Space between the borders?

ten Brummelaar, Mijntje Derkje Corneeltje

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Chapter Six

The Best Interest of the Child – Self-Report questionnaire (BIC-S): Results of a participatory development process

ABSTRACT

This paper provides insight into the participatory development process of a self-report questionnaire for young people: the Best Interest of the Child Self-report questionnaire (BIC-S). The BIC-S is based on the ‘Best Interest of the Child’ model. This model articulates, in line with the UN Convention on the Rights of the Child, 14 childcare conditions promoting the wellbeing and development of young people. The primary intention of the BIC-S is to give young people in care a voice regarding decisions in legal and care areas that impact their future.

The development process of the BIC-S consisted of three main phases (exploration, consultation, pilot), containing a total of five different research stages. Young people placed in secure residential care, care professionals and university students were involved in the process.

We developed a differentiated instrument that enables young people to express their own views on key aspects of their current and future living conditions. The digitised questionnaire is developed to be comprehensive, accessible and attractive for young people, and to generate an evaluative profile of care conditions from the young people themselves.

The paper shows how a theoretically sound questionnaire can be constructed to conform to standards set by young people themselves. The BIC-S can serve as a productive vehicle for assessment and shared decision-making in the field of youth care – both at the micro level of individual treatment and at the meso level of evaluating group programmes. Further research into its use in practice is recommended.

Key words: youth participation, assessment, instrument, adolescence, Convention on the Rights of the Child, shared decision-making
INTRODUCTION

Why should they listen to us? They already have an opinion about us! They think we only give socially desirable answers. Professional experts such as psychologists and psychiatrists have written about us. We can’t change the views of the judges by telling our own story.

The story above was told by a 15-year-old boy placed in a secure residential treatment facility in the Netherlands. When asked about what he would say to a judge about his views as to where to grow up after leaving care, he got frustrated and said that his opinion would not contribute in any way to the decision-making process.

According to Article 12 of the Convention on the Rights of the Child (CRC), professionals should be taking that young man’s opinion into account in any judicial or administrative procedure. In 2009 the UN Committee on the Rights of the Child published General Comment no. 12 regarding the right of the child to be heard. As the Committee states in the introductory paragraphs of this General Comment, “… a widespread practice has emerged in recent years, which has been broadly conceptualized as participation […]

This term has evolved and is now widely used to describe on-going processes, which include information-sharing and dialogue between children and adults based on mutual respect, and in which children can learn how their views and those of adults are taken into account and shape the outcome of such processes’ (UN Committee on the Rights of the Child, 2009, p. 5).

Recently, the Committee on the Rights of the Children has published General Comment no. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, section 1). In this General Comment the Committee states that ‘the concept of the child’s best interests is aimed at ensuring both the full and effective enjoyment of all the rights recognised in the Convention and the holistic development of the child’ (p. 3). The Committee links article 3 to the other general principles of the convention (art. 2, 6 and 12). The Committee mentions ‘the inextricable links between article 3, paragraph 1, and 12: “Assessment of a child’s best interest must include respect for the child’s right to express his or her views freely and due weight given to said views in all matters affecting the child” (p. 11, our italics).

Research indicates that when decisions are made in dialogue with a young person and his or her parents, decisions have a greater chance of being realised (Bartelink, Ten Berge, & Van Yperen, 2010; Schmidt et al., 2003). However, shared decision-making in judicial and administrative procedures is not yet commonly practised, nor is it always present in the subsequent care trajectories that could arise from these decisions.
The development of the Best Interest of the Child – Self-report (BIC-S) questionnaire

Decision-making is the process of assessing and deciding (Hardman, 2009). In the field of child and youth care the professional caregiver assesses which problems need to be addressed and what kind of care and treatment in terms of quality and quantity are required (Metselaar et al. 2004). Increasingly many instruments are being used to assess and/or to analyse information about children and parents, as well as to evaluate the progress of the clients and the outcomes of the implemented care (Veerman & Van Yperen, 2007). Instruments are sometimes also used as decision aids to elucidate where problems lie and, more specifically, how to address them (Stacey et al., 2011).

