Shared roads, shared risks: understanding the needs of youth with severe and enduring mental health problems

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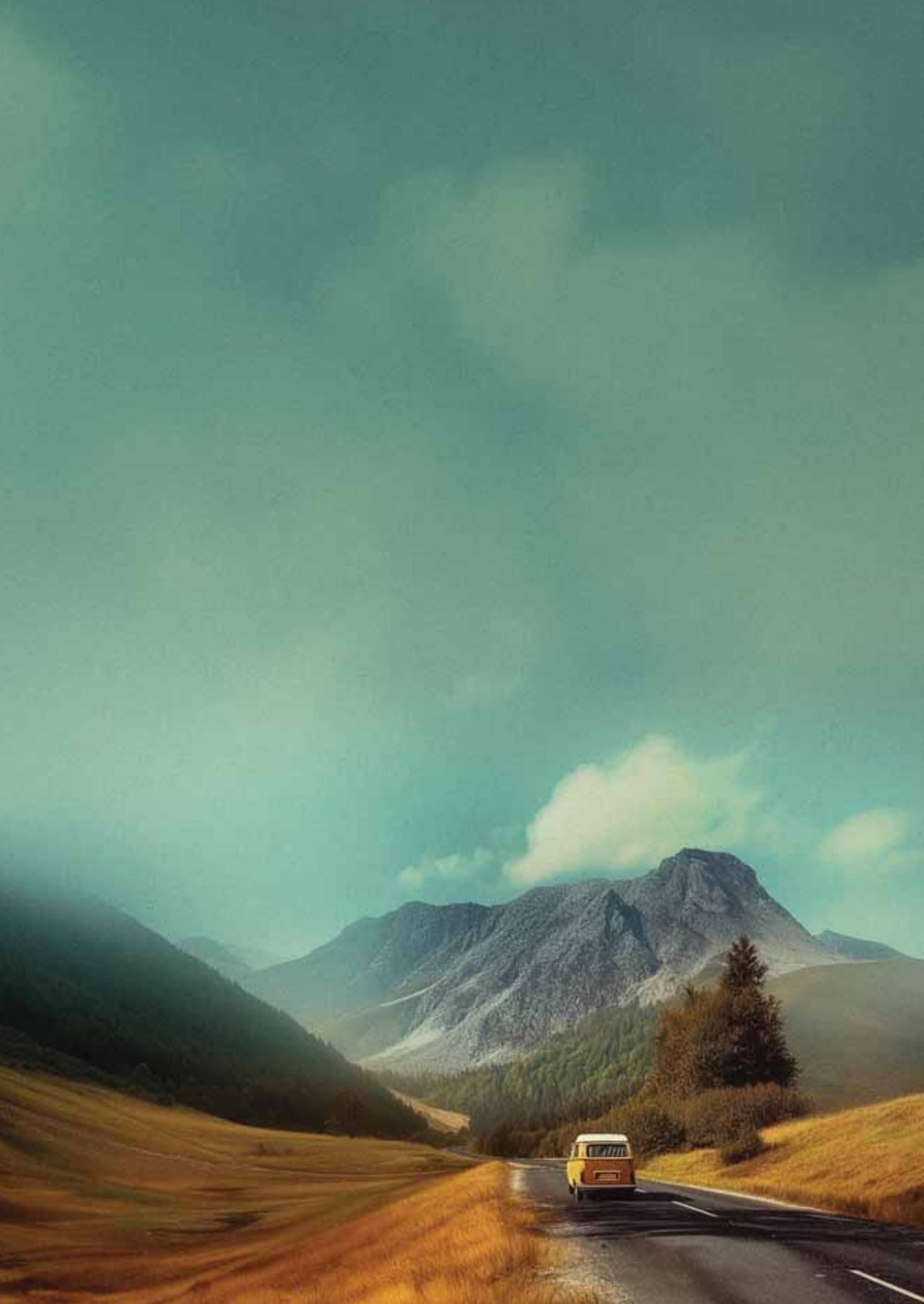

Chapter 5

Balancing autonomy and safety in care for youth with severe and enduring mental health problems

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Under review:
European Child & Adolescent Psychiatry, 2025

Abstract

Balancing autonomy and safety for youth with severe and enduring mental health problems (SEMHP) is a major challenge in (residential) child and adolescent psychiatry (CAP). While autonomy supports engagement and recovery, high-risk behaviors such as suicidality often necessitate safety measures that restrict autonomy. These conflicting priorities lead to clinical dilemmas and inconsistencies in care. To provide a nuanced understanding and enhance clinical support for youth with SEMHP, this study explores how autonomy and safety are understood and negotiated in residential CAP from the perspectives of youth, caregivers, and practitioners. In this qualitative study, we conducted two focus groups and eleven semi-structured interviews, involving youth with SEMHP (n = 7), practitioners (n = 8), and caregivers (n = 6). A reflexive thematic analysis was applied, and perspectives were compared. Autonomy and safety emerged as deeply interrelated concepts. Three main categories were deducted: (1) Foundation for safety and autonomy, (2) Regulation of safety and autonomy, and (3) Tensions and risks. Youth highlighted the need for relational proximity, trust, and shared decision-making, while practitioners emphasized boundaries and procedures. Caregivers expressed varied views, often evolving over time. These differences can lead to tensions, particularly in high-risk situations, where autonomy and safety are difficult to uphold simultaneously. Balancing autonomy and safety requires staying connected to support gradual growth within a predictable and supportive care environment. Particularly in high-risk situations, maintaining a relationship-centered approach, involving youth and caregivers in decisions, and creating space to slow down are key to fostering safety and autonomy in residential CAP.

Introduction

In residential child and adolescent psychiatry (CAP) facilities, in which youth with severe and enduring mental health problems (SEMHP) are admitted, autonomy and safety of these youth are often at odds with one another (Inspectie Gezondheidszorg en Jeugd, 2022). While experiencing autonomy is essential for achieving recovery and promoting a sense of self-agency (Ng et al., 2012), concerns among caregivers and treatment providers about youth posing a risk to themselves or others, often result in the restriction of autonomy (Hendin, 1981; Roy et al., 2021). This creates tension, as the need to protect youth can conflict with the long-term benefits of exercising autonomy. This tension is particularly the case in youth with SEMHP, as these youth display high-risk behaviors such as self-harm, suicidal behavior, aggression, and disordered eating (Bansema et al., 2024; de Soet, Vermeiren, et al., 2023). Moreover, providing effective treatment to this group of youth poses a challenge, given the high rates of treatment failure (Sellers et al., 2019). A potential point of tension lies in differing perspectives among youth, caregivers, and practitioners regarding the level of autonomy for youth with SEMHP (de Soet, Nooteboom, et al., 2023). The present explorative study therefore aims to contribute to a better understanding of how autonomy and safety are perceived and navigated by youth, caregivers, and practitioners within residential CAP facilities.

