

YOUTH WORKERS IN MENTAL HEALTH CARE: ROLE, MENTAL HEALTH LITERACY DEVELOPMENT, AND FRAMING FUTURE RESEARCH

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Abstract: Youth workers' role in mental health care requires articulation and further examination. Establishing a role in the provision of mental health care leads to queries regarding youth workers' mental health literacy and what knowledge is required to have a presence among other mental health care providers. The aim of this paper is to articulate the current role of youth workers in mental health care, examine emerging perspectives in research and education on mental health literacy development, and encourage fresh directions for future education and research that are aligned within the physical and philosophical position of the youth work field.

Key words: youth work, mental health care, mental health literacy, gatekeeper training

Nearly two decades ago, White (1996) proposed that child and youth care professionals could participate in preventing youth suicide, "by virtue of their proximity to potentially vulnerable youth across a wide array of settings" (p. 48). While several articles in child and youth care and youth work academic journals have taken up aspects of mental health and suicide in practice (Banks & Bartlett, 2006; Broadbent, Corney, Plessis, & Papadopoulos, 2013), White's early proposition of youth workers' participation in suicide prevention, and thus the mental health care of young people, still requires further articulation and exploration. The limited research that has been conducted has demonstrated child and youth care workers' roles in mental health and suicide care as the professional in-between (Ranahan, 2013a), whereby youth workers often serve as a referral agent rather than care provider. Rickwood and Mazzer (2011) articulate the role for youth workers as the "gateway providers" or facilitators of a young person's "pathway to mental health care" (p. 5). Yet emerging research on mental health literacy (MHL) and youth help-seeking preferences have established a need for closer examination of the role and process of youth worker engagement with young people who may be experiencing mental health concerns.

The purpose of this paper is to articulate the current role of youth workers in mental health care, examine emerging perspectives in research and education on MHL development, and propose directions for education and research in this area. First, explore the current role of youth workers in mental health care from both insider and outsider perspectives located within the literature. In examining

this role, we also draw upon the help-seeking literature that provides information on young people's preferences for obtaining support when struggling with mental health related concerns. Second, because youth workers' MHL is important in delineating their role in the provision of mental health care, we describe and critique the traditional, standardized approaches to investigating and enhancing mental health literacy. Thirdly, we discuss directions for future research and MHL education for youth workers and suggest areas that require inquiry so that youth workers can move beyond pathway facilitators or being in-between. Thus, through increased understanding, youth workers can take up the position of collaborative partners with young people, families, and allied professionals in providing mental health care. This is the first paper that we are aware of to take up a critical examination of the role youth workers have in the provision of mental health care.

The Current Role of Youth Workers in Mental Health Care

To date, there has been limited discussion within the youth work profession and academic conversation on the function and capacities of youth workers providing mental health care. Current discussion has ranged from dismissal of a psychiatric approach in which an individual's diagnosis and treatment guidelines steer practice (Fewster, 2002), to a focus on the physical proximity of youth workers to those who are most vulnerable (e.g., Bourke & Evans, 2000; White, 1996). Perspectives from within and outside the field of youth work on the role of youth workers in mental health care need to be considered, including what young people themselves are voicing about their preferred sources for help.

What is Youth Work?

Youth work and child and youth care practice have been discussed within the field as an approach or designation (Vachon, 2013). Professionals utilize a therapeutic approach in providing relational interventions with children, youth, and families that serve to promote development and well-being (Vachon, 2013). Relationships are not only therapeutic, but also educative in providing experiential opportunities for young people to engage with others and learn skills in supportive relationships (Rodd & Stuart, 2009). Anglin (1999) posits that the philosophy underlying child and youth care practice is what distinguishes the profession from other roles within the helping field. He maintains that child and youth care is orientated towards personal change, viewing development holistically, with a focus on relationship. The relationship with young people is viewed as voluntary even in situations where an individual has been mandated or required by programs or systems to have a youth worker involved (Merton, 2004). In such circumstances, youth workers are often able to negotiate how the relationship is constructed via activities involved and how support is offered and received (Merton, 2004). Further, youth workers view young people in a holistic manner, and not solely focused on one particular issue or need (Anglin, 1999; Merton, 2013). Thus, youth work

may be viewed as an interactive and multifaceted process (Davies, 2010). This brief overview is an insider perspective on youth work. In relation to the provision of mental health care, those outside the profession are defining youth workers as gatekeepers—a role that requires further discussion.