A specific instrument to support decision-making for children is the Best Interest of the Child-Questionnaire: BIC-Q (Kalverboer & Zijlstra, 2006). This instrument, a questionnaire completed by professionals, has been designed as a tool to collect information about the quality of the present care situation of a child and the expectations regarding one or two future environments for upbringing and care. The aim of the questionnaire is to serve as a support tool for decision-making by professionals in various jurisdictions, such as civil law, juvenile criminal law and immigration law. The BIC-Q complies with the principles of the UN Convention on the Rights of the Child (CRC). The Convention integrates three key principles, known as the three Ps: provision (of maintenance, housing, health and education), protection (from abuse, exploitation and harm) and participation (implying, among other things, the right to access to information, to be heard, to freely express one’s thoughts, etc.) (Thomas, 2011). The 1989 CRC is the leading agreement in the global and European youth care and justice field.

The questionnaire was first examined on its psychometric qualities and feasibility by applying it in decision-making procedures with refugee children in asylum law (Kalverboer et al., 2011; Zijlstra et al., 2012; Zijlstra et al., 2013). Subsequently, it was examined for children with severe behavioural problems and juvenile offenders who were just about to leave care (Kalverboer et al., 2012). Its psychometric properties were found to be adequate.

The starting point for the construction of the BIC-Q was the Best Interest of the Child (BIC) model (Kalverboer & Zijlstra, 2006). This theoretical model comprises 14 environmental conditions (see Figure 1), which focus on protective factors in the childcare and social environments that influence a child’s development (Belsky & Vondra, 1989; Bronfenbrenner, 1979).

This paper is about the development of a self-report questionnaire for young people in decision-making procedures in the legal and care contexts: the Best Interest of the Child Self-report questionnaire (BIC-S). This questionnaire is derived from the abovementioned BIC-Q and has been designed as a feasible instrument aiming at yielding a positive contribution to shared decision-making between the young person
and care professionals in youth care (cf. Elwyn, 2001; Scheibler & Pfaff, 2003; Van Staveren, 2011). Indeed, the questionnaire could be used to inform professionals about what young people themselves think to be ‘the best future environment’ to grow up in after a period of out-of-home care. In addition, professionals can use this instrument in the process of deciding where a young person should best be treated to protect his/her development and to secure his/her future.

**Youth in care in the Netherlands**

In January 2013 Netherlands counted 3,666,148 children in the age of 0 to 18 years old (CBS, 2013). In 2010 a total of some 107,000 children and youth (0-18 years) made use of child and youth care services (Jeugdzorg Nederland, 2011), not including the number of children and youth using mental health care and child psychiatric services. Approximately 35,000 stay in out-of-home care, i.e. foster family care or residential youth care. Similar to other European countries, the number of children and youth in out-of-home care in the Netherlands has increased over the last 15 years (Knorth & Koopmans, 2012).

The most intensive type of residential care is secure residential care (Harder, 2011). Both young offenders’ institutes and secure residential treatment facilities fall under the scope of secure residential care. Young offenders’ institutes do house juvenile offenders or juveniles who are suspect of a crime; youth with severe emotional and behavioural problems can be placed in a secure residential treatment facility. In the year 2011 a total of 5,199 youngsters were placed in secure residential care (Jeugdzorg Nederland, 2011; Jeugdmonitor, n.d.). Research shows that young people in secure residential care commonly show externalizing and internalizing behavioural problems (Van Dam et al., 2010; Kalverboer et al., 2012). Furthermore, the quality of the youth’s rearing environment before admission, i.e. the family situation, is often poor (Boendermaker & Uit Beijerse 2008; Harder, 2011).
**Child participation methodology**

There is an increased awareness of children and youth being capable of active participation in scientific research (Dedding, Jurrius, Moonen, & Rutjes, 2013). Research shows that the view of the researcher on childhood impacts his/her attitude in these matters (Morrow & Richards, 1996; Powell & Smith, 2009). For instance, when youth participants are considered as vulnerable and the nature of the research topic is regarded as sensitive, researchers tend to exclude children as participants, and vice versa (Powell & Smith, 2009). At the same time there has been an increasing debate and awareness of children having rights, independently of the adults surrounding them (Emond, 2008; Munro, 2001; Sinclair, 2004; Thomas, 2007). Some researchers consider article 12 of the CRC also to be applicable on the participation of children and youth in scientific research (Morrow & Richards, 1996).

When focusing on the participation process of children and youth in scientific research Dedding and Moonen (2013) distinguish between consultative participation, collaborative participation and child-driven participation. Today’s research in which the voice of the child in sought, is broadly considered to be consultative participation in which researchers seek the perspective of children and youth with the intention to gain knowledge and understandings of the child’s views. Contrary to Dedding and Moonen, Hill (2006) notes that there is a difference between consultation and participation, in which ‘…(consultation is) finding out views in order to inform decisions, and participation (refers to the situation) where direct inputs are made into decision-making’ (p. 72).

