

**Assessing Child and Youth Well-Being:
Implications for Child Welfare Practice**

Christine Lou, M.S.W., BASSC Doctoral Research Assistant
Elizabeth K. Anthony, Ph.D., BASSC Research Director
Susan Stone, Ph.D., Research Consultant
Catherine M. Vu, M.P.A., Doctoral Research Assistant
Michael J. Austin, Ph.D., BASSC Staff Director

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The Center for Social Services Research (CSSR) in the School of Social Welfare at the University of California at Berkeley conducts research, policy analysis, program planning, and evaluation toward the improvement of the publicly supported social services. The focus of the Center is on populations who are considered needy or disadvantaged, including victims of child abuse and neglect, the chronically mentally ill, the aged, the medically indigent, and the poor.

Housed at CSSR, the Research Response Team of the Bay Area Social Services Consortium (BASSC) was organized in 1995 to respond rapidly to the emerging needs of county social service agencies for information for their changing environments. Structured reviews of the research literature are undertaken in close collaboration with agency administrators and program staff.

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Introduction

Current guidelines for family assessment from the Children's Bureau of the U. S. Department of Health and Human Services (HHS, 2006) recommend the use of a comprehensive assessment of individual children and youth to guide service planning and delivery. A key component of the assessment process is the concept of child well-being and its systematic measurement. Although the Children's Bureau has consistently included child well-being as one of its three primary goals for child welfare services, the goals of safety and of permanency have traditionally been the principal indicators of program success and, accordingly, represent the most concretely defined and measurable outcomes in child welfare policy and practice (Altshuler & Gleeson, 1999). However, with the passage of the Adoption and Safe Families Act of 1997 (ASFA), well-being has moved to the forefront of child welfare reform, policy development, and program evaluation (Wulczyn, Barth, Yuan, Harden, & Landsberk, 2005). The ASFA explicitly and legislatively mandates that the outcome of child well-being be actively pursued and regularly assessed. These two directives of assessment and outcome indicate the need for identifying and for developing standard assessment tools for use with children and youth by child welfare workers in order to develop and monitor service plans that are rooted in the concept of child well-being.

Child and youth assessments are related to both risk and family assessment, namely constructs of risk for deleterious child/youth outcomes and family functioning for identifying problematic behaviors and ecological difficulties. Two previous structured reviews, *Risk and Safety Assessment in Child Welfare: Instrument Comparisons* and *Family Assessment in Child Welfare Services: Instrument Comparisons*, address the array of valid and reliable instruments. However, the purpose of this review is to utilize the strengths-based and well-being perspectives to identify valid and reliable assessment tools for use in child welfare practice.

The introduction to this structured review of the literature is divided into three sections. The first section provides an overview of the need for assessing child and youth well-being in child welfare, the existing and potential uses of such assessments, and the challenges related to utilization. The second section highlights the concept of well-being and how it was used to develop the criteria for inclusion/exclusion of reviewed measures

and assess existing guidelines for the evaluation of measures. The third section is a brief description of the framework and methodology of the review. The remainder of the report includes major findings and implications for practice.

Need for Child and Youth Well-Being Assessment in Child Welfare

The impetus for assessing child and youth well-being in child welfare is the convergence of conceptual changes, policy directives, and practical concerns that have surfaced in recent years. In response to the shortcomings of the deficit- and pathology-based model that has guided social work policy and practice in the past, the field has undergone a paradigm shift towards incorporating strengths-based practice and policy in order to “discover and embellish, explore and exploit client’s strengths and resources in the service of assisting them to achieve their goals” (Saleebey, 2006, p. 1). Influenced by these broad changes, the field of child welfare has increasingly adopted the terms “positive youth development,” “youth assets,” and “resilience and protective factors” as a part of the lexicon for daily practice (Damon, 2004; Park, 2004). Beyond rhetoric, the child development and child welfare fields have realized that the process of incorporating strengths, assets, and abilities in the assessments of children and youth provides a more complete and accurate picture than those that focus on risks alone and can help identify pathways for successful development (Gilgun, Klein, & Pranis, 2000).

However, as these terms and goals have gained currency in the child welfare field, so have the demands for evaluation of service efficacy and goal attainment. The ASFA indicates that “The child welfare system must focus on results and accountability. The law makes it clear that it is no longer enough to ensure that procedural safeguards are met. It is critical that child welfare services lead to *positive* [italics added] results” (HHS, 1998). Moreover, the federal guidelines for comprehensive family assessment issued by the Children’s Bureau make explicit the need to identify individual and family strengths and protective factors that are “relevant and dynamically involved in offsetting the risks related to abuse/neglect” (HHS, 2006). Thus, the child welfare system and its workers are not only charged with the responsibility of ensuring basic safety levels for children and youth, but also must conduct ongoing standardized assessments of children and youth from a strengths-perspective and provide evidence that children and youth demonstrate positive outcomes and well-being as a result of service delivery.

Finally, several research studies have indicated that children and youth that come to the attention or care of the child welfare system demonstrate significantly lower levels of well-being than any other subpopulation of children and youth in the United States (Leslie, Gordon, Ganger, & Gist, 2002; Zimmer & Panko, 2006). Many of these disparities in well-being have been documented by the National Survey of Child and Adolescent Well-Being (NSCAW), a study sponsored by the U.S. Department of Health and Human Services (1997-2007) that examines the characteristics of children and families who come in contact with the child welfare system. Their findings include the following: 53% of all children aged 3 to 24 months whose families were investigated for maltreatment are classified as high risk for developmental delay or neurological impairment, 38% of all children in the study are classified as having “fewer” social skills than the general population, 30% of all children in the study have low or moderately low scores for daily living skills, substantially lower than the general population and, all children in the study were at least five times more likely than the normative sample to have problem behaviors and poor psychosocial functioning (HHS, 2001). While these findings still focus on deficits, they highlight the critical need for comprehensive assessments of children and youth in the child welfare system that also feature strengths and well-being (Leslie et al., 2003). Moreover, the identification of protective factors and the promotion of positive child and youth development can be used to offset deleterious outcomes for such high-risk populations.

Based on these deficit and strengths perspectives, the uses of a comprehensive assessment of child and youth well-being in child welfare can include the following:

1. To ensure normal development and functioning based on observable characteristics, self- and caregiver-reports, and other sources of information (including school records and other care agencies);
2. To identify child/youth strengths in order to inform service/treatment planning, to reduce identified risks, to monitor the course of service, and to provide outcome scores;
3. To obtain a quick “snapshot” of the child or youth’s general status in order to make referral to specialty care; and

4. To inform policy and program development and evaluation at a county- or state-wide level based on population surveys.

Challenges to Child and Youth Well-Being Assessments in Child Welfare

The concepts, operationalization, and measurement of “well-being” present numerous challenges. One of the major challenges relates to assessment instruments that emphasize deficits, often developed by researchers in medicine, psychiatry, education, and clinical psychology. The tools are often designed to identify physical illness, psychiatric diagnosis or maladaptive child/youth behaviors, educational and intellectual abilities, or personality characteristics. Further, there is no consensus on the definitions, domains, indicators, and measures of child well-being amongst or within these professions (Altshuler & Gleeson, 1999; Wulczyn et al., 2005). To further complicate matters, assessment procedures have historically ignored the context in which the child resides; research now supports the notion that the well-being of a child is not simply the product of the child’s internal characteristics but rather the interaction between the child and the environment. As a result, child assessment needs to be multidimensional, including a multisystems perspective that addresses family and community influences (Ungar, 2004).

In addition to instrumentation issues, child welfare workers face additional challenges in the form of federal guidelines and outcome criteria for “well-being” with no accompanying valid and reliable performance indicators. There are no specific measures in the Child and Family Services Review process that monitors state child welfare programs (Wulczyn et al., 2005). Consequently, not only is the concept of well-being not clearly defined by the literature, but also the outcome of well-being is not clearly defined in mandated performance indicators.