According to the 'Convention on the Rights of the Child', all children have the right to express their views on matters affecting them, and adults have the responsibility to listen and take these views seriously (Cashmore, 2002; United Nations, 1989). The right to be heard is closely linked to a child's autonomy: their ability to participate in decisions about their own lives. However, applying these rights becomes complicated when youth's behavior poses a danger to themselves or others (de Valk et al., 2016). Moreover, adolescence is a critical period for developing autonomy and competence, making it essential for treatment facilities to provide opportunities for youth to exercise choice and control in their care (Benjamins, de Vet, Jordaan, & Haveman-Nies, 2023; Stocker, Théron, & Revet, 2023). According to the Self-Determination Theory (Ryan & Deci, 2000), autonomy, competence, and relatedness are core psychological needs, and their deprivation during residential admissions can negatively affect motivation, self-esteem, and recovery (van Dorp, Nijhof, et al., 2021; de Valk et al., 2016; Meinema, 2017; Ryan, Patrick, Deci, & Williams, 2008). This highlights the need to foster autonomy even within safety-oriented settings, such as residential CAP facilities, aligning with the principles of the recovery movement, which emphasizes self-determination and ownership of care decisions (Meinema, 2017).

For youth with SEMHP, autonomy can be a complex and sensitive issue, particularly in residential facilities where maintaining safety for both youth and practitioners is of importance. In these environments, restrictive measures are all too often employed to prevent harm (de Soet, Nooteboom, et al., 2023; de Valk et al., 2016; Inspectie Gezondheidszorg en Jeugd, 2022; Van de Koppel et al., 2022). The tension is particularly heightened in the context of high-risk behaviors, where a fear of suicide among treatment providers often leads to a more managerial approach, focused on ensuring safety (Kaijadoe et al., 2023). In addition, out of parental concern, caregivers often request containment measures for their child in care (So et al., 2024). This puts even more pressure on practitioners, often leading to restrictive custodial crisis measures. Consequently, the youth's sense of autonomy is often compromised, impacting their treatment experience, engagement, and long-term recovery (Ryan & Deci, 2000; Stein & Dumaret, 2011).

Safety in CAP is multidimensional, encompassing physical, procedural, and relational security (Collins & Davies, 2005). While physical and procedural security – such as fences, restrictions of belongings, or visitor policies – are often applied to contain high-risk behavior (Clausen, Larsen, Bulik, & Petersen, 2018; Inspectie Gezondheidszorg en Jeugd, 2022), relational security – understanding and connecting with patients – can play a vital role as a protective factor in CAP. Research shows that strong relational security can reduce risk, strengthen engagement, and improve treatment outcomes (Souverein et al., 2023). However, for practitioners trained to actively intervene rather than step back, "ceding authority" over youth's choices may pose significant challenges in maintaining relational security (de Soet, Nooteboom, et al., 2023; Meinema, 2017). These considerations underscore the need to better understand how safety is perceived and maintained in practice.

Previous qualitative research indicates a disparity in how autonomy is understood (Van Bijleveld, Dedding, & Bunders-Aelen, 2014). Professionals often frame youth autonomy in terms of participation, seeing it primarily as a means to gain cooperation or compliance, while youth emphasize the importance of being heard and taken seriously. Additionally, although the role of caregivers in shaping autonomy and safety within residential CAP facilities has been largely overlooked in previous research, studies on emergency consultations suggest that caregivers do impact these dynamics crucially (So et al., 2024). Moreover, integrating multiple perspectives is essential to foster a treatment environment that respects the rights and enhances the well-being of youth with SEMHP, their caregivers, and practitioners working in CAP. While some existing literature touches on these issues, it is often in the form of commentary or opinion pieces (Michaud, Blum, Benaroyo, Zermatten,

& Baltag, 2015; Stocker et al., 2023), leaving a gap in empirically based studies that incorporate the views of youth, caregivers, and practitioners. This study aims to fill this gap by systematically exploring how autonomy and safety are understood and navigated within residential CAP settings, using a qualitative approach to offer a nuanced understanding of this complex issue, and thereby better tailor CAP care to youth's needs.

Method

Study setting and design

This qualitative study is part of 'DevelopRoad', a research project focused on understanding the characteristics and needs of youth with SEMHP within CAP in the Netherlands. The project received ethical review from the Medical Ethics Review Board of Leiden University Medical Center (LUMC), which determined it was not subject to the WMO and complies with the Dutch Code of Conduct for Research Integrity (reference number: N21.094). The research team, based at LUMC Curium (a CAP facility in the Netherlands), included researchers, patient experts, and CAP specialists.

A grounded theory methodology was applied for the overall 'DevelopRoad' project (Strauss & Corbin, 1994). This qualitative approach supports exploration in areas with limited prior research, establishing a framework across multiple complementary studies.

For this specific study, we initially selected focus groups as our primary research method, as this approach offers more than individual perspectives; it facilitates an exploration of how participants think and the reasoning behind their views. Through group discussions, focus groups create a dynamic environment where participants can share diverse perspectives, explore motivations, and offer insights into the complexities of their attitudes and needs (Kitzinger, 1995). However, logistical challenges, such as coordinating suitable meeting times, along with participants' reluctance - particularly among youth and caregivers who felt apprehensive about group settings - made it difficult to assemble enough participants for the focus groups. Previous research with this population showed that both youth and caregivers often experience a high level of helplessness and that tailoring is key, not only in treatment practices but also in the way we approach them in research, to prevent them from falling between the cracks of health care and research (de Soet, Nooteboom, et al., 2023). Therefore, we introduced individual interviews alongside focus groups, allowing for flexibility and encouraging broader participation of practitioners, caregivers, and youth. To ensure transparency in reporting the sequence of events, the checklist from the Consolidated Criteria

for Reporting Qualitative Research (COREQ) was applied (see Appendix A) (Tong et al., 2007).

