Mental Health Literacies for Interprofessional Collaboration: Youth Workers' Perspectives on Constraining and Supporting Factors

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ABSTRACT

Interprofessional relationships between youth workers and mental health service providers are now understood as an integral aspect of mental health literacy and care provision. This paper reports on findings from an online survey exploring youth workers' (N = 74) perceptions of mental health literacy, specifically in regards to interprofessional relationships in Canada. Discourse analysis of participants' qualitative responses revealed three themes: constructing us/them binaries, differential positioning contributing to collaboration, and hierarchical differential positioning contributing to learned helplessness. Constraining and supporting conditions for collaboration include organizational structures and policies that support the development of interprofessional relationships, knowledge of different professions' roles and responsibilities, and respectful experiences during collaboration.

Key words: interprofessional collaboration, youth work, mental health literacy, discourse analysis

RÉSUMÉ

Les relations interprofessionnelles entre les travailleurs auprès des jeunes et les fournisseurs de services de santé mentale sont aujourd'hui envisagées comme faisant partie intégrante de la culture de la santé mentale et de la prestation de soins connexes. Le présent article rend compte des résultats d'un sondage en ligne explorant la perception de travailleurs auprès des jeunes (N = 74) à l'égard de la culture de la santé mentale, particulièrement en ce qui concerne les relations interprofessionnelles au Canada. Une analyse du discours portant sur les réponses qualitatives des participants révèle trois thèmes : l'établissement d'une

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classification binaire « nous/eux »; un positionnement différentiel contribuant à une collaboration; et un positionnement différentiel hiérarchique contribuant à une impuissance acquise. Les conditions limitant et favorisant la collaboration comprennent les structures et les politiques organisationnelles qui appuient le développement de relations interprofessionnelles, la connaissance du rôle et des responsabilités de différentes professions ainsi que les expériences fondées sur le respect durant ladite collaboration.

Mots clés : collaboration interprofessionnelle, travail auprès des jeunes, culture de la santé mentale, analyse du discours

Current conceptualizations of mental health literacy (MHL) include "knowledge of professional help available" (Jorm et al., 1997, p. 143) and the "capacity to seek formal mental health care" (Kutcher, Wei, Mcluckie, & Bullock, 2013, p. 84). MHL is a "relational and contextualized social practice" (Ranahan, 2015, p. 119) and is dependent on context and the meanings people attribute to the context they are in (Street, 2009). Knowledge of mental health resources within a community and an individual's capacity to access these resources is dependent on interactions and relationships with service providers and the meanings people ascribe to the process of accessing mental health care. For example, an individual may have knowledge of the outpatient mental health clinic within her community, and possess the requisite skills to obtain an appointment at the clinic. However, the clinic is across the street from her workplace, and her neighbour is employed as an administrator at the clinic. She is nervous about her colleagues seeing her walk into the clinic and wonders if their perceptions of her competency would change. She is also concerned that her neighbour will have access to her file. Although she has knowledge and capacity to access this resource, the relational and social context renders her unable to use these literacies. Factors then, that constrain or support MHL, such as perceptions of interprofessional relationships between care providers, require examination.

Models of collaborative care in mental health have begun to recognize the important role of non-medical professionals (Nadeau, Rousseau, & Measham, 2012) and there has been a shift in viewing mental health as "owned" by particular professional groups (Kutcher, Davidson, & Manion, 2009). Youth work (YW) practice occurs with young people in a variety of settings including residential care, community-based youth centres, schools, or child welfare. This profession and field of study "has straddled the boundaries between… child welfare, medicine, mental health and education" (Lochhead, 2001, p. 73) and is well situated for interprofessional collaborations.

