Participation and health – a research review of child participation in planning and decision-making

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ABSTRACT

Effective child participation in child protection proceedings has proved difficult to achieve in Norway. Although participation is in principle accepted as a human right and something of benefit to children, when children’s health is at stake there is a tendency to view participation in decision-making processes by children as potentially disruptive to their well-being. The purpose of this study is to review the research evidence for effects, positive or negative, of participation on health outcomes for children in care.

A scoping review of major health and social work research databases was undertaken. Searches in five databases yielded 1830 studies of which 21 were finally included in this review. Studies were included if a relationship between health and participation was evident from the data presented, even if this was not the main objective in the study at hand.

We conclude that when participation is successful, it may have beneficial side effects. Chief among these are that participation may improve children’s safety, increase the success of care arrangements and increase feelings of well-being for children involved. Evidence for long-term effects of successful or failed participation attempts on subsequent health outcomes is however largely absent.

INTRODUCTION

Since the turn of the century, two issues that have become prominent in public debate relating to child protection services in Norway are the children’s participation and the health of looked-after children.

The identification of children’s participation as a fundamental principle in all case processing was theoretically driven and originated in a children’s rights framework introduced with the UN Convention on the Rights of the Child (UNCRC). It has become increasingly evident that the health of looked-after children is not good compared with their peers, and that this health inequality carries on into adulthood. At the same time, research suggests that few children are given the opportunity to participate and that this could be improved; two points to which we return later.

The study was commissioned by the Norwegian Ministry of Children and Equality and was to inform policy-makers about the current level of evidence that participation in decision-making benefits looked-after children.

The aim of the research review was to assess the state of knowledge of health effects that may be associated with child participation in decision-making in care and protection cases. In this context, we mean health in its broadest sense as defined by the World Health Organization (WHO): that is, a state of physical, mental and social well-being rather than merely...
The opportunity to attend meetings such as reviews and child protection conferences does seem to increase participation and influence on behalf of children (Vis & Thomas 2009). In Norway, where no mandatory review system is in place, the decision to let children attend planning meetings is entirely at the discretion of the case manager. Children are more
likely to attend meetings in the UK, where this is an expectation of the review system, than in Norway where there is no specific guidance on this matter (Vis & Thomas 2009).

In healthcare services, recent studies have addressed children’s decision-making competence (Martenson & Fagerskiold 2008) and children’s understanding of health and illness (Moss-Morris & Paterson 1995; Runeson et al. 2007), as well as their level of involvement (Runeson et al. 2002; Winter 2006; Baston 2008). Positive examples exist of children and young people being given a choice, but there is less evidence of whether these choices were acted upon or resulted in more responsive services (Coad & Shaw 2008).

HEALTH OF LOOKED-AFTER CHILDREN

The health of looked-after children has been extensively reviewed over the last 10 years. Norwegian national statistics comparing looked-after children with their peers in the general population make sobering reading, showing that adults who were looked after as children have a lower standard of education, lower income, higher dependency on social welfare, shorter life expectancy and increased risk of suicide, substance abuse and criminal behaviour (Clausen & Kristoffersen 2008). Studies from Norway (Kristoffersen 2005; Clausen & Kristoffersen 2008), Sweden (Vinnerljung & Ribe 2003; Vinnerljung et al. 2005) and the UK (Barth 1990; Stein 2006; McAuley & Davis 2009) all show a similar pattern. Looked-after children are more likely to suffer from mental-health problems when they enter the care and protection system (Fernandez 2008; Tarren-Sweeney 2008) during their time in care (Attar-Schwartz 2008) and into adulthood (Dixon 2008). In contrast, it is worth noting that many children can show improved outcomes (Forrester et al. 2009), taking into account such factors as behaviour problems, age at placement and permanency of placement (Minty 2000; Barber & Delfabbro 2005; Tilbury & Osmond 2006; Oosterman et al. 2007).

In understanding why some children do better than others, we may look at both risk and protective factors. Fuller accounts of how risk factors such as abuse, neglect and exposure to poor living conditions impair health and well-being are to be found elsewhere (e.g. McAuley & Davis 2009) and will not be repeated here. We will, however, take a brief look at some protective factors, because this study aims to evaluate whether participation in decision-making may be one of these.

