INFORMATION PACKET

SAFE CHILDREN

How can we select the right tool to help us better **assess children's safety, permanency, and well-being needs?**

> The most important tasks a child protection agency leader must tackle on a daily basis are keeping children who come to their attention safe from future harm, and ensuring that children who are placed in out-of-home care find permanent families as soon as safely possible. There is little patience from the public for human error or failures in protocol. The good news is that there are a number of scientific tools that have been created to help child protection agency workers make sound, consistent, and less biased decisions. Although it is important to select the right tool for the right population, these tools in and of themselves are not foolproof. It is equally important to ensure that all members of the agency, partners, and the public understand the agency's values and priorities, staff are continuously trained on effective implementation, and that processes are in place to identify and eliminate human errors.
>
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In order for agencies to address the safety, permanency, and well-being of children placed in their care, an effective assessment process must be in place. Assessing a child's needs should not be a single event, nor should it be the result of a single tool. Child-level assessment should happen regularly, in myriad ways, in order to ensure the agency understands a child's individual needs and strengths, and is able to provide the necessary services to support a child's safety and facilitate a path to permanency.

This information packet was prepared in response to a request from a mid-size jurisdiction seeking information to aid in the selection and implementation of child screening and assessment tools to inform level of care decision-making, service planning and delivery, and child well-being, including placement stability and continuity of connections with family and community.

Screening and assessment tools

The Children's Bureau (2014) has articulated a three-pronged model for an effective response to assessing and addressing the needs of vulnerable children and their families:[1]

1. ***Universal screening*** *for mental health and trauma symptoms that can assist the decision to refer for clinical assessment and treatment;*
2. ***Clinical and functional assessment*** *together with outcome measurement and management;*
3. ***Selection and use of evidence-based interventions*** *(EBI) in response to clinical needs observed in the assessment process that have the potential for relief of symptoms/conditions and improvement in psychosocial functioning.*

Screening tools are typically brief questionnaires or procedures that examine risk factors or symptoms and help determine whether a more comprehensive or in-depth assessment, such as when addressing trauma, substance abuse, or mental health, is warranted. Functional assessments, on the other hand, are more comprehensive and designed to capture a range of specific information about a child's history, symptoms, functioning, and support systems.[2]

Multiple screening tools and assessments have been developed and implemented over the years. Some have been specifically created for use with the child welfare population, while others have been adapted or modified in order to better fit this population. A number of related implementation guidance and manuals have been developed as well.[3]

Child welfare agencies use a range of screening and assessment tools. Casey Family Programs conducted a national scan of assessment tools used in jurisdictions across the country in 2012. This scan is provided in the Appendix. A brief snapshot of the most frequently used tools, including descriptive elements, target age, and length of time to administer, are offered below:

ASSESSMENT TOOLS	DESCRIPTION	TARGET AGE	TIME TO ADMINISTER
Ages & Stages	Series of 19 parent-completed questionnaires designed to screen the developmental performance of children in the areas of: communication; gross and fine motor skills; problem solving; personal-social skills; and overall development across time.	4 months to 5 years	10-20 minutes

ASSESSMENT TOOLS	DESCRIPTION	TARGET AGE	TIME TO ADMINISTER
Child & Adolescent Needs and Strengths	Comprehensive assessment of psychological and social factors for use in treatment planning. Domains assessed include: life domain functioning; strengths; cultural factors; caregiver resources and needs; child behavioral and emotional needs; risk behaviors; and other modules, such as developmental disabilities, trauma, substance abuse, violence, sexual aggression, runaway, juvenile justice and fire-setting.	0-5 years or 5-18 years	10 minutes
Child and Adolescent Functional Assessment Scale (CAFAS)	Measures functional impairment for children who are at risk for developing emotional, behavioral, substance use, psychiatric, or psychological problems.	6-17 years	10 minutes
Child and Adolescent Service Intensity Instrument (CASII/ESII)	Assesses the strengths and needs of children who are seriously emotionally disturbed or have a mental health, developmental, or substance abuse disorder. It measures: risk of harm; functional status; co-occurrence of conditions; recovery environment; resiliency; involvement in services.	6-18 years	10-20 minutes
Child Behavior Checklist (CBC)/6-18	Obtains reports from parents, other close relatives, and/or guardians regarding children's competencies and behavioral/emotional problems. Parents provide information for 20 competence items covering their child's activities, social relations, and school performance.	6-18 years	10-20 minutes

