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What is This?
A qualitative analysis of implementing shared decision making in Child and Adolescent Mental Health Services in the United Kingdom: Stages and facilitators

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Abstract

Objectives: To explore the implementation of shared decision making (SDM) in Child and Adolescent Mental Health Services (CAMHS), and identify clinician-determined facilitators to SDM. Methods: Professionals from four UK CAMHS tried a range of tools to support SDM. They reflected on their experiences using plan-do-study-act log books. A total of 23 professionals completed 307 logs, which were transcribed and analysed using Framework Analysis in Atlas. Ti. Results: Three states of implementation (apprehension, feeling clunky, and integration) and three aspects of clinician behavior or approach (effort, trust, and flexibility) were identified. Conclusions: Implementation of SDM in CAMHS requires key positive clinician behaviors, including preparedness to put in effort, trust in young people, and use of the approach flexibly. Practice implications: Implementation of SDM in CAMHS is effortful, and while tools may help support SDM, clinicians need to be allowed to use the tools flexibly to allow them to move from a state of apprehension through a sense of feeling “clunky” to integration in practice.

Keywords
Shared decision making, child mental health, Child and Adolescent Mental Health Services, plan-do-study-act, implementation

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Introduction

Shared decision making (SDM) is a process in which clinicians and patients work together to clarify treatment aims, establish goals, and support self-management, through sharing information about options and preferred outcomes, with the aim of reaching mutual agreement on the best course of action (Coulter, Edwards, Elwyn, & Thomson, 2011). The use of SDM in mental health services is supported by patients (Chewning et al., 2012), and there is evidence that young people both want to be involved in decisions about their treatment (Coyne, 2006; Kelsey, Abelson-Mitchell, & Skirton, 2007) and have the capacity to be involved (Alderson, Sutcliffe, & Curtis, 2006). In recognition of this, the Chief Medical Officer has recently called for there to be more SDM in services for young people with long-term conditions (Chief Medical Officer, 2013).

While the mechanisms by which SDM can enhance patient experience and outcomes are not yet fully clarified, research in this area is developing. It would appear that one way SDM can enhance outcomes is by promoting self-efficacy (Da Silva, 2012; Joosten, De Jong, de Weert-van Oene, Sensky, & van der Staak, 2011). SDM enables patients to feel more motivated, take a more active role in their treatment, and improve health behaviors (Bodenheimer, MacGregor, & Sharifi, 2005). Although the detail of the mechanisms may not be fully elucidated, there is increasing evidence of the range of therapeutic benefits, including increased self-esteem, improved self-management and health coping strategies, greater adherence to treatment, improved outcomes, and improved support for a successful transition into adulthood (Costello, 2003; Drake, Cimpean, & Torrey, 2009; Hibbard & Gilburt, 2014; Huffine, 2005).

Despite the many benefits of SDM that have been observed across different health settings, its implementation in day-to-day practice can be challenging (Legare, Ratte, Gravel, & Graham, 2008). Studies exploring the barriers and facilitators to the implementation of SDM have found many factors to be involved, from the characteristics of the patient and professional, to the way they interact, the type of decision that has to be made and the culture and infrastructure of the service (Friedberg, Van Busum, Wexler, Bowen, & Schneider, 2013; Kraetschmer, Sharpe, Urowitz, & Deber, 2004; Lown, Clark, & Hanson, 2009; Shepherd, Tattersall, & Butow, 2008). Strong leadership and an adaptive organizational culture, alongside practitioner engagement, are crucial to implementing SDM successfully (Allaire, Labrecque, Giguere, Gagnon, & Legare, 2012; Reed, Conrad, Hernandez, Watts, & Marcus-Smith, 2012). Specific facilitators of the implementation of SDM in general health contexts include use of automatic prompts for practitioners (Friedberg et al., 2013), allowing extra time for decisions to be made, involving family members and other members of the treatment team in discussions (Shepherd et al., 2008), and addressing the power balance between service users and practitioners (Lown et al., 2009).

To date, there is a paucity of research exploring implementation of SDM in Child and Adolescent Mental Health Services (CAMHS). The context of CAMHS raises particular challenges. CAMHS interventions may involve complex conversations with young children, a series of sessions within the context of an on-going relationship (rather than a single decision point) and balancing multiple perspectives and objectives (e.g. child, parents, and other stakeholders, such as social workers, general practitioners (GPs), or schools).

