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Triadic Perspectives on Decision Making in Psychiatry: A Qualitative Study on Service Users, Caregivers and Healthcare Professionals in Latvia

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Abstract: Background/Objectives: Decision-making in mental health care is essential for personal autonomy and a cornerstone of person-centered, rights-based psychiatric care. This study aimed to explore and describe the perceptions and experiences of decision-making in psychiatric care from the perspectives of service users, caregivers, and healthcare professionals. It also examined the decision-making contexts that either facilitate or hinder these practices. **Methods**: An exploratory-descriptive qualitative design using semi-structured interviews was employed. A total of 21 interviews were conducted with 8 service users, 6 caregivers, and 7 healthcare professionals. The interviews were transcribed verbatim and analyzed using inductive content analysis. **Results**: Four main categories emerged: (1) Antecedents for decision-making: a) mental healthcare factors, b) service user factors; (2) Challenges in decision-making; (3) Consequences of decision-making: a) benefits, b) risks, c) burden; and (4) Recommendations for better decision-making: a) informational support, b) other help and support. **Conclusions**: This study highlights the complexity of decision-making in Latvian psychiatric care, as perceived by service users, caregivers, and professionals. All participants identified both benefits and risks in the decision-making process. Factors influencing decision-making stemmed from the mental health system and the service user's personal circumstances. Systemic improvements, including better informational support and communication, are needed to strengthen decision-making agency in psychiatric care.

Keywords: decision-making; psychiatry; service users; family caregivers; healthcare professionals; qualitative study; Latvia

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1. Introduction

Decision-making about one's life—including the right to choose one's mental health care—is fundamental to personal autonomy and personhood [1]. International human rights laws and medical ethics codes, including the Convention on the Rights of Persons with Disabilities (CRPD) [2] and national laws such as the Constitution of Latvia [3] and the Law on the Rights of Patients of Latvia [4] protect the dignity and integrity of individuals in mental health care. These laws also require the protection of informed consent rights.

Decision-making in psychiatry is a cornerstone of patient-centered care [5] and a prerequisite for rights-based mental health care [1]. However, individuals with cognitive or psychosocial disabilities have historically been—and continue to be—disproportionately affected by substitute decision-making regimes [6].

The decision-making process is complex and multifaceted for many reasons. It is a dynamic process involving multiple stakeholders—service users, caregivers, and healthcare professionals—each with distinct roles, responsibilities, and perspectives. All these actors contribute to the decision-making process.

Various factors can influence this process, either facilitating or hindering it. These factors include established practices in the application of rules and ethical norms, cultural context, service users' health status, available support, healthcare professionals' beliefs and competencies, legal frameworks, and resources.

Furthermore, qualitative studies indicate that service users, their relatives, and psychiatric staff often perceive the clinical decision-making process differently. These differences can be attributed to varying experiences, knowledge levels, and expectations among these groups [7–11].

Different types of decision-making in mental healthcare are studied, ranging from substitute to shared and supported decision-making [12]. These approaches reflect a spectrum of autonomy for service users, ranging from decisions made on their behalf to those made collaboratively or with support, depending on their decision-making capacity [13].

Several studies have shown that shared decision-making (SDM) emphasizes the importance of therapeutic relationships in fostering better decisions [5,9]. The quality of the decision-making process enhances overall care quality, while decision aids and SDM approaches improve treatment adherence and service user satisfaction [14].

According to the Convention on the Rights of Persons with Disabilities, Art. 12, supported decision-making is required when a person with psychosocial disabilities experiences difficulties in making decision [2]. Supported decision-making enhances service user autonomy [15,16], empowering individuals to make choices about their lives while ensuring that these decisions are legally recognized. It provides tailored support and information, fostering self-determination and improving decision quality.

For professionals, supported decision-making offers a clear, structured legal framework, shifting away from binary assessments of capacity and instead emphasizing a dynamic, supportive approach. This process promotes better mental health outcomes respects individual rights, and helps reduce stigma surrounding cognitive impairments and paternalism [17]. Additionally, it decreases the application of coercive measures.

Recent studies on decision-making in psychiatry indicate that greater service user involvement in and satisfaction with clinical decision-making are associated with better outcomes [18]. Interventions such as coaching, peer support, and decision aids further enhance service user involvement [19]. Service users increasingly seek greater participation in treatment decisions and more balanced, collaborative relationships with psychiatrists [20].

Research often focuses on either the perspectives of healthcare professionals [21–23], service user or patient experiences [20,24], or other stakeholders, such as family members, caregivers in social services, and peer support workers [25–28]. However, these perspectives are typically examined in isolation.

Some studies have adopted a dual-perspective approach, involving people with mental illness and their caregivers [9,29] or healthcare professionals [30]. The use of a triadic perspective in studies is less common but highly valuable [31–33].

The exploration of triadic perspectives in decision-making is crucial because decisions are made collaboratively among service users, healthcare professionals, and often caregivers. Studying only one or two perspectives in isolation cannot provide a complete understanding of the situation. By examining decision-making in psychiatric healthcare from all major perspectives, the conclusions drawn can be more accurate and better reflect the reality of the situation. This will provide a more comprehensive understanding of decision-making and care within mental health services.

Because of this, the current study employs a triadic perspective, building upon previous research that incorporated multiple viewpoints [31].

The phenomenon of decision-making in psychiatry remains understudied in Latvia. This study aims to investigate and describe the perceptions and experiences of decision-making in psychiatric care from the perspectives of three key actors: service users, caregivers, and healthcare professionals. This analysis is relevant both within the context of Latvia and on a broader scale.

