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ORIGINAL ARTICLE

Participation of youth in decision-making procedures during residential care: A narrative review

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Abstract

Participation in decision-making procedures of young people in care is considered a key element that affects their current or future living circumstances and might improve the quality of decision-making on and delivery of provided services.

This narrative literature review, covering the period 2000–2016, focuses on the opportunities of young people to participate, the challenges and facilitators to participation, and the outcomes of care related to participation.

Sixteen studies met our search criteria. Several studies show that young people seem to have limited possibilities to "meaningful" participation in decision-making. Various challenges and facilitators in the participation process emerge with regard to the level of the young person, the professional, and the (sociocultural) context. None of the studies provides evidence for a connection between the "amount" of youth participation in decision-making and/or treatment during the care process and the outcomes of residential care. Implications for research and practice are reflected upon.

KEYWORDS

children's participation, children's rights, residential care, young people

1 | INTRODUCTION

"A child temporarily or permanently deprived of his or her family environment or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State" (Article 20, para 1, Convention on the Rights of the Child 1989). According to Article 20 of the Convention on the Rights of the Child (CRC), such care could include the placement of a child in family foster care or, if necessary, in residential care.

In residential youth care services, young people reside away from their homes, most of the times in a nonfamilial setting. The aim of residential youth care services is to offer care and protection and to prepare the young person for a return to society. Services intend to do so by creating a therapeutic living environment (Whittaker et al., 2016). Over the years, residential youth care on a policy level has increasingly committed itself to multidisciplinary collaboration and to the application of effective treatment interventions within the care process (De Swart et al. with James, 2017). In addition, young people are more and more regarded as active stakeholders in their own care process (Friesen, Koroloff, Walker, & Briggs, 2011; Gyamfi, Keens-Douglas, & Medin, 2007).

This notion of young people participating as active stakeholders in care can be seen in the light of a tendency towards democratization and changing images of childhood, that is, perceiving the young person as a "social actor" instead of only seeing him or her as vulnerable and in need of protection (Bell, 2011). At the same time, with the establishment of the CRC in 1989, there is an increased notion of children having their "own" (participation) rights (Emond, 2008; Sinclair, 2004; Thomas, 2007).[1] From a psychological and pedagogical stand of view, the participation of young people can be linked with a perspective on development and upbringing (Bell, 2011; De Winter, 2002).

1.1 | Participation in decision-making

Knowledge on the concept of young people's participation in decision-making has increased over the years, due to a growing body of international literature on participation in care and decision-making (Bell, 2011; Cashmore, 2002; Sinclair, 2004). As a side effect, there are various definitions and models regarding "participation" in circulation (e.g., Arnstein, 1969; Hart, 1992; Kirby, Lanyon, Cronin, & Sinclair, 2003). Generally speaking, youth participation is the process of

involving young people in the institutions and decisions that affect their life (Checkoway, 2011, p. 341).

In 2009, the Committee on the Rights of the Child published General Comment no. 12 in which the Committee links Article 12, "the right to be heard," of the CRC to the concept of participation. The Committee defines participation as

> *"ongoing 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" (p. 5).*

When we look at participation in the context of youth care, most of the existing literature focuses on youth in child welfare and child protection services (e.g., Gallagher, Smith, Hardy, & Wilkinson, 2012; Vis & Thomas, 2009), young people confronted with the family law due to separation of their parents (e.g., Röbäck & Höjer, 2009; Taylor, Fitzgerald, Morag, Bajpai, & Graham, 2012), or youths dealing with decisions in (mental) health care (e.g., Coyne & Harder, 2011; Day, 2008). To a much lesser degree, research has focused on the participation of young people during residential care, despite the fact that in that context decisions are made regarding the treatment process and concerning everyday issues that substantially impact the lives of these young people (Southwell & Fraser, 2010).

1.2 | Opportunities, challenges, and facilitators of participation

Although participation of young people in decision-making procedures is considered important, research indicates that there are still numerous challenges in the participation process of young people. For example, a review in England on the levels and ways in which children are currently involved in decision-making regarding different areas that affect their lives (e.g., education, health services, and child protection services) shows that in some areas, such as asylum procedures and child protection cases, young people are hardly heard in the most personal decisions (Burke, 2010). And when they were heard, their opinion had little or no impact on the final decision (ibidem). Other studies that focused on the experiences of youths with decision-making procedures during their contacts with child welfare and child protection services show that young people experience feelings of helplessness, a lack of knowledge and little self-confidence by a lack of opportunities to make decisions about their own life (Bessell, 2011; Leeson, 2007).

In a recent review by Van Bijleveld, Dedding, and Bunders-Aelen (2013) on the challenges and facilitators to youth participation in child welfare and protection services, the personal relationship between the young person and the social worker was one of the most important facilitators to participation. However, the review showed that there seemed to be multiple challenges in creating this personal relationship, such as the social workers' lack of understanding of what participation actually means, their perception of the young person as a vulnerable individual, and the urgent feeling to protect the child by not letting him or her participate in "difficult" decisions.