ASSESSMENT TOOLS	DESCRIPTION	TARGET AGE	TIME TO ADMINISTER
Child Behavior Checklist (CBC)/1.5-5	Includes 99 items that describe specific kinds of behavioral, emotional, and social problems that characterize preschool children. Items are scored on syndrome scales designated as Emotionally Reactive; Anxious/ Depressed; Somatic Complaints; Withdrawn; Attention Problems; Aggressive Behavior; and Sleep Problems. Items are also scored as Affective Problems; Anxiety Problems; Pervasive Developmental Problems; Attention Deficit/ Hyperactivity Problems; and Oppositional Defiant Problems.	1.5-5 years	10-20 minutes
Children's Functional Assessment Rating Scale (CFARS) & FARS	Measures 16 domains: Depression; Anxiety; Hyperactivity; Thought Process; Cognitive Performance; Medical/Physical; Traumatic Stress; Substance Use; Interpersonal Relationships; Behavior in "Home" Setting; ADL Functioning; Socio-Legal; Danger to Self; Danger to Others; Security Management Needs.	Not available	Not available
Daily Living Functional Assessment	Designed to assess what daily living areas are impacted by mental illness or disability.	6-18 years	15 minutes
OHIO Scales (Ohio Youth Problems, Functioning & Satisfaction Scales)	Instruments developed to measure outcomes for youth who receive mental health services. The Ohio Scales consist of 4 domains : Functioning Scale, Hopefulness Scale, Satisfaction Scale, and Problem Severity Scale. The agency worker form used in the state of Ohio also includes the Restrictiveness of Living Environment Scale (ROLES).	5-18 years	15 minutes
Strengths and Difficulties	Screening measure for early detection of behavioral problems and strengths in children and adolescents. Topics in SDQ subscales include emotional symptoms, conduct problems, hyperactivity/inattention, ADHD, peer relationship problems, and pro-social behavior.	4-16 years	5 minutes

ASSESSMENT TOOLS	DESCRIPTION	TARGET AGE	TIME TO ADMINISTER
Treatment Outcomes Package (TOP) – Child TOP	TOP consists of a simple, web-based, checklist completed by the child, birth and foster parents, clinicians, teachers and caseworkers. Assessments consist of 48–58 easy-to-understand questions related to 11–13 different dimensions of well-being. TOP automatically collects and scores the results using multiple analytical methods to present immediate results and easy-to-follow graphs. There is also a Trauma Screen available.	Age 3 and above	10-15 minutes
Youth Connections Scale (YCS)	The YCS is designed to measure permanent, supportive connections for youth 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 the relational permanence of youth.	15-21 years	10-15 minutes

Instrument selection considerations

Agencies need a structured process for understanding, in real time and over their time in out-of-home care, children's needs, especially with regards to identifying appropriate placement settings as well as informing effective service planning and delivery to support the achievement of timely permanency.

It is also important for agencies to have in place a process for reviewing, piloting, evaluating, and selecting screening or assessment tools, in order to explore and evaluate their utility for the population of children who may be in care. In many instances, agencies are undertaking reviews of their tools in order to identify other tools they may need to replace or complement them, given the current population of children in care and the agency infrastructure available to support implementation. For example:

- *The California Department of Social Services is currently partnering with counties to pilot two assessment tools: Treatment Outcomes Package (TOP) and Child and Adolescent Needs and Strengths (CANS). Both assessment tools measure the well-being of youth in foster care in order to identify needed services as well as support effective case planning. The TOP pilot is underway in the following four counties; Los Angeles, San Diego, Fresno and Tuolumne. The TOP pilot counties are actively engaged in training and have completed assessments for over 390 youth in child welfare. The CANS is being piloted in San Francisco, Humboldt and Shasta counties. The department is developing a request for proposal (RFP) to select an independent party to conduct an evaluation and report on the efficacy of each assessment tool.*[4]

- *For years, the Iowa Department of Human Services had used its own state-created assessment tool for children in care, but recently worked with Outcome Referrals to develop and implement the Treatment Outcome Package statewide.*[5]
- *While CANS had been used for many years across Nebraska, following a review of the CANS alongside the Structured Decision-Making's Family Strengths and Needs Assessment (SDM-FSNA) tool, in 2015, Nebraska DHHS determined that: The SDM FSNA is adequate in gathering the necessary information to identify the areas of needs of the child. Utilization of CANS is a duplication of assessments. DHHS completed a survey with Child and Family Services Specialists regarding utilization of the CANS and FSNA. The majority of staff surveyed preferred utilizing FSNA and felt the CANS and FSNA were duplication of assessments. DHHS recommends discontinuing the use of the CANS and utilizing only the FSNA.*[6]

Ultimately, agency decisions regarding the selection of tools should be data-driven, structured and collaborative. As the authors emphasize in Screening, Assessing, Monitoring Outcomes and Using Evidence-Based Interventions to Improve the Well-Being of Children in Child Welfare (2014), before selecting a tool or measure for screening or assessment, a jurisdiction should work with staff and partners to consider a number of key questions at both the agency and child levels:

JURISDICTIONAL CONSIDERATIONS FOR TOOL SELECTION[7]

CHILD LEVEL	AGENCY 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?	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? Do we need to work with information technology to create a system that stores the information gathered? Are we able to provide feedback to the caseworker or clinician in an efficient and timely manner? 5. How is the information shared? Are we able to share the information across the child welfare and mental health systems? 6. What staff do we have 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 allow us to see if the child has improved?