In this article, we have chosen to refer to people who use mental health services as 'service users' rather than 'patients'. In choosing this term, we have followed the recommendations of the European Network of (Ex-)Users and Survivors of Psychiatry. In Latvia, the definition of 'patient' is contained in Article 1(11) of the Law on Medical Treatment [34], which states that a patient is a person who receives or seeks health care services.

2. Materials and Methods

2.1. Study design

The study used an exploratory-descriptive qualitative research design (EDQ), which integrates elements of both exploratory and descriptive qualitative approaches. This design is particularly well suited for investigating healthcare phenomena that have received limited attention from researchers. Its aim is to gain a deeper understanding of these phenomena. EDQ research is especially valuable in research contexts where information must be gathered directly from individuals experiencing the phenomenon. This interpretative approach ensures an insider's perspective, capturing subjective knowledge and real-life experiences of research participants to create a comprehensive picture of the phenomenon under study [35].

2.2. Participants

The study included service users, their caregivers, and healthcare professionals. A purposive-criterion sampling technique was employed to recruit participants based on predetermined inclusion criteria, focusing on informants with certain qualities or experiences relevant to research objectives [36]. The inclusion criteria for the participants are outlined in Table 1.

Table 1. Inclusion criteria for the participants**.**

Participants	Inclusion criteria
Service Users	1) aged 18 years or older, 2) having the mental disease* diagnosed by a psychiatrist at least 2 years, 3) history of at least one treatment in the hospital as an inpatient, 4) interest in participating in the study, 5) the ability to talk about experiences.
Family caregivers	1) aged 18 years or older, 2) care of an adult with a mental disease of at least 2 years, 3) related to the patient by blood or marriage, 4) is not a professional caregiver, 5)provides care at no charge, 6) interest in participating in the study, 7) the ability to talk about experiences.
Healthcare professionals	1) professionals (psychiatrists and nurses) working in mental health care, 2) at least 3 years of practice in mental health care, 3) interest in participating in the study, 4) the ability to talk about experiences.

** Except impaired consciousness, dementia, acute psychotic state, psychomotor agitation, disorganised thinking, moderate/severe mental retardation, severe depression/manic illness, moderate/pronounced cognitive decline, under the influence of neuroleptics, tranquillisers, high anxiety level, severe pain.*

The recruitment of study participants took place between February 2023 and August 2024. Researchers prepared and distributed official invitation letters to healthcare professionals. They were asked to disseminate this information to potential study participants. Invitations were also distributed through Facebook and Twitter (currently, X) as online advertising. Finally, some potential participants were identified and recruited informally through personal and social contact with the researchers who advertised the study. Those interested in participating in the research study contacted the researcher, who provided them with the study's details and arranged the interview's time and venue. Service users and family caregivers did not form dyads; i.e., they were independent persons with no ties to each other.

This study involved 21 participants, including 8 service users, 6 family caregivers, and 7 healthcare professionals. The characteristics of the research participants are presented in Table 2. None of the participants requested to withdraw from the study. Information on potential participants who were approached but rejected the offer to participate was not collected or analyzed.

Table 2. Characteristics of the research participants.

Variable		**Service Users (N = 8; (%))**	**Family caregivers (N = 6; (%))**	**Healthcare professionals (N = 7; (%))**
Gender	Female	7 (87.5)	3 (50)	4 (57,1)
	Male	1 (12.5)	3 (50)	3 (42,9)
Age	20-30	3 (37.5)	-	-
	31-40	3 (37.5)	-	5 (71,4)
	41-50	1 (12.5)	3 (50)	1 (14.3)
	51-60	1 (12.5)	2 (33.3)	1 (14.3)
	60 +	-	1 (16.7)	-
Service user's primary diagnosis / Primary diagnosis of the service user being cared for by the caregiver	Bipolar disorder	1 (12.5)	1 (16.7)	
	Schizophrenia	2 (25)	3 (50)	
	Depressive disorder	2 (25)	2 (33.3)	
	Schizotypal personality disorder	1 (12.5)	-	
	Unknown	2 (25)	-	
Caregiver relationship with the service user	Parent		3 (50)	
	Son or daughter		2 (33.3)	
	Husband or wife		1 (16.7)	
Duration of disease (years)	2-5	1 (12.5)		
	6-10	4 (50)		
	11+	3 (37.5)		
Years of working in psychiatry	3-10			4 (57,1)
	11-15			2 (28.6)
	16+			1 (14.3)
Setting	Inpatient			2 (28.6)
	Outpatient			4 (57.1)
	Forensic			1 (14.3)
Specialization of healthcare professional	Physician (Psychiatrist)			5 (71.4)
	Nurse (in psychiatry)			2 (28.6)

2.3. Data collection

Semi-structured interviews were conducted to collect the data from May 2023 to August 2024. The design and course of this type of interview are characterized by flexibility. Although a pre-prepared interview guide coordinates it with a list of topics or questions, the form and sequence of questions can be modified and adapted to the interview situation, allowing new aspects to emerge during interviews [37]. A semi-structured approach emphasizes the experiences and perspectives of the participants. It avoids closed questions, predefined responses, and leading questions, allowing participants to provide rich data on the topic of interest [38].

