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Abstract:

Despite considerable quantifiable data about the circumstances of care leavers in the UK, there is less qualitative data about how these circumstances are experienced. The current article is underpinned by positioning theory, with a particular focus on the unfolding personal narratives of young care leavers in relation to their mental health and wellbeing and the role of a life-skills programme in supporting them in this respect. The research illustrates that leaving care projects, such as the one in the current study, are more focused on employment and housing issues than on addressing the mental health and wellbeing needs of young people. Our analysis of interviews with young people illustrates the ambiguity of understandings of concepts such as 'mental health' and 'wellbeing', and the complexity of responses to questioning around this area. This illustrates one of the major problems in evaluating the outputs and outcomes of such projects in terms of simplistic targets, where mental health and wellbeing are not clearly defined or understood by young people themselves. The current research provides a more complex picture. More research is needed that involves in-depth and longitudinal assessment of specific mental health needs of care leavers and how they can be addressed successfully.

Introduction

Since the mid-1970s the adversities faced by young people leaving care have been recognised (Stein and Carey, 1986). These adversities, coupled with the reasons why young people are in care, and how the care system manages and responds to their needs, are associated with higher levels of mental health, emotional, behavioural and neurodevelopmental problems. These problems can become chronic or deteriorate if they are not treated or if managed with inappropriate interventions (Pinto and Woolgar, 2015; Stein and Dumaret, 2011). Official government data does not include specific information about 'mental health and wellbeing' (the focus of this article) but 'emotional and behavioural health' is assessed using the Strengths and Difficulties Questionnaire (SDQ) (see Goodman, 1997). This data shows that half of all children looked after for at least 12 months have 'normal' emotional and behavioural health (DfE, 2015a). However, the other half are assessed as either cause for concern (37% are referred to as having 'abnormal' emotions and behaviour in the SDQ assessment tool) or they are borderline cause for concern or 'abnormality' (13%). Boys generally score higher in relation to 'abnormality', compared with girls (DfE, 2015a). More broadly, official

data shows that the rate of 'mental health difficulties' amongst children in care is about four times that of the general population of young people (NSPCC, 2016).

The adversities faced by young people leaving care should be understood in relation to a context of '*accelerated and compressed'* transitions to adulthood, in comparison with other young people (Stein, 2006, p.274).   In acknowledgement of these issues there has been an increase in the duties of local authorities in relation to the ongoing support of care leavers. In essence this has meant that local authorities continue to support young people leaving care for longer. When young people are close to leaving care, local authorities are required to appoint a 'personal adviser' until the age of 21 so that care leavers should have at least one relationship or link with a local authority (Community Care, 2001). Duties continue to age 21 and over, if the young person is still in education or training. However, official data shows that around a quarter of young people have either never had an advisor or are not in contact with them (CSJ, 2015, p.9). The Children and Families Act 2014 introduced a new duty on local authorities to support young people to continue to live with their former foster carers once they turn 18 (the 'Staying Put' duty). This duty came into force on 13 May 2014 (DfE, 2015b).

Young people in care are a small minority of all children (under 0.5% of the total population of children in England and Wales). Those who fall into the specific category of 'leaving care' are a tiny proportion of their age group. However, the number of children in care at any one time has increased in recent years, from 65,510 in 2011 to 69,540 in 2015 (DfE, 2015b, p.3). In a one year period, over 90,000 children pass through the care system and over 30,000 cease to be 'looked after'. Around a third (10,830 of the 30,000 in 2014-15) of those who cease to be 'looked after' are classed as 'care leavers'. After the Children (Leaving Care) Act 2000, a child was classed as a 'care leaver' if they are aged 16 or 17 and looked after by a local authority for a period of 13 weeks, or periods amounting in all to that period, which began after he/she reached 14 years of age and ended after he/she reached the age of 16. Increasingly children 'cease to be looked after' at age 18. By 2015, most (7,390 of the 10,830 16-18 year olds who ceased to be looked after) were 18-years-old (DfE, 2015b, p.8).

