in general will now be examined, to provide a context for the discussion about young homeless people.

In the post-war period, drug use was typically associated with atypical sub-cultural groups (South, 1997). More recently, researchers have suggested that there is widespread drug use amongst very large numbers of ordinary, conventional young people. Coffield and Gofton (1994) suggest that drug taking is part and parcel of the process of growing up in a contemporary Britain and is one of a number of ordinary, unremarkable activities. Drug use by young people relates to a new social order where identity is formed through consumption. Such drug use is frequently centred around cannabis but with strong support from LSD and the 'dance drugs' (poppers, amphetamines and ecstasy) (Parker, Aldridge and Measham, 1998a). Indeed, one explanation for soaring drug use in the late 1980s and early 1990s is the emergence of the 'rave' dance scene (Collin, 1997; Dale, 1996; Mignon, 1993). There have also been recent concerns about use of cocaine (DrugScope, 2000a) and heroin (Parker, Bury and Eggington, 1998b, Egginton and Parker, 2000).

Some researchers emphasise the normalisation of drug misuse in young people's lives, and highlight the availability of drugs, high levels of drug experimentation, sometimes leading to continued drug use, and the notion of 'drugwise' youth (Measham, Newcombe and Parker, 1994; Parker et al, 1998a). There is some evidence to support this view but it is important to stress that for most people drug use is uncommon or short-lived (Ramsay and Partridge, 1999). Shiner and Newburn (1999) are critical of the notion of normalisation arguing it exaggerates levels of drug use by young people and downplays the fact that many do not, and have never used, illegal drugs. Studies also demonstrate that only a proportion of those who experiment with drugs continue with regular sustained use (Parker et al, 1998a; Aldridge, Parker and Measham, 1999; Ramsay and Partridge, 1999). More young people experiment with alcohol and tobacco than illicit drugs (DrugScope, 2000a) although these can be predictors of later use of illicit drugs (Advisory Council on the Misuse of Drugs, 1998).

The question 'what causes young people to take drugs?' is difficult to answer. Frequently offered explanations include: the search for enjoyment, the impact of their environment, (particularly multiple deprivation, high unemployment, low

quality housing and poor local services), curiosity, the need to manage trauma and pain linked to relationships and abuse, the natural rebellion of youth and the widespread availability at low cost of illicit drugs (DrugScope, 2000b). Policy-makers and practitioners need to appreciate the benefits of drug use as perceived by young people (Coffield and Gofton, 1994). For young people, one of the most decisive influences on the development of drug use are friendship networks (Advisory Council on the Misuse of Drugs, 1998).

There may be some overlap between the reasons why the young homeless and young housed individuals take drugs but it is important to consider some key differences as well. The Advisory Council on the Misuse of Drugs (1998) comments that is difficult to envisage a situation more encouraging of drug use than homelessness. Young people are likely to find themselves in an unsupported environment surrounded by other people using a range of substances. Some researchers have gone as far as to argue that drug use is part of the homelessness subculture (Flemen, 1998) but this fails to recognise that not all homeless people take drugs. Others have drawn upon arguments discussed above that drugs (alongside alcohol and tobacco) are embedded in British society and are available to all young people (Collison, 1995; Parker et al, 1998a) to highlight the ways in which drug use may seem an attractive, even functional, option for the young homeless (Carlen, 1996). Drugs can provide a means of escape from an unhappy reality, emotional pain or anxiety, a sense of purpose in structuring the day, or a means of identifying with other young people (see also Fitzpatrick and Kennedy, 2000; Grenier, 1996).

Studies have also found high levels of harmful drinking amongst the homeless (Grenier, 1996; Willis 1999). Recent data from Alcohol Concern and the World Health Organisation (Moreton, 2000) highlights increasing rates of alcohol use and problematic drinking behaviour amongst young people in Britain in general, and this is likely to be reflected amongst the young homeless.

In sum, there is a consensus that problematic substance use and homelessness are connected, but the precise nature of this link is uncertain. It is known that drug and alcohol misuse constitute individual risk factors for homelessness and an increase in such misuse can act as a 'trigger' for homelessness (Fitzpatrick and Klinker, 2000). However, equally it could be argued that many young people become homeless for different reasons and then turn to substance misuse. One approach to explaining problem drug use has been to look at the characteristics of young people who use drugs and then provide a teleological explanation based on these attributes. This can lead to a circular argument because it is difficult to separate the cause of drug use from its effects. Problem drug use can lead to, and exacerbate serious problems including health problems, exclusion or truancy from school,

family problems, initiation into criminal activity, unemployment, homelessness and other features of social exclusion. Individuals can also be propelled into damaging situations as a result of drug use. At the same time, drug use is more prevalent in these contexts because people do not have the opportunity to lead fulfilling lives. There are two main problems with the approach outlined above. First, it does not explain the reasons for a young person's drug misuse at a particular point in time and second, it fails to acknowledge that many vulnerable young people do not use drugs, or at least do not become problem drug misusers. As Dale-Perera (1998) states it should not be assumed that vulnerability implies drug use. Research is needed to gauge the extent to which substance misuse precedes, begins with, or is intensified by the experience of homelessness. It also needs to focus on people's decisions about whether or not to use drugs and the factors that inform those decisions (see Boys, Fountain, Marsden, Griffiths, Stillwell and Strang, 2000; Hart and Hunt, 1997).

The problematic use of drugs and alcohol by the young homeless exacerbates their generally poor health, and reduces their life expectancy (Flemen, 1998). Drug use amongst the homeless can be unsafe: it tends to be chaotic, driven by whatever drugs are available or affordable and knowledge of the drugs taken and their effects is limited. Intravenous drug use involving shared needles or repeated use of the same syringe is particularly hazardous, and can radically increase the risk of contracting and transmitting blood-borne viruses (Klee, 1991). There are also some suggestions of risky patterns of drinking, often binge drinking with cheap, poor quality alcohol (Grenier, 1996). Substance abuse takes place against a backdrop of other health-related risk behaviours and as Measham et al (1994: 289) have noted 'drug use is strongly associated with drinking, smoking, early sexual experience, and various types of deviant and criminal behaviour'. Many of the young homeless further report sexual experience of a risky nature such as unprotected sex (sometimes under the influence of drugs (Plant and Plant, 1992)) and sex for material gain. The cluster of these risk-taking behaviours presents an additional threat to health. As Evans (1996) notes young homeless people are more likely to be involved in activities associated with increased risk of HIV such as injecting drugs, unprotected sex and multiple sexual partners. The above findings suggest that current prevention work with this group is limited and that ways of discouraging substance misuse, or at least promoting a harm reduction approach, are badly needed.

Access to Services

There is a dearth of services aimed at young substance users generally, and the evidence is that those that exist are not well used (Ghate and Chan, 1995; Woolgrove and Keene, 1997). Problems related to service access and usage are compounded in the case of the young homeless. Young homeless people face particular problems because, as Seddon (1998) argues, drug use acts as a barrier to housing services

and homelessness as a barrier to need services. Willis (1999) found that a significant number of homeless substance users do not seek assistance with their drug use for several reasons. Most significant is their need to concentrate on survival, but further obstacles relate to the attitudes of agency staff, the amount of time and effort required to secure assistance, previous negative experiences of services which affect the desire to seek help, and the failure by service providers to adopt a holistic approach that encompasses housing and resettlement support.

Homeless substance users often find it difficult to access accommodation (Seddon, 1998). Where the homeless individual presents with care/support needs in addition to accommodation needs, housing agencies may judge themselves unable to meet them (Baker, 1999). Direct access hostels frequently have strict screening procedures and exclude identified drug users; they will also usually exclude residents known to be using, dealing or possessing drugs. The possible legal ramifications for services of not doing so were highlighted by the convictions earlier this year (later freed on appeal) of two Cambridge hostel managers for permitting the use of heroin on the premises. Many young users, often awaiting detoxification or rehabilitation places, and seeking temporary accommodation, find themselves denied access to hostels whose rules commonly demand that use has ceased prior to admission. Some will feel forced to deny their drug use in order to access accommodation, and thus not be referred to treatment agencies. Hostels are needed which cater for continuing drug users, perhaps providing 'home detox' (Rough Sleepers Unit, 1999), as are 'wet shelters' for continuing drinkers, which can help work towards controlled/reduced drinking (Grenier, 1996).

Homeless people also report barriers in accessing general health services and some researchers have suggested that this is the key threat to the health of the homeless over and above the health disadvantages experienced by other socio-economically disadvantaged groups (Fitzpatrick and Klinker, 2000). These barriers result in a great deal of inappropriate use of hospital accident and emergency departments by this group (Shelter 2000b). Many homeless people are not registered with a GP; Shelter (2000b) suggest a figure of 37% , compared with just 2% of the rest of the population. Those that do try to register often encounter negative attitudes, hostility and bureaucracy (Seddon, 1998) and it has been suggested that the homeless are getting a second rate health service and are dying as a result (Millar, 2000). The specific problem of not having a postcode (commonly needed to register permanently with a doctor) was illustrated in the recently reported case of a health centre in inner-city Bristol, which (following consultation with the local health authority) allowed rough sleepers to register using a park bench as a fixed address; it adopted the same postcode as the surrounding houses. The government's homelessness 'tsar', Louise Casey, was critical, stating that it is every health authority's duty to

permanently register rough sleepers with a GP, using 'no fixed abode' as an address (Prasad, 2000); this is clearly not happening. The tendency of many homeless people to change address frequently also causes difficulties accessing and receiving continuous primary health care. One London health authority tackles this problem by operating a notification system in conjunction with its housing department - all homeless people are notified to health visitors, as are any changes of their addresses (Shelter 2000b).

Accessing health and care services is a particular issue in cases of dual diagnosis (substance misuse and mental health problems). Shelter (2000c) argues that it is this group of homeless that suffers most from the failure of social, psychiatric and housing services to respond in a co-ordinated way. It has been estimated (Shelter 2000c) that the rate of mental health problems amongst homeless young people is relatively high compared with those in the general population, and that more than 20% of the young homeless may be cases of dual diagnosis. As Barnard (2000) notes, each problem is exacerbated by the other, but rather than receiving additional service provision, these people find that no-one is prepared to accept responsibility for them and so they fall through the gap between services. To an extent, this situation is a reflection of the serious limitations in mental health services for children and young people generally; some areas of the country are almost totally lacking in any provision (Brindle, 2000).

A recurring theme in the research on homeless substance users is the discrimination they experience when accessing services. GP staff can appear indifferent, even hostile (Shelter 2000b); and homeless people have accused accident and emergency departments of treating them like 'junkie scum' (Doherty and Zobel, 2000). Alcohol agencies have also been identified as judgmental and punitive (Rickford, 1999). Blackman (1998) identifies two apparent forms of discrimination that this group experiences: structural (from policies and staff) and local (from dominant voices in the community). The relationship between these and public perceptions of the homeless substance user are also important. We feel it is important to highlight the difficulty of funding and delivering costly, labour-intensive policies in a general atmosphere of hostility towards, and negative public perceptions of, the homeless generally. As a group they have experienced increased levels of hostility from the public in recent times, including verbal and physical abuse (McVeigh, 2000). They have been characterised as criminal and amoral, or dangerous and demonic due to their alcohol and drug use (Blackman, 1998), a situation not helped by the recent spotlight on begging (however carefully communicated), and the government's collective categorisation of the young homeless as aggressive beggars (Blackman, 1998). Government pronouncements and policy should promote their social inclusion, not exclusion.

Implications for Policy and Practice

We have already highlighted some of the policy implications which flow from the available research literature on young homeless, substance use and health. These include the need for harm reduction work, overcoming some of the barriers experienced by young homeless substance users in accessing accommodation, health services and treatment for their substance use.

The breadth, complexity and inter-relatedness of the problems facing the young substance misusing homeless demand a multi-agency, multi-faceted response to address their panoply of health and social care needs. The implications of this for policy and practice have been usefully summarised by Fitzpatrick and Klinker (2000). They include addressing the structural causes of homelessness not just the symptoms, the importance of preventive work which targets groups identified as being at risk of or facing homelessness, the facilitation of effective inter-agency collaboration, and the development of responses tailored to meet individual need which aim at long-term resettlement rather than just crisis intervention.

Effective, targeted homeless prevention strategies may include family mediation, tenancy support and housing education in schools (Fitzpatrick and Klinker, 2000). Responses to those who are already homeless and involved in substance misuse need to be delivered within a context which gives them the option of taking control of their lives, and in an environment where they can learn to achieve personal control (Blackman, 1998) of their own lives and their health. Most of the interviewees in a study of Glasgow *Big Issue* vendors by Fitzpatrick and Kennedy (2000) stressed that in dealing with their substance misuse, the issue was more complex than just the availability of detoxification services, highlighting the importance of resettlement policy and ongoing support (particularly since the evidence suggests that a high proportion of those on the streets have experienced, or have come directly from, institutional living). Once housed, without ongoing support, their tenancies run the risk of failing (e.g. Crisis 2000). The ultimate aim is that of independent living, which is most likely to be maintained after interventions when young people are also supported in addressing relevant health and social problems.

