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School's out with fever: service provider perspectives of youth with mental health struggles

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ABSTRACT

Youth struggling with mental health issues is a major concern in Norway and other Western countries. As is the increasing rate of youth unemployment combined with high rates of disengagement from education. Rather than receiving support to complete their education or find work, they are often given a psychiatric diagnosis that may camouflage the social nature of their problems. Therefore, a multidisciplinary approach to meeting the needs of the population is called for. Through qualitative and dialogical methods, this study explores how service providers on an outreach team understand why youth are in need of care and what is considered quality care. The article raises issues about the difficulties of youth in an essential societal arena as school. The findings contributes to knowledge on how to develop a collaborative practice in a field of tensions between contradictory policies that require recovery-oriented practice within a discourse of pathologizing youth troubling.

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Mental health; youth;
dialogue; outreach team;
quality care

Background

A major concern in Norway and other Western countries is the increasing rate of youth unemployment combined with high rates of disengagement from education (Barth & von Simson, 2012; Maguire, 2015; Markussen, Frøseth, & Sandberg, 2011). During the last two decades, the rate of Norwegian youth who have not completed educational training in a five-year period has hovered at approximately 30 percent (Markussen et al., 2011). Alternatives to education are few (Barth & von Simson, 2012) as the labor market increasingly requires specialized competence, and jobs that do not require a higher level of education have decreased.

Meanwhile, the percentage of young people struggling with mental health issues is also growing (Bakken, 2018; Croninger & Lee, 2001; De Ridder et al., 2013; Lamb, Markussen, Teese, Sandberg, & Polesel, 2011; Norwegian Institute of Public Health, 2018). Studies have shown that health problems in youth predict weak labor force participation later in life (Pape, Bjørngaard, Holmen, & Krokstad, 2012; Winding & Andersen, 2015). Ose and Jensen (2017) found that mental health problems could camouflage social problems and that, although health, social, and other problems are highly prevalent among youth that are neither in employment nor in education or training (referred to as NEET), most youth want to work or complete their education. However, rather than receiving support to complete their education or find work, youth who are NEET are often given a psychiatric diagnosis that may camouflage the social nature of their problems. Therefore, a multidisciplinary professional approach to meeting the needs of the population is called for.

Extensive political reforms have occurred in the mental health profession in Norway since the 1980s (Ekeland, 2011; Karlsson, 2018). These reforms have led to a shift in the goals of care, from symptom reduction to participation in society, community inclusion, and citizenship (Ekeland, 2011). We have also observed a focus on recovery-oriented practices in Norwegian policies for mental health services, where recovery is understood as both a social and a personal process and for which service users' empowerment and own aims should guide the services provided (Norwegian Directorate of Health, 2014). Despite this shift in policies, biomedical understandings are still dominant in the mental health field. For instance, personal struggles are viewed as illnesses and service providers are often viewed as experts (Aarre, 2018; Ekeland, 2011; Karlsson & Borg, 2017).

In addition to changes in mental health policies, substantial policy changes have been made in the Norwegian public-school system in a move from segregation to integration (Ministry of Education and Research, 1998). In contrast to a segregated model, the shift to one school for the entire population has also opened up new challenges (Thuen, 2008). Thuen (2008) also states that integration contributed to the development of segregated special education that has an individualized understanding of the pathology of special needs pupils.

International discussions on how to strengthen knowledge production that have arisen from research and practice refer to such collaborations as 'bridging the gap' (Salisbury Statement, 2011). This study is a participatory research study that contributes to bridging such a gap. Knowledge was constructed through a collaboration between researchers and service providers that articulated different knowledge forms with each other in a dialogical setting (Phillips, 2011a). In using dialogical research methods, we hope to develop knowledge that will contribute to generating more democratic foundations for changes in practice in mental health services (Aubert & Soler, 2006; Olesen, Phillips, & Johansen, 2018; Phillips, 2011a, 2011b; Phillips, Carvalho, & Doyle, 2012; Phillips & Kristiansen, 2013). We also aim to bridge a gap in the practice field of mental health services in the area of tension created by contradictory policies that emphasize both biomedical diagnoses and understandings on the one hand and recovery-oriented practice on the other hand. These two perspectives are difficult to combine as service providers (Aarre, 2018). Therefore, knowledge about how service providers navigate, develop, and practice in this seemingly contradictory field is of importance in developing quality services. The aim of this study was to explore how service providers in an outreach mental health team understand why young people are in need of care from mental health services and what the service providers consider good care. This study sought to answer two research questions to explore these issues.

