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Beyond Shared Decision-Making in Youth Psychiatry: A Dynamic Continuum of Decision-Making Practices

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Abstract

While shared decision-making (SDM) is widely recognized as a reference model in adult psychiatry, its implementation in youth psychiatry remains under-explored, despite the specific challenges inherent to this field. This exploratory qualitative study investigates how child and adolescent psychiatrists describe and adjust their decision-making practices in clinical care, including their attitudes, strategies, and perceived limits of SDM.

Sixteen semi-structured interviews were conducted with youth psychiatrists via videoconferencing. Data were analysed using thematic analysis.

Five overarching themes emerged: (1) the perceived benefits of SDM, such as improved adherence and engagement; (2) a dynamic continuum of decision-making practices, from full collaboration to ethically guided protective decisions; (3) the role of parents as co-participants in the decision-making process; (4) the modulation of the clinician–patient relationship along a vertical-horizontal axis; and (5) contextual influences, including institutional constraints and limited resources.

Psychiatrists generally support SDM as a desirable framework. However, their accounts point to a broader and more flexible continuum of practices, in which the degree of sharedness varies depending on factors such as the young person's age, developmental stage, illness severity, crisis situations, and parental involvement. Some practices described by clinicians fall outside strict definitions of SDM and belong instead to the domain of substituted or protective decision-making. These findings invite a nuanced and context-sensitive understanding of decision-making in youth psychiatry.

Introduction

The burden of psychiatric disorders among children and adolescents is increasingly recognized as a growing public health concern. Globally, the WHO estimated that, in 2024, one in seven (14%) of 10–19-year-olds experience mental health conditions (WHO, 2024). Consistently, a recent UNICEF report documented that about 9 million European children and adolescents (aged 10 to 19) suffer from mental health issues (UNICEF, 2021).
However, access to care, satisfaction with services, and treatment adherence remain insufficient in this population (Häge et al., 2018; Mental Health Europe, 2021). Nearly 49% of young people in the European Union report having unmet mental health needs—a figure significantly higher than that of adults (23%) (European Commission, 2022).

To address these challenges, mental health policies have increasingly promoted the active involvement of users in care and treatment decisions (WHO, 2010). In contrast to traditional paternalistic models, where clinicians assume a dominant role, these newer frameworks encourage patients to engage actively in treatment decisions and to share their preferences, values, and goals. The Shared Decision-Making (SDM) model—conceptualized as a collaborative process involving healthcare providers and

users working together to make informed decisions consistent with the user's perspective (Verwijmeren & Grootens, 2024)—is central to these policies.

To date, SDM has been primarily studied in adult psychiatry. Research in this field suggests that SDM improves satisfaction, treatment adherence, and clinical outcomes, as it fosters a sense of ownership over the treatment journey (Slade, 2017). SDM also aligns with the broader "recovery model" in mental health, which emphasizes empowerment, self-determination, and agency (Anthony, 1993; Davidson et al., 2006), and which has become a guiding framework in clinical mental health practice. The recovery model posits that individuals with mental health challenges can lead meaningful, fulfilling lives regardless of diagnosis, if supported in making decisions that reflect their values and aspirations (Leamy et al., 2011).

This alignment between SDM and the recovery model is particularly relevant in youth psychiatry, where young people are navigating autonomy while also facing psychological vulnerability (Naughton et al., 2018). However, applying SDM in this population poses particular challenges due to young people's evolving capacities and significant dependency on adults (Légaré et al., 2014). Children and adolescents differ from adults in terms of cognitive, emotional, and social maturity, which can limit their ability to make fully informed decisions about their care (Kuther, 2003; Paul, 2004). They may struggle to comprehend long-term implications or be more susceptible to external influences such as peers (Roberson & Kjervik, 2012).

Moreover, although adolescents may express a desire for independence, they often rely heavily on parental support—both emotional and logistical—especially in psychiatric care (Coyne et al., 2015; Merayo-Sereno et al., 2023). This dual need for autonomy and support can create tensions. The involvement of parents in decision-making is therefore considered essential, not only to ensure adherence but also to preserve the adolescent's psychological well-being.

Beyond family involvement, studies have identified additional factors that influence the successful implementation of SDM in youth psychiatry. These include the quality of communication between clinician and patient, the young person's capacity for understanding, and the clinician's ability to facilitate shared decisions (Légaré et al., 2014; Coyne et al., 2015). Some research also points to the need for clinicians to show flexibility, build trust, and adapt to individual needs (Bjønness et al., 2020a; Abrines-Jaume et al., 2016; Grim et al., 2016).