In addition to this lack of clarity, child welfare workers are expected to assess the multiple dimensions of each child within the constraints of limited time and resources. For example, the categories for comprehensive child assessment recommended by the federal guidelines include the following: 1) physical and motor skills, 2) intellectual ability and cognitive functioning, 3) academic achievement, 4) emotional and social functioning, 5) vulnerability/ability to communicate or protect themselves, 6) developmental needs, and 7) readiness of youth to move toward independence. In

addition to these aspects, the categories of youth assessment include: 1) readiness to live interdependently, 2) ability to care for one's own physical and mental health needs, 3) self-advocacy skills, 4) future plans for academic achievement, 5) life skills achievement, 6) employment/career development, and 7) quality of personal and community connections. Given this wide range of categories it is unclear which aspects of assessment would be most helpful to a child welfare worker, especially since the majority of well-validated and psychometrically sound instruments do not focus on well-being.

Conceptual Framework

While there are multiple approaches to understanding child well-being, this structured review of the literature draws primarily upon the fields of child development, child psychology, and child health and is organized by developmental stages related to certain aptitudes and tasks. Given our emphasis on strengths, competencies, and positive adaptation, the risk and resilience literature informs our conceptualization of well-being. In contrast to the "fixed" indicators of healthy or abnormal development found in the developmental stages literature, a risk and resilience perspective presents a dynamic, bio-ecological, and transactional conceptualization of child development (Luthar et al., 2000).

Risk, protection, and resilience are the central concepts in a risk and resilience model. Risk factors are "influences that increase the chances for harm, or more specifically, influences that increase the probability of onset, digression to a more serious state, or maintenance of a problem condition" (Fraser, Kirby, & Smokowski, 2004, p. 14). Protective factors act to modify risk, either by directly reducing a disorder or dysfunction or by moderating the relationship among risk factors and problems or disorders, often called "buffering" effects (Fraser, Richman, & Galinsky, 1999). Promotive factors, on the other hand, exert positive effects regardless of risk exposure (Jenson & Fraser, 2006). Finally, resilience can be understood as the successful impact of protective factors on ameliorating or reducing risk factor outcomes and is usually defined as "the ability to function competently despite living or having lived in adversity" (Schofield & Beek, 2005, p.1283) or the "successful adaptational response to high risk" (Fraser et al., 1999). The notion of risk and resilience throughout the following stages of development is used to organize the findings:

1. Infancy (approximately 0-3): Developmental changes occur the most rapidly in this stage, such as language development, solidification of an attachment relationship, growth, and ambulation. Developmental delays, motor deficits, and poor neuro-development are some of the potential impairments that characterize this stage as a period of extreme vulnerability.
2. Early Childhood (approximately 4-5): This stage is characterized by significant progress in language, cognitive, social, and emotional development. “Early childhood can be conceptualized as a time of increased competence, but continued vulnerability. Preschool children in the child welfare system can use language and play to reveal their maltreatment experience, but are sufficiently young that their ability to self-protect is limited” (Wulczyn et al., 2005, p.34).
3. Middle Childhood (approximately 6-12): This stage is characterized by increased competence to take on additional roles and responsibilities and the development of broader social networks. This stage is also marked by increased behavioral self-regulation and identity development. Although increased competence might reduce vulnerability to maltreatment, this stage has been identified as a period when mental health issues emerge.
4. Adolescence (approximately 13-18): This stage is often characterized by complex changes across multiple developmental domains, including identity creation, primacy of peer group relations, and movement towards independence. Academic, mental health, and social functioning are often the indicators of wellness for this age group.

While well-being is not limited to concepts of risk and resilience, the definition of well-being used in this literature review relies heavily on the presence of, or potential for the development of, strengths and resilience. These include internal aspects (e.g., subjective life satisfaction and positive self-concept), external aspects (e.g., social connections), and biomedical and developmental aspects (e.g., physical health and intellectual ability). “Indicators” of health, stages of development, and the

multidimensionality of well-being inform this ecological and holistic approach. Consequently, findings are presented by developmental stage; within each stage, findings are discussed within the domains of well-being that are most pertinent to that developmental stage. This approach is particularly suited to child welfare practice because it provides a theoretical foundation for intervention and service planning, including the processes of “increasing felt security, building self-esteem, promoting competence, and working towards a range of often modest developmental goals that nevertheless reduce risk and increase resilience” (Schofield & Beek, 2005, p. 1284). Furthermore, the equal importance assigned to strengths and risks restores balance to the past deficit-based models used to assess children and youth.

Literature Review Search Criteria and Strategy

This review used pre-determined search terms and search sources to identify research literature within a given topic and to minimize the potential for selection bias. Using specified search terms delineated by search category (e.g., domain of interest, characteristics of interest, etc.) in multiple combinations, we searched numerous social science and academic databases through the University of California library. In addition, we conducted overall internet searches and also searched the websites of research institutes and organizations specializing in systematic reviews, conference proceedings databases, dissertation databases, and internet databases (see Appendix A for description of search strategy). The references in literature reviews and research studies were searched to identify additional sources. Only English language citations were pursued.

To illustrate the magnitude of the child assessment literature, an initial search with the key words “child or youth” and “assessment” in one database yielded 2,109 results. While it is beyond the scope of this review to provide a comprehensive evaluation of all child assessment tools, this review provides an in-depth examination of those instruments that are most pertinent to child welfare and most consistent with the federal mandates. The criteria for inclusion and the recommendation of promising instruments include: (1) instruments that provide comprehensive assessments of child and youth well-being; (2) instruments that assess for child and youth strengths and competence; (3) instruments that have been normed with a child welfare population or appear to be appropriate for child welfare use; and (4) instruments that have

demonstrated sound psychometric properties. Thus, the criteria for exclusion of instruments include: (1) instruments that assess psychiatric dysfunction and assign DSM diagnoses; and (2) instruments that focus on risk or deviance such as instruments that predict juvenile criminality. Two-hundred sixty-nine instruments were reviewed; given that most of these instruments are specialized for administration in professional settings other than child welfare, those presented below were determined to be of most use to a child welfare worker. Some of the instruments that have been excluded from this review but are used in related fields and may be encountered by child welfare workers are summarized in Appendix B.

Major Findings

Infancy and Early Childhood (Ages 0-5)

For infants and young children, the assessment of well-being reflects the normal developmental process in the four general domains summarized in Figure 1: (1) language development and communication; (2) intellectual ability and cognitive functioning; (3) physical development and motor skills; and (4) socio-emotional functioning (Capute & Accardo, 1996). Global measures of well-being focus on the continuum of functioning in each of these areas. Until children are old enough to verbally communicate, assessment occurs in the form of behavioral observation and reports from parents, care providers, or teachers. In general, child welfare workers are interested in identifying potential problems in order to refer the child to early intervention services.

The measurement of infant well-being is often the collaborative work of an interdisciplinary team of professionals and the family, particularly for infants born with a disability or at-risk. In infants and young children, the focus is on nutrition, immunization, and physical care along with signs of potential physical or sexual abuse and neglect. Normal developmental milestones are the markers by which delayed or insufficient development are judged and may lead to additional assessments or referrals as the need arises.

While specialized tests can be helpful in assessing infant functioning in different domains of living, a comprehensive evaluation of an infant's well-being should include broader measures of attachment and the infant's social ability (Davies, 2004). Further,

Figure 1. Domains of Infancy and Early Childhood Assessment

Domain	Sample Components	Measurement Types
Language	Language precursors; vocabulary; concepts; syntax; integrative language skills; phonological awareness; receptive; expressive; speech	-Intelligence tests -Standardized tests of early language -Developmental assessment
Cognition	Fluid reasoning; knowledge; quantitative reasoning; visual-spatial processing; working memory; non-verbal problem solving	-Intelligence tests -General measures of cognition -Developmental assessment
Physical	Normative standards for growth and development; gross motor; fine motor	-Developmental screening & assessment -Specialized instruments -Physical examination
Socio-Emotional	Internalizing and externalizing problem behaviors; regulatory problems; self-help; social competencies	-Behavior screening -Developmental assessment

assessment should be ongoing and include information about a child’s environment. As one component of assessment, instruments can be used to measure both strengths and limitations in the development of an infant in order to identify potential areas for intervention.