- (1) How do service providers on an outreach mental health team understand why the youth they collaborate with are in need of care?
- (2) How do service providers on an outreach mental health team view the provision of quality care for youth in their practices?

Methodology

This study used a qualitative design to examine the research questions within the context of a larger action research project conducted in a circular process of input (dialogues) and practice (Malterud, 2011). Sullivan (2012) argues that dialogue is an epistemology. A fundamental premise of this study is that knowledge is created through dialogue and not something that already exists to be found by the researcher alone. The core of the research project was to develop both practical and theoretical knowledge through a research design that provides opportunities to evolve practices in the community service being researched (Borg & Kristiansen, 2004; Bradbury & Reason, 2008; Kemmis, 2006). These types of methods and designs can make it possible to study human systems from within, where the researcher is a part of the system instead of just observing it from outside (Seikkula, 2011). Together with the participants, we developed a method for

dialogue-based teaching and supervision through what we came to call Dialogical Workshops. In this study, these same Dialogical Workshops were also the site for data collection.

Research context and participants

Participants included providers of mental health services for youth (aged 13–23) as part of a mental health outreach team based in a municipality in Norway. The team was a local community-based social and health service that had clinical contact with youth and their families and provided long-term services. They had a low referral threshold for entry into their services. Service users and families were referred to the treatment team by programs and institutions (e.g. schools and clinics for child and adolescent psychiatry) or through self- or family-based referral. A large proportion of the service users had received treatment from the clinic for child and adolescent psychiatry; however, they were either not benefitting sufficiently or still needed some manner of care from the municipality, but the treatment was about to end.

As part of the team's mandate, they were supposed to support the youth in such a way that enables them to perform activities constituting school or work. In addition, the team was to provide training in social skills and take responsibility for coordinating different services from the welfare system.

In all, eight members of the outreach team participated in the dialogical workshops. The team members had a different education within the fields of social, health, and education. Two of the authors participated in the dialogical workshops in the role of researchers facilitating the workshops and taking part in the dialogues with the rest as participants (AS and BK).

Data collection in dialogical workshops

We conducted nine dialogical workshops once a month in 2017. Each workshop was recorded, for a total of 18 hours. In a dialogical production of knowledge, every participant contributes to knowledge together by dialogically discussing different experiences (Olesen et al., 2018). Through a dialogical approach, the participants contributed to developing themselves and their practices. This occurred within the context of an underlying understanding of the incomplete nature of knowledge and recognition that different participants use different types of knowledge, including research and lived experiences both as professionals and from life as a whole, to create new understandings (Frank, 2005). Heron & Reason (2006, p. 144) state: 'Outcome of good research is not just books and academic papers but also the creative action of people to address matters that are important to them.' Given differences in implementing new practice methods, we believe that knowledge should be developed in collaboration (Karlsson & Borg, 2017). Each workshop was used to dialogue, which was based on the participant's storytelling from the teams' practice. Together, we reflected on the stories and dialogue to understand them in light of every participant's experiences.

Our approach to the dialogical workshops was inspired by the work of Seikkula in developing Open Dialogue (Seikkula, 2011; Seikkula & Arnkil, 2013). Open Dialogue has a collaborative form that focuses on relationships and is organized to facilitate dialogue and cooperation (Ulland, Andersen, Larsen, & Seikkula, 2014). Of the guiding values of Open Dialogue, we develop workshops on the principles of dialogism, responsibility, and the tolerance of uncertainty (Seikkula & Arnkil, 2013). As facilitators, we assumed responsibility for making room for all voices to be heard and created an environment in which tolerance of uncertainty exists, and different voices and opinions could come together around themes that emerged in the workshops.

Ethics

The Norwegian Center for Research Data (NSD) approved the study (52,349). Written informed consent was required before participation and data were made anonymous through the

transcription process by moderating or removing details that could identify participants (e.g. use of pseudonyms).

Analysis

Data were analyzed in five phases using thematic analysis (Braun & Clarke, 2006): (1) recordings were listened to and transcribed word by word; entire transcripts were read to develop an overall interpretation of the data; (2) transcripts were uploaded into Nvivo, and 37 codes were applied to the text; (3) codes were read code-by-code to determine whether both the categorization still made sense and if some of the text belonged in more than one code; also considered was how different codes could be combined to form overarching themes; (4) all themes were checked against their codes and original text to enhance rigor; and (5) two main themes and seven subthemes were defined and named (Table 1).