Youth Workers as Gatekeepers

Rickwood, Deane, and Wilson (2007) posit that youth workers, alongside school counselors and general practitioners, may be the “most likely to act as gatekeepers to mental health services” (S35). The position and proximity of youth workers to those young people who may be most vulnerable are often touted as the rationale for identifying youth workers’ role as gatekeepers (Bourke & Evans, 2000; Cartmill, Deane, & Wilson, 2009; Wright & Martin, 1999). Yet there is a paucity of mental health and suicide content in preservice education (Ranahan, 2012). Suicide prevention efforts in particular have often identified a gatekeeper role in identifying persons at risk for suicide and linking the person to mental health care. Several mental health and suicide educational programs described as gatekeeper training are based on the premise that those at risk of suicide or mental health problems often exhibit signs of needing help to others. Such educational programs are designed to increase participants’ self-confidence in suicide intervention, recognize warning signs, increase knowledge of mental health services available (Burns & Patton, 2000), reduce stigma associated with help-seeking, and promote organizationwide awareness of mental health and suicide (Mann et al., 2005). Standardized gatekeeper training programs, such as Mental Health First Aid (Jorm, Kitchener, Kanowski, & Kelly, 2007) or Applied Suicide Intervention Skills Training (LivingWorks Education Inc., 2007), are provided over 1 to 2 days and generally include pedagogical approaches such as lectures, role playing, video demonstrations, and group activities. Short interventions have raised concerns regarding retention of learning over time (Chagnon et al., 2007). Further, a short education program may limit the potential and capacity for youth workers to play a more significant, collaborative role in mental health care with young people. Defining the role of youth workers as gatekeepers who provide brief training programs limits the role of youth workers in mental health care. Vachon (2013) asserts, “Gatekeeping is about controlling access. Gatekeepers determine what is, and is not, allowed to enter” (p. 169). As such, youth workers are positioned merely at the doorway, facilitators to other service providers, waving young people through but not accompanying them to the other side.

Youth Preferences for Help

When referrals to traditional mental health care providers are suggested to young people, youth workers report that young people respond with “no, what I want is you” (Rodd & Stuart, 2009), or question why helpers are called upon to assist them, even in situations involving suicide, when they view the youth workers

as those who could help (Ranahan, 2013a). Young people prefer help from family, close friends, or partners when facing emotional problems or experiencing concerns about their mental health (Booth et al., 2004; Burns & Rapee, 2005; Ciarrochi, Wilson, Deane, & Rickwood, 2003; Gilchrist & Sullivan, 2006; Jorm, Wright, & Morgan, 2007). Young people want to speak to caring, nonjudgmental, supportive, and genuine people with whom they have an existing relationship (Boyd et al., 2007). Further, young people require encouragement and a positive attitude about seeking help from others (Guliver, Griffiths, & Christensen, 2012). Therefore, drawing on young people's desired characteristics of helpers, young people's requests for youth workers to be the ones to help, and the youth work profession's relational orientation to practice, youth workers' role in mental health care should extend beyond gatekeeping status to collaborative partners with youth, their families, and other service providers.