Instruments that are commonly used to assess infant/ young child functioning and well-being may be specific to infants or toddlers or cross the lifespan into middle childhood or adolescence as summarized in Appendix C. In addition, some instruments focus on one domain of well-being while others cross multiple domains. For example, the Griffiths Scales (Griffiths, 1984) are standardized scales of motor development whereas the Bayley Scales of Infant Development (Bayley, 1993) cross several domains by measuring cognitive, motor, and behavioral development.

The focus of this review is on comprehensive assessment of well-being, therefore the instruments described in detail below are those that best assess multidimensional functioning and developmental competence rather than a single dimension. Of the 87 infant/young child instruments reviewed, the following four met the inclusion criteria: Child Observation Record (High/Scope, 1992), Battelle Developmental Inventory (Newborg et al., 1988), Ages and Stages Questionnaire (Bricker, Squires, & Mounts, 1995), and the Child Development Inventory (Ireton & Glascoe, 1995). These instruments appear in bold type in Appendix C and are described below.

Child Observation Record (COR). The Child Observation Record (COR) was designed as a developmentally appropriate and culturally sensitive assessment tool of early childhood competencies. Focusing on strengths with the goal of obtaining an accurate picture of the infant or child's developing abilities, the COR assesses the whole child. The COR for Infants and Toddlers is designed for children ages 6 weeks to 3 years and the Preschool Child COR, Second Edition is for children ages 2 ½ to 6 years and was developed for use in early childhood programs such as Head Start.

The Infant-Toddler COR assesses development in six domains: sense of self, social relations, creative representation, movement, communication and language, and exploration and early logic. Specific items are assessed within each domain. For example, the sense of self category consists of the following items: *expressing initiative, distinguishing self from others, solving problems, and developing self-help skills*. The preschool version also measures developmental progress in six domains: initiative, social relations, creative representation, music and movement, language and literacy, and mathematics and science. A teacher or care provider who knows the child well can complete the 30-item COR with its 5-point developmental competence scale from lowest (1) to highest (5) level of competency. In studies with urban Head Start children, the COR produced generally reliable and valid results (Fantuzzo, Hightower, Grim, & Montes, 2002; High/ Scope, 2002; Sekino & Fantuzzo, 2005). Advantages of the COR include: 1) completion of the observations by the teacher or parent/care provider for at least one month rather than a point-in-time assessment, 2) observation in the natural context of a classroom or home environment rather than a doctor's office, and 3) ease of administration.

Battelle Developmental Inventory (BDI). Similar to the COR, The Battelle Developmental Inventory (BDI) is a multifaceted measure that seeks to assess developmental progress in several domains. Now in its second edition, the BDI-2 is appropriate for children from birth to eight years and incorporates the following domains: cognition, communication skills, psychomotor ability, personal-social skills, and adaptive behavior. The BDI-2 is offered in a full assessment that takes 1-2 hours to complete and a screening assessment that takes 10-30 minutes to complete and is available in Spanish and English. Domains can be tested separately if the examiner has an interest in one

particular area or together when a global assessment is desired. Unlike the COR, the BDI-2 utilizes multiple administration formats including interviews with parents or other sources, direct observation, and structured tasks. The psychometric properties of the BDI have been tested and results generally support the reliability and validity (content, construct, concurrent) of the BDI (Merrell & Mauk, 1993; Newborg et al., 1988; Snyder, Lawson, Thompson, Stricklin, & Sexton, 1993). The BDI has generally better predictive validity for older children (Berls & McEwen, 1999).

Strengths of the BDI include the comprehensive nature of assessment captured via multiple domains and multiple testing formats, making it desirable for assessment of the developmental trajectory. Additionally, the BDI includes adaptations and guidelines for testing with children with various disabilities. Particularly for early intervention programs, the BDI appears to have the sensitivity to detect individual differences and assess degree of developmental delay. The fact that the full BDI takes approximately 1 ½ hours to administer and has a complicated scoring process, however, are drawbacks for general use as well as repeated measures administration (Berls & McEwen, 1999).

Ages and Stages Questionnaires (ASQ). The Ages and Stages Questionnaires (ASQ) are completed by a parent or primary caregiver and assess the developmental progress of infants and young children from 4 to 48 months. The ASQ takes approximately 10-15 minutes to complete and parents select the appropriate questionnaire by the age of the child. Each questionnaire consists of 30 items that address five domains: personal-social, gross motor, fine motor, problem solving, and communication. The parent responds to a series of questions in each domain about the child's behavior by responding "yes" (10 points), "sometimes" (5 points) and "not yet" (0 points), with a maximum possible score of 60 points in each domain. Sample questions include "Do you think your child hears well?" and "Does your baby use both hands equally well?" Cut-off scores (two standard deviations below the mean domain score) have been established for referral purposes. The ASQ has been tested with a normative sample as well as samples of children with medical risks and children with environmental risks (e.g., extreme poverty, low maternal education, and parental involvement with Child Protective Services) (Squires, Bricker, & Potter, 1997).

The ASQ has been revised and the psychometric properties have been studied extensively with evidence supporting the general reliability and validity of the instrument (Bricker & Squires, 1989a, 1989b; Squires et al., 1997). Additional information regarding the construct and predictive validity would provide further support of the ASQ (Naar-King, Ellis, & Frey, 2004). An advantage of the ASQ includes the dynamic nature of the questionnaires, allowing an infant and child's developmental status to be tracked over time. The ASQ is also cost-effective, easy to administer, and makes use of reports by individuals who spend the most time with the child. Because the ASQ does not require highly trained specialists to administer, the likelihood of repeated measures to monitor a child's progress increases. In addition to the ASQ, the Ages and Stages Questionnaire: Social-Emotional (ASQ: SE; Squires et al, 2001) was developed to assess the social and emotional development needs of infants and young children.

Child Development Inventory (CDI). The Child Development Inventory (CDI), originally known as the Minnesota Child Development Inventory (MCDI; Ireton & Thwing, 1972-1974), was designed as a developmental screening instrument for use with children ages 15 months to 6 years. The standardized inventory consists of 300 items that capture development in the following domains: social, self help, gross motor, fine motor, expressive language, language comprehension, letters, and numbers. The CDI also includes a general development scale comprised of age-discriminating items from each of the other scales. The parent responds to the series of items about the child's development with "yes" or "no."

The CDI is easily administered and time efficient, taking approximately 30-50 minutes to complete. The CDI appears to have promising psychometric properties although the extensive results from studies evaluating the MCDI cannot be assumed for the CDI given the reduction in items and modifications to scale structure (Naar-King et al., 2004). Further study of the construct and predictive validity of the CDI is warranted. The usefulness of the MCDI (and presumably the CDI) for children under the age of 2 is unclear and has not been recommended due to concerns about under-referral (Byrne et al., 1986; Kopparthi et al., 1991). Lastly, the standardization sample was not representative and relatively small, which Byrne and colleagues (1986) suggest may have

impacted the norms and consequently the over-identification of developmental delay in their study. The test developers encourage use of norms for specific populations.

Middle Childhood (Ages 6-12)

As children grow and develop, the assessment of well-being takes on a different meaning from that of infants and young children. As children become more verbal and autonomous, the focus of assessment shifts from heavy reliance on the observations and assessments of parents and care providers to a combination of child and adult data collection. Observation remains an important component however, as children's verbal and communication abilities vary. Less emphasis is placed on basic developmental and cognitive abilities and more emphasis is placed on the child's interaction with the social world. Consequently, the conceptualization of well-being in middle childhood involves the assessment of socio-emotional functioning and general social competence, academic achievement, peer relationships and social skills, a developing sense of identity, and the nature of social support.