Text box 1: The context of residential CAP facilities in the Netherlands
In the Netherlands, youth with SEMHP may be admitted to residential CAP facilities. These facilities are generally open settings, but have the authority to temporarily restrict youth's freedom in cases of severe risk, such as self-harm or aggression. The use of coercive measures (e.g., seclusion, physical restraint, or restriction of movement or contact) is subject to legal regulation under the Dutch Compulsory Mental Healthcare Act (Wet verplichte ggz, Wvggz), which allows for such measures in cases of acute danger to the individual or their surroundings, and only if less invasive alternatives are insufficient. In addition, some CAP facilities apply institutional protocols for restrictive measures within voluntary treatment settings, though the boundaries between formal coercion and informal pressure can be difficult to define in practice. The Dutch Health and Youth Care Inspectorate (Inspectie gezondheidszorg en Jeugd: IGJ) has noted variability in the use and registration of restrictive measures across open psychiatry facilities, and emphasizes the need for clear documentation, proportionality, and legal justification when applying any restriction of freedom (Inspectie Gezondheidszorg en Jeugd, 2022).

Participants
The DevelopRoad project focuses on youth with SEMHP; defined as youth aged 16 to 25 years who experience or have experienced interrelated and enduring mental health problems requiring (professional) care, and who are currently or have previously received treatment in CAP (de Soet, Nooteboom, et al., 2023). This study included three participant groups: (1) youth with SEMHP, (2) caregivers of youth with SEMHP, and (3) practitioners working with youth with SEMHP in a residential CAP facility. Through this triangulation of participant perspectives, we aimed to compare viewpoints and enhance the credibility of the findings (van Staa & Evers, 2010).

Participants were purposefully selected using a non-random sampling method, focusing on specific criteria that would maximize our understanding of the phenomenon (Onwuegbuzie & Leech, 2007). While we initially aimed for four to eight participants per focus group (Kitzinger, 1995), low response rates led us to supplement the data collection with additional individual interviews. This adjustment ensured a diverse range of perspectives and sufficient depth in the data, enabling a thorough exploration of autonomy and safety in the context of residential CAP.

To be included in this study, participants had to meet the following criteria:

Youth with SEMHP: Youth who met the SEMHP definition above and had experience with residential CAP facilities were eligible. Recruitment was conducted through social media announcements (Instagram and LinkedIn), newsletters, and via the Dutch National Youth Council (Nationale Jeugdraad: NJR), a commission for youth peer support workers. Five youth initially confirmed participation in the focus group, but one participant did not attend. Consequently, one focus group was held with four participants, and three additional youth participants were interviewed individually.

Practitioners: Practitioners working with youth with SEMHP in the residential departments of LUMC Curium (a Dutch CAP facility) were invited. Team leaders in relevant departments distributed information letters to potential participants. A total of six practitioners participated in a focus group, and two additional practitioners were interviewed individually.

Caregivers: Caregivers, defined as parents and/or legal guardians of youth with SEMHP (as defined above), whose child had experience in residential CAP, were eligible for the study. They were recruited through social media announcements and newsletters. Due to a low response rate for the focus groups, we conducted individual interviews with caregivers. A total of six caregivers participated in the interviews.

Project information was shared via information letters sent by email, which included details about the overall research project, practical information on the focus groups or interviews, and agreements regarding the use and secure storage of study data. Potential participants were then contacted by email. All eligible participants provided informed consent prior to the focus group or interview.

Procedure

The focus group manual was collaboratively developed through brainstorming sessions involving a youth peer support worker from the research project, a child psychiatrist, and other experts associated with the research team (one psychiatrist and two (clinical) psychologists). These two sessions were grounded in insights from existing literature on autonomy and safety in the broad field of youth care and aimed to refine the research questions and design of the focus groups. The goal was to ensure the research framework was evidence-informed while addressing gaps in the literature. Specifically, the sessions focused on exploring autonomy and safety as both separate and interconnected concepts, emphasizing their relevance in the treatment of youth with severe and enduring mental health problems (SEMHP). Key topics—such as definitions, barriers, facilitators, and responsibilities related

to autonomy and safety—were discussed, analyzed, and incorporated to guide the focus groups and interviews. The final set of questions, detailed in Appendix B, was consistently used across both focus groups and interviews.

The focus groups took place in May 2024 and lasted 73 minutes (youth) and 77 minutes (practitioners). The interviews were held from June to December 2024 and lasted 46 minutes on average (range: 34-61 min). The practitioner focus group was held in person at LUMC Curium, while the focus group with youth participants and the individual interviews were conducted online via Microsoft Teams, to accommodate the practical needs and preferences of the participants. Both focus groups and interviews were facilitated in Dutch by an experienced researcher (RS, female), who led discussions, and a research intern (EK, female), who took detailed field notes throughout the process. Neither researcher knew the participants before the start of the study. All sessions were audio-recorded and transcribed verbatim post-session. The transcripts were pseudonymized and saved on a secure platform of the Leiden University Medical Center. Demographic data were collected from participants before the sessions: via email for the online focus group and interviews, and through a physical questionnaire for the in-person focus group. All participants were offered to add additional information after the focus groups or interviews. One participant (a caregiver) made use of that offer and additional information was incorporated in the transcript. All participants were offered a 20,- euro voucher for their invested time.

Data analysis

The transcripts were imported into Atlas.ti version 23, a software program for qualitative data analysis. A reflexive thematic analysis was conducted, following the approach described by Braun and Clarke (2019). We began with an inductive process, using open coding to identify initial patterns within the data. The focus group transcripts were initially coded independently by three researchers (RS, EK & youth representative SS). During this process, reflexive meetings were held to discuss interpretations and collaboratively develop a shared code tree, thereby reducing individual bias. This finalized code tree was then applied to the remaining interview transcripts. Data saturation - defined as the point at which no new codes were formed and data became redundant - was reached after coding nine transcripts (Saunders et al., 2018). Following open coding, individual quotes were summarized per theme. Similar summarized quotes were then grouped and organized into overarching themes. Throughout the process, differences in perspectives between youth, caregivers, and practitioners were noted and carefully considered during thematic development to ensure that the analysis reflected the diversity of experiences and viewpoints in the data. The final code tree was reviewed and

refined by two researchers (RS and LN) to ensure coherence and thematic clarity.

Results

Demographics

This study included two focus groups (youth: n = 4, practitioners: n = 6) and 11 additional interviews (youth: n = 3, practitioners: n = 2, and caregivers: n = 6). Detailed participant information is provided in Appendix C.