One of the arguments often put forward in favour of children’s participation in scientific research are the ‘beneficiary’ effects associated with the participation process (Hill, 2006; Leeson, 2007). For example, Trotter and Campbell (2008) undertook a research project in 2004 in the northeast of England, in which three young men aged between 17 and 21 participated as co-researcher. They were unemployed and not engaged with any social welfare institutes. The authors found that for one of these young men engaging in the research as a co-constructer, led to an ‘observed increase in social engagement and improved well-being’ (p. 273). Trotter and Campbell make a strong point for participatory practices in research; ‘professionals may wish to continue to work and research in this way because of the ‘bi-product’ of improvements to mental health and well-being for this at-risk group’ (p. 273).

Several authors specifically report on the involvement of children and young people in scale construction (Casas, Gozález, Navarro, & Aligué, 2012; Walker, Thorne, Powers, & Gaonkar, 2010). Different participatory techniques are being explored in which children and young people have different levels of say during the research process. In a study by Walker, Thorne, Powers and Gaonkar (2010) on the development of a scale (the YES-MH) to measure the empowerment of youth consumers of mental health services, the authors used an existing questionnaire for caregivers of children.
with significant emotional and behavioural problems, the Family Empowerment Scale (FES). In the construction of the questionnaire Walker and colleagues used participatory techniques (e.g. consultation with youth and focus groups) by adapting the initial items from the FES, in consultation with youth who had received services from child and family agencies. Next to this, the research team organised several feedback groups of youth to review the complete items and measures. Likewise, Casas and colleagues (2012) used a focus group methodology with children from different age groups (8, 10 and 12 years) to investigate which formats of questionnaires were the most suitable for children. Through the use of focus group methodology, in which children were trained prior to the focus group to guarantee that they understood the aims of the research, the researchers obtained useful information on what kind of formats are most suitable for different children’s age groups.

**Aim of this study**
The aim of this paper is to inform the professional and scientific community about the BIC-S, and especially to provide insight into how young people participated in developing a self-report questionnaire for young people in decision-making procedures. We will show (a) how a theoretically sound questionnaire can be constructed to meet requirements set by young people, and (b) what lessons can be drawn from this participative developmental process.

**METHOD**

The present study is part of a broader research project focusing on the participation of young people with severe emotional and behavioural problems in decision-making procedures regarding their life-course.

The research into the construction of the BIC-S took place at four different locations. The first location is the University of Groningen, Faculty of Behavioural and Social Sciences, located in the northern Netherlands. The second and third locations are part of a secure residential centre located in the northern Netherlands. Young people aged 12 to 23 with severe emotional and behavioural problems are placed in the centre either by civil or criminal court order. The fourth location is an emergency shelter. Young people placed in emergency shelters are experiencing problems either in their behaviour/emotions or in their home circumstances and are awaiting further treatment.

The development of the BIC-S questionnaire consisted of different research stages (see Figure 2). These stages are divided into three research phases. Each research phase contributed to the subsequent phase.
Exploration phase

The first research phase (exploration) is considered to be a precondition for the following research process. In this period, running from December 2009 to April 2010, 100 university students, three research associates and an assistant professor of the University of Groningen developed a draft version of the Best Interest of the Child Self-report questionnaire.

Stage one: Assignment for university students

Students participating in the (2009-2010) ‘Ethical and juridical aspects in child and youth care’ course unit of the second-year Special Needs Education and Youth Care Bachelor’s curriculum were asked to create a ‘youth’ version of the Best Interest of the Child-Questionnaire (BIC-Q).

A total of 30 groups, consisting of two to five students, each created a BIC-S. The students had to use the BIC-Q model as a starting point for the youth version and the questions had to be formulated in such a way that they were understandable to young people aged between 12 and 18. The layout of the questionnaire needed to be suitable for teenagers and the self-report questionnaire had to contain an appropriate instruction guide or manual.

