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Assessing social and emotional difficulties of children in residential care settings: A systematic review of strengths-based measures

Danielle Day, Sarah Elgie, Christopher Robinson

Abstract

The number of children in residential care in England has increased over recent years. Studies have shown that these children often have poorer emotional wellbeing and social outcomes compared to their peers. It is therefore crucial that the care these children receive is informed by the child's own needs. Strengths-based measures seek to use a collaborative approach to assess a young person's areas of strength, and to use these to help the young person during times of adversity. The current research sought to systematically review existing strengths-based measures used in residential care settings. Results showed that there were four measures in total, including strengths-based questions. Psychometrics and the usability of these measures are discussed.

Keywords

Systematic review, strengths-based measures, residential care

Corresponding author:

Danielle Day, Assistant Psychologist, Keys Group, Danielle.day@keys-group.co.uk

Introduction

Across England, there are 78,150 children in care, 12,175 of whom currently reside in a residential care setting (Ofsted, 2020). These figures have risen over recent years and are reportedly higher than other European countries such as Hungary, Denmark, and Sweden (Jackson & Cameron, 2011). The children and young people coming into care have often suffered significant adverse traumas which can have detrimental effects on their physical, emotional, and social development (Parry et al., 2021). Specifically, research has shown that 80% of young people who experienced maltreatment and trauma throughout their childhood met the diagnostic criteria for at least one psychiatric disorder by the age of 21 (Leslie et al., 2010). In addition, by the age of 16, only 14% of looked after children in England achieve five passes at A*-C in their GCSEs, compared to 65% of children with no experience of being in care (Bazalgette et al. 2015). These statistics are considerably lower than those of looked after children in countries such as Denmark and Sweden; however, these countries also report significantly lower levels of attainment for looked after children compared to their age equivalent peers (Jackson & Cameron, 2011).

Many young people in care are also at risk of exploitation and engagement in criminal activity. Worryingly, young people in care often make up a large proportion of those in youth and adult forensic services and homeless communities, due to a lack of secure relationships and appropriate support throughout their childhood (Brannstrom et al., 2017). This partly contributes to the predominantly negative characterisation of looked after children, which in turn impacts upon the young person's emotional wellbeing and can compromise the effectiveness of future intervention (Patricio et al., 2019). Research conducted into the social perception of residential care showed children residing in these services were frequently assigned negative attributes regarding their assumed behavioural, social, and emotional presentations (Calheiros et al., 2015). These social perceptions are frequently informed by the young person's educational attainment and their family's socioeconomic status, whereby lower attainment and status increased negative perception (Patricio et al., 2019). This further aligns with previous conclusions arrived at by the American Psychological

Association (2003), wherein the strengths and competencies of those considered to have lower socioeconomic status are frequently overlooked. It is therefore important that once a young person moves into a residential care setting they receive the correct care and support, that seeks to maximise their strengths and positive attributes, to reduce the effects of their early traumas on future wellbeing. In order to achieve this, residential care homes must utilise appropriate methods of assessment as this process not only aids in decision-making about the young person's care (Salvia & Ysseldyke, 1995), but also helps to ensure interventions are appropriate and effective.

There are several different models of assessment, each with different assumptions regarding gathering data and utilising information to inform intervention (Epstein, 1999). For young people with social and emotional difficulties many of these assessment methods are focused on deficits and problems, highlighting what is 'wrong' with the child's functioning, such as the Child Behaviour Checklist (Achenbach, 1999), as opposed to focusing on their strengths and attributes, or adverse experiences. With this population already facing negative social perception (Calheiros et al., 2015) further focus on areas of deficit could result in the young person being stereotyped in a way that impacts upon professionals' general view of their ability to achieve, and thereby the support offered. Research has shown that certain stereotypes cause people to behave and respond in stereotype-consistent ways (Chen & Bargh, 1997). This stereotyped response can cause the individual to conform to the behaviours of the original stereotype, thus causing a cycle of behaviour that matches other people's expectations (Jussim, 1986). If professionals predominantly assess and focus on young people's deficit areas, it is possible that they will begin to view the individual as predominantly having deficits, and to provide support accordingly. Using the cycle described by Jussim (1986), the young person will likely then begin to conform to their stereotype, thus increasing problematic behaviours. This process is known as a self-fulfilling prophecy (Rosenthal & Jacobsen, 1968). If, however, the young person's strengths were the focus of assessment it is possible that the cycle would increase the likelihood of them viewing themselves more positively and beginning to adjust their behaviours in line with their strengths.

