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Title:

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Date:

2022-02-01

Citation:

Malatzky, C., Bourke, L. & Farmer, J. (2022). 'I think we're getting a bit clinical here': A qualitative study of professionals' experiences of providing mental healthcare to young people within an Australian rural service. *Health and Social Care in the Community*, 30 (2), pp.519-528. <https://doi.org/10.1111/hsc.13152>.

Persistent Link:

<https://hdl.handle.net/11343/276245>

Title

'I think we're getting a bit clinical here': A qualitative study of professionals' experiences of providing mental health care to young people within an Australian rural service

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Acknowledgements

The authors would like to thank those who participated in the study for their time and commitment to the research. Also, Olivia Mitchell and Zubaidah Mohamed Shaburidin for their contributions to the research, Barbara Pini for critical feedback and Jo Dolan and Naomi Stekelenburg for editing. We acknowledge that this work was supported by the Australian Government Department of Health's Rural Health Multidisciplinary Program and funded by the Australian Research Council [DP number 170101187].

Conflict of Interest statement

No conflict of interest has been declared by the authors.

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/HSC.13152](https://doi.org/10.1111/HSC.13152)

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Article type : Original Article

'I think we're getting a bit clinical here': A qualitative study of professionals' experiences of providing mental health care to young people within an Australian rural service

Abstract

This paper contributes to scholarship on the medicalisation of mental health support for young people through a case study of a multidisciplinary mental health service in rural Australia. All staff (n=13) working at the service participated in semi-structured, individual interviews. Transcripts of interview data were read and selectively coded and interpreted in relation to the overarching question of how participants view and experience mental health care provision to a diverse range of young people. Following analytical reflection, codes pertaining to engagement, accessibility and care provision were re-examined using the concept of medicalisation to understand the biomedical underpinning of mental health care and how this plays out in the experiences and perceived challenges participants talked about in responding to the mental health concerns of diverse young people. The resulting analysis is presented under five theme headings: (1) privileging clinical expertise and priorities within service provision, which was an important source of conflict for some participants; (2) 'multidisciplinary' teams – a 'difficult kind of culture at times'; (3) articulations of where cultural barriers lie; (4) the tracks along which young people are directed to 'engage' with 'mental health'; and (5) a clinical 'feel' to space. We suggest that service and system investment needs to be given to alternative ways of thinking about and approaching mental health and care provision that are cognisant of, and engage with, the inherent connections between individual circumstance and social, place, cultural, economic and political contexts. This is particularly relevant to the provision of care in rural contexts because of limited service options and the

complexities of access and providing care to a diverse range of young people living in isolated environments. Interdisciplinary frameworks need to be enacted and services must acknowledge their own cultural positions for alternative ways of working to become possibilities.

KEYWORDS

Youth/young people, mental health, rural/regional health services, qualitative, medicalisation, multidisciplinary health care, clinical approaches to care provision

What is known about this topic?

- Interest in young people's mental health is growing.
- Poor access to services for young people is exacerbated in rural communities where models of care are often inappropriate for context.
- Young people are diverse and those living rurally require care that is accessible.

What this paper adds

- A critical exploration of how alternative approaches to young people's mental health are predominately sidelined.
- Empirical evidence of how the practice of multidisciplinary care is undermined by the privileging of biomedical views and a lack of understanding and respect for alternative positions.
- An analysis that explains the limited capacity for reflection on the cultural orientations and practices of health services as fundamental 'cultural barriers' to access.