Figure 2 summarizes the focus of assessment in middle childhood. The instruments that assess language ability in middle childhood continue to measure developmental progress from early childhood. By middle childhood, the comprehension of basic syntax and grammar structures is developed and children are learning to make connections between cognitive processes and communication (Davies, 2004). Language ability is directly related to a child's ability to navigate the social world, a significant developmental task in middle childhood. Similar to language ability, intellectual functioning and cognition is measured as a continuation of the progress made in early childhood. Many of the traditional tests of cognitive ability, such as the Stanford-Binet (Roid, 2003), are used in middle childhood. Unique to middle and later childhood, however, are measures of academic functioning and aptitudes that assess academic progress. The Children's Skills Test (SmarterKids, 1998), for example, measures achievement in math, language arts, science, and social studies. Such instruments are useful in obtaining information about whether a child has achieved the basic academic skills for a particular grade level.

Physical development remains an important factor in middle childhood, as young people develop and grow in relationship to progress based on normative health care

Figure 2. Domains of Middle Childhood Assessment

Domain	Sample Components	Measurement Types
Language & Communication	Basic syntax; grammatical structures; receptive; expressive; speech	-Intelligence tests -Standardized tests of early language -Assessment of delays
Cognitive Ability & Academics	Fluid reasoning; knowledge; quantitative reasoning; visual-spatial processing; working memory; academic achievement and skills	-Intelligence tests -General measures of cognition -Standardized academic tests
Physical Health & Development	Normative standards for growth and development; risk-taking behaviors related to health	-Physical examination -Self-report surveys of behaviors
Socio-Emotional	Social competence; internalizing and externalizing problem behaviors; self-concept; identity development; self-regulation; coping; peer relationships; social skills; self-esteem	-Behavior checklists/ screening tools -Self-report surveys

standards. As young children near puberty and adolescence, assessment of physical well-being begins to include risk-taking behaviors that contribute to poor health, such as cigarette smoking and unsafe sexual activity.

The majority of instruments in middle childhood feature aspects of socio-emotional competence. In general, basic social and emotional competence is considered crucial for a child's ability to relate to others and develop a strong and healthy sense of identity. Therefore, psychological constructs such as self-esteem and self-concept are presumed to be indicators of child well-being. Certain constructs, such as self-regulation, are associated with behavior patterns that can become problematic. For example, poor impulse control and sensation-seeking are risk factors for adolescent substance abuse (Jenson, Anthony, & Howard, 2006).

Assessments of socio-emotional competence have traditionally been used for psychological research rather than for assessment or treatment. However, multidimensional assessments of socio-emotional competence are used in clinical, school, and community-based settings. For example, the Social Adjustment Inventory for Children and Adolescents (SAICA; John, Gammon, Prusoff, & Warner, 1987) assesses adaptive functioning in the outcome areas of activities, peer relations, family relations, and academic performance. Also, the Elementary School Success Profile (ESSP; Bowen, 2006) is a notable example of a multidimensional instrument that uses an ecological

perspective of neighborhood, school, friends, and family and assesses factors related to health and well-being.

Given the large number of single domain and risk-focused behavioral instruments in middle childhood, no instrument fully met the inclusion criteria of comprehensive *and* strengths based assessment of well-being. Of the 99 middle childhood instruments reviewed, three met most of the criteria and are described below. These instruments appear in bold type in Appendix D.

Behavioral and Emotional Rating Scale- Second Edition (BERS-2). The Behavior and Emotional Rating Scale (BERS; Epstein & Sharma, 1998) and the Behavioral and Emotional Rating Scale- Second Edition (BERS-2; Epstein, 2004) were developed in response to the need for standardized measures for assessing emotional and behavioral strengths in children and youth. Behavioral and emotional rating scales tend to rely on a deficit model of assessment and the BERS is one of the few instruments to incorporate a strengths-based orientation to assessment. The BERS offers parents, care providers, and teachers a more comprehensive picture of the child by describing positive functioning skills. The BERS was designed for use in child welfare agencies, school settings, mental health clinics, and juvenile justice programs and has been tested with school-aged children ranging from 5 to 18 years of age. The BERS consists of 52 items that address the following five domains: interpersonal strength (e.g., reacts to disappointment in a calm manner), family involvement (e.g., participates in family activities), intrapersonal strength (e.g., demonstrates a sense of humor), school functioning (e.g., pays attention in class), and affective strength (e.g., acknowledges painful feelings) (Epstein, Hertzog, & Reid, 2001). The BERS-2 allows for three perspectives to be evaluated via parental observation (Parent Rating Scale), child self-report (Youth Rating Scale), and teacher or other professional observation (Teacher Rating Scale). Responses to statements about how much a characteristic is representative of the child are on a 4-point Likert scale and include 0=not at all like the child, 1= not much like the child, 2=like the child, and 3=very much like the child. The BERS also includes open-ended questions designed to elicit information about the unique strengths of the child.

The BERS has strong psychometric properties that have been confirmed in multiple studies (Epstein, Harniss, Pearson, & Ryser, 1999; Epstein et al., 2001; Epstein, Ryser, & Pearson, 2002). Given the wide age range for the BERS, establishing separate age-based norms is warranted (Dumont & Rauch, 1998). With its focus on strengths related to assessment and intervention, the BERS can be useful in child welfare settings for pre-referral assessment as well as evaluation of the effectiveness of an intervention over time. The BERS takes only 10 minutes to administer and is scored manually.

Clinical Assessment Package for Assessing Clients' Risks and Strengths (CASPARS). The Clinical Assessment Package for Assessing Clients' Risks and Strengths (CASPARS; Gilgun, 1999) is a set of five instruments designed to assess assets and risks in children and families experiencing a range of adjustment issues and problematic behaviors. The CASPARS instruments assess strengths and risks in the following five areas: 1) emotional expressiveness (14 items); 2) family relationships (20 items); 3) family's embeddedness in the community (13 items); 4) peer relationships (16 items); and 5) sexuality (13 items). The instruments are completed by practitioners in a two-step evaluative process: practitioners first decide whether an individual demonstrates an asset or risk on a particular item and then rate the asset and risk as high, medium, or low. Sample items include the following: 1) "Child has a person in the family and/or community who facilitates appropriate expression of feelings" and 2) "Neighborhood has resources for children: playgrounds, recreation programs, libraries."

Psychometric properties of these instruments were evaluated with a sample of 146 children and their families; ninety-two of the children were in foster care or residential treatment or had experienced at least one out-of-home-placement in the past. Internal consistency and inter-rater reliability were found to be strong and content and construct validity were found to be good to adequate. The advantages of these instruments include: consistency with the goal of assessing well-being, brevity, ease of use and scoring, ability to demonstrate progress over time, and useful assessments for treatment planning and evaluation. The CASPARS instruments have only recently been developed, however, and have not been rigorously evaluated. The initial study of the CASPARS' psychometric properties and applicability to child welfare populations is promising but additional studies are needed to confirm these findings (Gilgun, 1999).

Social Skills Rating System. The Social Skills Rating System (SSRS; Gresham & Elliott, 1990) is a self-report, multi-rater instrument that provides a comprehensive picture of the social behaviors of children and youth in grades 3-12. The SSRS has three subscales related to 1) social skills (cooperation, empathy, assertion, self-control, responsibility), 2) problem behaviors (externalizing problems, internalizing problems, hyperactivity), and 3) academic competence (reading and mathematics performance, general cognitive functioning, motivation, and parental support). The SSRS is completed by a teacher, parent, and student for use in assessing problematic social behaviors and is suitable for service planning and intervention.

The SSRS was standardized on a national sample of over 4,000 children and provides separate norms for boys and girls as well as for students with disabilities. The advantages of the SSRS include the use of multiple raters who know the child, ease of administration and scoring, and strong psychometric properties. In a study of urban Head Start children, the preschool version of the SSRS demonstrated reliability and construct validity (Fantuzzo, Manz, McDermott, 1998).