Youth Workers as Collaborative Partners

Emerging efforts to encourage a collaborative approach among service providers of mental health care are evident (Thomas & Hargett, 1999). Collaborative mental health care refers to mental health service providers of different disciplines, including family medicine, psychiatry, psychology, social work, and nursing (Mullvale & Bougeault, 2007). Collaborative mental health professionals are encouraged to establish partnerships with families receiving mental health services in all aspects of intervention, treatment, and evaluation of services (Huang et al., 2005). Manion (2010) posits that professionals' attitudes must be adjusted "whereby young people themselves are not viewed simply as recipients of care but as partners in care" (p. 55). In this transformation of care from families and young people as service recipients to collaborative partners, a new consideration emerges of how the mental health professional is positioned in relation to the individual (Jobes, 2006). Jobes (2006) designed a suicide risk assessment that emphasizes a collaborative approach with the mental health professional physically positioned alongside the person-at-risk instead of sitting in front of the person behind a desk or with a notebook in hand. Such positioning is an important literal and symbolic move for the professional from a distant expert to a collaborative partner. This collaborative physical stance is philosophically aligned with youth work practice in the development of therapeutic and educative relationships with young people and the perspective that such relationships are central to practice (Rodd & Stewart, 2009), and the context in which intervention and change occurs (Stuart, 2009). Though youth workers become partners in the provision of collaborative mental health care with young people, it is not clear what mental health knowledges and practices are required of the youth workers for their full participation in young peoples' care. Kutcher, Davidson, and Manion (2009) state that there is a "growing realization that mental health care competencies, not professional identification, should define roles and functions of mental health care team members" (p.

315). Thus it is important to consider how MHL is currently understood, examined through research, and enhanced through education with the aim of identifying and strengthening youth workers' role and function in mental health care.

Developing MHL

Jorm et al. (1997) defined MHL as "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (p. 182). As this concept has been developed, a customary approach to research has been adopted and so have standardized methods of training and programming. However, innovative experiential programs are also being used to understand and increase MHL. The following is an overview of literature specific to the MHL of youth and those who work with youth.

Customary MHL Research Approaches

Current research on MHL is primarily comprised of quantitative studies and tends to focus on measuring levels of declared knowledge, attitudes, and awareness of resources among both youth and those who work with them. For instance, large-scale surveys have been conducted in both Canada and England to assess young people's recognition of depressive symptoms and their perceived barriers and facilitators to help-seeking (Kids Help Phone, 2010; Klineberg, Biddle, Donovan, & Gunell, 2010). These factors are measured by providing a vignette, or a series of vignettes, portraying a young person who is showing symptoms of mental illness with varying degrees of severity. For example, the following vignette used by Olsson and Kennedy (2010) depicts symptoms of depression in a young person:

Jenny is a 15-year-old girl who has been feeling unusually sad and miserable for the last several months. She is tired all the time and has trouble sleeping at night. Jenny doesn't feel like eating and she has lost weight recently. She can't keep her mind on her studies and her grades in school have dropped. She puts off making decisions and even day-to-day tasks seem too much for her. The people who know her are very concerned about her (p. 293).

This same style of vignette has been used by a number of researchers. The details such as gender and age may be altered depending on the target population under study, but the overall theme and symptoms are similar. To illustrate, in the study conducted by Klineberg et al. (2010), the survey was divided into two sections. The first depicted a fictional person with mild to moderate symptoms of depression and anxiety; the second section described clinical depression. Participants were asked to identify signs of mental health issues and discuss their reactions to the hypothetical situations. While the majority of respondents were able to identify symptoms of severe depression, the results showed a significant gap

between intentions and actions. Many respondents suggested that a person with mental health issues should see a doctor, yet few believed that the person would actually seek help.

Other studies have taken a more specific approach by identifying a particular barrier to help-seeking around mental health issues and investigating further. In a study conducted by Bowers, Manion, Papadopoulos, and Gauvreau (2012), young people's perception of stigma was compared to that of school-based service providers. The researchers found that the young people in the study were more likely to consider stigma as a barrier than the service providers.