Strengths-based practice offers a holistic and multidisciplinary approach that focuses on the collaborative exploration of an individual's strengths and abilities and how they can be used to aid them in times of adversity (Department of Health and Social Care, 2019). This collaborative process allows potential risks to be explored and managed in a way that maximises benefits and reduces potential negative consequences for the individual. This approach holds the individual at its core and allows them to take control of their situation and to be leaders in their own lives, which increases motivation and engagement with services and interventions (Kemp et al., 2014). It further seeks to empower the individual, rather than labelling them with faults (Saint-Jacques, Turcotte & Pouliot, 2009).

An assumption of strengths-based practice is that all individuals have unused resources that can help them in times of adversity (Saleebey, 1992). Peterson and Seligman (2004) created the Values-in-Action (VIA) classification which identified 24 character strengths and six universal virtues. They state that all individuals possess between three and seven of these character strengths, which are known as their signature strengths (Peterson & Seligman, 2004), with later research showing that use of the signature strengths in innovative interventions increased happiness levels for six months and beyond compared to the placebo control (Seligman et al., 2005). It is believed that strengths are malleable and therefore can be successfully used in strengths-based interventions that target areas of wellbeing (Peterson & Seligman, 2004).

Strengths-based interventions are informed by a strengths-based assessment, which seeks to gather information about the individual's skills and abilities, through means of discussion and observation. The aim is to highlight these untapped resources and use them to aid the young person's progression. The assessment process supports clinicians to recognise that even those children presenting with the most challenging behaviours have strengths that can be built on when implementing interventions (Epstein, 1999).

Whilst the approach has gained traction in the field of family and social care over recent years, there appear to be significant gaps in knowledge with respect to the correct application of the approach (Kemp et al., 2014). This is thought to be due to existing literature not providing robust information about the means of

assessing and alleviating risk or the appropriate application of strengths-based interventions (Staudt, Howard & Drake, 2001). As mentioned, many of the existing assessment tools used for looked after children focus on deficits and labelling the individual's problem areas (Mason, Chmelka & Thompson, 2012). There are also some assessment tools that seek to identify both deficits and strengths, such as the Strength and Difficulties Questionnaire (Goodman, 1997). The purpose of this systematic review is to review the existing measures used to assess children in a looked after setting. Specifically, the review seeks to analyse strengths-based measures that are currently available for this population by looking at the measures in terms of psychometric properties, usability, age range, areas of focus, and costs. The paper aims to highlight which strengths-based measures are available and appropriate for use with the population of looked after children.

Method

Search strategy

Prior to conducting the systematic literature review, an initial search of existing literature on strengths-based measures was conducted using Google Scholar. The purpose of this initial search was to source any existing reviews of the current literature, as well as to determine appropriate search terms. Based on previous reviews and the aims of the current paper, the search terms shown in Table 1 were used to conduct this review. The literature search was conducted using EBSCOhost, which allowed for a simultaneous search through the following databases: APA PsychInfo, APA PsychArticles, APA PsychNet, Medline, Child Development and Adolescent Studies, and Psychology and Behavioural Sciences collection. A total of 959 articles were found, with a further seven being sourced through Google Scholar. After the removal of non-English, secondary and duplicate sources, a total of 966 articles remained.