Clinicians may also face ethical tensions—particularly when balancing the adolescent's expressed wishes with their professional duty to protect safety and well-being. For instance, when a young person refuses treatment, clinicians may struggle with how to respect the adolescent's autonomy while ensuring adequate care (Paul, 2004; Roberson & Kjervik, 2012). This dilemma is especially pronounced when refusal stems from emotional immaturity or impaired judgment (Paul, 2004).

Although SDM aligns with current mental health policies and the recovery paradigm, its application in youth psychiatry remains complex. Consistently, studies show that SDM is not consistently implemented

in mental health contexts, partly due to these specific challenges (Chmielowska, 2023b).

Given these complexities, a more comprehensive understanding of how professionals enact SDM in youth psychiatry is needed. This includes not only identifying techniques, barriers, and facilitators, but also exploring professionals' lived experiences and the challenges they face in navigating this model. Although SDM is increasingly promoted as a gold standard in youth mental health, it remains unclear how it is interpreted and applied by clinicians in everyday practice. Given the developmental, ethical, and contextual complexities of child and adolescent psychiatry, decision-making processes may take various forms—some of which align with, adapt to, or diverge from formal SDM frameworks. This study therefore aims to explore how youth psychiatrists (YP) approach decision-making in clinical practice, and how they navigate the opportunities and limits of the SDM model.

In a similar study by Bjønness et al. (2020b), based on focus group discussions, professionals emphasized the importance of involving patients at the admission phase, allocating sufficient time for decision-making, providing access to care meetings, and individualizing therapy. While these findings are informative, they do not fully illuminate the complexities and ethical dilemmas involved. The present study seeks to expand on these insights by examining whether similar themes emerge and whether additional complexities are raised. To allow for deeper exploration of individual experiences, we opted for in-depth, one-on-one interviews, which may elicit more nuanced, less normative content.

Methods

Study Design

This study employed a qualitative research design using semi-structured interviews with youth psychiatrists, i.e. psychiatrist employed in child and adolescents' mental health services. Given the exploratory nature of the study, qualitative methods were deemed appropriate to capture the depth and complexity of professionals' experiences and perceptions regarding SDM in this field (Creswell & Poth, 2018).

Participants and Sampling Strategy

Participants were youth psychiatrists with a minimum of five years of clinical experience in child and adolescent mental health. This criterion ensured that participants had substantial exposure to decision-making processes in their practice, providing nuanced insights into the feasibility, challenges, and implications of SDM.

A purposive sampling strategy was employed to ensure a diverse range of experiences. Participants were recruited from various practice settings, including hospitals and mental health services. This diversity facilitated the exploration of potential differences in decision-making processes across contexts. Additionally, variation in professional experience, geographical location (Brussels, Liège, and Luxembourg), age, and gender, was considered to enhance the diversity of perspectives.

Initial recruitment was conducted through hospital and mental health centers' secretariats, followed by direct email invitations. A snowball sampling approach was then used, whereby participants recommended colleagues who met the inclusion criteria (Robinson, 2013).

Given that our study targets a relatively homogeneous population, with a specific objective of exploring SDM practices, we estimated that a sampling with approximately 15 to 20 participants would reach data "information power", a principle used in qualitative research to decide the end of the data collection process (Braun & Clarke, 2019; Vasileiou et al., 2018).

The resulting sample consisted of 16 youth psychiatrists, including 11 women and 5 men, with an age range from 32 to 67 years. The mean age of participants was 45.69 years, with a standard deviation of 10.96 years, while the average experience is 17.69 years, with a standard deviation of 8.96 years. These high standard deviations indicate significant variability in both age and years of experience, reflecting a heterogeneous population about these criteria. Regarding work settings, 9 participants work in a hospital setting, while 7 in a mental health service; among them, 3 also have a private practice in addition to their institutional employment. In terms of geographical distribution, 9 participants were practicing in Liège, 5 in Brussels, and 2 in Luxembourg.

Data Collection

Data were collected through individual semi-structured interviews conducted via videoconferencing (Microsoft Teams®). The duration of the interviews ranged from 25 to 45 minutes. This format provided flexibility and ensured accessibility for participants while maintaining the depth of discussion. Before initiating each interview, participants were provided with detailed information about the study's objectives, procedures, and ethical considerations. Informed consent was obtained for both participation and audio recording. We adopted a predefined interview guide with prompts aimed at stimulating a general discussion and narrative (Box 1).This included a general opinion about the SDM approach, interrogation about factors eventually influencing the SDM process, perceived effects of SDM and successes and challenges experienced in implementing SDM with children and adolescents.