1.3 | Participation and outcomes

In addition, even though various studies stress the importance of youth participation in care, there are few studies that evaluate the effect of participation on possible outcomes. In a review study on the participation of young people (0–18 years old) in child protection proceedings and the relationship with health outcomes, Vis, Strandbu, Holtan, and Thomas (2011) found that "… health effects could only be indirectly assumed" (p. 328). The authors suggest that when participation is successful, beneficiary effects may be reflected in better decisions and tailored services, improvements of child's safety, and therapeutic effects such as increased self-esteem. However, Vis et al. conclude that evidence of long-term outcomes of participation on health effects (e.g., physical, mental, and social well-being) is lacking. In line with this, the National Youth Agency (2011) found no empirical evidence that youth participation in the context of youth justice is related to positive long-term outcomes, such as a reduction in the number of young people in contact with juvenile justice. Just like Vis et al. (2011), the National Youth Agency suggests that this lack of empirical evidence does not imply that participation does not work, but points out the lack of "rigorous research" as an important factor for the absence of proof.

1.4 | Aim of this study

Because participation of young people is thought to improve the quality of decision-making on and delivery of provided services, and to contribute to positive therapeutic effects (cf. Vis et al., 2011), this may also be the case for the participation of young people in decision-making procedures while staying in residential care. With this review study, we intend to contribute to the current discussion on the topic of participation (e.g., Križ & Skiveness, 2015; Van Bijleveld et al., 2013; Vis et al., 2011). Therefore, the aim of this review is to assess the current state of knowledge on the level and type of participation of young people in decision-making procedures related to their stay in residential care. We hereby focus on (a) the opportunities of young people to participate, also in relation to the content and setting of decisions that are being made, (b) the possible challenges and facilitators to participation, and (c) the possible outcomes of care related to participation.

2 | METHOD

We carried out a narrative literature search in July 2015–February 2016. Three electronic databases were used to carry out the search: PsycINFO, Education Resource Information Clearinghouse (ERIC), and Social Index (SocIndex). For the search in the electronic databases, we combined the following search terms:

- Adolescent* OR juvenile* OR youth* OR child* OR young*;
- Residential OR out-of-home OR detention centre* OR secure unit* OR secure care OR inpatient OR institutional OR incarcerat* OR group home* OR hospitalised OR juvenile justice facilit* OR secure residents OR correctional institution* OR coercive treatment OR congregate care;

- Participation OR child* participation OR youth participation OR consumer participation OR children's rights OR participation rights OR voice OR collaboration OR shared decision-making.

2.1 | Selection criteria

2.1.1 | Inclusion criteria

We collected literature published in English during the period 2000 up to February 2016. Literature was included that focused on studies regarding youth (aged 0 to 25) with emotional and/or behavioural problems and/or rearing problems; residential youth care as the main service in the study (e.g., psychiatric inpatient units, children's homes, residential treatment centres, and transitional houses); scientific, peer-reviewed publications; empirical studies; and studies that focused on the participation of young people in decision-making (Vis et al., 2011).

Participation in decision-making was defined as informing and preparing the young person, focusing on the young person's views and wishes, giving these views due weight, providing the young person with feedback, and/or being able to start complaint procedures and appeal against decisions (see also General Comment no. 12, p. 10). We included studies that focused on decision-making with regard to treatment (everyday matters and higher order affairs), treatment planning (including admission and transition planning), case planning (including social work decision-making), and/or decision-making procedures that related to the young person's stay in care (including decisions related to service delivery). Because the UN Committee on the Rights of the Child (2009) did not differentiate between a specific age from which the young person is able to participate, we also did not make a distinction on age in our search.

2.1.2 | Exclusion criteria

We excluded studies that focused on the following topics: medical care; school settings; participation in research; family/caregiver participation; institutional collaboration; family law; youth in family foster care; legal procedures; and outpatient care. Some studies report on both foster care and residential care (e.g., Munford & Sanders, 2015; Polvere, 2014), or a combination of day-patient and inpatient residential care (LeFrançois, 2008). We excluded studies in which it was not possible to address findings to the young people in residential care.

2.2 | Selection procedure

This search through the electronic databases resulted in 4,927 studies (see Figure 1). The first elimination of publications took place after screening the titles (N = 3,923) and screening the abstracts (N = 740), as they did not met up with the selection criteria. Hereafter, 248 studies were excluded after screening the full article. This procedure finally resulted in 16 studies. The complete selection procedure is available from the main author by request. To assess the quality of the resulting 16 studies, we (AH and MtB) used a critical review form for qualitative studies (Letts et al., 2007) and for quantitative (not intervention) studies (Potvin, 2010), (see Appendix A).