For the study, the research team developed three independent semi-structured interview question guides for each group of study participants. The interview guiding questions were based on the definition of supported decision-making [13,39,40] and after a literature review on similar issues for service users [24,41], family caregivers [28,42,43], and healthcare professionals [44,45]. The interview questions were piloted before official interviews began to reduce bias.

The interview guide for service users was structured around four key areas: (a) the interview began with an invitation to talk about the experience of being diagnosed with a mental illness and being involved in decisions about treatment and other life decisions; (b) service users’ general views on decision-making in psychiatric care; (c) their practical experience with decision-making in psychiatric care; and (d) service user expectations for the preferred decision-making model.

The interview guide for caregivers covered four aspects: (a) questions on caregiver perceptions of decision-making issues in mental health; (b) their practical experiences of decision-making while caring for a service user with mental illness; (c) their reflections on possible barriers and challenges of decision-making; and (d) caregiver preferences related to decision-making and proposals for improving the decision-making process.

The interview guide for healthcare professionals contained (a) open-ended questions that invited participants to describe the principle of service user autonomy in psychiatric care during the last 5–10 years in Latvia; (b) questions to explore the participants’ views concerning decision-making issues and factors affecting the decision-making process; (c) questions about their practical experience regarding decision-making; and (d) questions on the necessary improvements to strengthen the decision-making process in psychiatric care.

Research team members (KK, KB) interviewed each participant individually. The interviewer did not know the participants before the study. A pre-meeting only took place in cases where the interviewer met the interviewee before the remote interview to obtain signed informed consent from them. Before the interviews, all participants gave their informed and written consent to participate and self-identified as being able to participate fully. All participants were told that they could withdraw from the interview at any time for any reason. No financial compensation was offered for participation in the study.

The study participants chose the day, time, and location for the interviews. Ten interviews were conducted face-to-face, while 11 were conducted remotely through Skype, Zoom, and Teams.

The interviews were recorded on audio with the participants' permission. They lasted between 20 and 150 minutes and were transcribed verbatim in preparation for analysis. Personal data was protected throughout the study, and specific identifications were given to all participants (group ‘Service Users’ P1_1, P1_2, etc.; group ‘Family caregivers’ P2_1, P2_2, etc.; group 'Healthcare professionals' P3_1, P3_2, etc.).

2.4. Data analysis

A qualitative content analysis was used to analyse the data based on the Erlingsson and Brysiewich (2017) data analysis process, which has an inductive orientation. In the first stage, reading and rereading of the transcribed interviews were done to immerse in the data and achieve a general understanding of the participants' perspectives. In the second stage, the interview text was divided into meaning units and then condensed to shorten the meaning units. The primary codes were determined in the third stage by assigning descriptive codes to the condensed meaning units. At the fourth stage of data analysis, similar primary codes were grouped into subcategories, which, in turn, were classified under more comprehensive categories with a higher level of abstraction that report the findings of this study. The data analysis steps were indicative, so the data analysis was carried out iteratively as a continuous rather than a linear process [46].

Research team members (IS, KK) performed the content analysis manually. However, another researcher (SO) examined the assigned codes to ensure the trustworthiness of the analysis process. Furthermore, researchers discussed and redefined subcategories and categories until a consensus was reached, and a final collection of subcategories and categories was formed.

2.5. Ethics

Before data collection, the Ethical Committee of the University of Latvia (Nr. 71-35/36) granted ethical approval for this study, which complied with the ethical principles established in the World Medical Association Declaration of Helsinki (2013) and stated by Latvian national laws concerning research.

3. Results

The results are based on interviews with 8 service users, 4 family caregivers, and 7 healthcare professionals (HCPs). Table 3 shows the categories, subsequent subcategories, and main codes constructed through qualitative inductive content analysis, representing research participants' statements and experiences regarding decision-making in psychiatric care.

Table 3. Categories, sub-categories and main codes of the study**.**

Categories	Subcategories	Main codes	Perspective
1. 'The antecedents for decision-making'	**1.1 'Factors related to mental healthcare'**	Access to HCPs Appropriate duration of consultation Qualities of HCPs Provision of information	*Service users' perspective*
		(Un)availability of service user information Service users' right to be informed	*Family caregivers' perspective*
		Strengthening service users' rights in mental healthcare Information available to service users HCP's personality and place of practice	*Healthcare professionals' perspective*
	1.2 'Factors related to service user'	Their attitude Having a reliable support person Mental health situation	*Service users' perspective*
		Service user's ability to cooperate Service user's current mental health situation	*Family caregivers' perspective*
		Active service user Service user's mental health condition	*Healthcare professionals' perspective*
2. 'Challenging moments in the	-	Decision-making at the onset of the disease	*Service users' perspective*

decision-making practice’		Outpatient facility versus hospital Conflicting information	
		The onset of the service user's illness and the caregiver's tough decision Forced to take part in coercion Disagreement on what constitutes coercion Who is the main decision maker regarding service user healthcare? Justification of coercion by caregivers	*Family caregivers’ perspective*
		Between service user and caregiver on disclosure of information Service user’s relationship with the caregiver Difficulties in assessing a service user's decision-making capacity Deciding that you must decide for the service user	*Healthcare professionals’ perspective*
3. ‘The consequences and side effects of decision-making'	**3.1 ‘Benefits’**	Benefits related with medical treatment Felt more safe and secure Sense of control Felt important Felt empowered	*Service users’ perspective*
		Reduced caregivers' responsibility Increased service user motivation	*Family caregivers’ perspective*
		Benefit from an assessment of the service user’s decision-making capacity Choose a food	*Healthcare professionals’ perspective*
	3.2 ‘Risks’	Wrong, dangerous, harmful decisions	*Service users’ perspective*
		Risks of service user abuse	*Family caregivers’ perspective*
		Caregivers' intentions	*Healthcare professionals’ perspective*
	3.3 ‘Burden’	Additional burden, especially if you feel ill Little interest in health topics	*Service users’ perspective*
		Additional burden on caregiver daily responsibilities	*Family caregivers’ perspective*