YWs have been defined as *gatekeepers* with young people in distress (Rickwood, Deane, & Wilson, 2007). This situates YWs on the periphery of mental health care (Ranahan & Pellissier, 2015) with the limited purpose of "befriending" and "linking" youth to formal services (Rickwood et al., 2007, p. S38). YWs' response to suicidal adolescents typically involves contacting and informing numerous service providers known, and sometimes unknown, by the adolescent (Ranahan, 2013a). Ranahan (2013a, p. 138) refers to this practice as "flooding the zone" and suggests that flooding has "the potential to disrupt [a YW's] relational proximity to the adolescent and may reinforce a devalued role for [YW's] in suicide intervention within the larger mental health system of care." As an integral aspect of MHL, interprofessional relationships between YWs and formal mental health providers require attention.

Findings are presented here from a discourse analysis of qualitative data derived from an online survey that sought to answer the following broad research question: What are YWs' perceptions of MHL, specifically in regards to the relationships between YWs and formal mental healthcare providers? *Youth work* serves as an umbrella term for child and youth care work, youth care work, or child care work. YWs may be found in a variety of workplace settings with a diversity of role titles (e.g., family support workers, child care counsellors, youth development workers, or youth protection workers). Features of YW include the importance of collaborative relationships, drawing on a developmental knowledge, using a rights-based approach, adopting an ecosystemic perspective, and an emphasis on practitioners' ethical and reflexive practice (Ranahan, Blanchet-Cohen, & Mann-Feder, 2015).

As voices representing YW perspectives, youth workers, youth work educators, and youth work supervisors were invited to respond to the online survey. Educators and supervisors have considerable influence on YW practice (see Ranahan, 2013a). Analysis revealed three central themes: constructing us/them binaries, differential positioning contributing to collaboration, and hierarchical differential positioning contributing to learned helplessness. Conditions that constrained or supported interprofessional collaboration were also identified. We begin with a description of the methods, followed by the presentation of the results, and conclude with a discussion that situates our research within the context of current scholarly conversations and identify implications for practice and future research.

METHODS

In order to deepen our understanding of YWs' perspectives on various aspects of MHL we used a cross-sectional survey design. Cross-sectional surveys are used to examine the attitudes, beliefs, opinions, and/or practices of a group(s) of people (Creswell, 2012), and allowed us to collect qualitative data (i.e., text responses to a variety of questions). The first survey instrument developed by the author consisted of 15 questions. Content validity was established via engagement with existing MHL literature (Jorm et al., 1997; Wei, Hayden, Kutcher, Zygmut, & McGrath, 2013) and recent MHL research conducted by Ranahan (see Ranahan & Pellisier, 2015; Ranahan, 2013a, 2013b, 2014). The aim was to refine the questions posed within our questionnaire in order to address gaps in existing studies and to contribute to the body of knowledge about YWs' perceptions of MHL and involvement in interprofessional care teams.

Postcards providing a brief overview of the purpose of the research and a link to the online survey administered via Fluid Surveys™, were distributed to more than 300 attendees at the national child and youth care conference held in Moncton, New Brunswick in October 2014, and mailed to various organizations randomly chosen across Canada. The International Child and Youth Care Network additionally distributed a link to the online survey via the free discussion listserv that connects over 3,500 members worldwide. The survey was available online between October 2014 and December 2014 and required participants to self-identify as a youth worker, youth work supervisor or administrator, or a youth work educator. More than one role could be selected (i.e., youth worker and educator). The survey generated 84 valid responses in total. Ten respondents were from outside Canada and are not included in the present discussion.

The 74 participants included 50 YWs, 12 educators, 11 participants who identified as YWs and supervisors, and 1 participant who identified as an educator and supervisor. The majority of respondents were from

Ontario (n = 31), followed by Nova Scotia (n = 13), British Columbia (n = 10), Alberta (n = 6), Manitoba (n = 6), Northwest Territories (n = 2), and 1 participant responded from each of Quebec, New Brunswick, and Newfoundland respectively. Participants were predominantly female (86%), and fell between 26–35 years of age (35%) or 36–45 years of age (31%). Twenty-seven participants had completed a college diploma, 27 participants had completed a baccalaureate degree, 16 participants had obtained a master's degree, and 4 participants held a doctorate degree. Participants were not asked where they were employed or the nature of their employment. Over half of participants (51%) had more than 11 years of YW experience. Twenty-eight participants reported they had over 16 years of experience, 10 participants had between 11 and 15 years of experience, 18 participants had between 6 and 10 years of experience, and 10 participants reported five or fewer years of experience.