In addition, there are challenges in terms of the perceived issues in relation to risk management for vulnerable young people who may be in states of high distress and where decisions have to be considered in the light of safeguarding, duty of care, and consideration of overall wellbeing. It is interesting to note in this regard that the research from physical health settings exploring children’s experiences and views of decision making about their hospital care found that they wanted to be consulted and involved in decisions about their care and treatment, and to have their opinions respected. Children appeared to use active information seeking to cope with being in hospital.
Information about illness and treatments and inclusion in decisions helped children to feel actively involved and in control of their care, treated as a person with rights and better prepared for treatment or surgery. They also found information about risks reassuring rather than upsetting (Coyne, 2006).

The objective of this study was to explore and understand the professional’s experience during the process of implementation of SDM in CAMHS, with a particular focus on describing the clinician-related facilitators and to understand their states of mind clinicians may experience when engaging with SDM.

**Methods**

**Setting for the study**

This study was part of a larger project: Closing the Gap: Shared Decision Making in Child and Adolescent Mental Health Services (Hoong, Heathfield, Fitzpatrick & Benson, 2014). Four CAMHS were selected to be part of the project on the basis of their interest in further developing their already innovative practices in SDM. The selected services included inpatient and outpatient services from across the United Kingdom (see Table 1 for more information about the services involved).

Professionals from the four sites were encouraged to try a range of tools to support SDM. Across two years, they received regular cross-site learning events (about one every 3 months) delivered by the Closing the Gap team, which included provision of information and materials, group discussions, and action learning sets. Professionals were also supported in implementation of approach and use of these tools via regular site meetings and phone and email guidance.

**Participants and procedure**

A total of 23 professionals (psychiatrists, psychologists, nurses, family therapists, social workers, play therapists) across the four CAMHS clinics were involved in the project. These clinicians were experienced in working in CAMHS and had volunteered to trial aspects of using SDM as part of

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**Table 1.** Details of participating CAMHS teams.

<table>
<thead>
<tr>
<th>CAMHS: Child and Adolescent Mental Health Services; PDSA: plan-do-study-act; OCD: obsessive compulsive disorder.</th>
<th>Most frequent types of problems where evidence of use in PDSA reports</th>
<th>Age range of Children and Young People (CYP) worked with as reflected in PDSA reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient service</td>
<td>Anxiety, autistic spectrum, eating disorders, and deliberate self-harm</td>
<td>6–18 years (most frequent age range was from 13 to 16 years)</td>
</tr>
<tr>
<td>Community CAMHS (including learning disabilities)</td>
<td>Anxiety, OCD, deliberate self-harm, and learning disabilities</td>
<td>7–17 years (most frequent age range was from 14 to 17 years)</td>
</tr>
<tr>
<td>Outreach team</td>
<td>Anxiety, low mood, anger and deliberate self-harm</td>
<td>7–18 years (most frequent age range was from 14 to 17 years)</td>
</tr>
<tr>
<td>Forensic inpatient unit</td>
<td>Complex mental health problems (e.g. attachment problems, eating disorders, psychotic symptoms). Young people pose a risk to themselves or others, are detained under the Mental Health Act, and may be subject to Ministry of Justice restrictions.</td>
<td>12–18 years (most frequent age range was from 14 to 17 years)</td>
</tr>
</tbody>
</table>
The clinicians completed plan-do-study-act (PDSA) log books (see Figure 1), which were created especially for the project to capture learning from implementation of tools and approaches to support SDM.

Each clinician was given a PDSA log book to record their experience of trialling different tools and approaches to SDM. They were instructed to complete a PDSA in the log book every time they tried an aspect of SDM practice. Once the log book was complete, it was returned to the central team and new log books were issued as required. Over the course of the project, 307 PDSA forms were completed (see Table 2).

Data analysis

The content of the PDSA forms was transcribed and inputted into Atlas.Ti (a qualitative software analysis program) to be analysed using Framework Analysis (Ritchie & Lewis, 2003). Framework Analysis is an approach to qualitative data analysis developed for applied policy research. The framework for this study was created through an iterative and systematic process of coding, sorting, charting, and interpreting data. The key states were as follows:

1. Familiarization. In order to become familiar with the data, three researchers read all the data and made annotations to start identifying emerging themes.
2. Identifying a thematic framework. A total of 100 PDSA forms were analysed together with the notes from the previous stage in order to identify the key issues and emerging themes. An index of categories was created and 20 PDSAs were randomly selected to test whether the data fit these categories.
3. **Indexing.** Once the categories had been agreed, all 307 forms were coded on the Atlas.Ti database, using this framework.

