



An Interview Study with Professionals on Shared Decision-Making in Child and Adolescent Mental Health

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Abstract

Shared Decision-Making (SDM) is a paradigm that involves collaboration between healthcare professionals and service users to reach decisions jointly. This approach is based on the exchange of information, identification of service users' values and preferences, analysis of treatment options, and consensus on an action plan. The present study aims to explore the beliefs and attitudes of mental health professionals regarding this model, in a context where its implementation has not yet begun in services for children and adolescents but is starting in the adult mental health system. A qualitative investigation was conducted through thematic analysis of semi-structured interviews with eleven mental health professionals including social workers, psychologists and psychiatrists. While SDM offers potential benefits, its implementation entails a series of requirements, limitations, and dilemmas that must be addressed. In the child and adolescent context, it is particularly complex to establish specific ages for applying this model and to determine in which situations it is appropriate. The adoption of SDM would represent a significant advancement that could contribute to improving the experience of service users and align with social work values of empowerment and person-centred care.

Keywords Children · Shared decision-making · Thematic analysis · Qualitative research · Youth

Introduction

Within collaborative practices, shared decision-making (SDM) in healthcare represents a paradigm shift, encompassing a set of processes that recognise and empower service users' capacity to actively participate in decisions affecting their health and well-being (Buedo & Luna, 2021). SDM models integrate the clinical expertise and evidence-based knowledge of professionals with the lived experiences and contextual insights of service users (Barry & Edgman-Levitan, 2012; Shepherd et al., 2014). At its core, SDM involves information exchange, identification of

service users' values and preferences, deliberative discussion of treatment options, and reaching a consensual decision on a treatment plan (Charles et al., 1997, 1999; Slade, 2017; Villagrán et al., 2015).

A growing body of evidence suggests that SDM is associated with greater satisfaction and better quality decisions in terms of knowledge, decisional conflict, and values, in physical health (Hughes et al., 2018; Lauck & Lewis, 2023; Shay & Lafata, 2015), as well as in mental health (Aoki et al., 2022; Drake et al., 2009; Marshall et al., 2021) and addiction recovery (Marshall et al., 2022) services. In particular, for mental health care, a recent systematic review of the use of SDM in anxiety and depressive disorders (Marshall et al., 2021) and a Cochrane meta-analysis including a wide range of conditions (Aoki et al., 2022) show that SDM is associated with greater treatment involvement and self-management of well-being without increasing consultation time, but appears unlikely to improve symptoms. The quality of the evidence is noted to be low, limiting the ability to draw definitive conclusions (Aoki et al., 2022).

In an effort to broaden the scope of SDM, recent years have seen proposals to extend the evidence generated in adult health contexts to the fields of child and adolescent

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physical (Alderson et al., 2006; Coyne, 2008; Moore & Kirk, 2010; Wyatt et al., 2015) and mental health. A scoping review by Cheng et al. (2017) mapped SDM approaches in different child and adolescent mental health contexts, identifying six key strategies: therapeutic techniques, psychoeducational information, decision aids, action planning, discussion prompts, and patient mobilisation. They were evaluated against nine essential SDM elements, revealing variability in their comprehensiveness and highlighting the complexity of applying SDM to young service users. A recent systematic review carried out by the same group (Hayes et al., 2023) explored the use of intervention ingredients such as theory, mechanisms, and active units of change in SDM interventions. The review identified eight interventions that leverage functions like education on treatment options, environmental restructuring through decision aids, and clinician training to foster collaboration among service users and multidisciplinary professionals working in diverse settings. These interventions, incorporate behaviour change techniques such as discussing pros and cons and clinician rehearsal to promote participation, though low-quality evidence limits conclusions about their impact on SDM engagement.