The questionnaire contained demographic and targeted questions inviting answers in multiple choice or text box formats. Participants completed the survey in approximately 18 minutes. The study received ethical approval from Concordia University's Human Research Ethics Committee in August 2014. In this paper we report on the analysis of the following survey questions:

1. Describe what your relationship is like with the formal mental health service providers in your community; and
2. What is your perspective on the role youth workers should play in mental health care?

Each participant provided a qualitative response in the text box that followed each question.

Survey Methodology

Survey methods typically refer to quantitative investigations that aim to describe "numerical distribution of variables" including prevalence rates within a population (Jansen, 2010, para. 4), whereas qualitative surveys focus on examination of the "diversity of some topic of interest within a given population" (Jansen, 2010, para. 5). We were interested in the diversity of YWs' perspectives on their roles and relationships within mental health systems of care.

Online surveys can be advantageous for researchers with regard to access to participants across a large geographic area, and provides the convenience of automated data collection (Wright, 2006). The use of an electronic questionnaire facilitated wide distribution of the survey within Canada and helped to access views of professionals representing disparate geographic regions and care systems. Adopting this approach permitted the inclusion of multiple targeted questions resulting in eliciting a broad scope of perspectives relating to the research question leading to a comprehensive representation of the complexity of participants' responses. Given these two benefits, the data collected for this study provide an initial impression of YWs' perspectives of their role in mental health care and relationships with mental health providers.

Analytical Framework

As an aspect of MHL, one of the purposes of this study was to gain an understanding of what facilitates and impedes YWs' involvement in interdisciplinary teams and collaborative relationships with mental health providers as represented in participants' qualitative survey responses. To realize this aim, we drew upon

Laclau and Mouffe's ([1985] 2001) discourse theory, which enabled us to both analyze how participants discursively construct, understand, and represent their professional roles and relationships, and what power differentials certain relations signify. "Discourse theory aims at an understanding of the social as a discursive construction whereby, in principle, all social phenomena can be analysed using discourse analytical tools" (Jorgensen & Phillips, 2002, p. 24). Discourses are material such that individuals and groups are established linguistically *and* materially within physical spaces (Jorgensen & Phillips, 2002; Laclau & Mouffe, [1985] 2001). That is, YWs' interprofessional relationships can be established discursively through qualitative textual responses to survey questions, and materially within the physical spaces where they work (e.g., hospitals, residential group home settings) that may allow for face-to-face collaboration. This framework allowed us to approach participants' responses from the perspective that all social phenomena are never fixed: There is constant struggle involving dominant interpretations of social relationships and identities. We analyzed participants' qualitative responses with a view to identify various interpretations of the role that YWs play in mental health care, and the relationships that YWs hold with other mental healthcare providers.

Analytic strategies. Initially, we highlighted the diverse, competing interpretations of YWs' roles and relationships with mental health providers in order to identify positive, negative, and neutral accounts. Second, we examined the varying interpretations in order to determine what meaning different interpretations suggested with regard to power relations and professional positioning. Lastly, we examined the interpretations for understanding what facilitates and impedes realization of the perception of successful roles and relationships between youth workers and mental healthcare teams.