Box 1: Interview Guide

- What is your general opinion on the shared decision-making approach?

- In your opinion, what are the specificities of shared decision-making in the care of minor patients?

- Do you think certain factors can impact your approach to shared decision-making?

- How do you perceive the role of patients' socioeconomic status (and that of their families) in this process?

- How do you consider the severity of the diagnosis to influence decision-making?

- Are there any other factors that might play a role?

- How does the active participation of a minor patient in the decision-making process regarding their treatment or care influence their satisfaction with these interventions?

- How does this approach affect treatment adherence or overall care compliance?

- Could you share an experience where the shared decision-making approach was highly successful, and another where it faced challenges?

Data Analysis

We employed a reflexive thematic analysis approach to identify and interpret patterns within the data, following the framework outlined by Braun and Clarke (2021). The analysis proceeded through a structured and iterative process, including: (1) transcription and familiarization with the data; (2) generation of initial codes; (3) construction of candidate themes; (4) refinement of the thematic structure, including the identification of sub-themes; and (5) review of the final thematic map to ensure internal coherence and resonance with the dataset.

The analysis was primarily conducted by the second author and supervised by the last author, a senior qualitative researcher, which contributed to enhancing the credibility and trustworthiness of the findings. Codes and themes were discussed collaboratively to reach analytical consensus.

This approach is grounded in a contextualist epistemology, acknowledging that meaning is co-constructed and situated within specific social and professional contexts. Specifically, we drew on a ***hermeneutics of empathy,*** aiming to interpret participants' perspectives from within their own frames of reference, and to understand how they make sense of their professional practices and to shed light and their lived experience **(**Willig & Stainton-Rogers, 2017**)**.

Ethical Considerations

This study was approved by the Ethics Committee of the University of Liège (file identification number: 2324-012MEM/2425-076). Participants provided informed consent, and confidentiality was ensured through anonymization of data. Identifiable details were removed from transcripts, and all records were securely stored. Participants retained the right to withdraw at any time without consequence.

Results

Thematic analysis resulted in the development of a thematic map comprising five overarching themes: (1) the recognized benefits of SDM; (2) the dynamic continuum of SDM practices; (3) the role of parents as privileged partners; (4) the flexible modulation of the patient–professional relationship; and (5) contextual influences on decision-making. These themes, along with their corresponding sub-themes and core characteristics are presented in detail in the following sections and summarized in Table 1.

Table 1
Thematic Table

Theme	Sub-theme	Core characteristics
1. Benefits of SDM	Improved satisfaction	SDM perceived as enhancing satisfaction
	Increased adherence	SDM perceived as enhancing treatment adherence across the care process.
2. Persuasive decision-making	Collaborative decision-making	Adolescent and parents perspective are the main argument to be considered *(aligned with SDM)*
	Guided and negotiated decision-making	Clinician offers information about pros and cons without overriding adolescent's agency *(aligned with SDM)*
	Persuasive decision-making	Clinician uses competence and emotional arguments to convince patient to accept treatment *(partially aligned with SDM)*
	Protective or substituted decision-making	Clinician imposes decision unilaterally due to perceived lack of capacity or safety risk *(non-aligned with SDM)*
3. Parents as privileged partners	Parents are final decision makers	Parents are central to decision-making due to legal role and therapeutic continuity at home.
	Considering the family's socio-economic level	Reflects a pragmatic and context-sensitive approach to treatment planning
	Considering parental conflicts	Clinician may need to mediate or delay decisions until consensus is found or an external authority is involved
	Obstructive parental profiles	Parents perceived as unable or unwilling to engage constructively in decision-making due to pathology, cognitive limitations, or history of abuse.
4. Relational posture	Patient information and education	Psychoeducation is key tool and clinician can assume the posture of a mentor
	Balancing verticality and horizontality	Clinicians adapt stance based on trust, maturity and alliance
5. Contextual influences	Emergency situations and refusal of care	Urgent contexts often justify directive strategies or override of user's preferences.
	Structural barriers	Limited access to case can reduce the available options and therefore

