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The Role of Social Workers in Slovenian Mental Health Institutions:

Interdisciplinarity approach addressing Youth Mental Health

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ABSTRACT

Title: The Role of Social Workers in Slovenian Mental Health Institutions: Interdisciplinarity approach addressing Youth Mental Health.

Abstract: This qualitative study examined how social workers enact their roles within interdisciplinary mental health services for children and youth in Slovenia, amid an ongoing shift from hospital-centred, biomedical care to community-based, rights-oriented practice, through the process of deinstitutionalisation. Grounded in model of interdisciplinary collaboration (Bronstein's, 2003; Kelly et al., 2019) and the psychosocial ecosystemic approach (Martinez-Brawley & Zorita, 2017; Walker, 2003), using methodological triangulation through observational journaling, across public mental health settings in Slovenia, semi-structured interviews with practicing Slovenian social workers with experience in mental health, and Slovenian mental health document analysis. Objectives were to: (1) explore the perceptions about the role of social workers within interdisciplinary mental health teams in Slovenia; (2) identify the challenges commonly encountered concerning mental health care and different discipline approaches in a social workers viewpoint; and (3) describe the strategies and practices social workers develop to address these dilemmas in everyday professional contexts.

Findings indicated that social workers provide a distinctive, humanizing, and integrative contribution: bridging clients and systems; integrating intrapsychic, relational, family, school, community, and policy dimensions; and advocating for autonomy, inclusion, and rights guarantee of the clients. Interdisciplinarity is present but uneven: formal case conferences coexist with informal collaboration, while medical hierarchies, staff shortages, workload, over bureaucracy and weak interministerial/sectorial coordination constrain shared decision-making, prevention, and continuity of mental health treatment. In response, practitioners rely on relational investment, role flexibility beyond formal remits, and supervision, even though scarce, to sustain reflexivity and resilience. Document analysis corroborates a policy–practice gap: despite national goal to community treatment and intersector aims, deinstitutionalization proceeds slowly and rights concerns persist in institutional settings as it is highlighted by the reports analyzed within violations.

Recommendations include operationalizing cross-sector governance, embedding protected interdisciplinary reflection and joint goal-setting in team routines, strengthening education background and services training for collaborative practice, and accelerating rights-aligned, co-produced deinstitutionalization. Future work should foreground power dynamics in mental health services and also seek for service-user perspectives to assess whether interdisciplinary psychosocial practice yields measurable gains in youth mental health and social inclusion.

Key-words: Mental health; Social Work; Interdisciplinarity; Slovenia; Children and Youth.

POVZETEK

Naslov: Vloga socialnih delavcev v slovenskih ustanovah za duševno zdravje: Interdisciplinarni pristop k obravnavi duševnega zdravja otrok in mladostnikov.

Povzetek: Ta kvalitativna študija je preučila, kako socialni delavci izvajajo svoje vloge v interdisciplinarnih službah za duševno zdravje otrok in mladostnikov v Sloveniji, sredi nenehnega prehoda od bolnišnično usmerjenega, biomedicinskega modela obravnave k skupnostno zasnovani, pravicam usmerjeni praksi, skozi proces deinstitucionalizacije. Študija temelji na modelu interdisciplinarnega sodelovanja (Bronstein, 2003; Kelly et al., 2019) in psihosocialnem ekosistemskem pristopu (Martinez-Brawley & Zorita, 2017; Walker, 2003), pri čemer je bila uporabljena metodološka triangulacija prek opazovalnega dnevnika v javnih ustanovah za duševno zdravje v Sloveniji, polstrukturiranih intervjujev s slovenskimi socialnimi delavci z izkušnjami na področju duševnega zdravja ter analize slovenskih dokumentov s področja duševnega zdravja. Cilji so bili: (1) raziskati percepcije o vlogi socialnih delavcev v interdisciplinarnih timih za duševno zdravje v Sloveniji; (2) opredeliti izzive, s katerimi se socialni delavci pogosto soočajo v zvezi z obravnavo duševnega zdravja in različnimi disciplinarnimi pristopi; ter (3) opisati strategije in prakse, ki jih socialni delavci razvijajo za reševanje teh dilem v vsakodnevnih poklicnih okoljih.

Ugotovitve so pokazale, da socialni delavci zagotavljajo svojevrsten, humanizirajoč in integrativni prispevek: vzpostavljajo mostove med klienti in sistemi; združujejo intrapsihične, odnosne, družinske, šolske, skupnostne in politične dimenzije; ter zagovarjajo avtonomijo, vključenost in zagotavljanje pravic klientov. Interdisciplinarnost je prisotna, a neenakomerna: formalne multidisciplinarne konference soobstajajo z neformalnim sodelovanjem, medtem ko medicinske hierarhije, pomanjkanje kadrov, preobremenjenost, prebirokratiziranost ter šibka medresorska in medsektorska koordinacija omejujejo skupno odločanje, preventivo in kontinuiteto obravnave duševnega zdravja. Kot odgovor na te izzive se strokovnjaki opirajo na vlaganje v odnose, fleksibilnost vlog onkraj formalnih pristojnosti ter supervizijo – čeprav redko dostopno – za ohranjanje refleksivnosti in odpornosti. Analiza dokumentov potrjuje vrzel med politiko in prakso: kljub nacionalnemu cilju skupnostne obravnave in medsektorskim prizadevanjem deinstitucionalizacija poteka počasi, pomisleki glede pravic pa ostajajo prisotni v institucionalnih okoljih, kar izpostavljajo analizirani poročili o kršitvah.

Priporočila vključujejo operacionalizacijo medresorskega upravljanja, vključitev zaščitenih interdisciplinarnih refleksij in skupnega postavljanja ciljev v rutino timov, okrepitev izobrazbene podlage in usposabljanja za sodelovalno prakso ter pospeševanje pravicam usklajene, soustvarjene deinstitucionalizacije. Prihodnje delo bi moralo v ospredje postaviti dinamike moči v službah za duševno zdravje ter iskati perspektive uporabnikov storitev, da bi ocenili, ali interdisciplinarna psihosocialna praksa prinaša merljive izboljšave na področju duševnega zdravja mladostnikov in socialne vključenosti.

Ključne besede: Duševno zdravje; Socialno delo; Interdisciplinarnost; Slovenija; Otroci in mladi.

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List of Abbreviations

EU — European Union

UN — United Nations (appears via UN bodies/reports)

WPA — World Psychiatric Association (in the journal subtitle)

GDP — Gross Domestic Product

MHSW — Mental Health Social Work

CMHCs — Community Mental Health Centres

CDZOM — Center for Mental Health of Children and Adolescents

WHO — World Health Organization

UNCRPD — United Nations Convention on the Rights of Persons with Disabilities

MHPP — Mental Healthcare Plans and Policies in Europe

MIRA — Slovenian National Mental Health Programme

HPCs — health promotion centers

NIJZ — Slovenia's National Institute of Public Health

CAMHCs — Child and Adolescent Mental Health Service centers

CAPs — Child and Adolescent Psychiatrists

MIRA — National Mental Health Programme

MDBS — Mental and Behavioral Disorders

Introduction

Background of the Study

Globally, mental health problems represent a significant and growing challenge, affecting millions of children and adolescents worldwide. According to the World Health Organization (WHO, 2025), one in seven adolescents experiences a mental disorder, which accounts for 15% of the global burden of disease in this age group. Sadly, suicide is now the third leading cause of death among young people, reflecting the urgent need for effective prevention and intervention strategies. Risk factors such as family conflict, poverty, social inequities, trauma, bullying, and misuse of digital platforms contribute to rising levels of anxiety, depression, and behavioral issues. Despite this immense need, investment in child and youth mental health care remains low, especially in low- and middle-income countries, and access to quality services is limited for most affected individuals (WHO, 2025).

In Europe, mental health challenges among youth are similarly acute and have been further exacerbated by recent socioeconomic stressors and the COVID-19 pandemic. The World Health Organization Regional Office for Europe (2025) highlights that one in five adolescents in the European Region is living with a mental health condition, and life satisfaction has been declining among young people. Suicide is the leading cause of death among those aged 15–29, and overall, about 17% of people in the region are impacted by mental health conditions, with a striking number of adolescents and young adults reporting unmet mental health needs (WHO Regional Office for Europe, 2025).

These alarming trends underscore the urgency of rethinking mental health care provision, and in Europe, this has taken shape through a profound transformation over recent decades. Gradually shifting from highly institutionalized and biomedical models toward more community-based, interdisciplinary, and preventive, recovery-oriented approaches, this paradigm change reflects a growing recognition of the need to move beyond narrow medical treatments and instead foster a psychosocial approach, more holistic, person-centered, and socially integrated systems of care (Semrau, Barley, Law, & Thornicroft, 2011, p. 220). The psychosocial approaches emphasize the empowerment of service users, embedding mental health within broader social realities, and addressing factors that impact well-being beyond clinical interventions (Allen, 2014).

The Mental Health Declaration for Europe and the Mental Health Action Plan for Europe in 2005 marked a major turning point in the formulation and reform of mental health policies over Europe. In this scenario, all European health ministers agreed that mental health was a top priority, that evidence-based mental health policies were necessary, that these policies should have a broad reach, and that they should be developed, implemented, and reinforced (Semrau, Barley, Law, & Thornicroft, 2011, p. 217).

The European viewpoint on mental health has explicitly transitioned to a holistic, rights-based, and interdisciplinary approach that regards mental health as equivalent to physical health. At the EU level, this is prominently reflected in the 2023 European Commission Communication regarding a holistic approach to

mental health and the WHO European Framework for Action on Mental Health 2021–2025, both of which underscore prevention, early intervention, community-based care, and the mitigation of stigma and disparities (European Commission, n.d.; WHO, Regional Office for Europe, 2021). These frameworks emphasize "mental health in all policies", indicating that education, employment, social protection, migration, digitalization, and climate policies must take responsibility for their effects on population mental health and address social determinants like poverty, discrimination, and adverse childhood experiences. The EU and WHO Europe highlight vulnerable populations, such as children, adolescents, individuals affected by emergencies, and healthcare professionals, in response to the heightened mental health demands resulting from the COVID-19 pandemic and other crises.

Recent initiatives by the EU and WHO integrate policy guidance, funding, and capacity-building with public campaigns through concrete approaches and instruments. The EU's holistic strategy organizes efforts to establish conducive conditions and resilience, enhance mental well-being and disorder prevention, improve timely and equitable access to high-quality services, and safeguard rights and social inclusion, including addressing stigma and discrimination. Operationally, this includes EU-funded technical assistance to Member States, national mental health action plans, and interdisciplinary training for professionals such as health workers, teachers, educators and social workers, alongside WHO–EU capacity-building programmes and guidance on strengthening promotion, prevention and community-based services (European Commission, n.d.; WHO Regional Office for Europe, 2021).

Slovenia is a central European country with a population of 2,2 million people, and it presents an interesting case of a small European country implementing WHO-inspired, community-based mental health services with interdisciplinary teams (Horvat Golob et al., 2025). “Although health care is an universal right, access to some health care services is limited due to lack of providers or long waiting times” (Možina e Okorn, 2022, p. 1). For this research purpose, the focus is on social workers in Slovenia because of the recent mental health system reforms that are rapidly shifting care from hospitals onto the community.

Social workers are one of the key professionals expected to take responsibility for this change in practice, being crucial to better understand the roles and complexities within interdisciplinary teams. Since the 2018 mental health reform, Slovenia has been building community mental health centres (CMHCs) to provide regional, accessible treatment and care, instead of relying mainly on psychiatric hospitals. “The transition has been encouraged by guidelines from the European Expert Group and further specified in the Slovenian Resolution on the National Programme of Mental Health 2018–2028” (Horvat Golob et al., 2025, p. 1) however the authors also writes about “the transition to community-based care is welcomed for promoting independence and respecting individuals’ wants, there are cases where institutional care remains necessary to ensure safety and treatment during the exacerbation of chronic mental health disorders” (Horvat Golob et al., 2025, p. 1).

According to the WHO Summary of the rapid assessment of the mental health system in Slovenia stating the “Key challenges and needs” also the “Possible measures or recommendations” first highlights the

need of “Intersectoral coordination, planning and financing: Investing in interdisciplinary, intersectoral governance mechanisms to ensure coordinated planning, financing, implementation and evaluation of the activities of the National Mental Health Programme 2018–2028 at national and local levels” (Program Mira, 2025). Building on this principle, the Slovenian mental health framework emphasizes the strategic importance of strengthening intersectoral and interdisciplinary governance structures to support the effective implementation of the National Mental Health Programme. By prioritizing coordinated mechanisms for planning, financing, implementation, and evaluation, the programme seeks to overcome the traditional fragmentation between health, social, and community services. Such an approach recognizes that mental health outcomes are shaped by multiple social determinants and therefore require sustained collaboration across sectors and professional domains. Investing in these governance mechanisms at both national and local levels is essential to ensure policy coherence, efficient resource allocation, and accountability, while also fostering integrated, community-based responses that are better equipped to address the complex mental health needs of children and youth (Program Mira, 2025).

Within this Mental Health landscape, the role of social work has been particularly significant (Allen, 2014; Zappi, 2020; Možina & Okorn, 2022; Whitaker et al., 2024). Also, it’s interesting to notice that the history of social work is deeply interwoven with the evolution of interdisciplinary collaboration in mental health (Ruth, B. J., & Marshall, J. W., 2017). From its early beginnings, social work started to recognize that poverty, urbanization, and diverse emerging social problems, “related to housing, health care, sanitation, employment, poverty, and education” (Reamer, 1992, in Reamer, 2013) so it could not be addressed within disciplinary silos, but required integrated knowledge and collective strategies across the society. Today, practitioners continue to navigate complex challenges that demand not only technical competence but also a nuanced understanding of values, ethical dilemmas, and professional risk management (Reamer, 2013, p. 176).

In the mental health field, the limitations of a strictly biomedical model became readily apparent. Social workers were among the first to advocate for the psychosocial approach, which considers the interplay of biological, psychological, and social factors in mental health, “By accepting the reality that mental disorders are ‘higher-order disturbances in multi-level mechanisms’...” (Kendler, 2012, p. 17, in Deacon, 2013, p. 11). The psychosocial paradigm overcomes professional disputes over a particular category of analysis and prevents pointless searches for simple definitions of complicated phenomena that are mental health diseases (Deacon, 2013, p. 11).

The psychosocial model shift emphasizes the social dimensions of mental health and the importance of holistic, person-centered care. This is particularly in the case of children and youth, whose well-being is shaped not only by individual factors but also by complex social, familial, and structural determinants**.** This perspective encouraged collaboration between disciplines, moving away from viewing mental illness in isolation and towards integrated care, where social workers worked alongside psychiatrists, nurses, psychologists, and community health workers (WHO Europe, 2021). The psychosocial approach encourages

communication and cooperation amongst healthcare professionals with different theoretical and technical backgrounds (Deacon, 2013, p. 11)

As society became increasingly complex, interdisciplinarity emerged as a natural and necessary extension of social work's historical mission. Early social workers started working with practitioners after realizing the limitations of working in their respective professional spheres, from fields such as education, health, law, and public policy to address the multifaceted needs of the people. This interdisciplinary approach honors the profession's roots in social justice and community engagement while equipping social workers with a broader array of tools and perspectives to tackle contemporary challenges in creative, innovative and holistic ways (Ruth, B. J., & Marshall, J. W., 2017; Reamer, 2013).

The field of social work has evolved significantly since its inception in the late nineteenth and early twentieth centuries, rooted in the commitment to serve marginalized, oppressed, and vulnerable populations (Zappi, 2020). Born out of the need to respond to poverty, inequality, and social injustice, the profession drew on the energies of pioneers from diverse backgrounds and cultural traditions. Over time, social work established itself as a vital profession whose ethos is grounded in ethical practice, advocacy, and the pursuit of social change, continually adapting to shifting economic, political, and cultural landscapes (Zappi, 2020).

Social work plays a pivotal role in shaping modern mental health systems, contributing not only to providing psychosocial support but also to broader functions such as rights advocacy, user participation in decision-making, and the facilitation of intersectoral collaboration. This professional involvement reflects the recognition that mental health recovery is deeply tied to social inclusion, structural conditions, and the protection of individual rights, making social workers key actors in advancing equitable and integrated mental health care across Europe (Allen, 2014).

Collaborating with psychiatrists, psychologists, educators, medical staff, and families; social workers help bridge gaps between clinical treatment, social reintegration, and prevention, ensuring that mental health care is both person-centered and contextually grounded (Gould, 2010). The expertise in assessment, case management, crisis intervention, and empowerment not only addresses the individual needs of clients but also supports the overall enhancement of mental health services, making them indispensable members of interdisciplinary teams working to improve mental health outcomes for children and youth (Gould, 2010). Nonetheless "there are particular concerns about the integration of health and social care services and the location of social work within multidisciplinary structures where social work is the minority player, and is heavily outnumbered by medical and ancillary professionals" (Gould, 2010, p. 1).

In a context where the growing complexity and prevalence of mental health challenges demand innovative, collaborative, and ethically grounded professional interventions, this research addresses a problem area situated at the intersection of mental health care, the role of social workers and interdisciplinarity. Despite the recognized benefits of integrated care, the practical realities of working within interdisciplinary mental health teams remain under-explored, especially regarding the day-to-day perceptions, roles, and strategies enacted by social workers in these complex settings. Critical tensions frequently arise between the imperative

to protect vulnerable populations and the equally important need to respect their autonomy, ethical dilemmas that are central to professional social work practice within other professionals. In this context, interdisciplinarity is understood not as a simple aggregation of professional roles, but as an orientation toward complexity and the integration of multiple perspectives, in contrast to the fragmentation of knowledge into isolated and highly specialised disciplinary fields (Giacomini & Rizzotto, 2022, p. 262).

Research Aim

This study aims to examine how social workers enact their professional roles within interdisciplinary mental health teams serving children and youth in Slovenia, at a time of significant systemic transition from hospital-centred, biomedical care toward community-based, rights-oriented practice. Situated at the intersection of mental health care, social work practice, and interdisciplinary collaboration, the research seeks to explore social workers' perceptions of their own role within these teams, identify the challenges they encounter when navigating different disciplinary approaches and institutional structures, and describe the strategies and adaptive practices they develop to address these dilemmas in everyday professional contexts.

Research Focus and Objectives

The research focus of this study is the role of social workers working within interdisciplinary mental health teams in Slovenia. It closely examines how these professionals interpret their responsibilities and navigate the collaborative environment, particularly when working across multiple systems. By focusing on the interdisciplinary challenges, the research aims to illuminate the real-world dilemmas faced by social workers and the agency they exercise within interprofessional teams.

The primary research objectives are to: (1) explore the perceptions about the role of social workers within interdisciplinary mental health teams in Slovenia; (2) identify the challenges commonly encountered concerning mental health care and different discipline approaches in a social workers viewpoint; and (3) describe the strategies and practices social workers develop to address these dilemmas in everyday professional contexts. Through this investigation, the research seeks to deepen understanding of interdisciplinary collaboration in mental health services and to inform best practices that enhance outcomes for youth, and the broader mental health system.

The literature review chapter aims to critically examine existing articles, researches and policy frameworks related to the mental health context in Europe and Slovenia, then discuss the literature available about the role of social workers within interdisciplinary mental health teams serving youth. It will explore European mental health policies, the evolving professional role of social workers in mental health settings across Europe. By synthesizing current knowledge and identifying gaps, this review will provide the contextual and conceptual groundwork necessary to understand the challenges and professional practices within interdisciplinary settings that constitute the focus of this study.

This study employs a methodological triangulation approach by combining three distinct research methods to gain a comprehensive understanding of social workers' roles within interdisciplinary mental health teams for children and youth. The first method involves observation journaling of social work practices within

a public mental health institution, providing direct insight into everyday professional contexts. The second method consists of semi-structured interviews with social workers actively engaged in the mental health field, capturing their lived experiences and reflections within interdisciplinary contexts. The third method includes a document analysis of Slovenia's mental health plan MIRA Program 2018, which outlines the national strategic framework for mental health care, including its guiding principles, priorities, and planned reforms, and the Human Rights Ombudsman Annual Reports from 2020 to 2024, which document complaints, findings, and systemic rights violations identified across public institutions. This triangulation strategy enhances the validity and reliability of the findings by cross-verifying data from multiple sources and perspectives, allowing for a nuanced exploration of ethical dilemmas and practical strategies in social work mental health interventions.

A complex and contradictorious picture of Social Workers mental health interdisciplinary practice in Slovenia is revealed by the findings, which are arranged along three analytical dimensions: interdisciplinarity, psychosocial ecosystemic, and social workers' role. As unique contributors to interdisciplinary teams, social workers holistically integrate micro, mezzo, and macro levels of intervention concurrently while enacting a humanizing and person-centered orientation that connects individual clients with larger systems of care, also playing a major role advocating for the clients rights and autonomy. The interdisciplinarity practice is not uniform, while formal structures like weekly case meetings coexist with informal collaboration through conversations in the hallway and shared breaks, shared decision-making and continuity of care are hampered by enduring medical hierarchies, strict pathological views, bureaucratic workloads, staff shortages, and poor interministerial coordination.

The findings of this study underscore the indispensable yet structurally constrained role of social workers within Slovenia's interdisciplinary mental health system. While these professionals demonstrate remarkable adaptive capacity through relational investment, persistent rights-based advocacy, role flexibility, ecosystemic framing, and the use of reflective spaces, their contribution remains undervalued and insufficiently supported by institutional and policy frameworks. The gap between the aspirations goals and the practice realities in services documented, to the urgent need for operationalising intersectoral coordination, embedding protected reflective practices within team routines, strengthening professional training for collaborative environments, and accelerating a genuinely rights-aligned deinstitutionalisation process. Ultimately, this research affirms that advancing equitable and effective mental health care for children and youth in Slovenia requires not only structural reform but a deeper institutional commitment to the psychosocial, person-centred, and rights-based values that social workers already carry into practice every day.

Significance of this research

This study holds significance at multiple levels — theoretical, empirical, professional, and policy-oriented. Theoretically, it contributes to the growing body of literature on interdisciplinary collaboration in

mental health by applying and extending Bronstein's (2003) model of interdisciplinary collaboration and the psychosocial ecosystemic framework to a specific national and institutional context, demonstrating how these theoretical lenses illuminate the lived realities of social work practice in ways that abstract policy frameworks alone cannot capture.

1. Literature Review

This chapter examines the mental health context in Europe and subsequently narrows the analysis to Slovenia, before exploring the role of social workers in the mental health field and then proceeding through the next chapter: Theoretical Framework about Interdisciplinary and Psychosocial approaches (Francis, A., 2014, Gould, N., 2022). Over the past decade, mental health has become a central public and social priority across Europe, marked by a shift from biomedical and institution-centered models toward community-based, psychosocial, and rights-oriented approaches. ‘There is unequivocal evidence that the dominance of and the overreliance upon the biomedical paradigm, including the front-line and excessive use of psychotropic medicines, is a failure... not as a crisis of chemical imbalances but a crisis of power imbalances” (United Nations General Assembly Human Rights Council, 2017).