Although we have a lot of quantifiable data about the circumstances of care leavers in the UK, we do not have so much qualitative data about how these circumstances are experienced. Specifically, there are two areas of focus that remain under-developed: firstly, research that draws attention to the lived experiences of young people such as the various transitions they go through; and secondly the development of conceptual frameworks that centralise their perspectives to support the development of practice (Eronen, 2011; Jobe and Gorin, 2012; Winter, 2014). Much of the support provided to care leavers tends to take a functional approach, focused on the immediate practical issues of accommodation and employment (Hood, 2014).

The current article is underpinned by positioning theory, with a particular focus on the unfolding personal narratives of young care leavers in relation to their mental health and wellbeing and the role of a local life-skills programme in supporting them in this respect. We use this focus as a starting point in order to gain an insight into the process by which certain trains of consequences (intended or unintended) are set in motion. We draw on positioning theory and multi-level synthesised discourse analysis (Harre et al, 2009; Sims-Schouten and Riley, 2014) as a methodological framework, with a

specific focus on acts of positioning and re-positioning in narratives relating to young people's mental health and wellbeing.

We acknowledge at the outset that mental health and mental illness are contested terms, which have been used to represent a range of concepts from psychological states to dimensions of health (see Lofgren et al, 2015). It is generally acknowledged that mental health is broader than the lack of a mental disorder. Contemporary interpretations of mental health are informed by two major epistemological positions about psychological distress, namely medical naturalism and social constructionism, neither provide a usable solution for practitioners (Pilgrim and Bentall, 1999). Stigma plays a significant role in how mental health and wellbeing are conceptualised (see Ford et al, 2005). Understandings are subject to the interests or values of the people and organisations attempting to define and interpret terms. For example, the World Health Organisation (WHO, 2012, p.3) defines mental health as:

> "… *a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*".

This definition has informed the way the concepts 'mental health' and 'wellbeing' have been used in the current study.

Mental health and care leavers

It is well known that young people leaving care are over-represented in relation to unemployment, homelessness, teenage parenthood, disability, lack of formal qualifications and in the prison population (Richardson and Lelliott, 2003). For example, official data on 26,330 former care leavers (aged 19, 20 or 21) shows 39% not in education, employment or training (NEET) (DfE, 2015b). Some (7%, 1840) were living in unsuitable accommodation and for others (12%, 3,160) there was no available data (DfE, 2015b). Unemployment, homelessness, and imprisonment are much higher in care leavers and are known to intersect with higher levels of mental health problems (WHO, 2012). How mental health and wellbeing also intersects with the reasons for entry to the care system is complex and varied. How mental health and wellbeing later intersects with the experience of leaving care adds to this complexity (Dixon, 2008).

Aside from the official data referred to earlier, a range of studies provide some insight into the mental health and wellbeing of children in care (e.g. Dixon, 2008; Stanley, 2007). This research is often relatively small scale with little focus on particular mental health problems. Changes in placement, differences in terminology, poor systems of data collection and the complexity of reasons why children are in care, make this group of young people difficult to research (Richardson and Lelliot, 2003). Dixon (2008) interviewed young care leavers and their care workers and found a rise in mental health problems after leaving care, which could be due to the complex difficulties of post-care transitions, e.g. the transition from child to adult mental health services. Such transitions happen in a context in which councils often fail to monitor the mental health of children in care (Bazalgette et al, 2015).

Specialist services for care leavers developed in the 1980s and offered various forms of support and help with practical skills (Stein and Carey, 1986). Since the Children (Leaving Care) Act 2000 in England and Wales a 'Corporate Parenting Model' is