1 INTRODUCTION

Attention to mental health 'issues' among young people is a growing phenomenon (Guy, Furber, Leach, & Segal, 2016; McGorry, Bates, & Birchwood, 2013; World Health Organization, 2019a). In Australia, mental illness is the second leading cause of disability (Guy et al., 2016). The highest prevalence of mental illness is among people aged 16–24 years (Guy et al., 2016). Those in this age range also experience the most restricted access to mental health services for complex and compounding reasons, including the rigid and fragmented nature of contemporary healthcare systems designed for an adult population that neither address the needs of young people nor take into account the heterogeneity of the category 'young people' (Ambresin, Bennett, Patton, Sancic, & Sawyer, 2013; Fusar-Poli, 2019; Guy et al., 2016; McGorry et al., 2013; McGorry, Goldstone, Parker, Rickwood, & Hickie,

2014). Access barriers for young people are heightened in rural places (Bartik, Maple, & McKay, 2015) where on-the-ground services are sparse, smaller, generalist and need to 'service as many people as possible' with limited workforce capacity (van Spijker et al., 2019, p. 1010) and system-level support (Wirth et al. 2019).

Consistent with international trends, the need for health services in Australia to integrate mental health support for young people into primary care has been identified and an increasing focus placed on service provision approaches that cater to a range of interconnected health needs under a multidisciplinary framework (Ambresin et al., 2013). The aim of these approaches is to improve access to mental health support for young people and encourage early intervention (Lee & Murphy, 2013; Sibiya & Gwele, 2013). However, additional resources to support the adoption of such approaches has not been forthcoming (Rosenberg & Hickie, 2019), leaving services to rely on existing capacities. In rural places, resources and workforce capacity are already stretched to service community needs (Church et al., 2010; Cosgrave, Maple, & Hussain, 2018). Thus, while current approaches to the provision of mental health support for young people aim to increase access, examination of the ways rurally-located community-based services are provided is warranted.

This article presents findings from interviews with all staff at one multidisciplinary mental health service in rural Australia. We use the term medicalisation as a conceptual tool to analyse and interpret participants' accounts of providing care to young people. This is undertaken because the increasing medicalisation of community-based services limits the provision of the care that might be needed and further marginalises and excludes those who experience greater vulnerabilities in our societies (Duncan & Reutter, 2006).

1.1 Medicalisation

As Lusardi (2019, p. e12698) notes, medicalisation is a 'key theoretical construct of the sociology of health and medicine'. It is also a term subject to significant contestation. In an important contribution to literature on this subject, Busfield (2017) examines criticisms of medicalisation and assesses its contemporary sociological efficacy. Busfield (2017, p. 766) highlights how medicalisation analysts do not assume patient passivity. Rather, they find patients can also 'question and resist medical power' (Busfield, 2017, p. 766), as evidenced in empirical research (Kharicha et al., 2017). Further, as contemporary reflections on past cases attest, questioning specific extensions of the medical domain is an important undertaking. Busfield (2017, p. 768) is clear such questioning does not claim 'all instances of medicalisation are unacceptable'. Along with other key scholars (Conrad, 2008; Frawley, 2017; Rafalovich, 2013), Busfield (2017) argues for the continuing value of medicalisation as a lens for analysing how contemporary societies understand key social and political issues.

This argument is supported by two principal points. Firstly, medicalisation 'identifies an important process that is still occurring...continuing to transform everyday understandings of human behaviour, experiences and problems' (Busfield, 2017, p. 769); it proliferates new disorders and various processes that encourage increased use of medications and other pharmaceutical interventions to reduce potential risks to health (Clarke & Van Amerom, 2008; Rafalovich, 2013). Conrad (2008) examines these trends, particularly in relation to young people and the increasing use of prescription drugs during the adolescent period. Relatedly, Rafalovich (2013) highlights how children and childhood have become the objects of scientific study and are (dis)ordered in new ways that require contestation.

Secondly, the concept of medicalisation draws critical attention to the social processes that explain the extensions of the medical domain and their consequences. Defining an issue in medical terms circumvents alternative understandings and approaches to inherently complex social phenomena (Busfield, 2017; Conrad, 2008; Frawley, 2017). Medicalisation clarifies how social issues become depoliticised; focus is directed to defining issues/problems on individualised terms rather than people's social and institutional contexts (Busfield, 2017; Conrad, 2008). In this process, deficiencies are detected in the individual rather than within society, and individualistic approaches rather than deep, structural change initiatives are resourced (Clark, 2014; Clarke & Van Amerom, 2008; Taylor, Bradbury-Jones, Kroll, & Duncan, 2013).