Despite the methodological limitations highlighted by these reviews, there is evidence of successful implementation strategies both with families (Butler et al., 2015; Ramon, 2021) and directly with adolescents (Bjønness, Grønnestad, et al., 2020; Bjønness, Viksveen, et al., 2020). Nevertheless, in the child and adolescent context, implementing SDM presents unique challenges due to young people's developmental and legal status (Liverpool, Hayes, et al., 2021). Their evolving cognitive and emotional capacities affect their ability to participate in decision-making, and their lack of legal autonomy necessitates collaboration with parents or guardians (Bjønness et al., 2022). Moreover, disagreements between young service users and their caregivers are frequent, and decision-making capacity does not always correlate with age (Moore & Kirk, 2010). Many young service users also struggle with low motivation or confidence to engage in the process (Delman et al., 2015). Since many enter treatment involuntarily, this can affect their engagement, highlighting the need for efforts to foster their agency (Bjønness, Viksveen, et al., 2020). Actively involving young people in SDM, even when treatment is externally initiated, can improve outcomes and promote a sense of ownership in their care (Bosch et al., 2024). In this context, parents can act either as facilitators or barriers depending on their involvement (Bjønness et al., 2022; Hayes et al., 2019; Liverpool, Pereira, et al., 2021). Their perspectives, along with that of other stakeholders, can lead to conflicts that require mediation to ensure the child's voice is heard and considered (Bjønness, Viksveen, et al., 2020; Hayes et al., 2019).

Professionals play a crucial role in navigating these dynamics, as their insights and mediation skills are essential for balancing the diverse interests involved.

Research indicates that successful implementation of SDM in CAMH services requires clinicians to nurture positive relationships and demonstrate key attitudes, such as preparedness to invest effort, trust in young people, and flexibility in applying the approach (Abrines-Jaume et al., 2016; Gondek et al., 2017). However, professionals may disagree with the concept of SDM, lack motivation or adequate preparation for its implementation (Hayes et al., 2019). They must balance ethical and legal obligations, prioritising the child's safety and well-being, including mandatory reporting of abuse or intervening in cases of harm (Bjønness, Viksveen, et al., 2020). Furthermore, successful communication is critical in overcoming barriers to SDM, where inappropriate terminology or insufficient communication skills can hinder the process (Coyne, 2006, 2008; Runeson et al., 2002). Additionally, institutions must provide the necessary resources and support to implement these practices effectively (Bjønness, Viksveen, et al., 2020; Gondek et al., 2017).

Despite these challenges, including children and young people in decision-making has demonstrated significant benefits. It can increase their sense of being valued, improve self-esteem, and promote self-care, thus contributing to their overall well-being (Day, 2008). Therefore, although complex, implementing SDM in the child and adolescent context represents a valuable opportunity to improve mental health care (Cheng et al., 2017; Gondek et al., 2017; Hayes et al., 2023).

In light of these considerations, the present study aims to explore the views and experiences of CAMH professionals regarding SDM in a territory where its implementation is beginning in the adult mental health system but without current or planned SDM implementation in CAMH services. Specifically, the objectives are to examine the perspectives of different professionals on SDM, identify the barriers and facilitators to its implementation in the child and adolescent context, and understand the perceived benefits and challenges for children, young people, and their families.

Methods

This study adheres to the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007) and Standards for Reporting Qualitative Research (SRQR; O'Brien et al., 2014) guidelines to ensure comprehensive and transparent reporting.

Participants

The study involved eleven mental health professionals recruited through snowball sampling. Initial participants were identified through the first author's professional network, and subsequent participants were recruited based on referrals from these initial contacts. Participants were included if they were professionals specialising in CAMH with at least five years of experience in the field. Exclusion criteria included professionals who were not currently practising in CAMH.

The sample was purposively selected to ensure representation from diverse professional roles and settings, including four social workers, four psychologists, and three psychiatrists, comprising seven women and four men. Participants worked in multidisciplinary teams across various healthcare centres in Catalonia, selected to represent both inpatient and outpatient services as well as urban and rural settings. Specific locations are omitted to maintain confidentiality. The sample size was determined based on the principle of data saturation, defined as the point at which no new themes or perspectives emerged from additional interviews. No study refusals were recorded, as recruitment targeted professionals who expressed interest in participating. Healthcare services were chosen to reflect the diversity of CAMH services in Catalonia, including community mental health clinics and hospital-based units, addressing all types of mental health problems, and providing a range of treatments including pharmacology, therapy (including cognitive-behavioural, psychodynamic, and humanistic approaches), and social work interventions such as case management and family support.