The same method of relying on large-scale vignette-based surveys was used to investigate MHL for those working with youth, in particular, educators (Daniszewski, 2013; Masillo et al., 2012; Reavley, McCann, & Jorm, 2012). The intended outcome was to evaluate teachers' levels of declared knowledge, awareness of available resources, comfort level with mental health issues, and interest in improving their MHL. Results showed that while many educators were able to identify symptoms of mental illness in students, many were unaware of available resources and unfamiliar with mental health legislation. However, there was a high level of interest in continued learning about mental health issues (Daniszewski, 2013; Masillo et al., 2012).

For youth and those working with youth, the customary approach to determining MHL has been based on assessing current levels of knowledge in a quantifiable manner. Large-scale surveys are the dominant method relied upon to reveal gaps in declared knowledge that can then be addressed in MHL educational programs.

Programs to Improve MHL

Aligned with the dominant research procedures reviewed above, much of the current educational programming on MHL is focused on increasing levels of declared knowledge and awareness among youth and those who work with youth. However, increased levels of knowledge do not necessarily impact barriers and facilitators to youth help-seeking. For example, Pinto-Foltz, Lodgeson, and Myers (2011) evaluated the short- and long-term effects of a ten-week knowledge-contact program for adolescent girls, *In Our Own Voice*. The researchers concluded that while the level of MHL increased, there was no change in the perception of stigma around the issue of mental problems. Pinto-Foltz et al. (2011) stated that the findings "illustrate a potential disconnection between thoughts and feelings" (p. 2017). This indicates that MHL programming cannot focus solely on mental health education; it is necessary to take steps towards decreasing barriers to help-seeking as well.

Youth-serving professionals who are designated as gatekeepers are often provided with standardized educational programs to address MHL. Wei, Kutcher, and Szumilas (2011) proposed a model of school-based interventions for which it is

necessary to train teachers. They argued that such a method would “ensure quality and sustainability through evaluation of desired outcomes such as changes in knowledge, attitudes, help-seeking behavior, referral processes, referral outcomes, and ongoing collaboration” (p. 224). Similar programs have been shown to increase participants’ knowledge about depression and suicide. Furthermore, this program provided gatekeepers with contact information for local resources, which targeted the previously mentioned issue that many educators were not aware of referral options for youth with mental health concerns.

Outside school-based interventions, one of the most commonly used training programs in Canada is Applied Suicide Intervention Skills Training (ASIST). This two-day intensive program trains participants to recognize when a person is at risk of suicide, to intervene with that person, and to refer them to appropriate services. Recently, Sareen and colleagues (2013) conducted a study on a First Nations Reserve comparing the impact of the ASIST program to that of a Resilience Retreat, which focused on strengthening communities rather than suicide prevention. The two programs did not show any significant difference in one’s capacity to intervene with suicidal behavior. The researchers concluded that “The lack of efficacy of ASIST in a First Nations on-reserve sample is a concern in the context of widespread policies in Canada on the use of gatekeeper training in suicide prevention” (p. 1).

Despite the lack of clear evidence that these programs shift MHL over time, such programs continue to be offered to other professionals in the healthcare field. In a study to investigate the impact of a MHL program for nurses, researchers discovered that the value of the experience was the process of sharing knowledge and workplace experience, as opposed to actually increasing MHL (Joyce et al., 2011). Such results indicate that while MHL educational programs may have prespecified intended outcomes, participants may place a higher value on experiential aspects of the program. This suggests incorporating a more experiential approach to enhancing MHL may be warranted.