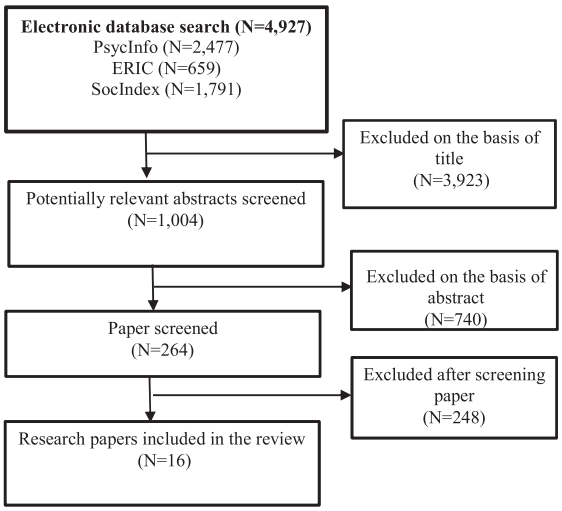

FIGURE 1 Schematic representation of selection procedure

2.3 | Data analysis

After the selection procedure, the first author uploaded the 16 studies in Atlas-ti, version 7. In this qualitative data processing programme, the studies were coded. The first author closely read the studies and used an open coding strategy. The first author hereby searched for unique themes, which related to the stage (everyday matters/activities, young people's own life course, and service delivery) and content of the decision-making (individual meetings and collective meetings), the experiences of young people/professionals with participation (poor or good opportunities), the factors that were brought up as challenging or facilitating factors (factors related to the young person, care trajectory, professional, organization/service, and [cultural] context), or the reported outcomes of the participation process (lack of participation and meaningful participation). In several group discussions, both between the first two authors and between all the team members, these themes were discussed multiple times to reach consensus on the interpretations.

2.4 | Characteristics of included studies

The 16 studies were conducted in mostly English speaking countries (United States, Canada, UK, Ireland, and Australia) and Scandinavian countries (Sweden and Norway). We also found one study from Ghana, one from Germany, and one from Italy (see Table 1).

3 | RESULTS

3.1 | Opportunities of young people to participate in decision-making

In Table 2, we show the results from 12 studies about the opportunities of young people to participate in relation to the contents of the decisions. The contents of decisions can generally be divided into (a) everyday activities, (b) young people's own life course, and (c) service delivery.

Several studies report on mainly poor opportunities for young people to participate in decisions regarding their admission to

TABLE 1 Characteristics of studies focusing on young people's participation in decision-making procedures in residential care

Study	Type of residential care	Participants	Research design	Study aim
1. Brown et al. (2010) USA	Mental health and substance abuse for youth <17 years old	293 treatment providers	Quantitative data: survey data	The perceptions of residential care providers on youth-guided and family-driven principles and how they applied these practices in their facilities
2. Brown et al. (2011) USA	Mental health and substance abuse for youth <17 years old	293 treatment providers (survey); 24 stakeholders; 2 young people (interviews)	Mixed methods data: interviews and survey data	The evaluation of youth and family participation in the governance of residential treatment
3. Carrà (2014) Italy	Facilities in the area of child protection	133 managers of organizations; 187 care workers; 97 young people (aged >10 years)	Quantitative data: survey data and structured phone interviews	The quality of residential care on the dimensions "Quality4Children" (efficiency, effectiveness, participation in planning and intervention, and empowerment)
4. Cousins and Milner (2006) Ireland	Residential care in general	15 young people (14–19 years old); f = 9; m = 6; 21 policymakers and professionals	Qualitative data: semistructured interviews with professionals and focus group discussions with young people	The participants' experiences of children's rights (protection, provision, and participation) in residential care
5. Fudge Schormans and Rooke (2008) Canada	Ward of child protection agency, child welfare supported residential placement	5 transition-aged young people with intellectual/development disorders (ID/DD; 19–21 years old) f = 4; m = 1; 24 social service groups	Qualitative data: in-depth semistructured interviews with young people and focus groups with social service groups	Young people with ID/DD who are transitioning from child welfare
6. Henriksen et al. (2008) Sweden	Residential treatment centres (RTC)	46 young people from 10 RTCs (14–20 years old) f = 23; m = 23	Qualitative data: semistructured interviews at intake and follow-up (after 1 year)	The attitude of young people towards key staff members (KSM) on personal involvement and participation
7. Hepper et al. (2005) England	Psychiatric inpatient unit for children aged 5 to 13 years	18 children (8–13 years old) f = 7; m = 11	Qualitative data: semistructured interviews at admission and before discharge	The way children in inpatient units made sense of their admission, including their participation in decision-making
8. Hitzler and Messmer (2010) Germany	Child welfare institutions	14 care planning conferences in four institutions, participants ranged between 3 and 8 per meeting	Qualitative data: audio tapes of care planning conferences from different stages of care (beginning, middle, and termination)	The participation of young people in group decision-making in the context of care planning conferences
9. Malmsten (2014) Sweden	Unaccompanied minors living in transitional houses	8 young males (14–17 years old) living in transitional houses; 3 young males formerly staying in transitional houses	Qualitative data: interviews	The perceptions of unaccompanied minors with the time they spend in transitional houses
10. Manful and Manful (2013) Ghana	Residential care in general	40 professionals working in residential care and government staff	Qualitative data: semistructured interviews	The implementation of children's rights (including participation) in residential work.
11. Pålsson (2015) Sweden	Residential care in general	8 inspectors; observations on 10 occasions; information from 147 case files	Mixed methods data: observations and semistructured interviews with inspectors and case files	The role of children in the audit of residential care
12. Roesch-March (2014) Scotland	Secure residential care facility	8 young people; professionals (focus groups, interviews, and observations)	Mixed methods: paper records, questionnaire data, observations, interviews, and focus groups	The significance managers, practitioners and young people attached to the notion of "out-of-control" behaviour
13. Salamone-Violi et al. (2015) Australia	Psychiatric inpatient unit	11 young people (15–17 years old) f = 5; m = 6	Qualitative data: semistructured interviews	The experiences of young people with the referral and admission process to inpatient care