Adolescence (Ages 13-18)

As individuals progress from middle childhood to adolescence, the assessment of their well-being becomes increasingly complex. The appraisals of adolescent developmental competencies and the global health indicators rely less on observable and objective characteristics and more on subjective appraisals of internal life (i.e., thoughts, emotions, and perceptions), social adaptation, and role acquisition. While identity formation and awareness of the social world typically emerge during the period of middle childhood, these developments gain primacy as adolescents become more sophisticated in their psychological, emotional, and social development. Additionally, academic achievement and preparation for adult roles and responsibilities represent major markers of adolescent well-being. Consequently, the majority of adolescent assessment instruments address one or more domains related to personal, social, and general achievement competencies.

Given the nature of instruments available, as well as the developmental considerations for adolescent populations, the domains summarized in Figure 3 represent

Figure 3. Domains of Adolescent Assessment

Domain	Sample Components	Measurement Types
Personal Competence/Emotional	Identity; sense of self; self-esteem; self-concept; self-image; self-efficacy; positive outlook	-Self-report surveys -Standardized tests
Social	Social networks; social interaction; peer relationships; social competence; social support; coping; social skills	-Self-report surveys -Standardized tests
Environmental Context	Prevalence of violence; community disorganization; opportunities for self-fulfillment and participatory activities	-Self-report surveys -Neighborhood or community level data
Cognitive/Intellectual	Academic achievement; reasoning and problem solving skills; decision-making	-Academic reports -Standardized tests -Self-report surveys

the four general areas of adolescent well-being assessment: (1) personal competence/emotional well-being; (2) social well-being; (3) environmental context and participation; and (4) cognitive/intellectual well-being (Zill & Coiro, 1992). Examining well-being in these domains represents one part of comprehensive adolescent assessment and other types of information (school and medical records) are needed to form a complete profile of adolescent well-being. Appendix E summarizes the instruments that are frequently used to assess adolescent well-being.

Although numerous instruments have been developed for the purpose of assessing a single domain of adolescent well-being, very few instruments include multiple domains with demonstrated reliability and validity. Of the 83 adolescent instruments reviewed, fourteen met the criteria however, their appropriateness depends on the purpose of assessment. For example, only three instruments (bold type in Appendix E) identified in this structured review process can be categorized as comprehensive assessment measures for clinical/treatment planning purposes: *Child and Adolescent Social and Adaptive Functioning Scale* (Price, Spence, Sheffield, & Donovan, 2002), *4-D Strengths-Based Assessment Tools for Youth in Care* (Gilgun, 2004), and *Family, Friends, and Self Form* (Simpson & McBride, 1992). These instruments are described below.

Individual Assessment

Child and Adolescent Social and Adaptive Functioning Scale (CASAFS). The Child and Adolescent Social and Adaptive Functioning Scale (CASAFS) is a self-report

inventory that assesses the social and adaptive functioning of youth (i.e., the degree to which an individual fulfills various roles in his/her life). Although the measure was developed for use in the general community, the content was also designed for assessment of social and adaptive functioning in clinical samples. The CASAFS is comprised of 24 items assessing functioning in four key social role areas relevant to adolescents: school performance, peer relationships, family relationships, and home duties/self-care. Responses are on a four-point Likert scale ranging from 1 (never) to 4 (always). The CASAFS has a valid factor structure and demonstrated acceptable levels of internal consistency, test-retest reliability, and construct validity.

The CASAFS is designed to be brief and easy to complete by older children and adolescents, and catered for group or individual administration in both clinical and community settings. It can provide an overall indicator of perceived social functioning and assessment in each of its sub-domains. Initial evaluations have found acceptable psychometric properties of the instrument, however, further psychometric investigations should be conducted to confirm its sensitivity as a screening tool. Additionally, the CASAFS was normed with a primarily homogenous sample within a relatively narrow age band; thus, the utility of the measure for diverse populations and a broader age range has not been determined.

4-D Strengths-Based Assessment Tools for Youth in Care. The 4-D Strengths-Based Assessment Tools for Youth in Care (4-D) is a strengths-based and ecological battery of instruments that direct the practitioner's attention to positive aspects of youth development in family, peer group, school, and community contexts. The 4-D instruments assess these aspects in the following domains: (1) Belonging – 11 items; (2) Knowing (Mastery) – 19 items; (3) Becoming (Independence); and (4) Giving (Generosity). Developed by the author of the CASPARS, these instruments have a similar structure, scoring process, and clinical application. Specifically, practitioners rate items in the same two step process of evaluating whether the youth demonstrates a strength or risk on a particular attribute and then assigning a rating of the extent of the strength or risk on a Likert scale. This scoring process yields two scores, a strength score and a risk score, from which the practitioner can identify both strength and risk attributes

of the youth, develop interventions based on this information, and estimate treatment progress.

The norming sample for these instruments included 114 youths ages 12 to 19 in social service care from a national therapeutic foster care agency. The sample was 55% Anglo, 25% African American, and 20% Asian American or Native American. The youth typically participated in psychotherapy and other supportive services, had experienced some form of child maltreatment and/or parental chemical dependency, and had been placed in foster care anywhere from one to fifty-two times. The initial study with this sample found high indices of reliability and good indicators of construct validity.

The advantages and limitations of the 4-D instruments mirror that of the CASPARS instruments. While the theoretical orientation, initial psychometric evaluation, applicability to child welfare populations, and practical considerations (i.e., ease of use, scoring, and interpretation) indicate the 4-D battery as promising assessment tools in the child welfare field, these instruments are in a beginning stage and have not yet been subject to the extensive validation studies necessary for their absolute endorsement.

Family, Friends, and Self (FFS) Form. The Family, Friends, and Self (FFS) Form is a 60-item self-report questionnaire designed to measure the social relationships and psychological adjustment of youth. Although this measure was originally developed to monitor drug and alcohol use, school problems, and legal involvement of adolescents, the scales appear to be useful for assessment of youth at risk (Corcoran & Fischer, 2000). The FFS provides a comprehensive assessment of youth involving three domains with ten underlying dimensions: 1) Family settings and relationships (warmth, control, and conflict); 2) Peer activities and involvement (trouble, peer activity, familiarity with parents, and conventional involvement); and 3) Self-esteem and environment (environmental satisfaction, school satisfaction and self-esteem). For example, the youth responds to questions such as “Is there a feeling of togetherness in your family?” and “Do you spend a lot of your free time with friends?” on a 5-point Likert scale ranging from Never (0) to Almost Always (4).

The FFS was normed with 154 clients (mean age=15.4 years) in a statewide substance abuse program; the FFS scales have further been tested with over 1500 youth from diverse ethnic/racial backgrounds. Overall, the FFS has stable psychometric properties; factor analysis has demonstrated a sound factor structure, the subscales have excellent internal consistency, and the FFS appears to have good predictive validity in terms of demonstrating significant correlations between subscales and counselor diagnosis of drug problems. Although the FFS appears to be a brief, easy to score, multidimensional, and psychometrically sound instrument that may be appropriate for use in settings other than drug programs, its reliability with youth in the child welfare system and its ability to predict outcomes other than drug use have yet to be determined.

Resilience and Coping Assessment

Three instruments- *Adolescent Coping Orientation for Problem Experiences* (Patterson & McCubbin, 1987); *Resiliency Scale* (Jew, Green, & Kroger, 1999); and *Resilience Scale* (Wagnild & Young, 1987)- assess general resilience and coping skills that are related to adolescent well-being and are described below.