Using similar considerations, in their recent 2016 article, *Child Well-being Assessment in Child Welfare: A Review of Four Measures,* the authors share the following advantages and disadvantages in relationship to four of the most frequently used tools, noted in the table below. This information can be used by agencies to consider whether one instrument may hold more promise for the current population of children in care, as well as whether one instrument may be easier to use by the staff and function better within existing agency-level scaffolding to support administration and use of the findings to drive the selection of evidence-based services and supports.

ADVANTAGES AND DISADVANTAGES: A REVIEW OF FOUR MEASURES[8]

CAFAS	
ADVANTAGES	DISDVANTAGES
Good reliability, sensitivity to change, strong predictive usefulness	No published information on sampling procedures or sample characteristics for normative data; unclear whether age-specific norms are available
Provides: information on impairment levels across domains; precise identification of clinical needs	Few empirical studies of child and adolescent versions
Web-based database for instantaneous reporting	
Provides comprehensive training for new raters and ongoing follow-up training to maintain fidelity	

CANS	
ADVANTAGES	DISDVANTAGES
Can help child welfare agencies make appropriate placement decisions that lead to improved outcomes for children and youths.	Likely requires ongoing coaching and TA to ensure the measure is completed with fidelity
Standardized and widely used in child welfare and mental health	Not designed to detect quick or immediate change in children
Web-based database can be used for instantaneous reporting	
Rigorous training and user support materials for initial and annual re-certification (online or in-person)	
Affordable training costs ($10/person); tool is free	
Reliable and valid for the child welfare population	

CBCL	
ADVANTAGES	DISDVANTAGES
Standardized, widely used assessment tool included in 9,000 published articles internationally	Requires implementation supports for caseworker follow-up interviews
Well-validated psychometric properties verified in cultures worldwide	Must consider respondent discrepancies and aggregation of measure findings with other sources of information
Multiple versions allow for assessment of individuals aged 1½ to 90+	3-point scale may limit change at item level; shows sensitivity to change at the domain level
Normative comparisons available by cultural group, age, and sex	
Easy to use, with little caseworker time required	
PC- and Web-based data management for secure scoring and graphing of results	

TOPS	
ADVANTAGES	DISDVANTAGES
Data used to create risk-adjusted algorithms that match clients to practitioners with strongest outcomes for their profile	Requires implementation supports for caseworker follow-up interviews, consideration of respondent discrepancies, and aggregation of measure findings with other sources of information
Easy to use, with little caseworker time required	Relatively high cost
Large-scale, real-time data analysis with strong web-based data management system	No published information on sampling procedures or sample characteristics for normative data; unclear whether age-specific norms are available
6-point frequency-based scale has high sensitivity to change	Few empirical studies of child and adolescent versions

Appendix

JURISDICTIONAL TOOLS AND ADMINISTRATION PROCEDURES

JURISDICTION	ASSESSMENT TOOL	ADMINISTRATION PROCEDURE
Iowa	Treatment Outcomes Package (TOP)	The Consumer Registration (CR) form captures basic demographic information for the child and is completed only once, prior to placement or at least within the first 20 business days of placement. The Case Mix Form (CM) captures information regarding the child's trauma history, medical needs, and prescribed psychotropic medications, and should be completed prior to placement whenever possible, or at least within 20 business days of placement. The CM must be updated by the assigned worker every 90 days, or more frequently as needed, before other raters can be invited to complete additional Clinical Scales Forms (CS). The CS form captures recent information and observations regarding the child's behavior, and completion should be prior to placement whenever possible, and at least within 20 business days of placement. The assigned worker is to coordinate the completion of the CS by pertinent others every 90 days, or more frequently as needed and prior to scheduled FTDMs/YTDMs and emergency meetings.
Illinois	Child and Adolescent Needs and Strengths (CANS)	All interviews/screens, as well as the Comprehensive Health Evaluation (CHE) that addresses physical and medical issues, need to be completed by day 21. By Day 40 the Integrated Assessment team discusses assessment results with the family at meeting. CANS should be re-administered at various time intervals.
Indiana	Child and Adolescent Needs and Strengths (CANS)	Must complete initial Short CAN assessment within 5 days of removal; the Comprehensive CANS assessment must be completed within 30 days of completion of the Short CANS or prior to development of the Case Plan. DCS will continue to update the Comprehensive CANS every 180 days and at critical case junctures during the life of the case.
Massachusetts	Child and Adolescent Needs and Strengths (CANS)	Must be updated at least every 90 days.
Maine	Child and Adolescent Functional Assessment Scale (CAFAS)	Should be conducted within the first 90 days of entering care.