common in which the responsibility for the young person rests with a case worker or 'personal advisor' who works with other agencies in relation to key issues such as accommodation, education, employment and training (Stein, 2006). Stein (2008) has highlighted the importance of promoting resilience in care leavers, applying this concept to the aspects of both the care and leaving care experience that can be harnessed to this effect. The changes needed are wide ranging but in essence can be summarised as more stable and holistic experiences when in care and better quality and extended support when leaving care, '*more akin to normative transitions*' (p.35). Stein (2006) has suggested that there are three broad groups of care leavers, characterised as those who are 'moving on', 'survivors' and 'victims' (p.277). The 'moving on' group are likely to have had stability and continuity in their lives, made sense of their family relationships, as well as had some educational success before leaving care. They have been able to make good use of the help offered. 'Survivors' have experienced more instability, movement and disruption whilst in care, left care earlier and achieved few educational qualifications. They tend to believe in their own self-reliance but often need ongoing support. 'Victims' are the most disadvantaged and have had the most damaging pre-care family experiences. Their time in care is characterised by further difficulties, instability and disruption. After leaving care they are likely to be unemployed and to become homeless, to be lonely and isolated and have mental health problems. This latter group ('victims') most closely approximates to the young people interviewed in the current research.

Research context

The current research is based on data collected as part of an evaluation of a life-skills project for young care leavers (aged 16-25 years old) developed by a child-focused charity in southern England. The area that is the focus of the current study ranks amongst the highest quarter of most deprived areas in England. The project is designed to improve the life chances and outcomes for those who are moving towards, or have recently left care, with a specific focus on improving life-skills, employability, training, housing, as well as mental health and wellbeing. The project is part of a national network of nine local authorities committed to positive change (see Lindsay, 2014). One of the key aspects of the network has been to involve young people in driving forward improvements in the support provided for care leavers.

Essentially, the project is designed to explore how services for care leavers can be fully integrated and easily accessed, and responds to a call from the Care Leavers Foundation that more needs to be done to tackle the rising number of care leavers who are NEET(DfE, 2012). At the time of the study, 40 care leavers (aged between 16-25 years old; mean age= 18.7) out of the 78 in the local authority, had access to this additional support. The majority of participants were assessed as having 'complex needs'; some were homeless prior to their involvement with the life-skills project, and their needs related to relationship problems, isolation, loneliness and the mental health and wellbeing issues associated with this, placing them in the category of 'victims' (Stein, 2006). Specific mental health issues included anxiety, panic attacks and behavioural problems.

Framed within a strengths-based approach (Padesky and Mooney, 2012) the life-skills project is based around individual sessions, with support from a care worker, psychotherapist and Family Services Manager, and practical activities with the use of a 'workbook' (e.g. based around relationships). The project is underpinned by the

Family Star framework (Dickens et al., 2012) and the Bromford Assessment tool (Bromford Housing Group, 2015). Both are management and measurement tools for family support, with a specific focus on measuring immediate outputs and showing progress made towards targets focused on specific life-skills, employment and training, physical health, mental health and wellbeing (Killaspy et al., 2012). An internal survey within the project, based on the Bromford Assessment tool (Bromford Housing Group, 2015), showed that of all the care leavers using the project at the time (N=40) targets were being met in most respects (accommodation, education, training and employment) apart from mental health and wellbeing. Nearly a third (30.7%, N=12) were not 'managing their mental health and wellbeing needs'.

Theory and method

The current study locates talk around mental health and wellbeing within positioning theory, taking the viewpoint that individual responses and conceptualisations of experience and self-concept need to be seen in the light of discursive content and strategies (referring to the interpersonal and intrapersonal nature of positioning). Positioning theory looks at the normative frames within which people live their lives, and the way in which notions relating to their character, competence, traits and skills are shaped within this (Harre et al., 2009). As such, positions are more often than not part and parcel of the everyday practice of different groups of people. Positioning theory fits within the realm of both cognitive and discursive psychology. Whilst the first encompasses a focus on the cognitive processes that are instrumental in people's actions and meaning-making, the latter places the actions, and specifically the normative constraints and opportunities within this, in an unfolding story-line (Harre et al, 2009; Haste, 2014). Positioning can be thought of as operating on the inter-personal, intra-personal, intra and inter-group levels (Harre and Moghaddam, 2008).