Among the youth participants (1 male, 6 female), most began treatment in CAP around the age of 13 years and were still receiving care at the time of the study. All caregivers were female, consisting of five biological mothers and one adoptive mother. The children they spoke about were all female. Notably, two of these children had passed away due to complications related to their mental health. The practitioner group represented a range of roles, including sociotherapists, psychiatrists, psychomotor therapists, and system therapists. The majority (5 out of 8) worked in residential settings that applied an autonomy-supportive treatment approach. According to youth and caregivers, the mental health issues among the youth included depression, trauma-related problems, eating disorders, autism, and suicidal behavior.

Findings

This study explored how autonomy and safety are understood in residential CAP settings from the perspectives of youth, caregivers, and practitioners. The focus groups and interviews showed that autonomy and safety are highly interrelated constructs. When asked about safety, many participants mentioned autonomy, and vice versa.

Youth primarily associated safety with (physical) warmth, connectedness, and predictability, rather than rules or protocols. Practitioners, in contrast, emphasized boundaries as a means of preventing harm, often facing dilemmas in balancing structure with autonomy. Caregivers showed varying views, however, mostly evolving throughout treatment; they initially supported restrictive measures while later advocating greater autonomy, recognizing that excessive limitations could be counterproductive.

It is worth noting that many participants were inconsistent in their responses regarding autonomy and safety, highlighting the ambiguity of this topic. For example, some participants initially opposed all forms of coercive measures while later expressing uncertainty about whether alternative measures would be feasible if someone, for example were to stop eating.

An overarching observation was that the concept of shared decision-making (SDM) was mentioned across different categories and themes. Because the meaning and role of SDM varied depending on the specific context in which it was discussed, we chose not to present it as a separate theme, but rather to integrate it within the broader contextual findings to do justice to its nuanced application. In practice, SDM often intersected with themes such as trust, responsibility, and managing risk, making it analytically more appropriate to embed it within these themes rather than present it as a standalone theme.

Data analysis resulted in three main categories: (1) Foundation for safety and autonomy, (2) Regulation of safety and autonomy, and (3) Tensions and risks (see Table 1). Below, the key findings are described in more detail.

Table 1. Overview of categories and themes describing autonomy and safety in residential CAP

Category 1. Foundation for safety and autonomy
1.1 Trust
1.2 Proximity and connectedness
1.3 Feeling heard and seen
1.4 Communication
1.5 Continuity and predictability
Category 2. Regulation of safety and autonomy
2.1 Responsibility
2.2 Boundaries
2.3 Team factors
2.4 Privacy
Category 3. Tensions and risks
3.1 Managing risks
3.2 Restrictive measures
3.3 Group dynamics

Category 1. Foundation for safety and autonomy

This category reflects the fundamental conditions that shape both safety and autonomy for youth in residential CAP facilities. Across all participant groups, five themes were deducted: trust, proximity and connectedness, feeling heard and seen, communication, and continuity and predictability.

1.1. Trust

Trust placed in youth by professionals was identified by all participant groups as essential for both safety and autonomy. It is built through professionals being available, reliable, and transparent, as well as by carefully handling sensitive information, respecting boundaries, and maintaining clear communication with both youth and caregivers.

"I experienced a lot of safety with practitioners where I felt that they had trust in me. That they had faith in my recovery. It's really unsafe when you feel like practitioners think, 'Yeah, you're not going to make it.' You just sense that, and that's really unsafe. Whereas the practitioners who had confidence in me - even at points when I didn't – […] gave me something to hold on to." (youth focus group).

Youth emphasized that trust from others directly strengthens their trust in themselves, making it a prerequisite for autonomy. Several youth and caregivers reported feeling a lack of safety when decisions were made without their involvement. Practitioners underscored the need to convey trust by keeping agreements and maintaining confidentiality.

1.2. Proximity and connectedness

Warmth and proximity - whether through people, (stuffed) animals, or small gestures - helped youth feel safe and reduced feelings of isolation.

"Every time I ended up in the emergency room with wounds that needed stitches again. I never forget a nurse who brought me a warm blanket while I was waiting. It's small things like that that really help." (youth1)

Youth felt a lack of safety when professionals withdrew during difficult moments, leaving them feeling abandoned. Practitioners acknowledged the importance of being present and available, particularly in high-stress situations, though they referenced physical proximity less frequently than youth and caregivers. Caregivers valued staying close to their child, including being allowed to stay overnight, and felt a lack of safety when professionals kept them at a distance.

1.3. Feeling heard and seen

Feeling heard and seen was described as fundamental to safety and autonomy. Youth and caregivers reported feeling a lack of safety when they were not taken seriously, were labelled as a problem, or were excluded from decisions. Youth emphasized that not being acknowledged in their experiences felt as a lack of safety. They stressed the importance of speaking openly without

fear of judgment or automatic disclosure to caregivers, as illustrated by the following quote.

"*I've been in care for a long time but have never been able to tell anything.*" *(youth1)*

Practitioners highlighted the role of consistency and a non-judgmental attitude towards youth in creating safety. Caregivers emphasized the need to be heard in their concerns. Being excluded or approached with blame undermined trust and cooperation.

1.4. Communication

All participant groups emphasized transparent communication as essential to safety and autonomy.

"If I wanted to talk about my suicidal thoughts with my psychologist, they would say, 'We're in therapy now. Therapy is about learning to deal with your problems and move on with life.' So, then I would keep it in my head, and it would only get worse. These things need to be discussed openly." (youth3).

Youth expressed a strong need to be involved in decision-making, even in difficult situations**.** Secrecy or lack of information created a sense of powerlessness and distrust**,** while transparency - also about restrictive measures - fostered feelings of safety. Practitioners acknowledged the importance of clear expectations, especially at the start of treatment, though they noted that under pressure, discussions about autonomy and safety sometimes decreased. Caregivers frequently felt excluded from decisions and described secrecy within facilities as contributing to feelings of unsafety.

"When things got tense, professionals became more distant. Suddenly, my daughter would call me saying, 'Mom, this happened, and now something has been taken away from me,' but no one had communicated that to me. I used to be informed, but then suddenly, I wasn't anymore. You could feel the tension in the professionals." (caregiver3)

1.5. Continuity and predictability

Continuity and predictability in care were identified as crucial for both safety and autonomy, particularly by youth and caregivers.