JURISDICTIONAL TOOLS AND ADMINISTRATION PROCEDURES

JURISDICTION	ASSESSMENT TOOL	ADMINISTRATION PROCEDURE
Michigan	Child and Adolescent Functional Assessment Scale (CAFAS)	State mandates administration of the CAFAS at intake and exit.
Minnesota	Child and Adolescent Service Intensity Instrument (CASII) and ECSII	Must be administered within 5 working days of admission and then updated every 3 months and at discharge.
Minnesota	Strengths and Difficulties	Must be administered within 5 working days of admission and then updated every 3 months and at discharge.
Missouri	Daily Living Functional Assessment	Regular annual or biannual re-testing of inter-rater reliability to ascertain fidelity to administering the functional tool.
New York	CANS-NY	The CANS-NY must be completed within the first 30 days of entry, every 6 months thereafter, and at transition or whenever there is a significant change.
Oregon	Child and Adolescent Needs and Strengths (CANS)	Caseworker must refer every child entering care for a CANS screening, between the 14th and 20th day of the child's entry into care.
Pennsylvania	Ages and Stages	Must be screened within 30 days of case acceptance and then periodically for those who test normally.
Tennessee	Child and Adolescent Needs and Strengths (CANS)	Must be administered to child welfare and juvenile justice children ages 5 and older and within 5 business days of entering care. For children receiving Level 1-3 services, must be reassessed within 6 months. For Level 4 youth, must be reassessed within 3 months or at request of psychologist. It also must be administered during placement change and at time of exit.
Virginia	Child and Adolescent Needs and Strengths (CANS)	Every child receiving CSA funds shall receive a comprehensive CANS assessment initially, with reassessments determined based on the needs of the child and family and the intensity of services provided as described below. A comprehensive assessment is required annually and when the child is discharged from CSA. Birth to Four Version of the CANS must be administered for children ages 4 and under receiving CSA-funded services.

JURISDICTIONAL TOOLS AND ADMINISTRATION PROCEDURES

JURISDICTION	ASSESSMENT TOOL	ADMINISTRATION PROCEDURE
Washington	Children's Functional Assessment Rating Scale (CFARS)	Children entering Behavior Rehabilitation Services must be assessed within 14 days of entry and within 30 days prior to exiting BRS if youth is served more than 60 days. The Contractor is not required to complete a CFARS on youth being served under the Medically Fragile or Developmentally Disabled service levels.
Wisconsin	WI Comprehensive CANS	Must be completed within 30 days of placement into a foster home and will be updated every 6 months.

1 Conradi, L., Landsverk, J., & Wotring, J.R. (2014). *Screening, Assessing, Monitoring Outcomes and Using Evidence-Based Interventions to Improve the Well-Being of Children in Child Welfare.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/wp2_screening_assesing_monitoring.pdf

2 Children & Family Services Reviews: Information Portal. (2017). *E-Training Platform: Trauma-based Screenings & Assessments.* Retrieved from https://training.cfsrportal.org/section-4-trauma-child-welfare-system/2440

3 California Evidence-based Clearinghouse for Child Welfare. (2017). *Measurement Tools for Child Welfare.* Retrieved from http://www.cebc4cw.org/assessment-tools/

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4 Continuum of Care Reform Branch. (2016). *Newsflash #5.* Retrieved from: http://www.cdss.ca.gov/cdssweb/entres/pdf/CCR/CCRNewsflashEdition5.pdf

5 See protocol, Q&A, training, scales and domains at https://dhs.iowa.gov/child-welfare-systems/top

6 Nebraska DHHS, Foster Care Rate Committee. (2015). Nebraska Caregiver Responsibility Tool. Retrieved from http://childrens.nebraska.gov/PDFs/MeetingDocuments/2015/FCRRC/07.07.2015/FCRRC%20Handouts%2007.07.2015.pdf

7 Conradi, Landsverk & Wotring, 2014.

8 Rosanbalm, K.D., Snyder, E.H., Lawrence, C.N., Coleman, K., Frey, J.J., van den Ende, J.B., & Dodge, K.A. (2016). Child wellbeing assessment in child welfare: A review of four measures. *Children & Youth Services Review,* 68, 1-16.

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