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The Best Interest of the Child Self-Report Questionnaire (BIC-S)

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The Best Interest of the Child Self-Report Questionnaire (BIC-S): Results of a Participatory Development Process

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Abstract This paper provides insight into the participatory development process of a self-report questionnaire for adolescents: 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. Adolescents 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 digitized questionnaire is unique in its comprehensiveness, accessibility and attractiveness for young people, and generates an evaluative profile of care conditions from the adolescents themselves. The paper shows how a theoretically sound questionnaire can be constructed to conform to standards set by adolescents 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.

Keywords Youth participation · Assessment · Instrument · Adolescence · Convention on the rights of the child · Shared decision-making

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1 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 recognized 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 an adolescent and his or her parents, decisions have a greater chance of being realized (Bartelink et al. 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.

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 and 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 and 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 and Zijlstra 2006). This theoretical model comprises 14 environmental conditions (see Fig. 1), which focus on protective factors in the childcare and social environments that influence a child's development (Belsky and Vondra 1989; Bronfenbrenner 1979; Farrington 2003).

This paper is about the development of a self-report questionnaire *for adolescents* 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 adolescent and care professionals in youth care (cf. Elwyn 2001;

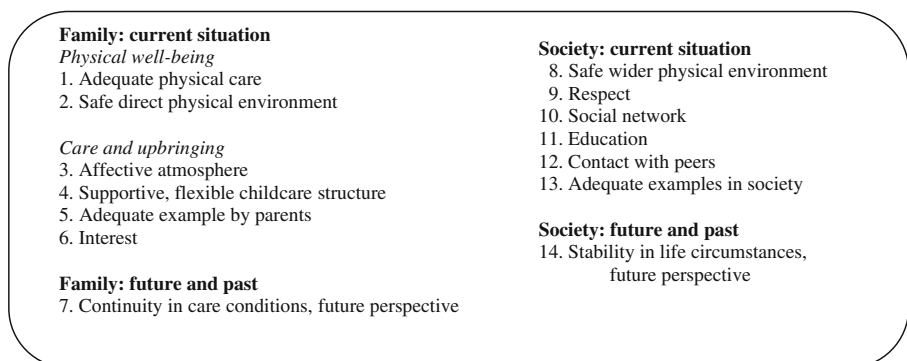


Fig. 1 The best interest of the child model

Scheibler and Pfaff 2003; Van Staveren 2011). Indeed, the questionnaire could be used to inform professionals about what adolescents *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.

1.1 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 and 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 2013). Research shows that young people in secure residential care commonly show externalizing and internalizing behavioural problems (Van Dam et al. 2010; Harder 2006). Furthermore, the quality of the youth’s rearing environment before admission, i.e. the family situation, is often poor (Boendermaker and Uit Beijerse 2008; Harder 2006).

1.2 Child Participation Methodology

There is an increased awareness of children and youth being capable of active participation in scientific research (Dedding et al. 2013). The use of the concept of participation in scientific research can be seen in light of a democratisation tendency and our changing images of childhood (Dedding et al. 2013). Research shows that the view of the researcher on childhood impacts his/her attitude in these matters (Morrow and Richards 1996; Powell and 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 and 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 1998). Some researchers consider article 12 of the CRC also to be applicable on the participation of children and youth in scientific research (Morrow and 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 is 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 favor 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 et al. 2012; Walker et al. 2010; Van Beek and Rutjes 2009). 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 et al. (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 behavioral 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 organized 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.

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

2 Method

The present study is part of a broader research project focusing on the participation of adolescents 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. Adolescents 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. Adolescents 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 Fig. 2). These stages are divided into three research phases. Each research phase contributed to the subsequent phase.

2.1 Phase One: Exploration

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.

2.1.1 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

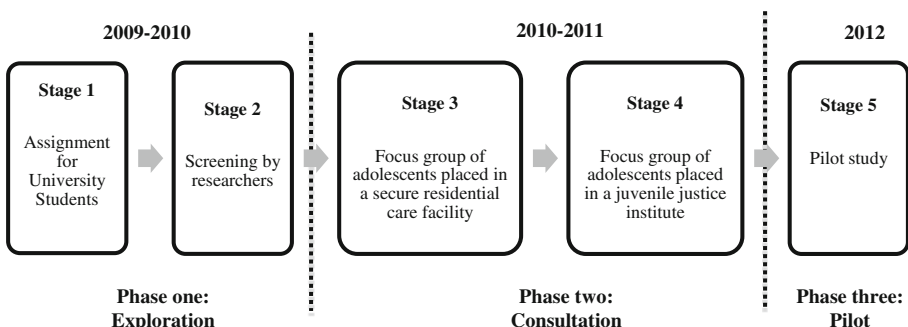


Fig. 2 Stages of development of the best interest of the child self-report questionnaire (BIC-S)

adolescents 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
- operationalization 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.