Implicit in prevention approaches is the idea that if we know what enables children to escape damage from adverse experiences, we will have the means to enhance their resistance to health problems (Rutter 1993). The concept of resilience is one contribution towards understanding the variations in children’s ability to cope in different circumstances. Three factors are commonly associated with resilience: a sense of positive self-esteem, a belief in self-efficacy and the ability to solve problems (McAuley & Davis 2009). Antonovsky (1979) called such factors generalized resistance resources and proposed that adaptive coping was the mechanism through which these protective factors affected moves towards health on a health-disease continuum. He suggested that successful coping was dependent on a sense of coherence through which stressors confronting us become comprehensible, manageable and meaningful. A relationship between sense of coherence and a variety of health measures has been established in numerous studies (see Eriksson and Lindström 2006 for a review).

METHODS

A scoping review of major health and social work research databases was undertaken. Search for relevant studies was carried out by means of electronic search in the following databases: PubMed, PsychINFO (OVID), Academic Search Elite (EBSCO), CINAHL (EBSCO), Web of Science (ISI) and ERIC (EBSCO). The search was done using the search string: (‘Participation’ OR ‘decision-making’ OR ‘child perspective’ OR ‘citizenship’ OR ‘engagement’) AND (‘Health’ OR ‘Empowerment’ OR ‘sense of coherence’ OR ‘resilience’) AND (‘Child protection’ OR ‘children in care’ OR ‘looked after children’). Searches were limited to publications in the period 1999–2009. The search string was developed through a process of 27 trials in which key words relating to participation, health and child protection were added and removed. The complete search history is available from the main author by request.

Four criteria were employed to select studies for inclusion: (1) the study was empirical; (2) subjects were children aged 0–18; (3) health or welfare measures were reported; and (4) some measure of child participation was reported. Studies were finally included if a relationship between health and participation (criteria 3 and 4) was evident from the data presented, even if this was not the main objective in the study at hand. Systematic reviews were not
Because we want to understand the processes through which participation might change health prospects, we considered it justified to include any study meeting the above criteria irrespective of research setting, and not to restrict the scope to child protection settings.

Screening of studies after the preliminary search was carried out in three steps. Duplicates were first discarded and remaining studies were screened according to inclusion criteria (1) and (2). Remaining studies were retrieved in full text and screened according to criteria (3) and (4).

The study systematically analysed all included papers according to (a) study objective; (b) study design; and (c) applicability of the results. The main findings in the included studies were extracted and a qualitative synthesis approach (Sandelowski & Barroso 2003; Dixon-Woods et al. 2006) was used to generate a synthesis of the extracted effects (described in a narrative manner in the Results section).

RESULTS

The initial search yielded 1830 publications; the screening process resulted in 18 of these being retained for inclusion in the review. A further three studies were included from those identified in manual searches. Results from the different stages in the search process are shown in Table 1 below.

The 21 studies selected used a variety of research methods and were drawn from different research settings. Among these were specific decision-making contexts such as family group conferences (3) or review meetings (5), hospitalized children (6), looked-after children living at home (8) and children living in foster or residential care (8). Sixteen were qualitative studies using either observation (3) or interview methods (13) to investigate children’s reports on participation and outcomes. Three studies used structured interviews or questionnaires for multivariate statistical analysis in cross-sectional designs. There was one longitudinal cohort study using register data and three randomized control trials.

We found no studies that set out to evaluate the interaction effect of participation and health in a child protection setting. In studies that used data from child protection, health effects could only be indirectly assumed; for example, a known predictor of outcomes such as permanency in care placement is measured, but the health of the individual child is not directly assessed in the study. Of the studies that did assess participation effects, two concerned healthcare decisions about asthma that were not located in a child protection context, and another one did use participation as a covariate in the analysis but participation was not the intervention being evaluated.