Theme 1: The recognized benefits of SDM

According to participants, SDM practice has advantages in two main areas: patient satisfaction with their treatment and/or care, and patient's compliance. The youth psychiatrists expressed that involving children and adolescents in the decision-making process regarding their treatment and/or care

influences their satisfaction. “The fact that the patient is active and listened to will have an impact on their satisfaction with the treatment and care.” (Interview 1)

YPs also affirmed seeing a clear association between users’ participation in the decision-making process and treatment adherence

“If we take the example of a pharmacological treatment, I believe that in terms of adherence, if things are not well understood, well accepted, and well approved—both by the child and the parents—then, from experience, I know the treatment is much less likely to be followed.” (Interview 9)

“Their adherence will improve when they are actively involved and seen as partners rather than having something imposed on them. If they are not convinced of its benefits, they won’t take it.” (Interview 13).

« The more informed adolescents are, the more engaged they become and the more time and importance they will give to it » (Interview15)

These results are consistent with previous literature showing that SDM fosters satisfaction and adherence to decisions in adult psychiatry (Slade, 2017), therefore implying that the same pattern can be observed when dealing with youth psychiatry. Although the present qualitative data cannot be generalised and no conclusion can be made, they provide an insight about the positive value of SDM in youth psychiatry, similarly to adult psychiatry.

Themes 2: The continuous shift of decision-making power in practice

Youth psychiatrists described a wide range of approaches to clinical decision-making with young people, often varying within the same interview or even within the same clinical encounter. These approaches can be conceptualized as existing along a dynamic continuum, which reflects the gradual shift in decision-making power between the clinician and the young person. This dynamic shift is illustrated in Fig. 1. This continuum includes four main modalities, that are summarized in Table 2.

Table 2

Typology of decision-making modes in youth psychiatry, with their core characteristics and compatibility with the SDM model.

Decision-Making Mode	Core Characteristics	Status Regarding SDM
Collaboration	The young person is fully involved and free to choose; no normative pressure	Fully within SDM
Negotiation	The psychiatrist provides balanced information to support an informed joint decision	Compatible with SDM
Persuasion	The psychiatrist presents one preferred option and tries to convince the young person	At the margins of SDM
Protection	The psychiatrist makes the decision in the young person’s best interest; participation may be limited or symbolic	Outside SDM

While some of these practices fall within the scope of SDM, others represent more directive or substituted forms of decision-making, which, although ethically motivated, do not meet standard definitions of SDM.

1. Collaborative Decision-Making (Fully SDM-Compliant)

At the collaborative end of the continuum, young people are actively involved in the decision-making process and free to express preferences and make choices without normative pressure. Clinicians emphasize autonomy, trust, and psychological empowerment.

"It's about ensuring that the child is an active participant in their own care. I think it's about trying to mobilize something on a psychological level in the child and allowing them to realize that they can move forward and make choices." (Interview 3)

2. Negotiated Decision-Making (Aligned with SDM)

In this modality, the psychiatrist engages the young person in a process of informed dialogue, presenting potential advantages and disadvantages of each option. While the clinician may guide the discussion, the final choice is made collaboratively, with attention to the young person's concerns and representations: "Some children are afraid of medication because they feel like they won't be themselves anymore…Sometimes it takes several sessions to help them fully understand that no harm is intended, and that they will still be themselves." (Interview 1)

3. Persuasive Decision-Making (At the Margins of SDM)

In persuasive approaches, clinicians attempt to influence the young person toward a particular course of action, usually aligned with medical norms. While some information is shared, and the patient's consent is sought, the decision is largely pre-determined by the professional. These practices occupy a *grey zone*, at the boundary between shared and unilateral decision-making.

"I try to give as many explanations as possible, so that they understand… But it's true that they won't be the ones choosing the medication. I've already made my decision about which treatment would suit them, and I try to convince them." (Interview 6)

4. Protective or Substituted Decision-Making (Outside SDM)

In high-risk situations or when the young person's capacity for judgment is significantly impaired (due to age, intellectual disability, or severe mental illness), psychiatrists describe adopting a more protective stance. In such cases, decisions are made by the clinician in the patient's best interest, with limited or no input from the young person. While communication is often maintained to foster adherence or reduce distress, these practices *fall outside the SDM framework*, aligning instead with substituted or paternalistic decision-making. "Sometimes it's like a cat-and-mouse game to get people to change… So what really matters isn't shared agreement, it's ethics. If the ethical approach serves the patient's best

interest, that's the only thing that counts." (Interview 2) "With anorexic patients… your illness is making you want to completely deprive yourself of food, but that's not possible: we cannot help you die!" (Interview 16)