Flexibility and breadth of response are also demanded in terms of actually reaching the homeless, and addressing their heterogeneity. The establishment of Contact and Assessment Teams as part of the Rough Sleepers Unit's more focused approach to outreach is a welcome step but is so far confined to London and a small number of other major cities, and only targets the visible homeless. Others have commented on the need for localised policies informed by, and responding to, the particular problems of a location. This will involve locating and tailoring services for a diversity of homeless youngsters such as drug-using sex workers (Kershaw, 1999). Examples of successful approaches endeavouring to respond to these various needs include

the Millennium Plus projects, which have increased service access, and provide ongoing care in the context of individual care plans, prepared by multi-agency panels (Shelter 2000b). A Barnardo's scheme, the Bays project in Swansea, has staff alongside those from the local health authority, housing department and social services under one roof; individuals are assigned a support worker, who, amongst other things, helps them settle into accommodation, and advises on income management–in other words, assists them towards independent living.

However, translating these principles and policies into practice has been generally fraught with difficulties, the most marked being the frequent failure to achieve the inter-agency working/collaboration which lies at the heart of successful service delivery (e.g.; Fitzpatrick and Klinker, 2000; Turnbull, McSweeney, Webster, Edmunds and Hough, 2000).

Concluding Comments

In January 2001, we began work on an exploratory eighteen month study. Through our fieldwork we will seek to determine patterns of substance use (tobacco, alcohol, illegal drugs, and illicit use of prescribed medication, over-the counter remedies and solvents) amongst homeless people, focusing on those under 25. This will help to address the shortcomings of our research knowledge to date, primarily the over-emphasis on illegal drugs. The involvement of the young homeless in substance use will be analysed against a backdrop of their involvement in other risky behaviours which may impact on health. Young people's pathways to homelessness and substance use are complex, and we will seek to explore these with young people themselves. In particular we will aim to highlight other risk factors besides homelessness which make them vulnerable to substance misuse. Studies have suggested that young homeless people have limited access to drugs information, drug services and health services in general. We will consider potential barriers with both young people and those who work with them and suggest ways of overcoming these barriers. The above research questions will be addressed through interviews and ethnographic observation in four geographical locations across England and Wales leading to the generation of qualitative and quantitative data. The results will feed into future policy by highlighting good practice, making recommendations for appropriate and accessible treatment services and offering suggestions for good quality targeted prevention activity based on evidence of identified need. Other researchers have noted (Fitzpatrick and Klinker, 2000) that many of the policy proposals in the homelessness field have lacked robust supporting evidence. We hope to address this with regard to problem substance use amongst the young homeless.

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'...FINDING YOUR OWN VOICE...'

Social action groupwork with young people who are suicidal and self harming.

KEITH GREEN

Group Poem

' Sometimes I can't feel my emotions,
I'm numb to the pain.
But sometimes I'm scared
I'm happy to be understood,
But my torment is my battle to win.
Ghosts from the past
Make us feel damned,
And they've kept us silenced.
But in the group we've been free to speak.
I feel safe and released within the group.
I love being a part of this group thing
Where we are heard and not judged.
Why am I recognised in this group
But not respected anywhere else?
The quiet sadness has become a hurricane.
When I get support in this group
It makes me feel good for a change.
We should be kinder to people
And be treated as one.
Our ability to compromise
Gives us a feeling of understanding and closeness
And it helps us to work together.
Because of the group I feel that I am being comforted and cared about.
Can help you on your way to finding your own voice.
You all bring warmth, you all bring fun, you all bring laughter.
You are a special group and I'm happy to be with you.
Changing from being a patient to feeling bloated with confidence
Ready to climb K2.
Be proud, not frustrated for yourself.
Have inner hope.'

(written collectively by the Suicide and Self Harm Group, 1999)

The following article reflects on the experience of running a group over a period of eighteen months for young people who are suicidal or self-harming at 42nd Street, a mental health resource for young people in Manchester. It is written from the facilitator's viewpoint on a piece of work that sought to be led by group members. It aims to explore 42nd Street's youth work based approach to group work and the process involved in arriving at using the Social Action model, and therefore describes and evaluates the processes involved. Some of the main achievements will be highlighted and issues and dilemmas of empowerment work with a group of young people with serious mental health issues will be discussed. The article concludes with an exploration of the key themes this approach raises, and their implications in the context of policies around suicide and self harm reduction.

The Context

In recent years there has been increased concern amongst policy makers about suicide rates and the increase in self-harm amongst young people. The Social Exclusion Unit produced statistics in March 2000, showing that 600 15-24 year olds commit suicide each year in England and Wales. In addition, 20,000

teenagers attend hospital each year having self harmed. Between the mid nineteen eighties and mid nineteen nineties, referrals for self-harm by young people increased by a third (Davies 2000: 11).

The Department of Health's (DOH) National Framework for Mental Health aims to

> *ensure that health and social services play their full part in the achievement of the target in Saving Lives: Our Healthier Nation to reduce the suicide rate by at least one fifth by 2010. (DOH,1999: 15)*

Increased funding in this area of work has engendered new initiatives to support young people with these experiences being implemented across the country. The national CALM (Campaign Against Living Miserably) helpline was launched by the Department of Health in 1997 to target young men who are depressed and suicidal. The recent move towards Health Action Zones to reduce health inequality, has, in Manchester, Salford and Trafford, focused upon funding services to help reduce the high suicide rates in Manchester, and the high rates of self harm, particularly amongst Asian women.

These initiatives have taken place alongside a growth in literature and campaigning work about self harm from the mental health survivor movement. Much of this movement has focused upon changing perspectives around self- harm. Pembroke (1994) and Arnold (1995) led the way in putting forward different perspectives to those of established psychiatric theory, and conducted research into the functions of self harm and suicide.

If, in the words of Spandler (1996:13), the predominant psychiatric and therapeutic response is to view 'repeated suicide attempts and self harm as "symptoms" of a "chronic personality disorder" "and that" from a medical perspective, a "chronic personality disorder" is usually regarded as untreatable, both psychiatrically and psycho-therapeutically', then Pembroke and Arnold challenge this by saying that self harm and suicide attempts perform a function that is about coping with very severe distress - 'Self harm is about self-worth, self-preservation, lack of choices, and coping with the uncopeable' (Pembroke 1994:1) - and therefore should be viewed and treated differently by health professionals.

This viewpoint has had a significant effect on beginning to change attitudes to suicide and self harm, with an attempt from some health professionals to explore more effective alliances and working practices with service users. As the psychiatrist Phil Thomas (1998: 5) states

> *It seems to me that there is no way forward unless we accept ...that for many people self harm is an essential coping mechanism, and*

we have no right to demand that people stop it, unless we have something better to offer them...we have a responsibility to ensure that the act is responded to as sensitively as possible...

42nd Street

42nd Street has been operating a mix of therapeutic and youth work based one to one work and groupwork over the past twenty years. It has sought to provide mental health services for 14-25 year olds that are more accessible, less formal and not medically based, compared to the traditional hospital and community based psychiatric services. (For a more detailed analysis of 42nd Street, see *StreetCred?* by Bernard Davies, 2000). 42nd Street initiated a specific Suicide and Self Harm Project five years ago, to explore best practice in relation to these issues.

42nd Street's Suicide and Self Harm Project

42nd Street firstly researched what self harm and suicide attempts meant to young people themselves - what functions they serve, what they had experienced both in terms of what made them self harm or feel suicidal, and in relation to services offering support to them around these issues. (See *Who's Hurting Who?* by Helen Spandler,1996.)

The Suicide and Self Harm Project was set up with the aim of providing one to one work and groupwork specifically around these issues, with a basis in the findings of the research. The project has attempted to offer an alternative to the mainly medicalised or behavioural approaches to these issues that have dominated psychiatric services.

Suicide and self harm, youth work and social action.

42nd Street has often had to deal with doubts about the validity of a youth work approach to mental health work. Davies (2000:39) describes the inception of the organisation as being:

Blocked by powerful professional interests...as mere youth workers based in an unproven voluntary organisation and using informal and open access approaches, they were certainly not to be trusted with the kinds of interventions essential for dealing with mental health problems

Over the twenty years of its history, 42nd Street has gained recognition for the effectiveness of this approach. A Mental Health Foundation report in 1999, states:

Within (42nd Street's) overall brief of meeting the needs of young people within a broad youth work philosophy, the development of distinctive projects has led to a number of important developments. (Davies 2000: 40)

In its suicide and self harm groupwork, 42nd Street has explored an informal groupwork approach that Davies (2000: 45) ,defines as

> *starting where young people are starting, including their recreational interests...unashamedly 'easy going, relaxing and an opportunity for a chat' ... which can often...look little different from a conventional adolescent leisure programme*

- albeit with a unique focus on suicide and self harm.

The group has run in various informal ways over the five years of the Suicide and Self Harm Project's existence. It was typical for group members to set the agenda of what issues they wanted to work on. These have included looking at coping strategies, relaxation techniques, talking about their experiences, and having social outings and activities. However, the workers would often decide upon how those issues would be approached, and ensure the social activities happened.

In planning a new group in 1998, the workers attempted to take our thinking about groupwork further. We wanted to retain elements of its informality and accessibility, but questioned the effectiveness of previous groups' abilities to help young people think about making changes in their lives, rather than just exploring ways to cope with their distress and reduce isolation. The young people who attended our groups would often express the desire for their feelings or situations to be different, but struggled with knowing how to achieve this. Maybe more importantly, they often expressed anger at their situations or experiences, particularly with the psychiatric system. This anger would often be turned inwards and directed towards themselves. Was there a way for us to help young people to explore expressing that anger in a more productive way?

We also questioned the amount of control we retained as workers. We framed this within the context that control, or the lack of it, is a major issue for young people who self harm. Spandler (1996: 33) states

> *Control... may be multi-faceted. It may...mean wanting to keep yourself under control; or being able to do something which other people cannot control; or harming yourself in order to lose control and then come back as a way of getting back into control... Young people could also lose control when other people tried to 'get in on it' - ...by trying to take it away or regulating it, or even perhaps by just getting to know about it and/or talking about it*

There was also a feeling that previous groups had focussed too much on individual change, and we wanted to provide a space where young people could explore the

broader social contexts in which they lived and the experiences that had contributed to their distress. We wondered if this would help young people to move away from the self blaming they often felt to help them understand the structures within which they existed and to ask how problematic these were.

To enable us to pursue these themes and find a way of working with them, we looked towards the Social Action model of groupwork, a community action model developed over the past twenty years. (For a more detailed debate about the effectiveness of the Social Action approach see Barry,1996; Barry, Davies and Williamson, 1997; Fleming, Harrison and Ward, 2000). Social Action has been described as -

> *an effective and empowering vehicle for change...through resisting labels, ...raising awareness...assisting service users in setting their own agendas for change (leading to) the achievement of apparently unattainable goals by individuals previously written off as inadequete and beyond help (with a) 'secondary advantage' of personal change within the group members as well as to the achievement of external change.*
> (Mullender and Ward, 1991: 12 - 13).

Part of what was immediately engaging about the idea of Social Action work was the clear set of principles and framework upon which the model is based. In the planning stages we liaised with the Centre for Social Action based at De Montfort University, Leicester. Later we worked closely with one of their associates who acted as a consultant. The Centre for Social Action defines the principles of Social Action as

- *All people have skills and understanding... professionals should not attach negative labels to service users...*
- *All people have rights to be heard,... to... define issues facing them, and the right to take action on their own behalf...*
- *People acting collectively can be powerful...Practice should reflect this understanding.*
- *Individuals in difficulty are often confronted by complex issues rooted in social policy, the environment, and the economy. Responses should reflect this understanding.*
- *Methods of working must reflect non-elitist principles...*
- *(The work) will strive to challenge inequality and discrimination... (1999: 6)*

The model has a framework to help group members explore and find solutions to their issues. It is process led, and it is important to state that this process is often non-linear. The workers job is to understand and facilitate this process which is in five stages.

It asks:

What	*are your issues, problems and concerns?*
Why	*do these situations exist?*
How	*can these things be changed?*

It then moves forward to:

Action	*to recognise young people as social actors and agents for positive change. It accepts that young people learn from doing. What they do may change things, but even if it doesn't then the group will have developed tools for dealing with problems in the future. The feeling of empowerment should remain with the group and is the most valuable part of the process.*
Reflection	*provides the opportunity for critical reflection, asking what has changed, whether the problems and concerns are still the same, and planning new action by beginning the process again.*

We felt that the principles of Social Action reflected our emerging ideas about the approach we wanted to take. It led us into thinking particularly about the labels 42nd Street itself may give the young people using its services, and what beliefs and attitudes towards them exist within its culture. This was particularly pertinent within a named suicide and self harm project. In our society these words have connotations of damage, helplessness, and people as problematic, or as victims. As issues they are often taboo, shrouded in silence and met with discomfort. At the beginning of the project, 42nd Street felt it was important to name the issues, hoping to address some of the inhibition in speaking about experiences. However, we began to wonder if naming the issue created limitations in how we as workers viewed young people and whether it affected how they might view themselves.