We have to conclude that a more precise evaluation of health effects of participation through meta-analysis is not possible, owing to the lack of primary studies. We thus focus this review on the indirect relationships between participation and health and the associated mechanisms of change. By mechanism of change we mean a tentative explanation of the relationship between participation and health, i.e. the reasons why these may interact. If the original author did not propose a mechanism of change, it was done at the discretion of the reviewers. This was achieved through analysis of all the results and discussions that are represented in the included studies. All main findings were first extracted and then linked to a mechanism of change. The different mechanisms of change were categorized and reorganized into three main categories as part of the review process. Each of the categories represents a different explanation of why participation could improve health: (a) participation has a therapeutic effect; (b) participation reinforces the effect of other interventions; and (c) participation has a safeguarding effect. We did not find any studies indicating that participation has clear negative health effects, although some of the positive effects that were assumed are obviously ambiguous. We will return to this in the discussion section.

A list of included studies is given in Table 2.

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<th>Table 1 Search process</th>
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<td>included</td>
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<td>Database searches</td>
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<tr>
<td>Duplicates discarded</td>
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<td>Not meeting criteria</td>
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<tr>
<td>Retrieved for full text screening</td>
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<td>Not meeting criteria</td>
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<td>Manual search</td>
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<td>Included in review</td>
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## Table 2 Included studies