The current study sees positioning as a discursive process, where social narratives and cultural repertoires provide the infrastructure for positioning, as well as the rhetorical resources for counter-positioning (see also Haste 2014). Here, positions are treated as clusters of beliefs that are more often than not evident in everyday practices of groups of people (Harre et al., 2009). This is also referred to as 'discursive practice', which relates to the ways in which people actively produce and reproduce their social and psychological realities (Davies and Harre, 2001). Harre et al. (2009) describe the act of positioning in terms of a phased procedure, with the first phase referred to as 'prepositioning', where the character and/or competence of the person who is being positioned is established. This often taken for granted phase involves attributes of skills and character traits deemed relevant to whatever positioning is going forward. Positioning itself refers to the actual positions of people in relation to rights and duties. Repositioning on the other hand refers to a re-arrangement and re-alignment of positions, practices and duties, sometimes through a number of prepositioning acts. As such, in speaking about specific events, speakers assign characters and traits both to themselves and to other people, bringing to that particular situation their history and multiple positions within this (Davies and Harre, 2001).

Semi-structured in-depth interviewing was the primary method used in the study, with some documentary analysis of organisational data used to contextualise what young people said. Twenty-two young people took part in the interviews – eleven males, eleven females; six of the participants were from a BME (black and minority ethnic)

background (2 males – 4 females) and five of the participants were parents (three of the females and two of the males). The average age of the participants was 18.5 years old, reflecting the average age of the young people attending this project as a whole. All participants were living in supported accommodation at the time of the interview and all had an unstable care trajectory. On average the participants had spent ten years in care. Although mental health and wellbeing issues were part of the referral criteria to the project, it should be noted that a specific diagnosis in relation to mental health was not included in the criteria for the support provided by the project.

Interviewees were randomly selected from the project database, and young people were directly contacted by their care worker (the non-response was four); interviews were undertaken by University researchers and took place within the centre that ran the life-skills programme. The study was approved by the University Ethics Committee. Participants were provided with information sheets about the study which acknowledged that the topic itself can be perceived as sensitive, and/or may evoke an emotional reaction. In this case, participants were assured that the interviews would be stopped, with the option to talk to an allocated confidant   Interviews covered the specific areas of the programme: living skills, mental health/wellbeing and relationships. These themes were also evident in the programme assessment tools (Bromford and Family Star framework). Mental health is referred to as 'emotional wellbeing and mental health' within the Bromford tool, and as 'wellbeing and emotional needs' in the Family Star Framework; this language was replicated in the semi-structured interviews.

The data used in this article focuses on mental health and wellbeing needs (with the terms being used inter-changeably). It is analysed using a two-level 'synthesized' discourse analysis (Sims-Schouten and Riley, 2014). Firstly, drawing on discursive psychology, we focus on the interactive accomplishments of talk, such as managing facts, blame and accountability (Potter, 1997). For example, Antaki and Wetherell (1999) refer to the tendency of people to use three arguments to strengthen a point as a 'three-way-list' completer. Pomerantz (1986) uses the notion of 'extreme case formulations' to describe extreme and normalising talk (such as '*everybody* is against me' or 'my mental health is *extremely complex*'). The second level of discourse analysis focuses on the wider discourses that participants draw on to make sense of themselves (Billig, 2001). In line with conversation analysis (Jefferson, 1985, Ten Have, 1999) in which the first stage of our two-level synthesised discourse analysis is grounded, data is transcribed in detail; for example, in relation to intonation ($\uparrow\downarrow$ in the extracts for rising and lowering intonation), pauses, speeded up talk (> <) and quiet speech (∘ ∘). Table 1 details the transcription notation.

Table 1: Transcription Notation

∘	*Encloses speech that is quieter that the surrounding talk.*
(1.0)	*Pause length in seconds.*
- Hyphen	*Word broken off.*
↑	*Rising intonation.*
↓	*Lowering intonation.*
CAPITAL LETTERS	*Talk that is louder than the surrounding talk.*

Underline	Stress/emphasis.
> <	Encloses speeded up talk.
( )	Encloses words the transcriber is unsure about. Empty brackets enclose talk that is not audible.
.hhh	In-breath.
[ ]	Overlapping speech.
[	Onset of overlapping speech.
{ }	Clarification, referring to tone or gesture, e.g. {laughs}
:::	Extended sound.
=	Marks the immediate 'latching' of successive talk, whether of one or more speakers, with no interval.