	‘Measuring' or 'measurement' or 'assessment' or 'assessing'
AND	‘Children' or 'child' or 'young people' or 'youth'
AND	‘residential care’ or 'out of home services'

Table 1 Search terms used in systematic review

Figure 1 shows the process through which studies were selected for the review. With the remaining 966 outputs, titles and abstracts were scanned using the inclusion and exclusion criteria (Table 2) to ascertain their relevance to the review. A total of 925 records were excluded due to irrelevance to the topic and failing to meet the inclusion criteria. A total of 41 outputs remained, of which the full text was screened and further assessed against the eligibility criteria. Following this full text screening, a further 23 outputs were excluded for not meeting the inclusion criteria of the review. Eighteen outputs remained and were included in the literature review. The reference sections of these 18 outputs were further scanned with respect to the inclusion criteria, however there were no additional articles deemed suitable. A total of 18 outputs detailing 12 assessment tools met the inclusion and exclusion criteria and will be used in this review. Details of these 18 outputs can be found in Table 3.

Inclusion Criteria	Exclusion Criteria
Written in English	Outcome measure designed solely for educational settings
Measure of children and young people	Measures used only in adult populations
Outcome measure can be used at least two time points to measure progress	Doesn't refer to a tool, scale, or measure of young people
Used for a wide range of children, not a specific disorder	
Article refers to most recent version of outcome measure	