The semi-structured interview script was designed by the first author to reflect key issues identified in the SDM literature, such as professional attitudes, family involvement, and implementation barriers. Questions were pretested in a focus group with CAMH professionals to ensure alignment with the study's objectives (Eiroa-Orosa & Sánchez Moscona, 2021).

Procedure

Ethical Approval for the study was obtained from the University of Barcelona institutional review board [IRB: 00003099]. Interviews were arranged individually with each participant, respecting their availability and preferences. Before proceeding, informed consent was obtained from all interviewees, ensuring their voluntary participation and understanding of the study objectives. Participants were assured of the confidentiality of their responses and their right to withdraw from the study at any time.

Data Collection

Interviews were conducted remotely using the Zoom platform. With the consent of participants, all interviews were recorded and transcribed verbatim for analysis. Each interview lasted approximately 30 min. A semi-structured interview format was employed to facilitate a focused yet flexible exploration of participants' experiences with and perspectives on SDM. This method was chosen to elicit relevant insights while allowing for in-depth discussions. The interview script was designed to address key aspects of the study, including the following questions:

1. To what extent do you think it is possible to implement shared decision programmes in infant-youth mental health care?
2. What benefits and difficulties can this type of approach generate?
3. What do you think you would need to put it into practice?
4. Do you think there would be any area or situation in which the preferences of the family, child, or young person should not be considered?

Analysis

Once the transcriptions were completed, they were organised into an ATLAS.ti hermeneutic unit. A Reflexive Thematic Analysis was conducted following the six phases outlined by Braun and Clarke (2006, 2019): familiarising with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. This process emphasised grounding the analysis in the existing literature while acknowledging the active role of the researchers in theme development and the importance of reflexivity throughout. To enhance the reliability of the analysis, both researchers independently coded the data. Triangulation sessions were subsequently conducted to compare, discuss, and achieve consensus on codes and themes, resolving any discrepancies through an iterative process of reflection, dialogue, and refinement.

Reflexivity

The research team comprised professionals with backgrounds in critical psychology, which may have shaped both the data collection and analysis processes. To address this, the team actively engaged in reflexive practices, including regular discussions during team meetings to examine and challenge their own assumptions, biases, and interpretations.

Table 1 Frequency and proportion of occurrence of categories and themes

Category	Topic	Codes	%	Words	%
Requirements	Current implementation	10	5.5	544	3.4
		74	40.4	6653	41.5
	Professional attitudes	22	12.0	1454	9.1
	Working with young people	36	19.7	3623	22.6
	Working with families	7	3.8	998	6.2
Benefits	Systemic changes	9	4.9	578	3.6
		22	12.1	1999	12.4
	Engagement	10	5.5	787	4.9
	Autonomy	4	2.2	404	2.5
Limitations	Shared responsibility	8	4.4	808	5.0
		36	19.7	2212	13.7
	Resource constraints	21	11.5	921	5.7
	Paternalism	6	3.3	486	3.0
Dilemmas	Family barriers	9	4.9	805	5.0
		41	22.4	4641	28.9
	Age	11	6.0	829	5.2
	Complex situations	20	10.9	2953	18.4
	Information management	6	3.3	581	3.6
	Individualised support	4	2.2	278	1.7

Bolded rows represent theme categories. The number of codes and words shown for these categories is the sum of the codes and words corresponding to the individual themes within each category

Results

Four theme categories were identified: requirements, benefits, limitations, and dilemmas, in addition to an independent theme consisting of excerpts in which professionals referred to the current existence of SDM elements (Current implementation). The Requirements category includes the themes of professional attitudes, working with young people, working with families, and systemic changes. The Benefits category is formed by engagement, autonomy, and shared responsibility. The Limitations category consists of resource constraints, paternalism, and family barriers. Finally, the Dilemmas category includes age, complex situations, information management, and individualised support.