Methodological rigor and warrantability. An effort to achieving rigor in conducting this discourse analysis of participants' qualitative responses was informed by a framework proposed by Nixon and Power (2007 p. 76). This framework has six elements: (1) a clearly defined research question appropriate for discourse analysis; (2) a clear definition of discourse and discourse analysis; (3) effective use of a theoretical framework; (4) analytic transparency and application of theory to analysis; (5) clear selection of texts; and (6) strategies to guide analysis. Our research question is well-suited for discourse analysis as it concerns how people construct aspects of the world, groups, and identities (Jorgensen & Phillips, 2002, p. 119). We have described discourse theory as our framework for analysis and identified the text (i.e., qualitative responses to two specific survey questions) in which we focused our analysis. We have woven our theoretical framework throughout the presentation of our results in a transparent manner, and we have outlined our strategies of analysis beginning with the identification of divergent interpretations. We then determined what the different interpretations evoked in relation to power and positioning, and finally analyzed each strategy to ascertain whether it supports or impedes YWs' interprofessional collaborations and roles within mental healthcare teams.

"Warrantability" is a more suitable term for determining validity of a discourse analysis, as validity is often associate with "truth"—a notion that is confusing to discourse analysts who hold the position that truth itself is socially constructed (Wood & Kroger, 2000, p. 167). Our analysis can be viewed as warrantable "to the extent that it is both trustworthy and sound" (p. 167). Trustworthiness is established through a clear description of the research provided, including details reported regarding the data collection process, and how analysis of the data was conducted. Below, excerpts from the data are made available in the presentation of the results to provide a transparent illustration of the analysis and interpretations. Warrantability is achieved through identifying patterns in the data and accounting for exceptions when present, while recognizing

"that there can be multiple alternative claims that are equally good at accounting for the data" (p. 172). In the discussion section, we link our findings in relation to relevant literature on YW and interprofessional collaboration to establish trustworthiness of our interpretations of the data.

RESULTS

We begin by discussing findings relating to three dominant interpretations of YWs' roles and relationships to other mental health providers. We then go on to discuss the enabling and constraining conditions that support successful collaboration between YWs and formal mental healthcare teams.

Constructing Us/Them Binaries

One of the central concepts in Laclau and Mouffe's ([1985] 2001) discourse theory is an emphasis on the importance of making self/other distinctions when constructing one's own identity. Any identity is dependent upon an affirmation of difference—i.e., identifying the *us* from which the *them* is differentiated (Mouffe, 2005). Our understanding of our own internal identities is created from processes of identification with objects that are similar to us, and from processes of disassociation with external objects that we deem to be dissimilar. YWs expressed an understanding of their identities both in terms of the frontline support and care that they provide to youth in crisis (e.g., "Youth workers are the frontline intervention when it comes to mental health") and in terms of how their work differs from the services provided by formal mental healthcare providers (e.g., "[Youth workers] need to play a leading role dealing with the life of a youth, but need backup support from mental health professionals"). The us/them relationships that YWs constructed between themselves and professionals working within the medical model helped to sustain their self-understanding and to provide justification for the roles that they play in the lives of youth.

YWs' responses to questions pertaining to how they understood and experienced their role(s) with formal mental healthcare providers contained many comments that attempted to define the us/them relationship. This binary construct was used alternatively as a neutral means to differentiate between two (or more) professions—i.e., YWs and formal mental healthcare professionals—and as a means to articulate and reinforce a hierarchical differential positioning between the two. Both interpretations of the us/them relationship were equally prominent; however, as we discuss in the following sections, each holds important consequences for the profession.

Differential Positioning Contributing to Collaboration

There were instances where participants expressed their understanding of their relationship to formal mental healthcare professionals as complementary. YWs identified each profession as playing a key role in responding to and supporting youth in crisis. While these expressions delineated boundaries between the work done by YWs and that done by professionals in the "medical model," these boundaries were not experienced as antagonistic or in tension with one another. Rather, they merely demarcated a difference whereby the strengths of one profession differed from the strengths of the other.

When asked to describe their relationship with the formal mental healthcare providers in their communities, participants responded with such comments as:

> The worker was available to speak to me and my clients whenever needed; very helpful, full of ideas and encouraged my relationship with client.