Table 2 Inclusion/exclusion criteria

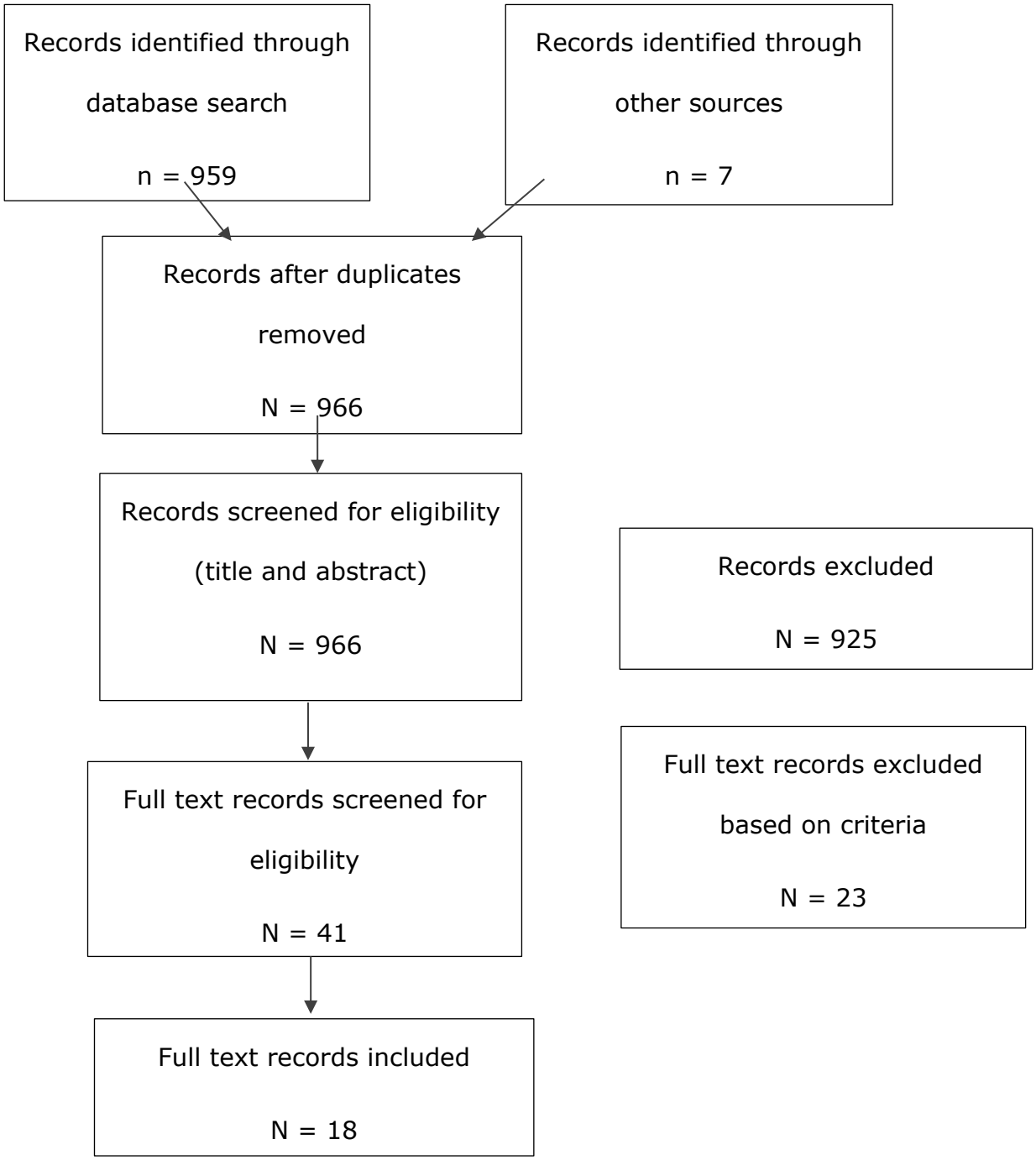

Figure 1 PRISMA Diagram of study flow

Characteristics of included outputs

The 18 outputs were published between 1996 and 2019. The papers detailed a total of 12 outcome measures. The 18 outputs covered the following outcome measures:

- Behavioural and Emotional Ratings Scale -2 (BERS-2)
- Residential Care Youth Needs Assessment Questionnaire (RCYNA)
- Strengths and Difficulties Questionnaire (SDQ)
- Achenbach System of Empirically Based Assessment (ASEBA)
- Child and Adolescent Needs and Strengths Assessment (CANS)
- Brief Assessment Checklist (BAC-C/BAC-A)
- Devereux Scales of Mental Disorders (DSMD)
- Child and Adolescent Functional Assessment Scale (CAFAS)
- Ohio Youth Problems, Functioning, and Satisfaction Scales
- Child and Adolescent Behaviour Assessment (CABA)
- Health of the National Outcomes Scale for Children and Adolescents (HoNOSCA)
- Assessment Checklist for Adolescents/Children (ACA/ACC)

Details of the papers and assessment tools referenced are shown in Table 4. The outputs were scanned to elicit further details about the assessment tools. Specifically, the search sought to identify which of the measures were strengths-based tools, also considering psychometric properties, usability, age range, areas of focus, and costs of use.

Author	Title	Measure
Ballesteros-Urpi et al. (2018)	Validation of the Spanish and Catalan versions of the health of the nation outcomes scale for children and adolescents (HoNOSCA).	Health of the National Outcomes Scale for Children and Adolescents (HoNOSCA)
Buckley & Epstein (2004)	The behavioural and emotional ratings scale-2 (BERS-2): Providing a comprehensive approach to strength-based assessment.	The Behavioural and Emotional Ratings Scale -2 (BERS-2)
Calheiros et al. (2011)	Assessment of needs of youth in residential care: Development and validation of an instrument.	Residential Care Youth Needs Assessment Questionnaire (RCYNA)
Calheiros & Patricio (2012)	Assessment of needs in residential care: Perspectives of youth and professionals.	Residential Care Youth Needs Assessment Questionnaire (RCYNA)
Chng et al. (2019)	Examining the relationship between the needs of children and young persons living in residential care and critical incidents using	Child and Adolescent Needs and Strengths Assessment (CANS)

	the Singapore CANS assessment tool.	
Gimple & Nagle (1999)	Psychometric properties of the Devereux scales of mental disorders.	Devereux Scales of Mental Disorders (DSMD)
Hodges & Wong (1996)	Psychometric characteristics of a multidimensional measure to assess impairment: The child and adolescent functional assessment scale.	Child and Adolescent Functional Assessment Scale (CAFAS)
Hurley et al. (2015)	Convergent validity of the strength based behavioural emotional rating scale with youth in a residential setting.	The Behavioural and Emotional Ratings Scale -2 (BERS-2)
Janssens & Deboutte (2009)	Psychopathology among children and adolescents in child welfare: A comparison across different types of placements in Flanders, Belgium.	Achenbach System of Empirically Based Assessment (ASEBA) Strengths and Difficulties Questionnaire (SDQ)
Liu et al. (2014)	Profiles of needs of children in out-of-home care in Singapore: School performance, behavioural and	Child and Adolescent Needs and Strengths Assessment (CANS)