		Additional resources	*Healthcare professionals’ perspective*
4. 'Recommendations for better decision-making'	**4.1 ‘Informational support’**	More information	*Service users’ perspective*
		More information	*Family caregivers’ perspective*
		Training professionals in decision-making in psychiatric practice	*Healthcare professionals’ perspective*
	4.2 ‘Other help and support’	More choices More involvement of HCP in service user care	*Service users’ perspective*
		Caregivers as reliable partners More support from the HCP More empathy from other services and institutions Additional help for caregivers	*Family caregivers’ perspective*
		Implementation of the concept of service user decision-making in psychiatric care in Latvia	*Healthcare professionals’ perspective*

3.1. Category 1 ‘The antecedents for decision-making’

The first category comprised information on the general circumstances that could influence the decision-making process from the participants' perspectives.

3.1.1.‘. Factors related to mental healthcare’

The subcategory highlighted the various factors related to mental healthcare that can stimulate or hinder decision-making about a service user’s health.

Service users’ Perspective

Regarding access to healthcare professionals (HCPs), service users insisted that they must have regular and timely access to a psychiatrist to make decisions about their health. This was especially necessary during acute episodes. This could be done through on-site or remote consultations using technologies. The service users noted that regular communication with specialists allowed them to clarify unclear issues and receive advice, which enabled them to make informed health decisions.

The appropriate duration of consultations was often mentioned as a prerequisite for decision-making. Service users expressed the desire for longer consultation times, especially longer on-site consultations. Rushed and quick consultations caused additional stress and confusion for service users, limiting their ability to think calmly, ask questions about unclear issues, and reason before making a health decision.

Service users mentioned several qualities of healthcare professionals that were important for productive service user-doctor interaction and decision-making. These included mutual trust and openness; empathetic, sensitive, tolerant, friendly, and non-judgmental attitudes; and an attitude free from arrogance and blame. Service users appreciated psychiatrists' ability to listen to and hear the service user, as well as to provide a conversation rather than a top-down monologue. They also highlighted the psychiatrist's knowledge of the latest treatment options, ability to build a complete picture of the service user, responsiveness to their needs, and interest in improving their quality of life.

The provision of information described the expectations of service users for truthful, accessible, clear, and understandable information about their mental health conditions and medical treatment options. Service users perceived the psychiatrist as the main source of this information. However, informational support was also received from internet sites, including social networks, books, and support groups. Service users felt that, to make a treatment decision, they should be informed about treatment options. It was impossible to make an informed decision without information. Moreover, they stressed that a lack of information can lead to wrong decisions. Several service users emphasised the importance of assessing the reliability of the available information.

“An informed decision is important to me. I am not going to take the place of a psychiatrist and decide what I will and will not take, but it is important to me that I am informed about the medication and the options.” [P1_3]

Family caregivers’ perspective

The (un)availability of service user information described the situations experienced by several caregivers where they lacked communication with healthcare professionals and did not receive detailed information about the service user's health. These situations were more often experienced in hospitals than in outpatient settings. This made it difficult to make decisions about service user care, causing stress for caregivers. Caregivers stressed that if they are responsible for their service users, they should also have access to information about the service user's health and treatment guidelines. Caregivers felt that it was the treating psychiatrist's responsibility to provide them with this information discreetly and preferably during an on-site consultation.

Caregivers emphasised service users' right to be informed. They stated that healthcare professionals must inform service users about their health condition, the treatment offered, the procedures to be performed, and the expected results. Service users should have the opportunity to express their views on the healthcare process. They have the right to be heard and to know their rights. Furthermore, information should be provided to the service user discreetly, without the presence of other service users and/or individuals.

"The patient must be fully informed. Thoroughly, nuanced, and deeply informed about everything happening to him/her. This is an elementary human right." [P2_3]

Healthcare professionals’ perspective

Strengthening Service Users' Rights in Mental Healthcare. Healthcare professionals stressed that the right of service users to participate in decision-making processes that affect their health should be accepted as a fundamental requirement. HCPs believed that positive changes have already occurred in the healthcare system and practice, supporting and strengthening service user autonomy and decision-making.

Information Available to Service Users. HCPs considered that access to information has already improved significantly. They believed service users could obtain health information through various means, such as leaflets, lectures, handouts, eHealth, and internet resources.

Hcps' Personality and Type of Facility. Several healthcare professionals felt that whether and to what extent a professional accepts service user participation in decision-making processes is, to some extent, related to the subjective views, beliefs, and character of the healthcare professional as an individual. The type of facility—outpatient or inpatient—can also have an impact. Some clinicians thought that service user autonomy may be less respected in hospitals.

3.1.2.‘. Factors related to the service user’

This subcategory summarised service user-related conditions that may affect their capacity to make healthcare decisions.

Service Users’ Perspective

Service users highlighted their attitudes as a key component for productive interactions with healthcare professionals. They believe that service users should be cooperative, polite, interested, and self-initiative in their healthcare. Service users should also be open with their doctors and relatives and not hide information about their health and symptoms.