<table>
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<th>Therapeutic effect</th>
<th>Context</th>
<th>Sample</th>
<th>Method</th>
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<tr>
<td><strong>Therapeutic effect (seven studies)</strong></td>
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<tr>
<td>Holland &amp; Rivett (2008), UK</td>
<td>FGC</td>
<td>$n = 25$ children + $n = 31$ adult family members</td>
<td>Grounded theory</td>
<td>Process of meeting may induce therapeutic effect.</td>
</tr>
<tr>
<td>Leeson (2007), UK</td>
<td>IAC</td>
<td>$n = 4$ age 12–14</td>
<td>Content</td>
<td>Feelings of helplessness, low self-esteem and poor confidence that have followed the lack of opportunities made available to children to make decisions about their own lives. Being involved in decision-making has a psychological impact of reducing stress and anxiety.</td>
</tr>
<tr>
<td>Kelsey et al. (2007), UK</td>
<td>Hospital</td>
<td>$n = 10$ age 13–16.</td>
<td>Phenomenology</td>
<td>Children’s presence was an important factor in achieving change, at least in the short term.</td>
</tr>
<tr>
<td>Bell &amp; Wilson (2006), UK</td>
<td>FGC</td>
<td>$n = 15$, age 6–16</td>
<td>Content</td>
<td>There are risks as well as benefits when children’s participation is encouraged.</td>
</tr>
<tr>
<td>Holland and O’Neill (2006), UK</td>
<td>FGC</td>
<td>$n = 25$, age 6–18</td>
<td>Content</td>
<td>There is a danger that, in trying to ensure maximum care for a looked-after child, professionals overprotect them from crucial stages of maturation.</td>
</tr>
<tr>
<td>Munro (2001), UK</td>
<td>IAC</td>
<td>$n = 15$ age 10–17</td>
<td>Content</td>
<td>Being given appropriate information helped children to feel less anxious. Enhancing the child’s self-esteem.</td>
</tr>
<tr>
<td>Coyne (2006), Ireland</td>
<td>Children’s Nursing</td>
<td>$n = 11$ children, 10 parents and 12 nurses</td>
<td>Grounded theory</td>
<td>Participation through advocacy services help children address their needs.</td>
</tr>
<tr>
<td><strong>Reinforcement effect (eight studies)</strong></td>
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<tr>
<td>Mullan et al. (2007), UK</td>
<td>IAC</td>
<td>$n = 37$ age 12–17, $n = 14$ aged 18 and over</td>
<td>Content</td>
<td>Young people’s lack of knowledge about the system and their role and voice within it.</td>
</tr>
<tr>
<td>Barnes (2007), UK</td>
<td>IAC</td>
<td>$n = 20$ age 12–20</td>
<td>Content</td>
<td>When everyone has worked on the service/care plan, there is a greater likelihood of its successful implementation. Allocation of resources is more realistic and better suited to client need.</td>
</tr>
<tr>
<td>Hubberstey (2001), Canada</td>
<td>Child protection</td>
<td>N/A</td>
<td>Content</td>
<td>Gathering information about children’s wishes and feelings has important implications for permanency and contingency planning.</td>
</tr>
<tr>
<td>Altschuler (1999), USA</td>
<td>IAC</td>
<td>$n = 5$ age 10–15</td>
<td>Case study</td>
<td>When the child is involved in the decision-making process, they retain a sense of control over the situation. Enable to endure the treatment better.</td>
</tr>
<tr>
<td>Runeson et al. (2002), Sweden</td>
<td>Hospital</td>
<td>$n = 24$ age 5 months to 18 years</td>
<td>Non-participant observation</td>
<td>Effective clinical communication contributes to achievement of desired results for patients.</td>
</tr>
<tr>
<td>Clark et al. (2008), USA</td>
<td>Physician</td>
<td>$n = 452$ parents</td>
<td>Multivariate analysis</td>
<td>Asthma education resources are useful for providing even the youngest children with information leading to better compliance and health than children in the control group.</td>
</tr>
<tr>
<td>Holzheuer et al. (1998), Australia</td>
<td>Hospital</td>
<td>$n = 80$ age 2–5</td>
<td>Randomized control trial</td>
<td>At the 6-month follow-up significantly fewer children in the intervention group had required oral steroids and had had time off school for asthma in the previous 6 months.</td>
</tr>
<tr>
<td>McPherson et al. (2006), UK</td>
<td>Hospital</td>
<td>$n = 101$ age 7 to 14 years</td>
<td>Randomized control trial</td>
<td>The position of being ‘visible’ allow children to address their own agenda.</td>
</tr>
<tr>
<td><strong>Safeguarding effect (six studies)</strong></td>
<td></td>
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<tr>
<td>Murray and Hallett (2000), UK</td>
<td>Children’s hearings</td>
<td>$n = 60$, hearings</td>
<td>Observation</td>
<td>Importance of the quality of relationship with an adult for participation to be effective.</td>
</tr>
<tr>
<td>Lambert et al. (2008), Ireland</td>
<td>Hospital</td>
<td>$n = 49$ aged 6–16</td>
<td>Ethnography</td>
<td>Many reports of children being maltreated run the risk of wrongly being screened out at the first gate-keeping point when the child was often left out of meetings.</td>
</tr>
<tr>
<td>Goldbeck et al. (2007), Germany</td>
<td>IAC</td>
<td>$n = 80$ child protection cases</td>
<td>Randomized control trial</td>
<td>Child co-operation predict implementation of decision to place child in care.</td>
</tr>
<tr>
<td>Bell (2002), UK</td>
<td>IAC</td>
<td>$n = 27$ age 8–16</td>
<td>Analysis driven by attachment theory</td>
<td>Child participation correlated with certainty in the estimation of suspected child abuse decreased and certainty with respect to intervention planning.</td>
</tr>
<tr>
<td>Cocozza et al. (2006), Sweden</td>
<td>IAC</td>
<td>$n = 202$ reports</td>
<td>Document analysis</td>
<td>Importance of the quality of relationship with an adult for participation to be effective.</td>
</tr>
<tr>
<td>Davidson-Adar et al. (2003), Israel</td>
<td>IAC</td>
<td>$n = 96$, age 3–13</td>
<td>Bivariate and multivariate statistical analysis</td>
<td>The position of being ‘visible’ allow children to address their own agenda.</td>
</tr>
</tbody>
</table>

Notes: Method was labelled as ‘content analysis’ if the analysis consisted of mapping and grouping of qualitative data according to themes, when no other specific analytic strategy was explicitly stated.

LAC, looked-after children; FGC, family group conference.
THERAPEUTIC EFFECTS OF PARTICIPATION

When participation for children is set-up as a process in which children are given information and explanations about what is going on and what the options are, when they receive help and support in expressing their feelings and are kept up to date on the progress of decision-making, this may have psychological benefits. We found some examples in the reviewed articles that the process of participation resulted in (a) relationships with social workers, children’s advocates or family members may be strengthened; (b) successful participation may lead to an increase in self-esteem; and (c) participation is associated with increased sense of mastery and control.