4. **Charting.** One table was created for each category. All the information was sorted by categories and by participant in order to facilitate interpretation, and at this stage, minor changes were made to the framework (e.g. the category ‘admin burden’ only had one quote and therefore was removed from the index).

5. **Mapping and interpretation.** At this stage, the research team explored all the data in the various charts and identified facilitators to the implementation of SDM, organized under two main domains, each with a number of sub-categories. These form the basis for the findings of the study, which are reported below.

### Results

**States of implementation**

Data analysis suggested that when attempting to implement SDM in daily practice, there are three different states that professionals can experience: apprehension, feeling clumsy or “clunky,” and integrated into practice. Although there was some indication that on occasion there might be a progression through the states from apprehension through to integration (see Figure 2), since many of the PDSAs were undated and anonymous it was not possible to chart individual clinician journeys through the states. It may be that people felt the different states at different times or contexts, or moved back and forth between them.

**Apprehension.** In this state or stage, professionals considered introducing changes to their practice but seemed to feel reluctant to put them into practice. Professionals seemed to be worried about the consequences of changing practice, aware of the possible risks, and conscious of why it might not work.

CAMHS professionals tend to be understandably protective of young people and SDM may have seemed to contain risks, thereby making them hesitant to try something different. It was not possible to determine how far the sense of risk related to concerns about the ethical implications regarding young people’s capacity for some shared decisions or was a more general concern about trying something new and being unsure of the impact.

Professionals in this state will consider trying the new approach but may end up procrastinating or deciding not to proceed, as they might not feel comfortable with it. One clinician wrote:

I wanted to do questions regarding feeling listened to etc. (feedback). Unable to ask as felt inappropriate . . . too high levels of upset by client . . . needs different approach. When calmer/less crisis I will ask questions. (PDSA No. 80)

<table>
<thead>
<tr>
<th>Number of professionals involved in completing PDSAs</th>
<th>Number of PDSAs submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient service</td>
<td>4</td>
</tr>
<tr>
<td>Community CAMHS (including learning disabilities)</td>
<td>5</td>
</tr>
<tr>
<td>Outreach team</td>
<td>11</td>
</tr>
<tr>
<td>Forensic Inpatient unit</td>
<td>3</td>
</tr>
</tbody>
</table>

PDSA: plan-do-study-act; CAMHS: Child and Adolescent Mental Health Services.
When coding these data we initially considered this flexible usage of the approach; it was later noted that this PDSA repeatedly reported reasons not to introduce SDM. Towards the end of the PDSA booklet, this clinician reported that, having begun using some of the SDM materials, she now found it helpful and wished she had made more use of it earlier. We therefore considered the earlier entry to be an example of ‘apprehension’ as a potential inhibitor of putting the approach into practice.

*Feeling “clunky.”* During this state, clinicians appear to be confident enough to actively try to put SDM into practice even though they still feel clumsy or unskilled. A certain amount of time might be required to adjust usual practice to the new approach. This feeling ‘clunky’ might include not knowing how to introduce and explain the approach, or forgetting specific actions or parts of the process. For example:

I wanted to plan goals, with the young person. Help them scale the goals and ask them to answer the 4 questions about how the session went. I found it difficult asking the young person to answer these questions in front of me. I handed her a sheet but then I realized that I didn’t have a chance to do anything about those. I will look at the answers to the 4 questions while the young person is still with me so that I can address any issues in the session. I am just not sure how honest the YP can be answering in front of me. (PDSA No. 14)

Forgot to do 4 feedback questions. Should do 4 questions even if not seeing the person again. Remember 4 questions! (PDSA No. 44)

*Integrated in practice.* Finally, some professionals felt they had found the best way to incorporate SDM in the way they work, with it becoming a natural approach for them and part of their usual practice. This was normally combined with the children and young people getting used to the new approach and feeling confident with it. The existence of both factors is probably required to completely integrate SDM in practice:

Discussed client’s goals in context of how it would be useful to spend our time together and what client would like to achieve/ what she’s motivated to do. It felt like a natural part of the conversation and a way of focusing what she wants to achieve as well as a way for me to find out what motivates her. (PDSA No. 184)
. . . Went well. YP used to the process. Seems to work to explain the feedback sheet and then for each session afterwards just hand it to the YP to fill in. (PDSA No. 61)

**Clinician-related facilitators to implementation**

Three key clinician attitudes and behaviors emerged as central to the successful implementation of SDM: effort, trust, and flexibility.