Having a reliable support person was also mentioned as a factor that can influence decision-making. All interviewed service users could name one or more people they classified as support persons and on whom they could rely in health-related situations. However, the service users perceived the psychiatrist as the main person involved in the health decisions. Some service users would trust the decision about their health to other support persons (relatives, friends, colleagues) if necessary. On the contrary, two service users reported that they did not want to involve people other than professionals in health decisions. They assumed that a relative or friend could help the service user get to the doctor but not make decisions.

Service users perceived and experienced their mental health situation as a precondition that could facilitate or hinder decision-making. Service users had noticed that the acute phase of the disease and severe symptoms (such as disinterest, drowsiness, euphoric feelings, overwhelming emotions, avoidance, being 'in another reality' or 'in a fog') harmed cognitive abilities and decision-making capacity. In the most severe episodes, they entrusted decision-making solely to the psychiatrist and, if necessary, to support persons.

"It doesn't work for more serious episodes. I've also been on medication that slows down. Then no decision can be made. Just sleep and that's it." [P1_2]

“At the moment of a manic episode, it is like being in another reality. It's a different perception of reality and then it's hard to make good decisions for yourself." [P1_4]

"I was euphoric. I felt so well in my euphoric state that I didn't even want to take the medications." [P1_7]

Family caregivers’ perspective

The service user's ability to cooperate with clinicians and the caregiver was essential. However, caregivers faced challenging situations in which the service user was uncooperative and refused any help, including medication. The caregiver's ability to influence the service user's decisions was limited, leading to confusion about whether and what decisions the caregiver should make regarding the service user's healthcare.

Caregivers were convinced that the service user's ability to perceive and evaluate the situation, as well as to make choices and decisions, was strongly influenced by the service user's current mental health situation. Caregivers experienced that in the acute and severe stages of the disease, the service user's behaviour was often unpredictable and inadequate. Additionally, the service user's perception of reality was often affected by medication. As a result, the service user was deemed to be unable to make appropriate healthcare decisions. Conversely, if the disease was well controlled and the service user's mental health was good, he or she could be actively involved in the decision-making process regarding his or her healthcare. Furthermore, one mother felt that due to her daughter's complex diagnosis, she was unable to assess her daughter's decision-making capacity.

Healthcare professionals’ perspective

Active Service User. The HCPs were convinced that the service user must be interested in and motivated to participate in decision-making, sufficiently active, and willing to collaborate with healthcare professionals. The service user was expected to take the initiative so that cooperation was reciprocal. The HCPs mentioned the concept of shared responsibility in this context.

Service User’s Mental Health Condition. The HCPs highlighted that some health conditions can significantly affect a service user's ability to be aware of their health status and limit their decision-making capacity (e.g., depression, affective bipolar disorder, severe cognitive impairment, acute psychotic states).

3.2. *Category 2 'Challenging moments in the decision-making practice'*

The second category described some critical moments experienced by service users, caregivers, and professionals in decision-making practices.

Service Users' Perspective

Decision-Making at the Onset of the Disease. Four service users shared their experiences of finding it difficult to make decisions about health at the beginning of their illness. The main reasons that prevented service users from participating in their own health decisions were shame and confusion about the diagnosis, fear of an unfamiliar doctor, lack of information about the disease, and lack of experience with treatment. Here, a service user was afraid to disagree with the doctor and did not ask questions they were worried about. Another service user pointed to insufficient information and no treatment experience at the onset of the illness, so more time was needed to decide, but this time was not always given.

Outpatient Facility Versus Hospital. Service users concluded that they could better make decisions about their health in an outpatient facility than in a hospital. In outpatient consultations, the psychiatrist seemed to talk more with the service user, examine the problem more carefully, and offer different treatment options, giving the service user time to reflect. Outpatient psychiatrists also seemed more accessible than inpatient psychiatrists.

Although all service users interviewed acknowledged that they needed information to make sound decisions about their mental health, the challenge was the large amount of information and sometimes conflicting information. This also happened when two or more physicians provided conflicting information to a service user on the same issue.

"It is hard for me as a nonmedical person when two doctors tell me two different – opposite – things. I cannot make the right decision." [P1_6]

Family caregivers' perspective

The onset of the service user's illness and the caregiver's tough decision. The service user's caregivers admitted that at the beginning of the service user's illness, they felt confused, worried, helpless, and even frightened by the significant changes in the service user's behaviour (i.e., symptoms). They also felt uncertain about the best course of action in this new situation. Caregivers experienced that their decision to hospitalise a service user and admit him or her into a facility was emotionally difficult.

"She [the daughter] started having hysterics. She was screaming and throwing herself on the ground. She did not go to the doctor. It only got worse. I remember it was difficult for me to call an ambulance the first time. It was difficult, emotionally it was difficult. It took me a while to call for help." [P2_2]

Sometimes, this decision was accompanied by doubt, self-recrimination, guilt, and uncertainty about whether the caregiver had made the right decision.

Caregivers reported that at certain stages of the illness, they were forced to take part in coercion or coercion-like behaviour. Coercion had been mainly linked to the service user's reluctance to be treated in the hospital during the acute and severe stages of the disease.