> [Formal mental healthcare providers] are open to consultation and will help suggest treatment plans, etc.

> [We have an] excellent relationship, as we are all partners in care and treatment.

> I have found them to be supportive and treat me like the professional I am.

Such an interpretation led to apparent feelings of genuine, two-way respect and authentic collaboration between professionals working within the field of YW and those working within the medical model.

HIERARCHICAL DIFFERENTIAL POSITIONING CONTRIBUTING TO "LEARNED HELPLESSNESS"

Twenty-five participants expressed their understanding of their relationship to formal mental healthcare professionals as either "disconnected," "non existent," or insufficient, reinforcing the idea that the us/them binary was largely a result of *them* (professionals in the medical model) not respecting the knowledge(s) held by *us* (YWs). This interpretation reinforced a hierarchy between the two professions whereby an implicit assertion was made that professionals in the medical model hold the ability (professional capital) to confer respect upon, and value and legitimize YWs.

> Our area is also one of hierarchy where the psychiatrist is at the top and those working daily with youth are on the bottom.

> We are not respected as professionals in the medical model.

> Those in hospital settings do not understand or respect our profession for the most part.

This view is problematic as it gives rise to a certain *learned helplessness* among YWs. To clarify: While expressions that either implicitly or explicitly identify hierarchical positioning may draw attention to relations of domination/subordination, on their own, they do little to critique and disrupt unequal power relations. Instead, they reinforce the status quo by using language that situates one group in a subordinate role. The following comments highlight this issue:

> There is contention because of the limitations mental health services play. They push back and expect for me/my agency to deal with the role they should be playing in a client's life with offering support services but they don't and expect my agency to fill the gaps of what they cannot offer clients.

> It is hard to get professionals in hospital/[community mental health services] to understand that there is only so much we can do as youth workers to deal with very high-risk youth that have severe mental health issues.

The use of this particular form of us/them language is unfortunate because, as we see from comments that point out the mutually reinforcing roles that YWs and formal mental health care professionals play, differences do not *necessarily* signify hierarchy. When differences are used as a means to justify one group's perception of their own inability to fully realize their role, they can become a crutch or a form of learned

helplessness. Using language that reinforces unequal power relations prevents subordinate groups from becoming fully self-actualized and in this case, from finding ways to engage in authentic relations with formal mental healthcare providers.

Upon initial examination, our interpretation may suggest we are pathologizing YWs' responses and ignoring the phenomenological experience of inadequate relations in the provision of mental health care. We are suggesting that YWs bear responsibility *in part* for the discursive construction of a hierarchy in which they are subordinates to other care providers. YWs have a responsibility to clearly articulate their role, articulate the nature and purpose of their therapeutic activities, and hold fluency in other professions' languages with which they interface (Gharabaghi, 2008).

Enabling and Constraining Conditions that Support Collaboration

Certain conditions enabled and constrained collaborative practice. Enabling conditions included structures in place that supported interprofessional contact, knowledge of other professionals' roles and perspectives, and perceived respect for each profession's contributions to care. These same conditions were also identified in the analysis as constraining forces.

Structures that supported contact between YWs and other care providers included worksites that comprised interdisciplinary teams where the physical space offered opportunities for relationship cultivation (e.g., hospital settings). The following participants' responses depict these physical spaces that fostered connection:

> [My relationship with providers is] excellent, mainly because I work in the premier mental health service in my area. I am aware of many, but not all, of the providers in my community.

> I worked in mental health case management and in a psychiatric hospital. My relationship was good to excellent.

Organizational policies that directed YWs to seek contact with mental health providers were additionally a structure that enabled the cultivation of interprofessional relationships. Participants indicated contacts were initiated in response to a crisis situation (e.g., suicide ideation).

> [The policy] supports us by allowing us to seek outside support.

> [Policies include] community support trees, emergency contact numbers.

> Depending on the severity, we would call police or access the mobile mental health crisis team.