"I always had the feeling that someone was in charge and could decide whether I got more or less autonomy. And sometimes, that decision came completely out of the blue for me." (youth, focus group)

Youth emphasized that unexpected changes or lack of follow-up care led to a lack of safety and increase of distress. Several youth expressed fear of the unknown, particularly when faced with changes in treatment providers or restrictive measures without explanation. Youth need stable relationships with practitioners to build trust, and clear agreements to provide stability, especially during crises. Practitioners acknowledged the importance of continuity but noted that long-term treatment could sometimes hinder autonomy if not carefully managed. Caregivers saw staff stability as essential, with disruptions in care leading to setbacks and loss of trust.

Category 2. Regulation of safety and autonomy
This category explores how safety and autonomy are regulated in daily care, based on the following themes: responsibility, boundaries, team factors, and privacy.

2.1 Responsibility
Responsibility was frequently mentioned as a key aspect of autonomy. Respondents emphasized that youth should be given responsibility in alignment with their capacity to manage it. While many participants stated that youth ultimately hold responsibility for their own safety and recovery, they also highlighted that autonomy cannot be imposed without support, which is the responsibility of practitioners and caregivers. Safety and responsibility are thus shared among youth, practitioners, and caregivers, requiring ongoing reassessment.

"Sometimes I was told, 'The responsibility lies with you', but in reality, that was not the case at all. On the other hand, when I was truly given responsibility, I realized: 'Okay, now it's up to me to change'." (youth, focus group)

"Of course, you always have your own responsibility, but I have found it very difficult at times, especially when I look back at CAP, that responsibility was placed on me at certain moments and as a result, a lot of distance was taken from me. Under the pretext of: 'You are responsible for yourself'." (youth, focus group)

Youth expressed a strong desire to take responsibility, but they stressed the need for guidance. Too much responsibility without support felt like abandonment, while too little responsibility undermined their sense of ownership and could hinder recovery. In that, SDM was seen as essential for maintaining feelings of safety. Practitioners viewed responsibility as a gradual process in which youth eventually take charge of their own lives. However, assessing individual capacity was challenging. Personal responsibility was

emphasized more strongly by practitioners trained in Dialectical Behavior Therapy (DBT). Caregivers wanted to be actively involved in ensuring safety and expected their expertise to be recognized. They also sought support in managing high-risk situations, such as with suicidal behavior, stressing that responsibility should not be shifted entirely onto youth or caregivers alone.

2.2 Boundaries

Boundaries serve as a regulatory tool for both autonomy and safety. Clear agreements, rules, and limitations provide structure and predictability, helping to foster a sense of safety - not only for youth but also for practitioners themselves. Boundaries were most effective when they were collaboratively determined, leaving space for individual differences.

"I think it is important that professionals can say, 'This is going well, I trust this youth.' That they aren't bound by all sorts of rules that force them to do things differently." (youth, focus group)

Youth rarely explicitly mentioned boundaries, however, they frequently emphasized predictability and jointly established agreements. Boundaries only felt safe when communicated warmly and when youth felt they had some influence over decisions. Rigid, imposed boundaries, however, felt like a loss of autonomy. Practitioners consistently emphasized boundaries as a necessary foundation for shaping autonomy in a responsible way, and stressed that unclear boundaries lead to uncertainty. However, balancing structure with flexibility to tailor care to the individual posed a challenge. Caregivers held diverse perspectives on boundaries. Most agreed that boundaries should be clear but not overly rigid. However, one caregiver argued that boundaries should be enforced more strictly, with fewer choices left to youth.

2.3 Team factors

Practitioners exclusively mentioned team dynamics as a critical factor in regulating safety and autonomy. A cohesive, well-trained clinical team that fosters open communication, mutual trust, and collaboration was seen as essential for safe and effective care. Team reflection and ongoing training were particularly emphasized.

"We recently had a change in the team with a different team leader. Then we had to reestablish how we work together. […] If boundaries aren't clear, I notice I struggle more. When things change quickly or we need to act fast, I sometimes feel lost." (practitioner, focus group)

Conversely, instability within the team, high workloads, and inconsistent leadership led to uncertainty, weakening safety frameworks. Practitioners noted that team cohesion directly influenced their confidence in decision-making, affecting the structure and safety they could provide to youth. Youth and caregivers did not explicitly mention team factors, but they emphasized the importance of continuity in staff, indicating that team stability indirectly influenced their sense of safety.

2.4 Privacy

Privacy regulations were primarily discussed by caregivers, who expressed concerns about the restrictive nature of privacy laws. While these laws safeguard youth autonomy, they limited parental involvement in treatment decisions, leading to frustration and uncertainty. Some caregivers felt excluded when privacy laws prevented them from accessing essential information, even when their involvement could contribute to safety. This theme was mentioned by two caregivers, indicating that while privacy concerns were particularly salient for them, other participants may have held similar concerns without explicitly articulating them during the interviews.

Category 3. Tensions and risks

This category highlights the dilemmas and frictions that arise when autonomy and safety are in conflict. It illustrates the complexity of CAP, where autonomy and safety must be continuously negotiated. The themes within this category - managing risks, restrictive measures, and group dynamics - highlight moments when autonomy and safety come into conflict, often in high-risk or emotionally charged situations.

3.1 Managing risks

The tension between autonomy and safety was most evident in high-risk situations, where decisions, for instance about crisis admission after a suicide attempt, carried immediate and significant consequences. While all participant groups generally agreed on the importance of both autonomy and safety, these principles became difficult to uphold in practice, particularly during crises or moments of uncertainty. Participants agreed that managing risks is unavoidable when working with youth with SEMHP.

"If you talk about safety in general, everyone agrees. But when it comes to an actual case where there's a real tension, things become complicated." (practitioner, focus group)

Youth recognized that autonomy involved risks but expressed frustration when self-harming behaviors led to disappointment from practitioners or

withdrawal of support. They stressed the importance of open discussions about risks and felt a lack of safety when autonomy was either denied or abruptly restored without preparation. Practitioners described feeling torn between granting autonomy and ensuring safety, often seeking team support in making difficult decisions. Practitioners noted that caregivers sometimes pushed for restrictive interventions, even when earlier agreements prioritized autonomy. Caregivers described their ongoing fear of suicide or escalation, which often led them to rely on control-based protocols despite recognizing the potentially harmful effect of long-term autonomy loss. Over time, some caregivers found that loosening control could contribute to safety, as they gained a better understanding of their child's needs.