	emotional needs as well as risk behaviours.	
Mason et al. (2012)	Responsiveness of the strengths and difficulties questionnaire in a sample of high risk youth in residential treatment.	Strengths and Difficulties Questionnaire (SDQ)
Morn et al. (2017)	Reliability and validity of the child and adolescent behaviour assessment (CABA): A brief structured scale.	Child and Adolescent Behaviour Assessment (CABA)
Ogles et al. (2001)	The Ohio scales: Practical Outcome Assessment.	Ohio Youth Problems, Functioning, and Satisfaction Scales
Reynolds & Kamphaus (2004)	Behaviour assessment system for children: Assessment for Effective Intervention.	The Behavioural and Emotional Ratings Scale -2 (BERS-2)
Rodrigues et al. (2019)	Psychological adjustment of adolescents in residential care: Comparative analysis of youth self-report/strengths and difficulties questionnaire.	Strengths and Difficulties Questionnaire (SDQ) Achenbach System of Empirically Based Assessment (ASEBA)

Tarren-Sweeney (2013a)	The assessment checklist for adolescents-ACA: A scale for measuring the mental health of young people in foster, kinship, residential and adoptive care.	Assessment Checklist for Adolescents/Children (ACA/ACC)
Tarren-Sweeney (2013b)	The brief assessment checklist (BAC-C, BAC-A): Mental health screening measures for school aged children and adolescents in foster, kinship, residential and adoptive care.	Brief Assessment Checklist (BAC-C / BAC-A)
Smith & Reddy (2002)	The concurrent validity of the Devereux scales of mental disorders.	Achenbach System of Empirically Based Assessment (ASEBA)

Table 3 Details of review outputs

Results

The articles were scanned to assess usability and the psychometric properties of the 12 outcome measures. Table 4 details the designated age, area of focus, number of items, who completed the measure, and the cost of the measures.

	Age range / years	Areas of focus	Number of items	Completed by:	Cost
Achenbach System of Empirically Based Assessment (ASEBA)	CBCL 6-18 YSR 11-18 TRF 6 - 18	Syndrome and DSM orientated scales	CBCL 113 YSR 112 TRF 113	Caregiver, teacher, youth	Yes
Assessment Checklist for Adolescents/Children (ACA)	ACC: 5-11 ACA: 12-17	Emotional states, behaviours, traits, manners of relating to others (7 clinical scales, 2 self-esteem scales)	105	Caregivers	Free to registered users
Brief Assessment Checklist (BAC-C / BAC-A)	BAC-C: 4-11 BAC-A: 12-17	Interpersonal difficulties, attachment difficulties, insecure relating, social, behavioural and emotional dysregulation, trauma related anxiety and dissociation, abnormal responses to pain, overeating and related food maintenance	20	Caregivers	Freely downloadable

		behaviours, sexual behaviour problems, self-injury, and suicidal behaviours and discourse			
Behavioural and Emotional Ratings Scale -2 (BERS-2)	11-18	Interpersonal strengths, functioning at school, affective strength, intrapersonal strength, family involvement, and career strength	58 carer, 58 young person, 52 teacher	Self-report, parent, teacher	Costs involved
Child and Adolescent Behaviour Assessment (CABA)	5-18	Externalising, internalising, and risk behaviours	32	Self-report, caregivers	Costs involved
Child and Adolescent Functional Assessment Scale (CAFAS)	5-18	Thinking problems, self-harm, substance use, home, school, behaviours towards others, mood, emotions, community. Caregiver material needs and social support		Self-report, caregivers	yearly fixed rate and nominal fee for each assessment
Child and Adolescent Needs and Strengths	6-20	Core domains: 1. Life Domain Functioning	50 core items, personalised	Caregivers	Cost involved

