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Chapter 6

Perceptions of mental health care providers´ roles in the care for adolescents

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Submitted

Abstract

The roles of professionals working within child and adolescent's mental health care services (CAMHS) have been shaped predominantly by a biomedical discourse. The transformation of CAMHS brings new challenges to these professionals. We aimed to understand the roles adopted by professionals, the discourses in the background of these roles, the subjective positions and practices related to these roles, and finally, which discourses promoted or hindered the transformational tendencies of CAMHS. Semi-structured interviews with professionals working in CAMHS were conducted and data were analysed using Foucauldian discourse analysis. We identified three categories of professionals' roles: those related to direct work with clients, those related to cooperation with other professionals, and those related to the functioning of the institution. Moreover, we found a total of nine discourses. The biomedical discourse hindered the transformation, whereas the psychotherapeutic discourse and the discourses of humanism and multidisciplinarity promoted it.

Keywords: Foucauldian discourse analysis, Children and adolescents' mental health care services, Professionals' roles, Transformation of mental health care

Introduction

Mental health problems in adolescence cover a wide range of problems varying in their intensity of expression and affecting the lives of individuals and their relationships with others. These problems are commonly classified as internal (or emotional), e.g. anxiety, depression

or other mood disorders, and external (or behavioural), e.g. aggressive, dissocial behaviour or problems with attention and hyperactivity (Achenbach, Rescorla & Ivanova, 2012). A meta-analysis (Polanczyk et al., 2015) showed that 13% of adolescents worldwide were affected by some mental disorder. Similarly, in a nationally representative Slovak sample (Madarasova Geckova et al., 2019), 11% of boys and 16% of girls suffered from emotional or behavioural problems (EBP), and suffering from EBP was the most common reason for entering psychiatric care for children and adolescents (Slovak National Health Information Centre, 2020). In addition, an increase was found in psychiatrist visits, psychotherapy, the use of psychotropic medication among youth (Olfson, Blanco & Wang, 2014) and the clinical treatment of child and adolescent psychiatric disorders (Collishaw, 2015).

Child and adolescent mental health care services (CAMHS) in Slovakia are organised by the Ministry of Health and therefore are predominantly included in the health care system. CAHMS consist of psychiatric and psychological care, inpatient and outpatient care, and state and private institutions that cooperate to some extent (Dankulincova et al., 2020). The current situation in Slovakia is changing, as the National Mental Health Programme (2002) emphasises the need to integrate CAMHS with social services, a shift from inpatient to outpatient care and community care, and care oriented towards individual needs. This development is in line with global changes in mental health care, where a new approach is focusing on community-based and recovery-oriented services, on respect, and on the promotion of human rights. Improvement of the quality of care in mental health and related services is gaining momentum (Funk & Drew, 2017). However, even though such changes are occurring, the way they are affecting the roles and everyday practices of providers is not clear. Therefore, more insight is needed on how traditional as well as new discourses affect these adopted roles and consequently result in different practices.

Because a qualitative inquiry provides deeper insight into and understanding of professionals' perceptions, discourse analysis was used in previous research, e.g., that of Zeeman & Simons (2011). They found three main discourses in the background of the practice of mental health practitioners: a biomedical, a person-centred and a psychological discourse. Shubert, Rhodes & Buus (2021) revealed that psychiatrists presented themselves as holding technical expertise in systemic thinking and prescribing medication, while psychologists perceived themselves as holding expertise in psychotherapies. Kent, Cooke & Marsh (2020) found that the role of *expert* was attributed to the psychiatrist, connected to his or her knowledge, expertise, and power to decide. Moreover, as different professions, such as psychologist and psychiatric social workers, also work in mental health care, the role and competencies of the psychiatrist in the

system has become less clear and needs to be redefined (Katsching, 2010). However, research on discourses influencing the roles of other CAMHS providers is rather scarce. A more comprehensive perspective is lacking but is highly needed.

In line with Foucauldian discursive analysis, this paper aimed to understand the roles as adopted by professionals, the discourses that were in the background of these roles, the subjective positions and practices related to these roles and finally, the degree to which the transformation of CAMHS can be identified in the roles and discourses of mental health care providers and institutions.

Methods

Design

We performed a qualitative study that was embedded in the Slovak Care4Youth (C4Y) study mapping the system of care provided for adolescents with EBP and its characteristics from the perspective of care providers. The study was approved by the Ethics Committee of the Medical Faculty at P.J. Safarik University in Kosice (protocol 2N/2015).

Study setting, sampling and participants

We obtained our sample of care providers from the institutions providing CAMHS following a two-step sampling. With the aim of reaching all representatives of each type of institution providing CAMHS in Slovakia, we first identified institutions of providers of CAMHS in the Košice region, Slovakia, as shown in Table 6.1. All these providers were approached based on our existing connections from a previous quantitative project covering the system of care for adolescents with EBP; they agreed to participate. Second, within each institution, all care providers working with adolescents were asked to participate in the study and all of them agreed. They received information about the study, were informed about the voluntary and anonymous basis of the participation, and provided informed consent.