Below, we present the definitions of the categories and themes generated by the researchers, along with illustrative verbatim quotations. Table 1 offers a comprehensive overview of these themes, including the frequency and proportion of each theme's occurrence. While these quantitative details are included for transparency, we adopt a cautious approach, emphasising that frequency should not be interpreted as a direct indicator of a theme's significance. Instead, we encourage readers to view these figures within the broader context of our interpretative process.

Current Implementation

Five of the eleven participants believe that elements of SDM are already being implemented in their practice. However,

there is a consensus that there is still significant room for improvement:

‘I think it can be done, it is done, but much more could be done’ (participant 6, social worker).

Participants noted that while some decisions are made collaboratively, there is a need for more consistent and widespread adoption of SDM practices. They highlighted the progress made and the shift towards a more inclusive and less hierarchical decision-making process:

‘I think there is a part that involves moving from a more paternalistic model of how mental health has been understood. I think we are in a different moment now; the paternalistic model is quite outdated. Mental health professionals today do not think that we have to make decisions for patients. Instead, our patients are autonomous and responsible for their lives, and they can start or stop treatment if they like or don't like it, and that is a responsible decision because one is responsible for what one does with their life’ (participant 3, psychologist).

Requirements

Participants identified several key conditions as essential for implementing SDM. For the professionals who participated in the study, factors such as professional attitudes, specific intervention strategies for the child and adolescent

population, engagement with families, and necessary organisational changes were considered indispensable for the successful implementation of SDM.

Professional Attitudes

Reference is often made to the role that professionals should play and the elements that should be considered when carrying out practice compatible with SDM. One of the points on which the different professionals placed the most emphasis was collaboration, both interprofessional and with service users and their families, thus promoting collaborative and networked practices. This collaboration allows for a sum of capabilities and resources, better complementing the history and process of individuals and their families. For instance, professionals highlighted the importance of regular multidisciplinary meetings and joint decision-making sessions to ensure all perspectives are considered:

‘It is also true that when there are many people giving opinions, it is more difficult to reach a decision, but once you reach it, I think the decision made is better’ (participant 11, social worker).

Working with Young People

Another important requirement identified was the need to consider key aspects when working with this population. Effective support for young people involves active listening and fostering a strong, trusting relationship with the professional, enabling them to feel confident and comfortable expressing themselves, even in complex situations like hospitalisations. For SDM to be successful, the young person’s participation must be active; they must have the opportunity to make decisions about their own process to feel truly involved. It’s essential to ensure that they understand their voice matters and will be heard:

‘I have always worked on having the person in the middle, at the centre of their process, of their treatment, it always improves. And I have severe cases, very severe cases. Always, always, if you want the person to improve, to be as good as possible, you must always consider their preferences and what they want’ (participant 4, psychologist).

Working with Families

The active involvement of families in the therapeutic process is revealed as a crucial component in CAMH care. Interviewed professionals unanimously highlighted the determining influence of the family environment on the

course of treatment and the young person’s overall well-being. The need for a networked and systemic approach that not only focuses on young service users but integrates and empowers families as agents of change is usually emphasised. For example, professionals noted that involving families in treatment planning sessions and providing them with resources and support can significantly enhance treatment outcomes:

‘Networked work, but it’s not just networked work, it’s work with the person, and accompanying the person. The network including the person and the family’ (participant 6, social worker).

The interviewees pointed out that when families feel prepared, informed, and supported, they become valuable allies, but it is necessary to accompany them and respect their needs and times:

‘Families need to go through a process, and there are processes that are slower’ (participant 5, social worker).

Systemic Changes

Many professionals agreed on the need for organisational-level changes that can facilitate the implementation of these types of collaborative practices. An example is the need for training to allow a change in approach to professional beliefs and attitudes. This includes not only initial formal training, but also ongoing professional development opportunities:

‘I think that first you have to educate people about what that means, which is the phase we are in, I would say, right? It’s a super new topic that we haven’t experienced it in our training, and there is more and more updating and more legislation regarding the topic’ (participant 1, psychiatrist).