Assessment (CANS)		2. Youth Strengths 3. Acculturation 4. Caregiver Strengths & Needs 5. Youth Behavioural/Emotional Needs 6. Youth Risk Behaviours Additional domains available	packages available		
Devereux Scales of Mental Disorders (DSMD)	5-18	Conduct, attention, delinquency, anxiety, depression, autism, acute problems, externalising composite, internalising composite, critical pathology composite	111	Caregivers and teachers	Free download
Health of the National Outcomes Scale for Children and Adolescents (HoNOSCA)	5-18	Behaviour, impairments, social, symptoms	15	Self-report (13+), caregivers	Free download
Ohio Youth Problems, Functioning, and	5-18	Functioning, hopefulness, satisfaction, problem severity	48	Self-report, caregiver	Free

Satisfaction Scales		(restrictiveness of living completed by AW)		s, agency workers	
Residential Care Youth Needs Assessment Questionnaire (RCYNA)		Living situation, social and family relationships, physical and psychological health, behaviour and skills, education and employment behaviours	168	Caregive rs	Cost?
Strengths and Difficulties Questionnaire (SDQ)	2-17	Psychological attributes (emotional symptoms, conduct problems, hyperactivity/inattenti on, peer relationship problems, prosocial behaviours), impact supplement, follow up questions after intervention	25	Self-report, caregiver , teachers	Online version involves cost, manual is free

Table 4 Characteristics of outcome measures

On looking further into these 12 outcome assessments, it became apparent that a number of them were deficit-focused. Of the 12 measures, only four were identified as being strengths-based or as including a strengths-based addendum. The psychometric properties of these four outcome assessments are shown in table 5.

	Population norms	Internal consistency	Inter-rater reliability	Test-retest reliability
Assessment Checklist for Adolescents (ACA)	Age and gender specific norms	Clinical scales .76 to .90 Self-esteem scales .76 to .90	Not reported	Not reported
Behavioural and Emotional Ratings Scale -2 (BERS-2)	Representative of children nationwide	TRS: .84 to .92 PRS: .79 to .88 YSR: .95 to .97	TRS: not reported PRS .50 to .63 YSR: .50 to .63	Short-term .84 to .98 Long-term .53 to .79
Child and Adolescent Needs and Strengths Assessment (CANS)	US and Singapore children	Not reported	.85 to .99	Not reported
Strengths and Difficulties Questionnaire (SDQ)	British normative sample, Dutch normative sample	PRS: .70 YSR: .64	Parent youth agreement is favourable for most scales	.70+

Table 5 Psychometrics of strengths-based measures

Discussion

This review focuses on those strengths-based measures that are routinely used within the looked after children population. The results of the review initially showed 12 assessment tools that are often used within this population, however upon further exploration many of them were in fact deficit-based. As a result, the current review was successful in identifying only four outcome assessment tools that are strengths-based or have a strengths-based addendum. With research highlighting the importance of strengths-based practice and its ability to motivate young people to achieve their goals (Kemp et al., 2014), it is a surprise that there are currently so few measures available that seek to highlight potential areas of strength of young people in residential services. The measures that have been highlighted as strengths-based have some advantages, but also some limitations. Some of these strengths and limitations are discussed below.

With regard to the extent to which the four measures assess strengths, some of the tools are fully strengths-based, whilst others contain strengths-based questions along with deficit-focused areas. For example, the Strengths and Difficulty Questionnaire (SDQ) measures both a young person's area of strengths and of deficit (Janssens & Deboutte, 2009). Specifically, only five of the 25 questions relate to strengths (prosocial behaviours). Whilst this measure is often widely used within the target population, and is psychometrically sound, it places greater emphasis on young people's deficit areas, which can often result in areas of strength being relatively overlooked when assessing need and planning interventions.