Findings

Two main themes were identified in the analysis: (1) care from the outreach team; and (2) youth troubling. Each of these two themes contained several subthemes. Further, the themes are illustrated through extracts of participants' dialogues. In the extracts, team members are referred to as 'T1,' 'T2,' and so on, and the researchers are referred to as 'R.' The extracts are translated by the first author.

Theme: care from the outreach team

The main theme that was highlighted and constructed through dialog detailed the views on how to provide care for the youth. The following subthemes were used to explore experiences with care from the outreach team: the need for flexible services, care created in dialogue, comprehension about nearness and distance in professional care, broadened perceptions about valuable knowledge in care, and the backside of flexibility. When asked to describe their practices, phrases such as 'Things take time,' 'We never give up,' and 'We are the red thread' were voiced, indicating that providers were taking a lot of time to develop relationships with the youth to provide help because these youth had been part of many services in the past and lacked trust in the welfare system. They described outreach practice as going on home visits and meeting closed doors for a long period before being let in. Participants described building trust in many different ways, including driving someone to school; frequently sending text messages to show interest in youth; talking to family members and friends of youth; making phone calls to other parts of the service system on behalf of youth; shopping with youth; and helping youth write their own curriculum vitae. Taking responsibility to be 'the red thread'

Table 1. Analytical process.

Text	Codes	Subthemes	Themes
'Where we were available by phone during the holidays.'	Flexibility	The need of flexible services	Care from the outreach team
'... I would rather be moved by a youth ... than just hold on to that professionalism then.'	Professionalism	Comprehensions about nearness and distance in professional care	
'... when it comes to what the school consists of, it makes kids ill.'	School system	School as an ejecting force	Youth troubling
'Which school is best at ADHD ... '	Diagnosis	The welfare system makes diagnosis necessary	

meant that they took the lead in coordinating different services that the youth might be receiving. They also had conversations with different family members individually or with the entire family together. They described themselves as advocates for the youth or negotiators between the youth and their families, schools, and other services. Success was defined as finding aims for their collaboration and helping the youth find a way in life that suited them. These aims were youth-defined; for some, aims included finishing school, whereas for others, aims included making friends, finding employment, or having improved relationships with their parents.

Subtheme: the need for flexible services

The participants agreed that good care in their practices was provided when it was suited to the service users' needs and when it was not office-based, which was viewed as more rigid and less helpful. Care was talked about in light of what the participants understood as the mandate for the outreach team.

T1: That we are supposed to fill just that gap where rigidity and the office-based service is of no use to people.

Care was described as lasting for an undefined period and that no strict boundaries existed when services should end. In dialogues about this topic, participants described having contact over time to remain available for the youth even after the formal contact ended. This example was used to show how good care is provided rather than having a rigid practice based on age or time limitations for treatment and so forth.

T1: Because now I am thinking about the girl that left for Folk High School. Where we were available by phone during the holidays. (...) But that you keep on telling her, I am here for you. Like that, if you come back for holidays, you know. (...) Moreover, that we can be, just sit on the fence and keep on like that. Until it is clear that it is not necessary anymore. I like that.

Subtheme: care created through dialogue

Participants agreed that helping service users define their own treatment aims was essential to providing good care. Ideas about care were created through dialogue among the youth, parents, and service providers. Participants strongly believed that the youth were able to set their own goals for change and that those goals need not be based on service providers' wishes. The dialogues generated the view that the aims and methods to be used should not be predetermined by a predefined portfolio or decided on at a structural level by policies or management on how to give care. The aims should be set at an individual level in collaboration among the team members, the youth, and their network.

R: But who has set the agenda of what the collaboration should be about? (...) How do you invite someone to a collaboration? In addition, who makes the plans about what you should work on together? How did you decide on the methods you use? (...) T1: Yes, the first round is to get him on my team. In addition, to let him see that he has an influence on what we should work on. At least I don't feel the need to make the agenda by myself. I think that we have to make the agenda together, and then after a while. (...) T1: But I believe it is such a good development with the boy, without me demanding or having wishes for what he should change. Moreover, I wish for him, that it should come from him, you know. In the last conversation, he expressed that he wanted to make some changes, and I think that is the best way that it is brought up. Instead of my wishes. That he himself wishes to have routines back in his life. Wishes to be better at showering, even though he finds it difficult. Then, it is much easier for me working towards the aims he put for himself. In addition, on that point I believe I have an advantage not working within a timeframe, and a predetermined number of conversations and so on. I can use time on this.