"At first, as parents, we went along with everything, believing that taking away autonomy would make her better. […] And you think, 'if we hadn't done that, would she have survived?' It's an impossible question. I do think; always stay in contact with the youth, and that didn't happen." (caregiver4)

3.2 Restrictive measures

Restrictive measures (e.g., forced hospitalization, restraint, limiting movement, or taking away decision-making rights) led to significant tensions for all participant groups. While intended to ensure safety, these measures often led to distress, frustration, and harm, particularly when youth felt excluded from the decision-making process.

"The first thing they did with my daughter was take away all her autonomy. That's standard practice for eating disorders. But at 12, 13, 14 years old, socializing with peers is everything. When you strip them of everything, their life becomes very, very small. And sometimes, that just makes them sicker." (caregiver4)

Youth reported feeling a lack of safety when restrictions were imposed without explanation or discussion. They wanted to be involved in decisions about restrictive measures and their gradual removal. Some also noted that the sudden ending of restrictive measures could be unsettling, as they lacked preparation or support. Practitioners struggled with ethical dilemmas regarding when to intervene and when to allow autonomy. They also experienced external pressure, for example, from hospital emergency staff who questioned why CAP practitioners did not 'secure' the youth to prevent a suicide attempt.

"I experienced tension when a young person had a severe suicide attempt. It was announced, but the team decided to […] stick to the treatment approach and not impose more restrictions. […] The medical staff at the ICU got involved

and were shocked. They thought; 'You should have secured her. How is it that a child who is known in psychiatry can still get so many pills?" (practitioner1)

Caregivers often supported restrictive measures out of fear, particularly in moments of crisis. However, many later reflected critically on the necessity and impact of those measures, even caregivers whose child had passed away. They observed that long-term restrictions could hinder autonomy and development.

3.3 Group dynamics

Group dynamics within clinical settings were described to have both positive and negative effects on safety. Youth described how competition among peers or exposure to harmful behaviors (e.g., self-harm, eating disorders) could worsen symptoms and complicate recovery. However, they found shared experiences helpful when properly facilitated by practitioners. While this theme was only explicitly discussed by youth and caregivers, it is possible that practitioners were also aware of the effects of group dynamics but did not emphasize them during the focus groups and interviews.

Discussion

Balancing autonomy and safety in residential CAP is a constant and complex challenge, particularly in care for youth with severe and enduring mental health problems (SEMHP). These youth often engage in high-risk behaviors such as self-harm or suicidal behavior, requiring constant risk management from care professionals, often forcing teams to make rapid decisions in ethically and emotionally challenging situations. This study explored how autonomy and safety are understood and navigated within residential CAP from the perspectives of youth, caregivers, and practitioners.

Participants described the foundation for both safety and autonomy as rooted in trust, proximity and connectedness, predictability, and the need for shared decision-making; elements that align closely with the concept of relational security as described by Collins & Davies (Collins & Davies, 2005). Our findings thus show that autonomy and safety are not independent or opposing constructs, but deeply interrelated in practice. Safety is fostered through autonomy, and thus not solely the absence of risk. Likewise, autonomy only holds value within a safe and stable context. These findings align with prior research on the central role of relationships in fostering safety (Johansen, Stuen, Brekke, Jensen, & Landheim, 2024; Souverein et al., 2023).

Across all groups, relationships were seen as essential, with youth, in particular, emphasizing the value of warm, trusting contact with practitioners. Yet, in moments of crisis, stakeholder priorities diverged: practitioners emphasized procedural boundaries, while youth and caregivers valued predictability and inclusion in decision-making. Although some caregivers initially urged professionals to impose safety measures, many later shifted toward supporting greater autonomy of their children. Youth described crisis interventions as unpredictable and disempowering, often driven by professionals' urgency to act out of fear. These findings highlight the importance of involving youth and caregivers in shared decision-making (SDM) during crisis care, such as emergency consultations. While SDM remains underexplored and complex in adolescent mental health due to its multi-stakeholder nature (Sobode, Jegan, Toelen, & Dierickx, 2024), relational approaches hold promise (Barnhoorn-Bos, Mulder, Nooteboom, Meurs, & Vermeiren, 2025). A strong therapeutic relationship may not only support SDM but also help prevent crises from escalating (van Dorp, Nijhof, Popma, & Mulder, 2023). Although no formal evaluation is yet available, preliminary observations from a recent pilot, in which psychologists instead of medical doctors were deployed during evening and weekend crisis shifts, suggest potential benefits, particularly due to their expertise in providing relational safety (Tepe, 2025). Further research is needed to better understand how decisions are made during crises and to explore strategies that enhance transparency and foster collaboration. Notably, several caregivers reported shifts in their perspectives over time, suggesting that peer-support caregivers could play a vital role in guiding and supporting families during crises. Peer-support caregivers may help de-escalate situations and offer valuable insight gained from their own experiences (Hoagwood et al., 2010).

Another key point highlighted in this study is the impact of team dynamics on the perceived safety and autonomy within residential care. Practitioners noted that team changes or high workloads affected the stability of the youth. Similarly, youth and caregivers mentioned that such changes disrupted their sense of predictability, which in turn diminished their feeling of safety. Recent research on force-feeding youth with anorexia nervosa in residential care highlights heightened risks of staff burnout and traumatization (Offringa et al., 2024). Working with youth exhibiting high-risk behaviors can have a profound impact on practitioners, which in turn influences the stability of the team. This leads to a parallel process, where the stability and safety of the youth are closely tied to the stability of the care team. To enhance the sense of safety for youth in residential settings, it is crucial to prioritize team stability and invest in strong supportive relationships, not only between youth and practitioners, but also within care teams. Relational work is just as important

among professionals themselves, and should be actively supported by leadership. Structured forms of reflection, such as intervision and supervision, can help teams process emotionally demanding situations, enhance mutual trust, and sustain a shared vision of care (Koekkoek, van Meijel, Schene, & Hutschemaekers, 2009; Seller-Boersma, Boot, van Oostveen, Jongerden, & van Vugt, 2023). This may help retain staff and mitigate burnout. Budget cuts in healthcare and excessive administrative demands, however, are counterproductive to achieving this goal.