These four modalities serve as *reference points on a dynamic continuum*, along which psychiatrists report moving fluidly depending on the clinical situation. Rather than being fixed in their stance, participants emphasized the importance of adapting their decision-making approach to a range of factors, particularly the young person's age and developmental stage. "With a 5-year-old child, I can explain the basics, but the treatment will definitely be imposed…With a teenager who is 15, 16, or 17, it's different—there will be real negotiation and collaboration." (Interview 13)

Other key factors influencing their position on the continuum include the severity and acuteness of the clinical condition (e.g., psychosis, anorexia, or severe autism), as well as the presence of intellectual or emotional impairments. In such cases, psychiatrists justify a more directive approach based on ethical concerns, especially when the patient's safety or survival is at stake. The urgency of the situation and the perceived capacity of the young person thus determine whether SDM can be meaningfully implemented, or whether it must be temporarily suspended.

Theme 3: Parents as privileged partners

YPs' discourse reveals a concern for building an alliance with parents, as they are often considered the ultimate decision-makers, responsible for administering treatment at home and maintaining the therapeutic framework in the professional's absence. This alliance necessitates considering the young person's family situation as a whole: *"It's the parents who make the final decision about the treatment, not the child."* (Interview 1)

The family's socio-economic status may influence decision-making practices. According to some YPs, the decision-making process must be adjusted when families have limited financial resources or are unwilling to allocate a certain amount to mental health care (including treatment costs, consultations, transportation, and hospitalization expenses).

"I am transparent. I say, 'It costs this much, can you afford it or not?' I say it, and sometimes they tell me, 'Oh no, I can't afford it.' It's true that there are times when I adjust or change the medication so." (Interview 6)

YPs emphasize that parental conflicts can pose a significant obstacle to the SDM process. Separated or divorced parents may disagree on decisions, leading to a deadlock in their child's care. In such cases, CPs turn to an external authority, and the decision is taken out of the family's hands.

"Parental conflicts clearly impact shared decision-making. That's quite common. For example, when mothers have primary custody and fathers only have visitation every other weekend, the symptoms tend to be much less noticeable and more subdued when the child is with the father. As a result, the father doesn't really understand the situation." (Interview 7)

Additionally, YPs perceive certain parents as unable to be included in the decision-making process due to intellectual limitations, severe pathology, or a history of abuse toward the young patient. In these situations, their exclusion is deemed necessary, as their decisions may not ensure the child's well-being as a primary outcome. In these cases, the YPs expressed facing ethical dilemmas when an adolescent opposes their parents in choosing a treatment.

"Shared decision-making can be difficult when a parent is abusive or inappropriate. It's not the child who blocks the decision-making process but rather the family environment. For example, I have a case where the father is violent and believes that medication is for "idiots" (Interview 7)

Theme 4: The flexible modulation of the patient–professional relationship

Finally, according to the interviewed YPs', decisions are embedded in a relationship between the YP and the interlocutors (young users and families), that may fluctuate between horizontality and verticality.

When adopting an horizontal position, YPs highlighted the use of transparent, informational, and educational communication with both the patient and their parents. They emphasize being transparent about their proposed treatments and care plans, explaining to young patients and their parents the rationale behind their recommendations, the objectives, as well as the benefits and potential side effects of treatments.

"I take the time to first explain my ideas and therapeutic plan to the young person—the reasons why I'm considering this approach, the goals behind proposing this type of treatment, and, if it involves medication, I clearly explain the possible side effects. [...] I also explain why I believe it is perfectly suited for them and what the objectives are" (Interview 10)

The educational approach also aims to address and deconstruct false beliefs held by the child and/or parents. Among the misconceptions identified by YPs are the beliefs that the child will no longer be themselves during or after treatment, that treatment will alter their thoughts, that they will become 'robotized,' or that they will follow the same psychiatric trajectory as a relative.

"Some children are afraid of medication because they feel like they won't be themselves anymore, that it will alter their thoughts or take away their ability to make decisions—as if they'll become robotic and lose their autonomy, etc. These are false beliefs, but sometimes it takes several sessions, rather than offering treatment right away, to help them fully understand that no harm is intended, that their brain won't change, that they will still be themselves, and that they will continue to think in the same way." (Interview 1)

The criteria for a shift toward verticality, as mentioned by YPs, include the young person's anxiety, their experience of a profound inner void, and the perceived expectation of a 'knowledgeable' doctor who provides clear direction.