**Effort.** Clinicians reported that the implementation of SDM required extra effort, beyond what they would typically do. One key element of ‘making an effort’ was going the extra mile to invite and encourage children to express their views. Examples of this as part of good SDM practice included prompting difficult discussions, helping young people to recognize their role in change, allowing them to be in control, using drawings and graphs to make information accessible, encouraging them to express their opinions and persevering when they found it difficult to be involved. Examples of this in the PDSA logbooks included the following:

She spent 45 minutes drawing obscene pictures and refusing to engage. Then started drawing small goals of wanting her make up and some leave. Need to wait, use humor before YP could express goals. We want to try to see if we can broaden the goal to a shared activity? (PDSA No. 97)

Persevere with completing care plans with young people even when I feel they are resistant to it. Perhaps these are the young people who most need to be involved in clarifying their problem and what they want . . . (PDSA No. 237)

Professionals wrote about the need to be prepared to work at the client’s pace to reach genuine shared decisions, and the importance of giving them time and space to think, reflect and express their opinion. They described the need to be prepared to put their agenda to one side and allow young people to share their own concerns. In order to do this, they wrote about the need to ‘give clients time and space to reflect on the question,’ or to ‘not rush—work at client’s pace.’ Another wrote:

Spend more time checking that client really understood. Double check for queries, questions. (PDSA No. 151)

In encouraging service users to express what they think and giving them more information and time to reflect on and discuss the process of treatment, clinicians identified that this might take a considerable portion of the time in sessions. Clinicians found that sometimes they had to refocus the session in order to move forward with the treatment, especially when trying to agree what they wanted to work on:

Initial assessment—use scaling measures on assessment to agree goals of work . . . had to pin down due to family having a lot to say. (PDSA No. 5)

Need to agree each session what mum/ family want to focus on at start and acknowledge we can’t focus on everything. (PDSA No. 243)

**Trust.** Trusting young people to be involved in meaningful ways about decisions about their care emerged as a key theme. For example, one clinician wrote,

I let child lead the session to allow her to feel in control and build trust. Child was able to mark on visual tool and able to state where she thought others might perceive her to be. (PDSA No. 205)
Another clinician described how she tried to support a young person to express thoughts and feelings that the clinician herself might not find easy or even agree with, and that this was part of SDM:

I have been encouraging her to feel confident to voice her opinions. Today she said that she did not want to continue seeing me. This was positive step for her and we agreed to break from sessions whilst some work with XX CAMHS service happened, and agreed to meet after this to review and close to me. (PDSA No. 219)

Trust and openness seemed especially important when dealing explicitly with the issues of deciding whether or not to attend the service at all. One clinician commented:

I talked with YP about options for support and acknowledged with her that she could choose not to seek help—as she finds it very hard/relevant to meet. We talked about options for self-help. The session was very hard. But by being open with her about discomfort with the help and her reluctance to meet we were able to talk about her rights choices about CAMHS support. (PDSA No.110)

Another clinician wrote:

Client made decision to engage in therapy after his exams. He acknowledged that exam stress could exacerbate his symptoms but was willing to take the risk of waiting. Informed him that I could respect his decision but it was his responsibility to contact me after exams. He agreed. He acknowledged that he may be delaying the inevitable but seemed relieved that as a professional I was not going to side with his father. The expectation was that he would be pushed to start therapy now. I feel he will be ready for change as he is more in control of that decision. I will offer him appointments after his exams. (PDSA No. 226)

Clinicians commented on the need to balance trust in the young person with the views and hopes of both young people and parents or carers. This could involve having to compromise over the format of the sessions, balancing how much time one gave to each member of the family, discussing who will be in the session, agreeing what the problem is and so on. Examples from the PDSA log books showed that this was not always easy or straight-forward:

It was good to have a clear goal. I wasn’t sure whether to include Mum’s goal as although it would be a positive thing for the young person, he’s not that interested! (PDSA No. 43)

Session was frequently interrupted by mum answering for client. I didn’t get a full understanding of client’s own perspective. I plan to meet with client alone (without mum present). Arrange separate times for mum to air her own worries etc. (PDSA No. 188)