Adopted in 2006, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is an international human rights convention that supports the fundamental freedoms and human rights of all people with disabilities. It was stated in its jurisprudence that human rights are violated by “institutionalisation and non-consensual commitment and/or nonconsensual treatment, seclusion and restraint carried out on the basis of actual or perceived impairment, disability or health condition – such as mental health problems or psychosocial disabilities – violates human rights.” (MHE psychosocial toolkit, 2023)

According to Mental Health Europe (2023) the understanding of disability, particularly psychosocial disability, has undergone a substantial transformation following the adoption of the UNCRPD. This transformation represents a paradigm shift from predominantly biological and deficit-oriented conceptions of mental health toward psychosocial and rights-based frameworks. Within this renewed perspective, mental health services have increasingly been called to shift from isolating, overly medicalised, and coercive practices toward human rights–based, community-oriented, and socially inclusive approaches. Central to this process is the promotion of autonomy and independent living for persons with psychosocial disabilities, positioning them as active agents rather than passive recipients of care (Mental Health Europe, 2023) .

Recently, the Mental Health in Europe was impacted as an effect of recent global and regional crises, including the COVID-19 epidemic, Russian War in Ukraine, other geopolitical unrests, and rising socioeconomic disparities, showing the importance of increasing mental health awareness and the multi-stakeholders responsibilities on this matter. European policy frameworks started to increasingly emphasise prevention, early intervention, and intersectoral collaboration, highlighting the need for coordinated responses to complex mental health challenges within institutional and community settings (WHO, 2024). While national reforms have aligned with European strategies through the development of community-oriented

services, challenges remain in ensuring effective coordination between health, social, and educational systems. These structural dynamics underscore the importance of professional roles that can bridge institutional boundaries and address both clinical needs and social determinants of mental health (Simpson & Murr, 2021)

1.1 Mental Health Context in Europe: surpassing the biomedical model towards community based care

The latest World Health Organization (WHO) definition describes mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their communities" (WHO, 2022) emphasising that it is more than just the absence of mental disorder. In Europe, major institutions largely adopt this WHO wording while embedding it in a broader biopsychosocial and rights-based perspective: the European Commission treats mental health as a cross-cutting aspect of overall health and well-being shaped by social, economic and environmental conditions and calling for a "comprehensive, prevention-oriented and multi-stakeholder" approach, and Mental Health Europe promotes a psychosocial understanding that locates mental health and distress in people's life experiences and social environments rather than in biology alone (European Commission, 2026; Mental Health Europe, 2024).

The UNCRPD (2006) is a foundational legal framework shaping contemporary European mental health services by establishing binding minimum standards for the protection of the rights of persons with disabilities, including those with psychosocial disabilities. According to the European Commission (n.d.), since its entry into force in the European Union in 2011 and its ratification by all EU Member States, the Convention has imposed a shared obligation to align national policies and practices with principles of equality, non-discrimination, and full participation in society.

The UNCRPD establishes a set of general principles that form the normative foundation for rights-based approaches to disability and mental health. These principles emphasise respect for inherent dignity, individual autonomy, and the freedom of persons with disabilities to make their own choices and live independently, alongside a firm commitment to non-discrimination and equality of opportunity. Central to the Convention is the promotion of full and effective participation and inclusion in society, grounded in respect for difference and the recognition of persons with disabilities as part of human diversity. The principles further underscore the importance of accessibility and gender equality, while explicitly recognising the evolving capacities of children with disabilities and their right to preserve their identities. Collectively, these principles provide a comprehensive framework for inclusive, participatory, and rights-oriented mental health policies and practices (UNCRPD, 2006).

According to WHO (2019) in the document 'Monitoring mental health systems and services in the WHO European Region' Mental health governance in the European Region reflects substantial progress alongside persistent structural gaps, particularly in relation to human rights and participatory practices.

Although almost all countries report having a mental health policy or strategy, only approximately two-thirds of responding countries align these frameworks with international human rights instruments, falling short of the global target of 80% set for 2020. Similarly, while nearly all countries have adopted stand-alone or integrated mental health legislation, only 65% of these laws comply with human rights standards; nevertheless, this figure exceeds the global compliance target of 50%, indicating comparatively stronger legal alignment in the region. Effective governance also depends on intersectoral collaboration and the meaningful involvement of stakeholders, including service users and their families. Despite 30 countries reporting some level of collaboration with advocacy groups, only 18 meet key criteria for strong collaboration, like formal agreements, dedicated funding, and regular meetings; highlighting a significant gap between policy intentions and robust participatory governance (WHO, 2019).

At the EU level, the European Commission coordinates the implementation of the UNCRPD, notably through the EU Strategy for the Rights of Persons with Disabilities 2021–2030, which operationalises the Convention across policy domains. The ratification of the Optional Protocol by most Member States has further strengthened accountability through individual complaints mechanisms (European Commission, n.d.). Within the mental health field, this framework has driven a gradual reorientation of services toward rights-based, community-oriented, and inclusive approaches, reinforcing the shift away from institutional and coercive models of care. As the Dr Tedros, the Director-General World Health Organization wrote about the Mental Health challenge "The original four major objectives remain unchanged: more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research" (WHO, 2021).

The existence of a distinct mental health policy or plan in the WHO European Region increased substantially over time, rising from 81% of responding countries in 2017 (n=39) to 91% in 2020 (n=42), and reaching 96% in 2024 (n=27), according to the Mental Health Atlas (WHO, 2024). In the European Region, 78% of responding countries (n=27) reported that their mental health policy or plan had been updated since 2020, while 19% updated their policies between 2013 and 2019, and only 4% had last updated their policies before 2013. In the European Region, 75% of responding countries (n=28) reported the existence of a distinct or integrated policy or plan for child and/or adolescent mental health, and among these, 85% indicated that the policy or plan had been updated since 2020 (WHO, 2025).

It is interesting to note the article "Mental health plans and policies across the WHO European region" (Guerrero et. al., 2024), the scholars were mapping and analyzing the content of Mental Healthcare Plans and Policies in Europe (MHPP) from 2011, 2017, and 2020 from WHO Mental Health Atlas, it was identified both significant progress and persistent structural limitations in their implementation. Guerrero et. al., (2024) highlight advances particularly in areas such as deinstitutionalisation and the increased inclusion of people with lived experience in mental health decision-making. However, it was also identified substantial gaps in mental health information systems, research capacity, and the availability of robust evidence to inform policy

development. Most critically, the absence of comprehensive and systematic evaluation of MHPP implementation is identified as a major concern, given that these policies constitute key instruments for translating strategic commitments into concrete practice (Guerrero et. al., 2024).

This lack of evaluative infrastructure substantially limits the ability to assess how policy commitments are enacted within mental health institutions and interdisciplinary practice. For fields such as social work, especially in relation to child and youth mental health, this gap is critical, as social workers operate at the intersection of policy, institutional structures, and lived experience. The findings of Guerrero et al. (2024) thus point to a broader research gap concerning how mental health policies are operationalised in practice, the extent to which interdisciplinary and psychosocial approaches are meaningfully implemented, and the role of social workers in mediating between policy intentions and institutional realities. Addressing this gap is central to understanding the effectiveness of mental health systems and underpins the focus of the present study.

According to the WHO (2022), good mental health enables individuals to connect with others, function effectively in daily life, cope with adversity, and realise their potential. This definition according to Reed (2024) "(...) suggests that mental health is not only more than the absence of mental disorders, but depends in part on access to opportunities to achieve one's potential". Rather than representing a fixed state, Reed (2024) defends that mental health exists along a complex continuum, ranging from optimal well-being to severe states of psychological suffering and emotional distress. This continuum perspective challenges dichotomous understandings of mental health and illness and highlights the dynamic, context-dependent nature of mental well-being, reinforcing the need for holistic, preventive, and rights-based approaches to mental health promotion and care (Freeman M., 2022). "One of the most important shifts that have occurred in public mental health in recent time, (...), is how important persons with lived experience are to the planning and policy process as well as to care interventions." (Freeman, 2022, p. 2).

This transition is further consolidated by the European Commission's new approach to mental health, launched in June 2023, which frames mental health as a shared political priority across all European Union policy domains. At EU level, the 2023 "comprehensive approach to mental health" (European Commission, n.d.) reframed mental health as a cross-sector issue, linking health systems, education, employment, social protection and digital policy, and committed funding to early intervention, anti-stigma action and support for vulnerable groups. In parallel, the WHO European Region's Mental Health Flagship (WHO, 2019) has supported countries to reform policies, expand data collection, and strengthen community-based, rights-oriented services, consolidating a regional shift away from large psychiatric institutions.

According to WHO (2024) on the document report about mental health services across European Regions 'Strengthening mental health in the WHO European Region in 2024' amongst four goals stated, is interesting to notice one of them that describes "The mental health workforce should be expanded and supported through capacity-building, such as by supporting general health and care workers in developing mental health competencies" (p. 13). The document discussed the requirements for better tailored policies for mental health highlighting the need to increase capacity for integrating mental health into the policies of

various governmental sectors, stating the importance that various sectors of society play in safeguarding and advancing mental health and well-being, evident by this approach to mental health in all policies (WHO, 2024).

1.2 Mental Health Context in Slovenia

Slovenia has moved over recent decades from a hospital-centred, asylum-type model of psychiatry toward a more community-based, rights-oriented mental health system, but this transition remains incomplete and uneven. This mix of progress and persistent gaps makes Slovenia a particularly interesting case for studying contemporary mental health policies, especially in a Central-Eastern European and post-socialist context (Možina & Okorn, 2022; Švab et al., 2006).

Slovenia is a Central European nation with a population of about two million people, with a universal access-based health care system (Možina & Okorn, 2022). According to the author's literature it is possible to highlight that Slovenia faces structural issues like provider shortages and lengthy wait times that continue to limit access to some health care. The cornerstone of Slovenia's healthcare system is primary care, which is most of the time provided by government owned primary care facilities in addition to independent primary care physicians. Primary care doctors manage patient lists and control access to secondary and tertiary levels of care, acting as gatekeepers to specialized services within this framework (Možina & Okorn, 2022).

Analyses of Slovenia's mental health system in the late 2000s revealed severe structural fragmentation and insufficient intersectoral cooperation (Švab et al., 2006). According to Švab et al. (2006) at this point there was not much potential for interdisciplinary integration at the time because social and health care services operated mostly in parallel and had different professional approaches, educational trajectories, and training frameworks. Undergraduate courses conspicuously lacked important cross-cutting topics like psychological rehabilitation and collaboration between higher education institutions was still scarce. In response to these deficiencies scholars and professionals in service pushed for the creation of flexible community mental health teams that included case management, outpatient care, and long-term community-based residential services in addition to primary care-based mental health units assisted by specialized services (Švab et al., 2006).

The Mental Health Act of 2008 (Ministry of Health of Slovenia, 2008), Slovenia's first law devoted to mental health, marks a major legislative milestone to this shift into community-based mental health approach and desinstitutionalization process. By explicitly connecting the health and social welfare sectors and encouraging a move toward community-based, multidisciplinary care at the primary level, this act marked a turning point in the organization of mental health care. The Act strengthened coordination across services by bringing additional stakeholders into mental health treatment procedures and clarifying their roles, responsibilities, and communication channels. Notably, it stipulated the development of multidisciplinary teams made up of psychiatrists, psychologists, social workers, community care coordinators, practical aid nurses, service users and their families, and representatives of non-governmental organizations. It also

established roles such as advocates for people with restricted rights in secure settings and community care coordinators. These teams served as vital tools for social reintegration and continuity of care, establishing the legal foundation for the integrated and intersectoral approach that the National Mental Health Programme eventually solidified (Možina & Okorn, 2022).

As Slovenia's first comprehensive strategy framework for mental health, the National Mental Health Programme 2018–2028 (Ministry of Health of Slovenia, 2022) is another historic development worth discussing into the mental health paradigm shift towards community treatment. In order to develop mental health promotion, prevention, treatment, and rehabilitation, the program seeks to unify current resources into an integrated, interdisciplinary, and intersectoral system while introducing crucial new structures. It emphasizes the coordinated participation of all pertinent stakeholders at the local and national levels and is based on interaction across the health, social, and community sectors. According to Maučec J et al. (2020) the understanding that only such an integrated strategy can guarantee early assessment, early intervention, and ongoing care for people experiencing mental health disorders is fundamental to the program. The Program creates a fundamental framework for raising the standard and efficacy of mental health care in Slovenia by encouraging universal and accessible treatment through intersectoral service networks and the active involvement of planners, providers, service users, and families (Maučec J et al., 2020).

Interesting to note in the Slovenian National Mental Health Programme (MIRA) (Ministry of Health of of Slovenia, 2022) and how it explicitly aims to respond long-standing structural challenges identified in earlier analyses of the mental health system, including fragmentation between health and social services, limited interdisciplinarity work and an overreliance on institutional care. According to Maučec J et al. (2020), for decades the majority of mental health investment was concentrated in institutional settings within both the health and social care sectors. Prior to the adoption of the Programme, direct healthcare costs for treating people with mental health problems amounted to approximately EUR 80 million, with as much as 85% allocated to hospital-based treatment (Maučec J et al., 2020).

Furthermore, Maučec J et al. (2020) explicits that in contrast to this historically institutional model, the National Mental Health Programme proposes a strategic reorientation of mental health care in Slovenia toward mental health promotion, prevention across all settings, and the development of accessible, integrated services delivered closer to people’s everyday environments. By prioritising primary-level and community-based care, and aligning funding mechanisms with these goals, the Programme marks a deliberate shift toward more coordinated, interdisciplinary, and person-centred mental health services (Maučec J et al., 2020).

Reorienting the health system toward prevention and public health initiatives, especially with regard to non-communicable diseases and their risk factors, has been a significant development in recent years. Slovenia created health promotion centers (HPCs) at each of the country's 61 basic healthcare facilities back in 2002, establishing them as the primary suppliers of health-promotion and preventive services, including mental health therapies. In addition to addressing structural disparities in access to care, these centers are crucial in moving the emphasis from treatment to early intervention and health promotion because HPCs seek

to enhance equality in health outcomes and lessen geographic inequities by decentralizing preventive services and integrating them into primary care, especially for vulnerable and disadvantaged populations (Možina & Okorn, 2022).

Slovenia's public healthcare system is divided into three tiers: The primary level provides emergency services, family medicine, and pediatric care for kids and teenagers with mental and behavioral disorders (MDBs) (Kumperscak, 2019; Radobuljac et. al., 2017). Patients may then be referred to secondary care, where concession outpatient clinics or Child and Adolescent Mental Health Service centers (CAMHCs) employ child and adolescent psychiatrists (CAPs). In Slovenia, referrals that must be consulted immediately are categorized as "very fast", should take place within 14 days, the "fast" category consultancy must take place within 3 months, and lastly "regular" within 6 months. The secondary care level is where all patients referred under these categories are assessed. Patients are referred to one of three triage emergency centers in tertiary university hospitals in emergency situations, such as those involving suicide risk or serious mental illnesses. These cases need to be evaluated within a day because they are classified as "urgent" (Kumperscak, 2019; Radobuljac et. al., 2017).

In the field of mental health, general practitioners serve as the main initial point of contact for individuals experiencing psychological distress, positioning primary care as a critical gateway to specialised services. However, chronic shortages of general practitioners represent one of the most significant structural challenges facing the Slovenian health system and have a direct impact on waiting times and continuity of care. These constraints create substantial barriers to timely access, as well as to sustained engagement in the treatment and prevention of mental health disorders, limiting the effectiveness of early intervention and integrated mental health responses (Možina & Okorn, 2022).

Slovenia has long been identified as having consistently high rates of suicide and alcohol-related problems, two serious mental health issues that generally affects the EU countries (Ministry of Health of of Slovenia, 2022). Between 400 and 450 people in Slovenia commit suicide each year; between 1996 and 2016, the average suicide rate was about 25 per 100,000 people, which is more than double the European average of 11 per 100,000. The impact on youth is especially concerning, since suicide is the second most common cause of death for teenagers between the ages of 15 and 19, behind auto accidents (Možina & Okorn, 2022).

<table>
<tr><th>Young children (up to 5)</th><th>Older children (6–14)</th><th>Adolescents (15–19)</th><th>Adults (up to 65)</th><th>Elderly (over 65)</th></tr>
<tr><td>Developmental disorders</td><td>Emotional disorders</td><td>Response to severe stress and adaptive disorders</td><td>Anxiety-related disorders</td><td>Dementia</td></tr>
<tr><td>Emotional disorders</td><td>Conduct disorders</td><td>Other anxiety- related disorders</td><td>Depressive episodes</td><td>Depressive episodes</td></tr>
<tr><td rowspan="3">ADHD</td><td>Hyperkinetic disorders</td><td>Depressive episodes</td><td>Stress-related and adaptive disorders</td><td>Anxiety-related disorders</td></tr>
<tr><td rowspan="2">Developmental disorders (minor)</td><td rowspan="2">Eating disorders</td><td>Alcohol-related problems</td><td rowspan="2">Stress-related and adaptive disorders</td></tr>
<tr><td>Schizophrenia</td></tr>
</table>

Figure 1: Most common mental disorders at different stages of life NIJZ health statistics 2008–2015 (Maučec J et al., 2020).

Additionally, alcohol use and abuse continue to be major risk factors for mental health in the nation. Slovenia is one of the European nations where alcohol use is extremely high, which greatly increases the risk of mental and behavioral disorders (MDBs). Since 2008, alcohol-related diseases have been linked to an average of 881 deaths annually; the second most common cause of alcohol-related mortality is mental and behavioral disorders brought on by alcohol consumption. When taken as a whole, these indicators show how serious mental health issues are in Slovenia and emphasize how urgently comprehensive, preventive, and psychosocial interventions are needed, especially for children and young adults (Možina & Okorn, 2022). The authors in the article show a figure with the most common mental disorders at different stages of life according to the Slovenia's National Institute of Public Health (NIJZ) health statistics 2008–2015:

It is important to note that individuals who face mental health issues, face certain systemic challenges when trying to seek help. These include referral procedures and long wait times. According to Možina & Okorn (2022) the referral procedures and wait times for specialized mental health services are examples of systemic limitations of Health services in Slovenia. Access to non-urgent specialized care is nevertheless greatly delayed, even though urgent referrals from general practitioners to psychiatrists are prioritized and usually evaluated within 24 hours, most frequently in cases of severe mental distress or imminent risk to oneself or others. Patients who are referred for regular psychiatric evaluation typically have to wait two to three months, whereas clinical psychologists typically have to wait six to nine months. In sharp contrast to shorter waiting lists in the commercial sector, access to publicly financed psychiatrists or clinical psychologists who also offer psychotherapy may take several months to up to two years (Možina & Okorn, 2022).

According to WHO Regional Office for Europe (2020) report about Slovenia mental health the 2018 resolution's interprofessional and intersectoral aspects present significant legislation progress but the services are still dealing with the implementation challenge. The Resolution (WHO, 2020) encourages coordinated action in social welfare, health, education, and other areas, but its successful implementation has been challenged by persistent fragmentation and points out that the integration of services has been slowed and accountability has been weakened by insufficient interministerial cooperation and interprofessional disagreement over leadership, supervision, and coordination. Inadequate political and financial support, as

well as the lack of regional or local mental health councils that can promote cross-sector cooperation at the community level, exacerbate these difficulties. Consequently, the proposed intersectional and interdisciplinary approach is only partially implemented in practice (WHO, 2020).

The institutional constraints in mental health that shortage of workforce represents are intimately related to these client access to the services issues reported. Slovenia had a total mental health workforce density of 75.9 professionals per 100,000 people, according to the Mental Health Atlas (WHO, 2019). Also, there were only 0.7 child psychiatrists available per 100,000 people in both the governmental and non-governmental sectors. This severe lack of specialists, particularly in the field of child and adolescent mental health, limits the capacity of services and directly causes longer wait times and postponed interventions. In addition to highlighting the vulnerability of children and young people within the mental health system, the disparity between workforce availability and population demands emphasizes the need to develop multidisciplinary and psychosocial responses in order to reduce gaps in specialized care (WHO, 2019).

Slovenia's public healthcare system is divided into three tiers. The primary level provides emergency services, family medicine, and pediatric care for kids and teenagers with mental and behavioral disorders. Patients may now be referred to secondary care, where concession outpatient clinics or Child and Adolescent Mental Health Service centers (CAMHCs) employ child and adolescent psychiatrists (CAPs). In Slovenia, referrals that must be consulted immediately are categorized as "very fast", should take place within 14 days, the "fast" category consultancy must take place within 3 months, and lastly "regular" within 6 months. The secondary care level is where all patients referred under these categories are assessed. Patients are referred to one of three triage emergency centers in tertiary university hospitals in emergency situations, such as those involving suicide risk or serious mental illnesses. These cases need to be evaluated within a day because they are classified as "urgent" (Kumperscak, 2019; Radobuljac et. al., 2017).

1.3 Social Workers role in Mental Health

The relationship between social work and mental health is still poorly understood, understudied, and has not gotten much attention in European policy frameworks, as noted by Stone et al. (2021). When it is acknowledged, the profession's main contribution is to address the "social" aspects of mental health by offering unique viewpoints, ideas, attitudes, and practices that enhance those of other allied health practitioners (Stone et al., 2021). Prior attempts to define and legitimate social work's professional scope were framed by this partial recognition, which places social work as a significant but frequently peripheral actor within interdisciplinary systems of care (Stone et al., 2021).

In the first century, Kumar (2001, in Karalam, 2014, p. 68) framed social work intervention in child and adolescent mental health primarily as an emerging practice in need of validation, emphasising the testing of its efficacy and the establishment of supportive linkages with psychologists, psychiatrists, and nurses to enable social workers through training and professional guidance (in Francis, 2014a, p. 68). While reflective

of the professional hierarchies and clinical dominance of its time, this position has been substantially reconfigured in subsequent research.

Nearly a decade later, Gould (2010) identifies a re-emergence of social work perspectives in mental health that challenges traditional clinical models and articulates a distinct contribution of social work practice. This shift foregrounds the centrality of power relations in shaping mental distress and recovery, drawing on social work's longstanding commitment to anti-discriminatory and anti-oppressive practice, which is argued to be more developed than in other mental health professions (Fernando, 1991, cited in Gould, 2010). Moreover, Gould (2010) highlights the renewed recognition of community and locality as critical contexts for understanding mental health, thereby reaffirming community development as a legitimate and integral dimension of social work practice alongside individual psychosocial interventions.

The *Mental Health Atlas* (WHO, 2024) defines social workers in mental health as professionals who have completed formal, university-level training in social work and hold a recognised diploma or degree. This category is clearly distinguished from "other health or specialised mental health workers," a broader group that includes primary care workers, psychosocial counsellors, and auxiliary staff who may have received some training in health or mental health care but are not qualified as medical doctors, nurses, psychologists, social workers, or occupational therapists. Through this classification, WHO delineates professional boundaries within the mental health workforce, enabling clearer reporting, comparison, and planning of human resources in mental health systems.