(Edwards, 1997; Jefferson, 1985)

Narratives of young people

The narratives of the young people, referred to as an 'unfolding storyline' by positioning theorists (see Harre et al, 2009), reflected the conflict and confusion around interpretations and understandings of mental health and wellbeing highlighted earlier in this article. This raises questions about how young people interpreted and responded to these issues within assessments (Bromford and Family Star tools) particularly as no formal mental health assessments were undertaken. A Strengths and Difficulties Questionnaire (SDQ) should have been completed for every child looked after for at least 12 months and aged 5 to 16 years-old as at the end of March but this data did not appear to be made available to the project.

In about a quarter of the interviews (N=6; 3 females, of which 2 were from a BME background and 3 males, non-BME), the question whether the programme had supported them in their mental health and well-being led to answers, such as 'I don't need help here', perhaps reflecting the controversies associated with this. However, in the same interview they would often talk about 'stress', 'isolation', 'confidence' and 'self-esteem', and explain how the project had helped them on these fronts. The responses also reflect the fractured nature of multi-agency working, as from the interviews it appeared that the majority of young people had support from CAMHS (child and adolescent mental health service) at some point in their lives, and a number of them were still receiving support from this service. Yet this information was not included alongside the project assessment tools and in the initial discussions with the young people.

Table 2 identifies the key themes in relation to how the 22 young people positioned themselves and their mental health and wellbeing, with a specific focus on prepositioning narratives (i.e. relating to their character/competence/traits/skills prior to their involvement with the life-skills project) and repositioning narratives (re-alignment of positions, as a result of participating in the project). Themes are organised in order of frequency, with the most common themes coming first.

Table 2: Prepositioning and Repositioning Narratives of young care-leavers

Prepositioning	Repositioning
Get really stressed – break down and cry.	*Have become a more resilient person; picking self up again.*
Fear of new people and new situations.	*Learning to communicate and feel confident.*
Loneliness and isolation.	*Being able to speak to people and socialise.*
Low self-esteem.	*Learning independent skills and confidence.*
Being nervous and anxious.	*Stress-relief and coping.*
Behavioural issues (being difficult, aggressive)	*Being able to trust and talk to people; assertiveness*
Panic attacks	*Being able to express myself and my fears*

These themes are illustrated by participants' narratives.

Extract 1 (Female, BME): Ambiguity of meaning (mental health and wellbeing)
1. I: Has the project helped you manage, your mental health and wellbeing?
2. P: (2.0) ^{0}It hasn't^0 r↓eally
3. I: N↓o
4. P: >I haven't really br↓ought it ↑up<
5. I: So what is the main thing that the programme does for you at the
6.   moment?
7. P: er::m (2.0), ind↑ep↓endent .hh living skills, erm, and s↑ometimes, maybe, .hh
8.   confidence (1.0) >I don't kn↓ow<, yeah (1.0), maybe, j↑ust, being independent,
9.   living and cooking and health and ^{0}wellb↓eing^0.

In the extract above, rather than positioning the project as inadequate or insufficient in fulfilling her mental health and wellbeing needs, this participant justifies the fact that it hasn't helped her by referring to her own stake and interest '>I haven't really br↓ought it ↑up<' (line 4)(see Potter, 1997). This is said very quickly (indicated by the ><), and functions as a justification for the earlier uttered '^{0}It hasn't^0 r↓eally' (line 2). Yet, the relatively long pause at the start of this (2.0 seconds; line 2) implies that the participant has some trouble with the subject (Speer and Potter, 2000), something that is also evident from the softly spoken '^{0}It hasn't^0', which is subsequently softened by the 'r↓eally' that follows. Nevertheless, in the section that follows (lines 7-9) she includes both 'confidence' (line 6) and ^{0}wellb↓eing^0 (said softly, indicated by ^{0}, in line 9) as main things that the care programme does for her. Again, there are suggestions that the participant has some trouble with the subject, which is evident from the pauses in lines 7 and 8, and the use of '>I don't kn↓ow<' in line 8. In addition to this, whilst most skills, e.g. 'living skills' and confidence (line 6), as well as living and cooking (line 9) are stressed and emphasised, ^{0}wellb↓eing^0 (line 9) on the other hand is uttered softly. This highlights the potential controversy and confusion associated with the terms 'mental health' and 'wellbeing'. Moreover, by referring to 'wellbeing' (line 8), rather than providing specific examples, she is merely repeating what the interviewer said (in line