Similarly, the Assessment Checklist for Adolescents (ACA) is predominantly deficit-based, however upon request the suppliers can provide a 30-item supplementary strengths checklist for the adolescent version of the measure (Tarren-Sweeney, 2013). This supplementary checklist however is not widely cited within the literature, suggesting it is a tool that is not frequently used alongside the ACA. In addition, whilst the psychometric properties of the ACA are well-established in the literature, the strengths-based supplementary checklist has not yet been assessed for its reliability or validity. This highlights a potential area for future research to focus on, to contribute to the growing knowledge of strengths-based measures.

The Child and Adolescent Needs and Strengths assessment (CANS) looks at the young person holistically, assessing their strengths and areas of need in a balanced ratio. Research has suggested that this approach increases placement stability as it encourages collaborative working across services and increases resources in areas of need (Conradi et al., 2011). However, the measure is only completed by the caregivers, thereby depleting the opportunities to hear the young person's voice. Allowing young people to have a say in their care empowers them to feel in control of their own lives. This increases motivation and engagement with services (Kemp et al., 2014). The lack of opportunity for young people's voices to be heard is also a limitation with the ACA, which is also solely completed by caregivers. In contrast to the above three measures, the BERS-2 is specifically strengths-based, with all domains and questions seeking to highlight the individual's areas of strength to inform intervention.

Considering the usability of the tools, some of the measures would be more suited to routine assessment than others. For example, the SQD consists of only 25 questions, making it a short measure that can be completed quickly and allows the carer to become familiar with the questions. In contrast, the ACA is a 105-item measure that requires more time to complete. At present, many services seek to be able to track and monitor progress over a period of time, and larger item measures may not be able to achieve this as efficiently (Wolpert et al., 2012). It is therefore possible that the ACA may be more suited to more in-depth assessments rather than repeated reviews. However, the strengths-based supplementary checklist consists of 30 items, which increases its ease of use in routine practice.

At first glance, the above results would appear to conclude that the BERS-2 would be the most appropriate measure, as it is psychometrically sound, fully strengths-based, and captures the views of the young person along with those of their carers. However, the BERS-2 is not specifically designed to be used with children in a residential care setting, and some of the questions, for example relating to family involvement, may be inappropriate for the target population. Items such as 'I get along well with my family' (Epstein, 2004) may be distressing to ask of young people who are estranged from their family or who are facing difficulty understanding why they cannot live with their families. The

BERS-2 is perhaps more suited for use with students within an education provision.

It is important that the tools used to assess looked after children are sensitive to the adversity and trauma they have experienced prior to moving into care. Of the measures highlighted, the ACA is the only measure originating from the looked after children population (Denton et al., 2017). The measure is also an age-specific assessment tool that allows for appropriate understanding of behaviours from a trauma-informed perspective. The measure is also sensitive to the difficulties young people have faced and understands how these difficulties may present in terms of behaviours observable by caregivers.

In conclusion, it is apparent from this literature review that there are few strengths-based measures suitable for routine use within the looked after children population. Of the measures that were identified, the ACA, along with the strengths-based supplementary checklist, appears to be most appropriate for use due to the core measure being psychometrically sound and rooted in the looked after children population. Unfortunately, the strengths-based addendum to this measure is not frequently cited and is yet to be psychometrically researched. Further research is needed to assess the psychometric properties of the strengths-based supplementary checklist and to understand if this can be used as a standalone measure, or only in conjunction with the ACC/ACA.

It is important to note that there could be additional measures detailed in papers outside of this review that did not fit within the inclusion/exclusion criteria employed. However, it is clear from the current review that there no entirely strengths-based measures have been developed for use within looked after children's services. Whilst this review has highlighted some potential measures that could be used within residential care settings, it has also identified an outstanding need for a solely strengths-based measure that is rooted within child residential care settings.

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About the authors

Danielle Day (Assistant Psychologist), Dr Sarah Elgie (Clinical Psychologist) and Dr Chris Robinson (Clinical Psychologist) work for a large provider of children's residential care and are in the process of reviewing the outcome measures used to assess and monitor children's progress whilst in their care. They are passionate about improving the outcomes for children in residential homes and in particular, the use of strengths-based measures.