The role of social workers in mental health settings is particularly relevant. Gould (2010) highlights that mental health problems are closely intertwined with multiple forms of social disadvantage, reflecting the cumulative impact of structural inequalities on well-being. There is a well-documented bidirectional relationship between mental health and employment, whereby unemployment or underemployment can contribute to psychological distress, while mental health difficulties often hinder sustained participation in the labour market. Individuals experiencing mental health problems are also disproportionately affected by poverty, driven by insecure employment, reliance on welfare systems, and barriers to accessing financial services (Gould, 2010).

These disadvantages frequently intersect with poorer physical health outcomes, linked to increased exposure to health-risk factors, side effects of pharmacological treatments, and unequal access to physical health care. Furthermore, mental distress is shaped by broader patterns of social exclusion, including housing insecurity, racialised inequalities manifested in coercive psychiatric practices, and gendered disparities in diagnosis and treatment. Growing evidence also highlights elevated levels of mental distress among homoaffective individuals, largely associated with experiences of discrimination and social marginalisation. Together, these dynamics underscore the central role of social determinants in shaping mental health outcomes and reinforce the need for psychosocial and interdisciplinary responses (Gould, 2010).

In the "Report: think ahead about public knowledge and perceptions of careers in mental health" (2021) it described 13 roles for which it tested the public awareness, placed in order of most well known to least well

known, the Social Workers role is placed in 7th underscoring amongst the overlooked mental health professions. The Mental health social workers role in this Report (2022) is described as "support people experiencing severe mental health problems with the social factors in their lives that help them to get well and stay well" the authors remarks that it includes working on their housing, employment and finances conditions but also thinking about the clients relationships and legal rights. It is stated in the report as a relational dependent work, so it's the Mental Health Social Workers role to "build relationships with individuals, families, and carers, and carry out both psychological interventions (e.g. talking therapies) and social interventions (e.g. advocacy, family therapy, and community development), as well as taking on various roles in legal processes" (Think Ahead, 2021, p. 11). Finally, the authors remarks "they work in community mental health teams, local authorities, or hospitals, and frequently visit or meet service users." (Think Ahead, 2021, p. 11).

Even though those role descriptions, it's important to highlight that studies frequently bring attention to the continuous inconsistency surrounding social workers' roles in mental health services in practice, a misconception that is harmful to both professional practice and the experiences of service users (Wilberforce et al., 2020). Since social work is essentially a relationship-based profession, service users' perceptions of the social worker's position and the types of support they are expecting are directly related to how effective social work is (Wilberforce et al., 2020), this position might restrict the perceived value of social work interventions and compromise therapeutic relationships if it is poorly defined or misinterpreted. Furthermore, worldwide research indicates that this kind of ambiguity has a substantial impact on practitioners as well as service users, with social workers reporting lower levels of job satisfaction when they encounter unclear roles in multidisciplinary mental health settings (Acker, 2004, as cited in Wilberforce et al., 2020).

Within this context, the article *What Do Service Users Want from Mental Health Social Work? A Best–Worst Scaling Analysis,* from Wilberforce et al., 2020, provides an empirically grounded examination of how service users themselves prioritize different aspects of social work practice in mental health settings. The study demonstrates that service users place particularly high value on social work's holistic orientation, especially its attention to the social dimensions of mental health that extend beyond immediate clinical symptoms, such a perspective widely regarded as foundational to the profession (Wilberforce et al., 2020).

According to Wilberforce et. al. (2020) the unique valuable contribution that social work makes to interdisciplinary mental health services is highlighted in this user-led review. The results also show that service users' perceptions of effective practice are heavily influenced by continuity, reliability, and ongoing relationship support, with interruptions such as staff turnover or time-limited treatments severely decreasing perceived value. However, the analysis shows that not all social work activities are equally regarded; in particular, respondents gave social workers' primary role as intermediaries between services less importance. When considered collectively, these findings highlight the significance of co-produced, tailored, and relationship-based methods, where service users actively influence the direction and structure of social work

interventions to improve their applicability and influence within intricate mental health systems (Wilberforce et. al., 2020).

Gould (2010) states that understanding how people with mental illness are impacted by direct and indirect forms of discrimination, an overall absence of awareness of their unique needs, and modification of policies that aren't always culturally sensitive relies substantially on social work practice. These structural and contextual determinants have far-reaching effects on a variety of life areas, including work, housing, education, and welfare, and they significantly impede access to support services. Social workers are tasked with tackling systematic exclusion while advancing social inclusion and equity in this setting, placing them at the nexus of opportunity and struggle. “So one can safely say that the role of a social worker in the field of mental health is quite crucial (...), where awareness needs to be brought about amongst the masses about these issues and people need to be rid of their biases and prejudices against those ailing.” (Francis, 2014, p. 16)

According to Bland et al. (2009, p. 65), mental health care is the most effective when it takes an integrated approach that incorporates counseling and social support, builds on the strengths and capacities already present in the community, and, when needed, offers ongoing support during procedures like family reunification. High levels of contextual variability characterize social work in mental health, with interventions, interactions, and professional expectations varying depending on the stage of contact and the particular setting in which practice takes place (Gould, 2010). According to Bland et al. (2009), this necessitates that social workers be prepared to adapt to a variety of problems that may arise in practice.

Both Whitaker et al. (2024) and McMahon (2014) draw on the International Federation of Social Workers’ definition to emphasize that social work is fundamentally oriented toward advancing social change and development, strengthening social cohesion, and promoting the empowerment and liberation of individuals and communities. Central to this mandate are the guiding principles of social justice, human rights, collective responsibility, and respect for diversity, which frame social work as a profession committed not only to individual support but also to broader structural transformation. As Whitaker et al. (2024) and McMahon (2014) argues, this internationally recognized brief aligns with contemporary calls for profound societal change, reinforcing the role of social work as an active agent in addressing inequality and fostering inclusive social development, consistent with the profession’s core definition articulated by the International Federation of Social Workers (2014).

Social workers’ roles in mental health vary across countries, reflecting distinct social, cultural, and policy contexts while sharing a commitment to holistic well-being. In Canada, mental health social work prioritizes the social and political determinants of health, with an emphasis on change, resilience, and recovery, and seeks transformative practice through respect for diversity and multiple ways of knowing (Regehr & Glancy, 2021; Canadian Association of Social Workers, 2022). In Northern Ireland, the profession focuses on improving and safeguarding social well-being, including the quality of relationships, a sense of belonging, personal choice and control, purpose and meaning in life, and feelings of safety and security (Morrison & Davidson, 2019). Similarly, in Australia, social work plays a distinctive role in challenging

overly individualistic and depoliticized views of mental health, advancing instead contextualized and holistic understandings of people's lived experiences (Morley & Macfarlane, 2019). Together, these perspectives highlight how social work internationally integrates structural, relational, and experiential dimensions to support mental health and social inclusion (Whitaker et al., 2024).

A European review, Stone et al., (2021), further underscores the distinctive contribution of social work to mental health practice through its grounding in holistic, social, and rights-based models of care. This perspective emphasizes empowerment, strengths-based interventions, and recovery-oriented approaches, positioning individuals as active agents in their own lives rather than passive recipients of services. It also highlights social work's critical attention to the broader social impacts of mental illness, including stigma and discrimination, and the ways these factors shape access to resources and participation in society. By integrating these elements, social work in the European context reinforces a practice framework that connects personal recovery with social justice and inclusion (Stone et al., 2021). In Slovenia, the MIRA Program describes the social workers roles as "(...) a professional who promotes social change, helps with integration into social life, and strives to empower individuals to advocate for their rights" (Program Mira, 2022). This MIRA (2022) document also highlights different working places the social worker are set in different sectors like the social services (social work centers, social institutions, employment agencies), education (kindergarten, primary and secondary schools, schools with adapted programs, educational institutions, welfare and work centers) and health care (pediatrics, hospitals and mental health).

Despite this clearly articulated contribution, evidence from the same European review points to persistent structural and professional challenges faced by mental health social workers. Stone et al. (2021) describe a strong narrative among practitioners of feeling comparatively powerless within medically dominant systems, particularly in contexts marked by funding cutbacks and insufficient resources. Participants also emphasized that effective service integration depends on mutual understanding across professional groups, yet resource constraints and status barriers frequently hinder collaborative work (Stone et al., 2021). In response to these tensions, the authors suggest that greater recognition of mental health social work may depend on more clearly defining and communicating the profession's specific role and functions within multidisciplinary settings (Stone et al., 2021).

Social workers work in a variety of scenarios, as Gould (2010) describes working as individual case management, clinical and non-clinical roles, community development projects, and interdisciplinary team settings. The complexity of mental health, which is influenced by interconnected social, environmental, psychological, and physical elements in addition to more general life stressors, is reflected in the scope of practice. The ethical and advocacy aspects of social work in this sector are highlighted by the disproportionate exposure of people with mental health issues to discrimination and rights abuses. In order to integrate knowledge, empathy, and action, mental health social work necessitates a methodology based on respect, social justice, and holistic engagement as stated by Kelly & Sewell (1991, p. 120) working with "head, heart, and hand".

2. Theoretical Framework

The theoretical framework that guides the research is based on three complementary approaches: theories of interdisciplinarity (Bronstein, 2003; Rosen & Callaly, 2005, Giacomini & Rizzotto; Hobbs, 2005; Bhaskar, Danermark, and Price, 2017; Colet, 2004; Kelly et al., 2019; Bronstein, 2003) and the psychosocial approach (Walker, 2003; Martinez-Brawley & Zorita, 2017; Robinson and Kaplan, 2011; Turner, 2017). Taken together, these perspectives provides the concepts and relationships that support the analysis of the research questions, elucidating the ways in which team dynamics, psychosocial processes and broader institutional and policy contexts influence social workers perceived roles, experienced challenges and common strategies adopted.

2.1 Social Work Interdisciplinarity Approach in Mental Health

Interdisciplinary collaboration has become a defining feature of contemporary mental health care, particularly in services for children and youth with complex psychosocial needs (Bronstein, 2003; Rosen & Callaly, 2005). Giacomini e Rizzotto states that "the interdisciplinary attitude involves leaning towards the complexity of objects and the integration of perspectives, as opposed to (...) the fragmentation of knowledge into increasingly restricted and specialized disciplinary fields, isolated in their theoretical constructs and practices" (2022, p. 262). Almeida-Filho (1997) states that the concept of discipline is historically associated with the Cartesian Method, which promotes the segmentation of study subjects and the specialization of researchers, thereby delineating rigid boundaries between domains of knowledge. This paradigm has been essential for the advancement of numerous existing technologies, but it faces constraints when dealing with phenomena that cannot be confined to a singular explanatory framework, despite remaining within the realm of science (Almeida-Filho, 1997).

In addressing the complexity and interrelation of reality, Edgar Morin (2014) presents the notion of complex objects, highlighting the necessity of integrating various disciplines and acknowledging the multifaceted nature of events as they arise. In Mental Health settings, no single profession can adequately address the whole biological, psychological, social, and structural dimensions of mental distress, which makes teamwork between psychiatrists, psychologists, nurses, social workers, and other mental health professionals indispensable (Asiri et al., 2024; Rosen & Callaly, 2005; World Health Organization, 2021). For social workers in mental health institutions, interdisciplinarity is not merely an organizational arrangement but a core context in which their professional role, practices, and ethical responsibilities are continuously negotiated (Bronstein, 2003). As stated by Bhaskar in Bhaskar, Danermark, and Price (2017, p. 3) the research on health and wellbeing is one area where the need for interdisciplinarity is most needed and that's because a human being is clearly a whole and cannot be examined as a collection of independent components.

The terms interdisciplinary, interprofessionality, multidisciplinarity, and transdisciplinarity are often used interchangeably in the literature; the similarities are that they refer to different degrees of integration between different professional perspectives (Bronstein, 2003; Choi et. al., 2006; Reeves et. al., 2018).

According to Choi & Pak (2006) the more general term 'Multidisciplinarity' indicates that this concept is used when the involvement of the different disciplines are not specified or are unknown. 'Multidisciplinarity' draws on knowledge from different disciplines but stays within their boundaries" (Choi & Pak, 2006, p.1), according to Reeves (2018) multidisciplinary work usually describes the professionals from different disciplines contributing in parallel but keeping separate goals and decision-making structures.

'Interdisciplinarity' is described by Choi & Pak (2006, p.1) as interaction between disciplines in order to analyze and synthesize harmonically, coordinated and coherent whole within, sharing the same goals and decision making structure all together. Interdisciplinary collaboration implies a higher level of integration, in which team members share information, negotiate meanings, and co-construct plans around common goals with mutual accountability (Bronstein, 2003, Asiri et. al., 2024). Bruner (in Bronstein, 2003) states that "interdisciplinary collaboration is an effective interpersonal process that facilitates the achievement of goals that cannot be reached when individual professionals act on their own".

Transdisciplinarity and interprofessionality can be understood as more advanced stages along the continuum of collaborative practice, building upon and extending the foundations established by interdisciplinarity in mental health care. This research considers transdisciplinarity and interprofessionality as outcomes stemming from interdisciplinarity. The term "transdisciplinarity" describes cooperative strategies that tend to go beyond combining disciplinary viewpoints; it purposefully crosses professional and disciplinary lines by collaborating with a variety of stakeholders, such as families, community organizations, and service users, to co-create knowledge and practices (Hobbs, 2005). "On a transdisciplinary team, the patient is a member of the team and takes part in decision-making" (Hobbs, 2005, p. 187). Choi & Pak (2006, p.1) states that "transdisciplinarity integrates the natural social and health sciences in a humanities context and transcends their traditional boundaries".

In turn, interprofessionality highlights the various practical ways that multiple professions collaborate on an integrated assignment, through an interdisciplinary approach (Reeves et al., 2018; Benjamins et al., 2024). According to Furtado (2009), interprofessionality is the process through which professionals can consider and cultivate connections and exchanges with the goal of exchanging knowledge, insights, and abilities. Furtado (2009) sustains that interdisciplinarity is an abroad conceptualization more towards the theoretical comprehension while interprofessionality is the in-site practical process in which interdisciplinarity appears during daily activities, by any matter being inseparable.

Colet (2004) indicates three basic principles that sustain the interdisciplinarity approach core; first of all, the author highlights the theoretical and methodological complementarity between disciplines from two or more different disciplines addressing a complex issue that cannot be solved solely by one of the professionals but from their effort together. In the second place the collaboration between professionals from

different disciplines as an aspect that is shown as vital for the interdisciplinarity approach, since the interdisciplinarity arises from disciplines combining of practitioners who must be willing to address their disciplinary references in addition to their practical-knowledge to solve problems in order to develop a new, more comprehensive, holistic, and integrated understanding of reality; finally, for the third aspect the author indicates that there must be a synthesis, a product, a tailored response for the issue being faced that could only be possible by the complementarity and collaboration from the professionals and their disciplines assuming (Colet, 2004).

Kelly et al. (2019, p.149) describe a set of attitudes and commitments required for the development of interdisciplinarity. They stress the value of developing strong expertise in one's field while continuing to be open to picking up new conceptual languages and viewpoints. The authors also stress the importance of broad cross-disciplinary cooperation, patience, openness, and acceptance of complexity. They also encourage researchers to actively support scholars working across disciplinary boundaries, intentionally reflect on their engagement with interdisciplinary work, push their own intellectual boundaries, and help cultivate an interdisciplinary culture (Kelly et al., 2019).

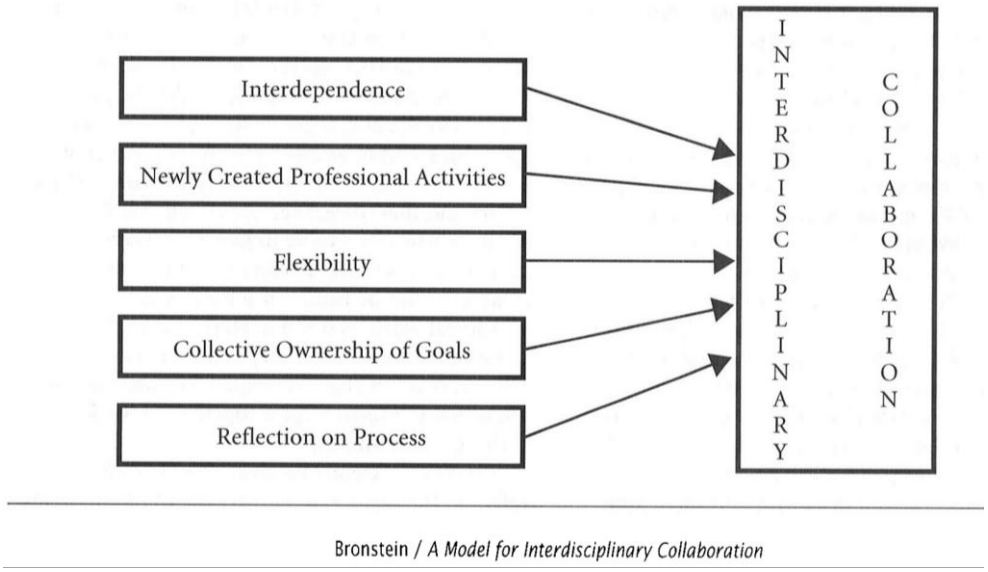


Figure 2:Components of an Interdisciplinary Collaboration model by Bronsetin (2003)

Bronstein (2003) describes interdisciplinarity components as: Interdependence, Newly Created Professional Activities, Flexibility, Collective Ownership of Goals and Reflection on Process. The author explains that interdependence is the occurrence and reliance on co-dependent interactions between professionals aiming to achieve the same shared goals, it includes formal or informal time spent together and oral or written communication. Newly created professional activities is described as the structure that proposes collaborative acts and programs that maximize the expertise of each professional integrating the knowledge into a tailored response that could not be achieved without the whole within its parts. Flexibility refers to the deliberate occurrence of role-blurring, collective agreements that surpass individual disagreements and creative responses that come from knowledge exchange. Collective ownership of goals means sharing

responsibility of the entire process within the team, supporting constructive deliberation among the professionals. Finally, the reflection on process highlights the specific attention that professionals must have within their process of working together, developing an environment in which thinking and talking about their work and relationships are open and there is space for feedback, in order to strengthen collaboration and intervention effectiveness.

2.2 Psychosocial Ecosystemic Approach

Youth Mental Health problems require innovative and flexible solutions to deal and alleviate their suffering (Davis and Spurr, 1998 in Walker, 2003). Youth mental health can be understood through multiple paradigms: a physician might emphasize genetic predispositions; a psychiatrist may diagnose and treat a specific mental disorder; a psychologist may identify cognitive distortions; a child psychotherapist may explore repressed unconscious conflicts; and a social worker may interpret distress as rooted in environmental and structural disadvantage, therefore, it is essential that social workers engage with and critically understand these differing frameworks by the psychosocial approach (Walker, 2003). “A psychosocial model of social work practice offers the optimum framework to take account of all the individual child, family and environmental variables interacting to produce the identified difficulties” (Walker, 2003, p. 677).

Social work based on a psychosocial model emphasizes current conditions over historical events; aims to assist individuals in achieving equilibrium between their internal emotional states and external pressures; and strategically utilizes the professional relationship between the service user and the social worker as a fundamental component of intervention (Stepney and Ford, 2000). “A modern, psychosocial model offers the appropriate holistic perspective for social workers to engage with other professionals in the community, to work in partnership with families and employ the personal relationship skills the majority aspire to use” (Walker, 2003, p. 679), the author defends that adopting a community-focused, psychosocial approach allows social workers to contextualize youth person's behavior, facilitating the synthesis and evaluation of all possible explanations (Walker, 2003). The importance of psychosocial assessment methods that consider not only the individual characteristics of the child, but also the family context and broader environment; an additional advantage of this model is that it can be employed by social workers as a tool for supervision and support of staff working with children and families (Walker, 2003).

The principals of Psychosocial approach are described by Martinez-Brawley & Zorita (2017) as Centrality of Person-in-Situation, Relationships are essential for the Method and a Broad Range of Techniques is used for eliciting information. Stone et. al., 2021 highlights “(...) psychosocial theory and practice to complement, and at times balance, more individual and bio-medical, pharmacological approaches, suggesting that MHSW is well-positioned to highlight the social determinants of mental health problems, and on preventative approaches through its holistic perspective and emphasis on the role of the systemic context of individuals”.

In the late 20th century, social workers began to see more clearly that each person is shaped by many factors, such as race, culture, religion and their place in the family. This meant that a young person's "situation" and the pressures they faced could no longer be seen in a simple, one-dimensional way. Instead, problems were understood as linked to how these different elements come together in everyday life. From a psychosocial point of view, this supports looking at both inner experience and the social world at the same time, so that youth mental health is understood in a more careful and context-sensitive way (Martinez-Brawley & Zorita, 2017) .

The psychosocial approach in social work is grounded in the centrality of the person-in-situation perspective, which assumes that individual experience cannot be understood apart from the social, relational and institutional contexts in which it is embedded. In this view, effective assessment and intervention require both a comprehensive awareness of the environment (family, community, organizational and socio-political structures) and a nuanced understanding of intrapsychic processes, such as emotions, internalized relationships and unconscious meanings. Robinson and Kaplan (2011, in Martinez-Brawley & Zorita, 2017, p. 414) capture this dual emphasis when they argue that "psychosocial understanding is ecosystemic", highlighting that psychosocial practice necessarily spans multiple, interacting systems rather than treating the individual or the context in isolation.

Relationships are essential to the psychosocial method, in other words: relationships in this perspective become central to how young people understand themselves and their place in the world (Martinez-Brawley & Zorita, 2017). Relationships help young people see who they are, giving them a sense of value, ability and belonging. In psychosocial social work, this shows how central relationships are both to understanding problems and to planning support, with the helping relationship and work on family and community ties becoming key spaces for recovery and change (Martinez-Brawley & Zorita, 2017).

Psychosocial practice for social workers uses a broad range of techniques to gather information and understand about the person experiencing a mental health issue and their surroundings. Psychosocial practice welcomes varied methods to help clients reflect and describe their experiences more clearly. This flexible interviewing style, less limited by concerns about influencing responses, allows for a fuller picture of both personal feelings and external pressures.

As the young person's narrative grows more complex during psychosocial assessment, the social worker can identify and highlight persistent patterns of behavior that might be worsening the situation (Martinez-Brawley & Zorita, 2017, pp. 414-415). The worker also assumes hidden feelings or thoughts may surface in sessions, making it their role to gently help uncover them through shared reflexivity that benefits both client and practitioner (Martinez-Brawley & Zorita, 2017, p. 415). The aim of all treatment is, in a way, the gaining of insight for the psychosocial caseworker, which is gained through reflection, but it is a guided reflection in which the worker plays a more active role than in the traditional psychodynamic interview, marking the approach's distinguishing trademark as flexibility and adaptation (Martinez-Brawley & Zorita,

2017, p. 416). This process strengthens the person-in-situation focus by linking recurring actions to emotional undercurrents and environmental triggers.