We chose providers working in different types of institutions within CAMHS, and we expected similar discourses, roles and practices to be found in other providers with a similar background. In the case of subjective positions, we cannot expect similar results because a subjective position represents how each provider perceives his or her own role, and this may be highly specific and individual for each person. In the case of institutions with a hierarchical structure, we also interviewed the chief of the institution, if they were also providing care. We did not aim for a sample of CAMHS providers fully representative of all CAMH providers in Slovakia, so we cannot generalise our findings to all CAMHS providers.

Procedure

We performed semi-structured interviews to gain insight into different aspects of CAMHS from the perspective of professionals. The interviews, which were conducted in the Slovak language and were recorded, lasted approximately 60–120 minutes and took place at the institutions where the care providers work. Each interview was conducted by one to three interviewers (the principal investigator conducted all interviews, others alternated). All interviewers were trained researchers (psychologists and social workers). Our research team consisted of researchers with a background in psychology and social work on a different level of their academic carrier, with various experiences from their previous work in the system of care.

The guide for the semi-structured interview included various questions about the different aspects of the care provided by the institution, including questions on the competencies of providers, the setup of the work with clients, the methods they used in their work, the theoretical background they have and their cooperation with other institutions (for full guide see Appendix). To prevent socially desirable answers by care providers, we used rather general questions which did not directly regard the perceived roles.

We conducted these interviews with care providers between May 2017 and November 2018. In the case of institutions with a hierarchical organisational structure, the head or the chief of the institution was interviewed separately from the employees to create space for open expression of attitudes otherwise potentially hindered by the power imbalance. In other cases, all interviewed persons answered together.

Data handling, analysis, and reporting

We handled the data by first transcribing the interviews verbatim in the Slovak language. The transcriptions were checked by the principal investigator to ensure the accuracy of transcription process. We next analysed data using Foucauldian discursive analysis (FDA). As Hall (2001) summarised, FDA considers the relationships between discourses and institutions as discourses bound up with institutional practices (Willig, 2015). According to our aim and in line with the literature on FDA (Parker, 1992; Parker 1994), we selected only those sections of interviews that provided information relevant to our research question.

We then analysed the raw data as follows. First, we identified the *discursive objects*. We interpreted as *discursive objects* the providers' roles in the care for adolescents and focused on the parts of the interview providing information about these roles. Second, we identified different discourses in the background of these roles. By *discourse* in FDA we mean sets of statements constructing objects and arraying subject positions that facilitate and limit and enable and constrain what can be said, by whom

and when (Parker, 1992; Parker 1994). Third, we identified the different *subjective positions* that providers adopted within roles. While the role is something that can be expected to fulfil, a *subjective position* is something providers identify themselves with and is related to the specific rights and duties for those who are identified with the *subjective position.* Finally, we explored the *practices* of providers that are bound and allowed within the various discourses they are based on. Once the analysis was done, we explored whether the identified discourses in the roles led to subjective positions and practices in line with transformational tendencies.

Results

Characteristics of the sample

The sample consisted of 12 care providers from five institutions within CAMHS with the following backgrounds: four psychiatrists, five psychologists, two social workers, and one nurse (for a detailed overview, see Table 6.1). All the respondents were women.

Table 6.1 Participating institutions and providers of mental health care, and number of people interviewed by profession:

Institution	***Psychiatric sanatorium*** (inpatient long-term care)	***Psychiatric hospital*** (inpatient acute care)	***Child psychiatrist*** (outpatient care)	***Child clinical psychologist*** (outpatient care)	***Psychosocial centre*** (complex care; non-profit organisation including psychological, social, psychiatric care)
Chief of department	1	1	0	0	1
Psychiatrist	2	1	1		
Psychologist	1	1		1	2
Social worker	1				1
Nurse	1				

What roles had providers adopted?

In the first step, we identified six different roles that mental health care providers had adopted, either all of them or at least some. The first role identified in all providers regarded the *expert* role of provider, characterised by identifying themselves as experts who have rights and power to assess adolescents' conditions, diagnose them, and decide

what procedure and treatment is right for them. This role is, according to many participants, also connected with the providers' need to educate themselves continuously and join a supervision session. The *diagnostician* role was found in all interviews, as the providers perceived their main task as being to make a diagnosis. A diagnosis was considered a cornerstone for treatment; therefore, this role is perceived as a very important one. All providers also specified the role of *therapist*, in which the care providers perceived themselves as those who are capable and responsible for providing therapy or therapeutic treatment. This role is also connected to therapeutic training, which is one of formal conditions for providing psychotherapy, but not all participants met this condition. The role of *participant in inter-institutional cooperation* was specified by all providers and occurred when care providers perceived themselves as a part of cooperation and communication with other providers or institutions.

We also found two specific roles. The first one, *participant in intra-institutional cooperation,* was specific for the psychosocial centre and psychiatric sanatorium that covered different professionals working with adolescents in one place. The second role, *businessman*, was connected to economic activities related to the functioning of the institution (Table 6.2).