“If I give too much choice, it can often be overwhelming for the child. They might think, “I’m seeing a doctor, and the doctor is supposed to know what I need.” We can try to have the most equal relationship possible. However, sometimes, in my role as a doctor, I need to take a slightly more authoritative position because if the dynamic is too equal, people will respond, “You’re the doctor, you’re the one who knows” (Interview 13)

Theme 5: Contextual Influences on Decision-Making

Most YPs highlighted constraints related to limited healthcare resources that impact SDM practices. The healthcare context sometimes includes a shortage of psychologists and/or psychiatrists, and consequently, a lack of access to specific therapies. When YPs reach an agreement with the patient and parents on a proposed care plan, this context can complicate its implementation. For instance, an impasse arises when a particular therapy is agreed upon, but no specialists in that approach are available in the region. Due to these resource limitations, long distances may need to be travelled to access a psychotherapy center or a day hospital, as these facilities are often spread over a vast territory. Additionally, the lack of resources results in healthcare professionals being overburdened, leading to limited availability and waitlists for patients. “Sometimes, the lack of access to care, the fact that there may not be available spaces in the centers we refer to, all of these are obstacles.” (Interview 15). Furthermore, in cases where parents refuse a necessary treatment for their child, YPs emphasize that this shifts the care context and, consequently, the shared decision-making process. Legal avenues are then pursued, involving external services. In such situations, YPs suspend SDM, as they deem the treatment essential, overriding parental refusal.

“We involve services such as youth assistance or judicial protection services when the situation is concerning, or when we know that the treatment won’t be followed because the family won’t be able to manage. In such cases, we call upon protective services.” (Interview 1)

Discussion

The objective of this study is to better understand the SDM process in youth psychiatry—its challenges and complexities—from the unique perspective of professionals. To explore this question, a qualitative investigation was conducted, using sixteen semi-structured interviews with child and adolescent psychiatrists, analysed through reflexive thematic analysis (Brown & Clark, 2021). As this is an exploratory study, no prior hypothesis was formulated. The exploratory nature of the present research is justified by the limited presence of this topic in the scientific literature, both theoretically and empirically.

The choice of individual interviews enabled us to achieve the objective mentioned in the introduction: capturing the lived experiences of psychiatrists and shedding light on complexity and challenges, beyond what might be expressed in group settings, which are inevitably more normative (cf. Bjoness et al., 2020b). Consistent with our expectation, rather than focusing on how SDM should ideally be implemented, our participants described how they are engaged in the ongoing effort to adapt to this

ideal in their daily clinical practice. This adaptation is dynamically negotiated with structural, social, and situational factors.

Key findings

At a general level, the findings highlight the tension between the normative ideal of SDM and its clinical reality, which is often shaped by developmental, relational, and contextual factors.

More specifically, five overarching themes were identified: the benefits of SDM, the shifting nature of decision-making practices, the role of parents as main partners, the modulation of the relational posture, and the contextual influences on decision-making.

The interviewed professionals recognize that SDM brings significant benefits throughout the treatment process, as it increases satisfaction among both parents and young patients, as well as treatment adherence. This is consistent with previous literature on adult psychiatry, which has already highlighted the positive outcomes associated with the SDM process (Slade, 2017). This also suggests that SDM in youth psychiatry may have similar overall value as in adult psychiatry, and that professionals tend to adhere to the idea that SDM is the model to pursue, expressing strong beliefs about its beneficial nature.

Nevertheless, the findings suggest that clinical decision-making in youth psychiatry is rarely static or uniform. Participants reported navigating in a dynamic spectrum of practices, ranging from collaborative and negotiated decisions to more directive approaches, including persuasion or unilateral action in high-risk contexts. While some of these approaches may still reflect the spirit of SDM, others clearly fall outside its definition. These nuances reveal the difficulty of implementing a rigid SDM framework in child and adolescent psychiatry, where ethical, developmental, and clinical considerations often compel professionals to adapt.

Almost all participants stated that the position adopted depends on the young person’s age and maturity. Most professionals differentiate between young children and adolescents, asserting that collaborative strategies are more easily applied with adolescents, who have more decision-making capacity and are more actively involved in their care. This focus suggests that developmental considerations should be central when implementing SDM in youth psychiatry.