Social workers thus assess client functioning by accounting for influences across systems and subsystems, ensuring a holistic view that links personal experience to environmental dynamics. Moving beyond highly individualistic models, the psychosocial approach recognizes the human system as complex and changeable, where components are interrelated, interconnected, and interdependent rather than isolated (Martinez-Brawley & Zorita, 2017, p. 416). It has flexibly accommodated narratives that have always been central to social work interventions, maintaining its core unit of analysis as the individual within their situation—understood as an element of the broader ecosystem (Martinez-Brawley & Zorita, 2017, p. 415).

2.3 Integrated Theoretical Framework for the Research

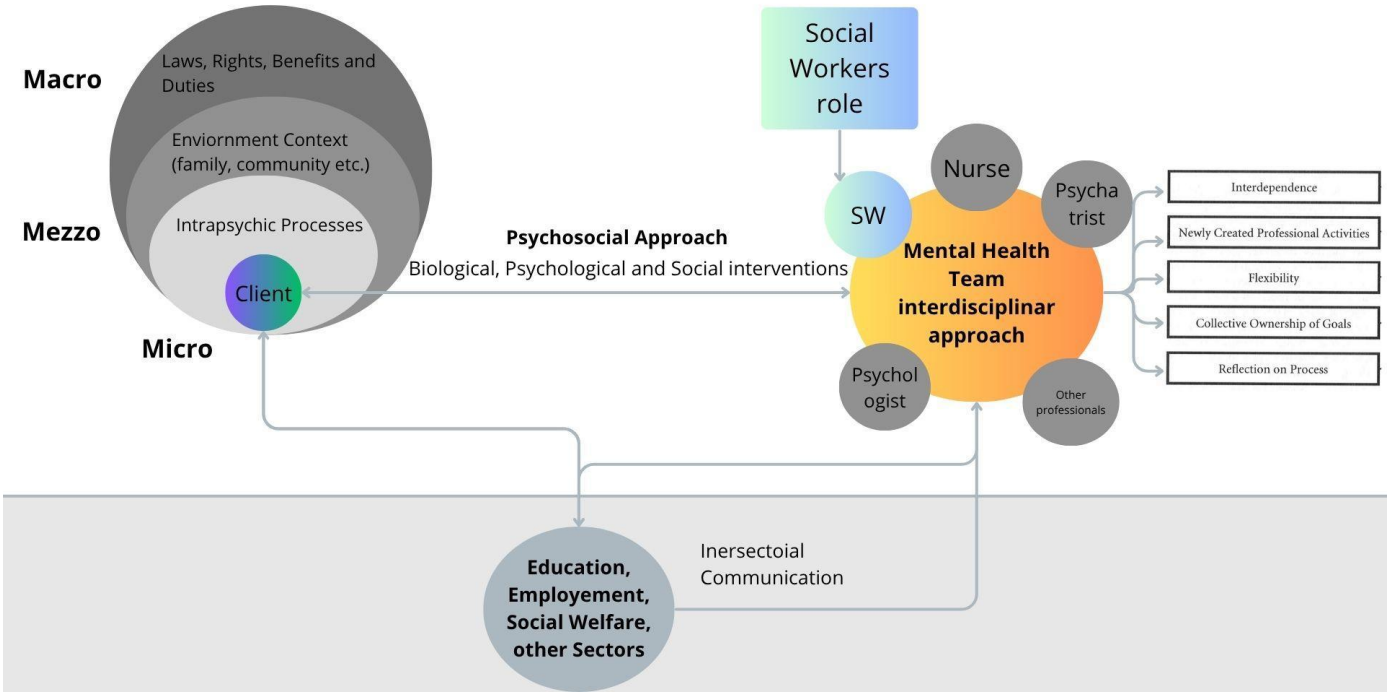


Figure 3: Presents the integrated theoretical framework guiding this study, visually synthesising the two complementary analytical lenses.

On the left side of the figure, the psychosocial ecosystemic dimension is represented through a nested circular model organised across three systemic levels. At the centre, the Micro level places the client as the primary subject of intervention, encompassing intrapsychic processes such as emotions, internalized relationships, and unconscious meanings that shape individual experience (Martinez-Brawley & Zorita, 2017). Surrounding this, the Mezzo level captures the environmental context, including family dynamics, peer relationships, school, and community networks, recognising that individual mental health cannot be understood in isolation from the relational and social structures within which the person is embedded (Walker, 2003). The outermost layer, the Macro level, encompasses laws, rights, benefits, and duties, it is the structural, institutional, and policy dimensions that both enable and constrain access to care and the protection of rights.

This three-level ecosystemic framing reflects the psychosocial principle that "psychosocial understanding is ecosystemic" (Robinson & Kaplan, 2011, as cited in Martinez-Brawley & Zorita, 2017, p. 414).

The central arrow connecting the client to the Mental Health Team represents the psychosocial approach as the mode of engagement, encompassing biological, psychological, and social interventions that together constitute a holistic, person-centred response to mental distress. This bridge illustrates the social worker's distinctive function as described across the literature: translating the complexity of the client's ecosystemic reality into the interdisciplinary team context, ensuring that the social, relational, and structural dimensions of the client's situation remain visible within settings that may otherwise default to clinical or biomedical framings (Gould, 2010; Walker, 2003).

On he right side of the figure, the Mental Health Team interdisciplinary approach is represented as the organisational and professional context. The team is composed of social workers (SW), nurses, psychiatrists, psychologists, and other professionals, visually depicted as overlapping circles to convey the shared space of interdisciplinary collaboration rather than parallel, siloed working. The social worker's role is positioned both as a member of this team and as a distinct professional whose contribution is shaped by the psychosocial and ecosystemic orientation described on the left. The five components listed to the right of the team, ‘ Interdependence’, ‘Newly Created Professional Activities’, ‘Flexibility’, ‘Collective Ownership of Goals’, and ‘Reflection on Process’, correspond directly to Bronstein's (2003) model of interdisciplinary collaboration, which provides the analytical framework for examining how teamwork is structured, negotiated, and sustained in practice.

Finally, the lower section of the figure introduces the broader intersectoral dimension, representing the connection between the mental health team and other societal sectors including Education, Employment, Social Welfare, and other sectors. The bidirectional arrows labelled Intersectoral Communication reflect the MIRA Programme's vision of coordinated, cross-sector governance and the recognition that mental health outcomes are shaped not only by clinical and psychosocial interventions but also by the structural conditions produced across multiple institutional domains. This intersectoral layer also speaks to the macro-level dimension of the psychosocial ecosystemic framework, underscoring that sustainable mental health support for children and youth requires coherent collaboration not only within the team but across the wider systems that shape young people's lives (Maučec et al., 2020; WHO Regional Office for Europe, 2020) even though that intersectorial aspects is not the main focus of the research it is important to acknowledge it and its interdisciplinarity needs.

Taken together, the figure captures the core analytical lenses of this study: that the social worker's role in Slovenian mental health services understood through the intersection of psychosocial ecosystemic practice and interdisciplinary collaboration, operating simultaneously across micro, mezzo, and macro levels, within teams whose interdisciplinarity is analysed by the five dimensions of Bronstein's model, and embedded in a broader intersectoral landscape, that affects the realisation of mental health treatment as an integrated care for children and Youth.

3.Methodology

3.1. Research approach

The methodology adopted in this study is qualitative based on triangulation by combining observation journaling, semi-structured interviews, and document analysis to enhance the rigor and trustworthiness of the research process. Triangulation can make qualitative research more rigorous and trustworthy by allowing researchers to gain a deeper and more comprehensive understanding of the setting and the participants (Bailey, 2018, in Morgan, 2024, p. 1846). Triangulation, as conceptualized within qualitative inquiry, is not merely a tool for confirming consistency across different data sources but rather a way of revealing diverse perspectives related to the phenomenon under investigation (Campbell et al., 2020, in Morgan, 2024, p. 1847).

As Merriam and Tisdell (2016, in Morgan, 2024, p. 1850) explain, the method of triangulation involves collecting data through multiple strategies, such as observation, interviews, and document analysis, to validate and enrich the understanding of a phenomenon. By comparing insights drawn from different sources, it is possible to verify the consistency of information and identify nuances that might be overlooked when relying on a single method. In this study, triangulation is employed to cross-check data obtained from participant interviews with field observations and relevant institutional documents, ensuring that the interpretations reflect a comprehensive and trustworthy representation of the research context. As stated by Morgan (2024, p. 1850) “Methods that involve interviewing and direct observation lead to reactivity issues, which occur because using these methods can change the behavior of participants”. For example, participants often alter their behavior when they are aware that they are being watched, additionally, the characteristics of the observers often result in increased reactivity, particularly when they diverge significantly from those of the participants.

Although reactivity occurs in any research process that involves interaction with participants (McKechnie, 2008), interviews and observations are beneficial because they allow the direct study of behavior (Denzin, 1978). In contrast, analyzing documents does not allow researchers to study behavior directly, but this method is useful because it does not influence the behavior of the participants (Merriam & Tisdell, 2016)

In this study, the combination of observation journaling, semi-structured interviews, and policy analysis was designed to address the multidimensional nature of mental health care interdisciplinarity practices by social workers in Slovenia. Observation journaling enables the documentation of interactions, routines, and relational dynamics within social work and mental health settings, providing insight into how professionals engage with each other to solve mental health problems in everyday contexts (McCombie et al., 2024). Semi-structured interviews complement these observations by allowing practitioners to articulate their experiences, values, and perceptions regarding interdisciplinary collaboration and Mental Health service quality (Smith & Nizza, 2022; Smith, Flowers, & Larkin, 2022; DeJonckheere & Vaughn, 2019; McIntosh & Morse, 2015,). Meanwhile, Document analysis offers a non-intrusive means of examining the institutional and legislative frameworks that guide professional practice across Slovenia mental health systems, thereby reducing

reactivity and contextualizing empirical findings (Frey, 2018; Dalglish, Khalid & McMahon, 2021, Morgan, 2022). Together, these three methods constitute a triangulated design that strengthens the study's credibility, deepens understanding of social work's role in mental health services, and reflects an integrated approach to research grounded in both practice and policy. By integrating these approaches, the study aims not to converge on a single definitive truth but to balance the strengths and weaknesses of each method, thereby fostering a multidimensional understanding of mental health practices and experiences within the research setting (McCombie et al., 2024).

The thematic analysis (Braun & Clarke, 2006) was conducted using MAXQDA, which supported the systematic organization, coding, and interpretation of qualitative data in alignment with the study's theoretical perspectives by the use of qualitative data analysis software, which facilitated the organization, coding, and comparison of the empirical material in accordance with the study's theoretical perspectives. This software was used to store documents, create and refine codes, and develop analytic categories iteratively, allowing the researcher to move between the data and the theoretical framework in a systematic and transparent way. The analytical process involved iterative coding cycles, the development of thematic categories, and the constant comparison of data segments to ensure coherence between empirical material and the conceptual framework guiding the research. This approach enabled a structured yet flexible engagement with the data, allowing themes to emerge while remaining grounded in the study's theoretical orientation.

In addition, artificial intelligence (A.I.) tools such as Perplexity Pro and ChatGPT were used in a supportive and reflexive manner to support the writing process, mainly to improve clarity of expression, consistency of languages, and the organization of ideas. These tools contributed as supplementary resources for refining language, organizing ideas, and stimulating critical reflection, serving as sources of inspiration rather than as primary analytical instruments. These tools were not used to replace the researcher's interpretation but rather as contributed supplementary resources and aids for drafting and revision, while the analytical decisions remained grounded in the researcher's critical reading of the material. In this sense, the use of these digital resources functioned as a form of research helping to sharpen the writing and inspire further conceptual reflection during the development of the study. Their use remained aligned with academic integrity principles, with all interpretations and final analytical decisions maintained under the researcher's responsibility (Conselho Cientifico do ISCTE, 2026).

3.2. Research methods

3.2.1. Observational Journaling

A crucial method of obtaining information about a social environment is to enter and observe (Lincoln & Denzin, 2008). Observational Journaling methodology in qualitative mental health research offers several strong points; it provides uniquely "rich data about experiences and phenomena as and when they happen, from the perspectives of participants themselves" (McCombie et al., 2024, p. 1) and it was incorporated in this research as a primary qualitative tool. The researcher must blend in with the surroundings during all of this

work in order to remain discrete while closely observing and aware of what is happening (DeWalt & DeWalt, 2011). This enables insights "in greater depth and detail than other quantitative or qualitative methods might offer," particularly around patterns and change over time (McCombie et al., 2024, p. 1).

"Qualitative diaries are defined here as any diary kept (...) detailing their experiences, thoughts, or feelings" (McCombie et al., 2024, p. 3); they allow documenting the daily challenges in real-time, generating rich and authentic insights that might be missed in retrospective interviews. Journaling is participant-led, giving individuals agency and enabling nuanced exploration of subjective mental health experiences, change over time, and contextual influences. These approaches "can be inherently participatory, enabling participants to take part in their own time and way, with greater control," increasing authenticity (Bijoux & Myers, 2006, in McCombie et al., 2024, p. 3).

3.2.1.1 Observational Journaling Sampling

The sampling for this methodology was by convenience (Jager et al., 2017), since the internship was taken in a Major Health institution in Slovenia focusing on Mental Health. The findings are based on systematically recorded daily observations across different settings, including institutional meetings, program presentations, professional interactions, and community-based initiatives. The criteria for the observational journaling entries was interdisciplinary activities occurring, within the interaction of the Mental health professionals and discussions about Mental Health. These records capture 120 academic hours of concrete situations, practices, and interactions involving mental health professionals, services, and youth in Slovenia, reflecting how care is organized and enacted in everyday contexts.

The findings derived from observational journaling conducted during the fieldwork experience in October of 2025 in Slovenia's National Institute of Public Health of non-communicable diseases focusing on the Mental Health System. Reflective entries were systematically produced throughout this period, documenting daily activities, professional interactions, and contextual observations within mental health services. This process also included meeting with workers in Mental Health set in different institutions across Slovenia contributing to a deeper understanding of institutional roles and service organization. In addition, the journaling incorporated observations from multiple professional settings, including weekly Mental Health Team meetings, Regional Mental Health Services meetings, and intersectoral meetings involving the education sector. These varied contexts allowed for a comprehensive reflection on interdisciplinary collaboration, service coordination, and the practical dynamics of mental health care delivery, enriching the analytical depth of the study.

3.2.1.2 Observational Journaling Limitations and Ethical Considerations

However, journaling methodology also presents weaknesses, as highlighted by McCombie et al. (2024, p. 7) stating "considerable variation in diary content, length, and structure…which could introduce bias". Further, participants sometimes experienced problems in keeping diaries over a long time, so in order to solve

this problem some advise using it for “shorter time periods or more frequent sampling points” (McCombie et al., 2024, p. 7). It is important to be aware that the participant's motivation and consistency can vary, leading to incomplete or sparse data, and also entries may be influenced by self-censorship or recall bias, especially if journaled retrospectively. There are ethical and privacy considerations regarding the sensitive nature of mental health disclosures, and the data produced can be difficult to analyze systematically due to its richness and unstructured nature.

To address the methodological challenges associated with journaling, several strategies were employed to enhance consistency, engagement, and ethical rigor throughout the three-week data collection period in this research. The decision to limit the journaling period to three weeks aimed to maintain motivation and minimize attrition commonly observed in longer-term diary studies. Entries were completed shortly after relevant experiences, thereby reducing recall bias and promoting the authenticity of reflections. Ethical considerations were upheld through careful attention to confidentiality and critical self-awareness regarding the sensitive nature of mental health-related content. Additionally, language barriers were carefully considered throughout the research process. A Google digital translation tool was used to support the reading and interpretation of institutional documents and written materials in different languages. During live observations and professional interactions, a staff member usually accompanied the researcher to assist with translation and provide contextual clarification when necessary, helping to ensure accurate understanding of discussions, practices, and interdisciplinary dynamics within the mental health setting. These strategies collectively contributed to the methodological coherence, trustworthiness, and analytical depth of the journaling process.

By applying the journaling methodology in this thesis, the aim is to capture the lived experiences of workers navigating mental health challenges within an interdisciplinary context. As described by McCombie et al. (2024, p. 2), the research seeks to “improve understanding of the experiences and needs of people with mental health difficulties and inform intervention development”. This approach seeks to illuminate the day-to-day realities, coping strategies, and emotional landscapes of participants in a way that structured interviews or standardized measures may not achieve. The goal is to support participants as “experts on their own experiences” and to allow “important topics to arise organically across time and participants, rather than being introduced by researchers” enhancing openness and relevance (McCombie et al., 2024, p. 4). Ultimately, this approach aims to illuminate from the mental health workers how is it to deal with patients committed to “day-to-day life with mental illness,” fostering “reflection and self-development” and “provide a wealth of information” for social work and interdisciplinary mental health support (McCombie et al., 2024, p. 2). In conclusion, the richness and immediateness of the data are the main factors that led to the selection of the qualitative diary technique. In the end, gathering detailed, long-term data will help to better understand how interdisciplinary services affect mental health outcomes, which will lay the groundwork for more adaptable and supportive treatment approaches.

3.2.2 Semi-structured Interviews

To complement the journaling methodology and deepen the understanding of interdisciplinary practices in social work and mental health, semi-structured interviews were incorporated as a secondary qualitative tool. This method was selected for its ability to balance structure and flexibility, allowing participants to express their perspectives while ensuring that the core themes of the research were addressed. By facilitating open and reflective dialogue, semi-structured interviews provided an opportunity to explore individual experiences, professional interactions, and contextual factors that shape interdisciplinary mental health care. The adaptive flexibility enables in-depth and nuanced exploration of lived experiences, providing rich and contextualized data (Smith & Nizza, 2022; Smith, Flowers, & Larkin, 2022).

3.2.2.1 Semi-structured Interviews Sampling

Purposive sampling (Campbell, S. et al., 2020) was applied through contacting different institutions with Social Work and Mental Health Institutions across Slovenia by email and telephone publicly available in order to invite possible volunteers. The criteria for the interviewers to be selected is to be a Social Worker professional within Mental Health experience in Slovenia. Potential participants signed up via a Google Forms (ANNEX) sent via email, LinkedIn and WhatsApp as part of the voluntary gathering process. After the first interviews a snow-ball sampling (Gierczyk et al., 2024) was applied, gathering other volunteers referenced by the previous participants. The semi-structured interviews were carried out online using Microsoft Teams, allowing for accessibility and flexibility across different locations. Each interview had an average duration of approximately 60 minutes, providing sufficient time for in-depth exploration of participants' experiences while maintaining a focused and manageable structure. It was possible to gather 10 volunteers in which only 3 of them took the interview during the research time programme. Most of the participants that couldn't make it to the interview, 4 of them, voluntarily explained about not having enough time available for the online meeting because of workload, the other 3 answered that by the time-frame presented it was not possible to schedule.

3.2.2.2 Semi-structured Interviews Limitations

For this thesis, which examines interdisciplinary social work and mental health practice, semi-structured interviews were applied through an interview guide (ANNEX) that encourages participants to discuss their roles and experiences within the Mental Health field. The semi-structured interview was based on the theoretical framework theories of Interdisciplinarity and Psychossocial approach articulated within the literature review about Social Workers role.

According to DeJonckheere & Vaughn (2019, p. 2), "semistructured interviews provide an effective and feasible research method (...) to understand the thoughts, beliefs, and experiences of individuals". This method empowers participants, giving individuals space to share their perspectives and fostering collaborative partnership between researcher and interviewees. However, these strengths come with potential weaknesses:

semi-structured interviews demand relational skill and rigor from the researcher, and the open-ended format poses risks of bias, inconsistency, or losing focus if not carefully managed (DeJonckheere & Vaughn, 2019).

As McIntosh & Morse (2015, p. 6) caution, "the interviewer must carefully balance structure and flexibility to avoid compromising data fidelity." To maximize strengths and mitigate weaknesses, the focus of the research was cleared in the beginning of each interview and the ethical rigor sustained while adapting the approach to each interviewee's context, aiming to empower participants to share both individual and collective insights into social work interdisciplinary care in the mental health field. In order to gather informed perspectives on their professional roles within interdisciplinary settings, only social workers with prior experience in the mental health field were interviewed during the study's semi-structured interview phase.

3.2.3 Document Analysis

In order to investigate pertinent written materials that might offer contextual, historical, and interpretive insight into the phenomenon being studied, document analysis was employed as a qualitative method. In addition to providing access to non-reactive, pre-existing data, this approach is especially helpful when the researcher wants to comprehend how a subject is framed, represented, and documented over time (Morgan, 2022; Frey, 2018).

Sampling through Purposive selection was used to choose the documents based on their content importance information to add significance to the analysis and their relevance to the research questions. The method's value is more dependent on the informational richness and relevance of the materials chosen than on numerical representativeness; purposeful sampling is essential to qualitative document analysis (Patton, 2015).

Documents can be used in conjunction with other data sources to improve the analysis's credibility, clarify institutional or discursive contexts, and deepen interpretation. In this study, the documentary data consisted of reports produced by internationally recognized organizations, as well as officially available governmental materials. The selection criteria focused on documents that directly address mental health in Slovenia, particularly those that describe the organization of services and the working dynamics within the field. The analysis followed qualitative reporting principles, emphasizing transparency regarding data sources, selection procedures, and analytical strategies. In this process, the researcher assumed an interpretative role, engaging critically with the material to identify relevant themes, contextual meanings, and underlying assumptions, while acknowledging their influence in shaping the analytical narrative (Dalglish, Khalid & McMahon, 2021).

3.2.3.1 Document Analysis Sampling

The documents selected for analysis were identified through purposive sampling, guided by their direct relevance to the organisation and oversight of mental health services in Slovenia. Two primary documentary sources were included. The first is the 'Mira Program', a nationally developed framework addressing mental health promotion and service delivery in Slovenia, chosen for its policy significance and its capacity to illuminate the institutional priorities and discursive framing that shape mental health practice at a systemic

level. The second source comprises the ‘Annual Reports of the Human Rights Ombudsman of the Republic of Slovenia’, covering the period from 2020 to 2024. These reports were selected because they provide a longitudinal and rights-based perspective on the conditions experienced by service users and workers within the mental health system, offering critical institutional commentary that complements governmental policy documentation.

The selection of this five-year timeframe was deliberate, as it allows for the identification of patterns, shifts, and continuities in how mental health concerns are reported and addressed over time. Both sources are publicly available, produced by authoritative bodies, and are directly germane to the research questions concerning the organisation of mental health services and the working dynamics within the field. Consistent with the principles of purposive sampling in qualitative inquiry, the emphasis was placed on the informational richness and contextual relevance of these materials rather than on numerical breadth (Patton, 2015). Together, the selected documents provide complementary perspectives: one reflecting official programmatic intent, the other offering critical oversight, thereby strengthening the analytical depth and credibility of the study.