1). As such, it could be argued that in this participant's narrative there is a focus on the interviewer's stake and interest, rather than her own.

<u>Extract 2 (female, BME); 'Getting stressed' – 'Becoming more resilient'</u>
1. P: I get <u>stressed</u>, struggle with m↓oney, ◦and◦ erm (1.0) >sometimes I dont<,
2. I dont have n↑obody to talk to as well .hh s↓o I was getting (1.0) <u>so</u> much
3. <u>stress</u> and, my hair is f↓alling out, err its so hard to <u>handle,</u> you know, l↓ike,
4. for <u>me</u> to have like somebody like, and <u>XXX</u> (1.0) that I can <u>talk</u> to, ◦even if
5. she comes once◦ ↑every two weeks to <u>see</u> me. So, I can <u>talk</u> to her, it makes
6. me feel <u>better</u>.

The participant in the extract above uses a three-way-list completer (using three arguments to strengthen a point, Antaki and Wetherell, 1999), 'n↑obody to talk to', '<u>so</u> much <u>stress</u>', and 'my hair is f↓alling out' (line 2,3) to show that the situation that she finds herself in is multi-facetted, as well as having a huge impact on her wellbeing. Yet, it is through the engagement with her care worker, that she is able to reposition herself: 'it makes me feel <u>better</u>' (line 6). As such, she constructs the provision of the support from which she has benefitted as a category-bound-activity (Silverman, 2001) of the programme.

<u>Extract 3 (Female, white British); 'Behavioural issues' – 'Being able to talk to people'</u>
1. P: >◦what we're just doing◦< erm: I think she's t↑aught me how to sp↑eak to
2. people, a:nd n↓ot like (2.0), as I used to be q↑uite <u>aggressive </u>and quite
3. h↑orrible, ↓and >stuff like th↑at<, <u>which</u> make you learn how to be ass↑ertive
4. >and stuff like that<, and to sp↑eak properly and not get wound up, and say
5. things in the <u>right</u> w↑ay.

Both the emphasised prepositioning of 'q↑uite <u>aggressive</u>' and 'quite h↑orrible' (line 2,3) function as footing (see Potter, 1997), leading into the repositioning of this participant as being able to 'sp↑eak properly' and 'in the <u>right</u> w↑ay' (lines3,4). Here, the programme is constructed as mediator, providing resources for counter-positioning, with the ultimate goal to fit in with society's rules and expectations and becoming more 'ass↑ertive'(line 3). Interestingly, whilst this participant uses emphasised speech, as well as rising intonation, in reference to her nature (<u>aggressive</u> , h↑orrible, line 2), and the fact that her care worker t↑aught (line 1) her to do things the <u>right</u> w↑ay (line 5), the means through which this was achieved are almost negated. This is evident from the quickly and quietly spoken '>◦what we're just doing◦<' (line 1), including the use of the word 'just' which functions to minimise the importance of the process itself (see Jeffries and Grogan, 2012).

<u>Extract 4 (Male, white British); 'Panic attacks' – 'Being relaxed and able to express oneself'</u>
1. P: <u>I</u> sort of have p↑anic attacks, ◦and that kind of stuff◦, <u>but</u> ↑er::m they s↓ort
2. of said, y↑ou know, we'll >try to get someone to sort of take care of you<,
3. <u>because</u> once I'm inside and have, w↑ell, rel↓axed a bit and had a chat with
4. someone, I'll be f↑ine.