External structures—such as physical locations and organization policies—can enable collaboration in mental health care. The worksite may afford ease of access and the policies may explicitly direct YWs to contact particular providers in the community. This provides an opportunity for relationships to be cultivated by virtue of these structures being in place.

Structures may also serve to constrain collaboration. YWs may practice in physical locations separate from other professionals. Contact may be limited and interprofessional relationships limited or, as several participants indicated, "non-existent." Without physical proximity, YWs "seldom deal directly with [formal mental health providers]" or only as a "last resort" in situations involving suicidal or homicidal indications.

External conditions impeding relationships also include structures within the mental healthcare system that limit accessibility such as wait times or lack of available resources. Examples of these constraints are evident in the following participant responses:

> They [mental health professionals] don't have the resources I need to help the youth I work with.
>
> There are not enough services and waitlists are too long.
>
> Hard to book appointments with [mental health service providers] because they are busy.

Structural constraints impede effective interprofessional relationships and can limit YWs' understanding of what mental health professionals have to offer in terms of care (e.g., "I am sceptical of how they are helpful").

Lack of physical proximity or interprofessional collaboration can impede knowledge of what each profession's contribution is:

> They don't know what our roles actually are though so we have to explain.
>
> Perhaps not informed about what we do.
>
> Other organizations have not been as supportive and they have not utilized my knowledge base.
>
> There is no cohesive relationship. The left hand doesn't know what the right hand is doing.

Whereas, knowledge of each other's role in providing care can support the development of interprofessional relationships: "Some providers understand what my role is and have been great to work with."

Participants' responses suggest that interprofessional relationships can be cultivated when YWs experience their role as being understood and their knowledge valued. YWs need understanding of the services and therapeutic benefits of care from formal providers for an interprofessional relationship to flourish.

Additionally, a perspective held by YWs that mental health providers can be "helpful" when consulted encourages collaboration. YWs' experience of providers being supportive and helpful contributes to the development of a respectful relationship. Providers who are "approachable," "helpful," or "easy to access" create pathways of respect and lay the foundation for interprofessional collaboration, whereas providers who are "difficult to talk to and not supportive" promotes a relationship that is "distant," "minimal," "strained," or "non-existent."

Enabling or constraining conditions that support YWs' relationships with mental health providers include structures, knowledge of each other's profession, and perceived respectful experiences during consultation. YWs' perceptions of being respected and understood along with physical proximity and access to providers can cultivate positive interprofessional relationships. In contrast, the absence of physical contact, limited access, and a lack of knowledge of each other's role and contribution led to scepticism and relational tensions.

DISCUSSION

Integrated service systems and structures to support collaboration along with a team approach are needed to ensure the continuity of mental health care of young people (Catania, Hetrick, Newman, & Purcell, 2011). Previous research has identified that YWs "were most often left out of discussions and decisions, and were, indeed, the least often consulted group" (Salhani & Charles, 2007, p. 13). Many YWs struggle to identify and articulate their own professional strengths (Gharabaghi, 2008) and can defer mental health care to formal providers based on a belief that they "have bigger screening tools" and thus greater expertise (Ranahan, 2013a, p. 146). Us/them binary positioning and hierarchical differential positioning as identified in the present analysis discursively constructs the YWs' role in mental health care as less than formal providers and reinforces a peripheral position. These findings are coherent with the inter-professional dynamics reported in the literature.

YWs have a role in providing mental health care, and a multipronged approach that incorporates various perspectives reflects the complexities young people and their families face when mental health concerns are present. Structures (i.e., policies and physical spaces) are conditions that promote collaboration in mental health care and aid the development of trusting and respectful interprofessional relationships. When professionals from different disciplines are positioned in the same premises learning and working together, care is enhanced and future liaison work is promoted (Kraemer, 2010). Physical space for connecting and time set aside to collaborate, are needed to enhance interprofessional relationships (Mellin, Anderson-Butcher, & Bronstein, 2011). YWs must take an active stance in relationships with service providers. This active stance is evident in the following participant's response:

> We believe it is important to work together with all service providers involved in a young person's life as this creates more positive outcomes. We seek consultations, attend appointments, communicate through phone and email all to work together on a unified treatment plan. … I personally try to have good relationships, which have to be founded on mutual respect, understanding, or each other's role and open communication.