3.2.3.2 Document Analysis Limitations

As with any qualitative method, document analysis carries inherent limitations that must be acknowledged to ensure methodological transparency. A primary consideration is that the documents examined in this study are institutional in nature, produced by governmental or quasi-governmental bodies with particular mandates, audiences, and discursive conventions. As such, they may reflect selective representations of reality, emphasising certain aspects of the mental health system while marginalising others, particularly those pertaining to the lived experiences of frontline workers or service users who are not themselves authors of these texts (Dalglish, Khalid & McMahon, 2021).

Furthermore, the Annual Reports of the Human Rights Ombudsman, while valuable for their critical function, are bounded by the complaints and cases formally brought to the institution's attention, and therefore may not capture systemic issues that go unreported or unrecognised within official channels. Similarly, the Mira Program, as a policy document, articulates aspirational frameworks that may diverge from actual implementation and practice on the ground. The researcher's interpretative role in analysing these materials also introduces an element of subjectivity; while this is acknowledged as inherent to qualitative inquiry, it necessitates reflexivity and transparency throughout the analytical process (Morgan, 2022). Finally, the scope of the analysis is constrained by the availability and accessibility of official documentation in English, which may have limited the inclusion of supplementary national sources. These limitations were mitigated, where possible, through the triangulation of documentary data with other data sources employed in this study, thereby enhancing the overall rigour and trustworthiness of the findings.

3.3 Ethical considerations

Ethical integrity constitutes a foundational dimension of qualitative research, particularly in studies that engage with sensitive subjects such as mental health and involve direct contact with professional participants (Guillemin & Gillam, 2004). Throughout this study, ethical considerations were embedded into every stage of the research process, from design and data collection through to analysis and reporting, in recognition that the researcher's presence and interpretative role carry responsibilities toward both participants and the integrity of the knowledge produced.

Regarding informed consent and voluntary participation, all participants engaged in the semi-structured interview phase were recruited on a fully voluntary basis. Initial contact was made through institutional channels, professional networks including LinkedIn, and direct communication via email and WhatsApp, with participation formalised through a Google Forms consent procedure (see Annex 2). This process ensured that prospective participants were informed of the study's purpose, their right to withdraw at any point without consequence, and the conditions under which their contributions would be used. The fact that a significant proportion of initially interested participants ultimately declined to take part due to workload or scheduling constraints further underlines the voluntary and non-coercive nature of the recruitment process.

Confidentiality and anonymity were maintained throughout the study, given the sensitive professional and institutional contexts in which participants operate, care was taken to ensure that individual contributions could not be traced back to specific individuals or organisations in the presentation of findings. Observational journaling entries, which documented professional interactions and institutional dynamics within a specific mental health setting, were handled with particular discretion. No identifying information pertaining to colleagues, service users, or institutional processes was recorded beyond what was necessary for analytical purposes, in alignment with the ethical obligations associated with participant observation in sensitive organisational environments (DeWalt & DeWalt, 2011).

The research site involved a major public health institution in Slovenia focused on mental health, and the observational component necessarily brought the researcher into proximity with discussions and practices relating to vulnerable populations, including persons experiencing mental illness. In this context, the researcher maintained a non-interventionist posture, prioritising observation and documentation over engagement, and remained attentive to the boundaries between researcher and professional roles throughout the fieldwork period. As noted in section 5.2.1.2, an internship supervisor regularly accompanied the researcher to assist with linguistic and contextual interpretation, and this relationship was itself managed with care to avoid compromising the naturalistic quality of observations or placing undue burden on institutional staff.

With respect to document analysis, the materials examined — the Mira Program and the Annual Reports of the Human Rights Ombudsman of the Republic of Slovenia — are publicly available institutional documents, and their use does not raise concerns of confidentiality. However, ethical rigour in this component was maintained through a commitment to representing these documents accurately and transparently, avoiding

selective citation that might distort institutional positions, and acknowledging the interpretative nature of the analytical process (Dalglish, Khalid & McMahon, 2021).

The use of artificial intelligence tools, namely Perplexity Pro and ChatGPT, in supporting the writing process was also approached with ethical intentionality. These tools were employed exclusively as aids for language refinement and organisational clarity, with all analytical interpretations and scholarly judgements remaining the sole responsibility of the researcher. Their use was disclosed explicitly in accordance with academic integrity principles, recognising the emerging ethical obligations surrounding AI-assisted academic work (Perkins, 2023, Conselho Cientifico do ISCTE, 2026).

Finally, the researcher's positionality was considered an ethical matter throughout the study. As an outsider to the Slovenian mental health system conducting fieldwork within institutional settings, reflexivity was exercised continuously to critically examine how the researcher's background, assumptions, and interpretive lens may have shaped the data collected and the meanings attributed to it. This reflexive stance, acknowledged across the methods employed, is understood not as a limitation to be eliminated but as an ethical commitment to transparency and intellectual honesty in qualitative inquiry (Guillemin & Gillam, 2004).

4.Findings and Analysis

This chapter presents the findings derived from the methodologies applied in the research: Observational Journaling, Semi-structured interviews and Document analysis. The findings are organized under the dimension of interdisciplinarity, and through the following subdimensions: interdependence, complementarity, and collaboration, synthesis, team flexibility and adaptability, collective ownership of the goals, reflection on the process. Also the dimension of psychossocial focused on the ecosystemic point of view and its subdimensions as: Micro level, Mezzo level and Macro level. Finally through the dimension of Social Workers role and its subdimensions: Social Workers Flexibility and Adaptation, Comprehension of Environment, Comprehension of intrapsychic processes and Professional Relationship, this within its own subdimensions classified as: bureaucracies, relationship with services, relationship with professionals and relationship with clients.

4.1 Observational Journaling Findings of the Mental Health Field in Slovenia

The journaling observations starts by contextualizing a fieldwork placement in Slovenia’s public mental health system, particularly in services and initiatives focused on children and youth. The observations took place across multiple settings, including the National Institute of Public Health (NIJZ), community mental health centers (CDZO), schools, and public mental health regional events. These environments involved both institutional and community-based spaces, allowing the documentation of practices at different levels of care, from policy-oriented discussions to direct interactions with young people. The fieldwork was conducted within the institutional landscape described by Možina and Okorn (2022) and shaped by the MIRA

Programme's community-oriented reforms, providing a direct observational window into how the policy commitments of the National Mental Health Programme 2018–2028 are enacted, negotiated, and sometimes resisted in everyday professional practice.

In order to address the health needs of children and youth a variety of professional fields work together on a daily basis with social workers, including psychologists, epidemiologists, pediatricians, psychiatrists, nurses and public health specialists being represented in the entries. Coexisting in the same work environment, these professionals are seen taking part in interdisciplinary team meetings for case discussion and also in scheduled gatherings to share and bond, there is also entries about interinstitutional meetings and also common forums for discussion with regional Mental health workers, also entries describe the workers as representatives of Mental Health program doing presentations for youth in schools and other spaces. Those entries including intersectorial activity are represented by other institutions like a Highschool, the Ministry of Labour, Family, Social Affairs and Equal Opportunities, a Center for Mental Health of Children and Adolescents (CDZOM).

'Interdisciplinarity' appears as a key dimension defining the structure and provision of mental health services in the observational journaling data. "Through an interdisciplinary approach, these fields do not merely coexist but interact, sharing knowledge, integrating perspectives, and creating coordinated responses to complex mental health and social challenges" (Pos. 10) as said by one of the Mental health workers during our interactions. The transition from the multidisciplinary aspect of the services to the interdisciplinary instance was broadly discussed with different professionals during the observational period, interesting to highlight that interdisciplinarity was portrayed as "professionals engage in shared case discussions, learning from one another and integrating knowledge into a unified treatment plan" (Pos. 70), in opposition to the multidisciplinary approach in which "professionals work in parallel, each applying their own methods, often with minimal communication or case integration. The patient interacts with several specialists independently, which can create fragmentation." (Pos. 69). It was indicated, under the category of 'Reflection on processes', that the interdisciplinary approach in Mental Health services "reduces the burden on patients, who no longer need to navigate multiple service providers with differing approaches, and improves continuity of care", "It also reinforced the value of combining theoretical knowledge with practical tools, ensuring that prevention initiatives are both engaging and meaningful for diverse populations" (pos 21).

Entries about "weekly interdisciplinary team meetings" (Pos. 71) reflect the categories of 'Collective Ownership of Goals', 'Collaboration' and 'Reflection on the process' being stated as serving as "the primary space for discussing new cases and establishing collective treatment strategies"(Pos. 71) in which was highlighted that "This aligns with international standards promoting collaborative care models in community mental health" (Pos. 71) in which was possible to see professionals from different disciplines could gather and share their perspectives of cases and mental health treatment for the community. Under the interdisciplinarity lens, a challenge described by one of the professionals in the field is that "Despite improvements in interdisciplinary practice, professional hierarchies, particularly involving medical doctors and clinical psychologists, continue to influence communication patterns and team decision-making" (Pos 72). By this

worker view the hierarchical dynamic present in some teams “may inhibit open dialogue, limiting contributions from other team members”, which portray challenges in all subdimensions of Interdisciplinarity. Through the ‘Collective Ownership of Goals’ a challenge that arises in the entries lays into the professional “dynamics (that) can compromise the full potential of an interdisciplinary model, where mutual respect and shared decision-making are key components” (Pos 72), further in observations it is stated by an interaction “(...) how crucial trust, communication, and shared responsibility are within mental health teams” (pos 80). An observational entry that can contribute to surpass this challenge is exemplified by one worker that exemplifies “the importance of interdisciplinary collaboration in mental health literacy efforts, particularly when preparing future care professionals” (pos 57). These experiences of professional marginalisation are not idiosyncratic to the Slovenian context. Stone et al. (2021) document a strong and consistent narrative among mental health social workers across Europe of feeling "comparatively powerless within medically dominant systems", while Acker (2004, as cited in Wilberforce et al., 2020) demonstrates that role ambiguity and hierarchical positioning in multidisciplinary settings are directly associated with lower job satisfaction among social workers. The Slovenian observations accounts reflects a structural pattern that transcends national boundaries.

Interdisciplinarity also appears in a discussion with a mental health worker described as “as both a formal and informal process”, the formal being represented by “weekly case meetings” in which “professionals from psychology, psychiatry, social work, nursing, and other fields jointly discuss new and ongoing cases to determine appropriate interventions” (Pos 78). As an informal process example, interdisciplinarity for this worker appears “through daily interactions, brief conversations in the hallway, quick exchanges over coffee, or spontaneous consultations when a professional encounters a challenge with a client”, the professional “emphasized that these informal moments are just as crucial as the structured ones” (Pos 79).

Still under the interdisciplinarity dimension, the ‘Team flexibility and adaptability’ are exemplified by entries such as an interaction that “highlighted the importance of cultural sensitivity and adaptability in preventive mental health education” (Pos 20), “youth mental health prevention requires flexibility and intercultural awareness, particularly when extending interventions beyond national boundaries” (Pos 21) and “interdisciplinary team assesses each new case, prioritizing emergency or high-risk situations immediately. This shift aligns with contemporary public mental health principles emphasizing accessibility, early intervention, and reduced bureaucratic barriers” (Pos 67) and the aim to “create a more flexible and responsive environment for problem-solving” (Pos 79).

The subdimension of ‘Collaboration’ in interdisciplinarity key dimension appears co-occurency with the other key dimension about ‘Social Workers Role’ in the entry that portrays Mental Health practices with Youth and Children “reflects the essence of social work’s commitment to collaboration and community well-being” and in one of the events the representative of the Mental Health for Children and Youth workers highlighted that “the collaborative structure behind the initiative, coordinated by the National Institute of Public Health (NIJZ) (...) integrates professionals from psychology, education, and social work to promote

youth mental health and emotional well-being". In an entry describing the weekly team meeting it is possible to see "(...) together professionals from different sectors, a psychologist , a social work, a public health specialist, pedagogist and a youth worker, to discuss ongoing issues" (Pos 60) where the discussions included "adjustments in project implementation, challenges faced in the field, and upcoming tasks". Some entries in the observational journal highlights 'Collaboration' crossing with the other subdimensions of 'Interdependence' and 'Complementarity' aspects of 'Interdisciplinarity' in which describes this experience of "both the inclusiveness of the team and the importance of communication accommodations in international or multilingual work environments" (Pos 60) also how "environment offered insight into how interpersonal relationships and shared rituals contribute to collaboration within interdisciplinary teams, complementing the more formal aspects of institutional work." (Pos 62). Crossing the 'Complementarity' and 'Interdependence' aspects of interdisciplinarity, when workers in different contexts brought up the importance of "strengthening communication channels" (Pos 74), "strengthen team cohesion" (Pos 79) and "communication" (Pos 80).

The subdimensions of 'Complementarity' and 'Interdependence' in Interdisciplinarity dimension are portrayed in co-occurrency with the entries across the Observational Journaling methodology exemplified by the discussion of professional scheduled meetings in which "These meetings allow the team to collectively construct an integrated understanding of each client, reducing fragmentation of care" (Pos 78) and "continuous share of knowledge" (Pos 79) also within 'Collective Ownership of Goals' and 'Synthesis' when described as "promoting shared responsibility". These entries even encompass transdisciplinary approaches within the client participatory when the workers share willingness to "The active engagement of students suggests strong potential for co-producing mental health initiatives directly with youth, rather than designing interventions solely for them" (Pos 57) and "preventive interventions in youth mental health benefit from a multidisciplinary and participatory model" (pos 17).

'Complementarity' subdimension aspects are also noted in entries like "rather than focusing solely on pathology, (..) promotes empowerment, education, and dialogue as protective factors against psychological distress" (Pos 17). In this matter, talking about Mental Health promotion and prevention digital program its noted interdisciplinarity aspects crosses with 'Social Workers Role' subdimension of 'Comprehension of Environment' when noted that "It also exemplifies how digital platforms can bridge the gap between institutional mental health services and the everyday experiences of adolescents". An specific Slovenian digital Mental Health program, named "To sem jaz", also covers the 'Psychossocial Ecosystemic', another key dimension, when it describes that it "combines policy indicators (youth mental health policies, education system buy-in), socio-economic variables (prevention spending), and digital readiness. This type of multidimensional analysis is critical in implementation" (Pos 37) showing 'Micro', 'Mezzo' and 'Macro' levels taking into account Youth and Children Mental Health. Entries exemplified by the discussion that Mental Health programs "should involve policy-makers, school leaders, and mental health professionals from the outset, to ensure structural support, fidelity, and resource allocation" highlights the need of different 'Psychosocial Ecosystemic' levels connection and 'Complementarity' interdisciplinary aspect by the practices

“integration into existing institutions” (Pos 44) in which the Regional Mental Health meeting event could portray when described entry in which “each one brought a unique perspective, shaped by their direct work with individuals and families in the region” (Pos 47)

Another entry of ‘Complementarity’ subdimension of ‘Interdisciplinarity’, crosses within the ‘Social Workers role’ aspects of relationship with ‘Clients’, ‘Services’ and ‘Professionals’ when addressed within the Highschool event within the Education professionals teams meeting and Mental health programs presentation to the youth students where it’s noted that the “educators emphasized their difficulty in identifying early signs of distress among students; students shared concerns regarding coping mechanisms; and Mental health professionals highlighted systemic approaches to school-based prevention” (Pos 54). ‘Complementarity’ is portrayed in the entries highlighting the “integration into existing institutions like schools, social services, mental health services through digital platforms”, co-occurring within ‘Social Workers Relationship with Services’, which “The multidisciplinary composition of the audience allowed for diverse perspectives on mental health promotion” (Pos 54) and “integrating relational, community-oriented approaches with structured educational programs” (Pos 56). ‘Social Workers Relationship with Services’ and ‘Complementarity’ co-occurencie also appear in the entry “Listening to their experiences highlighted how intersectoral collaboration is not only ideal but essential for effective mental health promotion, especially in small or mid-sized communities” (Pos. 47). During the Regional Mental Health meeting also was possible to see ‘Complemenarity’ in the entry that ntoes “each (group) brought a unique perspective, shaped by their direct work with individuals and families in the region” (Pos 44).

Through the Psychossocial Ecosystemic key dimension it is possible to notice an entry about “Slovenia’s approach, which combines health, education, and community development, aligns strongly with contemporary models of public mental health and ecological prevention frameworks”. These observations are analysed through the psychosocial ecosystemic lens articulated by Francis (2014) and Gould (2022), which frames mental health not as an individual condition but as a phenomenon shaped by interconnected systemic levels, from the intrapsychic to the structural. Portraying the ‘Macro level’ aspects of the observations, within “The ongoing shift from multidisciplinary to interdisciplinary practice reflects a broader international movement toward integrated, collaborative, and person-centered care.” (Pos 73) however in the same statement also shows an ongoing challenge describing “the persistence of hierarchical structures illustrates that organizational culture change often progresses more slowly than policy reform.” (Pos 73). An observation taken in the early stages that also portrays ‘Macro level’ when is “Although Slovenia has made significant progress in recent years by developing community-based mental health centers and promoting interdisciplinary collaboration through reforms aligned with the Resolution on the National Mental Health Programme (2018–2028), many systemic challenges persist.” (Pos 13) indicated by “Long waiting times for psychological and psychiatric services, especially for children and adolescents. Limited human resources, uneven regional distribution of professionals, and the coexistence of medical and social service silos make it difficult to ensure timely and coordinated care. As a result, early intervention efforts are frequently delayed,

and social workers and mental health professionals are required to navigate bureaucratic constraints while attempting to respond to urgent psychosocial needs. These challenges highlight the ongoing tension between the aspirations of a holistic, community-oriented mental health model and the practical limitations of its implementation within a small but complex welfare system" (Pos 13), also affecting the 'Social Workers role' dimension of 'Relationship with services'. The 'Mezzo level' and 'Micro level' of the Psychossocial Ecosystemic key dimension challenges were portrayed in different occasions, 'Mezzo Level' being noted when "the role of family dynamics and community networks" and then 'Micro level' is during the students meeting with mental health service highlighting "stress, identity, and peer relationships, demonstrating that while challenges may vary by context, many psychosocial experiences are shared across cultures" (Pos. 16), in which brings also the 'Social Workers role' dimension of 'Relationship with Clients'.

The key dimension of 'Social Workers Role' and its subdimensions of 'Social workers Flexibility and Adaptation', 'Comprehension of Intrapsychic Processes', 'Comprehension of Environment', and then 'Social Workers Relationship' which includes the subdimensions of 'Relationship with client', 'Relationship with services', 'Relationship with professionals' and 'Bureaucracies'. The entries describing the 'Social Workers role' are seen when professionals speak that the "social work(ers) plays a vital role in linking individual experiences to broader systems of care, ensuring that emotional, relational, and social dimensions of well-being are addressed holistically" (Pos. 10), which crosses within the Ecosystemic levels view through Psychossocial approach, in this case specially within 'Micro' and 'Mezzo' levels subdimensions. This holistic orientation, documented across multiple observational entries, corresponds with what Wilberforce et al. (2020) identify as the most valued dimension of social work practice from a service user perspective, and with Kelly and Sewell's (1991) foundational framing of social work as integrating cognitive, relational, and practical dimensions of engagement.

Another entry specifies the changes in the 'Social Workers Role' after the Mental Health act of 2018 through the point of view of a Mental Health primary field worker stating that "the reform expanded the role and autonomy of social workers within mental health services, giving them greater freedom to intervene, participate in case management, and function as integral members of interdisciplinary teams" (Pos. 77) in opposition to the previous vision of 'Social Workers role' more concerned about the bureaucracies and documental procedures, the 'Social Worker flexibility and adaptation' subdimension also goes along within this entry when it is noted about "how reforms reshuffle professional power, redefine responsibilities, and reshape collaboration" (Pos. 81) and also stating that "social workers must remain adaptable, politically informed, and proactive in advocating for their role" (Pos. 81). Talking about 'Social worker flexibility and adaptation' in the early stages of the observational journaling is stated that " (Social Worker) professionals in this field often find themselves doing a bit of everything sometimes even beyond their formal responsibilities" (Pos. 12) also another entry highlights the importance of "adaptation (that) must not be superficial; it should be sensitive to local (...) culture, (...) infrastructure and school system constraints." (Pos. 43).

About the ‘Comprehension of Intrapsychic Processes’ subdimension under the ‘Social Workers Role’ is interesting to notice the entries that portrays importance of identifying the “relationships, conflict resolution, communication, mental health digital life and screen use, identity, sexuality, peer pressures, emotional regulation, and coping strategies” (Pos. 5) also the entries in which professionals talked about “the idea that protective factors like social-emotional competences and self-image, are best developed through multi-modal interventions” (Pos. 28), intersectioning within the ‘Interdisciplinarity’ in Mental health field, also been discussed in the same event the need of “emotional regulation skills and social and emotional learning”. The prominence of digital environments in the observational data reflects the broader European policy shift identified by the European Commission (2026), which now explicitly includes digitalisation among the key cross-sectoral determinants of mental health, particularly for children and adolescents.

About the ‘Comprehension of Environment’ the digital space was highlighted as a very important space to be considered when tackling Mental Health of Youth and Children and its possible to note it in the entries that specifies the necessity of providing “accessible digital space where young people can seek information” (Pos. 15) but not letting the institutions aside when is noticed the potential of “combining a digital, low-threshold, open-access tool with a structured, face-to-face school-based prevention activity.” (Pos. 27) also “ to integrate universal prevention across both domains (online and institutional), which aligns well with public health goals.” (Pos. 27). “It became evident how evidence-based prevention programs can only succeed when adapted to local contexts: culturally, socially, and institutionally.” (Pos. 48). This ‘Social worker Role’ subdimension crosses within the ‘Psychosocial Ecosystemic’ levels when “emphasized the social determinants underlying substance use; the importance of early and school-based interventions; the role of family dynamics and community networks and the need for consistent public policies supported by reliable epidemiological data”, also an entry pointed out that Mental Health institutions should reflect in “supportive adults, and safe community environments” (Pos. 49).