We worked initially with our consultant on establishing the principles and beliefs of Social Action for ourselves. We were particularly interested to explore the role of facilitator and the notion of worker as ally. This idea is one that has been common within the more recent user/survivor-led movements (for example, the Hearing Voices Network and National Self Harm Network) and the health professionals wanting to work alongside them. Thomas (1997: 229) states that

psychiatrists have as much to learn from their patients' accounts of their experiences as they have from their learned professors. Once they appreciate that patients are people who have expertise and skills in their own rights, it may be possible to move into a position where an alliance is possible.

The Suicide and Self Harm Group

The group ran from December 1998 to May 2000, and had a total membership of twenty three, but a core group of around eight. There were more women in the group than men. It was almost exclusively white. The membership had an age range between 16-25. Most had had some contact with psychiatric services or their GP in relation to their mental health problems. This included attendance at Accident and Emergency Departments after self-harming or overdosing, and use of crisis respite services. Most had used or were using psychiatric medication. Many had been given some form of psychiatric diagnosis, including personality disorder and schizophrenia. Importantly, these young people had often experienced an individualised response to their support needs in the past. The idea of collectively working on issues was new for many.

The group went through a complex, non-linear process. We explicitly stated our intent at the beginning of the group: that this was about them doing things for themselves and exploring how to make changes, however small. The social action process was explained. Youth work games were introduced into the sessions to look at energy, movement, and expressing yourself in ways other than talking. Exercises were initiated to look at the qualities they all brought to the group, to challenge the negative views of themselves that we knew from experience were often internalised.

In the first two months the group explored what their issues were. Members identified that they often felt ridiculed, judged or dismissed for what they did or felt. They felt their choice to self-harm was often taken away from them by professionals. Some young people talked about having been asked to contract to stop self-harming, often with the threat that support would be withdrawn if they didn't.

Some had a fear of their self-harm, could see no hope and said they really wanted to die. They often felt they were bad or dirty. The men in the group talked of the pressure to be macho. Others talked about how they lacked confidence and a belief in themselves.

When asked why they felt this way, members talked about their experiences earlier in life - of being bullied at school, and of family problems. Some talked of encountering homophobia. There was a long discussion on how they felt GPs,

social services, psychiatrists, and schools, gave no support with their problems, made them feel like they were wasting their time, or misunderstood what was going on. They felt they were often treated differently because of their age and were often told that they had their whole life ahead of them so why should they feel so depressed. Many talked of how they have been labelled - either by psychiatric services (personality disorder, schizophrenic, attention seeking), or by family or friends (mad, nutter, freak, weird, psycho). They debated the usefulness of labels. Some felt they helped them to be taken seriously. Others asked the question: why is it the psychiatrists' labels which they are given and not their own?

The group then moved on to look at how members wanted to tackle some of these issues. They wanted to give mutual support - sharing experiences and information, developing self belief and confidence. Significantly, the group began to express a desire to move from an individual perspective to exploring more politically motivated action and awareness raising outside of the group and themselves. This included making demands of psychiatrists, petitioning, producing leaflets, protesting, contacting the media, organising conferences, and even just yelling.

The issue of control : setting groundrules

A common concern expressed by professionals in relation to group work with people who self harm, is that it is too risky. As noted by Babiker and Arnold (1997: 113)

> *Some workers are wary of allowing people who self-injure to take part in group work together, usually due to concern that members will encourage and copy one another's self -injury.*

The members of the group raised very quickly the issue of whether they were allowed to self harm on the premises of 42nd Street, and therefore hit this concern, and the issue of control of self harm by professionals, immediately.

During the first session of the group, a discussion took place about the advantages and disadvantages of being allowed to self harm on the premises. After a heated discussion, they decided that they would have a groundrule permitting them to do this - if they looked after the wound themselves, and didn't do it in front of other members.

This raised concerns from 42nd Streets managers. They wanted an exploration of what effect this would have on group members, on us as workers, and on other young people using 42nd Street. As facilitators, we made it clear that we weren't going to negotiate on behalf of the group. Our role here was to facilitate and support a process that enabled the group to form its arguments and decide what to do - a process that took several weeks.

The group eventually wrote to the managers stating that it was unfair to take away their freedom around this and that doing this made them feel out of control. They felt that the groundrule helped them *not* to self harm. The groundrule was important in taking the pressure *off* them, rather than being a licence to self harm. It enabled them to attend the group when they felt at their lowest and get support, instead of staying at home because they felt like harming themselves.

A meeting was requested by the members with the managers to discuss it further. The group facilitated the discussion and put forward their arguments. Despite the managers initial reservations and concerns, the powerfulness of the young people's viewpoint eventually persuaded the managers to change their position and allow the groundrule to stay in place. During group sessions, no incidents of self-harm were reported.

This process was important in being the first example of the group asking for what they wanted and getting it. Their usual experience, particularly with self harm, was to be told that they couldn't do this. This time they were able to successfully challenge what professionals told them to do.

Most importantly it was an example of group members taking their own responsibility for their self-harm. In the context of concerns about 'contagion', copying, and irresponsibility often raised when thinking about groupwork with people who self harm this was an important process for the group and 42nd Street to go through. It is in direct relation to the recommendations from Babiker and Arnold (1997: 117) in ways of addressing the

> *problem of apparent 'contagion' (by) encouraging direct verbal expression of feelings, conflicts and difficulties...giving (residents) as much say as possible in the circumstances and running of their own environment.*

The issue of communication: silenced voices.

As well as beginning to find its own collective power, the group spent the next few months exploring the collective voice they wanted. With the degree to which members felt they had been silenced in their lives, it became apparent that it was a huge task for us as facilitators to help the group believe that they had a voice that could be heard, and more importantly that their voice could make some difference to their lives.

However, there was a tension within the group between an *internal* voice - a need for the group to discuss their experiences and feelings - and an *external* voice - making public statements about their issues. The group often complained that there wasn't enough discussion during group time of suicide and self harm and

their personal experiences around this. They could feel that there was too much emphasis on action. However, when the opportunity to talk was provided in response to their request, it was difficult for members to communicate what they wanted. It seemed too exposing and distressing for them, often resulting in silence. This degree of 'silence' is not uncommon in work around self harm or suicidal feelings. As Babiker and Arnold (1997: 64) state -

> *People who self injure frequently describe themselves as confused and not very good at communicating painful experiences. It would appear that individuals who are at a disadvantage with regard to verbal fluency are more at risk of being drawn to immediate physical 'solutions' such as self-injury*

This is confirmed by the experience of the Crisis Recovery Unit, a therapeutic community for people who self harm based at the Maudsley Hospital:

> *Many self-harming individuals find verbal communication difficult and consequently use their bodies. We provide a range of alternative means of expression ... including creative writing, creative art, drama therapy...(Crowe and Bunclark, 2000: 51).*

Similarly, our group began to explore creative ways of expressing themselves. The members tried to write a play based on their experiences, make a video and audio tape of their views, wrote a group poem (reproduced at the start of this article), performed group 'sculpture', and used role play to put their views across. The use of creative techniques resulted in some powerful and positive expressions of their issues, but the group would often see the use of these techniques as play - talking was the real work. However, as the group progressed they embraced this far more and it started to become part of their collective voice.

Ideas about performing in public developed. However, the group felt scared of doing this. A dynamic evolved around a lack of safety in the external world as opposed to the group where they did feel safe to express themselves on some level.

Alongside this fear, ran an anger at how they had been treated - an anger which often remained internal. We explored how this anger could be externalised. In working with this we literally did ask direct questions such as 'how are people *out there* going to know what life is like for you?'. We would then reflect upon how the usual response of members seemed to be to sit at home depressed and remain inactive. At times we had to push the group to believe that this group *could* be different, and that they *could* do things to change how they are treated.

At the beginning of the group, one young woman expressed that she liked our idea of collectivity. However, what she liked about it was that it presented the possibility that it could collectivise her desire, and possibly that of some other members to kill themselves - a chance to form a suicide pact. This obviously shocked us as workers. We worked with this carefully. We ensured we took the distress seriously, whilst not over-reacting. We emphasised the aims of the group and the possibility of using the group to achieve change in some other way. We had to work hard in this early stage of the group to help the young people turn these very negative and self damaging ideas around, and to use this energy for other purposes.

This motivating voice was often used but wasn't without its problems - notably the conflict that arose for members about how to express themselves, or how to make change, combined with the depressed feelings with which they were often struggling. This often had the potential for them to feel as if they had failed, or as though they were under pressure to achieve. For us as facilitators, it raised feelings of guilt when we were being confrontational with a group of depressed young people, and feelings of frustration if they were finding it difficult to express themselves

The issue of identity: victims or experts?

Members identities as young people with mental health problems were actively challenged. For some, a different perspective on the negative messages they had been given in life was difficult to accept. We often noted that they felt that the cause of their problems was something inherent in them or an illness - messages that often seemed to have been internalised from an early age. If they let go of this identity then what did this ultimately mean? Members engaged in a process that challenged them about their beliefs in their own capabilities, skills and qualities, and attempted to value these and empower them in utilizing them.

Members often expressed their difficulty with this idea by showing a lack of motivation or a resistance to working. They often expressed their fear of change, and looked to the facilitators for answers or direction. A group member expressed that their silence was often as a result of having authority figures (us) in the room. We also realised there was an issue about us as facilitators holding a degree of responsibility that wasn't useful - it often meant just by being there. A turning point came when we decided to outline what tasks they had identified and then leave the room so that the members could work on their own without us. This seemed to work as tasks became more easily achieved.

Leaving the group to work alone provided a powerful message to the young people that they could be left alone, as they had often experienced attitudes that said they weren't responsible enough, or wouldn't be able to cope on their own.

For us too, it challenged the messages we had been given about the roles workers often adopt (that of rescuer, or of being the problem solver), and therefore our identities also. This could often feel particularly difficult as we were working with people who are perceived as very ' damaged'. Instead, our role here was to facilitate and support a process, but not to act for the young people themselves. As Mullender and Ward (1991: 11) state

> *Practitioners... are challenged to combine their own efforts with those of oppressed groups without colonising them...in the place of the customary 'we know best' of traditional practice.*

We had to constantly challenge *our* need for control. Combined with the difficulties the young people had with motivation and communication, this made the work very challenging and frustrating. At times this felt incredibly uncomfortable. These feelings often mirrored those of psychiatrists, nurses, and GPs, which young people had often described to us - that they got angry, frustrated and impatient with their patients around their self harm.

We often felt on an edge of these feelings, and had to make careful use of our consultancy sessions and our own reflection process to ensure that we kept in sight the real achievements and positives which the group showed. We also had to maintain a careful balance around our expectations whilst also taking seriously the very real distress and depression that they often showed us. We used our support (which the young people were aware of) to explore both how we could remain congruent with the feelings we had and how we could use them to constructively challenge or motivate the group.

The Group Takes Action.

Confidence did build, and the next phase of the group was when action did take place - where this group of young people began to walk out into the world and make their statements. The action focussed on two events - attending a demonstration in London to stop child sexual abuse, and putting on a stall at a World Mental Health Day event in Manchester.

The 'Stop Child Sexual Abuse' demonstration, organised by a coalition of survivor-led organisations, proved to be an empowering experience. Group members made their own banners, and defiantly marched through central London with hundreds of others. Some group members went on stage at the rally, and talked openly about their experiences of abuse and the confidence that attending the demonstration had given them. The young people described it as a moving and powerful experience for them, particularly as their abuse was so difficult to talk about.

The World Mental Health Day event involved group members contacting the organisers, planning and making displays, setting up a stall in a local market, and talking to members of the public who attended. Again they felt this was a success. During the course of the event one professional asked the group to provide training for their team on self-harm. Another asked whether he could use some of their poems to display in a local day centre.

These two pieces of action presented an opportunity for the group to reflect upon what they had done. Within this we were able to ask important questions of the members. What was it like to have shouted out their slogans and carried placards demanding the end of child sexual abuse? Did it feel different to externalise their feelings about this rather than internalise them or self- blame? How did it feel to be visible as survivors of abuse instead of feeling ashamed and hidden away, and what was it like to do this with hundreds of other people and therefore not feel as isolated?

Responses to these questions included an expression of their feelings of safety due to the support they got from each other, and statements that the anonymity of being in London had helped them to feel stronger. Most of them said that the effects of being on the demonstration had reached into their lives in Manchester, and they had continued to feel this strength for a few days afterwards.

The group talked about how the World Mental Health Day stall had been more difficult than the demonstration, as it had taken place in Manchester, therefore not providing the same level of anonymity. They said it had been useful to feel that they could support each other if members of the public asked difficult questions. There was some anger from the members that it had often been assumed that they were workers, and this led them to raise the question of why people assume that young people aren't responsible enough in themselves to even run a stall at an event.

Raising awareness

Following these events, the group felt more confident and agreed that it would be good to develop some of their original awareness raising ideas into an awareness day about suicide and self harm for professionals and other young people, with workshops, talks and displays. The group spent six months devising, and working towards the day, which went ahead in April 2000.