2.1.2 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 Fig. 3, the pedagogical environmental condition ‘adequate care’). 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.

1. Condition title

Adequate care

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?

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

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.

2.2 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 adolescents that were placed in a secure residential care centre (stage three) and adolescents placed in a young offenders institute (stage four) to assist in further developing the draft version of the BIC-S.

2.2.1 Stage Three: Focus Group of Adolescents Placed in a Secure Residential Care Facility

The first focus group consisted of eight adolescents (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 adolescents 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 2 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 adolescents 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 adolescents. In the second and third sessions the draft BIC-S was presented to the adolescents 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 adolescents had a final opportunity to provide feedback, which resulted in a draft BIC-S for elaboration in the next stage.

2.2.2 Stage Four: Focus Group of Adolescents Placed in a Young Offenders Institute

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

The adolescents 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 adolescents 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 held. In the first session information about the research project was supplied and the role of the adolescents in the research was discussed. The revised version of the questionnaire was provided to the adolescents. During the second and third sessions, the role and the value of the questionnaire were discussed along with possible suggestions for improvements.

2.3 Phase Three: Pilot

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

2.3.1 Stage Five: Pilot Testing with Adolescents and Care Professionals

Two of the four adolescents who participated in the pilot stayed in a residential care facility. The problems these adolescents face originate in their home environments prior to placement, in combination with behavioural and emotional problems. The other two adolescents were placed in an emergency shelter. These adolescents 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 adolescents 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 adolescents and professionals. Prior to the in-depth interviews, the students supplied the adolescents and the care professionals with information about the pilot study and the aim of the BIC-S.

The research students held one session per adolescent during which the adolescents completed the BIC-S questionnaire. Each adolescent completed the BIC-S at a random moment during his/her stay in care. After completing the BIC-S, the students asked the adolescents 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 adolescents and the professionals were analysed and presented in a Master's thesis (Wekema and 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.

3 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.

3.1 Consultation Phase: Focus Groups

During the first focus group session the general opinion of the adolescents was one of 'resistance' when asked to cooperate in the construction of the adolescent 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 adolescents 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 adolescents, 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 adolescents told the researchers that they could easily answer that they were not using drugs or alcohol even if this was not the case.

The adolescents 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 min, the attention span of adolescents. 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 an adolescent 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). Adolescents 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 adolescents living in institutions so that they can complete the list whenever they want.
- The questionnaire should not be too general. For instance, adolescents who live in an institution do not necessarily go outside, so the question ‘do your neighbours fight?’ does not directly relate to these adolescents and their living environment. By digitizing the questionnaire, the formulation of some questions can be adjusted per individual.
- The adolescents wanted a more attractive questionnaire, illustrated with their own drawings and pictures.

The adolescents 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 adolescents indicated that the main focus of the questionnaire should be in generating items for a conversation with a professional. According to the adolescents, 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.

3.2 Pilot Phase

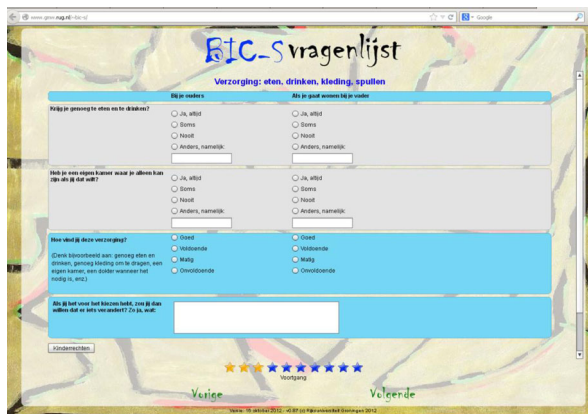
In the pilot phase it also became clear that *length*, *layout* and *distinctness* were essential elements to attract the attention of the adolescent user. Furthermore, the adolescents in the pilot study shared the opinion of the previous focus group that a ‘one-on-one talk’ should lead the questionnaire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

The adolescents 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 adolescents' 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 adolescent 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 Dutch version of the digital BIC-S for the condition 'Care: food, drinks, clothing, possessions.'

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



Translation in English:

Care: food, drinks, clothing, possessions		
	Now that you live in	When you will stay in
1. Do you receive enough food and drinks?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know <input type="radio"/> Something else:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know <input type="radio"/> Something else:
2. Do you have your own room, where you can be by yourself if you want to?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know <input type="radio"/> Something else:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know <input type="radio"/> Something else:
3. What do you think about this care?	<input type="radio"/> Good <input type="radio"/> Satisfactory <input type="radio"/> Moderate <input type="radio"/> Unsatisfactory	<input type="radio"/> Good <input type="radio"/> Satisfactory <input type="radio"/> Moderate <input type="radio"/> Unsatisfactory
<i>(For instance: do you receive enough food and drinks, you have enough clothes to wear, you have your own room, you can see a doctor when necessary, and so on)</i>		
If you had the possibility to change anything, what would it be?		