Recently, critical voices have emerged in the Netherlands regarding autonomy-supportive policies implemented in mental health care facilities. While these policies are intended to break the vicious cycle of high-risk behavior by avoiding overly restrictive interventions, a recent survey has raised concerns about a gap between policy intentions and clinical practice (Bureau Lenz - de Wael, 2024). Despite policy guidelines emphasizing tailored care and flexibility to deviate from the policy in situations of acute danger, patients and their caregivers often experienced autonomy-supportive care as inconsistent, shifting between extremes of overprotection and neglect. Our study underscores that promoting autonomy does not mean withdrawing support. Autonomy differs from independency as it highlights the relatedness (e.g., feeling connected) to others, which is a separate component of the Self-Determination Theory (Anderson, 2020). Rather, autonomy must be fostered gradually with a continuous relational context (Koepke & Denissen, 2012; Ryan & Deci, 2000). Care teams need to remain actively involved, ensuring that youth and caregivers feel supported rather than abandoned, especially in moments of acute risk. At the same time, withholding autonomy can undermine trust and reinforce dependency. Finding this balance is complicated, which is also highlighted by the ambiguity in the responses of the various respondents in this study.

Relatedly, restrictive measures (e.g., involuntary admission or coercion) all too often offer short-term safety while eroding autonomy and trust in the long term, ultimately hindering recovery. Our findings suggest that such interventions should always be embedded in a transparent and relational process, used with great caution and as part of a stepwise approach. A reflective, relationship-centered approach is therefore essential. One that balances safety and autonomy through predictable and compassionate engagement. Crucially, teams and organizations in CAP must create space to slow down and tolerate uncertainty together. Doing so likely enables more thoughtful, attuned responses to crises and reinforces a sense of relational security. The concept of non-violent resistance and new authority may offer a valuable framework here, providing strategies to sustain relational connection

while navigating the complex dynamics of safety and control (Omer & Dolberger, 2015; van Gink et al., 2018).

Strengths and limitations

This study offers several strengths. The inclusion of multiple stakeholder perspectives (i.e., youth, caregivers, and practitioners) enabled a nuanced understanding of how autonomy and safety are experienced and navigated in residential CAP settings. The qualitative design allowed for rich, in-depth accounts of complex and emotionally charged experiences that are often missed in quantitative research (Yilmaz, 2013). A key strength of this study is that it gave voice to those directly involved in the care process, especially youth and caregivers, whose experiences are often underrepresented. By articulating their perspectives, this study not only informs practice but also offers language that can support dialogue in treatment settings. This may contribute to fostering relational security by helping stakeholders express and negotiate their needs more openly.

However, several limitations should be noted. First, reflecting on concepts such as autonomy and safety in retrospect (e.g., past treatment experiences in residential CAP) may have introduced recall bias - particularly for youth and caregivers - due to fragmented care trajectories and rapidly changing treatment contexts. Future qualitative longitudinal research, including observational studies in CAP, could better capture how these experiences evolve in real-time (Audulv et al., 2023). In particular, such studies may shed light on how stakeholders experience crisis situations in the moment and whether these differ from their reflections afterwards - an area that remains underexplored. Second, the sample included an overrepresentation of female youth. Although this reflects a broader trend in CAP (Boer et al., 2022), it may limit the applicability of the findings to other settings. In addition, the modest sample size within each stakeholder group constrained the possibility of exploring within-group variation, for example, how youth with different gender identities or care trajectories may experience autonomy and safety differently. Future research could address these limitations by engaging more diverse and segmented samples, allowing for more nuanced comparisons within and across stakeholder groups. Third, all participating practitioners were affiliated with a single CAP facility, which may limit generalizability to other national or institutional contexts where organizational structures and cultural attitudes toward autonomy and safety may differ. Finally, while this study provided valuable insights into lived experiences, it did not assess the long-term outcomes of different approaches to balancing autonomy and safety. Further research is needed to evaluate how these approaches affect treatment trajectories and recovery over time.

Clinical implications

This study highlights several implications for clinical practice, care teams, and organizations in residential CAP:

- Practitioners should prioritize relational safety as a core strategy for managing risk. Building predictable, trusting relationships and involving youth and caregivers in shared decision-making, especially during crises, can foster both autonomy and safety.
- Care teams need stability and structured reflection to maintain relational attunement. Regular supervision, intervision, and peer consultation can help teams process emotionally demanding situations, strengthen mutual trust, and sustain a shared vision of care.
- Organizations must actively invest in team cohesion and relational competence. This includes protecting time for reflection, reducing administrative burdens, and supporting relational approaches to crisis care such as non-violent resistance.

Conclusion

This study highlights the complex and relational nature of balancing autonomy and safety in residential care for youth with SEMHP. Rather than opposing forces, autonomy and safety both depend on trust, predictability, and continuity in relationships. While youth, practitioners, and caregivers broadly agreed on the importance of these principles, moments of crisis revealed key differences in emphasis: youth prioritize proximity and predictability, practitioners lean more towards procedural boundaries, and caregivers' responses vary, depending on the path in care they have already taken with their child. Our findings emphasize that promoting autonomy and safety does not mean stepping back, but instead requires a responsive and continuous connection that supports gradual development within a clear framework. Crucially, the risks of not granting autonomy - such as diminished trust, dependency, and disengagement - often manifest gradually and indirectly, and may be overlooked when compared to the immediate and visible risks of physical harm. This imbalance in perceived urgency makes it even more important to take time during crises to reflect and involve all stakeholders in decision-making. A stable, reflective team that can tolerate uncertainty and maintain connection in the face of risk is essential to support both autonomy and safety for youth with SEMHP in residential care.

Appendix A. COREQ (COnsolidated criteria for REporting Qualitative research) Checklist (Tong et al., 2007)

Topic	Item No.	Guide Question/Description	Resported on Page No. (section)
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	Procedure
Credentials	2	What where the researcher's credentials? E.g. PhD, MD?	Title page
Occupation	3	What was their occupation at the time of the study?	Title page
Gender	4	Was the researcher male or female?	Procedure
Experience and training	5	What experience or training did the researcher have?	Procedure
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	Participants
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Appendix B
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	N/A
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Study setting and design
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Participants
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	Participants
Sample size	12	How many participants were in the study?	Results

Topic	Item No.	Guide Question/Description	Resported on Page No. (section)
Non-participation	13	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	Procedure
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	Procedure
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	Results (Table 1)
Data collection			
Interview guide	17	Where questions, prompts, guides provided by the authors? Was it pilot tested?	Procedure
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	Procedure
Field notes	20	Were field notes made during and/or after the inter view or focus group?	Procedure
Duration	21	What was the duration of the inter views or focus group?	Procedure
Data saturation	22	Was data saturation discussed?	Data analysis
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	Procedure
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	Data analysis
Description of the coding tree	25	Did authors provide a description of the coding tree?	Table 1
Derivation of themes	26	What themes identified in advance or derived from the data?	Data analysis
Software	27	What software, if applicable, was used to manage the data?	Data analysis
Participant checking	28	Did participants provide feedback on the findings?	N/A
Reporting			