The displays for the awareness day related to suicide and self-harm, but also reflected their ability to lead very ordinary lives. Their posters showed that they too could be, in their words, 'sexy and cool', that they enjoyed watching football, that they did voluntary work, and were able to draw and write poetry. The day also demonstrated that they could run workshops, and speak as experts with professionals and not be seen as victims.

The Suicide and Self-Harm Awareness day was a major success, with over thirty professionals, students, and young people attending. The group put on workshops looking at relaxation, art therapy, and treatment at Accident and Emergency departments. A Jerry Springer style play on suicide and self harm was performed. The day ended with a question and answer session. Most importantly the group members planned and facilitated the whole day without any help from us as workers. The young people produced their own report about the Awareness Day. The following extract (Suicide and Self-Harm Group, 2000: 2-4) illustrates the sense of planning, achievement and worth that the group members felt before and after the day.

> *We worked together as a team. We each had different tasks to do. We helped and supported each other. At the end of each group we would talk about what we had done towards the day. We did some of the work at home to get it finished on time.*
>
> *Sometimes it was hard because we had never done anything like this before. We had to make sure we were organised and had put all the practical things in place, there was a lot to think about.*
>
> *Some of us were unsure of what was going on and felt we wasn't (sic) doing enough work. We didn't know if it would come together. We were tired and found the preparation difficult. We gave each other support and reassurance and planned the final preparation on the day.*
>
> *There was a lot of interest in our play and suggestions we should perform it in schools...We had many compliments from people who attended, they were impressed by the day, this made us feel good and that it was worthwhile.*
>
> *We sat down afterwards for a short chat on the day. We were tired but on a high. There was a sense of achievement in the group. We'd done it and it all went alright and we felt we had got our message across to people. This is a rare opportunity for us to get our views across because it was done by us, the people who experience suicide and self harm in our lives. We could tell people what it is really like for us and what help we really need. All we want is to be listened to and not told who we are and what we need. A little understanding goes a long way*

After the Awareness Day, we announced that, as facilitators, we would be ending our involvement with the group soon, due to other circumstances. The last weeks of the group combined both a reflection on the whole experience of the group and

an airing of members' dissatisfaction with the group ending. Discussions took place about the idea of them facilitating the group themselves.

Reflecting on the group itself, members talked about how they had gained more confidence and felt an increased sense of personal power. Some said that they no longer felt that psychiatrists were 'God', and that they were no longer scared to stand up for themselves. One person talked about how they felt able to cry again, and that it had been useful to be able to have been both happy and sad within the group. Another described it as the place where she could 'breathe'. One member movingly drew two pictures - one depicting a large figure talking down to a little figure, and next, a drawing of two equal sized figures talking to each other, with the caption 'Me at home before I came to the group.... Me at home now'.

The last few weeks consisted of discussions about whether the group members were able to run the group themselves without worker involvement. There were some doubts about this, but the discussions showed a newly found confidence, maturity, and belief in their abilities. Alongside this they also expressed disillusionment and anger at 42nd Street for not providing a new worker to carry on the group.

Significant questions were being asked by the young people of themselves during this time. Issues of group commitment, location, safety, and leadership were discussed and whether they felt able and confident enough to take charge of the group.

As facilitators, we felt there could often be an overprotective streak within 42nd Street's culture and a number of practical barriers for young people attemting to access resources directly. Therefore, important questions were also being asked of 42nd Street. Would it trust and allow a group of young people to meet on their own, something that had never happened before in its twenty year history?

Members developed their thinking about these issues and requested that 42nd Street's managers allow them to use the premises to run the group. The managers agreed but wanted a worker to oversee this. Unfortunately no worker was available to do this. After discussion, the young people in the group decided it would be too difficult to continue. The members ended the group with a social event, with an emphasis on valuing the qualities they had all shown over the past eighteen months.

Conclusions: impact, development and implications

It was clear during the reflection process in the last few sessions that the young people's confidence and feeling of self worth had undoubtedly grown. As a group they had achieved a great deal in the eighteen months they had been together. We had witnessed a sense of internal change in many of the young people - an ability to express themselves differently and a willingness to take on leading roles in the

work they were involved in. They had also, on some level, effected broader, external change - particularly through the Awareness Day. Some of the professionals attending the day spoke of how the young people's presentations would inform their future practice.

However, the longer-term effects of being involved in the group process are more difficult to assess. Many of the young people have moved on from 42nd Street's services. Through contact with some of the group members, we know that several have gone on to attend college or become involved in voluntary work. We also know that some still experienced distressing times and have continued to use psychiatric services.

Towards the end of the group, within our consultancy sessions we reflected that, ideally, there was maybe a need for the group to have gone through the Social Action process again. If they had had the opportunity to explore again what their issues and concerns were, and how they could make a difference to these, then the group may have strengthened their learning and consolidated the sense of change they were beginning to feel.

However, it is important to remind ourselves of one of the challenges the Social Action model presented to us as workers - that we can play a different role as facilitators than that of 'rescuer' or 'problem solver'. The group too, should not be seen as the answer to all the young people's problems. Instead we were always conscious that, however powerful an experience the group was, ultimately all we could do was work alongside these young people in exploring some different options to the ones they had already explored. They could take from that process what felt useful for them.

In terms of 42nd Street's thinking and development regarding using the Social Action model in the future with this client group, we are exploring the following: the issue of accessibility, particularly for young people from Black communities; working with groups of young people on their own territories - for example, within crisis services or within hospital settings; and, developing the use of creative techniques, particularly drama, as an expressive tool.

What emerges from our practice is an argument that an informal and accessible youth work based approach can be effective in working with young people who are self harming or suicidal. However, through the experience of our previous groupwork we have concluded that the qualities typifying our previous work - looking at coping strategies, attempting to reduce isolation, and building relationships with young people and helping them to do that with each other (however valuable that may be) - were not robust enough to help young people achieve a sense of change and purpose.

What was needed in developing this groupwork, was a clearly defined model that had explicit beliefs in the power young people can have and upon which they can act. The Social Action model presented us with a means to explore more purposeful work with young people alienated from traditional mental health responses to these issues. The model enabled us to work with a group of young people who are often perceived as unable to take responsibility or control, and in need of or beyond treatment, in a more effective way than we had previously achieved. However, the tensions between taking action and the young people's need to talk about their feelings required constant attention.

As demonstrated in this article, emancipatory groupwork can highlight tensions, conflicts and challenges for workers and young people that require a sophisticated response. It is vital that funders and agencies ensure that this work is structurally supported. It was only with internal supervision and external consultancy that took seriously the emotional demands of suicide and self harm work and the challenges of working in the way we did, that we were able to work effectively. Our supervisors worked alongside us in taking appropriate risks, and helped us to reflect upon the process of the group.

For funders of health services, and policy makers the lessons are two-fold. First, there is a need to value a non-medicalised approach, combined with an understanding of the social contexts affecting young people. The youth work basis and emancipatory nature of this piece of work has demonstrated that it can engage young people who find it difficult to find value in traditional medical responses. Our practice asked important questions of the young people about the feelings and experiences that lay underneath the symptoms of their distress, and encouraged them to look at the broader social contexts they live in and the effects these may have upon their mental health.

Second, services need to ask questions about dominant attitudes towards young people who are self harming or suicidal. As demonstrated by the experience presented in this article, mental health practitioners, service providers and policy makers, must recognise that effective working with young people is best achieved by an openess to challenge around the identities and labels we give to young people and the powerful positions we hold as workers. Young people need to identify for themselves what their needs are and the framework in which those needs can be met.

Asking these questions and working alongside young people in implementing the answers for themselves is the crux of effective practice with young people alienated from mainstream mental health services.

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CONNEXIONS AND POST 16 PSHE - A VIABLE OPTION?

SARAH ANSELL

In April 2001 the government introduced the Connexions service, a co-ordinated, multi-agency initiative to *'provide a radical new approach to guiding and supporting all young people through their teenage years and in their transition to adulthood and working life'* (Department for Education and Employment [DFEE], 1999: 32), giving *'priority to those who are most at risk of disadvantage'* (ibid: 5). This article considers aspects of physical and mental health problems that are significant causes of disadvantage and the ensuing social exclusion, and discusses how the health of teenagers who are outside the statutory school system can be promoted. Connexions characterises young people's health in relation to particular negative practices through which the young become excluded from education and the labour market and inevitably, participation as citizens of the wider society. As with other aspects of current policy, service delivery through Connexions is linked to specific targets which in health terms aim to reduce *'...the proportion of 13-19 year olds using illegal drugs... by 50% (2008) and 25% (2005)'* and *'... by 50 per cent the rate of conceptions amongst under 18 year olds by 2010 and establish a firm downward trend in the conception rate for the under 16's'* (DfEE, 1999:34). This article argues that a more holistic approach to health promotion is required which is rooted in Personal, Social and Health Education(PSHE) processes, rather than focusing on 'negative' behaviour.

In the Centre for Guidance Studies annual lecture, Anne Weinstock the Chief Executive of the Connexions Service referred directly to PSHE through the question, *'How do we raise the profile of work experience as a valuable experience for all young people and how can it be better linked with PSHE?'* (Weinstock, 2000). This seems to imply a narrow, work oriented interpretation of PSHE. A wider conceptualisation would understand it rather as a process of learning and development that enables young people to engage in formative decisions about their life-styles and health practices, recognising constraining and enabling factors, some of which may be due to social divisions within society. PSHE can be applied to the health promoting/health educating aspects of work with individuals, groups and the wider community in a variety of practice contexts (Issitt, 1998). Viewed in this more comprehensive way a PSHE ethos and process could provide an underpinning for Connexions to facilitate young people's personal development and aspirations and promote equality of opportunity.

The Connexions strategy envisages a central, co-ordinating role for a personal advisor who

> *would be drawn from a range of backgrounds including the Careers Service, Youth Service, Social Services, teachers and Youth Offending Teams, as well as from voluntary and community sectors.*
> *(DfEE, 1999: 45)*

Personal advisors *'will refer young people to specialised services for particular needs such as health, drug treatment or housing'* (Social Exclusion Unit, :81), A central concern will be to develop a coherent service response to

> *ensure a smooth transition from adolescence to adulthood and working life so that every young person has the best start in life. To achieve this, the service must provide teenagers with the help and support they need to participate effectively so as to achieve their maximum potential.*
> *(Weinstock, 2000).*

Ideally, then, this multi-agency approach would enable every young adult with socially related 'problems' to be neatly processed before moving on to a Post Compulsory Education and Training (PCET) agenda. In reality, access to any specialist service takes time and in some instances a great amount of bureaucracy. Health interventions, particularly drug and mental health services, do not operate on an instantaneous basis; referrals have to be made, waiting lists adhered to. Moreover young people themselves have to concede that they have a need to be addressed before action can be taken; one person's problem is another's acceptable lifestyle.

Very few individuals go through a major health changing process without being driven by personal desire and/or extreme need. Targeting the negative health practices of young people as a barrier to PCET might be a realistic move but more acknowledgement of the external factors that are prevalent within the lives of young people and their intrinsic value within youth cultures, together with the use of appropriate methods are required to deliver positive health education. Addressing power relationships, external and internal environmental and social factors and previous negative experiences of the education system are as important as giving out factual information on positive health practices in relation to drugs, alcohol and sex. This needs to operate within an overall perspective that goes beyond individual behaviour to recognise the link between social inequalities and poor health. From this perspective it will be important to develop a young person-centred approach which can unify the different practitioners involved - practitioners whose professional backgrounds and organisational cultures may not always be in accord.

Social Exclusion and Young People's Health

Throughout history, social divisions have meant that low, or no income, households and individuals have been subjected to an inferior quality of living. Those members of society who have had the financial means to make positive lifestyle choices have notably lived longer and more healthy lives than those whose choices have been finanacially and educationally limited. The term social exclusion, although relatively new in political jargon, may be seen as just another way of labelling

individuals whom society has marginalised, mainly as a consequence of poverty (Levitas, 1996). Inclusion in society, as framed in current policy, is to be promoted primarily through employment (Levitas, 1996; Bloxham, 1999) and within this health related factors are an important feature. In the precursor to Connexions, *'Bridging the Gap: new opportunities for 16-18 year olds not in education employment or training'* (SEU 1999), the Social Exclusion Unit highlights the relationship between labour market exclusion and the role of young people within society. Areas of the report identify the correlation between social exclusion and health-related issues:

> *Non-participating young people are, by the age of 21, not only more likely to be unqualified, untrained and unemployed, but are also likely to earn less if employed, be a parent and experience depression and poor physical health.*
> *(SEU, 1999:33)*

'Bridging the Gap' was commissioned by the government after research statistics revealed that 9% of the above age group were not included in any formal activity after leaving full-time education. The report states that whilst there has been a general rise in the number of young people staying on in PCET there has also been an increase in the number of young people not involved in any formal activity such as work or training.