**Flexibility.** In CAMHS, users vary widely across services and sessions in terms of maturity or developmental stage. For example, younger children or children with developmental problem such as a learning disability (LD) or autism spectrum disorder (ASD) will need different explanations in order to understand the information and to participate in decisions about their care (e.g. pictures, drawings, diagrams). Analysis of the PDSAs suggested that it is essential that clinicians find creative ways of adapting tools and procedures to the specific needs of young people and their families. Some examples given of how to adapt tools to specific needs are using drawings instead of numbers in scales, using different colors to differentiate parts of the scale, using diagrams to explain options for care or services available, enhancing communication with pictures and visual tools, and allowing young people to take the information home so they have time to understand and process. For example, one clinician wrote in her PDSA:
As this YP has LD she finds it hard to use number scales. She will pick a number but then change her mind/ not really grasp what it means. Didn’t work. It might be useful to have picture versions for people with LD - maybe faces up/down. (PDSA No. 45)

Flexibility also included recognizing when using tools was not appropriate, or knowing when they might have to be used in different ways in order to be meaningful. For example, some young people struggled to set goals and write them on paper, but they were more able to express their hopes for the future during conversation. In these cases, clinicians did not insist on completing the form and tried to find alternative ways of exploring the young person’s goals. Flexibility was also needed when some questions from a specific tool were not appropriate for a particular session, and in that case clinicians adapted the questions to best fit the situation. Also, some professionals decided to use some tools, like the care plan, with the parents or carers if the young person was not interested at that time. Overall, it seems to be more productive to remain flexible and to not be ruled by the tool when making decisions. As one clinician put it:

When asking for feedback I changed last question to: ideas for what to do over next week. Previously with this patient rated low for that question—thought “future” too far. (PDSA No. 200)

Clinicians had to use their judgment and be flexible in order to find the best moment to introduce these discussions and to involve the user in these decisions. One clinician wrote;

Planned to use ‘option cards’ towards the end of choice appointment. Young person disclosed he witnessed a very traumatic event. Young person more concerned about impact on his mum, his relationship with her, felt inappropriate to use cards. Importance of listening to young person needs/choices. Young person was in this instance able to articulate what he wanted/ needed from CAMHS without choice cards. (PDSA No. 255)

**Discussion and conclusion**

The CAMHS context involves specific challenges: SDM needs to be done with children and young people, who are unlikely to be used to making decisions about their care and may be in vulnerable states and complex situations where safeguarding issues may also need consideration. They may also be with their parents, so different expectations need to be managed. Our study suggests that clinicians may feel apprehensive towards the approach and may experience first attempts as ‘clunky’ before moving to an experience of ‘integration’; it may also be that clinicians move back and forth between these feelings, according to the circumstances and situation with a particular young person.

While the study did not itself elicit young people’s views, there is existing evidence that SDM supports, among wider benefits, self-efficacy and self-esteem (e.g. Costello, 2003; Da Silva, 2012; Huffine, 2005; Joosten et al., 2011). The clinician reports suggested that SDM allowed young people to be more involved in decision making, which allowed them to make more explicit choices. This was particularly striking in relation to choices about session times and whether to come to sessions or not, with clinicians commenting that this allowed young people to make the decision not to come or to postpone a meeting until after other important events in their lives (such as exams), rather than just not showing up.

This study also suggested that implementation of SDM in CAMHS requires key positive clinician behaviors, including preparedness to put in effort, trust in young people, and willingness to use the approach flexibly.
Limitations

The number of clinicians taking part in this project was small, and they may not be representative of clinicians generally. Because this study was part of a quality improvement project, there were also some limitations in the approach to data collection, as the log books were not uniquely identified and could not be linked to individual clinician development. Moreover, those involved in the data analysis have also been involved in developing the SDM materials, so there was a risk that our analysis would overlook more negative feedback; the use of a systematic method of qualitative data analysis, and checks by other coders, was used to try and address this potential risk. The findings from this study should therefore be used cautiously, but can be the basis for further examination of SDM in the context of CAMHS.