Topic	Item No.	Guide Question/Description	Resported on Page No. (section)
Quotations presented	29	Where participants quotations presented to illustrate the themes/findings? Was each quotation identified? E.g. participant number	Results
Data and findings consistent	30	Was there consistency between the data presented and the findings?	Results
Clarity of major themes	31	Were major themes clearly presented in the findings?	Results
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	Results

Appendix B. Topic list focus group youth with SEMHP

Topics	Questions
Introduction	Explanation about the research project, the role of the interviewer, the target group, the reason for this study, the process of the focus group, and consent/withdrawal
Introductory exercise: Introducing safety	*The participants have been requested to bring something that represents safety to them.* Introduce yourself briefly and explain what you have brought: why does this symbolize safety for you?
Meaning of safety in child and adolescent psychiatry	What does safety mean for you in CAP? What gives you a sense of safety in CAP? What do you need to feel safe in CAP? What triggers feelings of insecurity in CAP for you? What hinders safety in CAP? Who is responsible for ensuring safety of youth in CAP treatment? (follow-up: why / can we guarantee safety at all times?)
Meaning of autonomy in child and adolescent psychiatry	What does autonomy mean to you? What do you need to act and decide autonomously? What do you need to have autonomy in CAP? Can youth always decide what they want or what is best for them? When does CAP hinder autonomy of youth?
Field of tension	Do you experience a field of tension between safety and autonomy? At what moments does this field of tension arise? How does that affect you? What is the consequence of that on your behavior? Can autonomy and safety also go hand in hand? What is the role of the environment and what is the role of CAP in dealing with safety and autonomy? Who determines the level of autonomy youth should have? (follow-up: are multiple persons/parties involved in this?)
Closing questions	Provide a summary and allow the participants to respond to this. What did you think of the focus group? Are there things we did not discuss that you would like to share? Do you have any final questions? Explain how the study will continue.

*The topic list was slightly adjusted in text to (1) type (focus group/individual interview) and (2) respondent (practitioners and caregivers).

Appendix C. Demographics participants

	Youth (n=7)	Practitioners (n=8)	Caregivers (n=6)
Age (mean [age range])	23 [22-26]	38 [31-49]	54 [61-62]
Age children			21 [15-24]*
Gender			
Male	1	3	
Female	6	5	6
Gender Children Female			6
CAP treatment experience			
Age first treatment (years) (mean [age range])	13 [8-16]		
Total experience (years) (mean [age range])	8 [5-13]		6 [3-10]
Job Position Sociotherapist Intern sociotherapist System therapist Team coordinator Child and youth Psychiatrist Psychomotor therapist		3 1 1 1 1 1	
CAP working experience Mean (range) in years		13 [1-28]	

Note. N/A= not applicable; *two children of caregivers deceased at the age of 20.

Autonomie en veiligheid in de kinder- en jeugdpsychiatrie

Doel van dit onderzoek

In de residentiële kinder- en jeugdpsychiatrie is het vinden van een **balans tussen autonomie en veiligheid** een voortdurende uitdaging, vooral bij jongeren met ernstige en langdurige psychische problematiek. Aan de ene kant is autonomie is belangrijk voor herstel en eigen ontwikkeling. Aan de andere kant brengt risicovol gedrag, zoals zelfbeschadiging en suïcidaliteit, zorgen mee overhun veiligheid, wat soms tot beperkende maatregelen leidt.

Dit onderzoek richt zich op hoe jongeren, opvoeders en behandelaren autonomie en veiligheid ervaren in de residentiële kinder- en jeugdpsychiatrie en welke spanningen en dilemma's daarbij spelen.

Methode

In deze verdiepende studie hebben we **2 focusgroepen** en **11 interviews** gehouden met 7 jongeren, 8 behandelaren en 6 opvoeders. We hebben hen gevraagd naar hoe zij thema's als autonomie en veiligheid beleven of hebben beleefd in de kinder- en jeugdpsychiatrie.

Resultaten

- **Autonomie en veiligheid** zijn geen tegenpolen maar hangen onderling samen: jongeren voelen zich veilig als ze ook zelf keuzes mogen maken, en autonomie werkt alleen als er een veilige basis is.

- **Verschillen in perspectief**
  - Jongeren geven aan dat vertrouwen, nabijheid, communicatie en voorspelbaarheid essentieel zijn om zich veilig te voelen en autonomie te ervaren.
  - In crisissituaties ervaren jongeren en opvoeders dat beslissingen vaak plotseling worden genomen, zonder overleg. Dit voelt onveilig en onvoorspelbaar.
  - Behandelaren legden de nadruk op heldere kaders en beschouwden veiligheid als voorwaarde voor autonomie.
  - Opvoeders denken verschillend over autonomie en veiligheid: sommigen vinden dat er meer regels moeten zijn, terwijl andere opvoeders naar mate de behandeling langer duurde merkten dat teveel controle juist niet werkte.

- De stabiliteit van het **behandelteam** is cruciaal. Wisselingen in behandelaren of hoge werkdruk kunnen onveiligheid bij jongeren en onzekerheid in het team vergroten.

- **Vrijheidsbeperkende maatregelen** (zoals dwang of opname) kunnen op korte termijn veiligheid bieden, maar schaden op de lange termijn het vertrouwen en de autonomie van jongeren, waardoor herstellen moeilijker wordt.

Aan de slag

1. **Autonomie betekent niet 'loslaten'.** Juist in risicovolle situaties willen jongeren ervaren dat er iemand naast hen blijft staan.
2. **Investeer in relaties en bekende gezichten.** Veiligheid en autonomie ontstaan in contact: door vertrouwen, nabijheid en écht luisteren.
3. **Vertraag in crisissituaties.** Kijk samen wat nodig is, grijp niet direct naar regels en maatregelen zodat er een balans komt tussen bescherming en eigen regie.
4. **Maak afspraken voorspelbaar.** Voorspelbaarheid helpt jongeren en ouders om zich veilig en serieus genomen te voelen.
5. **Blijf kritisch en reflectief.** Autonomie vraagt maatwerk, geen standaardbeleid.

Meer weten?
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