Adolescent Coping Orientation for Problem Experiences (A-COPE). The Adolescent Coping Orientation for Problem Experiences (A-COPE) is designed to assess the behaviors that adolescents display when managing problems or difficult situations related to themselves or family members. The A-COPE instruments can be used for educating adolescents about their coping style, pre-post assessment of stress management programs, and treatment planning for adolescents struggling to manage the demands of life transitions (Patterson & McCubbin, 1987). The 54-item self-report questionnaire assesses twelve different coping behaviors and patterns: (1) ventilating feelings; (2) seeking diversions; (3) developing self-reliance; (4) developing optimism; (5) developing social support; (6) solving family problems; (7) seeking spiritual support; (8) investing in close friends; (9) seeking professional support; (10) engaging in demanding activity; (11) being humorous; and (12) relaxing. Sample items include “Try to help other people solve their problems” and “Talk to a friend about how you feel.”

The A-COPE has been used with numerous adolescent populations; subscales of the A-COPE have fair to good internal consistency and reliability data from the Young Adult-COPE (a slightly modified version of the A-COPE) show excellent internal

consistency and good stability. Validity of the measure appears to be acceptable and predictive validity for illicit substance use is fair but other outcomes have not been assessed. The applicability of this measure for adolescents in the child welfare system needs to be determined. Nevertheless, the A-COPE appears promising as a multidimensional, relevant, and psychometrically sound instrument for assessing the coping and well-being of adolescents.

Resiliency Scale. The 35-item Resiliency Scale is a self-report questionnaire developed from the cognitive appraisal theory of resiliency conceptualized by Mrazek and Mrazek (Jew et al., 1999). It includes twelve skills and abilities that resilient people use to cope with stress, including information seeking and decisive risk-taking. The Resiliency Scale consists of three subscales: 1) future orientation (19 items), 2) active skill acquisition (10 items), and 3) independence/risk-taking (6 items). Items such as “Look forward to the future” and “Like helping others” are rated by respondents on a 5-point Likert scale ranging from “strongly disagree” to “strong agree.” The scale was developed using three adolescent populations including 9th grade students from lower to middle socioeconomic statuses, 7th to 12th grade students in a rural area, and residents in an adolescent psychiatric treatment facility. High internal consistencies were found for each of the subscales and correlations with other similar measures (such as the A-COPE) demonstrated moderate convergent validity. The measure was also able to effectively discriminate between institutionalized and non-institutionalized adolescents as well as between at-risk and not-at-risk students based on self-reports. This instrument shows promise for identifying adolescents who may be at risk but further research is needed before the Resiliency Scale can be endorsed for screening purposes.

Resilience Scale (RS). The Resilience Scale (RS) is a 25-item self-report questionnaire that measures personality characteristics or coping resources that facilitate individual adaptation. It has been used in several studies examining resilience in various populations, including older adults, graduate students, residents of public housing, and homeless adolescents. Similar to the Resiliency Scale, this scale was developed based on a review of the resilience literature, and measures five components of resilience: equanimity, perseverance, self-reliance, meaningfulness, and existential aloneness (O’Neal, 1999). Items representing the five components belong to one of two factors:

personal competence and acceptance of life and self. Respondents rate items on a 7-point scale, ranging from “disagree” to “agree.”

Internal consistency, test-retest reliabilities, and convergent validity for the instrument were found to be high across several studies. Although this evidence provides support for the scale as an accurate measure of resilience, the utility of the scale for the child welfare practitioner remains unclear. Future studies will have to determine whether this instrument can be administered as tool for identifying resilience in adolescents.

Independent Living Skills Assessment

Several tools have been developed to assess independent living skills (ILS) in youth in out-of-home placement or receiving child welfare services; these include the Daniel Memorial Independent Living Skills System (DMILA; Daniel Memorial, 2006) the Ansell-Casey Life Skills Assessment (ACLSA; Casey Family Programs, 2005), The Life Skills Inventory: Summary Report Form (Ansell & The Independent Living Skills Center South Bronx Human Development Organization, Inc., 1987), and the Independent Living Skills Assessment Tool (Blostein & Eldridge, 1988). The majority of these tools have either not established and/or reported their psychometric properties or have demonstrated poor overall reliability and validity (Nollan et al., 2000). For example, although the DMILA is one of the most widely used instruments in the national foster care system (Hahn, 1994), a recent evaluation of its psychometric properties demonstrates weak reliability and validity (Georgiades, 2005). The results from this initial psychometric evaluation suggest that further evaluation and revision of the factor structure and item content of the DMILA are needed before it can be endorsed as a valid and reliable measure of a youth’s preparedness for transition to adulthood. The ACLSA, however, focuses on independent living skills, demonstrates strong psychometric properties, and is relevant to child welfare services.

Ansell-Casey Life Skills Assessment (ACLSA). The ACLSA is a strengths-based measure of life skills and behaviors generally viewed as necessary for living successfully in the community upon emancipation from out-of-home care (Nollan et al., 2000). Applications of the ACLSA in the child welfare setting include identifying acquired life skills, setting goals for skills not yet learned, and evaluating program effectiveness.

Although the ACLSA was designed for youth in out-of-home care, the ACLSA is appropriate for life skills assessment regardless of the youth's living circumstances.

Four versions of the ACLSA are available: ACLSA-I for ages 8-9 (37 items); ACLSA-II for ages 10-12 (56 items); ACLSA-III for ages 13-15 (81 items), and ACLSA-IV for ages 16 and above (118 items). Additionally, a short form can be administered for youth ages 11-18 (18 items). All versions of the ACLSA assess life skills in the following domains: social development, educational/vocational development, physical development, moral development, and money/housing/transportation. Specific items in the moral development domain, for example, include "Refuses illegal, dangerous, or hurtful activities" and "Respects others' views, lifestyles, and attitudes." The ACLSA is administered both to youth and caregivers; youth respond to items on a 3-point Likert scale, with response options ranging from "not like me" to "very much like me," while caregivers respond to items with response options ranging from "not like the youth" to "very much like the youth."

Advantages of the ACLSA include initial psychometric evidence, ease of access (free for public use) and administration (pencil and paper and a web-based version). As a strengths-based and multidimensional measure of life skills with multiple developmentally appropriate versions, the ACLSA appears to be an especially useful tool for child welfare workers. However, evaluation of the reliability and validity of the most recent versions of the ACLSA should be conducted to ensure that revisions have not affected their psychometric characteristics. Furthermore, additional types of reliability and validity data should be collected; for example, predictive validity would be especially important to assess for this kind of measure.

Population Survey/Program Evaluation

As illustrated by the major findings, global measures of child and adolescent well-being that are appropriate for use by child welfare practitioners are limited. Most of the comprehensive instruments that address multiple well-being domains, especially those that are specific to middle childhood and adolescence, have not been tested on child welfare populations and/or evaluations of their psychometric properties are in preliminary stages. The majority of well-validated and widely-used assessments of child and youth well-being have been developed for the purposes of program planning and evaluation

where data are aggregated to assess and guide program implementation. The seven instruments summarized in Figure 4 are comprehensive assessments of child and adolescent well-being and examples of population surveys and program evaluation measures that are not intended for case or clinical decision-making.