The report goes on to argue that a higher proportion of non-participants are more likely to engage in the specific behaviours noted in the Connexions document. One example in relation to drugs states that *'non-participants are three times more likely to be drug dependent than participants'*. The cost to the state is estimated at:

> *between £3.2 billion and £3.7 billion, compromising £100 million health costs, £600 million unemployment and sickness benefits, £500 million criminal justice costs and costs of between £2 billion and £2.5 billion to victims of drug related crime...*
> *(SEU, 1999:36)*

and does not only affect health in youth :

> *some idea of the magnitude can be gained from the public expenditure cost of unemployment and poor health which are experienced disproportionately by non participants in later life.*
> *(SEU, 1999:36)*

The availability of health support networks for young people vary according to location and budget. Prioritising scarce resources can lead to the targeting of a wider audience who are already participating in PCET. This could include personal development elements of vocational training courses and student counselling and

information services in further and higher education colleges, and schools. Formal, and informal health education initiatives that deal with risky health behaviour are unlikely to be accessed by those outside the system either by accident or choice. It is extremely difficult for such young people to feel confidence and trust in staff and to access health related facilities that are used by their well-informed peers.

The Institute for Development Studies Report *'Poverty and Social Exclusion in North and South'* (1998), considers the relative nature of health and suggests that whilst overall young people as a social group are more affluent, and have increased lifestyle choices over previous generations, many still do not have a quality of life that is conducive to good health. For example, the report highlights the dietary deficiency of those living on low incomes. It argues that the insecurity felt by the individual in a market driven economy will produce a feeling of inequality, and disempowerment, which invariably takes its toll on the health of the individual, community and society as a whole.

Young people and society

Poverty and social exclusion will have particular significance for the health and well being of young people. As traditional routes to employment are being replaced with artificially constructed training schemes, and young people no longer see guaranteed employment as the norm, their position in society, which is most commonly held through employment status, is shrouded with uncertainty. Yet as Bradford and Urquhart show, for many adolescents *'ambitions were invariably constructed using stereotypical notions of "getting a good job and providing for my family"'* (1998:32) even though this cohort of young adults may well have parents who were the first generation to undertake compulsory youth training as opposed to employment. The mismatch between the aspiration and the reality operates within an insecure, 'flexible' labour market and high accommodation costs. Young people's experience contrasts with constant media imagery of successful and wealthy people. All this leads to a situation in which the self esteem and confidence of some groups of young people is extremely low. They can have little or no concept of their value within society, and hierarchical social structures have done little to address their needs.

A more individualistic perspective is taken by Ahier and Moore who suggest that the *'process cannot be understood simply as the expression of class cultural values, and young people are not lacking in general aspiration ... The calculations they make are more relative to their starting points than to a common baseline'* (Ahier & Moore 1999:522). They argue that not enough research has been undertaken to identify 'reconfiguration between independence and reliance' (528), that is central to understanding youth transitions.

Nevertheless, there are enough common baselines which emerge from research with teenagers to suggest that interlinking threads of disillusionment, risky health practices and non-participation in PCET have a material basis in wider social divisions. Neumark cites a number of examples showing the correlation between poverty and mental health and suggests that *'the risk of suffering mental health problems is higher for those who'*

- *Live in single parent households*
- *Live in reconstructed families*
- *Have four or more siblings compared with one*
- *Have both parents unemployed*
- *Come from a poor family*
- *Have parents in the bottom social class*
- *Live in rented accommodation*

The article goes on to suggest that *'what is more startling is the high correspondence between special educational needs and mental disorder'* (Neumark in TES, 2nd June 2000: 11-13). Whilst individuals may start their transition to adulthood on individual baselines, socio-economic factors undoubtedly play a major part in shaping their future and related health conditions.

The link between young men's health and social exclusion has become a particular cause for concern. A report by the Samaritans, *'Young Men Speak Out'*, suggests that *'macho stereotypes are preventing lads from asking for help'* and that *'distressed lads are more likely to use violence and anti-social behaviour to express themselves than tell someone how they feel'*. The statistical picture of young men's health indicates that 67% of suicidal young men say they have nowhere to turn for emotional help. Furthermore,

- *suicidal young men are four times more likely to smoke and ten times more likely to take an illegal drug to relieve stress*
- *more than one in three young men who are suicidal would smash something up instead of talking about their feelings*
- *less than one in five young people ask their father for emotional support*
- *78% of depressed and suicidal young men have experienced bullying*
- *69% of suicidal young men have experienced violence from an adult*
- *50% of suicidal young men have been in trouble with the police compared to 17% of the non suicidal (Samaritans, 1999).*

These facts were reiterated by Yvette Cooper, Minister for Public Health in a key note speech at a conference in Birmingham last year entitled *'Young Men's Health: Understanding Needs - Exploring Solutions'*:

> *In adolescence, teenage boys are less likely than girls to form the important social networks and support groups that act as a buffer against depression. That lack of emotional support is borne out in suicide rates, which are 4 times higher amongst teenage boys than amongst girls (Cooper 2000).*

It is also the case that 'four times as many young women than young men attempt suicide' but Bradford and Urquhart (1998:37) argue that the 'emotional literacy' that young women acquire enables them to manage their emotional needs more constructively in the long term.

In their research on *'Male Youth Street Culture'*, David and Cunningham-Burley (1999) indicated that: [young men]... *drank in order to aid and facilitate social interactions* (585); that *'smoking had become something that the young men shared, and ... strengthened their social bonds and bound them together* (592); and that ' ... *there was considerable status attached to knowing about and having tried different methods [of drug taking]'*(593).

How then to tackle some of these difficult, health related problems? Friss and Stock suggest that *'the family, the school, and society represent potential avenues for the primary prevention of mental illness through the emotional and social support that they provide'*(1998:151). Attempts to understand and move towards addressing health issues in these primary contexts may be faced with the fact that some young people will seek an alternative identity within their peer group, with the potentially health damaging consequences noted above.

When young people have been failed in these primary prevention levels, then the PCET context affords another opportunity to be proactive in supporting young people in their social and health development. For young people who have been through a negative school experience, which may have included bullying, segregation and low peer status, moving on to post compulsory education and subscribing to the youth culture that sets its own health and personal development agenda can be a difficult, if not an unobtainable hurdle without the appropriate support and guidance. At PCET level the aim should be to enhance confidence and self esteem, through a person centred agenda that moves away from the kind of power relationships that exist within formal education.

Young people and the PSHE context

The process of personal, social and health education (PSHE) is one method of delivering health education. PSHE is included in the national curriculum, but, as with other school subjects, ceases in its recognised form once the young person has left school. Rather than merely supplying factual information about health, PSHE should provide young people with a method of exploring their own value system in a health related context.

Whitty, Power, Gamarnikow, Eggleton, Tyrer and Youndell, state that PSHE programmes in later educational years are imperative, especially in relation to building positive health choices.

> *This is particularly the case when such interventions are linked to broader efforts to build social capital. For example, health education in schools organised within whole school PSHE frameworks provides some interesting examples of these kinds of interventions. A key feature of newer approaches to PSHE lies in the links they propose between learning how to develop relationships characterised by trust and reciprocity, gaining familiarity with structures of effective involvement and participation, and positive health, and educational, outcomes*
> *(Whitty et al 1999:70).*

While education can be used as a tool to assist young people in comprehending the nature of their situation and aid them in enhancing their health and personal effectiveness, the barriers that these young people have experienced in the statutory educational system need to be addressed with effective learning strategies to maximise the potential of any PSHE or health programme. To break the cycle of social exclusion, or potential exclusion, requires interventions that enable young people to build a sense of self worth, and identify their positioning in society, before addressing major health issues.

PSHE takes many differing forms of delivery but essentially puts the young person at the centre of the learning process. This may be achieved through debate, informal conversations, small groups, individual schemes of work. However it is delivered, PSHE aims to develop positive health practices in the individual through addressing personal and social circumstances, and it offers many challenges that move beyond the stereotype of arranging a series of workshops with routine learning materials. Curriculum topics and teaching and learning strategies have to be carefully selected, with the collaboration of participants, for them to gain maximum benefit, to meet their needs rather than an imposed, expert led agenda.

French argues that: *'the promotion of self esteem should be an integral component of all health education programmes'*, and states that: *the underlying principles of health education should include:*

1 *Client involvement in planning and evaluation*
2 *The promotion of self-esteem and autonomy*
3 *Non coercion and voluntarism*
4 *Sensitivity to social, economic and environmental factors influencing or of concern to clients*
5 *The valuing of others*
6 *Continuous evaluation*
7 *Responsibility for the accuracy of information and the appropriateness of methods used*

(French 1990:9).

These principles underpin many forms of formal and informal educational theory (Jeffs and Smith 1999). As a starting point for any project these principles would set the agenda by which young people could feel part of the learning and development process from the onset, rather than being passive participants. For students with negative experiences of the educational system, who may not have fitted into the conventional role of student easily, finding a comfortable starting point may be the biggest challenge to the project. Invariably some young people are bound to view any form of PSHE work as an extension of school work and employ defensive barriers accordingly.

A small scale research project I conducted in South Wales (Ansell, 2000) drew on the principles of informal education to implement PSHE with a group of young people on a two year residential training programme. In the first year this aims to provide NVQ and key skills based training alongside a personal development programme. In the second year, students return to their home town to undertake a further twelve months work based training.

The research was conducted over a period of nine months with fifteen 16-19 year old students, the majority being men, and who in Connexions terms would be socially excluded, being classified as having special educational needs and associated social, mental helath and/or behaviour problems. The project used action research methodology (Hart and Bond, 1995) to determine the type of PSHE provision required and the methods that suited the student group. The research focused on the need to include students in the decision making process of the PSHE agenda, giving them the opportunity to select the type of activity and methods of delivery that

suited their needs. This was achieved by holding regular meeting with the students to elicit their views on the course, the research process and other general issues. By involving them in decision making processes, such as the type of activities being undertaken, (the physical environment of the research being a outdoor activity centre), the length of activity and perceived outcomes, the students became aware of the influence they could have on desired outcomes of the programme. The research data was collected in a variety of formal and informal group contexts which included meetings with staff. Conversations with the students indicated that their contact with formal education and welfare agencies had generally been a negative and disempowering experience and that their sixteenth birthdays represented a benchmark where they could refuse to co-operate rather than actively participate.

The research concluded that to have the confidence to be part of a student centred change process, to feel a valued contributor to any project, takes a vast amount of self-confidence and self esteem that many young people do not have. The need to devise and/or facilitate positive learning strategies for these young people was a crucial part of the PSHE process. Strategies involved reshaping the kinds of programmes offered to make them more relevant to the young people's needs. It was clear from this that social, cultural, peer and media images all had to be taken into account, as these will probably have a stronger intrinsic, and extrinsic, influence on young people than expert figures and their relative values. Furthermore, the need for opportunities for informal exploration and discussion with their peers and appropriate adults was identified as a need by both the young people and the tutors. However, within a curriculum that was geared towards achieving specific targets and outcomes in terms of work and training, it was difficult to find the space for the kind of informal education that would be more a feature of youth work practice, yet which would offer the conditions for promoting PSHE.

Thus, as researcher and tutor, I had to seize the opportunities available to operate in a more informal way with the young people. This involved being prepared to abandon pre-ordained plans and working with the young people's discontent and disquiet. One short, informal, unplanned discussion illustrates a range of concerns for the young people. They raised issues such as racism, cultures and stereotyping; lack of rights for young people in care; lack of respect and privacy in medical examinations; questions about adoption; problems with benefits for their parents and themselves when going into education; discussion about differences between their lifestyle and that of their parents; relationships and involvement with police.

This experience endorses Dorn and Nortoft's research reported by Ryder and Campbell in which the recognition of the external environment is as important as

psychological and biological influences in young people's development. *'This is of paramount importance when considering the PSHE needs of young people in relation to gender, class and race'* (Ryder and Campbell 1998:95).

Both this and the example from my research show the significance of the starting point for PSHE curriculum being the knowledge and experience that the young people bring. However, this approach may not fit with that of some professionals who may view their role as getting individuals to change their behaviour, unaware of the adverse effects this may have when *'expert power in health education relationships have the potential to diminish client self-esteem and sense of control'* (van Ryn & Heaney 1997:687).

PSHE and Connexions

Using the PSHE process within the Connexions framework could provide a means of promoting young people's health in a positive way rather than focusing on negative behaviour that experts may regard as undesirable. It offers the opportunity to address both individual and social issues through a learning process to which Connexions aspires (DfEE,1999:32). The Connexions strategy indicates that this will be a negotiated process, with a *'general agreement' that 'young people should themselves be involved in deciding opening hours, location and type of premises, range of services, quality of services.... personal advisors and confidentiality'*, (DfEE, 1999:56). This raises questions about who would be PSHE workers within the Connexions context. Initially teachers would seem the obvious choice but youth workers are used to the informal approach that PSHE implies (Bloxham, 1999). As Connexions aims to embrace a range of professionals, there is scope to utilise the magnitude of skills and experience they bring alongside further training.