Table 6.2 Roles identified in mental health care providers

	Psychiatric sanatorium (inpatient long-term care)	*Psychiatric hospital (inpatient acute care)*	*Child psychiatrist (outpatient care)*	*Child clinical psychologist (outpatient care)*	*Psychosocial centre (complex outpatient care; non-profit organisation including psychological, social, psychiatric care)*
Roles found in every institution/ provider	Expert Diagnostician Therapist Participant in inter-institutional cooperation	Expert Diagnostician Therapist Participant in inter-institutional cooperation	Expert Diagnostician Therapist Participant in inter-institutional cooperation	Expert Diagnostician Therapist Participant in inter-institutional cooperation	Expert Diagnostician Therapist Participant in inter-institutional cooperation
Specific roles	Participant in intra-institutional cooperation				Participant in intra-institutional cooperation
				Businessman	Businessman

The roles as mentioned could be classified into three categories. The first category regarded the roles connected to the direct work with client (roles of expert, diagnostician, therapist). The second category regarded the roles connected to the cooperation with other providers (participant in intra- and inter-institutional cooperation). The third category included the role connected to the functioning of the institution (businessman).

Which discourses had providers drawn from?

We identified nine discourses related to the perceived roles of professionals, for a detailed description of these, see Table 6.3.

What subjective positions and related practices within roles had providers adopted?

In line with the next step of Foucauldian analysis, we identified subjective positions and practices within roles, related to the discourses as mentioned. We could categorise these into three groups, i.e. roles connected to direct work with clients, roles connected to cooperation with other professionals and roles related to the functioning of the institution. Table 6.4 provides an overview of the roles, discourses, positions and practices related to them.

Positions within roles connected to direct work with clients

Expert

First, we identified the *position of power* influenced by the biomedical discourse, resulting in the identification of professionals as experts with power and the right and knowledge to decide about the whole process of care. In a situation where biomedical discourse met with discourse of the patients' rights, the second position – the *position of helplessness* – occurred. In this case, providers perceived themselves as an expert authority who has knowledge on how to proceed in the treatment of a child or adolescent, who understands the diagnosis and what is needed to do; however, they believe it could not be done because parents disagreed with the suggested procedures. Finally, providers adopted within the role of expert the *position of gaining knowledge* as a part of psychotherapeutic discourse, as providers expressed their desire and need to become experts in their field through lifelong learning and supervision.

Diagnostician

The *position of expertise* within this role occurred mostly within the biomedical discourse in cases when providers identified themselves as someone who has the knowledge, abilities, tools, and power to diagnose and label the patient or client from a biomedical perspective. Besides the biomedical discourse, we also identified the supplementary biopsychosocial discourse, when providers highlighted the importance

Table 6.3 Discourses identified in mental health care providers

Discourse	*Description*
Biomedical discourse	This discourse was characterised by an unequal relationship between patient and provider, in which the provider is the one with power, authority, knowledge. The language used included the objectification of patients (talking about treating symptoms, not about treating people). Moreover, the use of scientific terminology was characteristic, talking more about procedures, pharmacotherapy, medical examination and testing, than about people and their feelings and experiences.
Biopsychosocial discourse	This discourse presented an extension of the biomedical discourse. In this discourse providers perceived patients as people living in a social context. They did not perceive mental health issue as only a medical problem, but they recognised that patients' difficulties had a broader context. Providers expressed the need to approach a patient as a biopsychosocial creature and to find procedures that enhance physical health, mental health and relationships, usually in the family and school environment. Typical was the effort to understand what was beyond the apparent problems of adolescents, talking about how the family and parents influence the development of the family and expressing the need for a complex treatment.
Psychotherapeutic discourse	The psychotherapeutic discourse was characterised by the theory, principles and practice of psychotherapy as an adequate treatment for psychiatric disorders and psychological difficulties. In the interviews we identified that psychotherapeutic theory and practice provided a specific way of thinking about pathology, disorders, difficulties, but also various effects of the family, school, and other environments. Providers also highlighted the importance of psychotherapy in their statements and declared that psychotherapy was a proper way to solve difficulties related to mental health. They also perceived that psychotherapy was still connected with some degree of stigma and prejudices and therefore some people hesitated to find help or had difficulties accepting the suggestion to start psychotherapy.
Discourse of behaviourism	We identified the discourse of behaviourism in statements of providers when they described different behaviours as learned, and difficulties as learned maladaptive reactions to different stimuli. As a proper treatment for this behaviour providers identified conditional, observational or social learning, rewarding desirable behaviour and punishing undesirable behaviour. Under this discourse we also put cognitive-behavioural therapy, which was identified by providers as an appropriate therapy in the setting of a hospital or sanatorium because of well-developed and standardised setups for different mental disorders.
Discourse of humanism	The discourse of humanism occurred in psychotherapy originally as the answer to the previous two – psychodynamic and behaviourism – and brought the respect for individuality and equal relationships between professional and patients. Providers with a humanistic background perceived psychotherapy as a meeting of two persons, not as a meeting of a doctor or therapist and a patient. Therefore, they recognised the positions of the care provider and client as equal. Next, within this discourse providers understood patients as individuals with their specific needs, ideas, feelings and experiences; so, they did not recognise any general treatment for all clients or their diagnosis, on the contrary, they maintained the need of individual plans of treatment for every client.
Discourse of institutional care	This discourse presents a set of beliefs and practices on what care for patients with psychological difficulties should look like. It is rooted in history, when patients with psychological difficulties and disorders were considered dangerous and were placed in institutions to kept them away and isolate them. Providers in these institutions presented strict rules and regime that patients had to accept. They also agreed with the restriction of rights and freedom to a level that is acceptable in these types of institutions. For example, we found in interviews a restriction of free movement outside of the institution, the allowing of visits of people from outside only during selected hours, and the right for workers in these institutions to check the personal possessions of patients, such correspondence or amount of money.
Discourse of patients' right	The patients' right discourse is characterised by maintaining the rights of patients in medical care and providing protection for patients. In interviews we identified that patients had the right to decide which treatment they will undergo and which not, i.e. they had the right to refuse treatment for any reason. From the providers, we learned that this discourse weakened the authoritative position of the physician or other providers and gave the power and opportunity to decide to the patient.
Discourse of multidisciplinarity	The discourse of multidisciplinarity is an increasingly used discourse in the theory and practise of providing mental health care. We identified it when providers talked about the need to treat patients based on collaboration of different professionals with the aim of realising comprehensive care. Within this discourse providers understand the contribution of each professional working with adolescents facing difficulties (e.g. psychiatrist, psychologist, social worker, teacher etc.) and understood that this discourse did not require one person to take care of every aspect of the problems, i.e. it supported the division of competencies among several professionals. They also recognised that every professional had his or her own education, expertise and procedures, but they all worked as a team and shared information and ideas and made decisions about the treatment.
Economic discourse	The economic discourse was identified when providers talked about how finances (from insurance companies or from clients) shaped their work (e.g. limits set by insurance companies or selection of clients due to inability to get remuneration for care for some of them). In the interviews we identified talking about psychotherapy or other procedures as products to be sold, competition between providers and marketing that helped to gain clients. These parts of the texts resembled more talking about doing business than treating people.