Benefits

The interviewees perceive that SDM increases service users’ interest in their treatment, which they believe can enhance treatment engagement and foster greater autonomy. Additionally, they suggest that SDM helps distribute responsibility more evenly between the service user and the professional, rather than placing it solely on the professional.

Engagement

Therapeutic engagement refers to the degree of active involvement and collaboration that service users demonstrate

in their treatment process. According to the professionals interviewed, when service users have greater awareness of their challenges, find meaning in their experiences, and feel motivated to participate in the treatment process, their level of engagement increases:

‘It involves the person, therefore the person has motivation, the person wants to do, the person will see the usefulness of what they do, why they have to go to consultations, why they have to do that thing they don’t feel like doing, why they have to do it this way and not another’ (participant 6, social worker).

Autonomy

Autonomy refers to service users’ ability to make decisions for themselves and actively engage in the process of change, independently of the opinions and desires of others. Based on the insights of the professionals interviewed, fostering autonomy through SDM might empower service users to take ownership of their treatment journey:

‘I have always raised the objectives when working with the person. Everything works much better. And if it is also shared with the rest of the professionals, much better, a case always works much better, because the person feels self-responsible for their life, which is what needs to be achieved’ (participant 4, psychologist).

Shared Responsibility

Interviewees highlighted the importance of awareness among service users, families, and professionals regarding their involvement in the treatment process, which promotes active participation. This approach contrasts with placing all responsibility on a single individual, often the professional:

‘A difficulty sometimes for families or the individuals themselves, in the sense of “no, no, you are the one who knows, you have to tell me what I have to do” or “what’s the solution?”, they sometimes ask you that directly. We don’t have a magic wand, there is no specific solution for your son or daughter, but rather we have to build it step by step, build it together. So that also generates a difficulty, the person themselves and the family have to take responsibility, just as they have to have an active role in their process, and that sometimes is difficult, because we are used to “I don’t feel well, I go to the doctor, they tell me what I have, they give me the pill and with that I will feel better”. And

sometimes it’s not that simple, and less so in mental health’ (participant 7, social worker).

Limitations

Participants identified several obstacles that hinder the implementation of collaborative practices, including a lack of resources, paternalism, and family barriers.

Resource Constraints

Interviewees highlighted significant resource constraints that hinder the implementation of SDM. These constraints include insufficient time, inadequate staffing, and a lack of common spaces necessary for effective collaboration. The professionals emphasised that these limitations make it challenging to fully adopt and sustain SDM practices within their current work environments:

‘I think that, given the current conditions in public child and adolescent mental health services, thinking that it is easy to implement is very utopian, because the truth is that... at least from my job position... I find that there are long waiting lists, people are seen with very weak follow-up... very insufficient, and there are no truly intensive follow-ups. That’s due to a lack of resources, right?’ (participant 9, psychiatrist).

Paternalism

In the interviews, there were frequent mentions of overprotection by adults towards service users. Several participants acknowledged exhibiting paternalistic attitudes themselves:

‘I think that doctors in general, I am a psychiatrist, still have a very paternalistic attitude, right? You have that, so we’ll put that’ (participant 2, psychiatrist).

Participants emphasised that deciding on behalf of the person or discussing their situation without their presence are practices they believe must be transformed:

‘It requires having joint meetings, not with the young person or with the parents alone, which I think is a mistake that has been made for a long time, which is that professionals only talked to the parents and believed the parents over the young people. So, private spaces must be maintained, but joint meetings must be held. You have to listen to what young people say, I think you also have to listen to what parents say and the young person has to listen to it, they have to know what people around them think and what professionals

think, and from there seek a work plan' (participant 6, social worker).

Family Barriers

Professionals noted that family dynamics, beliefs, and expectations can sometimes hinder the SDM process. For instance, some families may resist collaborative approaches that include young people's preferences, perceiving them as undermining parental authority or questioning their role as primary caregivers:

'And sometimes, I've even encountered families who, when I've tried to agree on the treatment with an adolescent, tried to see how I dose it... well, some families didn't like that I was agreeing with the kid, you know, that's happened to me too' (participant 2, psychiatrist).