Fig. 4 Screenshot of the Dutch version of the digital BIC-S for the condition 'Care: food, drinks, clothing, possessions'

The adolescents 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 adolescents 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 adolescents 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 Fig. 5, the general perspective of this particular adolescent is slightly more positive about the environment in the residential care facility than about the environment at home.

After completing the BIC-S, one adolescent 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 adolescent more aware of his situation and the issues for improvement.

3.2.1 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

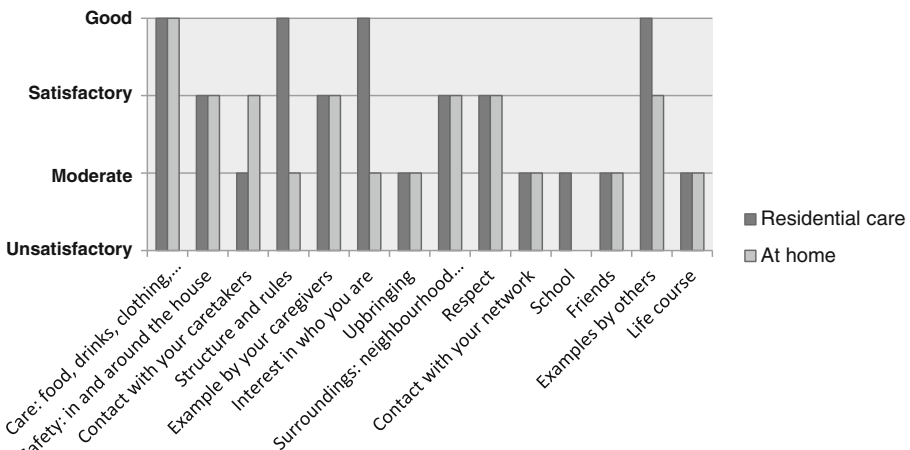


Fig. 5 Example of the output of the BIC-S when completed by an adolescent

adolescent. 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 adolescent's the parents. This could make 'triangulation' of perspectives possible (cf. Bogdan and Biklen 2006).

4 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 adolescents 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 characterized 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 et al. 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 adolescent. 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 adolescents (and their families) in the treatment process also determines the functioning of the adolescent when leaving care. This endorses the need for participation of adolescents 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 Convention on the Rights of the Child.

4.1 Gains of the Participatory Process

To develop the BIC-S we used a readily reproducible development process. Because three more or less similar focus groups of adolescents contributed to the construction and thus to the ecological validity of the BIC-S, broad support for the instrument was achieved. Since we wanted to construct a questionnaire that reflected the desires of adolescents, 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 adolescents 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 adolescents, which the adolescents had recommended previously.

The adolescents indicated that the time taken to complete a questionnaire should not exceed 15 min, 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 adolescents' involved (Casas et al. 2012), and were thus incorporated in the BIC-S.

4.2 Levels in Use

The BIC-S has the potential to be employed at different levels and at different moments during an adolescent'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 adolescent 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 adolescents and professionals. Simultaneously, the questionnaire can yield insight into where the differences in perspectives of the professional and the adolescent 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 adolescent. 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 adolescent and care professional. Adolescents 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 adolescent about his or her perspectives on current and/or future living environments. The output of the questionnaire could show adolescents 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 adolescent 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 adolescent. 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 et al. 2004; Van Nijmegen 2010).

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 adolescents experience the quality of their current living environment while living in care (see for another example Knorth et al. 2004). When multiple perceptions of adolescents are brought together, the BIC-S could be used to inform staff or the institution board how adolescents ‘generally’ experience their living environment. The BIC-S could thus be used at a (meso) *policy level*.

There is evidence that adolescents’ 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 adolescents stay serves as a moderator (Van der Helm et al. 2009): if adolescents 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 adolescents 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).

4.3 Implementation

The BIC-S is developed in the context of participation as a pre-condition to shared decision-making. For the adolescent 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.

Adolescents placed in secure residential care come from different and sometimes complex backgrounds (Harder 2006). They often have learning and attention difficulties. Some adolescents 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 adolescents sometimes questioned the questionnaire's value in obtaining a better view of their future living environment and which treatment goals they should have. When an adolescent 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.

5 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 adolescents. 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 adolescents. 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 adolescents 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 adolescents 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.

6 In Conclusion

Following elaborate consultations with adolescent 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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