"At the acute beginning of her illness, almost everything was imposed against her will. As parents, we insisted on her treatment because we saw that she was acting completely inadequate." [P2_1]

The caregivers decided to hospitalise the service user involuntarily, either by themselves or through the emergency services, with or without the involvement of the police. Some caregivers had specific 'strategies' to achieve the desired service user behaviour. For example, they used deception to get the service user to sign consent documents or threats of hospitalisation were used to force service users to take medications. Therefore, caregivers were forced to participate in coercive actions. This led to a variety of emotions, such as relief, feelings of victory, guilt, despair, anger, pity, doubts,

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etc. However, caregivers reported that coercive tactics were used as a last option when all other methods failed, such as a verbal discussion about the need for treatment.

In some cases, caregivers and service users disagreed on what constitutes coercion. For example, does verbal persuasion to go to the hospital constitute coercion? Does helping a service user get to an ambulance [emergency medical transport] constitute coercion? These situations created conflicts between the caregiver and the service user.

In some cases, caregivers reported confusion about who makes the main decisions about service user care and how this responsibility is shared. Is it a psychiatrist alone, a psychiatrist and a service user, a council of psychiatrists, or even a court? When and to what extent do caregivers become involved in this process? How significant is their influence? Caregivers reported that they needed clear guidance from HCPs on their responsibility level to avoid ambiguous situations.

Justification of Coercion by Caregivers. Coercion was justified when the service user endangered his or her own or others' safety and health and when a medical consortium determined coercive treatment following the law.

"When she is sick, things go so far that she stops taking her medication. She becomes hysterical, hits the dishes, and becomes aggressive and rude. Then the only thing left is to call an ambulance and take her to the hospital. And then comes treatment, including compulsory treatment by court order." [P2_2]

"This is clearly stated in the law. If a person is a danger to others, they must be treated and isolated from society. In this case, he/she must be treated forcibly." [P2_1]

Healthcare professionals' perspective

Between Service User and Caregiver on Disclosure of Information. Psychiatrists reported confusing situations when obtaining and sharing service user health information. For example, how much should they ask a family caregiver about a service user's health, or how much about the service user's health can they tell the service user's caregiver? Professionals have experienced suspicions from service users about so-called "withheld information." Service users felt worried about what the caregiver told the psychiatrist or what the doctor told the caregiver. Such episodes made it difficult to build trusting relationships.

The Service User's Relationship with the Caregiver. HCPs observed that the service user and caregiver relationship was not always positive and friendly. Decision-making about the service user was more difficult if the service user was hostile toward the caregiver (or vice versa) or if there was mistrust and tension between them. Sometimes, affected by the disease, the service user had negative beliefs and fantasies about their caregiver. In the imagination of the service user, the caregiver had become the enemy. Doctors saw this as a difficulty because the service user did not trust either the doctor or the caregiver.

Difficulties in Assessing a Service User's Decision-Making Capacity. Healthcare professionals pointed out that there was no single structured tool to assess a service user's decision-making capacity and to obtain relatively objective and consistent results. There have been cases in which two specialists had different opinions about the same service user. Therefore, the psychiatrists concluded that it would be important to use a common tool. Currently, the evaluation of a service user's decision-making capacity is based on clinical assessment. However, this assessment is also influenced by the physician's experience, subjective views, and even personality traits.

Deciding That You Must Decide for the Service User.

Several clinicians found it difficult to make a decision that requires them to decide about the health of another person (in this case, the service user).

3.3. Category 3 'The consequences and side effects of decision-making'

This category summarised information on the aspects that accompany the decision-making process from the perspective of the three groups of participants.

3.3.1. Subcategory 3.1 'Benefits'

Service users' perspective

The service users mentioned the benefits associated with medical treatment. They liked that the psychiatrist offered a choice of medications and gave the service user the option to choose the medication. Service users highlighted that allowing them to contribute to the consultation process can lead to a more personalised pharmacological treatment plan. Service users insisted that the psychiatrist should listen to their views on medications, including side effects.

The service users felt safer and more secure when the psychiatrist talked to them, allowed them to express themselves, and offered treatment options. This led service users to a greater sense of control over their health situation and treatment.

The service users felt important when the psychiatrist listened, showed interest in their thoughts, feelings, and opinions, and gave them a voice. They appreciated being seen as partners in the treatment process.

Finally, two service users felt empowered. They believed that the psychiatrist trusts the service user's self-awareness and activates the service user's ability to think for themselves and describe their symptoms, feelings, thoughts, actions, and beliefs, which can influence treatment."

Family caregivers' perspective

Reduced Caregivers' Responsibility. Caregivers felt that more active service user participation in treatment and care processes would increase service user autonomy and responsibility, which in turn would reduce their duties and burdens.

Increased Service User Motivation. Caregivers assumed that if the service user has made a specific decision about their health, they are more likely to be motivated to implement it, such as taking their chosen medication or seeing their chosen psychologist.

Healthcare professionals' perspective

Benefit from an Assessment of the Service User's Decision-Making Capacity. Assessing a service user's decision-making capacity allows for a more effective determination of prognosis, treatment dynamics, service user cooperation, and treatment compliance.

Choosing Food. The HCPs concluded that even if a service user is significantly impaired in decision-making capacity due to a medical condition, he or she can and should be involved in simpler decisions, such as the ability to choose food.

3.3.2. Subcategory 3.2 'Risks'

Service users' perspective

Service users recognised that in the acute stage of the disease and while experiencing severe symptoms, they could make wrong, dangerous, and harmful decisions about their health and safety.