Severe psychiatric conditions and/or intellectual disabilities were also identified as important modulating factors, making clinicians more likely to shift away from shared approaches. In such cases, professionals justify their position based on ethical concerns and safety imperatives. These findings echo those of Huang et al. (2020), which suggest that emergency or complex clinical situations can significantly impact the decision-making process. They also offer a contrast with the more optimistic findings of Bjoness et al. (2020b), who argue that collaborative SDM can be applied even in difficult cases, if sufficient support and time are provided. Our results suggest that in individual interviews, professionals may express more openly the tensions and ethical limits they perceive.

Another key finding is that parents are considered by psychiatrists as very important stakeholders in the process, since they hold legal authority, provide the therapeutic framework at home, and ensure treatment adherence. These findings are in line with the qualitative study by Mackova et al. (2022), which highlights the active and crucial role of parents in child mental health care. The presence of parents, though, further complexifies the SDM process, especially when conflict is present in the triad parents/patient and obliges professionals to give more weight to a perspective over another, or to work harder to find consensus.

The importance of modulating and adapting the relational posture—from vertical to horizontal—and of paying attention to the therapeutic alliance also emerged as a central theme. This further reinforces the idea of decision-making as a dynamic process, showing that adaptation and modulation are not limited to formal techniques, but are also reflected in the therapeutic relationship. Within this framework, the essential role of psychoeducation was emphasized by all participants, who underlined the importance of clear and transparent communication about care and treatment options, also when addressing children and adolescents. These findings are consistent with the literature, which sees psychoeducation as an intervention designed to inform patients and their families about psychiatric disorders, coping strategies, and treatment-related information (Bonsack et al., 2015), ultimately aimed at deconstructing patients' and/or parents' misconceptions.

Finally, emergency situations—such as acute crises, involuntary hospitalizations, or a child refusing a life-saving treatment—were frequently cited as another critical factor. Some participants reported using negotiation in these situations, while others described switching to directive strategies, given the urgency of the context.

Limitations

It is important to discuss the limitations of this study and to interpret its findings with caution for several reasons. A primary limitation lies in the exclusive selection of youth psychiatrists as participants. Including the perspectives of parents and young people would have enriched the study by broadening the range of viewpoints. Their experiences could offer essential insights into how SDM is perceived and experienced by the primary recipients of care, providing a more comprehensive understanding of the concept. However, for ethical reasons, the decision was made to begin this research with mental health professionals, in order develop a clearer understanding of a relatively underexplored topic before involving children and parents, who represent more vulnerable populations.

Additionally, recruitment was based entirely on voluntary participation, and the main theme of the study was clearly communicated to potential participants. Those interested were invited to respond to the call. This recruitment method may have introduced a selection bias, as youth psychiatrists who chose to participate were likely those already familiar with or actively engaged in SDM. As a result, the findings may be skewed toward a more favourable and engaged perspective on the practice.

Practical implications

Rather than adhering to a rigid SDM framework, clinicians must navigate a dynamic continuum of practices, adapting their relational posture and strategies to the young person's age, maturity, clinical status, and the family context.

This suggests several practical directions. First, psychoeducation efforts should be systematized and adapted to younger audiences using clear, accessible formats—such as illustrated materials, digital tools, and interactive media. These may include simplified decision aids, structured conversation guides, or participatory apps that scaffold the SDM process.

Second, clinical training should emphasize the ethical and relational modulation required in SDM, especially in high-risk or complex situations, and promote the culture and the ethics of SDM, even when adaptations are necessary due to safety or capacity concerns.

Conclusions and avenues for future research

This study highlights that decision-making practises in child and adolescent psychiatry cannot be conceived as a uniform, fixed model. Rather, it emerges as a dynamic process that can take various forms, depending on contextual, relational, and developmental factors.

Some components—such as its recognized benefits and complexity—are shared with adult psychiatry. However, other elements—such as developmental considerations and the role of parental authority—are specific to child and adolescent populations, underscoring the need for tailored approaches. Youth psychiatrists often navigate in tensions between respect for autonomy, parental authority, and the duty of protection—particularly during crises, involuntary admissions, or refusal of life-saving care. This research may help to identify institutional levers for supporting a more participatory culture in youth mental health care, promoting reflective practice and equipping clinicians with flexible, patient-entered tools will be key to wider adoption.

Overall, professional ethics and a genuine interest in patients' well-being motivate psychiatrists to pursue this ideal. Advancing this research and practice will require a deeper empirical and conceptual understanding, the inclusion of children's voices and the development of adapted tools. Only through these efforts can SDM realize its potential as a cornerstone of ethical, participatory, and high-quality mental health care for young people.

