INFORMATION PACKET

SAFESTRONGSUPPORTIVE

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# What are some screening and assessment tools that help support children's well-being?

The child welfare system is understood to have three main goals: the safety, permanency, and well-being of children. However, the main indicators of success for most child protection agencies typically reflect only two of those goals — safety and permanency. These two goals have clearer definitions and measures than well-being, and child welfare currently has no standard method of assessing well-being.[1]

There is a growing understanding, however, of the vital role that well-being plays in child safety and permanency, and hence the responsibility of child protection agencies to support the well-being of the children in their care. To fulfill this responsibility, it is critical that agencies use multiple tools to assess children for trauma, behavioral health, and developmental needs, which can provide a holistic picture of a child's overall well-being. Parents should be involved in the assessment process and any indicated follow-up services, as parents are critical to child well-being regardless of where their child may be living.

Early and regular assessments can help identify children's needs and strengths, inform appropriate service plans, lead to better-matched out-of-home placements, and support successful permanency outcomes,[2,3] all of which are essential to a child's well-being. These assessments should not create a barrier to family reunification. Instead, keeping parents at the center of this process is critical to supporting the parent-child relationship and reunification, whenever possible.

This information packet is intended to help child protection agencies identify and select screening and assessment tools that support child well-being, and includes descriptions of several commonly used tools.

## Considerations

Agencies need structured processes for understanding children's needs in real time and over time. This is key to identifying appropriate placement settings and informing effective service planning to support well-

being and the achievement of timely reunification or other form of permanency. Deciding how best to assess child well-being can be challenging, however. A 2024 review of tools assessing child mental health and well-being found little consensus across studies on which tools to recommend.[4] Among the 41 reviews examined, 60 tools were recommended — but only nine were recommended by more than one review. Two of those, both of which assess general mental health, are described below: the Pediatric Symptom Checklist and the Strengths and Difficulties Questionnaire.

To ensure tools are appropriate for the population of children served as well as the goals of the agency, agencies need processes for reviewing, piloting, evaluating, and selecting tools. A 2017 review of child mental health assessments conducted for the California Department of Health Care Services provides an example of a thorough review process, which included: (1) an environmental scan to identify tools; (2) an evaluation of the tools identified, through a review of the scientific evidence in combination with clinical expertise; and (3) a set of minimum criteria for selecting a tool, based on the agency's goals.

Ultimately, **decisions regarding the selection of tools should be data-driven, structured, and collaborative, including input from individuals with lived experience**. A 2014 Children's Bureau publication on child well-being screening and assessment includes several questions for jurisdictions to consider at both the agency level and the child level:

### Agency level

1. What is the purpose of the tool? Is it being used to facilitate case decision-making or to inform clinical practice?
2. What type of research has been conducted on the tool? Does it have established reliability, validity, and norms?
3. What are the budget and the cost for the tool?
4. How are data from the measure scored and stored? Is it necessary to create a system that stores the information gathered? Does the tool provide feedback to the caseworker or clinician in an efficient and timely manner?
5. How is the information shared? Can information be shared across the child welfare and mental health systems?
6. What staff are available to administer the tool? What is their level of education and experience? How much extra time is involved in completing a screening and using the information for case and/or treatment planning purposes?
7. Does the tool track change over time and indicate if the child has improved?

### Child level

1. Is the child old enough and able to answer questions about personal history?
2. Can the child read, or will a computer read the question to the child?
3. Is the caregiver a reliable informant?
4. If the caseworker is completing the screening, do the case files provide enough information?
5. With whom will the information be shared?
6. Will the results inform case and/or treatment planning?

## Child well-being screening and assessment tools

Various screening and assessment tools are available. Some have been specifically created for child welfare, while others originate from other fields and have been adapted. Screening tools typically are **brief questionnaires examining risk factors or symptoms** that help determine whether more comprehensive assessments — such as for trauma, substance use, or mental health — are warranted. Assessments are more comprehensive, designed to **capture specific information about a child's history, symptoms, functioning, and support systems**. Both types of tools can be used by child protection agencies and their partners to address various needs. In addition to the aforementioned 2017 recommendation report on child mental health, which examined 11 tools, the California Evidence-based Clearinghouse for Child