In the extract above, again there is evidence that the participant is able to reposition himself and his anxieties (prepositioned as '<u>I</u> sort of have p↑anic attacks', line 1) through the support provided. This leads to the repositioning in terms of 'w↑ell,

rel↓axed' (line 3), ending with the emphasised 'I'll be f↑ine'. The repeated use of the word 'sort of' (lines 1,2) is interesting here, as it gives a sense that none of this is all that clearly defined, again suggesting that talk around mental health and wellbeing is complicated (see also Akister et al, 2010).

Extract 5 (Male, white British); 'Behavioural issues and complicated mental health' – 'Getting the help that I need'
1. I: Has the project helped you manage your emotions and mental
2. health?
3. P: Yes
4. I: Do:n't, don't feel that need to go into detail or anything
5. P: No, ha, b↓asically, e::rm, m↑y my mental health is extr↑emely
6.   c↓omplicated, er:m, ◦you know◦, its gone, gone on for an extr↑emely l↓ong
7.   time, b↓ut since its come out, they, they've ◦sort of◦ understood th↓at it is a
8.   d↑ifficult s↓ubject ◦and◦ that I'm not >inclined to talk about it n↓aturally<, ◦you
9.   you know◦. But they've ↑always made sure that i'm g↓etting the help i n↑eed,
10. a::nd gave me the motiv↑ation, trying to give me a lot of positives (2.0) I: can
11. be quite difficult ◦sometimes◦ you know.

As with extract 4, the mental health talk in the extract above is softened through the use of the word 'sort of' (line 7). This is used as a disclaimer (see Speer and Potter, 2000), and follows on from the reference to his mental health as extremely complicated (line 5). Thus, as well as referring to how their engagement with the programme allowed them to reposition themselves and their abilities to cope and engage with their problems, participants also consistently showed evidence of trouble and confusion around conceptualisations of mental health and wellbeing. In the extract above, the participant uses an extreme case formulation (Pomerantz, 1986) 'my mental health is extr↑emely c↓omplicated', and 'gone on for an extr↑emely l↓ong time' (lines 6), to suggest that this is not an issue that can be easily assessed or measured. Here, the life-skills project seems to be constructed in terms of only providing the help and support when needed – interestingly, while positioning the care workers as understanding and giving 'a lot of positives' (line 10), the participant portrays himself in terms of being 'quite difficult' (softened by the 'sometimes' at the end, line 11). This suggests that the 'complicated' mental health issues that this participant refers to at the start of the extract, are also responsible for his difficult behaviour at times, regardless of the 'positives' received through the project. Constructing 'mental health issues' in terms of 'difficult behaviour', also highlights the ongoing stigma around the topic (see also Ford et al, 2005).

Extract 6 (Female, white British); 'Fear of new people' – 'Communication and Confidence'
1. I: Is there anything in particular that y↑ou have achieved now, that you didn't
2. necessarily achieve bef↑ore you joined XXX?
3. P: >it w↓as< mainly m↓y confidence w↓ith talking to ↑other people, ◦with like◦
4.   (1.0) business-like, b↓anks, d↓octors, ◦people like th↑at◦ (1.0) > I never really
5.   had confidence to do it<
6. I: And how did you gain the confidence?
7. P: Erm, my (2.0), my old care w↓orker, >took me out to the bank< (2.0), a::nd
8.   I↓ike, was getting me to talk, l↑ittle b↑its, n↓ot constantly ◦just little bits◦. And then
9.   she will talk for a little bit and then she will get me to do, do some j[ust]

10. I: [ok]
11. P: <u>like</u>, she was <u>constantly</u> trying to get me to <u>do</u> it, by, by boosting it ↑up.
12.   Gr↓adually, <u>not</u> straight <u>away</u>.
13. I: Oh, that good.
14. P: Its like n↑ew p↑eople, and I don't really get on with n↑ew people. <u>So</u> I was like
15. ^{0}oh new people^0, {soft nervous laughter} ^{0}Oh no, leave me alone^0