Frawley (2017) outlines some of the 'positive' consequences of medicalising social problems, including improved treatment for some people previously considered 'bad' or 'mad' and stigma reduction. However, Potter's (2017) analysis of the medico-legal borderland involved in the diagnosis of conduct disorder among young people challenges the assumption that diagnosis necessarily results in social support, receipt of treatment, or reduced stigma. Potter (2017) points to how practitioners have to carefully weigh the potential benefit of leveraging medicalised labels to elicit support from health services for young people with the likelihood of stigmatisation. Building on this work, the current research illuminates the implications of privileging biomedical approaches in the provision of mental health care to young people and how engagement, accessibility and care provision are structured and managed in alignment with a medicalisation agenda within a rural service.

2 METHODS

In this research, we examined the meanings and practices informing health professionals' experiences. For this kind of investigation, a qualitative approach is most suitable (Braun & Clarke, 2013; Creswell, 2007; Goodson & Vassar, 2011; Petty, Thomson, & Stew, 2012). All staff (n=13), including allied health, medical, community, youth work, management and

administration professionals, working in the service as employees or privately were invited to participate in face-to-face, individual, semi-structured interviews in 2018 as part of a larger research study undertaken with this and three other mainstream rural health services in the same region. The service is located within a large rural town and was selected because it provides an option-of-care for a diverse (including hinterland) population. It is government funded but relies on cash and in-kind contributions from other local services and organisations and its operations are overseen by the local public hospital. The service has experienced significant staff turnover. No incentives were given for participating in this research.

All participants gave written consent. With one exception, interviews were audio-recorded and ranged from 28–90 minutes in length. Dialogue was guided by questions about: the participant's role within the service; how the service engages young people; clients who are perceived as challenging to engage; disengagement; young people who are known to be 'hardly reached' (Sokol, Fisher, & Hill, 2015); and alternate strategies for engaging young people.

Interviews were transcribed verbatim, and a number assigned to each transcript. With the participant's consent, the interviewer took detailed handwritten notes during the non-audio-recorded interview and these were typed as a transcript. All transcripts were then read by four researchers and the first author selectively coded and interpreted data over multiple rounds during which codes were developed, collapsed, re-formulated and refined (Braun & Clarke, 2013; Saldana, 2009). All instances of each code were collated and related to the overarching question of how participants view and experience providing mental health care to a diverse range of young people (Braun & Clarke, 2013). It was clear that embedded in these codes was a tension around medicalisation within the service (stemming from its attachment to a hospital, evidence-based approach and reporting frameworks based on individualised care overseen by psychiatrist/s) that contrasted with other forms of practice engagement and diversity of clients. Following analytical reflection (Saldana, 2009), codes pertaining to engagement, accessibility and care provision were re-examined using the concept of medicalisation to extend and deepen understanding of this tension. This choice of conceptual construct (medicalisation) and how data was subsequently interpreted was shaped by the authors' disciplinary training in sociology, rural health and community development and theoretical predispositions towards critical poststructuralist approaches to the examination of social and power relations (Denzin & Lincoln, 2011). The authors' unique experiences and subject positions also necessarily influenced the analytical process more broadly. This process of meaning-generation ultimately requires time and distance from the research to extensively deconstruct and appreciate (Mauthner & Doucet, 2003).

The resulting analysis was developed into five themes (Boyatzis, 1998; Saldana, 2009). Effort was made to enrich current understandings of the nature and consequences of medicalisation within the youth mental health sector through the analysis by extending existing debates and knowledge, and care was taken to be sensitive to the contexts and positionings of participants by keeping these at the forefront of our minds when interrogating data. We were also conscious of the potential implications disseminating our interpretations from the research could have for participants (Finlay, 2006). Given the comparably small number of employees and the sensitivity of some issues explored, to protect participants' anonymity, broader contextualising categories (e.g. clinical/practitioner and non-clinical) rather than specific identifiers are used. In this paper, clinical/practitioner participants are those with a tertiary health qualification preparing them to work directly with patients/clients on an individual or group level. Participants categorised as non-clinical are those working in community engagement and front-of-house administrative roles. Ethics approval for this research was received from The University of Melbourne's Human Ethics Committee (Ethics ID number 1750296.1).