of searching for the original cause of problems considering the broader context of the individual.

Therapist

First, we identified the *humanistic position* that was adopted by providers within the psychotherapeutic discourse and the discourse of humanism. Providers perceived themselves and clients as equal partners and considered clients' needs and adapted the interventions in line with clients' individual needs and characteristics. Next, we identified the *position of the protector* that was found within the psychotherapeutic discourse. These providers strongly identified themselves with the role of therapist and had passion for their work and for helping clients. For them, their work represented an essential sense of life; they are used to taking responsibility for their clients; they perceived their clients as vulnerable individuals that need protection. Within the psychotherapeutic discourse we also found the position of the *child psychotherapist* that was characterised on the one hand by a strong identification with the role of child therapist, the need to understand the nature of the problems that children or adolescents are facing and a very high level of orientation in this area. By taking this position, the provider denied being involved in therapy for parents or family therapy. The last position identified within the role of the therapist was the *position of the authority*, with discourse of behaviourism and discourse of institutional care on a background with providers perceiving their role as more authoritative and dominant using restrictive practices.

Positions within roles connected to cooperation with other professionals

Participant in inter-institutional cooperation

First, we identified the position of *coordinator of care* with a discourse of multidisciplinarity in the background in cases when providers talked about their initiative in contacting and cooperating with other professionals for the requirements of diagnosis, therapy or inpatient care. The provider managed the care and was aware of other providers working with the child. Next, we found the position of *active cooperation*, which was also adopted when the discourse of multidisciplinarity was in the background. This position was characterised by understanding that some problems needed interventions from various professionals and in order to achieve this goal cooperation between providers needed to be established or the provider expressed his or her willingness to cooperate. Within the biomedical discourse the *passive position* was identified and it was related to receiving clients from another provider or sending them to another care provider without communication between these institutions or providers and with no real cooperation established. In some cases,

especially in the case of a child psychiatrist, this position was shaped by the collision of biomedical discourse with the discourse of patients' rights. Without parents' agreement, a child psychiatrist was not able to accept a child into therapy, send him or her to some other professional or send important findings about the child to another professional, and this resulted in the passivity and resignation of the provider. The last position found in the interviews was that of *individualist*, which was characterised by insecurity and the impossibility of sharing information about clients with other colleagues. We identified two discourses in the background: the psychotherapeutic and the discourse of the patients' rights.

Participant in intra-institutional cooperation

The position of *coordinated care* was found with the discourse of multidisciplinarity. Providers expressed their need to cooperate closely, to discuss and share information with other professionals. They also expressed the need to cooperate with other professionals to optimise procedures for adolescent in the care.

Roles connected to the functioning of the institution

Businessman

The *dependent position* was identified within the economic discourse, especially its collision with the discourse of humanism. We found it in those providers who were working under a contract with insurance companies. This resulted in the submissive position of providers to insurance companies and less freedom in the provider's work (e.g. in the selection of clients, procedures, treatments, length of the procedure). Another position found was the *position of freelancer* that arrived in providers who had no contracts with insurance companies. The services of these providers were fully paid for by the parents of adolescents resulting, on the one hand, in the selection of clients, as not all parents could afford to pay for the care, and on the other hand, in the freedom for provider in his or her work (in such aspects as the length or frequency of treatment). The last position adopted within the role of businessman was the position of a *propagator*, which also occurred within the economic discourse and was identified when providers were talking about how marketing was used to become known among other providers or clients.