The participant in the extract above uses a sandwich argument (Riley, 2003) to explain the role that the programme has played in building her confidence. This is evident from lines 3-5, where she starts off by highlighting the impact the project has had on her confidence '<u>main</u>ly m↓y <u>con</u>fidence w↓ith <u>tal</u>king to ↑other people', followed by a reference to the kind of people that she never felt confident to talk to, after which she returns to her main argument '> I never really had <u>con</u>fidence to do it<'. In lines 6-12 she refers to the techniques used by her care worker to support her in building her confidence in this area, with a specific emphasis on the staged and step-by-step nature of this approach; e.g. see line 12 '<u>Gr</u>↓adually, <u>not</u> straight <u>away</u>'. Here she shows how her confidence has been 'boosted' ('by boosting it ↑up', line 11) gradually. The conflicting use of the word '<u>con</u>stantly' (lines 8 and 11) is interesting, and ties in with Billig's (2001) work on the contradictory nature of arguing and thinking. The fact that 'new people' (uttered three times in line 14,15), are still a troublesome and problematic issue for this participant is also evident from the laughter in line 15 (Edwards, 2000).

Overall, the extracts provide evidence of the ambiguity of meanings, understandings and interpretations around mental health and wellbeing. In their narratives the care leavers have to negotiate conflicting viewpoints in relation to their own mental health (stress, panic attacks) and the need to 'not get wound up', be resilient and in essence fit in with society's rules and regulations (to not be aggressive and 'horrible'). Time and time again there is evidence of trouble and confusion around conceptualisations of mental health and wellbeing, highlighting that this is a complicated and misunderstood issue.

Conclusions and implications

The evidence about leaving care and adversity, including mental health problems is well established (e.g. Stein, 2006; 2008). Mental health and wellbeing issues can underpin and result from other problems – such as being NEET. It is clear that leaving care projects need to have a more skilled and targeted approach to addressing mental health and wellbeing issues and building resilience (see also Coman and Devaney, 2014; Hood, 2014; Paul et al, 2014). Coman and Devaney (2011) refer to the need for an intrapersonal approach in identifying and tackling factors that contribute to better mental health outcomes for children in care.

The strengths-based, staged and gradual approach in the project, came some way towards supporting the young care leavers in their mental health and wellbeing needs, by addressing lower-level issues as a way of preventing further escalation of problems. For example, there is evidence of repositioning in relation to the young care leavers' subjective wellbeing (e.g. from being lonely and stressed, to talking to people and feeling better within this), although this may only touch the surface of their needs. However, it is clear that the project was not addressing mental health and wellbeing needs to the same extent as employment and housing issues. In part this may be

explained by conceptual issues and stigma that surrounds talking about mental health and wellbeing. Importantly, there was evidence of poor use of existing assessments on these issues by practitioners in the project. Neither SDQ nor CAMHS assessments were readily available to the project.

Our analysis of interviews with young people illustrates the ambiguity of understanding of concepts such as 'mental health' and 'wellbeing' and the complexity of their responses to questioning around this area. This highlights one of the major problems in evaluating the outputs and outcomes of such projects in terms of simplistic targets. The current research provides a more complex picture of the changes that were happening, including the role of care workers in supporting the young care leavers with issues around loneliness and isolation. By drawing on positioning theory we were able to weave together the complex positions and personal narratives of the participants and the emotional meaning attached to this. This showed that having someone to talk to (i.e. the care worker) played a mediating role between the pre-positioning and repositioning narratives of the participants.

This research has implications for practice and policy. Firstly, it shows that there is a need to tackle stigma and understanding about mental health in care leavers' projects. Secondly, practitioners need to make better use of existing assessments in this respect as a starting point to inform more focussed work. Thirdly, the research highlights the need for programmes that address the broader transitional care needs of young care leavers in relation to mental health. Robust transitional and evidence-based mental health care, drawing on the young person's voice and stronger collaborations between the different professionals and agencies involved, will come closer to filling to the policy–practice gap of accessible, acceptable, responsive, age-appropriate provision.

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