Figure 4. Population Survey and Program Evaluation Instruments

Instrument	Description	Domains/ Subscales
Child Health and Illness Profile (Starfield et al., 1995)	Standardized measure documenting health in groups of children or adolescents; tested in child welfare population as a measure of well-being.	Satisfaction; discomfort; resilience; risks; achievement; and disorders
Communities That Care Youth Survey (Arthur et al., 2002)	Designed to collect data on the epidemiology of risk and protection among community youth populations for prevention purposes.	Broad risk and protective factors in community, school, family, peer, and individual domains; health and behavior outcomes
Healthy Kids Resilience Assessment (Constantine et al., 1999)	Optional module of the California Healthy Kids Survey intended to serve as a tool for local and state education agencies and researchers; assesses a variety of external and internal factors associated with positive youth development.	Caring relationships; high expectations; meaningful participation; social competence; autonomy and sense of self; and sense of meaning and purpose
Individual Protective Factors Index (Springer & Phillips, 1997)	Developed to measure adolescent resiliency; tool for evaluating prevention programs for youth.	Social bonding; personal competence; and social competence
Quality of Life Profile-Adolescent Version (Raphael et al., 1996)	Generic quality of life instrument to assess psychosocial aspects of well-being and comprehensive health.	Being (physical, psychological, spiritual); belonging (physical, social, community); and becoming (practical, leisure, growth)
Search Institute Profiles of Student Life: Attitudes and Behaviors (Leffert et al., 1998)	Designed to assess developmental assets in groups of youth for the purposes of informing intervention strategies.	External assets (i.e., health-promoting features of the environment); internal assets (i.e., personal commitments, values, and competencies)
Youth Asset Survey (YAS; Oman et al., 2002)	Developed to assess and compare prevalence of youth assets across populations.	Family communication; peer role models; future aspirations; responsible choices; community involvement; cultural respect; good health practices; use of time; nonparental adult role models

The analysis of service outcomes for a child population related to the overall well-being of children and youth is essential for the informed development of agency-level program planning (Altshuler & Poertner, 2002). While the instruments in Figure 4 have been developed for the purposes of evaluating client populations, they can also offer individual level indications of a child's well-being as part of a more extensive and thorough assessment (Lyons, Doueck, Koster, Witzky, & Kelly, 1999).

Implications for Practice

The ability to assess child and youth well-being is hindered by a number of factors. A lack of consensus about how well-being should be defined and subsequently measured can lead to inconsistent use of the term across disciplines and studies. In addition, the historical emphasis on the assessment of individual characteristics in isolation of a child's environment, as well as the focus on risk, has overshadowed efforts to examine the strengths and competencies of children and youth. Lastly, as the results of this structured literature review indicate, the majority of measures assessing global well-being in children and youth have not yet attained the level of reliability and validity that are associated with instruments that assess maltreatment risk and family systems. The field of well-being assessment is largely at a formative stage.

The instruments presented in this structured review are representations of the status of the field and thus embody an improvement on previous deficit-focused measures. The instruments also reflect the measurement challenges related to studying well-being. From a risk and resilience perspective, measures of well-being show promise when conceptualizing child development as dynamic, bio-ecological, and transactional and balancing the assessment of risk and protective factors. A number of lessons can be identified for child welfare practice.

First, consideration of the *developmental process of a child* is essential in the assessment of well-being. What constitutes well-being in infancy versus middle childhood varies considerably; a one-size-fits-all approach to assessment fails to consider this complexity. Effective service planning can occur when developmentally appropriate instruments are employed. Furthermore, while global assessments of well-being in infancy and early childhood are relatively well-established, the complexity of the socio-emotional aspects of well-being in older children makes it difficult to develop similarly

well-grounded instruments. Efforts to develop well-being instruments for middle childhood and adolescence should consider the need for multiple informants, assessment of subjective factors related to self-perception, and the impact of social networks on children and youth.

Second, assessment of child and youth well-being may have several purposes at the client as well as the service level. In the processing of a case, for example, child well-being assessment can be particularly useful during *critical decision-making points* such as: (1) temporary removal and disposition, (2) out-of-home placement considering reunification, (3) permanent placement hearing, and (4) transition and emancipation. Child well-being assessment may also be influential in the *prevention* of abuse or neglect for the referred child (i.e., reoccurrence) as well as for other children in the family (i.e., occurrence). On a broader scale, individual level well-being assessments can be aggregated to *inform policy and program development*, as well as to identify needs in specific communities.

Third, the demands of child welfare practice require that global well-being instruments be *inexpensive and available, relatively brief, and easy to administer and score*. Further, instruments must yield practical results that can be translated into effective practice or policy strategies. The broad nature of well-being can be seen from the range of instruments resulting from this structured review. Further psychometric testing and evaluation for use in child welfare practice will strengthen the promising global instruments.

Finally, assessment of child and youth well-being is multidimensional and therefore single domain instruments cannot capture this complexity. Even comprehensive well-being assessments need to be interpreted along with other indicators of well-being. *When used in conjunction with medical and school records as well as existing risk and safety measures, a strengths-based assessment of child well-being can offer something sorely missing in the assessment of children*. Such measures have the potential to “complete the evaluation triangle” between safety, permanency, and well-being in child welfare practice and policy (Altshuler & Gleeson, 1999, p.143) by restoring balance in a heavily risk-focused process.

When considering the lessons discussed above, the assessment of well-being in child welfare practice can have a number of advantages for the child and family, worker, and the broader service system. Figure 5 provides a framework for discussing these advantages by capturing the convergence of individual child and youth well-being assessment in the different stages of a child welfare case. A promising instrument from each developmental stage was selected as an example. First, the assessment can *serve as a baseline indicator* by providing a measure of the child’s status at initial stages of case-processing. A baseline measure allows the worker to compare the child’s well-being at intake to later points of intervention and follow-up. Such information is useful in *tracking progress* for the child and the family. Second, assessment of child well-being can *steer intervention and service planning*. As one component of a broader family assessment, an emphasis on the well-being of the child can inform needed services and interventions for a child at different points in the process. Third, individual child assessments *contribute to a larger database of information assessing outcomes*. As depicted in Figure 5, the outcomes may be related to specific needs of the child and relevant interventions or broad service outcomes such as safety, permanency, and well-being. Outcomes are specific to the individual child or youth and therefore intentionally left blank in Figure 5.

Figure 5. Child and Youth Well-Being Assessment in Child Welfare Practice

	Disposition	Reunification	Permanent Placement	Emancipation	CHILD WELFARE OUTCOMES: Safety, Permanency, Well-Being
Infancy/ Early Childhood	Ages and Stages Questionnaire	Ages and Stages Questionnaire	Ages and Stages Questionnaire		
Middle Childhood	Behavioral and Emotional Rating Scale-2 nd Ed.	Behavioral and Emotional Rating Scale-2 nd Ed.	Behavioral and Emotional Rating Scale-2 nd Ed.		
Adolescence	Behavioral and Emotional Rating Scale-2 nd Ed.	Behavioral and Emotional Rating Scale-2 nd Ed.	Behavioral and Emotional Rating Scale-2 nd Ed.	Ansell-Casey Life Skills Assessment	
CHILD NEEDS					

Assessments of child well-being also have advantages for the family and the child welfare worker. For example, when joining with the parent(s) to reach the common goal of child well-being, the worker can conduct assessment processes with the family rather than to the family. This legitimation of the *partnership with the family* can help combat obstacles a worker might encounter. Furthermore, the assessment of child well-being can *enhance worker satisfaction*. In the midst of necessary risk and safety assessments, well-being assessment offers a unique perspective on the strengths and assets of the child and family. The ability to see a child's development unfold can offer glimpses of progress and change. Both the worker and the parent may learn new things about the child in the shared assessment process.

Lastly, child well-being assessment has some practical advantages for the worker in court presentations. A well-being assessment can help a worker *organize observed behavior* by synthesizing necessary pieces of information. An objective assessment of well-being can further substantiate narrative reports of well-being, thereby increasing credibility in court. Finally, child well-being assessments contribute to the overall comprehensiveness of a worker's report. By anticipating questions, a comprehensive assessment of well-being may reduce the need for outside psychological tests.