Which discourses fitted with the transformational tendencies?

From the interviews, we understood that within the roles related to direct work with clients, the psychotherapeutic discourse and the combination of this discourse with that of humanism enabled involving patients in decision-making, taking into account individual needs of patients, and emphasised the importance of the relationship between provider and client.

The biopsychosocial discourse enabled considering the social context in the process of diagnosis. Next, in the roles related to cooperation with other professionals, we identified that the discourse of multidisciplinarity resulted in practices such as networking and searching for an optimal solution for the client together with other professionals. Interestingly, the patients' rights discourse occurred in interviews and led to different results in different professionals. In the role of expert with the biomedical discourse in the background, it was associated with disagreement of the care provider, who only unwillingly left his or her position of authority and power over client. In the role of participant in inter-institutional cooperation, it was associated with the position of individualist and contributed to an atmosphere of fear of sharing information.

Table 6.4 Identified roles in providers and discourses on their background leading to the different positions of professionals and practices.

Roles	*Discourses*	*Subjective positions*	*Practices*	*Institution provider*	*Examples*
Roles connected to direct work with clients					
Expert	Biomedical	Position of power	Taking responsibility for decisions, objectification of patients and reduction of patients to the symptoms or diagnosis, dominance over the client, selection of clients, selection and implementation of pharmacological and therapeutical strategies, medical reports	Psychiatric sanatorium Psychiatric hospital	"It is a success here because the conditions of patients who come are mostly... The symptoms are just, I would say, in the initial phase of treatment, you see?"
	Psychotherapeutic	Position of gaining knowledge	Strong identification with the professional role, lifelong learning, supervision, psychotherapeutic training, limits of expertise	Child psychologist Psychosocial centre	"But I do not understand how it can be done without individual therapy and supervision. These are the channels that quasi need to be present."
	Biomedical vs discourse of patients' rights	Position of helplessness	Parental agreement, negotiating with parents, resignation, signing reverse	Child psychiatrist	"You will not do anything without the consent of a legal representative. Nothing."
Diagnostician	Biomedical	Position of expertise	Diagnostic tests, clinical observations, questionnaires, diagnostician labels, making decision about treatment, validity of the diagnostic process is unquestionable	Psychiatric sanatorium Child psychiatrist Psychosocial centre	"For the most part, I establish the diagnosis at the first session."
	Biopsychosocial & discourse of humanism	Position of expertise	Flexible use of diagnostic methods reflecting experiences of professional, complex diagnostics, including an assessment of factors other than individual (social, family)	Child psychologist Psychiatric hospital	"I found out that it was more useful to say 'draw me what you want'. The child will simply more freely project there what they need to show."
Therapist	Psychotherapeutic & Discourse of humanism	Humanistic position	Respect for clients, clients are equal partners, contract, empowerment of the client, interventions in line with individual needs of clients	Child psychologist Psychiatric sanatorium	"The essence of therapy is to be a good match with a client in terms of personality. However, I cannot tell beforehand whether or not I will suit the child and will be capable of establishing a relationship with them as well."

Roles	***Discourses***	***Subjective positions***	***Practices***	***Institution provider***	***Examples***
	Psychotherapeutic	Protector	Warm feelings for clients, provider–client relationship resembles the relationship of a mother and child, a secure environment, arranging appointments with other professionals, crossing boundaries, meetings for free	Psychosocial centre	"[Clients] are so helpless in that world. But now they are protected at our facility, they are provided for, we care about them..."
	Psychotherapeutic	Child therapist	Denial of therapy for parents or whole family, psychoeducation of parents, interventions suitable for children and adolescents	Child psychologist	"I raise that question with the child in therapy as well. The bigger one, of course. Like what they would want. So that they do not feel excluded somehow or that something that concerns them is being done without them."
	Discourse of behaviourism & discourse of institutional care	Position of authority	Authoritative and dominant role of the provider, teacher–student relationship, regime therapy, training of desired behaviour and regulation of behaviour, confrontation with consequences of behaviour, cognitive-behavioural psychotherapy	Psychiatric sanatorium Psychiatric hospital	"We take such measures here and I strongly identify with that. I think it is very good. Children must not even have mobile phones here, or some sharp objects or valuables. They may have some pocket money, 5 to 10 euro at the most."
Roles connected to the cooperation with other professionals					
Participant in inter-institutional cooperation	Discourse of multidisciplinarity	Coordinator of care	Networking	Psychosocial centre Child psychiatrist	"At times I need to contact, for example, a class teacher or a headmaster. Or a neurologist or a psychologist or a counselling centre. It is arranged either by the parents themselves, or they ask me and I make a call with their consent."
	Discourse of multidisciplinarity	Position of active cooperation	Sharing information, searching for optimal procedures with other professionals	Psychiatric sanatorium Psychosocial centre	"I do not employ anyone in my office, but I work with psychologists located next to me."