(*Continues*)

TABLE 1 (Continued)

Study	Type of residential care	Participants	Research design	Study aim
14. Southwell and Fraser (2010) Australia	Facilities in the area of child protection	169 young people (6–18 years old) f = 34%; m = 66%	Quantitative data: self-report questionnaire	The satisfaction of young people with residential care
15. Stevens (2008) Scotland	Residential care in general	24 young people (15–19 years old) f = 8; m = 16	Qualitative data: semistructured interviews and focus groups	The views of young people about their care experiences/impact of Article 20 of the CRC
16. Vis and Fossum (2013) Norway	Social work with regard to residential care and foster care	38 social workers planning for foster care; 49 social workers affiliated with residential care	Quantitative data: questionnaire data	The differences in social workers views about child participation and service quality

residential care (Hepper, Weaver, & Rose, 2005; Roesch-March, 2014; Salamone-Violi, Chur-Hansen, & Winefield, 2015), transition or discharge planning (Fudge Schormans & Rooke, 2008), medication use (Hepper et al., 2005), and the care inspection process (Pålsson, 2015). With regard to everyday matters (Henriksen, Degner, & Oscarsson, 2008; Malmsten, 2014; Pålsson, 2015; Southwell & Fraser, 2010), care planning (study Brown et al., 2010; Henriksen et al., 2008; Hepper et al., 2005; Southwell & Fraser, 2010), and the care complaint system (Cousins & Milner, 2006; Fudge Schormans & Rooke, 2008; Stevens, 2008), studies show mixed participation opportunities for young people.

In Table 3, we show the results from five studies regarding the opportunities of young people to participate in relation to the setting in which the decision-making takes place.

In one study, there are mainly poor opportunities for young people to participate in individual meetings with a staff member of their choice (Stevens, 2008). The study by Brown et al. (2011) points towards poor opportunities for young people to participate in board or management meetings of the residential care facility (Brown et al., 2011). Several studies show that there are both poor and good opportunities for young people to participate in collective care planning meetings (Cousins & Milner, 2006; Hitzler & Messmer, 2010; Stevens, 2008).

3.2 | Challenges and facilitators

All studies report on challenges and facilitators related to the young person's participation process (see Table 4). We distinguish between challenges and facilitators related to (a) young person; (b) care trajectory; (c) professional; (d) organization/service; and (e) (cultural) context.

3.2.1 | Young person

Six studies report on the assumed challenges and facilitators related to the young person, such as his or her age (Southwell & Fraser, 2010) and abilities and wishes (Brown et al., 2011; Cousins & Milner, 2006; Fudge Schormans & Rooke, 2008; Henriksen et al., 2008; Roesch-March, 2014; Salamone-Violi et al., 2015). Southwell and Fraser (2010) found that older children (16–17 years old) are significantly more satisfied than younger children (<15 years old) with regard to having a say what happens to them. In addition, when young people show improved behaviour during residential care (Henriksen et al., 2008), are able to voice their opinions (self-assertiveness), or insist to voice their opinions during the decision-making process (Cousins & Milner, 2006), this is regarded as a facilitating factor in their participation process.

3.2.2 | Care trajectory and treatment

Challenges and facilitators related to the young person's care trajectory and treatment are shown in four studies and refer to the number of prior placements (Southwell & Fraser, 2010) and the stages of the care path (Carrà, 2014; Hepper et al., 2005; Salamone-Violi et al., 2015). With regard to prior placements, young people who experienced less than four alternative placements prior to their stay in residential care reported more often that their caregivers (professionals) listened to them compared with their peers reporting more than four placements (Southwell & Fraser, 2010).