Statement

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Declarations

Author Contribution

All authors contributed substantially to the conception and design of the study. Material preparation, data collection, and analysis were conducted by R.D.S., P.R. and M.M.. The first draft of the manuscript was prepared by R.D.S. and M.M. All authors have read and approved the final manuscript and agree to be accountable for all aspects of the work.

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Data Availability

The interview transcripts generated and analyzed during the current study are stored on a secure, password-protected platform hosted by the University of Liège. At present, the data are accessible only to the authors of the study. However, they may be made available upon reasonable request and pending appropriate ethical approval.

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Figures

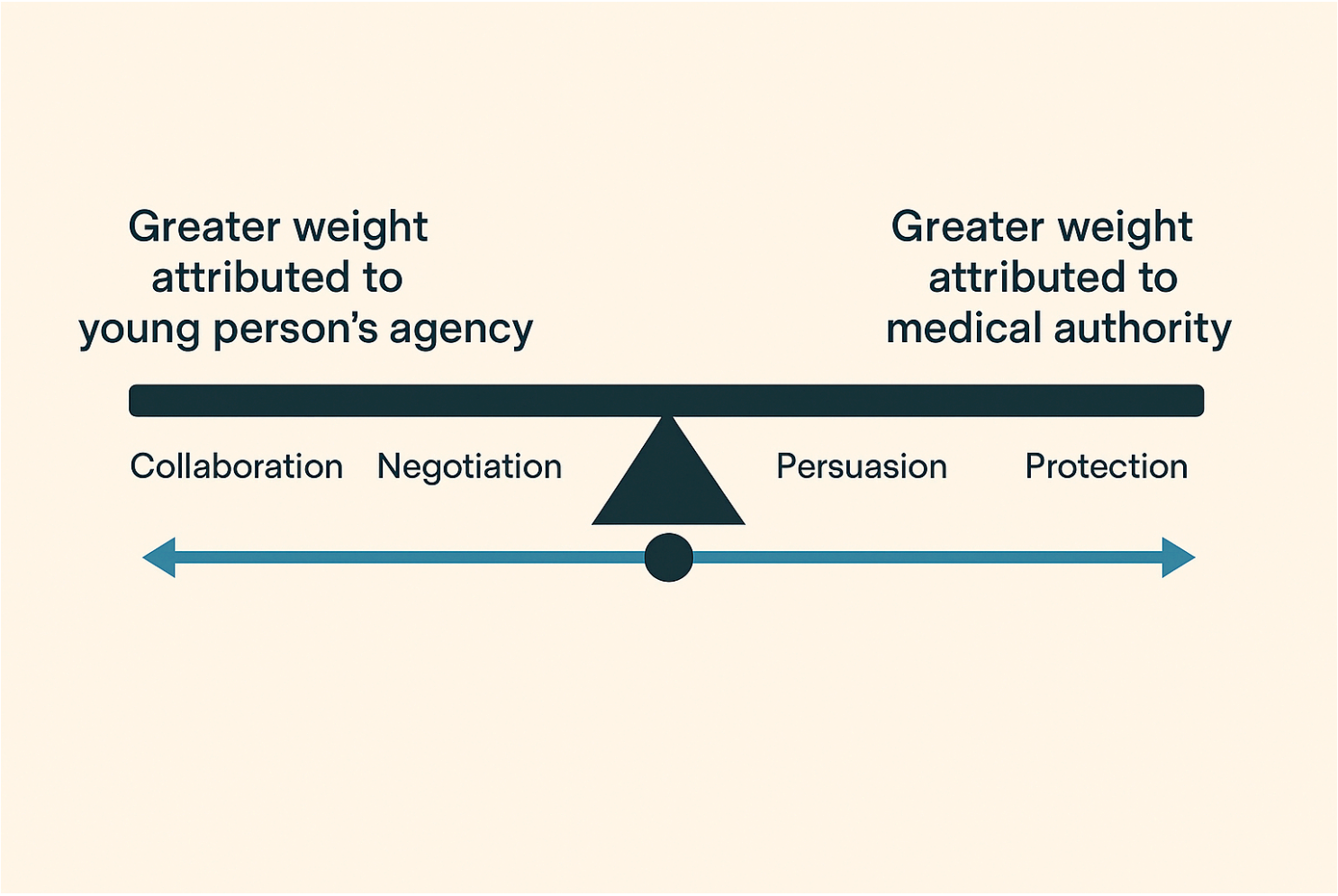

Figure 1

Legend not included with this version