Roles	*Discourses*	*Subjective positions*	*Practices*	*Institution provider*	*Examples*
	Biomedical vs discourse of patients' rights	Passive position	Giving and requiring recommendations from other professionals, no communication between professionals, requirement of parental agreement	Psychiatric sanatorium Psychiatric hospital Child psychiatrist	"You will not even arrange admission to a hospital, when they tell you the child will not go anywhere. You will not do anything."
	Psychotherapeutic & Discourse of patients' rights	Individualist	Isolation of providers, no opportunity to share information or ask for advice, atmosphere of fear	Child psychologist	"At times I perceive the impossibility to work with colleagues, discuss certain types of clients we have in common, due to the Act on Personal Data Protection."
Participant in intra-institutional cooperation	Discourse of multidisciplinarity	Position of coordinated care	Cooperation aimed at achieving procedures' optimalisation, all providers are equal partners with defined competencies	Psychosocial centre	"... when I have a client who comes for the first time and I see their problems are very profound, very difficult, and cannot be managed psychologically, that they need psychiatric therapy, then there is a doctor right next door, a psychiatrist, and she will offer them this service, and I can even introduce them to the doctor, and she schedules them an appointment."
Roles connected to the functioning of the institution					
Businessman	Economic vs discourse of humanism	Dependent position	Limitations from insurance companies, unnecessary diagnostic labels, crossing boundaries of psychotherapy, refusing of economic discourse	Psychosocial centre	"Because of insurance companies. We cannot describe and justify a psychological intervention in some human and psychological way if we want to have it paid for by the insurance company. We have to use the ICD... and we have to assign a diagnosis... psychiatric to each client who comes to us."
	Economic	Freelancer	Selection of clients, freedom in work, rivalry, competitive environment	Child psychologist	"The fact we use direct payments makes us incredibly free. We can do what we want. Totally."
	Economic	Propagator	Marketing strategies	Psychosocial centre	"When you search for a psychologist in [name of city] in a search engine, we are the first that pop up on Google."

Discussion

We identified six roles of CAMHS providers, which could be divided into three categories (direct work with clients, cooperation with other providers, functioning of the institution). Within these roles we identified subjective positions and practices that resulted from nine discourses. Moreover, we found that the biomedical discourse in particular hinders the transformation, whereas the psychotherapeutic discourse, the discourse of humanism and multidisciplinarity promoted it. Further, we will discuss whether these roles and discourses reflect transformational tendencies in institutions and providers of CAMHS in a more detailed way.

Roles connected to direct work with clients

Role of the expert – the biomedical discourse provides a dominant position with power and knowledge unless it collides with discourse of patients' rights

In the expert role, the biomedical discourse persisted as the most dominant discourse in psychiatric care (Jørgensen, Praestegaard & Holen, 2020; Jacob, 2012; Zeeman & Simons, 2011), even though this discourse has been criticised (see Deacon & McKay, 2015; Deacon, 2013). This discourse also resulted in a position related to the power (Kent, Cooke & Marsh, 2020), knowledge and ability of care providers to make decisions about patients with the objectification of patients and reducing them to their symptoms (Ziółkowska, 2012). A position of power over the client also influences a patient's participation in decision-making. In line with previous research (Coyne et al., 2015), we found that the position of power within the biomedical discourse might be connected with the insufficient involvement of adolescents, despite the fact that shared decision-making in adolescents' mental health care is expected to bring various positive outcomes (e.g. Day, 2008). A possible explanation is that providers may not be trained to correctly involve the adolescent into this process or they are afraid that this would take away some of their responsibility for the treatment (Bjønness et al., 2020).

Moreover, as the biomedical discourse collided with discourse of patients' rights, a position of hopelessness in providers appeared; they only reluctantly retreated from their position of power and expertise and felt forced to negotiate with parents in questions of care for their children. This may be explained by the concerns in care providers that they would lose their responsibility for treatment (Bjønness et al., 2020). Moreover, regarding the transformational tendencies, the biomedical discourse may provide a barrier to the involvement of patients in the shared decision-making process. The discourse of patients' rights on one hand provided space for patients to express their feelings and thoughts about treatment,

but on the other hand this was only for adults, not yet for adolescents.

Role of the expert – the psychotherapeutic discourse brought the need for continual learning and gaining of knowledge

Within the expert role we also found the position of gaining knowledge with the psychotherapeutic discourse in the background. Psychologists perceived themselves as holding expertise in psychotherapies (Shubert, Rhodes & Buus 2021). We understand these discrepancies between positions as a result of different discourses: a psychiatrist is a doctor with a background of the biomedical discourse and power and knowledge are attributed to his or her status by lay people and society (Kent, Cooke & Marsh, 2020); a psychologist is usually someone without a medical education and his or her profession requires lifelong learning and through it he or she progressively gains the confidence and knowledge of his or her practice (Salter & Rhodes, 2018).