Experiential Programs

In contrast to the standard MHL programs, a small number of individualized, experiential programs have been developed in order to target the needs of particular groups and communities. A more holistic approach to MHL educational programs would be beneficial as evidenced by a study conducted with Aboriginal mental health workers (Nagel, Thompson, Robinson, Condon, & Trauer, 2009). Researchers concluded that the use of metaphors, local people as educators, inclusion of pictures and artwork, and a more strengths-focused approach were beneficial strategies for enhancing MHL. Furthermore, theater has been shown as a useful medium for arts-based programs designed to disseminate mental health information and reduce stigma. A study conducted by Blignault et al. (2010) analyzed the impact of this strategy and found that audience members showed a

positive attitude towards people with mental illness as well as a greater use of mental health services. Koh and Shrimpton (2013) discuss another strategy using an art exhibition by people who have experienced mental illness. This strategy was shown to be highly effective in helping others understand mental illness, sympathize with those suffering from mental illness, and appreciate the creativity of those with mental illness.

As mentioned above, Sareen and colleagues' (2013) study compared the ASIST program to a Resilience Retreat. The Resilience Retreat, conducted over two days, included cultural activities, sharing circles, group discussion, and storytelling. Rather than focusing exclusively on suicide education and awareness, the Resilience Retreat approach was to build resiliency in youth and the community at large. The researchers found that despite the fact that the program did not focus on suicide prevention specifically, the outcomes were much the same as the ASIST program. Furthermore, the Resilience Retreat was developed by members of the community themselves, making the experience contextually specific and culturally relevant to the participants. Such considerations are essential to the efficacy of MHL programs. Participants can understand and relate to the content in a way that is meaningful to them.

Critique of MHL Educational Programs

The implementation of programs to enhance MHL is viewed as an important step in suicide prevention and mental health care. The standardized programs offer people an opportunity to increase their knowledge about mental health, learn to recognize symptoms of mental illness, and raise their awareness of how to deal with mental illness, either in themselves or in others.

However, within standardized MHL programs, such as ASIST, there is a prevalence of treating recipients all the same. The same knowledge and training is offered regardless of culture or context. White and Morris (2010) argue that the evidence-based curricula of standardized programs "authorize expert knowledge to the exclusion of all other ways of knowing, locate problems inside persons, make no room for uncertainty and ambiguity, inhibit local and relational meaning-making, and stifle creativity" (p. 2193). These programs do not take into consideration the different kinds of knowledge relevant in differing contexts. There is a limit to what they can achieve. Furthermore, there is a gap between intention and action. Even if persons are aware that they should seek help, it does not mean that they will. An increased level of education on mental health issues does not necessarily decrease barriers to help-seeking.

MHL programs using experiential strategies are not widespread, and there is little research available as to the impact of such programs on MHL and how this in turn supports the mental health of young people. Furthermore, those that have shown positive outcomes are individualized programs, and thus, further examination of them is needed. The initial feedback has been positive. These programs

not only educated participants on the subject matter, but were also effective in reducing stigma, which is a major barrier to help-seeking. For example, Nagel et al. (2009) noted having prominent community members speak about their own struggles with mental illness in order to encourage others to openly discuss their own. This approach allowed participants to speak and receive information in a language that is familiar and resonates with their own experience. Such experiential approaches are relational, and emphasize participation—features that are congruent with the philosophical and practical application of youth work. In order to articulate the role of youth workers in the provision of mental health care and how MHL may be conceptually understood and enhanced, more research is needed.

Future Research Directions

Relationships are viewed as central to youth work practice, or “the glue that holds our work together” (Rodd & Stewart, 2009, p. 4). It is a relationship of service whereby the youth worker is committed to prioritizing young people’s interests, working towards transforming the social context and youth within it (Sercombe, 2007). Child and youth care professionals described being with a young person experiencing suicidal thoughts as a key action within the intervention (Ranahan, 2013b). Further, young people are saying they prefer to have a personal relationship with a provider for mental health concerns (Boyd et al., 2007). Such relationships are “no longer a connectivity where solutions flow to the problem; it is instead one where the relational context is shaped by the collision of identities, realities, and imaginations that merge into complex and ultimately unpredictable outcomes” (Gharabaghi, 2008, p. 31). Thus, relationships are experiences occurring within an interactional context and require innovative, qualitative examination.