Dilemmas

There are dilemmas about characteristics or situations that imply doubts about the possibility of implementing SDM. We have classified the dilemmas into those related to age or developmental stage, complex situations, information management, and personalisation of the approach.

Age

The age of the service user is an important factor, as it can either hinder or facilitate the SDM process. Professionals highlighted the importance of considering the young person's legal capacity and advocated for a staggered implementation of SDM. Participants agreed that implementing SDM is more feasible with adolescents than with younger children, but they also noted the complexity of establishing a specific age threshold:

Under 12 years old I see it very difficult, and here we really should maintain the family unit in the sense of the child's living nucleus to make these decisions, and start introducing shared decisions from 12 and in a position of security from 16 years old.

Professionals also raised the concept of capacity, referring to cognitive development. They frequently noted that chronological age and developmental stage are relatively independent factors that must be considered in complex decision-making contexts:

'(...) but it is true that we must adapt to the person's age, to the person's mental age and their psychopathological state' (participant 2, psychiatrist).

Complex Situations

Participants demonstrated a strong consensus regarding substantial constraints on the implementation of SDM in scenarios involving acute risks, encompassing both self-harm and potential harm to others. They highlighted particular challenges in cases of significant mental health distress that impact an individual's ability to engage with reality as perceived by others and reflect on their situation:

'I believe there are cases where this becomes significantly more complex. Cases characterised by high levels of resistance from the individual, extensive negativity, and complete lack of awareness' (Participant 6).

Under such circumstances, some interviewees posited that professional intervention may be warranted, even in the absence of explicit consent. Additional scenarios that appear to constrain the potential implementation of SDM are related to negligence on the part of primary caregivers:

'If we detect a situation of risk, we have to protect this child, and protect this child at some point may involve going against what the family thinks, for example, removing the child from the family if the family is mistreating or neglecting this child, and that can be something that the family doesn't want and that the child doesn't want to be separated from the family either, but if we detect a risky situation, we have to act, we have a duty to act' (participant 3, psychologist).

Information Management

In line with existing paternalism as a limitation, and age as a dilemma, the interviewed professionals questioned what information is appropriate to share with the young person and what level of participation in decisions they can assume, according to their capacity and maturity:

'At the age of 5, they can express preferences or choose between options, or have this more listening-oriented treatment or be able to express themselves, but I understand that when they are very young there are things they cannot decide, right?' (participant 10, psychologist).

Individualised Support

Several interviewees emphasised that each situation is unique, with every young person and family experiencing the process differently. This raises the need to tailor treatment considering specific circumstances, environment, prognosis, and available resources:

‘The treatment should be adaptable, not generalised. A person with a certain disorder should not necessarily be treated in ways A, B, and C; there might be a way Z that has to do with what the user knows, what the family knows about this person, and this professional also uses their mind and thinks that they don’t know everything, but rather, should construct jointly’ (participant 7, social worker).

Discussion

The present study aimed to explore the perspectives of CAMH professionals on the implementation of SDM. The findings provide a multifaceted understanding of this process, underscoring both substantial opportunities and key challenges. This research offers a distinctive contribution by examining the perspectives of CAMH professionals within a context where dedicated SDM implementation programmes have not yet been established.

Consistent with previous studies (Langer & Jensen-Doss, 2018), most of the interviewed professionals recognised the potential benefits of SDM. Its capacity to improve treatment engagement and adherence, foster individual autonomy, and promote shared responsibility in the therapeutic process was particularly emphasised. These findings support the idea that SDM can significantly contribute to improving the quality of decisions and satisfaction, as observed in both physical (Hughes et al., 2018) and mental health (Aoki et al., 2022; Marshall et al., 2022) settings. However, the implementation of SDM in child and adolescent mental health presents unique challenges compared to adult mental health. The developmental and legal status of children and young people significantly impacts their ability to participate in decision-making (Liverpool, Hayes, et al., 2021). Additionally, professionals have a critical responsibility in child protection, which includes mandatory reporting of abuse and intervening in cases of potential harm (Bjønness, Viksveen, et al., 2020). This responsibility can sometimes conflict with the principles of SDM, particularly when immediate protective actions are required.