Finally, tackling the ‘Social Workers role’ key dimension by the subdimension of the ‘Social Workers Relationship’ and its own subdimensions of ‘‘Relationship with Professionals’was possible to see in the entry “At the end of the meeting, the team held an informal gathering where several professionals brought food to share. This shared moment created a warm and collegial atmosphere, reinforcing the role of informal interactions in strengthening team cohesion. The convivial environment offered insight into how interpersonal relationships and shared rituals contribute to collaboration within interdisciplinary teams, complementing the more formal aspects of institutional work.” (Pos. 62) co-occurring within ‘Collaboration’. On the other side, most entries about ‘Relationship with other Professionals’ highlighted the challenge of “hierarchical dynamics within mental health teams.” (Pos. 72), while in discussion with a worker it was noted that “professional hierarchies, particularly involving medical doctors and clinical psychologists, continue to influence communication patterns and team decision-making. These hierarchies in his vision may inhibit open dialogue, limiting contributions from other team members” (Pos. 72) and “Such dynamics can compromise the full potential of an interdisciplinary model, where mutual respect and shared decision-making are key

components.", bringing a threat to 'Interdisciplinarity'. Still, in this matter "physicians and clinical psychologists may still work in a more individualized and isolated manner, which reflects broader trends in clinical culture and professional identity." (Pos. 72) which portrays a challenge to 'Interdisciplinarity' and is known by the worker when noted that "In practice, it suggests that quality mental health care depends not only on institutional structures but also on everyday relational dynamics." (Pos. 80). This hierarchical dynamic observed in the field mirrors what Stone et al. (2021) identify across European mental health systems, where social workers consistently report feeling marginalised within medically dominant team structures, a pattern that predates and transcends any single national context.

4.2 Semi-structured Interviews

Through the semi-structured interviews it was possible to note the Social Workers impressions about the 'Social Workers role' in mental health revolves around the possibility of a person-centered treatment, highlighting aspects of the client humanity beyond the mental health diseases. The "role as a social worker is to be a voice for the person in that medical field (...) gets their voice heard in this situation where it's often (...) disregarded." (Interview 3, Pos. 24), another interviewer indicates that " (...) the 1st and the most important is to respect human rights. So to respect the person that we are working with, (...) cooperating with, that we see the person as a human being, we don't see the person as someone who has mental issues or a disease or whatever" (Interview 2, Pos. 8), also "(...) In social work we see the person, the human being. I think it's a very big (role), a very important contribution, especially because sometimes I feel like we need to remind other people that the person we are working with is a human being." (Interview 2, Pos. 10-12), later on adds "we need to listen to the user." (Interview 2, Pos. 74). Under 'Social Workers Relationship with Professionals' subdimension it's said that "other professions maybe, sometimes, they forget that they are working with people. Like they are just working with the disease or with, I don't know, the definition of the person and they forget that it's just a person" (Interview 2, Pos. 14-16), later on it is stated as challenge "because they try to explain the situation of a person just based on the Diagnosis" (Interview 2, Pos. 242). Interview 3 also brings that "they focus on the person's mental health from their perspective, which is, you know, they've been taught that way, but they don't look at the person as a whole, as someone who lives in their community" (Pos. 22) complements later on "it's always the clinical perspective" (Pos. 50). This person-centred orientation, articulated consistently across all three interviewees, resonates with what Wilberforce et al. (2020) identify as the most valued dimension of social work practice from a service user perspective, its holistic attention to the social dimensions of mental health that extend beyond immediate clinical symptoms. It also reflects the foundational framing articulated by Francis (2014, p. 16), who describes the social worker's role in mental health as crucial precisely because of the need to address biases and bring awareness to the full humanity of persons experiencing mental illness.

This brings the quote under 'Relationship with Clients' that "Diagnosis, which is very often in mental health. If they have this, it doesn't mean that that's all they are. Like it's just part of them and it's not even the

biggest part. It doesn't have to be. There is still a person behind this. So I would feel like this is a very strong (aspect of Social Workers' Role"(Interview 2, Pos. 64) and "the user needs to be heard every time. Like they are the main person in the process, so they need to be heard" (idem, Pos. 72). This critique of diagnostic reductionism articulated by interviewees corresponds directly with the paradigm shift described by Mental Health Europe (2023), which frames the move from deficit-oriented, biomedical conceptions of mental health toward psychosocial and rights-based frameworks as an ongoing and contested process. The interviewees' descriptions of colleagues who "work with the disease" rather than the person reflect precisely the dominance of the biomedical paradigm identified by the United Nations General Assembly Human Rights Council (2017) as "a crisis of power imbalances" rather than chemical ones.

Interview 1 (Pos. 10) also says that the 'Social Workers Role' is to "protect the dignity of a human and see the whole picture of a person (broader) than other professionals", which brings the co-occurrency of the 'Social Workers Role' connecting different dimensions in clients life within 'Psychosocial Ecosystem levels' that will be brought later. It's interesting to notice as Social Workers "We can address a lot of different issues, different parts of life and the problems he has, connecting different perspectives of the client would be the main contribution of the social worker". In the interviewer 1 (Pos. 14-16) perspective another role of a social worker, which can contribute to the team is that the "the social worker tries and really, really tries to understand (...) what this person is suffering from, how he feels and how he can engage much more and then really connects to people" this contributions which "are, in my experience, a little different than the psychiatrists and other experts. So for social workers, in my opinion, the person is more than the number. We really try to see the person in all his good and maybe a little in its not so strong aspects" (Interview 1, Pos 16). 'Relationship with Clients' in 'Social Workers Role' in Mental health is said once again about 'connecting different perspectives of the client' (Interview 1, Pos 13), later it's portrayed by meaningful questions like "what is the situation? Why did they search for help? What are their resources? Are they alone? Do they have any friends? How is their social network? I present what are the possibilities and what are the options? How does he see this situation? Is this something that he can do?" (Interview 1, Pos. 38-44).

This brings to the subdimension of 'Social Workers Role' of 'Flexibility and adaptability' when Interviewer 1 (Pos. 46) says that "usually there is not only the main issue which was the problem that (the client) was of that what he came, and there are some deeper issues and some" portraying the need of sensibility to different contexts and challenges each mental health client is facing, which need different types of approaches that the Social Worker must be ready to adapt "to make the plan" (Pos. 38), for that "sometimes I may need 15 or 20 minutes more. And then we go step by step. We detect what are the main issues" (Pos 42) but on the other side under the 'Team Flexibility and Adaptability' under 'Interdisciplinarity' key dimension it is interesting to notice that it is said "we don't plan what would be better. We never plan. We rarely sit together to plan what we should do, what would be better, what to do for prevention" (Interview 1, Pos. 126). Those entries also co-occur with 'Comprehension of Intrapsychic Processes' because this goes aligned with the need of "relating to (the client) own personal view of himself, self-esteem, maybe some trauma experiences

from childhood or during teenagers or maybe later" (Interview 1, Pos. 48). 'Comprehension of Environment' is acknowledged that "Mental health issues are growing" and people "are also more keen to find the help and all the situations going on in society", "There's a lot of pressure and people cannot manage it anymore" (Interview 1, Pos. 172-176). This attentiveness to the social dimensions of the client's life, their relationships, social network, housing, and resources, reflects what Gould (2010) identifies as one of social work's most distinctive contributions to mental health practice: its grounding in the social determinants of mental health and its capacity to address the structural inequalities that shape psychological distress in ways that clinical approaches alone cannot reach.

Another difference from other professionals is when it is said that "We (Social Workers) are very enthusiastic and also (…) find a way where other professionals don't" (Interview 1, Pos. 148), which goes along with Interview 2 (Pos. 284) "we need to hear other perspectives". 'Flexibility and adaptability' is also well portrayed in Interview 3 (Pos. 188-192) "as a social worker,(...) we were expected to do things that were maybe not defined,(...). I have no problem with doing other things that come up if they help people that live there or that were in the hospital". In more institutionalized experiences the adaptation and flexibility of social workers might indicate a symptom of institutionalization process of the profession "social workers who are more (...) working in institutions or hospitals. I think with time, (...) if you're not self-observant and (...) get this kind of mindset and they adapt, they institutionalize in that (institution) way" (Interview 3, Pos. 30-32). This risk of professional identity erosion through institutional absorption resonates with Gould's (2010) warning about the tendency of social work within medically dominant settings to become reframed in clinical terms, gradually ceding the psychosocial and structural dimensions of practice that constitute its distinctive contribution. It also points to the importance of what Stone et al. (2021) identify as the need to more clearly define and communicate social work's specific role within multidisciplinary settings as a safeguard against this drift.

Important to notice what Interview 3 (Pos. 150) said "from the social worker's perspective, we had to do a lot of convincing and we really had to stand behind what we were saying and just say it more, you know, a lot of times, maybe not just once, and just not give up" portraying negotiating and communication skills needed for 'Social Worker Role'. Although in this aspect it is also said that "(...) a lot of times we don't say anything because we feel like we internalize that we are less important and we have less knowledge (...) I feel like as social workers, we are just there, we observe, we don't say anything, or we are afraid to speak up" (Interview 2, Pos. 26-28). Interview 1 speaks about how Social Worker feels like "a lower position (...) they don't really respect our opinion or, you know, maybe just disregard it." (Pos. 38-40) and most of the time don't feel "Competent enough, or, you know...brave enough to say something and yeah, then the doctor's voices I think were… Louder and yeah" (Pos. 68-70). These experiences of professional marginalisation, documented consistently across all three interviewees, are not idiosyncratic to the Slovenian context. Stone et al. (2021) document a strong and consistent narrative among mental health social workers across Europe of feeling comparatively powerless within medically dominant systems, while Acker (2004, as cited in Wilberforce et

al., 2020) demonstrates that role ambiguity and hierarchical positioning in multidisciplinary settings are directly associated with lower levels of professional satisfaction. The Slovenian interviewees' accounts thus reflect a structurally documented European pattern rather than individual professional insecurity, and point to the need for institutional responses that actively redistribute professional authority within interdisciplinary teams rather than assuming that collaboration will emerge organically.

Some interesting contradictory aspects appears when it's said that "when they (other professionals) don't know what to do with that person, when they find it more difficult to help them on their own, with the tools or approaches they use, they ask for help to social workers, which sometimes is the last hope you call when you don't know what to do" (Interview 1, Pos. 18-20). In 'Relationship with professionals' subdimension it is said that "They (other professionals) were not able to help this person and they kind of give up, and then they kind of expect that the social worker won't give up and will do something" (Interview 1, Pos. 78) and later on it reveals that there is towards the social workers "Sometimes (...) higher expectations" (Interview 1, Pos. 142). In this participant's view, what brings this up to the 'Social Worker Role' is that "We really care for the clients, so we maybe take a step more or do something which is not required, but when we see that there's a need, we respond to that. We are very enthusiastic and also find a way where other professionals don't. Usually they say we can't, we don't care, this is not a law or maybe they are only by book and we need to find something", once more showing the subdimension of 'Flexibility and Adaptation' (Interview 1, Pos. 146-148). This paradoxical positioning is simultaneously marginalised within the team hierarchy and indispensable when complexity exceeds the capacity of clinical approaches — reflects what Stone et al. (2021) describe as the tension between social work's peripheral institutional status and its recognised practical value in addressing the multi-dimensional and socially complex presentations that resist purely clinical resolution. It also resonates with Wilberforce et al.'s (2020) finding that service users place particularly high value on social work's holistic orientation precisely in those situations where other approaches have proved insufficient.

This leads to 'Social Workers Relationship' with 'Professionals' and 'Services' and also portrays the 'Interdisciplinary' co-occurencies within the dimension of the 'Social Workers Role' as Interviewer 1 (Pos. 204) says it takes "a lot of knowledge and a lot of skills and you (Social Worker) need to recognize and to know all other organizations and professionals to understand what is their role and how do they do so you can be like a translator (for the client)" which also takes place within 'Complementarity' aspect of the work in Mental Health.

A co-occurrency between 'Complementarity' and the 'Social Workers Role' is portrayed by Interviewer 2 "... it's very helpful if you can hear other professionals speak about it and you can maybe understand the story better (...) like what is happening to the person or why he's acting this way or whatever" (Pos. 116-118), "It's really helpful and it's also like a very big deal in social work. Like you need to hear everyone. You need to hear different perspectives because it's the only way you can have the full picture, the full story" (Interview 2, Pos. 120). It's said that "...we are lacking some information, knowledge, experience,

and that's where the other professionals come in. So if we really want to help a person, because I believe in the systematic approach, like the world and everything is connected." portraying the co-occurrency of 'Interdisciplinarity', 'Psychosocial Ecosystem' levels and the 'Social Workers Role'. Also the professionals' roles "could be more complementary, they could be more integrative"(Interview 3, Pos. 97) signalling both an aspiration and an acknowledgement that current practice does not yet fully realise this potential., then it's said "...they're planning what to do with this person. And of course, they did their own individual assessment… So how to help them (other professionals)?". This admission of professional interdependence, far from representing weakness, reflects the epistemological humility that Wilberforce et al. (2020) associate with effective social work practice in complex interdisciplinary settings.

This leads to the 'Interdependence' aspect highlighted by Interview 1 saying "everybody has his role and everything was very important, and only when we worked as a group, we were successful. Every part and every expert was needed." (Pos. 102). In the 'Collaboration' subdimension it is reported that "If I need some collaboration, I always get it. So I have good experiences (…) there was a need for collaboration with the police, courts, advocacy, hospital, social, social centre, government… " (Interview 1, Pos. 88-94) co-currying within the 'Mezzo' level of 'Psychosocial Ecosystemic', "I think it's like working with other professionals or just other people, it's really important." and "I think the important thing is, (...) basic in social work, that everybody is heard" (Interview 2, Pos 122-128). Interview 3 notices that "...there's still room for improvement, especially for collaboration between medical professionals and social workers" (Pos. 250) and expressed that "... the social workers should be more included, to maybe help them in this process of working with the person" (Pos.120) because "with people who had, (...) more problematic or more complex problems, then yes, they called us. So the doctor called us to help them to communicate with the relatives or things like that (...) when the problem was more complex" (Pos. 118).

The co-occurrency of 'Social Workers Role' and 'Interdisciplinarity' also portrays some challenging aspects regarding hierarchical dynamics and the sense of undervalue of the Social Workers perspective, like Interview 2 (Pos. 24) brings " I feel like a lot of times in interdisciplinarity approaches, we are the least important.". About 'Interdisciplinarity' key dimension it is said that this approach in the Mental Health field "...is better than it was 20 years ago, or even 10 years ago when multidisciplinarity was like a dream. It 's developing." (Interview 1, Pos. 226). This distinction, observed directly in the field, resonates with the trajectory described by Švab et al. (2006), who identified the predominance of parallel, siloed professional working in Slovenia's mental health system, and with Maučec et al. (2020), who frames the MIRA Programme's strategic reorientation as a deliberate move from fragmented multidisciplinarity toward integrated interdisciplinary practice.

On the other hand, still "the interdisciplinary approach is heard (that) … it takes so much time to do all the paperwork and all the bureaucracy. So they sometimes don't do it just because they feel like it's too much work." highlighting the 'Bureaocracy' (Interview 2, Pos. 112), which leads to the occasions in which Mental Health workers practice the interdisciplinarity to be "... if they (clients) are like a danger to themselves

or to someone else (...) these are the situations where the team really wants to come together to just share what they know.", in the same sense Interviewer 1 reports that "the joint efforts mostly happen when the case is challenging. So not much of joining efforts for prevention, but mostly when the case is out, it's already challenging." (Pos. 125). Interviewer 3 reports in its experience "every morning we had a short briefing on the things that happened that were, let's say, urgent or we had to discuss about. They were in a very wide circle, so almost all the healthcare professionals and doctors were there and social workers" (Pos. 56).

About 'Reflection on the process' when asked throughout the interview its said that "in my in my experiences not so much, only (...) when there is a lot, when there is a need, when it's urgent, we collaborate very well and when we discuss and arrange, then everybody do his work and engage together" (Interview 1, Pos. 117) and then is added "I don't remember that we ever get together after the case was case was over and discuss (...) I don't have this experience. Only in the beginning, then we work and we leave the case closed". About conflicts in each perspective it's stated that "contacts with other professionals that are not going very smoothly or something is not okay, (...) we don't discuss even that, we don't discuss and bring and talk about. There is no time to discuss, arrange or organize for the better future of working" (Interview 1, Pos. 170). On this same path Interview 2 says that there is "The only one (moment to reflect on the process) that I do know, I never had it so far, but I know that we do it in Slovenia, is supervision, which is not supervision as like supervising someone, but as like therapy, I guess, for social workers, but I think that's only for social workers. And it's also, it's not focused on clients, it's focused on social workers, like to help them deal with stress they feel at work. So not interdisciplinary, I don't know, I don't think so" (Interview 2, Pos. 174-176) then its added that "if you're dealing with a dilemma and you don't know what to do, like you can say, okay, I want to see what's been done. I want to reflect on it. Yes, sure. I feel like they (the team) would listen to you for sure and like to discuss it with you. But I don't think it's like a point on the schedule" (Pos. 190). Interview 3 states that "we had intervisions, let's say once a month or maybe less if there was no time. But yeah, we had intervisions between ourselves, all the social workers that worked there. And yeah, I feel like we had time to discuss that" (Interview 3, Pos. 153) and complements "we just did the necessary, the urgent stuff, and we didn't really do anything that would, I don't know, that wasn't necessary at that moment" (Interview 3, Pos. 158). Afterwards, its reflected that "when some lecture from another professional and then we had time to discuss there … but that wasn't really … the standard" and "when we had them, they were good, they were planned very well. I mean, they also asked us what we would need and then they organized it, if it was possible" (Interview 3, Pos. 172-174).

The 'Collective Ownership of Goals' subdimension is portrayed by the Interview 2 as "usually they already set the goal before the meeting(…) but of course you can also during the meeting find out, okay, this goal is not possible. Now we need another one. And I don't know, of course, sometimes you don't agree on it for sure" (Pos. 202-204) and exemplifies with Social Workers view stating that "the home environment is very supportive for him, like it's making good things for him, and the psychiatrist would say, no, no, no, it's too dangerous" then proceeds speaking "So what is the goal? Okay, now we need to find the goal together.

What is our goal? To achieve what?" (Interview 2, Pos. 208). Portraying some conflicts that might arise within different professional perspectives, in the subdimension of 'Collective Ownership of Goals' the way to solve the disagreements is said to be like to "...just say, okay, let's calm down. Now, first you speak and then when you stop this person can speak and when he's finished, this person. So we give the space and time to everyone to explain what they think, what they see, and in the end we can just ask ourselves, okay, we have a conflict, we don't agree, but what are we prepared to do for the benefit of the client, of the user?" (Interview 2, Pos. 130). Finally, speak as a possible solution crossing also within the 'Synthesis' subdimension exemplified as "The person can go home for the weekend and stay there (at Psychiatric Hospital) during the week" (Interview 2, Pos. 210) portraying an approach that combines different perspectives. 'Synthesis' subdimension however when asked is not really recognized in the team interdisciplinary approach: "I can't think of anything right now" (Interview 3, Pos 195) although hard to recognize the 'Synthesis' it is stated by Interview 2 that "I think that most of the cases would not have the outcome they have without that" (Interview 2, Pos 122).

'Collective Ownership of Goals' Interview 3 gives a very similar example as "doctors and nurses had their own perspective and they were always focused on, so if we were discussing, I don't know, releasing someone home, their main point of view would be okay, but will this person be safe? Will they hurt themselves or someone else? Will they take their medicine and things like that? And the social workers, so our perspective was always… Let's make their relationships stronger. Let's help them to be able to live in their community again. So yeah, definitely different perspectives" (Pos. 141-144) and states that "Mostly the goal for medical health professionals was to keep the people in the institution, in the hospital. And yeah, just that was their, they didn't think that people are to be trusted and that they could live alone again in the community. So yeah, their goal was to just keep them there and keep them safe" (Interview 3, Pos. 148). This divergence in professional goal orientation between the medical emphasis on safety and containment and the social work emphasis on relationships, autonomy, and community reintegration is not merely a practical disagreement but reflects a deeper epistemological tension between clinical and social models of mental health. As Bland et al. (2009) argue, effective mental health care depends on an integrated approach that builds on existing community strengths and supports reintegration into social life, rather than defaulting to institutional retention as the safest option. The social workers' consistent orientation toward the client's relational and community environment, even in the face of medical resistance, reflects precisely the distinctive contribution that Gould (2010) identifies as central to social work practice: its capacity to hold the social determinants of recovery in view when other perspectives have narrowed to risk management alone.

The 'Collective Ownership of Goals' co-occurs often within the 'Team Flexibility and adaptation' aspects of 'Interdisciplinarity' mostly to deal within conflict perspectives "sometimes we don't agree on how to deal and what would be the best interest of clients. Then we try to discuss" (Interview 1, Pos 104-106). But, this appears as a bigger challenge within the picture that "Also, my colleagues, who have a lot of skills and tools to help themselves, usually say: I don't know how to manage all this, I cannot go like this anymore. People who are working in health or mental health or social worker or psychology fields are not

able to manage all these pressures" (Interview 1, Pos 178-180). The 'Macro' level of 'Psychossocial System Approach' overlaps within the 'Team Flexibility and adaptation' when it is reported that "It's a different rhythm on the daily work basis and how the policies are being made and they need their time also. But at the same time, on a daily basis, the challenges keep coming" (Interview 1, Pos. 195). Within the 'Psychossocial Ecossytemic Approach' the 'Macro' level is perceived that "They (policies)... are trying very hard, but they are always one, two or three years behind" (Interview 1, Pos 182) and "the problems are… going faster, so we don't predict what will happen. We only see the problem afterwards, make some new policies or open new programs" (Interview 1, Pos 184). This experienced gap between policy aspiration and daily practice reality is not merely a subjective perception. The WHO Regional Office for Europe (2020) independently documents that the intersectoral and interdisciplinary approach mandated by Slovenia's 2018 Resolution remains only partially implemented in practice, hindered by insufficient interministerial cooperation and interprofessional disagreement over coordination and leadership. The interviewees' frustration with the pace of policy change thus reflects a structurally documented phenomenon rather than individual professional discontent.

Specifically talking about Slovenia's 'Macro' level it is said "that the government and the institutions in Slovenia try very hard to follow all this, … I have a feeling that they are" (Interview 1, Pos 192-194). In this matter, Interview 3 states the importance of having proper legal base to make decisions in daily practice "The policies, you know, it always comes down to that. So whenever you have to do something, help someone, there's always the question, even in institutions: oh, do we have a law mandate to do that?" (Interview 3, Pos 224). As portrayed by Interview 2, the 'Macro' level co-occurs within the 'Social Workers Role' when stated that "The first thing that comes to my mind is they (policies) support me as a social worker. Because, for example: we have the law that the person cannot be detained at a mental health institution. For example, if they have addiction problems, they have to decide for themselves. They have to sign the paper that they want to be there. This is a very important thing for social workers because it's like the basics for us is to let the person decide for themselves" (Pos 234-238). For the 'Mezzo' level it's interesting to notice "I feel like we are working a lot, like the social work is really fighting. Our, for example, academics are really fighting for deinstitutionalization in general, which also includes mental health institutions" and recognizes the interplay between 'Macro' and 'Mezzo' highlighting that "mental health is not only about the mental health services, but it's a matter of every, almost every institution, almost every sector of society" (Pos. 313). Lastly, the 'Micro' level is mostly portrayed by the families of the clients, like Interview 3 shows that "So I had that first talk with them (clients) to learn more about them, do the plan, the personal plan, and so, oh, there was also work with the relatives. So either alone with them or with relatives and the patients or people" (Interview 3, Pos. 96). This professional commitment to deinstitutionalisation expressed by the interviewee reflects the alignment of social work values with the rights-based frameworks established by the UNCRPD (2006) and affirmed by Mental Health Europe (2023), which position independent living and community inclusion not as aspirational goals but as fundamental rights. It also resonates with Gould's (2010) identification of community

development and the challenging of discriminatory institutional practices as core dimensions of social work's contribution to mental health.