Next, the results of the 30 assignments were rated on a scale from 1 to 10, first by a research associate and then by an assistant professor, based on the following criteria:

- formulation of the questions adapted to the age group
- operationalisation of original BIC-Q questionnaire
- clear and attractive layout
- inclusion of relevant articles of the Convention on the Rights of the Child
- quality of the questionnaire manual.
Stage two: Screening by researchers
Three research associates from the University of Groningen selected the five assignments with the highest scores to prepare a draft version of the BIC-S. The research associates brought the five assignments together in a single document, which served as a document in progress (see for an example Figure 3, the pedagogical environmental condition ‘adequate care’).

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Original description of the BIC-Q pedagogical environmental condition
Adequate physical care refers to the care for the child's health and physical wellbeing by parents or care-providers. They offer the child a place to live, clothing to wear, enough food to eat and some personal belongings. A family income provides for all this. In addition, the parents or care-providers are free of worries about providing for the child's physical wellbeing.

2. Original question of the BIC-Q pedagogical environmental condition
Are the child's basic living necessities provided for?

3. Possible description of the BIC-S pedagogical environmental condition
It is important that you receive good care. Good care is, for instance, enough food and drink, clean clothing and a well maintained home.

4. Possible questions for the BIC-S pedagogical environmental condition
- Do your parents give you enough to eat and drink?
- Are they currently taking good care of you?
- When you are sick, is there someone to take care of you and take you to a doctor when necessary?
- Do you have enough clothes to wear, or do you receive money to buy clothes?
- When you leave for school do you take food with you for lunch or do you receive money for lunch?

Figure 3. Example of the development of questions for the ‘adequate care’ pedagogical environmental condition

The 14 conditions of the original BIC-Q were included in this document. All 14 conditions of the BIC-Q were matched with the formulations drawn from the assignments prepared by the students. Not all the formulations drawn from the assignments were included, due to overlap.

In the selection process that followed the research associates amalgamated all the various formulations per condition, to arrive at one which resembled most closely the principles of the original BIC-Q. This version of the BIC Self-report questionnaire became the draft for the subsequent research phase conducted in the secure residential treatment facility.
Phase two: Consultation

The second phase (consultation) of the study was conducted from April 2010 to January 2011. We asked two different focus groups in two stages, consisting of young people that were placed in a secure residential care centre (stage three) and young people placed in a young offenders institute (stage four) to assist in further developing the draft version of the BIC-S.

Stage three: Focus group of young people placed in a secure residential care facility

The first focus group consisted of eight young people (boys and girls). These young people were all placed into state care because of severe behavioural problems, mostly in combination with severe problems in their home environment. Although not convicted for criminal offences, most had been in contact with the law prior to placement.

The young people in this focus group participated voluntarily after being approached by the researchers during a youth council meeting. They were asked to convey the opinions of the other members of their respective young person’s residential units.

Once every two weeks, two researchers spoke with the focus group about the improvements to be made to the draft questionnaire. Altogether, the process of improving the questionnaire carried on until it was felt to be sufficient by both the young people and the researchers. This took six sessions.

The first session was dominated by getting acquainted with the members of the youth council. The researchers provided both written and oral information about the research project to the young people. In the second and third sessions the draft BIC-S was presented to the young people and discussed in a group. In the fourth and fifth sessions comments and alterations from earlier sessions were discussed with the focus group, as well as an adjusted version of the BIC-S. During the sixth and final sessions the first real draft version of the questionnaire was shown to the youth council. The young people had a final opportunity to provide feedback, which resulted in a draft BIC-S for elaboration in the next stage.

Stage four: Focus group of young people placed in a young offenders institute

The second focus group included eight young people (only boys) staying in a young offenders institute. These young people were all suspected or convicted of committing crimes.

The young people participating in this focus group were not all members of the youth council, although most were. The members of the group participated voluntarily after being approached by the researchers at their residential units. The young people represented all four of the institutes’ residential units.

Two researchers discussed the draft BIC-S questionnaire, as obtained in stage three, with eight members of this focus group. The aim of these sessions was to decide
whether, in their opinion, the questionnaire was relevant and applicable to their situation. A total of three sessions were conducted. In the first session information about the research project was supplied and the role of the young people in the research was discussed. The revised version of the questionnaire was provided to the young people. During the second and third sessions, the role and the value of the questionnaire were discussed along with possible suggestions for improvements.

**Phase three: pilot**

The young people from the first focus group suggested that the BIC-S should be digitised. After the final session in the secure residential care facility, this digitisation was implemented. In the third research phase (*pilot*), which took place in spring 2012, a digitised draft BIC Self-report questionnaire was tested in a pilot study. Four young people with severe emotional and behavioural problems and five care professionals participated, examining the quality and the practical application of the questionnaire.