Family caregivers' perspective

Caregivers acknowledged that deciding for someone else was a complex issue. According to caregivers, there were various risks of service user abuse, especially concerning involuntary treatment. There was also the risk that the caregiver's intentions might be dishonest, selfish, and mercantilist. Therefore, caregivers felt that the question of who makes the decision instead of the service user should be carefully considered in each service user's situation.

Healthcare professionals' perspective

Caregivers' Intentions. The HCPs expressed concern that the intentions of the service user's caregiver were not always in the service user's best interests. It was difficult, and sometimes even impossible, for the clinician to reveal the caregiver's hidden motives. Clinicians perceived this as a significant risk to the health and safety of service users.

3.3.3. Subcategory 3.3 'Burden'

Service users' perspective

Being involved in decision-making was an additional burden, especially if they felt ill. Two service users interviewed expressed this. They also admitted that they had little interest in health topics, so they were reluctant to discuss the details of, for example, therapy. However, they had full trust in the physicians who treated them.

Family caregivers' perspective

Several caregivers pointed out that being responsible for the service user was an additional burden to their daily duties. Caregivers monitored service user behaviour to spot changes that could indicate a relapse. They cared for the service user daily and were involved in various decisions about the service user's healthcare. Moreover, interaction with the service user was often complicated by symptoms of the service user's illness, such as aggressive, defiant, or oppositional behaviour; apathy; disinterest; unpredictable and manipulative behaviour; denial of illness; hiding or exaggerating symptoms; refusal to take medication; etc. Although caregivers tried to find and develop the most appropriate strategies to interact with service users, they described this as a difficult task.

Healthcare professionals' perspective

Additional resources. The professionals emphasised the necessity for extra resources to enhance the decision-making process. Firstly, the psychiatrist required more time to evaluate the service user's decision-making capacity. Secondly, ensuring that service users have access to professional caregivers (as opposed to family caregivers) with formal legal status and clearly defined responsibilities entails the recruitment and professional training of these individuals.

3.4. Category 4 'Recommendations for better decision-making'

This category collected ideas on how to make the decision-making process more inclusive and accessible to all stakeholders.

3.4.1. Subcategory 4.1. 'Informational support'

Service users' perspective

Service users felt they should receive more information about treatment plans and options, risks associated with treatment and with not being treated, and how to deal with acute episodes. Service users should also be informed of their rights. This could be done through special brochures or other information tools (including digital ones) written in easy-to-understand language without complicated medical terminology. Some service users had already received such information material and appreciated it. The service users expressed their belief that while in the hospital, they should be informed about the rules of the internal order of the hospital, the healthcare received, as well as leisure activities, clothing, and diet. In addition, service users also needed more up-to-date information on other support options, such as support groups.

Family caregivers' perspective

Caregivers reported the need for more information in the form of specific recommendations, guidelines, formulas, or algorithms on how to deal with different situations related to the service user's health and behavior. Caregivers would also like a list of things not to do when caring for a service user with mental illness to avoid unnecessary escalation. Caregivers concluded that to be more involved in the decision-making process, they would need more detailed information on the service user's health status, better explanations of treatment tactics, description of medications, and their side effects.

Healthcare professionals' perspective

Training professionals in decision-making in psychiatric practice means providing professionals with the latest theoretical and practical information on service user autonomy and decision-making in psychiatry. Specialists desired to attend informative activities (courses, seminars) that would facilitate a deeper understanding of the concept of service user decision-making and enable its practical application.

3.4.2. Subcategory 4.2. 'Other help and support'

Service users' perspective

More Choices. Several service users thought they should be trusted more and allowed to make more independent choices about their healthcare. For example, they could choose from the treatment options offered, decide between treatment in a hospital or at home, or select complementary therapies (psychologists, art therapy, etc.).

More Involvement of Healthcare Professionals in Service User Care. Three service users felt that more intensive involvement of general practitioners in their care would be highly desirable. Some service users indicated that they would like to receive more interest from HCPs, i.e., to have HCPs show interest in the service user's daily life and their goals, instead of asking short, standard questions and prescribing medication.

Family caregivers' perspective

Caregivers wanted to be seen as reliable partners in the service user's healthcare. Caregivers thought they could provide objective information about the service user's health and behaviour based on their daily observations.

More HCP Support is Needed. In addition to informational support, caregivers would like to have better availability of professionals, easier access to specialists in acute cases, better exchange of information between professionals and the caregiver, longer and more informative consultations, more openness, friendliness, and compassion from professionals, more attention, and listening to caregiver observations about the service user. Caregivers wanted to avoid being blamed for the service user's mental health problems.

More Empathy from Other Services and Institutions. Caregivers emphasised the need for more empathy from other services and institutions, such as emergency services, police, social services, and courts.

Additional Help for Caregivers. Caregivers also expressed the need for additional help, such as support groups (on-site or online), psychological help, and informative seminars specifically designed for caregivers.

"As a relative [and caregiver], I want to know and understand more. And I always ask why there are no special support groups for relatives who are faced with such patients." [P2_2]

Healthcare professionals' perspective

Implementation of the concept of service user decision-making in psychiatric care in Latvia. By this, psychiatrists understood, first, the need for a thorough acceptance of the concept of service user decision-making, and second, the importance of developing a unified approach to service user decision-making in psychiatry and law.

4. Discussion

This paper examined the perspectives of service users, caregivers, and healthcare professionals to determine factors that might facilitate or hinder decision-making in psychiatric care. Experiences varied greatly from individual to individual, highlighting the complex interplay of factors that affect decision-making in these settings.