In the Connexions document details of the training are unspecific apart from noting that it *'will need to be consistent with any developments in the reform of social work'*(DfEE, 1999:46). The contention in this article is that training will also need to develop the PSHE ethos and expertise within the team as a whole, in order to address the range of young people's developmental needs including health.

For many health professionals this will mean relinquishing the locus of control provided by a medical model and viewing young people as part of the change process rather than as recipients of advice and guidance. This could involve working with individuals or small groups on information sharing and discussion projects in a youth work setting rather than providing information points, clinics and centres which some young people may feel unable to access. Rather than starting with negative behaviour, the broader approach offered by PSHE should enable practitioners who work with socially excluded young people to build levels of self-esteem and confidence that lead to the empowerment of the individual:

> *By engaging in a participatory process in which all information, decision-making power, and other resources are shared, we avoid the potential for creating problems that are worse than those we are trying to address.*
> *(van Ryn & Heaney 1997:698).*

PSHE practice involves an awareness of the role of power within the health promotion process which van Ryn and Heaney describe *as referent power, informational power, expert power.* While expert and informational power are seen as giving limited autonomy to the recipient, referent power *'exists when a client feels valued by, likes, esteems, identifies with and trusts the formal helper'* (van Ryn & Heaney 1997:685). Whilst there will always be differentiated power relationships within teaching and learning environments and professionals and service users, acknowledging these differentials, and working to understand their impact on the young person, is an integral part of PSHE practice.

Informational power arises from the level of information the practitioner holds and imparts to the young person, the manner in which the information is conveyed, and the amount of information absorbed by the student. These factors may vary according to the perceived needs of the student, relevant legislation and the values of the host organisation. The information giving approach lends itself to value the student as a 'receptacle' for facts rather than a participatory agent. But informational power can be effective when coupled with referent power:

> *Thus, the presence of referent power enhances the likelihood that the information health educators provide will have an impact on client beliefs, attitudes and behaviour and thus facilitate progress toward health promoting goals*
> *(van Ryn & Heaney 1997:686).*

In many ways the two can be linked to Ryder and Campbell's educational model of PSHE which aims to provide young people with a range of knowledge using a variety of teaching and learning strategies.

Expert power draws parallels with medical models of PSHE, holding the professional practitioner as the fountain of knowledge. The student is expected to accept the information offered as being the ultimate truth and acknowledge the expertise of the health educator. Whist this method of delivery may be effective for the imparting of factual information to groups or individuals it is not suitable for young people whose experience of authoritarian figures is negative. Factual information may be important but putting it in the context of the lifestyle of the individual is more important. For example, a report in the Guardian (11th December 2000) on the government's decision to make the morning after pill available without prescription was welcomed by many agencies working with young people. Yet without the knowledge to

understand its usage or the confidence to purchase it from the pharmacy, its potential will be reduced. Putting PSHE in the context of the lifestyle of the individual not only requires a greater level of skill and understanding in the worker but can be daunting for young people who have low levels of self-esteem and confidence. Information may appear to be irrelevant, or unobtainable; they may view goals and aspirations as out of reach; they may not see the point of changing their lifestyle or value systems. This is where the ability and expertise of the practitioner comes into its own. It is not the quantity of information that is important in PSHE with young people but the method of delivery at whatever level: '(the) *empowering process is as important in micro levels of practice as it is at the community level.*' (van Ryn & Heaney 1997:691).

For those committed to informal education through a youth work approach the principles and practice of PSHE as described above will be familiar territory. The question is can this be integrated across the Connexions team?

Conclusion

Overall, within the context of PSHE, young people need to be given support and guidance in their move to PCET without being coerced into accepting value systems that are alien to their lifestyles. Indeed the Campaign for Real Education's (2000) claim that PSHE is 'totalitarian' is completely opposed to the approach to PSHE advocated here. PSHE should be an empowering experience that aims to put the young person at the centre of the learning and decision making process, moving away from prescriptive teaching and learning methods to allow the student to explore and contest relevant social and health related issues in an environment where they feel comfortable.

Health is a complex issue with many conflicting areas that need to be questioned in order for the young person to work towards positive health strategies. Social and environmental factors have an overriding influence on health from a very early age, and need political measures and responses that are outside the scope of the PSHE process. Current policy acknowledges the high level of under, and non achieving, school leavers whose health, especially mental health, may be affected long term by not finding a sustainable role within society. Developing positive health practice, and a sense of self worth, may not be easily achieved through conventional teaching and learning strategies and service responses geared towards 'advising and guiding' young people. Thought and creativity needs to be applied to assist young people who have been on the fringes of society, and the education system, to undertake PSHE programmes that may assist in developing their personal and social skills as well as promoting positive health practice.

PSHE is part of the national curriculum, undertaken with varying commitment and effect in schools. For those students outside the mainstream school system its potential benefits may be unobtainable. Investing in a PSHE system within the Connexions strategy, can only be an asset to the social wellbeing and health of some of the most vulnerable young people in society.

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CLASSIC TEXTS REVISITED

Classic Texts Revisited

Robert Baden-Powell
Scouting for Boys
London: Pearsons 1908

TOM WYLIE

The creation myth

Religions, and nations, have their own creation myths. So do many youth organisations. It is little surprise that what became the world's largest youth movement has its own tale to tell of its creation and of its creator. Their story is as follows: as the twentieth century opened, one of Britain's few heroes in the Boer War, Robert Baden-Powell ('B-P'), defender of Mafeking, returned home with some half-formed ideas about character development in boys. He tried these out in various lectures and tried to persuade the leaders of the few existing youth organisations to adopt them. He piloted the approach in a summer camp for twenty-two boys mostly aged 13–16 on Brownsea Island in Poole Harbour in 1907. The following year he set them out in a series of booklets under the title 'Scouting for Boys', published in six fortnightly parts at a cost of 4d each. Boys eagerly seized the serials, met around lamp-posts, formed themselves into Scout patrols, adopted a crude uniform and persuaded an unsuspecting adult to act as a Scoutmaster. Within months these spontaneous troops had to be shaped into an organisation – the Boy Scouts. When, at a great rally in 1909, girls turned up as well he set up a parallel organisation – the Girl Guides. Over the course of the next century, despite two world wars, the organisations grew into the greatest youth movement the world has seen, with some 25 million current members and 500 million former members in 150 countries. *Scouting for Boys* probably outsold every other title in the twentieth century apart from the Bible.

It is a fine tale and the core of it is true, if romantic. It is doubtful, for instance, that many boys purchased their own handbooks which required not only cash but quite a high level of literacy. Later studies also show how well-organised the movement was even from its earliest days, building on existing local groups (such as the 'Legion of Frontiersmen' and even the 'B-P Anti-cigarette League'). Arthur Pearson was nearly as important as Baden-Powell in Scouting's creation. Pearson, a newspaper publisher, had, from 1906, been encouraging Baden-Powell to draw up a scheme with its own handbook for the education of boys as Scouts. Pearson saw the commercial attraction not just of the original series but the possibility of a weekly newspaper *The Scout*, designed for a new organisation:

indeed, it was soon selling 100,000 copies. The ideas which Baden-Powell used as the basis for Scouting did not come exclusively from his own imagination or army experience but drew also on the writing of Ernest Thompson Seton, an American who had gathered an appealing set of stories about native Americans and backwoods experiences and had created an embryonic badge system to promote achievement in young people. Some of these themes would also find their way into the later Woodcraft Folk movement.

Whatever their exact provenance, Baden-Powell's ideas speedily took organisational form. They were attractive to young people who lacked other diversions - no TV or even cinema or radio, few youth organisations. They also tapped into concerns in adults about young people's health and their readiness for military service, should it become necessary. They may well have proved particularly attractive to the 'respectable' working class as well as, more obviously, to the middle classes.

By the end of 1908, membership of Scouting had already outpaced the rather more militaristic and Church-based Boys Brigade and the junior YMCA. By 1910 Baden-Powell had left the Army, ploughed the royalties from 'Scouting for Boys' into his new association and distanced it from Arthur Pearson. He put in place an elaborate infrastructure fanning out from its London headquarters, across the country and Empire. Marrying Olave in 1912 (half his age, she replaced his sister as Chief Guide after a bitter power struggle), Baden-Powell oversaw the growth of Scouting throughout the world, not least in the United States, was made a peer of the realm, and died in Kenya in 1941 aged 83.

Baden-Powell: the man

Winston Churchill was to write of B-P that he created '...an institution and an inspiration, characteristic of the essence of British genius... It is difficult to exaggerate the moral and mental health which our nation has derived from this profound and simple conception'. But Baden-Powell, and his organisation, had critics, satirists and revisionists from its earliest moments. He, and it, were a good deal more complex than its defenders or attackers often allowed. And the movement itself unconsciously permitted those involved, young people and adults, to attribute different meanings to their attachment.

Some criticised B-P's role in Mafeking, his alleged disregard there for native soldiers and of Scouting's role in preparing young people to accept military discipline or, for some critics, in promoting an escapist

refuge in nature from the world's realities. He was seen by some, and indeed presented himself, as a Peter Pan figure never quite growing up. A fairer picture of Baden-Powell would suggest that he was a man of his time, shaped by a specific class and military background (although he had little time for military drill or organised religion), and who genuinely believed that 'I wish I had time to tell you the story of how we came to have this [British] Empire. It is a wonderful tale of adventure and romance....' But even before he wrote *Scouting for Boys* he had expressed his hopes for international peace: 'he would like to see all nations brought up to a high standard of brotherhood so that there would no longer be heard rumours of wars'.

Before starting Scouting he had written to William Smith, the founder of the Boys Brigade,

> *the ulterior object...[of a scheme of Scouting] is to develop among boys a power of sympathising with others, a spirit of self-sacrifice and patriotism, and generally to prepare them to become good citizens... spotting people in everyday life who were wanting help, and helping them in however small a way.*

And, in the first edition of *Scouting for Boys*, he would write: 'the Socialists are right in wishing to get money more evenly distributed so that there would be no millionaires and no paupers'.

So much for the man, what of the book itself?

The book

A key point is it was written primarily for young people themselves ('Part 6', the final section, laid out for adults the principles and methods Baden-Powell was advocating for youthwork). Each chapter was presented as a 'campfire yarn' and the whole tone including use of the author's own illustrations, sought to suggest that young readers would not just read about adventures but have them. The outdoors was to offer the site for many of these so a good deal of the text is devoted to camping lore and skills. Each 'yarn' blends exhortation, tales with a character-building moral, the odd mystery, and a raft of tips – about how to locate north in the night sky, or bake bread over a campfire, or recognise particular birds or trees. Much of the text is devoted to helping readers build their powers of observation - tracks in the sand or in the woods - or their skills in first-aid. As an aid to the goal of 'Be-Prepared', explanations are given on how to stop a runaway horse or deal with snakebite or rescue

someone in a fire. There are tales of derring-do drawn from Africa, America, the frontiers of the Indian Empire. There is advice on how to grow strong and stay healthy: Baden-Powell is in favour of fresh air and against smoking, drinking and masturbation. Moreover, in a theme developed more fully in his later book *Rovering to Success*, he advises on the conduct of interpersonal relationships – 'don't lark about with a girl you would not like your mother or sister to see you with'. There is much emphasis on chivalry with stories of King Arthur and of St George, who was presented as Scouting's patron saint. The concept of the good turn is introduced: 'Don't think of yourself, but think of your country and the good that your work is going to do for other people'. It's not quite J. F. Kennedy's inaugural address of fifty years later but we're in the same moral territory.

This was not the only feature of his writing which would pre-figure later social policy prescriptions. Baden-Powell's stern warnings against a boy becoming a 'waster' or a 'loafer' would find an uncanny echo nearly a century later in the analysis of David Blunkett, Labour Secretary of State for Education and Employment of 'a disconnected generation... a nocturnal society where people get up at lunchtime, stay up to the early hours and make their neighbours' lives a misery'.

And one might discern also a prototype of the Blairite Third Way in this exchange with Baden-Powell by one of his early lieutenants: 'What you must do is find a common ground for moderate imperialists and for non-conformists who do not like militarism... it will require prophets such as you and I to join the ends'. Joining the ends, however, may well have required him hold to in his head two dissonant concepts – how does one create autonomous, free-spirited individuals who nevertheless accept the social status quo?

Of course, some of the tales in the text are quaint to the modern eye; some even edge into what we would now view as racism or sexism. But when all the advice and the stories are peeled away, at the heart of *Scouting for Boys* is a philosophy and a method of youth work. The philosophy derived from Baden-Powell's long-standing concern for character formation, for the combination of young people's physical and moral health which he found neglected in English schooling of the day and, more deeply, with individuality. His own time in the army had been one of rather idiosyncratic behaviour, indeed his defence of Mafeking provided ample proof of his eccentricity and capacity for amateur theatricals

and self-publicity.' So, in part 6, it is not surprising to find him urging on Scoutmasters - 'the most important item of all – the promotion of character... is the most difficult to carry out in practice since it needs the separate study of each individual mind and its development from within.'

But it would be wrong to see Baden-Powell as defining youth work as something which only adults did. Rather, his emphasis was on boys organising themselves in their peer groups – Scout patrols: 'His unit is the band of six, commanded by their own boy leader. Here's the natural gang of the boy, whether for good or mischief. Here's responsibility and self-discipline for the individual'.