3 FINDINGS

Participants were not asked to identify specific demographic details about themselves. However, from researcher observations, participants were of varying ages and, consistent with global health workforce trends (World Health Organization, 2019b), many participants were female-identified. A small number had worked for the service since its establishment around five years prior, while others were relatively new. The five themes, which reflect the central meanings produced by researchers based on participants' commentaries related to the influence and effects of medicalisation for the provision of mental health care to young people, are articulated below.

3.1 Privileging clinical expertise and priorities within service provision

Some participants described the potential function of services like the one they worked in to challenge the medicalisation of normal human emotions. These participants provided a space for young people to experience emotions, such as depression or sadness, in response to reasonable stimuli validated and contextualised as 'alright' and 'ok to feel' (P3).

...I think that we get a lot of young people in and sometimes it's kind of like, 'oh everyone at school's going, I thought I'd go down and have a chat' and things like that...if that's what they need, then that's fine, but that's where it comes into having those medical diagnoses and going, 'but you're not depressed, it's okay to feel a bit sad at times' and just validating those feelings that that's alright...you don't have to be, like, medicalised or, you know, you don't have to think there's anything wrong with your

mental health...that's why it's still worthwhile people coming in because you can just say, 'hey, that's alright, you know, it's okay to feel like that sometimes' (P3).

Relatedly, participants suggested, consistent with the increasing medicalisation of the adolescent period and its internalisation (Conrad, 2008), some young people may be seeking a clinical diagnosis in order to be considered 'normal'. This reflects how pathologising so-labelled 'negative' human emotions has become normalised (Fullagar & O'Brien, 2013), a process some participants sought to challenge. However, these participants expressed that the service, and the broader mental health system, simultaneously applies and reinforces clinical approaches to human emotions, which construct emotions as biological and 'mental' phenomena, and draw emotion into medicalised practices and discourses (Tilbury, 2007). Resistance to these approaches—which one practitioner-participant in particular remarked made her feel like 'we're getting a bit clinical here...' (P6)—is difficult to achieve. Participants highlighted how many young people want support—for which there are few options in many rural places (van Spijker et al., 2019)—to cope with, for example, sadness, emotional regulation or difficult times, quite usual aspects of socialising and growing up. Yet clinical approaches structuring the service pull young people into the mental health system and assign diagnoses that follow them for life.

Some participants described how the clinical dimension within the service is privileged, explaining that funding and support are primarily sought for clinical work despite an equally substantial need for community and non-clinical dimensions. Non-clinical participants expressed the view that 'the clinical part is [treated as] way more important' (P10), or as holding greater value than non-clinical components. They claimed the work of engagement, prevention, social connection and promotion is less valued in a medicalised environment, leaving non-clinical employees feeling frustrated and marginalised. These participants explained the need to 'push' for consideration of their (non-clinical) position as equally important as other (clinical) positions within the service.

Some participants also highlighted several implications of privileging the clinical work undertaken for one of the underlying goals of the model in which the service operates: the empowerment of young people. The integration of young people's views and perspectives into the design and delivery of the service is, theoretically, an important dimension to its model. However, challenges in engaging young people with mental illness and the extent to which young peoples' voices can be centred when clinical perspectives are prioritised was a point of contestation. For example, one participant expressed that 'it is a great model, *as long as the clinicians are doing it* [emphasis added] [shared decision-making]' (P9). Further demonstrating this condition, most participants did not mention young people's involvement in the design or

delivery of the service's operations. Some participants suggested the 'clinical feel' (P3&P13) within the service prevents other therapeutic approaches from being more widely and openly implemented.