Just as the development of MHL programs has begun to include experiential elements in educational and mental health promotion programs, the focus of research must include qualitative examination of how MHL is enacted and constructed in context. Kutcher and colleagues (2009) posit that education and monitoring are required for primary health care teams to be restructured to include youth work professionals, and Cartmill, Deane, and Wilson (2009) maintain that future research needs to examine youth workers’ process of helping young people seeking help in more detail. The following are examples of inquiry into how MHL may be used and how language is a factor in localizing MHL.

Examining Process

A qualitative research method, grounded theory, can be valuable for exploring social or interactional processes (Maijala, Paavilainen, & Astedet-Kurki, 2003), such as youth workers’ interactions with young people and other professionals in providing mental health care. This allows the researcher to generate theories that explain human behavior as it occurs within a social context (Wuest, 2012). Theory development is the explicit goal of grounded theory research such that the

researcher moves beyond description of the phenomenon under study “towards a theoretical rendering that identifies key explanatory concepts and the relationships among them” (Wuest, 2012, p. 226). For example, asking youth workers to explain their experience with suicidal adolescents or discussing implementation of suicide intervention protocols can result in producing a practical and relevant theory of how youth workers make use of MHL in practice. Theories will provide knowledge for making suggestions for changes and areas of improvement for the future in youth work practice and education in mental health care. Further, a grounded theory approach requires seeking out more than one data source (Schreiber, 2001), which is a highly relevant means of exploration for examining the youth work profession in mental health care practice as youth workers may engage multiple persons (e.g., supervisors, psychologists, youth, peers, teachers, foster parents, or family members) in caring for an adolescent. Further, in a grounded theory approach, data collection and analysis occur simultaneously and new data is compared to data collected at earlier points in the research (Charmaz, 2006). For example, data collection may begin with interviews with youth workers, and analysis of these interviews may suggest that young people’s voices must be added to the analysis of what is happening in mental health care. Focus groups with young people who have received mental health care may follow, and data from young people (e.g., how young people experience the process of mental health intervention) may be compared with youth workers’ perspectives. Through such constant comparison, identification of patterns, emerging explanations, and depiction of the interactional process in visual diagrams, an integrated theoretical framework emerges of how youth workers provide mental health care and how MHL is used and constructed in context (Gibbs, 2007).

Examining Language-In-Use

Communication is a key aspect of current conceptualizations of MHL. For example, youth workers may use different communication techniques (e.g., open questions) to engage youth in discussions about their observations of youths’ changes in affect or energy level, communicate verbally or through documentation their observations to other professionals and family members, or youth workers may read, interpret, and apply various texts such as agency protocols or suicide intervention checklists with the youth during an interaction. This language is used in all forms of communication constructs and supports. It may also impede the interaction between youth and youth worker. As such, discourse analysis is a well-suited method to explore MHL in the context of youth worker-youth interactions. Gee (2012) states, “Literacy practices are almost always fully integrated with, interwoven into, constituted as parts of, the very texture of wider practices that involve talk, interaction, values, and beliefs” (p. 374). Further, “language both mediates and constructs our understanding of reality” (Starks & Trinidad, 2007, p. 1374). Discourse analysis can address the contextualized role of discourse in shaping social relations and sub-

jectivity in which experiences occur that is often ignored in circumstances involving mental health (Crowe, 2000). By describing how language-in-use (e.g., sentences, utterances) are meaningful in the context of youth workers-youth communication, inquiry will advance current knowledge of youth workers' discursive use of MHL in practice. Analyzing discourse "contributes to our knowledge and understanding of the various social and clinical activities that take place in [youth work] settings" (Harvey & Adolphs, 2012, p. 479). It also contributes to "the role discourse plays in conveying and shaping individuals' personal experiences" of practice with youth experiencing mental health problems (Harvey & Adolphs, 2012, p. 479). Data analysis based on Gee's (1999) set of 27 questions "about how language, at a given time and place, is used to construe the aspects of the situation network as realized at that time and place and how the aspects of the situation network simultaneously give meaning to that language" (p. 110). The analysis addresses questions such as, "What are the situated meanings of some of the words and phrases that seem important in the situation?" and, "How are identities stabilized or transformed in the situation?" (Gee, 1999, pp. 110–111). Another question, "How are youth workers' identities as gatekeepers constructed through language used by youth workers and other professionals in the context of providing mental health care?"