These patrols would be the basis for Scout activity and the collective meeting of patrol leaders, the 'Court of Honour', would be the basis for decision-making about the activities of the scout troop and the behaviour of its members. The demands of running an organisation acceptable to parents and the wider society would soon get in the way of this vision, so that Scout leaders tended, in time, towards the authoritarian rather than libertarian. By the 1920s, Baden-Powell himself was warning his own national leadership of its tendency to neglect 'the Spirit' in favour of 'the Form'.

The text itself holds a balance between which activities are for the patrol and which for the individual within the group. The binding device and centrepiece is the Scout Promise and Law to which all new members would subscribe in a ritualistic ceremony. In the original *Scouting for Boys* Baden-Powell presented his code in nine Laws, a tenth was added later and, in the late 1960s, they were reformulated to seven much to the displeasure of Olave Baden-Powell. In today's world these Laws appear a curious mixture: the autocratic 'A Scout obeys orders of parents, patrol leaders and Scoutmasters' sits alongside 'A Scout smiles and whistles under all circumstances'. But all were couched in a positive form - they were an expression of what a Scout is, rather than what he is forbidden to do.

And how are we to read the fourth law which became: 'a Scout is a friend to all and a brother to every other Scout, no matter to what country, class or creed he may belong'? Was this simply an attempt to smooth over class and other distinctions by a paternalist who disliked extremes of wealth and poverty? Perhaps: but, in a world sharply riven by national and racial tensions it was also to act as a constant lodestar for Scouting's internationalism. The World Scout jamborees, held every four

years from 1920, were a constant reminder of Baden-Powell's growing commitment to the role of Scouting in international peace-building, not just the nation-building with which he had begun in the original *Scouting for Boys*. By 1936 he was urging: 'our patriotism should be of the wider, nobler kind which recognises justice and reasonableness in the claims of others'. This stance may well have taken him into a rather naïve, if short-lived, attempt to encourage good relations with the emerging fascist youth organisations on the continent. And the organisation itself would be tested as it sought to sustain its inter-racial brotherhood in India and, especially, in South Africa.

For individuals involved in Scouting there could be a strong tug in the hidden curriculum of the text between two of Baden-Powell's key concepts: his encouragement towards joy - 'laugh as much as you can: it does you good' and his rather more frequent invocation to respond to the demands of duty. In his identification of what constitutes the good Scout he picks out fair play, loyalty, cheerfulness and 'duty before all'. It was a sense of duty, perhaps, which took six of the young men who had been on Brownsea to their deaths in the killing fields of Flanders within a decade. But while 'duty' can be a stern and demanding master, it was also meant to be expressed altruistically – 'a Scout is active in doing good, not passive in being good'. And *Scouting for Boys* offered firm views on the issue of citizenship, a topic which lay close to Baden-Powell's heart: 'Education in citizenship as a subject can scarcely be considered complete unless it gives the pupil the opportunity of expressing in practice the spirit which it inculcates in theory. And that is difficult in a school'.

The longer view

The educational ideas of Baden-Powell expressed in *Scouting for Boys* were to be endlessly re-formulated and re-examined within the movement which he founded. He revised the text within a year and it would eventually go into several editions, each one trying to adjust the original carefully to the changing world, especially after World War 1, and to the emergence of Scouting in countries outside the British Empire. Only in 1967 did Pearson eventually concede that the book was possibly on a declining market: by then there were limits to the likelihood of boys in Britain's backstreets expecting to have to stop a runaway horse.

Baden-Powell himself wrote a further twenty-four books expanding his philosophy and methodology. None, of course, captured the excitement of *Scouting for Boys*. They did not need to. In that work he had created an

approach which was right for its time – and, would, when re-modelled, prove right for many more, well beyond the class assumptions and values of Edwardian England.

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Scouting for Boys was turned from a serial into a single volume within a few months in 1908. Reprinted four times in the first year alone, almost forty editions were produced over the next seventy years.

A good general account of the origins and early growth of Scouting *is B-P's Scouts: an official history* (Collis, H et al; 1961). But this work and the first major biography of Baden-Powell, *Baden-Powell: two lives of a hero* (Hillcourt, W; 1964) tend towards the hagiographic. Critical accounts of the man and the movement include *Youth, Europe and Society: British Youth Movements 1883-1940* (Springhall, J; 1977) and *The Character Factory* (Rosenthal, H; 1986). Notable interpretations of Baden-Powell and of Scouting from within the organisation *include Baden-Powell Aujourd'hui* (Scouts de France; 1975) and *Scouting and the Open Society* (Loades, D; 1977).

But by far the best, balanced, definitive history is *Baden-Powell* by Tim Jeal (1989).

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Combating Educational Disadvantage – Meeting the Needs of Vulnerable Children
Falmer Press 1999
ISBN 0 750 70900 6
pp 281

Celia Bark

Against the backdrop of New Labour's Third Way 'Education, education, education' lies at the heart of combating inequality (or social exclusion as it is referred to in the current discourse). This book aims to locate the discussion and debate surrounding educational disadvantage within the socio-political context of the 1980s and 1990s and the marketisation of education.

Part 1 examines educational disadvantage experienced by particular 'at risk' groups.
Within this section, there are chapters on the new perspectives on disadvantages for people from minority ethnic groups; boys' underachievement and changing masculinities; pupil absenteeism in primary schools; promoting educational achievement for looked after children and social disadvantage and disruptive behaviour in school.

Part 2 focuses on a variety of approaches to meeting the needs of disadvantaged children.
This includes recognising difference; reinterpreting family involvement in early literature; early childhood education and pupil perspectives on their education. There are also chapters examining school improvement, the role of the LEAs and international perspectives. Chapter 15 is a piece about life long learning as a concept that needs contextualising in a cradle to grave sense.

One of the challenges of producing a book that tackles such a current live and ever changing issue, is that there is a risk of developments overtaking the debates within some of the chapters. I say this particularly with regard to chapter fifteen. This article contains no reference to the work of Coffield, Eraut, the National Strategy for Life Long Learning or the work of the Economic and social Research Centre (ESRC) although this is mentioned in Cox's overview.

As a reviewer with a Social Work and Social Welfare background, I was interested in reading a text that aimed to promote the meeting of the needs for vulnerable children, especially against the backdrop of so many social welfare initiatives aimed at challenging the impact of inequality (the Sure Start Scheme: 1998, for example). I was concerned however,

that some aspects of the book were heavily laden with the language of exclusion. For example the book refers to 'the disadvantaged' and the 'ethnic minorities'. This is the language of exclusion because it fails to take account of 'people' and hooks straight into labels. You may feel this is somewhat pedantic of me but I believe it is important to regard children and young people as the partners in education rather than the objects who are exposed to a process.

In terms of vulnerability, the book does not refer to child sexual abuse or, to any great extent, bullying (other than in Chapter 12 where bullying is mentioned in terms of those most at risk and some preventative measures). The impact on children of such life events will have potentially massive implications for their achievement within an educational setting. They demonstrate the impact of community and family experiences on the creation of emotional and social unmet need. A greater use of research from social work and social welfare could have given the book a greater depth. I say this particularly with regard to the operation of oppression in the creation of vulnerability and social exclusion. Obviously, I say this because I am informed by the knowledge base for social work and welfare but I cannot help thinking how cross fertilisation of ideas would enrich understanding and reflect the current political discourse of New Labour's Third Way in terms of partnership and inter-professional collaboration.

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Nick Luxmoore
Listening to Young People in School, Youth Work and Counselling
Jessica Kingsley Publishers 2000
ISBN: 1-85302-909-2
£12.95
pp.144

Tony Jeffs

This is a book which a goodly number of youth workers will thoroughly enjoy reading. Photocopied chapters are going to be passed from worker to worker, whilst some sections will be long employed on training programmes to provide a focus for discussion. It is definitely one of those books. The sort you ask yourself – why didn't someone think of doing this before? Accessible,

serious and unapologetically written with the practitioner in mind, it promises to have a lengthy shelf life and find a ready audience.

Listening to Young People is written by someone with an understanding of youth work, with a sympathy for it. Here is a text which grasps the essential reality that you cannot measure the outcomes of youth work except by the use of crude short-term means of calibration. That youth workers have to work through conversation with groups and individuals and can 'never really know when they've helped' (p.101).

The format is simple in the extreme. Ten short chapters initially written, the author tells us, as a series of occasional articles for friends and colleagues whilst he was working as a school counsellor and youth worker. Designed one assumes to encourage dialogue between practitioners and help the author reflect on his own practice. They read like conversations and are all the better for that. Drawing continuously on exchanges with young people, significant incidents and the events that fill the daily round of practice, the end result is not dissimilar to that of sitting down to enjoy the company of an enthusiastic youth worker. One who wants to share that enthusiasm with anyone willing to lend an ear.

Each chapter discusses an aspect of young peoples' lives. The choice is random but that hardly matters for all deal with a cross-section of the concerns, anxieties and behaviours that youth workers, teachers and counsellors encounter daily. For example one considers the squabbles and falling out which beset young peoples' relationships with each other. With typical compassion it commences by reminding us of the need not to complain of the 'pettiness' of 'their nagging, trivial stories' (p.35) but to acknowledge the extent to which squabbles can impinge on the lives of those experiencing them. It asks the reader to recognise the vital importance of relationships to young people, the unpleasantness of being used as an emotional punchbag, the fear of isolation. Then as with the other chapters it considers how workers can engage with young people to enable them to deal with their 'issues'. This chapter also offers a helpful exchange of ideas regarding the challenges likely to be encountered in operating alongside a peer-counselling programme. As with all the other ten it introduces the reader to a number of useful exercises and activities the practitioner might usefully employ. In fact the book is a compendium of group exercises carefully interwoven within the narrative of the text.

A particular favourite was the chapter on young people's use of joking. A contribution that, perhaps for the first time, pays serious attention to an activity which lies at the very core of youth work – laughter and the creative use of humour by workers and young people alike. Long convinced that it

is impossible for anyone lacking a sense of humour to be a youth worker the author confirms that prejudice. However like a true educator Luxmoore identifies the learning opportunities inherently contained within 'having a laugh', for example, 'the task of helping them to laugh with rather than at each other' (p.92).

Although built around examples of practice this is not merely a collection of off-the-peg accounts of working with young people. The author, much as he weaves into the narrative examples of useful exercises and games, seeks to draw upon research findings and theoretical insights the reader, who may be unfamiliar with the literature, will find helpful. The end result is a minor gem. A book like Hazler's *Helping in the Hallways* that succeeds in achieving the almost impossible task of offering something for everyone. The cynical old-timer who has seen and done it all and the nervous beginner unsure where to begin (or stop) along with all the gradations between will 'enjoy' reading this book. They will surely put it down with a sense that reading it was time well spent.

Tony Jeffs *University of Durham*

Reference

Hazler, R. J. (1998) *Helping in the Hallways*, Corwin Press.

Kerry Young
The Art of Youth Work
Russell House Publishing 1999
ISBN 1 898924 49 X

Stephen Harrison

The Art of Youth Work is an exercise in identifying the core purpose of youth work. It is split into three main sections. 'Philosophy', 'Practice' and the concluding section 'the Art of Youth Work' which seeks to synthesise the previous two. Young's research is based upon the testimony of youth work practitioners from a wide range of settings and an examination of key thinkers concerned with moral philosophy. The book is essentially concerned with identifying a unifying imperative for youth work.

Probably anybody who has entered into youth work at whatever level has been confronted with the question posed by the uninitiated 'what is youth work?' Trying to explain to friends and families the value of what we do is never an easy task. This is understandable as the values appealed to in the name of youth work are not always self evident in the activities we

undertake. Equally it is not surprising the same question can and often does cause some considerable level of debate amongst practitioners, themselves trying to locate the essence of what 'youth work is'. Witness the debates, discussions and ongoing drafting of National Occupational Standards for Youth Work, or the current attempt to distinguish between Youth Work and Work With Young People (not to mention Informal Education and Life Long Learning). The field of youth work in its widest possible sense represents a diverse and disparate range of practices, activities, values and beliefs.

It is then either a courageous or foolish exercise to make any attempt at a definitive statement about the nature of 'youth work'. I should say it is my view that Young's undertaking represents the former rather than the latter.

The central question that the *The Art of Youth Work* is concerned with is the nature of youth work, the common qualities that unite various forms of activity within the practice of youth work. In writing this book Young has undertaken a task that many would baulk at. In this book she has sought to describe the philosophy of youth work, how this is manifest in practice and subsequently draws this endeavour together to make substantive claims about the nature of youth work. This is as the author identifies within the introduction a 'brave' and 'bold' piece of 'work'.

The book's potential readership falls mainly between two stalls. Firstly she writes for the practitioner wishing to give voice to the values that underpin their practice and secondly it will be a useful text for students at any level wishing to undertake a critical analysis of youth work practice and philosophy. Both these groups are reasonably well catered for. The mix of examples from practice and a commentary that seeks to make connections with broader bodies of knowledge means one will not get bored quickly as can be the case with more dense philosophical works. However at times the mix can become tiresome as the reader tries to locate and follow Young's underlying arguments.