These participants highlighted how clinical approaches assume a shared language between client and worker and suggested there is an underlying tension in how alternative approaches and practices are constrained by the privileging of clinical approaches (Baum, Bégin, Houweling, & Taylor, 2009). Further, participants suggested mental health conditions in the Diagnostic and Statistical Manual of Mental Disorders are considered more 'severe' or important for the necessary work of the service than young people seeking emotional support for less 'categorisable' issues. By making a young person a labelled medical problem, the socially derived and situated nature of their experiences and circumstances is denied or downgraded.

3.2 'Multidisciplinary' teams: 'it's a difficult kind of culture at times' (P3)

Most participants expressed that a team comprised of professionals with different disciplinary training and perspectives (a multidisciplinary team, see Cioffi, Wilkes, Cummings, Warne, & Harrison, 2010) is 'really good' (P3). However, working in a multidisciplinary team was also described as difficult, because, depending on their disciplinary training, workers will take different perspectives on situations and matters not easily reconcilable. Ultimately, a decision must be made about which 'perspective is going to be best for a particular young person' (P3). In elaborating on this issue, a practitioner-participant used the example of differences in training and subsequent practice of a psychologist and a social worker, arguing the former's education and approach are typically aligned with a medical model focused upon individual diagnosis while the latter's are embedded within a societal-oriented framework. They explained how this difference shaped their response to meeting the needs of clients:

Say I have a young person who's like 12, and you're going, 'okay, maybe it's good that they sit with one of the social workers rather than getting into a more, like, intense therapeutic atmosphere at such a young age'. And then, you know, obviously there's that psychiatric viewpoint as well, which is again another layer of like, medical stuff. So yeah, I guess that you can still provide the client-centred care, but you've got to kind of make a decision about what perspective's going to be the best for a particular young person (P5).

This description of the decision-making process suggests care decisions are determined more by which discipline's knowledge dominates discussion than an assessment of which disciplinary perspectives align the closest with the client's perspectives. Medicalised

disciplines based on the established hierarchy of evidence and focused on therapeutic outcomes are prioritised. There is an inherent tension within multidisciplinary health teams between medicalised/individualistic and social approaches to understanding and responding to need. Relatedly, in talking about the benefit of having a service that operates a 'one-stop-shop' model, participants expressed that while this may mean young people do not have to go into multiple services, it does not necessarily mean they are working with professionals who have shared values, professional approaches or worldviews (Cole, 2018).

3.3 Articulations of where cultural barriers lie

Despite some critique of the clinical paradigm's dominance within the service and descriptions of the cultural challenges of working in a multidisciplinary team environment, in talking about the (dis)engagement/lack of engagement of First Nation Australian young people and young people from culturally and/or linguistically diverse backgrounds, few participants reflected on how the culture of the service itself may affect its accessibility. Rather, most participants directed focus to the culture of the Other and to the relational context as core explanations for why cohorts of young people who experience greater vulnerabilities within the broader community (Botfield, Newman, & Zwi, 2018; Priest et al., 2013) are under-represented amongst the service's users.

...It's the culture, because their culture's different to our culture. I can quite understand why they would be the ones that disengage because they would probably find it harder to bring it up at home with their parents and that sort of thing (P4).

However, some participants articulated the effect of an overly clinical approach coupled with cultural assumptions of experience (Ferrazzi & Krupa, 2016) on how young people from culturally Other backgrounds may experience the service. For example, one participant described how assumptions can be made about the reason a young person from a refugee background may be seeking care from the service:

...I've got a young person sitting in my chair and they must be so traumatised...That might be the case and they might have gone through a hell of shit to get where they are, but...[they could be there because] 'these people are picking on me' or 'my parents, you know, want me to become a doctor but I don't want to'... (P10).

In considering why young people from culturally Other backgrounds under-utilise the service, another participant speculated that the service may be experienced as too clinical for First Nation Australian young people, but also how it can be difficult to fully 'get' (P9) the stories of

some young people who are differently culturally situated than normalised subjects in White Western contexts.

...I'm not sure if that [safe environment; engagement] happens...maybe it's too clinical for them [First Nation Australian young people] straight up and that can be confronting... And with CALD [culturally and/or linguistically diverse] stuff, sometimes we just don't get it, you know...We might not get their story well enough (P9).