Holland & Rivett (2008) found that Family Group Conferences (FGCs) often appeared to have a therapeutic effect for many families through the process of ‘meeting, expressing feelings, listening to each other and through the act of achieving something positive when previously they may have felt that they had not succeeded as a family’ (p. 32). Bell & Wilson (2006) found that children mostly valued the experience of being consulted and welcomed opportunities for families to develop relationships and work together on issues. The formality of the setting in a neutral venue with the presence of a facilitator or social worker leading the meeting often means that families are able to communicate more calmly, and that children are able to speak and be listened to.

Participation may also increase children’s ability to reflect and deal with family relationships, if the social worker manages to establish a relationship with the child during investigation (Bell 2002). Poor quality of social worker relationships is one of the most common complaints from children as reported by Munro (2001), who links participation to empowerment as a developmental task that the child needs to accomplish to reach mature adulthood.

Child participation in a child protection investigation was found to enhance the child’s self-esteem (Coyne 2006). If, on the other hand, children are not informed or consulted, this is associated with a sense of losing control and with lowered self-esteem as well as feelings of helplessness and poor confidence (Leeson 2007). Young people can feel very disoriented about why they remain in care. This disorientation can persist after they leave and is ‘perpetuated by young people’s lack of knowledge about the system, how it is supposed to work, what it is supposed to achieve and their role and voice within it’ (Mullan et al. 2007, p. 431).

In studies involving hospitalized children who were about to undergo medical procedures, participation was found to reduce stress and anxiety (Coyne 2006; Kelsey et al. 2007). The same is also true for children involved in child protection investigations and reviews (Bell 2002). Runeson found that involving children in decision-making enabled them to retain a sense of control over their situation and made it easier for them to endure painful treatment (Runeson et al. 2002). Children who take part in child protection assessments, or in conferences and reviews about their care and accommodation, also seem better able to handle the stress associated with uncertainty of care arrangements and contact with family and friends (Munro 2001).

PARTICIPATION AS EFFECT REINFORCER

The presumed mechanism here is that children’s participation in decision-making can increase the effectiveness of interventions (a) by making them more responsive to the child’s wishes and expectations and (b) by including the child’s agenda, so allowing more issues to be addressed and more realistic plans to be made.

In a study exploring how advocacy impacts on young people’s care arrangements, Barnes (2007) found that participation helps children to maintain contact with their family of origin, to solve problems with their carers and, where necessary, to oppose or negotiate decisions of local authorities (examples included change of placement, accommodation and finance, and bullying). When children participate in planning and problem-solving, it can help to bring children’s agenda to the fore, so increasing the likelihood of successful implementation. Hubberstey (2001) found that allocation of resources was more realistic and better suited to client need when children helped to write their own care plans. Gathering information about children’s wishes and feelings has also been shown to have important implications for permanency and contingency planning, where it is suggested that greater permanency in care is achieved through child participation in the matching and preparation process (Altshuler 1999).

Participation in development of treatment procedures has shown to increase treatment effectiveness in health care. It has been demonstrated in two separate randomized controlled trials that children who received information and education about asthma and self-management had better treatment compliance, better health and less time off school (Holzheimer et al. 2001).
1998; McPherson et al. 2006). Another study found that good co-operation between child and physician makes the problem itself, and the clinician’s judgement about therapeutic actions, clearer, more acceptable and more relevant to the patient. Children were subsequently better able to carry out recommendations. Clark et al. (2008) conclude that effective clinical communication contributes in a real way to achievement of desired results for patients and healthcare providers.

SAFEGUARDING EFFECTS

Safeguarding children from abuse or neglect is of course the first priority in child protection policy, because of the impact of abuse or neglect on children’s development and health. In this respect, failing to include children’s perspectives can have two important effects: (a) it may decrease the probability that abuse and neglect will be discovered and acted upon speedily and (b) it is more difficult for children who have not experienced participation to speak out if something is wrong.