TABLE 2 Contents of decision-making (DM) and opportunities for young people to participate

Content of DM	Poor opportunity	Good opportunity
1. Everyday matters/activities	Young people experience a lack of possibilities to influence and make decisions about the planning of everyday activities (6, 9, and 11).	Young people experience the possibility to participate in everyday matters (feeling listened to, having a say; 9 and 14).
2. Life course youth		
Admission to care	Young people do not always feel well informed at (pre-) admission phase (7 and 13) and feel that admission is beyond their control (12 and 13); there are ways in which young people would like more "say" in decision-making about admission (7 and 12).	
Care/treatment planning[a]	Young people experience lack of involvement in formulating their treatment plan/goals (6, 7, and 14) or in what happens to them (7 and 14).	Some facilities reported that the young person was the primary decision-maker in the development of the treatment plan (1).
Transition planning/discharge[a]	Young people experience a lack of choice; decisions (where) to move are not within their control (5).	
Care complaints system/advocacy services	Young people experience a flawed/ineffective complaint system (4 and 15).	
	Professionals rate the complaint system as poor: Young people do not know how to complain (4).	Young people are aware of complaint system (4 and 5) and have mixed experiences of support in accessing advocacy services and external organizations (4 and 15).
		Professionals are mostly satisfied with complaint system (4)
Medication	Young people have concerns about taking medication, feel that their concerns are not taken into account, and would like more "say" in medication decisions (7).	
3. Service delivery		
Audit/inspection processes	Files demonstrate difficulties for young people to influence the inspection process in a substantial way (11).	
Service operations and practices		Some of the facilities reported to include youth in service operations and oversight practices (1 and 2).

Note. The numbers between brackets refer to the studies in Table 1.

[a]These decisions can both relate to social work decisions (case planning) and decisions made by care professionals working in the facilities.

TABLE 3 Opportunities of young people to participate in different decision-making (DM) settings

Setting DM	Poor opportunity	Good opportunity
1. Individual meetings	Some young people express not being able to talk to a staff member of their choice (15).	
2. Collective meetings		
Youth council	Less than half of the facilities report to have an advisory board/youth council (1).	
Care planning meetings	Some professionals reveal that young people are not invited to meetings nor involved in their care plans (10); others acknowledge that some young people feel intimidated/overwhelmed by these meetings (4). Audio tapes reveal that some care professionals display a strong orientation to the involvement of young people into the decision-making process, but the social workers seem to make choices which strategy (client exclusion vs. inclusion) to employ, and they strive to maintain control over the process (8).	Some young people feel prepared and involved in care planning and case reviews and feel that attention is paid to what they say (15).
Board meetings	Few facilities included youth on the board of directors and none of the facilities included them on the management team (2).	

Note. The numbers between brackets refer to the studies in Table 1.

3.2.3 | Care professional

Eleven studies included information about challenges and facilitators related to care professionals. When it comes to these challenges and facilitators, the professional's age (Vis & Fossum, 2013) and attitude against participation (Brown et al., 2011; Fudge Schormans & Rooke, 2008; Hitzler & Messmer, 2010; Manful & Manful, 2013; Pålsson, 2015; Roesch-March, 2014) are noticed, as well as the skills of the professional and the relationship between the young person and the care professional (Brown et al., 2011; Cousins & Milner, 2006; Henriksen et al., 2008; Salamone-Violi et al., 2015; Stevens, 2008). Several studies show that the professional's ability to create a safe and warm atmosphere—consisting of listening to the young person, being available, taking wishes of the young person seriously, and showing respect, reciprocity, and trust—is regarded as a facilitating factor to

TABLE 4 Challenges and facilitators related to the young person's participation in decision-making

	Challenges	Facilitators
1. Young person		
Age	Under 15 years old (14)	Above 15 years old (14)
Abilities/wishes	Intellectual and/or developmental disabilities (ID/DD) (5) Not willing to participate (6) or uncomfortable with participation (2, 6, and 12)	Self-assertiveness and abilities (4) Improvements of young person's behaviour and development (6)
2. Care trajectory and treatment		
Number of placements	More than four alternative placements (14)	Four or less alternative placements (14)
Stages of the care path	Lack of information and inadequate contact at pre-admission phase (7 and 13) Decreased involvement at end of the care path (3)	Shift towards own agency at discharge (7)
3. Professional		
Age	Higher age of social worker (16)	
Attitude	Different rationales (5, 10, 11, and 12), such as protective rationale, or regulatory rationale (11) Relying on own expertise (8), negative attitude about engaging youth (2 and 10) Different interpretations of what participation actually entails (10)	Supportive rationale (11)
Skills/relationship	Lack of formal treatment strategy that includes the young person's active participation (6)	Supportive relationship between young person and professional (2, 4, 6, 13, and 15)
4. Organization/service	Workload (11, 13, and 15), plans rushed through (7)	
Time		
Organizational culture	Staff knowledge/lack of training/tools (1) Intimidating nature of review meetings (4), offensive/intimidating jargon (2) Lack of continuity/staff turnover (6)	Strategies to include youth in service (2)
Policy context	Statutory regulations (2 and 4) Lack of funding/lack of choices (2, 5, and 10) Government agendas (5)	Licensing and accreditation standards (1) Financial honoraria (2)
5. (Cultural) context		
Different stakeholder groups	Social workers affiliated with a residential unit (15)	
Cultural context	Cultural attitude of how children should behave (12)	

Note. The numbers between brackets refer to the studies in Table 1.

participation (Brown et al., 2011; Cousins & Milner, 2006; Henriksen et al., 2008; Salamone-Violi et al., 2015; Stevens, 2008). Several studies also show that professionals seem to have contrasting attitudes, which (might) influence the importance children's views are assigned in decision-making processes. For instance, perceiving the young person as manipulative or engaging in inappropriate behaviour (Manful & Manful, 2013), or in need for protection (Fudge Schormans & Rooke, 2008; Manful & Manful, 2013), may be used as a justification for not allowing young people a voice.