To provide good care for youth, participants seemed to agree that they needed to have enough time to provide different types of care outside their office settings. In the dialogues, participants' comprehension of how to provide care was framed in opposition to what they experienced from

other services in the welfare system. To adjust practice to the individual's need, they discussed having autonomy as professionals as opposed to being measured and controlled by management.

T1: I find that makes it worth working here. That I have time to think, that I have time to do the things I believe right to do, you know. In addition, use enough time, being a part of school conferences, visit at home, be much more flexible and have time to do that in a way. As I believe to be very important.

Subtheme: comprehensions about nearness and distance in professional care

A central subtheme generated by the dialogues reflected different comprehensions about professional care in relation to the role of both the entire team and its individual members with respect to service users. Participants had different opinions about this topic when talking about nearness and distance in relation to service users. Participants felt that good care was given when they had close relationships with service users. However, regarding some matters, they talked about this outcome as something that was in contrast to being professional in a more traditional understanding of professionalism.

T1: Or in a private setting we are also parents who have stood up for our child. Or been sick or had to talk to someone because life has been difficult. In addition, I think that we shift roles in different parts of life. Moreover, that it is the experiences of vulnerability that moves us. (...) Because I feel that, I would rather be moved by a youth, or a mother, then just hold on to my professionalism then. I think that we are moved when we feel recognition.

Subtheme: broadened perceptions about valuable knowledge in care

Participants highlighted that their ability to provide good care was connected to a reflective relationship in using their own life experiences. They described using the time in their meetings to reflect on their own states of mind and experiences, in both professional discussions and collaborations with service users.

T1: And I feel we had an example of that yesterday, in the team meeting, when we discussed how to think further around a family. Where you bring in some personal experiences that I feel helped improve the discussion. Because you dare to share from your life. That brings in new thoughts and new perspectives. Therefore, I believe it to raise the standards of the profession using life experiences we have.

Subtheme: the backside of flexibility

Although using their own life experiences was considered to improve their professional skills, the dialogues about nearness and distance left participants with a sense of uncertainty around professional boundaries. They needed to consider both the service users' needs and their own when providing care in a flexible manner. In a way, it was understood as the backside of a flexible service.

T1: And I sometimes feel the need to set up boundaries. Maybe that is not right? Like the right boundaries? We get confronted by one's self at all times. At least I feel that. (...) It was easier at the clinic for child and adolescent psychiatry. With the office and that appointment, you know. But when you sort of have to be more out and flexible, that's more demanding.

Youth troubling

A second main theme reflected the different understandings about why the youth were troubling. This theme contained two subthemes: school as an ejecting force and the welfare system makes diagnosis necessary. We define the concept of 'troubling' as referring to youth being affected by

different types of external factors that have an impact on their coping abilities and sense of self-worth and achievements. Participants understood youth themselves as not being troubled; rather, they viewed their troubles as being embedded within different contexts (i.e. school, social situations, families). These troubles were viewed as reactions to poverty, being bullied, having difficulties learning, and so on. Participants did not view these troubles through a diagnostic lens as pathological but, rather, saw the troubles as arising from a lack of adequate social accommodation and support. Participants viewed youth as being held to unreasonable expectations and demands without being provided the means to accomplish or satisfy them.

Subtheme: school as an ejecting force

This view was especially true of the school system, which participants understood to be an ejecting force and an institution embodying a societal discourse on how to be successful and what constitutes failure. Participants described how service users were unable to find their place in school and that their schools were unwilling to accommodate their needs because of the mandate to get every pupil through in a rigid manner. They highlighted that the school system had a direct impact on why the youth were troubling. As the following extract exemplifies, the participants understood the school as an institution that contributed to youth troubling and becoming 'ill':

T1: But I think, when it comes to what the school consists of, it makes kids ill. I read an article that put focus on this, those self-evaluations. That it is harming the ones who struggle in school. That you have to do that several times a year. They are put in a situation to self-evaluate. In addition, it is necessary to evaluate yourself quite low. (...) It is a recipe for giving children bad self-esteem.

Participants talked about school as driven by an increasing focus on standardized tests of theoretical skills to which the youths were exposed. In addition, a school system required and pressured pupils to manage theoretical material and get good grades, as well as develop good social skills. They also saw a cultural change in what the school demanded of the pupils as having an impact on the diagnosis given when the youth did not live up to the school's expectations.