**Stage five: Pilot testing with young people and care professionals**

Two of the four young people who participated in the pilot stayed in a residential care facility. The problems these young people face originate in their home environments prior to placement, in combination with behavioural and emotional problems. The other two young people were placed in an emergency shelter. These young people experience problems either in their behaviour/emotions or in their home environments.

The care professionals involved in the pilot group consisted of two care coordinators, one system therapist and two professional caregivers. The four young people and five care professionals participated voluntarily.

Two research students, who were doing their internships at the secure residential care facility, conducted in-depth interviews on their experiences with the BIC-S with both the young people and professionals. Prior to the in-depth interviews, the students supplied the young people and the care professionals with information about the pilot study and the aim of the BIC-S.

The research students conducted one session per young person during which the young people completed the BIC-S questionnaire. Each young person completed the BIC-S at a random moment during his/her stay in care. After completing the BIC-S, the students asked the young people the following questions:

- Were they able to complete the questionnaire?
- Did they get a better view of their current living circumstances at home?
- Did the completion of the BIC-S change their view of how they were being brought up?
- Did the completion of the BIC-S questionnaire present new treatment goals to work on when returning home?
• How did they experience the process of completing the BIC-S?
• Did they have any suggestions for improvements to the BIC-S?

During various interview sessions the two research students asked the five professionals if and how they thought the BIC-S was suitable for:
• the diagnostic assessment process
• forming an opinion on the current and future living environment
• treatment motivation
• the treatment relationship
• decision-making.

Finally, the interviews of both the young people and the professionals were analysed and presented in a Master’s thesis (Wekema & Post, 2012). Based on these findings, the results of the pilot study led to several improvement recommendations for the questionnaire. These recommendations were incorporated, leading to the present version of the BIC-S.

RESULTS

In the result section we will discuss the consultation and pilot phases, which are the two phases during which the future BIC-S users were involved and the feasibility of the instrument was studied. Phase one will not be discussed because this phase served solely as an exploratory phase to construct the initial version of the BIC-S.

Consultation phase: focus groups

During the first focus group session the general opinion of the young people was one of ‘resistance’ when asked to cooperate in the construction of the young person version of the BIC-S. They did not feel they needed another questionnaire ‘since there are already so many questionnaires to be completed throughout the whole care process’. In addition, they stated that questionnaires ‘are only a snapshot and do not represent reality’. One young person expressed his displeasure with the system by saying that he saw no point in giving his own opinion, ‘when there are already numerous professionals who have given their opinion on the state of young people’.

In the group sessions which followed, opinions gradually changed and the participants grew increasingly enthusiastic about the questionnaire. The young people were pleased to be approached as consultants. This was illustrated by how the group members appreciated our introduction of a preliminary digital version of the BIC-S in the second session, a recommendation the group proposed during the first session.

According to these young people, however, the questions were formulated too vaguely and were not specifically adjusted to their situation. They pointed out that in the form
it had at that time, the questionnaire did not fully cover their 'life story': for instance, life in a secure residential facility is fairly different from the living with your parents. Another important statement the group made was that the questionnaire used at that time made it quite easy to provide socially desirable responses. The young people told the researchers that they could easily answer that they were not using drugs or alcohol even if this was not the case.

The young people suggested the following, most important alterations to the BIC-S:

- The questionnaire has to be short. Completing the questionnaire must take no longer than 15 minutes, the attention span of young people. When the questionnaire was first presented to the focus group, it had over 80 items.
- The language used in the questionnaire should be simple: no long sentences, no difficult words. The questionnaire would thus be more accessible to most young people. For instance, the term ‘social network’ was used to refer to the contacts a young person has with his or her social environment. However, the group thought that this term was about the internet network they had at home.
- In addition to the closed format questions in the questionnaire, there should be extra space for respondents to tell their own personal story (open format questions). Young people want to explain why their home circumstances are the way they are when they provide questionnaire responses as to their quality.
- The questionnaire should be digital, because this is easier, neater and more fun to complete. The list should be available on the internet to all young people living in institutions so that they can complete the list whenever they want.
- The questionnaire should not be too general. For instance, young people who live in an institution do not necessarily go outside, so the question ‘do your neighbours fight?’ does not directly relate to these young people and their living environment. By digitizing the questionnaire, the formulation of some questions can be adjusted per individual.
- The young people wanted a more attractive questionnaire, illustrated with their own drawings and pictures.