Grounding his or her actions on the belief that working together impacts outcomes, the YW seeks, attends, communicates, emails, tries, respects, and understands the other professionals involved. An *active* pursuit of relationships can aid in thwarting an us/them binary position that consequentially constrains collaboration. It is the opposite of learned helplessness evident in the perspectives of some respondents, and actively challenges the notion of a subordinate or subservient role.

Binary positioning situates YWs on the periphery of mental health care and limits the opportunities for enhancing knowledge and improving professional confidence. Kraemer (2010) posits liaison between professional groups *is* a relationship (italics added for emphasis). A relationship requires nurturance, opportunities, and respectful curiosity towards the *other* (i.e., formal mental healthcare providers). The "quality of partnership and of collaboration appears especially crucial to provide optimal care to vulnerable families" (Nadeau et al., 2012, p. 91), whereas a lack of collaboration can lead to service duplications and service gaps including a lack of follow-up or continuity in providing mental health care (Powers, Webber, & Bower, 2011).

[W]hen clinical teams are developed to support youth workers and the group care facility, superior services can be provided. When knowledge and skills are shared within the "circle of care," professionals are likely to feel better about the jobs they do (Carson, 2011, p. 130).

Confidence, knowledge, skills and service to young people are improved when interprofessional relationships are characterized by active efforts to collaborate, communicate, and cultivate connections.

PRACTICE AND RESEARCH IMPLICATIONS

The absence of interprofessional relationships between YWs and mental healthcare providers is of great concern. "Given the focus on life spaces in child and youth work, it is nearly impossible and certainly not desirable to avoid contact and connections with the other systems involved with the children, youth, or families to whom we are connected" (Garabaghi, 2008, p. 247). YWs must actively pursue collaborations with mental health providers for several reasons. First, YW is a relational, client-centred practice (Stuart, 2013). It is in the best interests of the child, youth, or family served by YWs to cultivate relationships with other service providers to be able to support clients to navigate systems of care. Second, YWs possess the skills needed to cultivate interprofessional relationships. Pre-service YW education focuses on developing skills in interpersonal communication (Ranahan et al., 2012), group processes and leadership (Mann-Feder & Litner, 2004). YWs must refrain from using language that co-constructs the position of the profession on the periphery or as subordinate to other disciplines. YWs must be cautious about relaxing into a "not-knowing stance," or "minimizing the specialized knowledge we do have" (Hoskins, 2011, p. 130).

Critics of the study of discourse suggest analysis is entirely subjective (Shaw & Bailey, 2009). To justify the trustworthiness of our interpretations of the data, we have provided clear examples of participants' comments and located our findings within the relevant literature. While a survey provided macro-level insight into this particular concern, some may argue that this means of collecting data fails to capture the context of participants' responses (see for example Booth, 2014). The survey was designed to elicit as much information as possible from participants by using open-ended questions and providing text boxes for responses. Despite our efforts, some participants limited their answers to "yes" or "no" without elaboration.

Exploring MHL as a social practice requires further research. Qualitative inquiry to explore interactions and processes of interprofessional relationships in responding to mental health needs is essential. Grounded theory methods may be used to explore the process of cultivating interprofessional relationships. Phenomenological inquiry could explore the experiences of collaboration between youth, families, mental health service providers, and YWs as this may assist in identifying what impedes or supports mental health care. Ultimately, YWs need to be able to answer the question "Why did you call for them?" when responding to young people in distress (Ranahan, 2013a, p. 138), by explaining they are a part of an interprofessional team.

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