Going back to the ‘Team Flexibility and adaptation’ Interview 2 states that is challenging that “we have different opinions, we have different perspectives and it's very frustrating to hear sometimes someone saying the opposite of us” and for that it’s needed to seek for “where can we compromise and where we are not stepping back and just like to negotiate: I will step back here, but this is too important and here I don't want to step back. Giving space to everyone and just reminding the others, you know, they should respect different opinions” (Interview 2, Pos. 132-136). The informality plays a part of the ‘Team flexibility and adaptation’ Interview 3 recognizes that “we talked about on a daily basis, whenever we had the time, you know, just to sit down for a coffee between break or something, it was very informal” (Pos. 168).

4.3 Document Analysis

The document analysis begins with an examination of the MIRA Programme, exploring how Slovenia's national mental health framework articulates its vision for interdisciplinary practice, community-based care, and the psychosocial dimensions of mental health service delivery. This is followed by an analysis of the Annual Reports of the Human Rights Ombudsman of the Republic of Slovenia, drawing on selected excerpts from the 2020–2024 reports to interrogate how systemic challenges, rights violations, and institutional shortcomings within the mental health system are identified, framed, and addressed through an independent oversight lens.

Through the 'Psychosocial Ecosystemic' key dimension it is noticed that the document begins by acknowledging that "mental illness presents modern public health with considerable challenges. It places a huge burden on the individual and those closest to them, and leads to huge losses for and burdens on society as a whole and on its sub-systems" (MIRA Programme, p. 6). At the 'Macro level', this burden is quantified in concrete terms: "Mental illness and suicide reduce Slovenia's GDP by 4.1%", and the document proceeds to recognise that "we are witnessing a growth in the amount of outpatient provision, unacceptably long waiting lists and a rise in the number of psychotropic medications being prescribed to children and adolescents" (MIRA Programme, p. 6). At the 'Mezzo level', the document identifies that "most mental health treatment takes place in overworked and expensive specialist hospitals and social care institutions", pointing to the need to relieve this pressure "by establishing services at the primary healthcare level" (MIRA Programme, p. 6). At the 'Micro level', the individual and developmental dimensions of mental health are foregrounded: "half of all mental illness occurs after the age of 14, and as much as three quarters by the time we reach 24. Anxiety and depression are the most common forms of mental distress. The impact of depression on quality of life is equivalent to the impact of serious physical illness, such as a stroke" (MIRA Programme, p. 5).

In response to these identified challenges, the MIRA Programme outlines a set of strategic goals operating across the same systemic levels. At the 'Macro level', the Programme envisions "the establishment and upgrading of the administrative structures for coordinating, monitoring and evaluating the implementation

of the Resolution on the National Mental Health Programme" (MIRA Programme, p. 10). At the 'Mezzo' and 'Micro levels', the goals include "the upgrading of social care programmes and programmes to support families, integrated with healthcare programmes and with services and programmes for dealing with people with associated mental health problems" (MIRA Programme, p. 8), as well as "the upgrading of the network of mental health centres for children and adolescents" and "the establishment or upgrading of interdepartmental cooperation and the cooperation of all stakeholders at the national level and in local environments" (MIRA Programme, p. 10), the latter underscoring the centrality of the 'Interdisciplinarity' key dimension within the Programme's vision.

The document further affirms that "the population's mental health depends on the timely and comprehensive interdepartmental implementation of the national mental health plan" (MIRA Programme, p. 11), reinforcing the importance of the 'Social Workers Role' within the 'Relationship with Services' dimension. Notably, the Programme explicitly acknowledges the concern of workforce scarcity, setting as a goal "the elimination of staff shortages in mental health care systems in all departments, and additional education and training for the successful implementation of reforms in the area of mental health care" (MIRA Programme, p. 11). This institutional recognition of understaffing and the need for professional development resonates directly with what emerged across the observational journaling and semi-structured interviews, where mental health workers described navigating excessive workloads, bureaucratic constraints, and the pressure of insufficient human resources, challenges that bear directly on 'Team Flexibility and Adaptation' and on the sustainable enactment of interdisciplinary practice.

While the MIRA Programme thus offers a comprehensive and rights-oriented policy vision, the gap between its aspirations and everyday professional realities points to the need for a critical, ground-level perspective. It is precisely this perspective that the Annual Reports of the Human Rights Ombudsman of the Republic of Slovenia provide. The period from 2020 to 2024, offers a longitudinal and rights-based counterpoint to the programmatic vision articulated in the MIRA Programme. Where the MIRA Program outlines institutional aspirations, the Ombudsman's reports document the persistent gap between policy intent and lived reality, providing a critical oversight perspective that cuts across all three analytical dimensions of this study.

Through the 'Psychosocial Ecosystemic' key dimension, the reports consistently reveal systemic failures operating simultaneously at the Macro, Mezzo, and Micro levels. At the 'Macro level', the Ombudsman identifies deep structural dysfunction within the state apparatus, noting that "the key problem with these reforms is not a lack of courage, as every government expresses the desire for reforms, but above all a lack of vision and a constructive and inclusive dialogue between the various stakeholders" (Annual Report, 2023, p. 3). This structural inertia is further evidenced by the observation that the same institutions most prominently the Ministry of Labour, Family, Social Affairs and Equal Opportunities and after the Ministry of Health appears repeatedly as the sources of the highest number of human rights violations across all five years of reporting, pointing to what the Ombudsman explicitly describes as "systemic problems that are not being

remedied" (Annual Report, 2023, p. 8). The slow pace of deinstitutionalisation processes is a recurring concern that affects all levels of 'Psychosocial Ecosystemic' view, 'Micro', 'Mezzo', and 'Macro', throughout the reports, with the Ombudsman reiterating across multiple years that "this process is still too slow and must adhere to the wishes of persons wanting to remain within their home environment" (Annual Report, 2022, p. 13), and warning that Slovenia increasingly risks falling short of its constitutional identity as a welfare state.

At the 'Mezzo level', the reports illuminate the institutional and community-based dimensions of these failures, particularly regarding the conditions within psychiatric hospitals and social care institutions. Across the five-year period, the Ombudsman consistently draws attention to "living conditions (overcrowding), treatment, care, and attitude of medical and other staff towards patients" (Annual Report, 2023, p. 22), as well as the accommodation of children and minors with mental health disorders in secure wards described as neither "adequate nor appropriate" (Annual Report, 2021, p. 18). The reports also repeatedly flag the absence of coordinated inter-institutional responses, pointing for the 'Interdisciplinarity'key dimension, while noting that "the responsibility for full protection of children's rights is being shifted from one to another, when institutions only bureaucratically write to each other and do not advocate the destiny of each and every child in need" (Annual Report, 2020, p. 124). This observation also resonates directly with what interviewees described as the bureaucratic burden that impedes genuine interdisciplinary practice, and with journaling entries documenting the tension between institutional procedures and person-centred care.

At the 'Micro level', the reports foreground the impact of systemic failures on the most vulnerable individuals, particularly children, adolescents, and persons with psychosocial disabilities. The Ombudsman consistently highlights the consequences of chronic workforce shortages, noting across multiple years "the critical shortage of child psychiatrists, clinical psychologists, and other experts", Social Workers included, and warning that "care for children with special needs is still not systemically regulated, but rather depends on the awareness of individuals and their individual efforts" (Annual Report, 2023, p. 16). By 2024, this concern extends beyond the healthcare sector, with the Ombudsman noting that "we are increasingly facing an acute shortage of personnel in social welfare as well — in retirement homes, social care institutions, and also at centres for social work" (Annual Report, 2024, p. 9), a finding that directly mirrors the workforce pressures documented in the observational journaling and described by interviewees as a daily reality shaping the limits of interdisciplinary engagement.

Within the 'Interdisciplinarity' key dimension, the Ombudsman reports reveal a persistent tension between the ideal of coordinated, intersectoral collaboration and the fragmented institutional landscape in which it must operate. The government's position described as the "stoic response that each ministry is responsible for its own department and that there is no need for additional coordination" (Annual Report, 2023, p. 4) stands in direct contradiction to the interdisciplinary and intersectoral logic promoted by the MIRA Programme and affirmed throughout the empirical findings of this study. Moments of positive interdisciplinary practice are nonetheless acknowledged: the opening of the Children's House in 2022 is highlighted as "an example of good practice for effective interministerial and inter-institutional cooperation

for the benefit of children" (Annual Report, 2022, p. 10), suggesting that effective collaboration is achievable but remains the exception rather than the systemic norm.

The 'Social Workers Role' key dimension, the reports illuminate the structural conditions within which social workers must operate, and the consequences when institutional support is inadequate. The recommendation to "additionally reinforce centres for social work in terms of personnel and expertise in order to provide the best possible treatment and support to users" (Annual Report, 2023, p. 48) implicitly acknowledges the degree to which social workers are currently operating under conditions of scarcity. The Ombudsman's repeated calls for the legal and regulatory recognition of persons with mental health disorders on equal terms with other persons with disabilities further contextualises the rights-based advocacy role that social workers are called to perform, a role that, as this study's interviews and observations demonstrate, is frequently enacted in the face of hierarchical resistance, bureaucratic constraint, and systemic under-resourcing.

Under the ‘Social Workers Role’ key dimension is also interesting to notice that the 2024 Annual Report adds a particularly poignant dimension to this picture, moving beyond systemic recommendations to acknowledge the human cost borne by the professionals working within these structurally deficient conditions. The Ombudsman notes that "numerous long-standing issues in the area of healthcare remain unresolved", describing this not only as "a source of frustration for the Human Rights Ombudsman but also widely echoed in public discourse", and emphasising that "these challenges are especially difficult to comprehend when they affect vulnerable groups such as children" (Annual Report, 2024, p. 11). Most strikingly, the report explicitly recognises that "harsh working conditions, coupled with inadequate compensation, are forcing some of the most burdened healthcare professionals to rely on their personal ethics to persevere", acknowledging that this is "particularly unfair to those individuals — of whom there are many — who continue to make extraordinary efforts and contribute far beyond what is expected of them within the healthcare system" (Annual Report, 2024, p.12). This institutional acknowledgement carries particular analytical weight when read alongside the interview data, in which social workers described absorbing responsibilities beyond their formal remit, persevering where other professionals had given up, and feeling simultaneously indispensable and undervalued. The Ombudsman's recognition that the system's functioning increasingly depends on the personal ethics and extraordinary commitment of individual professionals rather than on adequate structural support points to a profound vulnerability at the heart of Slovenian mental health provision, one that neither policy vision nor oversight recommendations have yet been able to resolve.

Within the 'Relationship with Client' subdimension of the 'Social Workers Role', the Ombudsman reports reveal the extent to which the rights and dignity of service users, particularly those with mental health disorders, pointing that this is structurally compromised within the Slovenian system, “Ongoing systemic issues leave patients in uncertainty and distress” (Annual Report 2024, p.14). This context creates the very conditions that social workers must navigate in their direct practice with clients, the finding speaks directly to the tension between institutional convenience and person-centred care that emerged consistently across the

interviews and observational data, where social workers described their role as precisely that of advocating for the humanity and individuality of the client within systems that tend to reduce persons to diagnoses or legal categories.

The Ombudsman highlights that most complaints regarding persons in psychiatric hospitals and social welfare services is about "restrictions of movement of persons in psychiatric hospitals and social care institutions once again focused on involuntary admission to treatment in special supervision wards of psychiatric hospitals, the treatment received therein, and disagreement with residing in secure wards of social care institutions. They also addressed issues regarding living conditions (overcrowding), treatment, care, and the attitude of medical and other staff towards patients, residents, or users in these settings, as well as limitations on visits and other related concerns." (Annual Report, 2024, p. 21), pointing to the bureaucratic and legal architecture within which client relationships are embedded and constrained. At a broader rights-based level, the reports also address the political and civic dimensions of client dignity, affirming that "all efforts must be made towards a regulation that does not limit the participation of persons with disabilities in political or public life but one that encourages and forms the circumstances for its realization" (Annual Report, 2024, p. 21). This assertion aligns with the person-centred ethos articulated by interviewees, who consistently emphasised that their fundamental role as social workers is to uphold the humanity, voice, and self-determination of clients within environments that do not always do the same. Taken together, the Ombudsman's reports across the 2020–2024 period confirm that the rights-based, person-centred orientation that social workers articulate as the core of their professional identity remains not merely an aspirational value but an actively contested institutional and legislative terrain one in which the gap between commitment and realisation continues to define the conditions of everyday mental health practice in Slovenia.

5. Conclusion

The findings are presented and discussed in relation to the three research questions guiding this study: the perceptions of social workers regarding their role within interdisciplinary mental health teams in Slovenia; the challenges encountered in mental health care from a social work viewpoint; and the strategies and practices social workers develop to navigate these dilemmas in everyday professional contexts. Through the triangulation of observational journaling, semi-structured interviews, and document analysis, a complex and layered situation has emerged, one that is simultaneously encouraging in its potentiality of interdisciplinarity within mental health professionals, positioning the Social Workers an important role in the mental health activities, and also the articulation of Slovenia systemcontext, portrayed within its documentation, picturing the systemic reality.

5.1 Insights

5.1.1 The Role of Social Workers

Across all three methodologies, a consistent and compelling portrait of the social worker's role in mental health emerges. Social workers occupy a distinctive position within interdisciplinary teams, characterised by a fundamentally humanising and ecosystemic orientation. Where other professionals tend to approach the client through the lens of diagnosis, symptomatology, or legal risk, social workers consistently demonstrate a commitment to person-centered treatment seeing the whole person and their relationships, their community, their history, and their potential for self-determination to bridge client-authonomy. Social worker roles in mental health functions as a translator, a navigator, between the client and the state system, as an advocate for voice and dignity within environments that can otherwise reduce individuals to pathological categories, and as a bridge between the micro-level realities of individual lives and the mezzo and macro-level structures that shape them.

Social workers demonstrated an inclined sight of the ecosystemic model, while attending to the intrapsychic and relational dimensions of the client's experience at the micro level, navigating family, community, and institutional dynamics at the mezzo level, and engaging with policy frameworks, legislative mandates, and systemic reform processes at the macro level. There is a repeated emphasis documented on the need for professionals who can understand and connect clients to the services, advocate for rights-based care within the team, and operate across institutional intersectoral boundaries making it clear that the role of Social Workers in mental health is important.

The findings also illuminate the emotional and ethical dimensions of social work practice in mental health. Interviewees described their perception as a profession that frequently operates beyond its formal boundaries, absorbing the gaps left by under-resourced systems and persevering where other professionals disengage. The documentation acknowledges that the system's functioning increasingly depends on the "personal ethics" and "extraordinary efforts" of individual professionals is a structural indictment that the interview data renders deeply personal. Social workers in this study described contradictory feelings simultaneously indispensable and marginalised, highlighted by being called upon when situations become too complex for other disciplines, yet consistently positioned at the lower end of professional hierarchies.

5.1.2 Strategies and Practices Developed by Social Workers in mental health

Beyond documenting the challenges social workers face, the findings across all three methodologies reveal a set of strategies and adaptive practices that social workers consciously or intuitively develop to navigate the tensions inherent in interdisciplinary mental health work. While these strategies are rarely formalised or institutionally recognised, they represent a body of professional knowledge that deserves explicit acknowledgment.

The first identifiable strategy is the importance of relational investment, Social Workers finding an environment where it is possible to cultivate relationships with colleagues is a major precondition for professional sharing. The investment in peer-relational spaces is highly considered by professionals as it

improves the quality share of professional perspectives, consequently improving mental health treatment and reinforcing the rights of the clients.

The second strategy Social Workers adopt is persistent advocacy, described by interviewees as the willingness to continue asserting the client's humanity and social work's distinctive contribution even when met with dismissal, hierarchical, or institutional resistance, caused mostly because of the lack of environment to share their perspectives. As one participant noted, social workers "had to do a lot of convincing" and "just not give up", reflecting a professional orientation in which advocacy is understood not as a single act but as a sustained commitment requiring resilience and political awareness.

The third strategy is role flexibility and boundary stretching, whereby social workers consciously absorb tasks and responsibilities beyond their formal contract when they identify an unmet need that would improve the mental health treatment. While this carries the risk of professional overextension and workload, mostly because of staff shortage, it also represents a practical response to systemic gaps, and reflects the profession's fundamental orientation toward the client's wellbeing over rigid role definitions.

Together, these strategies illuminate a profession that is actively and creatively responding to structural adversity, not merely absorbing it.

5.1.3 Interdisciplinarity

The findings reveal that interdisciplinarity in Slovenian mental health services is a value that is widely affirmed but unevenly enacted, is recognized as important but also is indicated a need to be better approached systematically. Across the findings, a consistent tension emerges between the aspiration for genuine interdisciplinary collaboration and institutional constraints. It was possible to discuss the challenges of everyday realities in Mental Health services that creates more resistance for interdisciplinary practice: professional hierarchies dynamics, bureaucratic workload and fragmentation, shortage of staff, time scarcity and siloed institutional cultures.

It was possible to verify that interdisciplinarity practice has both formal and informal aspects. The first tends to do so through informal channels, like the corridor conversation, the shared coffee break, the spontaneous consultation, as much as through formal aspects like team meetings within scheduled meetings, mental health conferences and regional reunions, even though this last was pointed out that could be improved. This finding suggests that the relational infrastructure of interdisciplinary teams is as important as its structural design, and that institutional cultures which support trust, professional exchange, and relational safety are preconditions for genuine collaboration rather than optional extras. The distinction between multidisciplinary and interdisciplinary is recognized by professionals but in practice it still within the transition from parallel working toward integrated practices, and co-constructed responses are still very much in progress.

Important to highlight the persistence of medical hierarchy emerges as Social workers across the interviews described feeling silenced, overlooked, and undervalued within team settings dominated by medical and clinical psychological authority. This dynamic not only diminishes the contribution of social work

to collective decision-making but also compromises the quality of care for clients, whose social, relational, and environmental needs may go unaddressed when the diagnostic-clinical perspective dominates.

5.2 Major Challenges

The first major challenge highlighted is the chronic shortage of qualified personnel across the mental health and social welfare system. Documented consistently and experienced daily by the professionals interviewed, understaffing places unsustainable pressure on individual workers, compromises service quality, and makes the realisation of genuine interdisciplinary practice structurally challenging because of the workload.

The second challenge is the persistence of institutional and professional hierarchies that inhibit the full participation of social workers and other non-medical professionals in mental health teams decision-making, it's also one of the most significant barriers to full interdisciplinary realisation across services in Mental Health. This is not merely a relational problem but a structural one, rooted in patterns of professional identity, training culture, education background and institutional design that has proven resistant to policy-level reform, as it has been done until now.

The third challenge identified is the yearly gap between policy aspiration and its implementation in the reality of services. Even though there is a sophisticated and rights-oriented vision for mental health in Slovenia, the longitudinal oversight confirms that many of its goals remain unrealised, that the same systemic violations recur year after year, and that the political will for intersectoral coordination and genuine deinstitutionalisation remains inconsistent through last years.

The fourth challenge is the inadequacy of structured space and time for reflection, supervision, and collective learning within interdisciplinary teams. The findings reveal that reflective practice is largely absent from team routines, occurring only in crisis-driven situations rather than as a systematic feature of professional life or informally depending on the professional relationships. This absence limits the capacity of teams to learn from experience, process conflict constructively, and develop shared professional cultures.

The fifth challenge is the guarantee of rights and dignity of service users within institutional settings. It was possible to verify that most of the denounced rights violations recorded over recent years were concentrated in the Ministry of Labour, Family, Social Affairs and Equal Opportunities and the Ministry of Health, this is very concerning for children and youth specially within mental health disorders. The reported rights violations point primarily to psychiatric hospitals and social care institutions, where recurring issues include overcrowding, inadequate accommodation of children and young people, and the denial of autonomy through exclusion from decisions affecting their own lives.

5.3 Recommendations

This study offers the following recommendations directed at policymakers, institutional leaders, professional training bodies, and practitioners.

First of all, at the policy and systemic level, it is recommended that the intersectoral coordination mechanism envisioned by the MIRA Programme be urgently operationalised, moving beyond ministerial boundary-keeping toward genuine shared accountability across health, social welfare, education, and justice systems. The Ombudsman's repeated observation that "each ministry is responsible for its own department" must be recognised as a structural failure rather than an administrative norm. In this process, social workers hold significant potential to contribute as coordinating professionals capable of facilitating communication between sectors, advocating for service users' needs, strengthening community-based interventions, and promoting holistic approaches that integrate social, psychological, and institutional dimensions of mental health care. Furthermore, a comprehensive and rights-compliant deinstitutionalisation strategy, aligned with the UNCRPD and developed in genuine dialogue with persons with psychosocial disabilities and civil society, should be adopted without further delay.

Regarding the institutional level, all mental health services should invest in creating structured and protected spaces for interdisciplinary reflection, supervision, and collective goal-setting. These should not be reserved for crisis moments but embedded as regular features of team life, enabling professionals to process relational dynamics, address hierarchical tensions, and develop genuinely shared approaches to complex cases and the whole system longitudinally. The informal practices that currently sustain interdisciplinary relationships should be recognised as professionally significant and supported rather than left to chance.

At the level of professional training and workforce development, it is recommended that Mental Health professionals' education and formation in Slovenia strengthen the preparation for interdisciplinary environments, equipping them with the skills to assert their professional perspective and articulate the distinctive contribution of each discipline horizontally. Furthermore, future studies should examine the power dynamics inherent in mental health service delivery, exploring how hierarchical structures and differential professional status shape interdisciplinary collaboration, decision-making processes, and ultimately the quality and equity of care provided to service users.

At the practice level, social workers are encouraged to sustain and deepen their commitment to person-centred, rights-based advocacy, including through peer support networks, professional associations, and the availability of supervision and intervision as tools for maintaining reflexivity and resilience.

Finally, this study recommends that future research attend more systematically to the experiences of service users within the Slovenian mental health system, whose perspectives remain absent from the present analysis since it wasn't the scopus. This recommendation aligns with the reports that consistently shows the gap between institutional intent and the lived realities of those in care; it seems extremely important to tackle this gap not only policy reforms and professional development but the active co-production of knowledge with the clients and families, listening and elaborating within the people whose lives mental health services are designed to support.