Role of the diagnostician – from biomedical discourse focusing on diagnostic tools to the biopsychosocial discourse considering the social context in the assessment

A second role directly related to providing care was that of diagnostician, with two discourses in the background: the biomedical and the biopsychosocial. The biomedical discourse resulted in the use of various diagnostic tools whose validity was considered unquestionable and being taken for granted. As no mental disorder met the criterion to be defined as a "disease" (Szasz, 2001) and there was no single biological marker for any of the mental disorders found (Deacon, 2013), it is common practice to use less rigorous diagnostic tools, including clinical observations, interviews and psychodiagnostic tests, and therefore diagnoses are usually the result of a subjective report of psychological symptoms (APA, 2003). Considering this, we assumed that the position of expertise in the diagnostic role was more a result of the status of professionals than a result of gained knowledge and scientific progress in this field.

We also found an attempt to include social factors in the diagnostic process, i.e. adopting the role of diagnostician within a biopsychosocial discourse that is based on a biopsychosocial model of health (Engel, 1977). Within this discourse, professionals claimed that they used diagnostic tools in a more flexible way, adapted in line with their experiences and the individual needs of clients. The need for a complex diagnosis, including an assessment of the family and other social factors, was more present in the role of diagnostician with the biopsychosocial discourse in the background, as it allows an individual to be perceived as part of a different system that has influenced him or her.

Role of the therapist – the psychotherapeutic discourse together with the discourse of humanism provides space for patient-centred care

Next, we identified a third role connected to providing care, i.e. that of therapist, predominantly with the psychotherapeutic discourse in the background, but the discourse of humanism, behaviourism and institutional care also occurred. The first position, the humanistic position, was driven by the psychotherapeutic discourse and the discourse of humanism. In line with the assumption of successful psychotherapy, the psychotherapeutic discourse emphasised the relationship between professional and clients that previous research has confirmed (e.g. Shirk et al., 2011; Karver et al., 2008). The discourse of humanism can be observed in the attempts of patient-centred care that emphasise the individual needs and the equal relationship between professional and patient, where the perspective of the patient is respected and his or her participation is maintained. This need for patient-centred care in mental health care for adolescents has been recognised (Kongerslev & Storebø, 2017) and positive outcomes have been revealed (Kapp et al., 2017).

Within the role of therapist we identified the position of protector, which resulted in high identification with the professional role and crossing the boundaries of psychotherapy. On the one hand, Pope & Keith-Speigel (2008) claimed that crossing nonsexual boundaries can enrich therapy and serve the treatment plan and best interests of clients; on the other hand, professionals should be aware of the risks and able to analyse whether their practise is in line with the ethics of their profession, as was discussed in the context of residential care for adolescents (Bunner & Yonge, 2006). Taking responsibility away from the client is, moreover, in contrast with the empowerment of the client and shared decision-making and may be understood as an unequal power relationship between professional and client.

Another identified subjective position within the role of the therapist was that of child psychologist, with the psychotherapeutic discourse in the background. This was the only position where professionals mentioned using interventions adapted for children and adolescents. However, taking this position resulted in refusing to do family therapy despite the fact that professionals perceived working with parents and the whole family as a necessary part of the treatment for children (Dankulincova et al., 2020). This position provides the opportunity to involve the adolescent in the decision-making process, which previous research has shown to be a significant factor for positive care outcomes (Day, 2008).

Role of the therapist – discourse of behaviourism and institutional care brought control of behaviour

A last position identified within the role of therapist was that of authority, with the discourse of behaviourism and institutional care in

the background. This position led to practices such as regime therapy, cognitive-behavioural interventions and a teacher-student relationship between professional and patient. Although institutionalisation in psychiatry has changed over time, paternal relationships between professionals and patients have still been considered as one of the traits (Chow & Priebe, 2013), in line with our findings. Moreover, as LeFrançois (2007) summarised, children's participation rights in inpatient care were ignored within different countries and children were controlled within children's services and their direct involvement in decision-making was limited (Coppock, 2002).

Besides the discourse of institutional care, we found the discourse of behaviourism regarding this position. This is not surprising finding, as cognitive-behavioural therapy has been considered as an evidence-based practice (e.g. Butler et al., 2006). To sum up, while the psychotherapeutic discourse and especially the position of the child psychologist provided space for an adolescent's involvement in a shared decision-making process as a part of the transformational tendencies in CAMHS, the discourse of institutionalised care restricted the rights and voice of adolescents and were not very open to transformational tendencies in mental health care for adolescents.

Roles connected to the cooperation with other providers

Role of cooperation – the discourse of multidisciplinarity brings a vision of cooperation, but a clear definition of roles and competencies is needed

All providers identified themselves to some extent with the role of inter-institutional cooperation, though the way such cooperation was realised differed from very active to very passive and was dominantly influenced by the discourse of multidisciplinary. Similarly, in other studies (e.g. Bramesfeld et al., 2013), interdisciplinary cooperation was considered as a basic requirement in CAMHS. Attempts to solve mental health problems in multidisciplinary teams may also be observed in practice aiming to provide holistic care for adolescents and their families (Child and Adolescent Mental Health Service: Model of Care, 2013). An explanation for the range of positions within cooperation with other care providers from the very active to the very passive might be found in the unclear or completely missing definition of roles and competencies between specific care providers, which created a certain barrier for cooperation. As Suter et al. (2009) found, for good cooperation between different professionals it is important to understand the roles and competencies of all of them. A second barrier and potential explanation for the more passive position resulted from the patients' rights discourse; in cases where parents did not agree, the provider could not contact or cooperate with other professionals. Such a position of parents was perceived by providers as a

potential barrier for effective care (Dankulincova et al., 2020).