These participants highlight the importance of reflective practice for revealing cultural assumptions (Foronda, Baptiste, Reinholdt, & Ousman, 2016) and acknowledge the specificities of culturally-located experiences; the ways 'emotional meaning is fundamentally structured by particular cultural systems and particular social and material environments', making emotional experiences 'preeminently cultural' [emphasis original] (Lutz, 1988, p. 5). Yet the broader systems in which mental health services are provided are not culturally diverse or adaptive but seek to efficiently provide the 'same' experience to all. The medicalisation process seeks to standardise experience and ignores culture as an adaptive mechanism at the heart of mental health. Predominately, participants were unaware or unreflexive about how 'they' have a culture that needs to be focused upon rather than deflecting onto some culturally Other young people. Culture of the self/practitioner and the broader health system remained 'the elephant in room' (Farmer et al., 2012, p. 243).

3.4 The tracks along which young people are directed to 'engage' with 'mental health'

In considering young people's disengagement from the service, many participants problematised and deconstructed the notions of 'engagement' and 'disengagement', which captured how dominant conceptualisations of and approaches to 'mental health' structure the pathways along which young people are directed. These pathways position the individual as the 'problem' to be 'fixed' (Baum et al., 2009) and require other social institutions to 'tick a box' (Ferrazzi & Krupa, 2016). For example, participants described how young people can be directed into the service, either by parents, medical professionals or child and family services, sometimes for quite technocratic reasons. In these circumstances, participants emphasised how young people themselves may not have made the decision or be ready to 'engage' with the service. They have not 'engaged' in the first place.

Relatedly, participants described how young people's 'disengagement' from the service can sometimes result from decisions to meet their social and emotional needs by prioritising alternative connections, from peers for example:

It's not necessarily that they're disengaging...I've got one young person who's been coming really regularly, and suddenly... [they're not]. ...[They have] still been coming but [they're] like, 'oh, I don't,' because that's [their] time to spend with [their] friends, so little things like that, like young people will always, you know, will more often take those options of peer connection and various things that they want (P3).

These perspectives offer a different way of understanding (dis)engagement. They highlight and challenge an assumption of linear engagement embedded within medicalised understandings where health care users engage, engage more, and then disengage. In reality, participants suggested engagement aligns with need, which is organic and fluctuating. Working within a system that accepts a biomedical understanding of engagement and directs young people along pathways in accordance with that thinking can create, as one participant expressed, a too 'intense' (P5) clinical experience. Rather, some participants tried to offer young people engagement when they needed, disengagement when other priorities emerged, and re-engagement with the same or different clinicians as an ongoing option. However, the medicalised system of intake, referral and record-keeping resisted open, fluid and dynamic forms of engagement.

3.5 A clinical 'feel' to space

Participants understood a non-clinical feeling to the service's space as important for engaging young people. The service's environment, or sense of space, featured a range of colours, beanbags, a television often screening music videos, board games and posters. This space was viewed by most participants as a 'comfortable place', without a 'traditional clinical feel' (P3). Participants reported that a non-clinical feeling to the space was important for making the service 'accessible' (P3) and 'user friendly' (P2–P5,P7&P13) and creating a 'relaxed' (P5&P11) atmosphere. One participant explained that often when parents rang the clinic hoping to access help for their child, their anxiety was alleviated by an invitation to make an informal visit. The participant acknowledged there are some clinical necessities for a mental health service, such as private spaces and sound-protected rooms, but argued these requirements do not have to equate to a formal clinical setting.

Other participants echoed the view that a non-clinical environment is crucial to quality mental health care for young people, asserting the clinical encounter is greatly facilitated when the setting is more relaxed as trust and rapport can be built incrementally and organically. As one clinician-participant described, fostering a non-clinical spatial environment can help to avoid going 'straight into' (P11) problematising experiences:

...the place how it's set up, it's so visually appealing...like it's a non-clinical environment so they don't feel like they're at the doctor's surgery...like there's games and stuff in the rooms so you can kind of build that rapport without, you know, just getting straight into, 'Well, what's wrong with your mental health?' kind of thing. So they can trust you, because it's really scary for them obviously... (P11).