Welfare and The National Child Traumatic Stress Network also review a variety of screening and assessment tools. Tools frequently used in child welfare are presented below:

| Screening or assessment tool | Utility and considerations for use | Target age / Time to administer |
|---|---|---|
| Ages and Stages Questionnaires, Third Edition (ASQ-3®)<br><br>The ASQ is a standardized tool for screening children's development. It consists of questions documenting developmental progress in five domains: communication; gross motor skills; fine motor skills; problem-solving; and personal-social skills.<br><br>Parents/caregivers complete the questionnaires, which are scored by professionals, paraprofessionals, or clerical staff. | The ASQ can identify potential delays or issues early in children's development to keep them on track toward meeting their developmental milestones.<br><br>Also available is the Ages and Stages Questionnaires: Social-Emotional, Second Edition (ASQ:SE2®), which screens young children's social-emotional development in seven key areas: adaptive functioning; affect; autonomy; compliance; interaction with people; self-regulation; and social-communication.<br><br>A cost is associated with ASQ use. | 1 month to 5½ years old<br><br>10 to 20 minutes per questionnaire |
| Child and Adolescent Needs and Strengths (CANS)<br><br>The CANS is a multi-purpose standardized assessment tool developed to support care planning and level of care decision-making, facilitate quality improvement initiatives, and monitor service outcomes.<br><br>The CANS has six core domains: life functioning; strengths; cultural factors; caregiver resources and needs; behavioral/emotional needs; and risk behaviors.<br><br>Certified professionals, such as caseworkers, clinicians, and family advocates, complete the CANS. | The CANS identifies strengths and needs of the child, which can aid in case planning. It is used in child welfare, mental health, juvenile justice, and early intervention settings. The CANS rates caregivers' strengths and needs, making it particularly informative for service planning.[5,6]<br><br>While the CANS does screen for trauma, the CANS-Trauma Comprehensive Version also is available as a tool that focuses more specifically on the impact of trauma across various domains in a child's life.<br><br>Although the CANS is a free, open-domain tool, initial certification and annual re-certification are required. | 6 to 20 years old<br><br>10 to 15 minutes |
| Child and Adolescent Functional Assessment Scale (CAFAS)<br><br>The CAFAS measures functional impairment for children who are at risk of developing emotional, behavioral, substance use, psychiatric, or psychological problems. It is used to inform decisions about level of care, | The CAFAS can assess functioning, strengths, and goals in developing treatment plans for children across various domains.<br><br>The CAFAS was adapted from the North Carolina Family Assessment Scale for General Services. | CAFAS:<br>3 to19 years (kindergarten and higher)<br><br>PECFAS:<br>3 to 7 years |

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| treatment type and intensity, placement, and referral needs.<br><br>The CAFAS has eight youth assessment scales: school/work role performance; home role performance; community role performance; behavior towards others; moods/emotions; self-harmful behavior; substance use; and thinking problems.<br><br>Mental health clinicians or other trained professionals working directly with children and their families complete the CAFAS. | For children ages 3 to 7 (depending on developmental level), The Preschool and Early Childhood Functional Assessment Scale (PECFAS) is available.<br><br>The CAFAS requires comprehensive and ongoing training to maintain fidelity.<br><br>Ongoing costs are associated with administration and training. | 10 minutes |
| Child and Adolescent Service Intensity Instrument (CASII)<br><br>The CASII assesses the service intensity needs of children and adolescents who have psychiatric, substance use, medical, or developmental concerns.<br><br>The CASII assesses service needs in six areas: risk of harm; functional status; co-occurring conditions; recovery environment; resiliency/response to services; and involvement in services.<br><br>Mental health clinicians or other trained professionals working directly with children and their families complete the CASII. | The CASII was developed based on a system of care approach. As such, it assesses children's needs within the context of their family and community rather than focusing only on a child's symptoms.<br><br>It does not provide clinical diagnoses and does not replace comprehensive clinical evaluations.<br><br>The Early Childhood Service Intensity Instrument (ECSII) is available for children ages 0 to 5. It measures degree of safety, child-caregiver relationships, caregiver environment, functional/developmental status, impact of the child's condition, and services profile fit.<br><br>There is a cost for initial training. | CASII:<br>6 to 18 years<br><br>ECSII:<br>0 to 5 years<br><br>10 to 20 minutes |
| Child Behavior Checklist (CBCL)/6-18<br><br>The CBCL can be used to identify behavioral and emotional problems in school-age children and adolescents.<br><br>It is a standardized measurement tool completed by the parent or caretaker, | The CBCL is the most commonly used parent-completed instrument that assesses child and adolescent psychopathology.<br><br>The CBCL/1½-5 is available for toddlers and preschoolers. It includes DSM-oriented scales that align with the following DSM-5 diagnostic categories: | CBCL:<br>6 to 18 years<br><br>CBCL/1½-5:<br>1.5 to 5 years |