A recurring theme in our results was the fundamental role of the family in the SDM process, appearing in all categories. This omnipresence of the family in the professionals’

discourse reflects the complexity of the child and adolescent context, where the family can act as both a facilitator and a barrier in the SDM process (Hayes et al., 2019; Moore & Kirk, 2010). Our findings underscore the need for an approach that actively integrates the family into the SDM process, recognising its determinant influence on the course of treatment.

Also consistent with the literature, the lack of resources emerged as a significant barrier to the implementation of SDM (Gondek et al., 2017; Hayes et al., 2019; Légaré et al., 2008). Professionals cited shortages of time, staff, and adequate spaces as important obstacles. However, it was also suggested that certain aspects that can facilitate SDM, such as training and changes in the professional mindset, could be implemented even with limited resources. Persistent paternalism in some professional practices was identified as another obstacle, reflecting the need for a broader cultural change in mental health care (Barry & Edgman-Levitan, 2012; Peltó-Piri et al., 2013).

In line with previous studies (Moore & Kirk, 2010) the question of the young person’s age and ability to participate in SDM emerged as a central dilemma. While some professionals suggested age 12 as a guiding age to initiate SDM, others advocated for a more flexible approach based on individual capacity. This discussion reflects the complexity of applying SDM in a context where decision-making ability may not directly correlate with age. Additionally, complex situations, such as imminent risky situations or family neglect, were identified as scenarios where the application of SDM could be limited (Hamann & Heres, 2019). The professionals interviewed emphasised that, from their perspective, in cases involving acute risks, such as self-harm or potential harm to others, or when there is evidence of neglect by primary caregivers, the priority must be the immediate safety and well-being of the child. Our results underscore the need for a personalised and flexible approach in implementing SDM in CAMH. Professional training, collaborative work with families, and adaptation of processes to the individual capacities of young people emerged as key elements for successful implementation.

It is important to acknowledge the limitations of this study, including the small sample size and its specific geographical location. Additionally, the absence of perspectives from young people and their families represents a significant limitation that should be addressed in future research.

Implications for Social Work Practice and Policy

The findings of this study highlight critical implications for social work practice and policy in advancing SDM within CAMH services. Social workers, as key members of multidisciplinary teams, are uniquely positioned to facilitate

SDM due to their training in family systems, empowerment, and advocacy. The emphasis on family involvement as both a facilitator and barrier underscore the need for social workers to adopt a systemic approach, engaging families as active partners in treatment planning while addressing potential resistances. This involves employing skills in mediation and communication to ensure the voices of young people and their families are balanced, fostering collaborative decision-making environments. From a policy perspective, the study's findings on resource constraints and the need for systemic changes point to the necessity for increased investment in CAMH services to support SDM implementation. Managers should advocate for funding to address staffing shortages and provide dedicated spaces for collaboration. Additionally, policies should mandate comprehensive training programmes focusing on SDM principles, interprofessional collaboration, and strategies to navigate ethical dilemmas.

Conclusions

The adoption of SDM in CAMH offers a transformative opportunity to enhance mental health care by prioritising collaboration and empowerment. Our findings affirm professionals' recognition of SDM's potential to improve outcomes for young service users, despite its inherent complexities. Moving forward, achieving meaningful implementation will depend on fostering a cultural shift in mental health services toward greater inclusivity and shared responsibility. This study highlights the urgency of developing evidence-based strategies to address ethical and developmental challenges unique to CAMH, particularly in determining young people's decision-making capacity. Future research should explore perspectives from young people and families to further refine SDM practices, ensuring they are responsive to diverse needs. The pursuit of SDM, though challenging, holds significant promise for advancing person-centred care in CAMH.

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Declarations

Conflict of interest The authors report no conflicts of interest.

Ethical Information All subjects gave informed consent in accordance with the Declaration of Helsinki. The study was approved by the Uni-

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