3.2.4 | Organization/service

The 10 studies focusing on the organization/service show challenges and facilitators with regard to the aspect of time (Pålsson, 2015; Salamone-Violi et al., 2015; Stevens, 2008), the organizational culture (study Brown et al., 2010; Brown et al., 2011; Henriksen et al., 2008), and the policy context (Brown et al., 2011; Cousins & Milner, 2006; Fudge Schormans & Rooke, 2008; Manful & Manful, 2013). For instance, the study by Brown et al. (2011) shows that facilities that agreed licensing and accreditation should require family and youth involvement and were more likely to be either licensed or accredited than facilities that disagreed. Inadequate funding for services (Brown et al., 2010; Fudge Schormans & Rooke, 2008; Manful & Manful, 2013), greater level of statutory regulations (Cousins & Milner, 2006), intimidating jargon (Brown et al., 2011), and contrasting government agendas (Fudge Schormans & Rooke, 2008) were regarded as challenges to the young person's participation process.

3.2.5 | (Cultural) context

When we look at the two studies that looked at the possible influence of the (cultural) context, one study reports on the assumed challenges and facilitators related to the different stakeholder groups care professionals belong to (Vis & Fossum, 2013). Vis and Fossum (2013) found that social workers affiliated with a residential unit saw more challenges to participation compared to social workers responsible for investigating reports of child abuse and neglect. One study reports on the cultural context (Manful & Manful, 2013). The study showed that in Ghana, child participation is perceived as "expressing an opinion." However, the cultural attitude of how children should behave (e.g., do not question adults' decisions) "… is believed to contradict the concept of children's rights, where it is accepted for children to express an opinion on decisions made by adults" (Manful & Manful, 2013, p. 324).

3.3 | Participation and outcomes

Several studies do report on indirect effects of participation during residential care in terms of young people's *experiences* related to the (lack) of participation (Brown et al., 2011; Carrà, 2014;Fudge Schormans & Rooke, 2008; Hepper et al., 2005; Roesch-March, 2014). In Figure 2, we present a schematic overview of the outcomes we found, which related to the young person's participation process. Herein, we make a distinction between outcomes related to "lack of participation" and "meaningful participation." Several studies report on the assumed negative outcomes of a lack of participation (Fudge Schormans & Rooke, 2008; Hepper et al., 2005; Roesch-March, 2014). Reported negative outcomes can be divided into three groups:

1. emotional and behavioural problems of young people, such as showing oppositional behaviour as a consequence of being denied a voice (Roesch-March, 2014);
2. passiveness, as young people stopped asking or did not try to question or challenge a certain decision (Fudge Schormans & Rooke, 2008); and
3. general bewilderment about how certain decisions (e.g., working on treatment goals) related to their own problems/situation (Hepper et al., 2005).

Focusing on meaningful participation (Brown et al., 2011; Carrà, 2014), studies either reported a rationale why participation was necessary, which related to the young person (e.g., autonomy and valuing the role of the young person), or related meaningful participation with care effectiveness (e.g., service delivery and reduction of inadequate planning). One study (Carrà, 2014) reports on the relationship between participation and care effectiveness. The author found a significant, positive correlation (r = 0.44) between the sense of participation in decision-making and young people's level of emotional well-being.

4 | DISCUSSION

This review focused on the participation of young people in decision-making procedures while staying in residential care. The aim of our narrative review was threefold: (a) to investigate the opportunities to participate in relation to the content and setting of decisions that are being made during the time in residential care; (b) to assess the possible challenges and facilitators to participation; and (c) to look at the possible outcomes of care related to participation.

In the studies included in this review, the young people have mixed participation opportunities with regard to decisions about everyday matters, care planning, the care complaint system, and decisions in the setting of collective care planning meetings. These findings suggest that they experience some opportunities to participate in important decisions during residential care regarding everyday activities in the facility and their individual life course (cf. Southwell & Fraser, 2010). However, young people mainly experience poor opportunities to participate in decisions regarding their admission to residential care, transition or discharge planning, medication use, and the care inspection process. With regard to the setting of decisions, they also experience poor opportunities to participate in individual meetings with a staff member of their choice and in board or management meetings of the residential care facility.

In the studies included in this review, the young people have limited possibilities to "meaningfully" participate in decision-making while staying in residential care (cf. Sinclair, 2004). In several of these studies, young people express being asked by professionals on matters that concern them. However, their participation in decision-making does not always seem meaningful or really impact a decision. Most young people wish to be included in a meaningful manner during every stage of the care trajectory, including the pre-admission (Hepper et al., 2005; Roesch-March, 2014) and transition out-of-care phases (Fudge Schormans & Rooke, 2008). Our findings are consistent with studies conducted in the area of child welfare and child protection, in which young people experience a lack of meaningful participation in decisions that are most important to them (Gallagher et al., 2012; Van Bijleveld et al. 2013).