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| with alternate versions completed by teachers or youth (ages 11 to 18).<br><br>The CBCL/6-18 provides ratings for competencies and problems. It includes six DSM-oriented scales that align with the following DSM-5 diagnostic categories: anxiety; attention deficit/hyperactivity; conduct; depressive; oppositional defiant; and somatic. | aggressive behavior; anxious/depressed; attention problems; emotionally reactive; somatic complaints; sleep problems; and withdrawn.<br><br>There are ongoing costs associated with administration. | 15 to 20 minutes |
| Ohio Scales for Youth<br><br>The Ohio Scales for Youth are a set of questionnaires that parents, agency workers, and youth (ages 12 and older) complete. The scales consist of two domains: functioning and problem severity. The agency worker version includes the Restrictiveness of Living Environments Scale, and the parent and youth versions include domains assessing hopefulness and satisfaction with treatment. | The Ohio Scales for Youth assess the outcomes of children and adolescents who have received mental health services. They were developed to track service effectiveness and inform treatment plans, not as a diagnostic tool.<br><br>The tool is free to download, and technical and users manuals also are available for free. | 5 to18 years<br><br>15 minutes |
| Pediatric Symptom Checklist (PSC-35)<br><br>The PSC-35 identifies and assesses changes in psychosocial functioning. Parents or youth can complete it. Subscale scores assess internalizing, externalizing, and attention problems. | The PSC-35 is not a diagnostic instrument. For children ages 6 to 17, scores above the cutoff suggest psychosocial impairment, and for children ages 3 to 5, scores above the cut off suggest risk of psychosocial impairment.<br><br>The PSC also is available in a shorter 17-item version and a pictorial version.<br><br>The tool is free to use. | 3 to 17 years<br><br>5 to 10 minutes |
| Strengths and Difficulties Questionnaire (SDQ)<br><br>The SDQ measures the early detection of behavioral problems and strengths in children and adolescents. Parents, teachers, or youth ages 11 and older can complete it. | The SDQ can be used as a screening instrument, for initial clinical assessment, and for evaluating outcomes during and after treatment. Norms are available by age group and country.<br><br>Slightly modified versions of the SDQ are available for different age groups. | SDQ 11-17:<br>11 to 17 years<br><br>SDQ 4-10:<br>4 to 10 years<br><br>SDQ 2-4:<br>2 to 4 years |

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| The SDQ includes five domains: emotional symptoms; conduct problems; hyperactivity/inattention; peer relationship problems; and prosocial behavior. | The SDQ is free, and training is available. Although hand-scoring is an option, instrument developers recommend using the online scoring platform for a nominal fee. | 5 minutes |
| Well-being Indicator Tool for Youth (WIT-Y)<br><br>The WIT-Y is designed for youth 15 to 21 years old who are currently in or have had prior contact with the child welfare system. It is an online tool that youth can complete to explore well-being across eight domains.<br><br>It is designed as an inventory and to be a conversation starter with youth about their overall well-being. Youth also can use the tool on their own. | The WIT-Y is a free, online tool.<br><br>Following completion, youth receive a WIT-Y snapshot that gives a picture of their well-being based on the assessment, as well as a WIT-Y Blueprint that is a planning document for help them take steps to increase their well-being in a particular area. | 15 to 21 years<br><br>10 to 15 minutes |
| Youth Connections Scale (YCS)<br><br>The YCS is designed to: measure permanent, supportive connections for older youth (15 to 21 years old) in foster care; guide case planning around strengthening youth connections to caring adults; track the efforts of caseworkers as they identify, maintain, and help strengthen connections; and evaluate practices and strategies that aim to increase relational permanence for youth.<br><br>The YCS assesses the number of meaningful connections older youth have with supportive adults, the strength of those connections, specific types of supports the connections provide, and the overall level of connectedness youth have with caring and supportive adults. | While youth can complete the YCS independently, the tool was designed to be administered as part of a conversation between youth and a caseworker or other caring adult.<br><br>The YCS is free, and a brief training module is available at no charge. | 15 to 21 years<br><br>20 to 30 minutes |

[1] Rosanbalm, K. D., Snyder, E. H., Lawrence, C. N., Coleman, K., Frey, J. J., Van Den Ende, J. B., & Dodge, K. A. (2016).
[2] Akin, B. A., Collins-Camargo, C., Strolin-Goltzman, J., Antle, B., Nathan Verbist, A., Palmer, A. N., & Krompf, A. (2021). Screening for trauma and behavioral health needs in child welfare: Practice implications for promoting placement stability. *Child Abuse & Neglect*, *122*, 105323. https://doi.org/10.1016/j.chiabu.2021.105323.
[3] Collins-Camargo, C., Strolin-Goltzman, J., Verbist, A. N., Krompf, A., & Antle, B. F. (2021).
[4] Jacobs, P., Power, L., Davidson, G., Devaney, J., McCartan, C., McCusker, P., & Jenkins, R. (2024). A scoping review of mental health and wellbeing outcome measures for children and young people: Implications for children in out-of-home care. *Journal of Child & Adolescent Trauma*, *17*(2), 159–185. https://doi.org/10.1007/s40653-023-00566-6.
[5] Rosanbalm, K. D., Snyder, E. H., Lawrence, C. N., Coleman, K., Frey, J. J., Van Den Ende, J. B., & Dodge, K. A. (2016).
[6] Collins-Camargo, C., Strolin-Goltzman, J., Verbist, A. N., Krompf, A., & Antle, B. F. (2021).

## Casey Family Programs

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