Practice implications

If SDM is to become a reality in CAMHS, more detailed consideration is needed to understand the factors that may prevent CAMHS professionals from implementing SDM. More research is needed to fully understand this, but there appear to be themes that are worthy of further exploration:

1. **Resource issues.** SDM in CAMHS is effortful and takes time to integrate into practice. This is a potential barrier to implementation, particularly at a time when many CAMHS are experiencing reduced resources and increasing referrals putting pressure on clinicians’ time to adapt to a ‘new’ approach. While tools may help encourage attempts to develop SDM practice, clinicians need support to be allowed to use the tools flexibly to ensure they feel able to move from a state of apprehension, through a sense of feeling ‘clunky’, to integration in practice. The initial apprehension clinicians report is perhaps not surprising given that implementing SDM requires clinicians to make changes to their practice and they might feel worried about the consequences of those changes.

2. **Protection issues.** SDM, done well, requires clinicians to share information with young people, to equip them with the facts to make an informed judgment and to understand the consequences of a decision. Clinicians may feel a need to protect service users from the information and the SDM approach could be seen as therapeutically risky; a burden to protect vulnerable young people from. However, once adopted, we found no evidence in this study of clinicians reporting additional risk or adverse events as a result of use of SDM approaches or tools. Indeed, there was some evidence that allowing young people to be part of decision making actually made management of key decisions, such as session attendance, more explicit and planned and therefore less risky.

3. **Expertise issues.** SDM requires some handing over of control of therapy to the young people and families with whom clinicians work. This in itself requires adaptation on the part of the clinician. Clinical training is geared towards the production of ‘expert professionals’ who use their expertise in benign ways to provide the best, highly skilled, evidence-based interventions. Sharing the decisions with young people and families, who are perceived as ‘less expert’ in mental health and therapy, may be perceived as risking less good, less expert, and less effective, decisions being made. At its extreme, SDM can be misperceived as a handing over all control to the client; a total adoption of the ‘customer is always right.’ This can lead to some clinicians feeling they cannot share their views based on their own expertise and training. This is not SDM. SDM pools the expertise of the therapist and the service user and leads to better, more effective interventions than professional judgment alone (Frueh, Ford, Elhai, & Grubaugh, 2012; Weisz et al., 2012).
At this stage, it is crucial that managers of the service encourage the initiative and provide support to the clinicians trying to implement the new approach. If professionals feel supported and encouraged, they are more likely to take the risk and try a new approach. If SDM leads to positive results, the professional’s confidence will increase, as will the chance of them introducing more changes to their practice.

In order for SDM to be integrated into practice, clinicians are likely to need time, support, positive feedback, perseverance, and practice along with reassurance that feeling clunky or clumsy may be a necessary part of the process of learning a new skill. As with all developments in a clinical setting, this study suggests that professionals are most likely to embrace new approaches when they have direct experience of the benefits of it to their work with children and young people.

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**Author biographies**

**Neus Abrines-Jaume** has worked across several CAMHS service improvement initiatives and is currently working on a two-year MRC-funded project: Children’s Health State Preferences Learnt through Animation (CHILDSPLA). She is a Lecturer in Clinical Psychology with a background in clinical child psychology.

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**Katherine Hopkins** is a Research Associate in at UCL, primarily working for the Research Design Service London, providing support to healthcare researchers at all stages of the research design process. At the time of writing, she was an Improvement Fellow at the Anna Freud Centre, managing Department of Health funded projects that aimed to promote best practice in the Child and Adolescent Mental Health Service (CAMHS).

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Kate Martin is the Director of Common Room Consulting Ltd., a consultancy that works to connect the experience and expertise of children, young people, practitioners, researchers and policymakers across disability and mental health. Kate is a PhD student at the Institute of Education, researching shared decision making in young people’s mental health care.

Duncan Law is a Consultant Clinical Psychologist with over 25 years of experience in the NHS, voluntary sector and higher education. He is the Professional Lead for Psychological Services (CAMHS) for the Hertfordshire Partnership NHS Foundation Trust and the Clinical Lead for CYP-IAPT London & SE Learning Collaborative at the Anna Freud Centre. Duncan’s interests lie in collaborative practice, Shared Decision Making (SDM) and authentic participation, in Child & Adolescent Mental Health.

Miranda Wolpert is founder and director of the Evidence Based practice Unit (EBPU). Part of both Anna Freud Centre and University College London, EBPU is committed to research and develop approaches for the benefit of youth mental health. Miranda is Chair of the Outcomes Research Consortium (CORC), a collaboration of child and adolescent mental health services in England committed to using routine outcome evaluation to enhance service quality. Miranda led the Health Foundation funded work that this article draws on.