In a five-year follow-up of 220 cases of suspected child maltreatment that had not initially been substantiated, it was found that 45% still showed indications of maltreatment when the case was reinvestigated. Most of the children (53%) were never seen by the social worker, 36% were seen together with the parent, and just 5% were seen individually (Cocozza et al. 2006). This is a clear finding that many reports risk being screened out at the first gate-keeping point. The study attributes these results to the fact that reports were often investigated by a single visit or telephone call to the family, without interviewing the child. Another study focused on why social workers did not implement decisions to remove children, looking at features relating to social workers, parents and children (Arad-Davidzon & Benbenishty 2008). The only feature found to be significantly associated with non-implementation was the child’s co-operation with the social worker, which appears to indicate the impact that children’s views can have on case processing.

Goldbeck et al. (2007) evaluated the effects of expert-assisted child abuse case management compared with a control group doing case management as usual. In expert-assisted case management, the involvement of children in planning interventions was significantly less. Children in the intervention group were less frequently informed about their legal rights, or about the consequences of the interventions. There was a statistical tendency towards more satisfaction with the perceived degree of child protection in the intervention group, but at the same time, certainty in the estimation of suspected child abuse decreased significantly. These findings suggest that expert assessments cannot be a substitute for children speaking for themselves. Investigating the Scottish children hearing system (where a lay tribunal considers what is in a child’s best interest following a discussion between the panel, the child and family, and social workers), Murray & Hallett (2000) found that in about 35% of cases, more than one possible solution was discussed. Where children participated in discussions the crucial importance of children’s views were illustrated by the finding that when children requested a supervision order or substitute care, it was unusual for this not to be the outcome.

The efficacy of participation in promoting safety appears to be increased if some preparation and assistance is provided for the child in connection with meetings, because it increases the likelihood that children will speak. If the child for some reason does not wish to take part in a meeting, the child’s views may still be represented by a children’s advocate or the social worker, if the child has taken part in preparatory processes. Again, the importance of the quality of relationship with an adult in the child’s professional network is highlighted as important in enabling children to put their views forward (Bell 2002). In a study of children admitted to a specialist children’s hospital, Lambert et al. (2008) show how the nature of communication is critical to helping children take part. A position of being ‘visible’ enables the child to feel valued and respected through inclusion in the communication process, and to have its own agenda addressed.

DISCUSSION

Family group conferences and review meetings for looked-after children are two arenas where child participation has been studied. These represent different models for decision-making, each of which may or may not lead to better or outcomes for the child, regardless of whether the child participated. We have to agree with Sundell & Vinnerljung (2004) that in relation to the FGC model, great care should be taken not to assume that a model based on ideals of democracy or human rights automatically translates into better outcomes. Neither can it be safely said that children who participate in reviews fare significantly better than those who do not. We do, however, put forward the notion that participation has the potential to impact on children’s health in different ways, a potential that may or may not be fulfilled. We would
expect children’s developmental maturity, the nature of the child protection case and the ways decision-making processes are implemented to be mediating factors in this respect.

We found that child participation in child protection procedures may have subsequent health effects: (a) because the participation procedure itself is therapeutic; (b) because participation leads to better decisions and tailoring of services; and (c) because it helps to keep children safe by discovering and substantiating cases of abuse and neglect. These findings highlight that, although participation in decision-making is commonly pursued in the interest of fairness and democracy within a children’s rights’ framework, there are a number of ways in which it may also have value in promoting the aims of good practice.

Children themselves often come into FGCs, review meetings or case investigations hoping for change to occur; and readiness for change may indeed be one of the most important prerequisites for participation to have any of the beneficial side effects discussed here. In a recent meta-analysis of 23 studies, Shirk and Karver (2003) reported a positive association between therapeutic relationship variables and measures of treatment outcome in child and adolescent therapy, suggesting that engagement improves outcomes. Cunningham et al. (2009) find that most work on engagement to date has focused on relatively simple services or therapies that involve an individual client with a therapist or caseworker, usually in voluntary settings that permit inference of commitment from levels of participation. As pointed out in several of the studies in this review, the relationship between child and social worker is instrumental in keeping children engaged. In residential psychotherapeutic treatment, client engagement is commonly identified as a prerequisite to effective intervention. Broadly conceived, ‘engagement’ refers to a client’s commitment to, and active participation in, the treatment process. Research literature generally supports the view that participation in treatment is a necessary element to achieve treatment success and behavioural change (see Englebrecht et al. 2008 for a review). In a study involving youths in residential treatment centres, it was found that readiness to change, bonding with staff and collaboration with staff were core components in an engagement scale used to assess youth engagement (Cunningham et al. 2009). Research on health promotion also emphasizes the importance of empowerment, through which children with positive feelings of self-esteem, mastery and control can more easily manage stressful experiences.