T1: The grades are very much in focus the tenth year and you are supposed to choose what to do next. For someone who has some kind of trouble comprehending, they will go under today. Nevertheless, they would have managed earlier, it was easier. Moreover, the social interactions are more advanced, even more arenas to fall out from than earlier. T2: Absolutely. T3: I think that's why we got so many more diagnosed with Asperger's. T1: But a development like that is frightening.

Participants seemed unified in their understanding of the school system as kind of a 'one size fits all' institution and that youth who were unable to fit in were not given the space, the support, or the accommodations they needed. Participants also talked about attempting to challenge the societal development that resulted in school becoming most important. However, they found engaging in a challenge difficult because the focus on doing well in school was strong throughout society and, thus, among the parents and youth as well. Although parents might have a sense that a school was harmful to their children, they were under pressure to make their kids attend and succeed.

T1: If it is upper secondary school that's the topic, we sometimes try to talk about that it is not the end of the world if you're not in school right now. (...) But, either way, that idea is strong. (...) T2: That you have to send your child to a place that you think makes them worse. Because they have to go to school and get an education, then it is also your responsibility as a parent to get your child to school. If not you are a bad parent. So, in a way that is the situation you're in as a parent. T1: They're almost falling apart sometimes.

Subtheme: the welfare system makes diagnosis necessary

The participants learned to understand that the welfare system was part of what makes a mental health diagnosis necessary. The explanations for youth troubling given by different parts of the welfare system were connected to individuals rather than their environment, and the explanations were given in diagnostic terms to engage different types of care both in and outside of school. Participants described a welfare system that perceived youth with different types of problems as all having mental health issues. A mental health diagnosis was necessary to gain access to adaptations or special help in school or from different parts of the welfare system. Participants talked about parents being put in a situation in which the pressure to get a diagnosis when their child was struggling came from the welfare system itself. To obtain benefits from the Norwegian Labour and Welfare Organization (in Norway called NAV) or other parts of the welfare systems that could be of help to the family, a diagnosis and being in treatment were viewed as requirements.

T1: Like in the clinic for child and adolescent psychiatry, I think they were very dependent on getting that kid into treatment. (...) Because of the severe eating disorder but also because they had to be in treatment. Because then the doctor could send messages about benefits to NAV, they could get compensation. Therefore, it was about the whole structure of getting the kid well. Much more “must” than “wish” in many ways. Then, there were many of the parents saying, that they did not want to be there, but they had to be.

Participants also talked about how they understood the dilemmas of being a parent to a child who had a hard time adjusting in school and parents’ expectations of the team to help them enable their children to do better and become capable of completing school. Moreover, they wanted a diagnosis that could explain and give them tools that would make them capable as parents in helping their children through school.

T1: -And which school is best at ADHD and handling bullying? (...) I think that many think that the child has mental difficulties. Then, they want a quick fix. (...) Then, you get like a manual or recipe to follow. (...) Yes, like in a diffuse situation where it is lots of: ‘Can’t you assess him to find out what is wrong with him, so we can find the right manual to use?’ Or a solution of the problem. Even though an assessment might not decide on a diagnosis.

Discussion

The mental health field in Norway is an area of tensions and contradictions (Aarre, 2018; Ekeland, 2011; Karlsson, 2018; Karlsson & Borg, 2017). This study raises two central themes for a discussion about tensions and adversities for youth troubling and for providers of care in mental health services.

Youth troubling in an area of professional tensions

The biomedical model is the dominant explanatory model used in different parts of the welfare system to explain why youth are in need of care. In our dialogues, we found that the service providers relied on broader comprehensions about why the youth were troubling beyond biomedically conceived mental health issues. They both described the school as not able to provide pupils with enough support if they needed it but also as an ejecting force and a societal institution that represents a way of determining what it means to be successful and to fail. In a modern state as represented by the Norwegian welfare system, citizens are objects of mandatory educational and health programs and could, thereby, be divided into larger categories as unemployed or mentally ill (Karlsson, 2018). Foucault (2000) described how modern governments rely on scientific knowledge to generate policy and, in so doing, create a mutual relationship between government and science. Knowledge is used to legitimate exercises of power (Foucault, 2000; Karlsson, 2018). By analyzing to Foucault’s work, we can see both inclusion and exclusion from societal arenas as school and labels such as mentally ill can be viewed as techniques to gain power over citizens

(Foucault, 1967, 1979, 1999). In his theory of power, discourse is a concept of how power is built and practiced. Research on what is considered normal or mentally ill behavior can create a societal discourse that again regulates the type of governance that taken over individuals and how much power they are given over their own life circumstances (Foucault, 1999). In some manner, this study shows what we understand as a type of resistance toward a discourse that values youth who are good at school as more successful than the ones who do not manage school well. Such resistance is part of a larger debate in Western countries over the concern for an increase among youth diagnosed and medicated and the school as dominated by testing, measuring, and having more of a focus on theoretical than practical skills.