The studies we found in our review report on challenges and facilitators in the participation process of young people. Most studies report on the role of the professional in promoting or obstructing the young person's participation process (Brown et al., 2011; Fudge Schormans & Rooke, 2008; Hitzler & Messmer, 2010; Manful & Manful, 2013; Pålsson, 2015; Roesch-March, 2014). Herewith, the professional's attitude, and underlying rationales (protective, supportive, or regulatory rational), may play a crucial role in the implementation of youth participation in decision-making (see also Van Bijleveld et al., 2013).

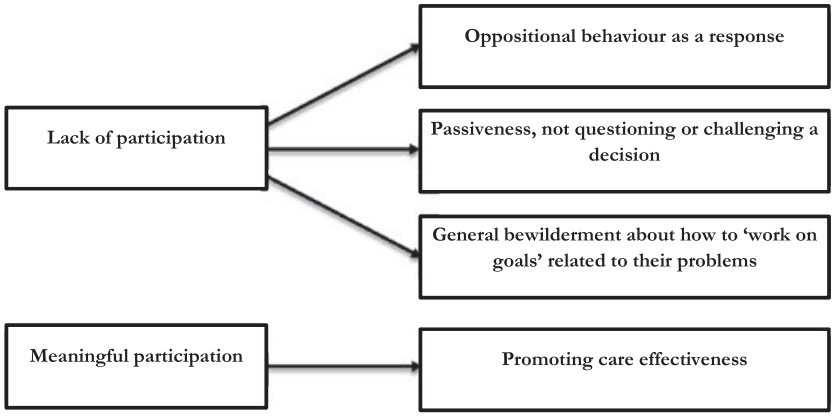

FIGURE 2 Outcomes related to the young person's participation process

When it comes to facilitating factors to participation, a positive relationship and communication between a young person and professional(s) whereby the focus lies on understanding, nearness, respect, and reciprocity is regarded as a key aspect in promoting the young person's participation (Brown et al., 2011; Cousins & Milner, 2006; Henriksen et al., 2008; Malmsten, 2014; Salamone-Violi et al., 2015; Stevens, 2008). This is consistent with studies focusing on client–therapist relationship factors, where this relationship is considered to be one of the most important predictors of outcomes of care (Carr, 2009; Harder, Knorth, & Kalverboer, 2013).

In order to facilitate the professional in creating a positive relationship with the young person, it is important that this takes place in a safe and stimulating context (see also Bell, 2011; Sinclair, 2004). However, several studies show that residential care providers often deal with challenges to youth participation, including contrasting government agendas and budget cuts/inadequate funding (Brown et al., 2011; Cousins & Milner, 2006; Fudge Schormans & Rooke, 2008; Manful & Manful, 2013). These challenges in residential care might ultimately lead to little room for the young person to participate.

Even though all studies do provide a rationale why participation of young people in treatment and decision-making is important, we did not find a study providing evidence for a connection between the "level" of participation in decision-making and/or treatment during the care process and the outcomes of residential care. Several studies do report on indirect effects of participation during residential care in terms of young people's experiences related to the (lack) of participation (Fudge Schormans & Rooke, 2008; Hepper et al., 2005; Roesch-March, 2014), such as distressing feelings and passiveness due to lack of participation (see also LeFrançois, 2008; Polvere, 2014). Only Carrà (2014) focused on the connection between participation and outcomes. The author reports that a higher level of youth participation in decision-making is significantly, but moderately, associated with care effectiveness in terms of the young person's level of emotional well-being.

One of the reasons that we found no study in which outcomes of participation were assessed might be the lack of longitudinal research designs and the lack of monitoring of participation during residential care with standardized measurement tools (cf. Charles & Haines, 2014; Vis et al., 2011). However, as Cunningham, Duffee, Huang, Steinke, and Naccarato (2009) explain, it might also depend on the way we look at outcomes. It could be that participation is more directly linked to outcomes for the "self" (e.g., self-determination and well-being) and only indirectly to outcomes on the long run (recidivism and re-entry into care). In addition, all studies included in our review put a strong emphasis on the experiences and perceptions of young people with participation. In line with this, following results from Schubert, Mulvey, Loughran, and Losoya (2012), the care process perceptions of young people seem to be predictive of outcomes. This suggests that the perceptions of young people with their participation process may be predictive of outcomes (both positive and negative).

4.1 | Strengths and limitations

Participation of young people is one of the basic principles of the CRC and therefore a fundamental right for all young people growing up in residential care. With this review, we assessed the young person's participation process while staying in residential care. We carried out a thorough screening and analysing process, which makes it possible to provide further insight into the young person's participation process (e.g., Križ & Skiveness, 2015; Van Bijleveld et al., 2013; Vis et al., 2011) while staying in residential care.