Although participation in decision-making is not psychotherapy, we should perhaps not draw too sharp a line between deciding what is good for children and helping children to cope. Within the Norwegian child protection system, case management and decision-making are usually defined so as not to include therapeutic work with children, resulting in the separation of consultations aimed at delivering developmental support from consultations about decisions. The lessons from research are that we may need to pay more attention to strengthening children’s engagement and supporting children to take part in decision-making.

The safeguarding effects of participation that were found in this review do illustrate the importance of having a deliberative arena in which children can put their views forward and have them considered. Because many children will choose not to speak in very formal settings, we need to find ‘child-friendly’ ways to include children in such processes. It is clear that this has the potential to provide child protection services with a safety valve that can have enormous impact for children living with severe abuse or neglect. Once children are placed in care they have access to independent support and oversight, but this may be too late if key decisions have already been made in ways that leave children in a state of confusion, hostility or disillusionment. We need to create routines in case processing that will allow social workers to work with children in decision-making processes, rather than simply listening to them in one-off events or encounters. This includes having consultations with children before and after decisions are made, as well as supporting children to attend reviews. We also may need to look at ways of securing some independent advocacy for the majority of children who remain at home.

We should note that this research synthesis is based largely on qualitative studies that can help to explain what is going on when participation is helpful for children, but with a few exceptions were not designed to infer causal relationships in a systematic way. It should also be noted that none of these studies includes any long-term measures or comparisons between groups over time. We cannot therefore safely conclude that the effects adduced here will translate into long-term health effects, nor that such effects are attributable solely to participation. The effect of children’s age with regards to these findings are uncertain and should be addressed by future research.

CONCLUSION

We would like to emphasize that although participation has the potential to promote children’s health in several
ways described in this paper, it does not automatically follow that participation always has a benefit for children. In particular, the relationship with the social worker, and the way in which the participation process is tailored to accommodate children’s expectations and abilities, seem to be of importance. We did find examples of children describing participation in reviews and FGCs as disappointing or troublesome; this was mainly attributed to failure in making processes and communication ‘child-friendly’. Although child participation may in theory be dangerous if children are given the final say in decisions for which they should not be responsible, we found no evidence of this in any of the studies reviewed.

It is a matter of concern that social workers report that case processing in child protection does not easily allow them to guide a child through the whole process from investigation and assessment to decision-making, implementation and evaluation of services, and that children are being alienated by a system that is not designed for them, and where not being listened to affects their feeling of self-worth (Leeson 2007). We need to look at ways to engage children in decisions that are affecting their lives in order to gain the potential benefits of participation, further evidence of which has been presented in this paper. Some of us (Skivenes & Strandbu 2006; Vis & Thomas 2009) have proposed that including children in review meetings and FGCs should be an expectation in Norway as it is in the UK, and that additional support and advocacy services may be needed for this to be effective. The emphasis in this review on the importance of relationships and engagement in processes, in order for participation to be helpful, further underscores this conclusion. Such attempts should include giving children the opportunity to form relationships with someone who can give information, explain what is happening and be open to children’s own agendas. From the studies reviewed, we conclude that when participation is successful in this respect it may have the power to increase safety for children, the success of care arrangements and children’s feelings of well-being. However, the long-term effects of participation and its bearing on subsequent health outcomes remain to be studied.

REFERENCES


Holland, S. & O’Neill, S. (2006) We had to be there to make sure it was what we wanted: enabling children’s participation in family decision-making through the family group conference. Childhood, 13, 91–111.