The critique against the system that this study underpins can be viewed as a form of what we know from social work and mental health work as *advocating* for change (Schneider, Lester, & Ochieng, 2013) – changes in both the school system and the welfare system in general. As service providers navigating in a field of tensions, daily resistance is not part of the practice. However, when given the room and ability to reflect on the system, the service providers used the opportunity to reflect on the critical boundaries, policies, and discourses that affected their practice and to advocate for change.

Care in an area of professional tensions

This study raises the issue of the tension created by contradictory policies within the mental health field that require recovery-oriented practice within a discourse of pathologizing youth troubling. Research on recovery stresses the importance of focusing on the dynamic relationship between a person's everyday life, living conditions, and services that enables connections to the community (Biong & Borg, 2016; Borg, Karlsson, & Kim, 2009; Tew et al., 2012). Having support, being able to renew hope, engaging in meaningful activities, overcoming stigma, becoming empowered, and exercising citizenship are basic components of recovery (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). The outreach teams' practices were based on building relationships over time, regaining trust, and – in that way – also building hope for the care they provide for the youth and their families. Professional autonomy is a premise for the core of a collaboration between a service provider and a service user and a prerequisite for re-enforcing the service user's autonomy (Karlsson, 2018).

On a local level, the service providers describe having the opportunity to exercise flexibility without being controlled by management in opposition to the services in other parts of the welfare system, as in school and specialized treatment. At the same time, the overarching explanatory model of the individual youth as ill creates challenges when attempting to work recovery and use the aims of the youth and their families as guiding care.

The societal understandings of youth troubling also affect youth and their families in their understandings of themselves. The team's mandate from society is to provide care that could enable youth to finish school or engage in other activities. This mandate may not always be what the service providers or services users found to be helpful in their situation, when school itself, for example, was viewed as part of what was troublesome for the youth.

Navigating in an area of professional tensions can shed some light on service providers' struggles with understandings of professionalism when it came to relational work in mental health services. These tensions are known in social work and mental health services (Levin, 2004; Ljungberg, Denhov, & Topor, 2017). Research on recovery processes emphasizes the relationship between the service user and the service provider. Methods for therapeutic work have a weaker impact than the significance of the relationship (Denhov & Topor, 2011). As in this study, professionals describe that being personal is important but also emphasize the need for boundaries for both their sake and to provide good care (Angell & Mahoney, 2007; Ljungberg et al., 2017; Scanlon, 2006). Studies have shown that service users find it important that their relationships with helpers are not merely based on professional roles but also are at a personal level (Ljungberg et al., 2017).

During the process of becoming experts in the mental health field, our lectures, readings, supervision, and concepts of knowledge seem to push away the subjectivity of the service provider and the service user (Strauss, Lawless, & Sells, 2009). Strauss et al. (2009) state that we should look more effectively at our own subjectivity filters and attempt to grasp the experience and the ways that our training both helps and hinders our learning about experiences.

Conclusion

This article raises issues about the difficulties of youth in an essential societal arena as represented by school, and the explanatory models that are given to understand their struggles in life. Mental health services for youth are conducted in a context of tension between different explanatory models. The heading of the paper quotes lyrics from Alice Cooper's song, 'School's Out,' which delivers a severe critique of the school system (Band, 1972). Asking whether only the youth are ill and not a school that fails to include a fair number of its pupils seems fair. Moreover, if a narrow societal discourse of pathologizing contributes to further excluding, rather than including youth, a flexible service created through dialogue with youth and their families and a more holistic understanding of youth troubling can contribute to broadening the understanding for both service providers and users of better care.

Similar to Frank (2005), we believe that this article offers an account of how researchers and participants came together during shared time and space to dialogue and cocreate knowledge. Moreover, the mutual effects continue to reverberate to readers of this article who now becomes part of the dialogue for further development of mental health services for youth.

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