However, there are several limitations to this review. First, despite the extensive research on participation in decision-making procedures, there is no common framework to define and measure participation in youth care (Charles & Haines, 2014; Gallagher et al., 2012). Therefore, we compared studies that used different ways of looking at the concept of participation (e.g., in ways of defining and measuring participation). It is possible that we missed certain studies due to the lack of a common framework on participation. In addition, because the focus of our review was on the concept of participation as used in the participation literature (Checkoway, 2011; Thomas, 2007; Vis et al., 2011), we purposely excluded studies on engagement, empowerment, and treatment alliance (e.g., Cunningham et al., 2009; Huang, Duffee, Steinke, & Larkin, 2011; Walker, Thorne, Powers, & Gaonkar, 2010). We are aware that there might be some overlap between the concepts and the way these concepts are constructed. For future research, we recommend to look at the linkage between these different constructs.

Second, there is a variation between countries in their welfare and protection policies, and the way they arrange out-of-home care (see, for instance, Thoburn, 2010). Most studies we found were conducted in western countries. Only the study by Manful and Manful (2013) provides some insight into the context of residential care in a nonwestern country. We therefore recommend expanding research into the topic of participation in countries with different cultural contexts.

A third limitation is that we included studies from different residential youth care contexts, such as psychiatric inpatient units, children's homes, residential treatment centres, or transitional houses. The professionals operating in such facilities may follow different logics, which may have consequences on how participation is brought into practice. When focusing on the topic of participation in residential care, this should include the acknowledgement of the diversity amongst different residential care facilities and professions.

A forth limitation is that in presenting our results, we did not make a distinction between the different research methods and the impact they might have on possible outcomes (quantitative, qualitative, or mixed methods). To take up this point, for future research, other tools for systematically reviewing quantitative, qualitative, or mixed methods studies, such as PRISMA (cf. Moher, Liberati, Tetzlaff, Altman, & The PRISMA group, 2009), SPICE (cf. SBU, 2014), or SPIDER (cf. Cook, Smith, & Booth, 2012), would be recommended.

4.2 | Implications with regard to future research

The narrative search provides a preliminary overview of the current knowledge on participation of young people in residential care. For future research, we recommend a further focus on what participation exactly entails within the context of residential care (i.e., content and setting) and how participation can be further implemented within daily practice (through tools, training, and dialogue). With this, it is important not only to focus on the actual implementation of participation but also to develop an in-depth understanding of the perceptions of the young

people processed through the system (cf. Butler, 2011) and the professionals responsible for these young people. We also recommend the use of a common framework in participation literature, especially when it comes to measuring and monitoring participation during residential care (cf. Charles & Haines, 2014).

In addition, we plead seeking for international cooperation between scholars from different countries to create a common understanding of participation, which makes it possible to investigate the linkage between outcomes and participation, and to further analyse barriers and facilitators to participation. An important aspect in the creation and final use of this common framework on participation should be the acknowledgement of the variation between countries in their welfare and protection policies, and the way they arrange out-of-home care. For instance, some countries do acknowledge the importance of youth participation and have written principles of participation into their child and youth care legislations, whereas other countries have not incorporated the concept of participation in their legislative context.

ENDNOTES

[1] Article 12 of the CRC is regarded as one of the key articles of the convention, besides Article 2 (non-discrimination), Article 3 (best interest of the child should be given primary consideration), and Article 6 (the right to life and develop). In addition, Article 12 is strongly related to Article 13 (freedom of expression), Article 14 (freedom of thought conscience, and religion), Article 15 (freedom of association), Article 16 (right to privacy), and Article 17 (access to information and mass media) of the CRC (Unicef, n.d.).

[2] I see that only Brown et al. (2010) has an * to show that it is included in our narrative search.

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APPENDIX A

QUALITY ASSESSMENT OF INCLUDED STUDIES (*N* = 16)

Quality criteria	Meets criterion	Does not meet criterion	Not addressed
Total included studies (*N* = 16)			
Was the purpose and/or research question stated clearly?	16		
Was relevant background literature reviewed?	16		
Was a theoretical perspective identified?	15	1	
Studies with qualitative methodology (*N* = 12)			
Was the process of purposeful selection described?	11		1
Was sampling done until redundancy in data was reached?	2	2	8
Was informed consent obtained?	6		6
Procedural rigour was used in data collection strategies?	12		
Data analyses were inductive?	9		3
Findings were consistent with and reflective of data?	12		
Decision trail developed?	7	4	1
Process of analysing the data was described adequately?	7	5	
Did a meaningful picture of the phenomenon under study emerge?	12		
Conclusions were appropriate given the study findings?	12		
The findings contributed to theory development and future OT practice/research?	12		
Studies with quantitative methodology (*N* = 7)			
Was sample size justified?	6	1	
Was power discussed?	2	4	1
Results were reported in terms of statistical significance?	4	3	
Was the analysis appropriate for the type of outcome measures and the methodology?	6		1
Clinical importance was reported?	7		
Were dropouts reported?	2	5	
Conclusions were appropriate given study methods and results?	6		1

Note. Because three studies had a mixed methods design, we used both forms to assess the quality of the quantitative and qualitative methodology. This form was based on Sleijpen, Boeije, Kleber, & Mooren, 2015.