Despite the importance of communication in youth work interactions and current conceptualizations of MHL, there is limited research in the discourse of this specific area. However, current research demonstrates the importance of inquiry into how language may limit or construct perceptions of mental health or illness.

Gladstone (2012) examined a MHL group intervention with children of parents with mental illness, completed a discourse analysis of the program manual, and explicated the language conveyed actively constructed knowledge and beliefs about mental health. However, the medicalized language and biomedical explanations of mental health were found to be inadequate in describing the children's experiences. Gladstone concluded that different knowledge, including children's knowledge, should be taken into account in determining good MHL.

White and Morris (2010) used a discursive critical constructionist methodology to examine a school-based suicide prevention program. The program followed a traditional approach whereby the focus was on teaching students information about suicide such as risk factors. The researchers found that concepts used in suicide educational programs could be deemed stable or viewed as "universalizing terms that transcend time and context" (p. 2187). They found the language used in the program excluded multiple ways of knowing about mental illness and suicide and therefore limited creativity and made "no room for uncertainty or ambiguity" (p. 2194) for the suicide educators and youth participants. Such findings indicate the limitations of the language used in current educational efforts to address MHL.

O'Reilly, Taylor, and Vostanis (2009) analyzed the discourse of homeless youths' perceptions of mental illness, which revealed that young people are resistant to engaging in services that are deemed mental health services. For example,

a participant in the study distinguished between a worker's title of mental health coordinator and her perception of and relationship to the worker. Despite the young person seeing the worker, she denied any mental health need or problems, thus suggesting resistance to the term "mental health." Further, O'Reilly et al. assert that "exploring the discourses of mental health, and investigating in depth the ways in which people construct the concepts and apply them to their lives, is an important step in advocating change" in deconstructing the stigmatization of mental illness in society (p. 1743). The language used by youth workers in mental health practice then can be influential on a young person's engagement. What language do youth workers use with youth in situations involving a mental problem? What terms, concepts, and definitions construct their experience and thus influence the construction of the contextualized interaction? Such questions remain unanswered and require further inquiry.

Discourse analysis and grounded theory methodology may address issues and questions currently unanswered in regards to youth workers' providing mental health care to young people. Understanding the process of MHL in an interactional context and the language-in-use by youth workers and youth will undoubtedly extend our knowledge of youth workers' role in interactions and how MHL educational programs for this professional population may be enhanced. Such methodological approaches are aligned with youth work practice, which is relational and contextualized. Traditional research approaches using vignettes as a means of examining MHL are not well-suited to the complexities and relational process-oriented approaches of youth work practice in mental health that encounters serious problems such as suicide (White, 2012).

Conclusion

Youth workers have a role in caring for young people experiencing mental health concerns. The nature and function of the role of youth work within mental health, as it is currently defined, is limited to a referring professional or gatekeeper on the path to formal mental health services. The construction of this gatekeeper role has been supported and sustained by current efforts in MHL research and education. The present methodological approaches are not able to illuminate the complexities of the youth worker-youth relationship process, and MHL education is provided in time-limited workshop formats, thus hindering the capacity of youth workers to respond in a meaningful role. Efforts to advance knowledge must include qualitative research approaches, such as grounded theory method or discourse analysis. The role and process of youth work in mental health care needs examination, and innovative strategies to enhance the capacities of youth workers through MHL curriculum design and education need development. Young people are asking why youth workers are referring them to other service providers. It is time to hear and respond to their query.

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