The young people from the young offenders institute agreed with the revised version of the questionnaire as suggested by their ‘colleagues’ in the secure residential care centre, although they had some additional comments. They still thought that the questionnaire was rather long, which could discourage some from completing it.

The young people indicated that the main focus of the questionnaire should be in generating items for a conversation with a professional. According to the young people, no instrument can replace a good ‘one-on-one talk’.

Elaborating on one of the alterations suggested by the previous focus group, one group member from the young offenders institute designed a graffiti drawing, which we used thereafter as the background for the digital version of the Best Interest of the Child Self-report questionnaire.
Pilot phase

In the pilot phase it also became clear that length, layout and distinctness were essential elements to attract the attention of the young person user. Furthermore, the young people in the pilot study shared the opinion of the previous focus group that a ‘one-on-one talk’ should lead the questionnaire content.

The young people were most positive about their ability to complete the questionnaire (feasibility) and about the contribution of the BIC-S to the process of participating in a decision. As one of the young people’ stated:

I was able to give my honest opinion and they listened to me […]. I have to go live with a foster family. I knew that even before my stay in [name emergency shelter]. I am not allowed to choose where I want to go, they decide for me. However, I do see that it’s better there with [foster family] than at the [name emergency shelter], because I can stay there for a longer period.

Another young person said that by completing the BIC-S, he was enabled to give fair answers to the questions and felt that he was taken seriously. Figure 4 is a screenshot of the English version of the digital BIC-S for the condition ‘Care: food, drinks, clothing, possessions.’

The young people were ambivalent or negative about the contribution of the BIC-S to getting a better view of their future living circumstances. All the young people reported having clear knowledge and views on this point.

The young people had mixed opinions about whether the BIC-S would be suitable for further treatment or for the forming of treatment goals. Two participants thought that completing the BIC-S questionnaire could lead to new treatment goals to work on when returning home, whereas the other two did not think that this would result in any treatment goals. Because the completion of the BIC-S was arranged at an arbitrary moment during their stay in residential care, it was not incorporated in a treatment plan session. Accordingly, one of the young people stated that if the BIC-S had been completed at the beginning of his placement, clear working goals could have been set from filling it in.

Two of the young people indicated that the questionnaire’s output is helpful clarifying where the problem areas in their home environment lay. Figure 5 is an example of how the output of the BIC-S would look like.

The output is expressed as a bar chart, where the dark grey bar shows the results of the perceived quality of the care environment in the present situation (residential care) and the grey bar shows the outcomes of the perceived care environment in the expected situation (at home). The horizontal axis shows the 14 BIC-S conditions.
As can be seen in Figure 5, the general perspective of this particular young person is slightly more positive about the environment at home than about the environment in the residential care facility.

After completing the BIC-S, one young person stated that he would like to have a conversation with the care professionals responsible for his care process: ‘Talking about it could help. The other person then knows what you think about your situation.’
Filling in this questionnaire made the young person more aware of his situation and the issues for improvement.

**Professionals**

The professionals stated that the various questionnaire domains could serve as a useful basis for diagnostic interviews. According to them, a conversation based on the BIC-S outcomes could result in better participation and increased motivation by the young person. This means that, according to the professionals, the BIC-S instrument could be a suitable/promising vehicle for shared decision-making.

The professionals who participated in the pilot study also recommended developing a version of the questionnaire that could be completed by one or both of the young person’s parents. This could make ‘triangulation’ of perspectives possible (cf. Bogdan & Biklan, 2006).

**DISCUSSION**

The aim of the paper was to provide insight into the participatory development process undertaken, including the final result, to construct the *Best Interest of the Child Self-report* questionnaire (BIC-S).

The results show that the BIC-S instrument could be a suitable/promising vehicle for shared decision-making in the field of youth care. The BIC-S has the potential to be a valuable tool to increase the participation and engagement of young people in care and this, in turn, could increase the number of well-grounded, multi-informant assessments and decisions in the field of youth care and treatment (Strijker, 2008). Or as Walker and colleagues (2010) formulate it: “Development of a measure of this kind is important given the evolution of the field of children’s mental health and its growing commitment to ensuring youth voice in mental health service design and delivery” (p. 57-58).