Those two barriers were not present in the case the provider was able to have the role of participant in intra-institutional cooperation in institutions providing complex care with a multidisciplinary team, where one institution was able to cover both psychological and psychiatric care. The benefits of clearly defined and encouraged multidisciplinary teams have been expressed by care providers (Dankulincova et al., 2020), and a multidisciplinary approach is one of the aspects of transformative tendencies within CAMHS (Australian Capital Territory Government, 2013). In sum, the realisation of a multidisciplinary approach in everyday practice within existing transformation processes is limited in the case of inter-institutional cooperation, even though it was present in the providers' perspectives as a part of their roles.

Role connected to the functioning of the institution

Role of a businessman – care only for clients able to pay or with a diagnostic label

The last group we found included the role of a businessman, with the economic discourse in the background resulting in the position of a freelancer and propagator. As the economic discourse collided with the discourse of humanism, it resulted in a dependent position. The position of freelancer occurred in providers who did not have a contract with insurance companies; this, on one hand, provided them freedom in their work, but on the other hand it brought a rivalry between providers, which is in line with previous research (Bramesfeld et al., 2013). This also brought a selection of clients who were unable to pay for treatment and therefore did not receive care. This was revealed as one of economic barriers to mental health care (e.g. Flisher et al., 1997). The position of propagator related to different marketing strategies aimed at gaining clients, which is also in line with previous work of Bramesfeld et al. (2013) and Dankulincova et al. (2020). They found that the need for marketing practices as a part of the competition between providers is usually a result of lacking state funding and/or complete independence from state funding. Last, the dependent position occurred in the situation when providers worked under contract with insurance companies that set limits for treatment.

Economic discourses thus relate to setting barriers to access to mental health care. First, the role of a businessman represented a work burden for professionals, as they had to spend work time on marketing practices, but it also represented a psychological burden, as they had to accept limits from insurance companies that were in contrast to their beliefs about the best interest of clients. Second, economic discourse creates the dilemma of whether to exclude clients unable to pay for treatment by themselves in exchange for gaining freedom in other factors of care (position of a freelancer) or providing psychotherapy fully paid by insurance company

in exchange for limits from these companies and in the case of exceeding these limits, working for free (dependent position). Although we found that the economic aspect of mental health care is also related to the roles of providers, we did not find any attempt to discuss this issue in the planned transformation of CAMHS in Slovakia.

Strengths and limitations

A major strength of this study was its qualitative design, which provided the opportunity to bring deep and detailed insight into the roles of professionals working in CAMHS, the discourses behind these roles, subjective positions and practices related to them and insight into where transformational tendencies are occurring and where they need to be supported. Another strength is that the sample covered all existing types of CAMHS. A limitation is that we may not have achieved the maximum saturation of different backgrounds of professionals with the number of interviews conducted. However, the sample selection was designed and able to reach a heterogeneous sample representative of the main types of CAHMS providers. Also, during data collection, we reached a point of saturation, where no new themes occurred.

Implications

Our findings may have several implications that need to be considered in the transformation of CAMHS. First, in the direct work with clients, we found that the biomedical discourse, the discourse of behaviourism and the discourse of institutional care hindered the transformational tendencies regarding patient-centred care and shared decision-making. There is a need to accept and develop the discourse of patients' rights and try to implement it into the dominant biomedical discourse that might support different aspects of patient-centred care. Our study suggests that there is a need to implement the assessment of an adolescent in his or her biopsychosocial context from perspective of the biopsychosocial discourse instead of rigid use of psychodiagnostics tests. In the case of cooperation among professionals, the finding from our study implies that there is a need to define roles and competencies of mental health care professionals working with adolescents, as the multidisciplinary approach requires clear definition of the role of each professional and the person responsible for the coordination of multidisciplinary care.

Last, regarding the economic discourse within CAMHS, our findings on the exclusion of certain clients who are not able to pay for treatment suggest that there is a need for a change in the financing of CAMHS so that it will not exclude some clients. At the same time, insurance should also cover treatment for patients without diagnostic labels and as such allow care to be provided in a more supportive and approachable way. Further study on possible improvements in the implementation of patient-centred

care, a multidisciplinary approach and changes in CAMHS financing is needed.

Conclusion

We found three categories of CAMHS professionals' roles: those related to direct work with clients, those related to cooperation with other professionals and those related to the functioning of the institution. The discourses related to these roles and the consequent positions and practices affected their positioning in the transformation with the biomedical discourse presented a barrier while the discourse of multidisciplinarity, psychotherapeutic with the combination of the discourse of humanism and the discourse of patients' rights provide a space and opportunity for implementing a transformational process. Finally, we observed a need to include the economic aspects of CAMHS into the transformational process. The discourses related to roles and consequent positions and practices highly affected the positioning of professionals in the transformation. These need to be addressed first to reach a successful transformation.

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