Rather than examining decision-making from a single perspective (service user, caregiver, or provider), the analysis in this study offers a more comprehensive and integrative approach by connecting factors from all three groups. This triadic perspective provides a deeper understanding of decision-making processes and their underlying determinants, resulting in a more holistic and nuanced representation of the phenomenon [33].

4.1. Facilitators of Decision-Making in Psychiatry

The initial section of the results explores the primary factors that support decision-making, such as trust, clear communication, and the availability of accessible information.

Service users value trusting relationships with psychiatrists, enabling open discussions and easing fears. Regular consultations and digital tools further support engagement. While service user preferences on delegating decisions vary, stronger trust with doctors reduces uncertainty. These

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findings align with existing literature that emphasises the role of trust and transparency in fostering service user autonomy and adherence to treatment plans [11,47].

Another crucial enabler is the availability of accessible and understandable information. When service users and caregivers receive clear, timely information regarding treatment options, side effects, and prognosis, they feel better equipped to participate actively in decision-making processes. This is especially important at the beginning of an illness, when service users often report uncertainty and a lack of knowledge about their diagnosis and what it might entail for their quality of life. Healthcare professionals play a vital role in service user education, tailoring information to individual needs [48,49].

The study also underscores the benefits of collaborative decision-making involving service users, caregivers, and providers. This approach leads to personalised care plans and better outcomes [50]. It empowers service users and allows caregivers to provide valuable insights based on their close observations of the service user's condition. It also enhances caregivers' ability to assess changes in the service user's health status through dynamic monitoring and supports them in adhering to healthcare providers' recommendations throughout the treatment process. The support network, including peer groups and online communities, further enhances the decision-making process by offering additional perspectives and emotional support.

4.2. Barriers to Decision-Making in Psychiatry

Despite recognising positive aspects, service users, caregivers, and professionals identified multiple barriers to accessing, providing, or influencing care, often stemming from practical challenges or uncontrollable factors like the course of illness.

Our findings confirm that cognitive impairments, acute psychiatric symptoms, and medication side effects can significantly reduce decision-making capacity. Participants reported that during severe depressive or psychotic episodes, their ability to assess risks and make informed choices was severely impaired, requiring temporary delegation of decision-making authority to psychiatrists or caregivers. These results align with studies suggesting that psychotic symptoms impact appreciation, reasoning, and understanding, making supported decision-making models essential for maintaining service user autonomy while ensuring safety [51].

Our findings indicate that paternalistic practices remain prevalent in psychiatric care. Many psychiatrists felt that service users with severe psychiatric disorders were incapable of making rational health decisions, leading them to override service user preferences in favour of what they deemed clinically necessary (Hamann et al., 2009). Moreover, decision-making was often dictated by the psychiatrist's personal beliefs and institutional culture, with inpatient settings being less autonomy-focused than outpatient settings. This reinforces previous research showing that hospitalised service users often experience reduced autonomy due to systemic constraints and paternalistic attitudes [52].

This shifts responsibility to caregivers and healthcare professionals, often creating tension with service user autonomy. In this case, service users express fears of betrayal and vulnerability, while caregivers struggle with the ethical and legal weight of their decisions. Caregivers, often being laypersons, are not presumed to have the legal or professional knowledge about the care and autonomy of service users that would be expected of professionals. Therefore, not only do they face a higher burden of effort to acquire the necessary knowledge, but they also voice struggles regarding their burden of care and what is or isn't within their legal rights. Professionals face similar uncertainty, especially when caregiver directives conflict with service user wishes. When assessing decision-making capacity, psychiatrists may take into account the service user's interests and whether their choices align with their well-being [45].

A major legal barrier highlighted in our study was the conflict between service user confidentiality and family involvement. Caregivers felt excluded from critical decisions due to strict privacy laws, which prevented them from accessing essential health information. Healthcare professionals also expressed uncertainty regarding how much information to disclose, fearing violations of confidentiality rules. This aligns with findings from Ní Shé et al. [53], who emphasise that existing legal frameworks need revision to balance service user autonomy with the need for informed family involvement.

Furthermore, during interviews, both caregivers and service users displayed uncertainty about the safety and confidentiality of their information. The previously mentioned confusion about information access was compounded by worries about possible breaches of confidentiality and the overstepping of any party beyond the service user's rights to privacy.

5. Conclusions

This interview-based study focused on decision-making in psychiatric care in Latvia from the perspectives of service users, family caregivers, and healthcare professionals. In this study, qualitative research methodologies proved essential for highlighting human experiences and acknowledging the significance of lived experiences.

The paper contributes to the understanding of how the decision-making process in psychiatry within Latvian healthcare institutions is experienced by all three groups of participants. The findings highlighted several key aspects of this process and identified several preconditions that affect its feasibility and quality.

Service users, family caregivers, and healthcare professionals experienced different challenges in their decision-making practices. It is essential to raise these challenges for discussion at a professional level and to take targeted action to mitigate them at a systemic level. The participants recognised both the benefits and risks associated with decision-making. Therefore, to facilitate a better decision-making process, the study also summarised recommendations to improve this process, such as strengthening information support and ensuring that clear and transparent communication is available to all stakeholders. In addition, structured support mechanisms, such as counselling for family caregivers and specific training for healthcare professionals, could improve decision-making practices and promote more effective service user-centred care in which service user autonomy is recognised and respected.

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Informed Consent Statement: All interviews were conducted after the researcher received an written informed consent for the interview.

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