However, some participants expressed that while the service's environment may be 'less' clinical than others, 'it's still clinical' (P13) and could be experienced as too clinical by some young people. These participants, who had different disciplinary training and workplace experiences, spoke about the clinical environment as a barrier to coming into the service for an appointment and the importance of outreach in this context. This highlights the complexity involved in creating a non-clinical space and suggests the extent to which such spaces can be created is limited by the fundamental grounding mainstream Australian health services have in a biomedical imagination that privileges clinical frameworks over others (Baum et al., 2009). Clinical settings seek to control individuals by expecting particular performances and practices (Busfield, 2017); for example, where those seeking care should be and how they should act. Here, the medical approach to service provision, which requires young people to come into a controlled setting rather than going into young people's environments, was raised by participants as a barrier to care and thus an important challenge for health and social care providers.

4 DISCUSSION

The research presented here is limited to the perspectives of staff working within a single rurally-located mental health service for young people, a case study site in a larger research project aimed at understanding processes of power and culture within mainstream rural health services (Malatzky, Mitchell, & Bourke, 2018). However, the current findings emphasise the inherent challenges of engaging with alternative perspectives on, and approaches to, care provision within a health system firmly structured by biomedical frameworks. Our findings illustrate how such frameworks underpin young people's mental healthcare and influence professionals' experiences, and also explain how this gives rise to a series of currently unaddressed challenges in responding to the mental health concerns of a diverse range of young people. While the context of this service is different to others, this research identifies challenges pertaining to medicalisation that are relevant to many rural, community, mental health and/or young people-focused services.

There has been little scholarly examination into feel of space in relation to mental health service environments designed for young people. However, there is some suggestion in existing literature that part of creating an age-appropriate environment for young people

involves disrupting traditional associations between health services and the feel to clinical spaces (Ambresin et al., 2013; Tivorsak, Britto, Klostermann, Nebrig, & Slap, 2004). The findings of the present research highlight how, even in contexts where a concerted effort has been made to minimise a clinical feel to space, an ethereal residue remains, left by the 'fabric of medical thought' (Waldby, 2000, p. 136) that is woven into the vast majority of designated 'health' spaces. The views of some participants regarding the clinical feeling to the space challenge the view of the apolitical, neutrality of clinical space supported by biomedical discourses (Busfield, 2017); a clinical feel to space clearly has neither a neutralising nor depoliticising effect but can exclude, intimidate and alienate. Outreach services for young people may be a powerful means of subverting the influence of biomedicine within health spaces. However, this needs to be done carefully so outreach environments are not medicalised (McGarry, 2003).

The mental health pathways for young people raise important questions about the kind of care provided under healthcare systems governed by biomedicine. Biomedical power subjects young people with mental health concerns to the biomedical gaze to make sense of those concerns, or to render them intelligible and treatable (Foucault, 1978). Through this process, young people are set on a path that 'treats' their embodied experiences in isolation from the contexts that shape and inform those experiences and thereby subjugates alternative understandings to a biomedical perspective on mental health/illness (Ferrazzi & Krupa, 2016). This has implications for the kinds of care available to young people through mental health institutions. Further, once a young person gains a diagnosis, they are identified as unwell and often carry this identity throughout life. This discourages understanding of their experiences as part of life's journey.

Some participants in this study indicated young people-focused health services, drawing on a multidisciplinary model of care provision, can represent a way to challenge the authority of biomedical approaches to care and offer alternative means of addressing the needs of young people, potentially, in more accessible and inclusive formations. While there were differences in how mental health was approached among staff trained in different disciplines, the different approaches were applauded but not integrated. Some workers within the service provided a space where common experiences or sensations of human emotions were normalised, but clinical frameworks that medicalise and 'treat' non-medical problems and contexts (Rose, 1994) were reinforced in the service environment through governance, reporting and leadership structures. Numbers rather than wellness are counted, individuals rather than education or outreach are prioritised, and oversight is assigned to psychiatrists. Thus, emotion, access and experience were predominantly understood through a medicalised lens

and, as some participants lamented, this is where resources and attention are focused (Rose, 2007), restricting the practice of health professionals. This reflects the widespread privileging of biomedicine over other approaches at the systems level (Baum et al., 2009), evidenced in participants' accounts of how alternative therapeutic approaches are predominately marginalised in the formal functioning of the service and are practised clandestinely by individual practitioners uncomfortable with the dominance of clinicalised approaches to care.