Although youth involvement in decisions is regarded to be important in order to come to well-grounded decisions, it is not always standard procedure. Bessell (2011) found that the young people felt their time in out-of-home care was characterised by ‘non-participation in decisions made about their lives’ (p. 498). As Bessell continues: ‘None of the young people participating in my study felt they had sufficient or consistent opportunity to express their views on matters affecting them while in care’ (p. 498). Even though they were present at moments of decision-making, they did not feel they were participating. The interviews with the young people showed that when care professionals listened to and acted by taking concerns seriously and providing real options, young people felt valued.

Compliance or consensus within the field of decision-making in youth care is closely related to participation. In order to achieve well-made decisions, the voice of the child...
should be taken into account. Whether or not the care professionals are capable of translating their views into the language of the client and adapting to his or her frame of reference influences the consensus process (Kromhout, Eldering, & Knorth, 2000). For treatment to be successful there needs to be a sufficient association between the intentions of the care professional and the expectations of the young person. Results of a study by Schmidt et al. (2003) in German child and youth care practices show that the risk of premature termination of care decreases when youth are actively engaged in the care process. The collaboration of young people (and their families) in the treatment process also determines the functioning of the young person when leaving care. This endorses the need for participation of young people and their family throughout the complete trajectory of care. And is thus in line with article 12 ‘The right to be heard’ and article 3 ‘the best interest of the child as a primary consideration’ of the CRC (1989).

**Gains of the participatory process**

To develop the BIC-S we used a readily reproducible development process. Because two more or less similar focus groups of young people contributed to the construction and thus to the ecological validity of the BIC-S, support for the instrument was achieved. Since we wanted to construct a questionnaire that reflected the desires of young people, we chose to employ a participatory approach. Participatory techniques in which children play a significant role have made their way into research practices (Holland, 2009). In the field of youth care there has been an emerging interest in the use of participatory techniques in research. In line with one of the findings of Kilkelly’s (2010) research on child friendly justice performed for the European Union ‘children should be involved in the design of the methodology/questionnaire – perhaps through a children’s steering or advisory group who could be involved throughout – which should then be fully piloted with specific groups of children in advance of their finalisation and general dissemination’ (p. 7).

During the participatory development procedure the young people in the secure residential care focus group showed increased motivation to participate in the research once their initial attitude of ‘resistance’ was overcome. This could be because they saw a direct result to their own input and felt taken seriously by this, resulting in their being more willing and enthusiastic to contribute to the development of the BIC-S. An example of this change in motivation was clearly seen when the researchers demonstrated an early digital version of the questionnaire to the young people, which the young people had recommended previously.

The young people indicated that the time taken to complete a questionnaire should not exceed 15 minutes, and that it should be written in plain and simple language. The outlook and language of the questionnaire should encompass the ideas of young people: it should be short, uncomplicated and attractive. These are essential elements to catch the attention of the young people involved (Casas et al., 2012), and were thus incorporated in the BIC-S.
Levels in use

The BIC-S has the potential to be employed at different levels and at different moments during a young person’s care path.

When the BIC-S is applied at an individual (micro) level, it can be used in the diagnostic process and in treatment. The questionnaire is a tool to support complex professional assessments in decision-making procedures, where the systematized view of the young person can be taken into account. In addition, it is designed to provide a clear picture of where the risk and protective factors within a care environment lie for both young people and professionals. Simultaneously, the questionnaire can yield insight into where the differences in perspectives of the professional and the young person lie and how to address these differences. Aspects such as feasibility and reality (is it really as bad or as good as you think?) and/or wishes and needs (what is necessary to make something happen, or to meet certain expectations?) regarding pedagogical environmental options can be addressed in conversation with the young person. The questionnaire could be used as a support for determining the most suitable treatment, targeting the improvement of the quality of the child’s living environment. The questionnaire can be applied next to other diagnostic instruments that form an expression of the perspective of the care professional (Strijker, 2008).

Key information that resulted from the participatory development process indicates that the BIC-S could serve as a tool in the conversation between young person and care professional. Young people suggested that the dialogue with the professional emerging from the completion of the questionnaire should be leading. The professionals who participated in the research also considered the questionnaire to be a good basis for conversations with the young person about his or her perspectives on current and/or future living environments. The output of the questionnaire could show young people clearly where their problem areas are, or the difference between their perceptions and what other parties who completed the professional version of the BIC questionnaire think about their current or future living environment.