Bibliographical References

Allen, D. R. (2014). *The role of the social worker in adult mental health services* (1st ed.). The College of Social Work. https://production.basw.co.uk/sites/default/files/2024-03/The%20role%20of%20the%20social%20worker%20in%20adult%20mental%20health%20services%202014_1.pdf

Almeida-Filho, N. (1997). Transdisciplinaridade e saúde coletiva. Ciência & Saúde Coletiva, 2(1–2), 5–20. http://www.scielo.br/pdf/csc/v2n1-2/1413-8123-csc-02-1-2-0005.pdf

Arajärvi, M., Mönkkönen, K., Kekoni, T., & Toikko, T. (2025). Psychosocial social work as part of interdisciplinary collaboration and care need assessment in psychiatric outpatient care. Nordic Social Work Research, 15(3), 348–365. https://doi.org/10.1080/2156857X.2023.2244502

Asiri, M. A. A., Alshahrani, S. A., Al, A. S., Alqahtani, N. H. A., & Al-Aqili, N. O. J. (2024). A multidisciplinary approach to mental health care: Collaboration between nurses, psychologists, social workers, and health administrators.

Benjamins, J., de Vet, E., & Haveman-Nies, A. (2024). Enhancing interprofessional teamwork between youth care professionals using an electronic health record: A mixed methods intervention study. *Journal of Interprofessional Care, 38*(3), 553–563. https://doi.org/10.1080/13561820.2024.2314461

Bhaskar, R., Danermark, B., & Price, L. (2017). Interdisciplinarity and wellbeing: A critical realist general theory of interdisciplinarity. Routledge.

Bland, R., Renouf, N., & Tullgren, A. (2009). *Social work practice in mental health*. Allen and Unwin.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bronstein, L. R. (2002). Index of interdisciplinary collaboration. *Social Work Research, 26*(2), 113–123.

Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work, 48*(3), 297–306.

Bryman, A. (2012). *Social research methods* (4th ed.). Oxford University Press.

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: complex or simple? Research case examples. Journal of research in nursing : JRN, 25(8), 652–661. https://doi.org/10.1177/1744987120927206

Canadian Association of Social Workers. (2022, May 20). *Social work practice in mental health*. https://www.casw-acts.ca/en/social-work-practice-mental-health

Choi, B. C., & Pak, A. W. (2006). Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: Definitions, objectives, and evidence of effectiveness. *Clinical and Investigative Medicine, 29*(6), 351–364.

Colet, N. (2004). Université et disciplinarité: Ose-t-on encore parler d'interdisciplinarité? In C. Pimenta (Ed.), *Interdisciplinaridade, humanismo, universidade* (pp. 203–221). Campo das Letras.

Comprehensive Mental Health Action Plan 2013–2030 (1st ed.). (2021). World Health Organization. https://www.who.int/publications/i/item/9789240031029

Conselho Científico do ISCTE. (2026). Guia para uma Utilização Responsável da Inteligência Artificial em Trabalhos Académicos.

Dalglish, S. L., Khalid, H., & McMahon, S. A. (2021). Document analysis in health policy research: The READ approach. *Health Policy and Planning, 35*(10), 1424–1431. https://doi.org/10.1093/heapol/czaa064

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846–861. https://doi.org/10.1016/j.cpr.2012.09.007

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health, 7*(2), 1–8. https://doi.org/10.1136/fmch-2018-000057

Department of Health. (2019). *Reflections: Social work and mental health in Northern Ireland* (Office of Social Services Reflection Series, No. 3). https://elevateni.org/app/uploads/2021/09/Reflections-3-Mental-Health-v4.pdf

DeWalt, K. M., & DeWalt, B. R. (2011). *Participant observation: A guide for fieldworkers* (2nd ed.). AltaMira Press.

European Commission. (2026, January 8). *Mental health – Public health*. https://health.ec.europa.eu/non-communicable-diseases/mental-health_en

European Commission. (n.d.). *United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)*. Retrieved January 18, 2026, from https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamental-rights/disability/united-nations-convention-rights-persons-disabilities-uncrpd_en

Francis, A. P. (2014). *Social work in mental health: Contexts and theories for practice*. SAGE Publications. https://doi.org/10.4135/9789351507864

Freeman, M. (2022). The World Mental Health Report: Transforming mental health for all. *World Psychiatry, 21*(3), 391–392. https://doi.org/10.1002/wps.21018

Frey, B. B. (Ed.). (2018). *The SAGE encyclopedia of educational research, measurement, and evaluation*. SAGE Publications. https://doi.org/10.4135/9781506326139

Furtado, J. (2009). Arranjos institucionais e gestão da clínica: Princípios da interdisciplinaridade e interprofissionalidade. *Cadernos Brasileiros de Saúde Mental, 1*(1), 1–11. https://periodicos.ufsc.br/index.php/cbsm/article/view/68439

Giacomini, E., & Rizzotto, M. L. F. (2022). Interdisciplinarity in mental health care practices: An integrative literature review. *Saúde Em Debate, 46*(spe6), 261–280. https://doi.org/10.1590/0103-11042022e623i

Gierczyk, M., Gromkowska-Melosik, A., Scott, S., & Parker, C. (2024). The snowball sampling strategy in the field of social sciences: Contexts and considerations. *Przegląd Badań Edukacyjnych (Educational Studies Review), 43*(2), 87–104. https://doi.org/10.12775/PBE.2023.029

Gould, N. (2010). Mental health social work in context. Routledge.

Gould, N. (2022). *Mental health social work in context* (3rd ed.). Routledge. https://doi.org/10.4324/9781003181323

Gregoric Kumperscak, H. (2019). Child and adolescent psychiatry in Slovenia in comparison with other European countries. *European Child & Adolescent Psychiatry, 28*(1), 147–151. https://doi.org/10.1007/s00787-018-1232-y

Guerrero, Z., Kågström, A., Aliev, A., Tomášková, H., Yon, Y., Lazeri, L., Reinap, M., Redlich, C., Tijerino Inestroza, A. M., Maurer, J., & Winkler, P. (2024). Mental health plans and policies across the WHO European region. Global mental health (Cambridge, England), 11, e110. https://doi.org/10.1017/gmh.2024.88

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative Inquiry, 10*(2), 261–280. https://doi.org/10.1177/1077800403262360

Hobbs, M. D. (2005). The social worker on the medical transdisciplinary team. *Journal of Health Care for the Poor and Underserved, 16*(2), 186–191. https://doi.org/10.1353/hpu.2005.0035

Horvat Golob, M., et al. (2025). Transition of mental health services from institutional to community-based care abroad and its context for Slovenia: Advantages and risks. *International Journal of Environmental Research and Public Health, 22*(7), 1066. https://doi.org/10.3390/ijerph22071066

International Federation of Social Workers. (2014). *Global definition of social work*. https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

Jager, J., Putnick, D. L., & Bornstein, M. H. (2017). II. More than just convenient: The scientific merits of homogeneous convenience samples. *Monographs of the Society for Research in Child Development, 82*(2), 13–30. https://doi.org/10.1111/mono.12296

Karalam, S. R. B. (2014). Psychosocial intervention model for the well-being of institutionalised and non-institutionalised adolescent girls in the institutions for care. In A. P. Francis (Ed.), Social work in mental health: Areas of practice, challenges, and way forward (pp. 68–96). SAGE Publications India.

Kelly, A., & Sewell, S. (1991). *With head, heart and hand: Dimensions of community building* (4th ed.). Boolalong Press.

Kelly, R., Mackay, M., Nash, K. L., Cvitanovic, C., Allison, E. H., Armitage, D., & Bonn, A. (2019). Ten tips for developing interdisciplinary socio-ecological researchers. *Socio-Ecological Practice Research, 1*(2), 149–161. https://doi.org/10.1007/s42532-019-00018-2

Lincoln, Y. S., & Denzin, N. K. (Eds.). (2008). *Collecting and interpreting qualitative materials* (3rd ed.). SAGE Publications.

Martinez-Brawley, E. E., & Zorita, P. M.-B. (2017). The psychosocial framework of social work practice. In F. J. Turner (Ed.), *Social work treatment: Interlocking theoretical approaches* (6th ed., pp. 411–426). Oxford University Press.

Maučec, J., et al. (2020). *MIRA for mental health programme: National mental health programme*. National Institute for Mental Health. https://www.nijz.si/sites/www.nijz.si/files/publikacijedatoteke/mira_resolucija_ang_splet.pdf

McCombie, C., Miguel Esponda, G., Schmidt, U., & Lawrence, V. (2024). Qualitative diary methods in mental health research. *European Psychologist, 29*(1), 1–12. https://doi.org/10.1027/1016-9040/a000511

McIntosh, M. J., & Morse, J. M. (2015). Situating and constructing diversity in semi-structured interviews. *Global Qualitative Nursing Research, 2*, 1–12. https://doi.org/10.1177/2333393615597674

McMahon, A. (2014). Emerging issues for social work practice. In A. P. Francis (Ed.), *Social work in mental health: Areas of practice, challenges, and way forward* (pp. 301–308). SAGE Publications India.

Mental Health Europe. (2023). *Psychosocial model of mental health: Toolkit*. https://www.mentalhealtheurope.org/wp-content/uploads/2023/04/MHE-Psychosocial-model-Toolkit.pdf

Mental Health Europe. (2024, March 7). *Understanding mental health: MHE's psychosocial approach*. https://www.mentalhealtheurope.org/what-we-do/understanding-mental-health/

Ministry of Health of Slovenia. (2008). *Zakon o duševnem zdravju* [Mental Health Act]. Official Gazette of the Republic of Slovenia, No. 77/2008. https://pisrs.si/pregledPredpisa?id=ZAKO2157

Ministry of Health of the Republic of Slovenia. (2022). *MIRA programme: The national mental health programme 2018–2028*. Za duševno zdravje. https://www.zadusevnozdravje.si/wp-content/uploads/2022/06/Knjiz%CC%8Cica-Predstavitev-programa-Mira-ENG.pdf

Morgan, H. (2022). Conducting a qualitative document analysis. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2022.5044

Morgan, H. (2024). Using triangulation and crystallization to make qualitative studies trustworthy and rigorous. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2024.6071

Morin, E. (2014). *Ciência com consciência*. Bertrand Brasil.

Morley, C., & Macfarlane, S. (2019). Repositioning social work in mental health: Challenges and opportunities for critical practice. *Critical Social Work, 11*(2), 46–59.

Možina, M., & Okorn, I. (2022). Challenges of the development of mental health care in Slovenia. *Journal of Global Health Neurology and Psychiatry*. https://doi.org/10.52872/001c.31788

Patton, M. Q. (2015). Qualitative research & evaluation methods: Integrating theory and practice (4th ed.). SAGE Publications.

Perkins, M. (2023). Academic integrity considerations of AI large language models in the post-ChatGPT era: ChatGPT and beyond. *Journal of University Teaching & Learning Practice, 20*(2). https://doi.org/10.53761/1.20.02.07

Program Mira. (2022, December 5). Socialni delavec [Social worker]. https://www.zadusevnozdravje.si/kam-po-pomoc/strokovnjaki-ki-lahko-pomagajo/socialni-delavec/

Program Mira. (2022, July 13). *Iskali site social*. https://www.zadusevnozdravje.si/?s=social

Program Mira. (2025, December 11). *Implementacija, spremljanje in evalvacija*. https://www.zadusevnozdravje.si/o-programu/implementacija-spremljanje-in-evalvacija/

Radobuljac, M. D., Hudoklin, M., Dajčman, N. P., & Kumperscak, H. G. (2017). Architecture and functioning of child and adolescent mental health services: A reply from Slovenia. *Lancet Psychiatry, 4*(9), e20. https://doi.org/10.1016/S2215-0366(17)30327-9

Reamer, F. G. (2013). The evolution of social work ethics: Bearing witness. *Advances in Social Work, 15*(1), 163–181. https://doi.org/10.18060/14637

Reed, G. M. (2024). What's in a name? Mental disorders, mental health conditions and psychosocial disability in the World Mental Health Report. *World Psychiatry, 23*(2), 166–168. https://pmc.ncbi.nlm.nih.gov/articles/PMC11083882/

Reeves, S., Xyrichis, A., & Zwarenstein, M. (2018). Teamwork, collaboration, coordination, and networking: Why we need to distinguish between different types of interprofessional practice. *Journal of Interprofessional Care, 32*(1), 1–3. https://doi.org/10.1080/13561820.2017.1400150

Regehr, C., & Glancy, G. (2021). *Mental health social work practice in Canada* (3rd ed.). Oxford University Press.

Report: Public knowledge and perceptions of careers in mental health. (2021, February 10). Think Ahead. https://thinkahead.org/news-item/report-public-knowledge-and-perceptions-of-careers-in-mental-health/

Rosen, A., & Callaly, T. (2005). Interdisciplinary teamwork and leadership: Issues for psychiatrists. *Australasian Psychiatry, 13*(2), 234–240.

Ruth, B. J., & Marshall, J. W. (2017). A history of social work in public health. *American Journal of Public Health, 107*(S3), S236–S242. https://doi.org/10.2105/AJPH.2017.304005

Semrau, M., Barley, E. A., Law, A., & Thornicroft, G. (2011). Lessons learned in developing community mental health care in Europe. *World Psychiatry, 10*(3), 217–225. https://doi.org/10.1002/j.2051-5545.2011.tb00060.x

Simpson, G., & Murr, A. (2021). An exploratory survey of mental health social work in Europe. *The British Journal of Social Work, 52*(5), 2793–2812. https://pmc.ncbi.nlm.nih.gov/articles/PMC8507626/

Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association.

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd ed.). SAGE Publications.

Stepney, R., & Ford, S. (2000). *Social work models, methods, and theories*. Russell House.

Stone, K., McCusker, P., Davidson, G., & Vicary, S. (2021). An exploratory survey of mental health social work in Europe. *International Journal of Environmental Research and Public Health, 18*(19), 10462. https://doi.org/10.3390/ijerph181910462

Švab, V., Groleger, U., & Ziherl, S. (2006). The development of psychiatric reform in Slovenia. https://pmc.ncbi.nlm.nih.gov/articles/PMC1472264/

United Nations General Assembly Human Rights Council. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21). https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/35/21

Walker, S. (2003). Social work and child mental health: Psychosocial principles in community practice. *British Journal of Social Work, 33*(5), 673–687. https://doi.org/10.1093/bjsw/33.5.673

Whitaker, L., Smith, F., Velander, F., et al. (2024). Mental health social work practice: Navigating tensions. *The British Journal of Social Work, 54*(6), 2565–2582. https://doi.org/10.1093/bjsw/bcae051

Wilberforce, M., et al. (2020). What do service users want from mental health social work? A best–worst scaling analysis. *British Journal of Social Work, 50*(5), 1324–1344. https://doi.org/10.1093/bjsw/bcz133

Winkler, P. & Guerrero, Z. et. al., (2025). Mental health in Central and Eastern Europe: A comprehensive analysis. *The Lancet Regional Health – Europe, 57*, 101464. https://doi.org/10.1016/j.lanepe.2025.101464

World Health Organization, Regional Office for Europe. (2020). *Looking back, looking forward: Rapid assessment of the mental health system in Slovenia*. WHO Regional Office for Europe. https://www.zadusevnozdravje.si/wp-content/uploads/2021/04/WHO-mission-report-on-mental-health-in-Slovenia-2020-1.pdf

World Health Organization, Regional Office for Europe. (2021). *WHO European framework for action on mental health 2021–2025*. WHO Regional Office for Europe. https://www.who.int/europe/publications/i/item/9789289057813

World Health Organization, Regional Office for Europe. (2024). *Mental health systems capacity in European Union Member States, Iceland and Norway*. https://iris.who.int/handle/10665/378308

World Health Organization, Regional Office for Europe. (2025, March 27). *WHO/Europe to launch quality standards for child and youth mental health care*. https://www.who.int/europe/news-room/events/item/2025/03/27/default-calendar/who-europe-to-launch-quality-standards-for-child-and-youth-mental-health-care

World Health Organization. (2019). *Monitoring mental health systems and services in the WHO European Region: Mental health atlas 2017*. https://iris.who.int/server/api/core/bitstreams/0a8c93d2-9208-4160-b2bc-b6347f8c2d97/content

World Health Organization. (2021). *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. https://www.who.int/publications/i/item/9789240025707

World Health Organization. (2022). *World mental health report: Transforming mental health for all*. https://www.who.int/publications/i/item/9789240049338

World Health Organization. (2025). *Mental health atlas 2024*. https://www.who.int/publications/i/item/9789240114487

World Health Organization. (2025, September 1). *Mental health of adolescents*. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

Zappi, L. (2020). Social work in Europe: Nineteenth and twentieth century. *Encyclopédie d'Histoire Numérique de l'Europe*. https://ehne.fr/en/node/12506

Appendix

Appendix 1. Semi-Structured Interview Guide: Social Workers in Interdisciplinary Mental Health Teams

Introduction

Thank you for agreeing to participate in this interview.
The purpose of this conversation is to understand social workers' perceptions, experiences, and professional practices within interdisciplinary mental health teams.
All information will be kept confidential and used only for research purposes.
There are no right or wrong answers—please feel free to share your thoughts and experiences openly.

Research Objectives

(1) Explore Social Workers roles experience in Mental Health Teams

(2) Identify main challenges within interdisciplinarity approach in Mental Health Teams

(3) Analyze practices social workers develop to address the Mental Health Clients issues within the team.

Dimension 1 – Social Workers' Role

1 Sub Dimension - Role and contribution

Q1 How would you describe your role as a Social Worker within your mental health team?

Follow-up: What do you see as your main contributions to the team? How do other professionals usually perceive your role?

Q2 In your experience, what helps professionals recognize and value the Social Workers role?

Follow-up: Have you experienced situations where your role was misunderstood or undervalued?

2 Sub Dimension - Practice and intervention

Q3 Can you describe the kinds of interventions or practices you usually develop with clients?

Follow-up:

How do these differ from or complement other professionals' approaches?

Dimension 2 - Interdisciplinarity

Sub dimension 1 - Complementarity, Interdependence

Integration of knowledge

Q4 Can you give an example of how different professional perspectives come together in your team's daily work?

Interdependence in practice

Q5 Can you describe a situation where collaboration with another professional was essential to address a client's needs?

Sub Dimension 2 - Collaboration and Managing Differences

Collaboration in practice (merged Q6–8)

Q6 How would you describe the working relationship within your team in day-to-day work?

Follow-up: What helps this collaboration work well? What makes it more difficult?

Conflict and negotiation

Q7 Have you experienced situations where professionals had different perspectives on how to approach a case?

Follow-up: How was the situation handled? What helped maintain collaboration or trust?

Negotiating perspectives

Q8 When differences arise, how do you usually negotiate decisions within the team?

Sub Dimension 3 - Reflection on Process

Q9 - How does your team reflect on the work you do together?

Follow-up: What usually triggers these discussions—successes, challenges, or routine check-ins?

Q10 - How is knowledge and practice from various disciplines integrated in your team's routine work?

Q11 - Can you describe a situation where interactions with another discipline was essential to addressing a complex client issue?

Sub Dimension 4 – Synthesis and Innovation

Shared goals and responsibilities

Q12 How are goals and responsibilities defined and shared within your team? Follow-up: How does this affect your sense of responsibility or motivation?

Innovative practices

Q13 Have you experienced any new practices, perspectives, approaches or ways of working emerging from within your team's joint efforts? Follow-up: Can you give a concrete example?

Follow-up: How were these situations handled, and what did you take away from them?

Dimension 3 Policies and institutional frameworks

Q14 How do mental health policies or institutional guidelines influence your work as a Social Worker within the team?

Follow-up: Can you give an example of when a policy supported or limited your practice? How do these policies affect collaboration within the team?

Closing

Thank you for sharing your insights and experiences. Your contribution will help deepen understanding of the social work role within mental health services and interdisciplinary practice.

Appendix 2. Google forms Interview Invitation

Mental Health Social Workers Interview: Invitation for an Interdisciplinarity approach research.

Dear Participant,

You are invited to take part in an academic research study entitled *"Social Workers in Mental Health Institutions: Interdisciplinarity Approach."* This study is part of a **Master's thesis in the Erasmus Mundus Joint Master's Degree in Social Work with Children and Youth.**

The aim of this interview is to engage social workers with professional experience in the Mental Health field, particularly those working with youth.

The **research object** of this study is the **role and lived experience of social workers working within interdisciplinary mental health teams**. It will examine how these professionals interpret their responsibilities and navigate the collaborative environment with different discipline professionals, particularly when working across multiple systems such as health, education, and social care.

"the interdisciplinary attitude involves leaning towards the complexity of objects and the integration of perspectives, as opposed to (...) the fragmentation of knowledge into increasingly restricted and specialized disciplinary fields, isolated in their theoretical constructs and practices" (Giacomini e Rizzotto, 2022, p. 262)

The primary research objectives are to:

1. Explore the perceptions and roles social workers adopt within interdisciplinary mental health teams;
2. Analyze the challenges commonly encountered concerning mental health care and different discipline approaches in Social workers viewpoint;
3. Identify the concrete strategies and practices social workers develop to address these dilemmas in everyday professional contexts.

Through this investigation, the research seeks to deepen understanding of interdisciplinary collaboration in mental health services and to inform best practices that enhance outcomes for children, youth, and the broader mental health system.

Your participation will involve an **individual interview** lasting approximately **45–60 minutes**, conducted **online by Google Meet platform**, according to your schedule availability.

Before beginning the interview, you will be asked **for consent to record the session** solely for **reviewing and analytical purposes**. The recording is **not mandatory**—you may freely decline, and your participation will still be fully valued.

All information shared will be treated with **strict confidentiality** and used exclusively for academic purposes. No identifying personal data will appear in the final report.

Participation is **voluntary**, and you may withdraw from the study at any time without any consequences.

If you are interested in participating or would like to receive more information, please complete the form below. You will be contacted to schedule an interview or clarify any questions you may have.

Thank you very much for your time and collaboration.

Researcher: Átila Gargione

Supervisor: PhDr. Lenka Štefáková, PhD.

Program: Erasmus Mundus Joint Master's in Social Work with Children and Youth

Contact: psi.atilagargione@gmail.com

www.linkedin.com/in/atilagargione

Name

*

E-mail

*

Telephone Number (insert your country code)

Country of Residence

*

Slovenia

Lithuania

Latvia

Slovakia

Portugal

Others

If you choose "Others" in the answer above, state your country below:

I prefer to be contacted by

*

E-mail

Whatsapp

Don't have a preference

Social Worker Graduation

*

Bachelor

Master

PhD

I don't have a Social Worker diploma

Outro:

Mental Health field years of experience

*

0-2 years of experience

2-5 years of experience

5-10 years of experience

+10 years of experience

If you like, leave any comments here

Appendix 3. Non-plagiarism declaration





Submitted to the Erasmus Mundus Master's Programme in Social Work with Child and Youth:

- Has not been submitted to any other Institute/University/College
- Contains proper references and citations for other scholarly work
- Contains proper citation and references from my own prior scholarly work
- Has listed all citations in a list of references.

I am aware that violation of this code of conduct is regarded as an attempt to plagiarize and will result in a failing grade in the programme.

Date (dd/mm/yyyy): 28/05/2026

Signature: .....

Name (in block letters): . Atila Gargione.