Young's 'fundamental' assertion is that 'youth work is an exercise in moral philosophy'. This type of statement is made throughout the book and typifies the positivist approach the author has adopted. Of course emphatic statements concerning the nature of youth work, as with other areas of practice, are subject to criticism and counter claim. It is in this sense that 'youth work' is a contested concept.

Therefore why should we accept the above claim? On what premise has it been made?

Young has certainly put a great deal of work into establishing the basis of her claims. Extracts and quotes from a range of people involved in youth work (32 in all including an assistant director of a national youth agency,

youth work managers, practitioners and volunteers and a number of young people themselves) are included to give some empirical basis to her claims. The quotations included are on the whole undigested and whilst providing a potential starting point for philosophical analysis in practice they have the appearance of adorning an investigation beginning in the abstract. Equally the author has invoked a wide range of thinkers from Aristotle and Plato's Socrates in ancient Greece through to Educationalists, Sociologists and Psychologists of more recent times with varying success.

This all leads to what is quite a complex read. The reader is driven to read the book from start to finish for two reasons; firstly because what the author has to say is interesting, secondly because it sadly lacks an index (this could limit its use as a reference text particularly for student practitioners).

Reading the title of the book caused some confusion to me. Not because I'm in disagreement that 'youth work is an art' but because a title such as 'the nature of youth work' might have been a more accurate description of what is contained inside. For what Young has done is make substantive normative claims as to the nature of 'youth work'. She has from the outset sought to explore what youth work *is*.

In light of this I am reminded of a warning offered by Wittgenstein cited by R.S. Peters in the opening chapter of *Ethics and Education* (1966:23) Here Wittgenstein reminds us that; 'the uses of a word is not always related by falling under a definition as in geometry where definitions are provided for terms such as "triangle". Rather they often form a "family" united by a complicated network of similarities overlapping and criss-crossing; sometimes overall similarities, sometimes similarity of detail.' Peters continues: 'This is particularly true of the sorts of terms in which philosophers are interested; for they are usually very general terms, which have developed a life of their own in a variety of contexts'.

In light of this it might be more useful to not think of youth work as having a 'purpose' *per se*, but what makes those activities made in the name of 'youth work' worthwhile? This kind of evaluative endeavour means that laying specific claims to the nature of youth work would severely limit the evaluative framework. If for example we accept Young's assertion that 'youth work' is an exercise in 'moral philosophising' then does it follow that all should be judged in this light? Therefore that which is not concerned with moral philosophising is not 'youth work'. What then are we to do with the rest?

This I believe is the danger in the approach and arguments put forward in this book. In laying specific claims we limit the potential for understanding

the importance of what we do in the name of 'youth work'. Furthermore why should we limit our understanding of 'youth work' simply to moral philosophising and not extend it to philosophising *full stop.*

What the book does well is outline some of the concepts relating to adolescent development, the nature of moral deliberation and its relationship to 'youth work'. It in effect seeks to locate current 'youth work' practice within a philosophical context.

Young usefully draws upon virtue theory as well as some of the ideas behind critical thinking, autonomy and moral development. However as far as I can see much of what has been offered is rather conservative and largely ignores some of the criticisms levelled at the nature of moral development and the over emphasis upon the role reason has to play - all particularly important to those who might be interested in thinking further in this area. It is in this area that the work fails to engage significantly with feminist philosophy and postmodernism for example. Furthermore the over emphasis on the moral has offered no real engagement with the political, a mistake due to the inextricable relationship they find themselves in.

Whilst the fundamentalism and reductionism of the author's approach leaves this reviewer more than a little uneasy, *The Art of Youth Work* does prove to be a book which will provide the basis of much needed discussion about youth work practice and its underlying philosophies.

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Rachel Pierce and Jenny Weinstein (eds)
Innovative Education and Training for Care Professionals:
A Providers' Guide
London: Jessica Kingsley, 2000
ISBN 1-85302-613-1
£17.95 (pbk)
pp 254

Mary Issett

This book presents a wide-ranging contemporary review of many of the key issues relevant to professional education and training. The focus is on social care, with much of the discussion and illustrative material based on the experience of using occupational standards and competence frameworks in social work.

The material presented includes reports of research on specific programmes or topics, such as quality and assessment, as well as discussion of the broader issues of historical and international comparisons in social work education, research-mindedness, professional development and lifelong learning, inter-professional education, the legal context, and partnership working. An important theme is concerned with the development of anti-discriminatory practice as an essential component of social work, and this is further considered in relation to overcoming barriers of access to professional qualification, and the involvement of service users in the training of social workers and other care professionals.

In the past there have been fierce debates within social work, as has indeed been the case within youth and community work, about the desirability of the competence approach for accrediting professional qualification. Although Dominelli, in her chapter covering international comparisons, argues that the competence approach is attractive to increasingly bureaucratised, privatised social work services in a number of countries, for this book debates about competence are largely a thing of the past, and the approach seems firmly established. Dominelli goes on to identify positive aspects of the information super-highway suggesting that this can lead to learning more about 'bottom-up' solutions from other parts of the world, and the promotion of shared values between nations.

The prevailing thrust behind those chapters that have competences and occupational standards as their concern is on how to make this approach work to develop professionals who are qualified to deliver services within the care market. Readers who remember the earlier debates about the shift to work-based learning, will be familiar with concerns that whilst it is important for professionals to demonstrate competent performance, it is also necessary to demonstrate understanding. A number of chapters are concerned with the integration of theory and practice and produce models and case studies based upon experience of working with outcomes-based competence approaches to show how this integration can be achieved.

The title proclaims the work as 'a providers guide' and within the text there are a number of useful illustrations and exercises that could have a wider application outside the social care context. Much of the illustrative material is concerned to enable those undergoing training, and as a consequence training providers, to think about the way they are approaching the theory/practice divide.

The book highlights a number of contradictions that are ever present within vocational training in caring work and contrasting views are presented. A

number of authors refer to the tensions between higher education providers and the requirements of employers, a theme that recurs in youth and community work. Some examples of long and fruitful partnerships are discussed in detail, with reflective lessons drawn about the secrets of their success. Other chapters show how the different political and financial pressures on higher education institutions and fieldwork agencies may lead to different agendas, with the need for creative thinking and action to preserve important principles.

A suggestion that goes against the stream of current thinking in the chapter by Rowlings, is that there may be advantages in the gap between higher education and the field which many partnerships are currently trying to close. She argues that social workers need a rigorous intellectual training to deal with the challenges and complexity of practice and wonders if a 'more honest arrangement than we currently have' (p 59) might be to have the practice qualification following on from academic assessment.

An irony that emerges elsewhere in the book is that whilst there is an emphasis on work-based learning this has not always led to increased resources, and the ability of the field to deliver good quality placements may be as severely constrained as it ever was. Examples are given of how in certain subject areas, for example, the law, this may be compensated through simulation exercises and case studies and that these may be more appropriate than the available practice in some instances.

The chapter on lifelong learning also notes that in today's world of social care competence is short lived. In order for professionals to remain up to date in theory and practice, and enthusiastic about pursuing learning needs, considerable resource investment is required. This should not only be about enabling practitioners to accredit and enhance their knowledge and skills, but in communicating the vast array of educational and training opportunities available to them.

Overall, the book is worthy of attention from those engaged in training for youth and community work whether from a higher education or fieldwork base. A number of the issues that the authors rehearse will be familiar as I have indicated. The implications of working with competence frameworks devised through functional analysis is more deeply embedded in the social care context than in youth and community work, and the problems and issues raised and solutions identified will therefore be of interest.

***Mary Issitt**, is a Senior Lecturer at Crewe and Alsager Faculty, Manchester Metropolitan University.*

REVIEWS

SHORT CUTS

Concept Northeast
Under the Surface
Concept Northeast 2001
ISBN 095 11 372 55
£5.00
pp 46

Dod Forrest, Sheila Wood and Tony Glendenning
Education for Citizenship: Evaluating the effectiveness of community education supported youth work in Aberdeen
Aberdeen City Council 2001
ISBN 095 11 37247
£3.50
pp 80

Les Johnson, Robert MacDonald,
Paul Mason, Louise Ridley and Colin Webster
Snakes and Ladders: Young people, transitions and social exclusion
Policy Press/Joseph Rowntree Foundation 2000
ISBN 1 86134 290 X
£10.95
pp 40

Alasdair Forsyth and Andy Furlong
Socioeconomic Disadvantage and Access to Higher Education
Policy Press/Joseph Rowntree Foundation 2000
ISBN 1 86134 296 9
£12.95
pp 40

The first two titles are available from Aberdeen City Council, Summerhill Education Centre, Stronsay Drive, Aberdeen AB15 6JA

Tony Jeffs

Under the Surface is a collection of articles and reports that emerged from a study group of practitioners involved with the Scottish journal *Concept*. The contributions vary in length and purpose but there is something here for most readers. All emerge from the work of individuals involved in Community Education in the City of Aberdeen. Dod Forrest provides a useful discussion of the role of evaluation and research linked to practice. Whilst Karen Forrest offers a sharply observed account of

practice that rightly reminds us of the dangers inherent in the 'recording culture'. An approach that requires workers to constantly collect data on their own work and the behaviour, beliefs and attitudes of those they work with. The account of what happened prior to the opening in 2000 of the Mastrick Youth Café by Sheila Wood not only gives a helpful overview of how new projects are born but reminds us of the variable timescales different groups of participants hold. Publications such as this are invaluable and one hopes other groups of practitioners will follow this example and draw a wider audience into their debates.

The second publication from Aberdeen is a report drawing on the findings of a substantive research programme designed to assess the effectiveness of youth work within the City. Forrest, Wood and Glendinning between October 1999 and June 2000 gathered responses from in excess of 1200 young people who were in contact with the youth service. They also over a fortnight observed a quarter of the youth work sessions taking place in the City. It is by any measure a substantive piece of work. The results indicate high levels of satisfaction amongst young people with the quality of the service being offered. For me the most telling point was the extent to which the same young people were engaged with different forms of youth work provision. Notably there was not an either or divide between detached and centre-based affiliation. The research confirms that those who assume detached work by itself is sufficient do not have the evidence to support such a contention. The report also draws on material relating to for example drug use, school attendance, family relationships and what characteristics young people adjudge a good youth worker is likely to possess. Besides offering useful data this report is likely to prove extremely helpful to any group seeking guidance regarding how to undertake a service wide evaluation.

Likewise *Snakes and Ladders* is also based upon a substantial research programme. The authors interviewed 98 young people living on a Teeside estate. Once a stable working class community the rise of wholesale unemployment and poverty following the loss of heavy engineering jobs in the 1970s and 1980s subsequently wrought terrible damage. The research sought to relate how the young people living there managed to negotiate moving into adulthood. It achieves this by the device of summarising the interviews and by offering six cameos of young people from the estate. The value of these portraits lies in the way they illustrate how diverse individual routes of transition are. They above all else remind the reader of the need to avoid crude assumptions linking outcomes to local-

ity. The study also confirms the findings of earlier research. For example in showing how crime has for some become the 'new work'; the extent to which drug usage and trading have impacted on the lifestyles of many living in such areas; the degree to which these young people tenaciously hold onto traditional aspirations regarding employment, family life and patterns of living. Finally the authors helpfully reflect on how the Connexions programme and personal advisors are likely to relate to the young people in this community.

Johnson et al offer a particularly chilling statistic – one young person within their cohort was in Higher Education whilst 11 were completing their education in prison when the interviews were undertaken. The study completed by Forsyth and Furlong confirms the extent to which such disparities between localities occur. They looked at patterns of entry (and non-entry) into Higher Education within a range of localities. The 16 schools surveyed embraced not merely a wide range of economic variables but also the whole gamut from inner-city to the isolated rural. The findings may surprise few who work closely with young people but it is nevertheless important because it offers hard evidence that takes us beyond the anecdotal. Certainly it would have been helpful if Gordon Brown and John Prescott had read this research before launching their silly and ill-informed attack on the recruitment policies of the 'Ivy League universities'. Forsyth and Furlong take us beyond crude head counting and cheap comparisons by evaluating destinations, showing that economic and social background influence not only the likelihood of entering Higher Education but the type of institution young people find themselves entering. Crucially they show the extent to which it is poverty rather than recruitment procedures that shape the proclivity to take up a university place. However streetwise we may be it never ceases to shock to discover that whereas in some localities 80 per cent of young people proceed to Higher Education in others the figure is as low as 3 per cent.

Tony Jeffs *teaches in the Community and Youth Work Studies Unit, Durham University.*

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Thus, for a book:
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For an article:
Hall, S. (1995) 'Grasping at Straws: The Idealisation of the Material in Liberal Conceptions of Youth Crime', in *Youth & Policy*, No 48, pp 49-63.

And for a report:
The Thompson Report (1982) Experience and Participation, CMND 8686, London, HMSO.

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