Results show that shared decision-making where the young person has a significant role in assessing and deciding is not solely achieved through the ‘static’ completion of a questionnaire. This raises the question of when the BIC-S instrument process should be employed to be meaningful to the young person. The dialogue flowing from the BIC-S questionnaire and the way a treatment process is further designed could contribute to or result in shared decision-making (Fraser, Lewis, Ding, Kellett, & Robinson, 2004; Van Nijnatten, 2013).

Another option is to use the BIC-S as a scale for measuring the inhabitants’ satisfaction with their social environment at their institution or living unit. The various questionnaire domains can serve as an evaluation tool of how the young people experience the quality of their current living environment while living in care (see for another example Knorth
et al., 2004). When multiple perceptions of young people are brought together, the BIC-S could be used to inform staff or the institution board how young people ‘generally’ experience their living environment. The BIC-S could thus be used at a (meso) policy level.

There is evidence that young people’ previous adverse experiences, such as background or treatment history, are negatively correlated to positive future treatment outcomes. However, there is also empirical proof that the living environment in which young people stay serves as a moderator (Van der Helm et al., 2009): if young people stay in a ‘good’ living environment this could lead to better treatment outcomes, despite having had prior adverse experiences (see also Schubert et al., 2012). The BIC-S could reveal how young people experience their living environment. Where they point out negative ‘points’ in their current living environment, the institute could attempt to implement improvements (Anglin, 2002). Besides, one could expect that the use of a tool like the BIC-S in itself contributes to the experience by residential inhabitants of an open climate where ‘it does matter’ what they think and want (cf. Schubert et al., 2012).

Implementation

The BIC-S is developed in the context of participation as a pre-condition to shared decision-making. For the young person to be able to fully participate, the principles of protection and provision have to be taken seriously (Thomas, 2011). This implies that participation has to take place in a healthy environment under safe conditions, also with regard to the use of the BIC-S questionnaire. It is also necessary to consider how to create a safe environment in which the questionnaire serves an informative purpose, combining diagnostics and participation. The way the outcomes are used should be considered carefully in this context: for example, if a young person reports being maltreated at home, this should be considered in light of the fact that parents might also be present during treatment plan discussions.

Young people placed in secure residential care come from different and sometimes complex backgrounds (Harder, 2011). They often have learning and attention difficulties. Some young people are unable to read or write. These considerations should be taken into account when deploying the BIC-S instrument. An option in this respect is to break the questionnaire down into sections or to apply it as an interview.

When the BIC-S was tested in the pilot study, the young people sometimes questioned the questionnaire’s value in obtaining a better view of their future living environment and which treatment goals they should have. When a young person is already in an advanced stage in his or her treatment process and the future living environment is already set, the questionnaire has less to offer. We therefore recommend using the questionnaire during the first part of the treatment path.
Strengths and limitations

One of the strengths of the research is that we used a participatory approach to construct the Best Interest of the Child Self-report questionnaire, which strongly contributed to its ecological validity. In addition, we used a readily reproducible development process, which resulted in a practically applicable and appreciated instrument.

The questionnaire was tested on a small group of young people. We would like to determine the BIC-S’s reliability (e.g. intra-rater reliability) and validity (construct and criterion validity) on a larger group of young people. Because the BIC-S has not yet been examined on these qualities, the tool is currently only used for research purposes, and is not yet applicable in everyday clinical practice. Considering the fact that the BIC questionnaire for professional use – the BIC-Q – proved reliable, valid and feasible (Kalverboer et al., 2012), our expectations are positive. When examining the criterion validity of the BIC-S, we hypothesize that youths placed in a negatively experienced environment, will do worse on problem behaviour indices than young people who evaluate their environment positively (Van der Helm et al., 2009).

Further, we chose the moment at which the BIC-S was completed by participating young people more or less randomly during their stay in care. The added value of the BIC-S at the beginning of the treatment planning process seems reasonable, but further research requires the examination of this assumption.

In conclusion

Following elaborate consultations with young person focus groups and a panel of care professionals, a differentiated instrument has been developed, giving young people in care an opportunity to express their own views on their living conditions – currently and in the future. Its usefulness was appreciated as a transparent basis for dialogue on care and legal issues between young clients and their therapists/mentors. The BIC-S could serve as a suitable, productive vehicle for assessment and shared decision-making in the field of youth care – not only at the micro level of individual treatment but also at the meso level of evaluating group programmes. Further research into its use in practice, including its psychometrics, is recommended and has already been started.

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