The constant site of struggle between biomedical and alternative frameworks was highlighted in participants' discussions of how the 'multidisciplinary team' functions in practice. It was articulated that, rather than a multi-levelled and faceted negotiation and enactment, a decision is made about which viewpoint directs the care provided to a young person. This exemplifies how the privileging of one dominant viewpoint (the biomedical) poses a fundamental challenge to multidisciplinary practice, which, if truly possible, requires an understanding and respect for different professional cultures (Cole, 2018; Ferrazzi & Krupa, 2016) and ways of conceiving and experiencing 'symptoms', 'treatment' and their 'management' (Dogra, 2007). Relatedly, it poses a fundamental challenge to the accessibility and appropriateness of health services for a diverse range of young people. This is consistent with the findings of interagency collaboration research, which highlights the value of authentic integration for young people, but also the complexities and challenges (Morgan, Pullon, Garrett, & McKinlay, 2019).

Few participants related the challenges of multidisciplinary practice to the accessibility, acceptability or appropriateness of the service, yet there is literature documenting the ineffectiveness, and likely counter-productive consequences, of applying biomedical approaches to mental health care for young people (Dogra, 2007; Ferrazzi & Krupa, 2016; Tilbury, 2007). When broader conceptualisations of culture and cultural positioning, as well as the heterogeneity among 'young people', are taken into account, the biomedical approach is not 'equipped to accommodate' (Ferrazzi & Krupa, 2016, p. 164) many alternative socio-cultural conceptions of mental health. Rupturing current practices that support the dominance of existing biomedical ways of thinking, defining and responding would likely result in very different care—possibly a different setting, conversation, therapy and outcome.

5 CONCLUSION

Our findings confirm the need to develop alternative approaches to supporting the mental health of young people that are cognisant of and engage with the inherent connection between individual circumstance and social, place, cultural, economic and political contexts (Mills, 2000). Systematic approaches to support young people to negotiate emotional challenges are not served under a medical model where the implications are felt across different settings. For rural contexts, the conditions created through the privileging of biomedical approaches to

mental health care for young people are enhanced by the complexities of access and providing care to people with diverse identities living in isolated environments who have few support options.

The kinds of care and support health professionals can provide to address the health and social needs of young people are currently limited. The medicalisation of the youth mental health sector and the subsequent disordering of human experience and depoliticalisation of social issues needs to be challenged. Changing the way we think about mental health and the policies and practice approaches endorsed to embrace a wider range of meanings and explanations for (poor) mental health will help to achieve this. Care provision approaches need to move towards interdisciplinary rather than multidisciplinary frameworks. This will require services to acknowledge their own cultural positions and deconstruct the medicalised cultures in which they are/have been situated, thereby allowing alternative, non-medically-based ways of working to become possibilities, and for the perspectives of young people to be truly embedded in service design.

Such re-orientations to the provision of mental health support would have important implications for the workforce, changing the kinds of workers we classify as health and social care providers to include those who are currently either assigned to the periphery of the health sector or siloed into other domains. Changing the way we think about health, and thus the kinds of knowledge, expertise and actions required to foster good health, can change the system (Cui, Lancaster, & Newman, 2019). We contend that until health systems are recognised as cultural systems that include, intersect and generate multiple meanings and subject positions, having far-ranging implications beyond the 'health' sector, we cannot begin to understand engagement, accessibility and patient-centred care or address the temporal and fluctuating social challenges (re)created by processes of medicalisation.

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