Appendix A BASSC Search Protocol

Search Terms

VAR1

Protective Factor*

Resilien*

Coping skill*

Well-being

Strength-based

Efficac*

Competenc*

Asset*

VAR2

Infant*

Child*

Youth

Adolescen*

VAR3

Foster*

Child welfare

VAR4

Assessment*

Instrument*

Scale*

Inventor*

Measure*

Psychometric*

VAR5

Peer*

Famil* (only for four VAR)

School*

Relationship*

Develop*

Social support*

Databases

Academic databases for books and articles

Pathfinder or Melvyl

ArticleFirst

ERIC

Expanded Academic ASAP

Family and Society Studies Worldwide
PAIS International
PsychInfo
Social Science Citation Index
Social Services Abstracts
Social Work Abstracts
Sociological Abstracts

Systematic Reviews

Campbell Collaboration – C2-Spectre & C2-Ripe
Children and Family Research Center
Cochrane Library
ESRC Evidence Network
NHS Centre for Reviews & Dissemination
Social Care Institute for Excellence

Research Institutes

Brookings Institute
Manpower Demonstration Research Corporation
Mathematica Policy Research, Inc.
Urban Institute
RAND
GAO
National Academy of Sciences
Chapin Hall
CASRC (San Diego)

Conference Proceedings

PapersFirst (UCB Database)
Proceedings (UCB Database)

Internet

Google Scholar

Administration for Children and Families, DHHS, Resources for Measuring Services & Outcome in Head Start Programs Serving Infants & Toddlers:
http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_es_meas_toc.html

Violence Institute of New Jersey at UMDNJ:
http://www.umdj.edu/vinjweb/research_projects/instrument_inventory/instrument_inventory.html

http://www.lib.berkeley.edu/SOCW/socw_instruments.html

Appendix B
Excluded Instruments

1. Brief Impairment Scale (Bird et al., 2005)
2. Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983)
3. California Child Q-Sort (CCQ) (Block & Block, 1969)
4. Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990)
5. Child and Adolescent Psychiatric Assessment (CAPA; Angold & Costello, 2000)
6. Child Behavior Checklist (CBCL; Achenbach, 1991)
7. Childhood Anxiety Sensitivity Index (CASI; Silverman, Fleisig, Rabian, Peterson, 1991)
8. Children's Depression Inventory (CDI; Kovacs, 1992)
9. Children's Depression Scale (CDS; Lang & Tisher, 1978)
10. Children's Global Assessment Scale (CGAS; Shaffer et al., 1983)
11. Colorado Client Assessment System Record (CCAR; Ellis, Wilson, & Foster, 1984)
12. Columbia Impairment Scale (Bird et al., 1993)
13. Devereux Scales of Mental Disorder (Naglieri, LeBuffe, & Pfeiffer, 1994)
14. Diagnostic Interview Schedule for Children (DISC; Shaffer & Fisher, 1997)
15. Draw-A-Person: Screening Procedure for Emotional Disturbance (DAP: SPED; Naglieri, McNeish, & Bardos, 1991)
16. Dominic-R (Valla, Bergeron, & Smolla, 2000)
17. Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A; Butcher et al., 1992)
18. Moods and Feelings Questionnaire (MFQ; Angold et al., 1995)
19. Personality Inventory for Children (PIC; Wirt, Lachar, Klinedinst, Seat, & Broen, 1977)
20. Personality Inventory for Youth (PIY; Lachar & Gruber, 1993)
21. Preschool Behavior Questionnaire (PBQ; Behar, 1977)
22. Scale for Assessing Emotional Disturbance (SAED; Epstein, Cullinan, Ryser, & Pearson, 2002)
23. Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS; Kaufman et al., 1997)
24. Social Anxiety Scale for Children (SASC; La Greca, Dandes, Wick, Shaw, & Stone, 1988)
25. Social Phobia and Anxiety Inventory for Children (SPAI-C; Beidel, Turner, & Fink, 1996)
26. Stressful Life Events Schedule (SLES; Williamson et al., 2003)
27. Teacher Report Form (TRF; Achenbach, 1991)
28. Trauma Symptom Checklist for Children (TSCC; Briere, 1996)
29. Youth Self Report (YSR; Achenbach, 1991)

Appendix C
Infant and Young Child Instruments

	<i>Age Group</i>				
	I/P= Infant/Preschool C= Child A= Adolescent	Language Development & Communication	Intellectual Ability & Cognitive Functioning	Physical Development & Motor Skills	Socio-Emotional Competence
1. Preschool Language Scale-4 (PLS-4; Zimmerman et al., 2002)	I/P	X			
2. Reynell Developmental Language Scales (RDLS; Reynell & Huntley, 1985)	I/P	X			
3. Sequenced Inventory of Communication Development (Hedrick et al., 1984)	I/P	X			
4. MacArthur Communicative Development Inventory (MDCI; Fenson et al., 1993)	I/P	X			
5. Peabody Picture Vocabulary Test- Revised (Dunn & Dunn, 1981)	I/P	X			
6. Wechsler Preschool and Primary Scale of Intelligence, 3 rd Edition (WPPSI-III; The Psychological Corporation, 2002)	I/P, C	X	X		
7. Stanford-Binet Intelligence Scale, 5 th Edition (SB5; Roid, 2003)	I/P,C,A		X		
8. Kaufman Assessment Battery for Children, 2 nd Edition (KABC-II; Kaufman & Kaufman, 2004)	I/P, C, A		X		
9. Differential Abilities Scale (DAS; Elliott, 1990)	I/P,C		X		
10. Griffiths Scales of Motor Development (Griffiths, 1984)	I/P			X	
11. Peabody Developmental Motor Scales, 2 nd Edition (Folio & Fewell, 2000)	I/P			X	
12. Gross Motor Function Measure (Russell et al., 2002)	I/P			X	
13. Toddler and Infant Motor Evaluation (T.I.M.E.; Miller & Roid, 1994)	I/P			X	

14. Pediatric Evaluation of Disability Inventory (PEDI; Haley et al., 1992)	I/P			X	
15. Brief Infant-Toddler Social and Emotional Assessment (BITSEA; Briggs-Gowan et al., 2004)	I/P,C				X
16. Infant-Toddler Social and Emotional Assessment (ITSEA; Carter & Briggs-Gowan, 2000)	I/P,C				X
17. Preschool and Early Childhood Functional Assessment Scale (PECFAS; Murphy et al., 1999)	I/P,C				X
18. Social Skills Rating System- PreSchool Version (SSRS; Gresham & Elliott, 1900)	I/P				X
19. Vineland Social-Emotional Early Childhood Scale (SEEC; Sparrow & Balla, 1998)	C				X
20. Bayley Scales of Infant Development (Baley, 1993)	I/P,C		X	X	
21. Vineland Adaptive Behavior Scales (Sparrow et al., 1984)	I/P,C,A	X		X	X
22. Battelle Developmental Inventory (BDI; Newborg et al., 1988)	I/P,C	X	X	X	X
23. Brigance Diagnostic Inventory of Early Development, Revised Edition (BDIED-R; Brigance, 1991)	I/P,C	X	X	X	
24. Child Development Inventory (CDI; Ireton & Glascoe, 1995)	I/P,C	X	X	X	X
25. Child Observation Record (COR; High/Scope, 1992)	I/P,C	X	X	X	X
26. Early Screening Profiles (ESP; Harrison, 1990)	I/P,C	X	X	X	X
27. FirstSTEP Screening Test for Evaluating Prechoolers (FirstSTEP; Miller, 1993)	I/P,C	X	X	X	X
28. Ages and Stages Questionnaire (ASQ; Bricker et al., 1995)	I/P,C	X	X	X	X

Appendix D
Middle Childhood Instruments

	<i>Age Group</i> I/P= Infant/Preschool C= Child A= Adolescent	Language & Communication	Cognitive Ability & Academic Achievement	Physical Health & Development	Socio-Emotional Competence
1. Children's Skills Test (SmarterKids, 1998)	C		X		
2. Tests of Achievement in Basic Skills (TABS; EdITS, 2004)	C		X		
3. Tests of Academic Achievement Skills (Gardner, 1989)	C		X		
4. Childhood Asthma Questionnaire (French et al., 1993)	C			X	
5. Multidimensional Self-Concept Scale (MSCS; Bracken, 1992)	C				X
6. Pictorial Self-Concept Scale (PSCS; Bolea et al., 1971)	C				X
7. Piers-Harris Self-Concept Scale, 2 nd Edition (Piers et al., 1999)	C				X
8. Self-Perception Profile for Children (SPPC; Harter, 1985)	C				X
9. Child Self-Control Rating Scale (CSCRS; Rohrbeck et al., 1991)	C				X
10. Coping Scale for Children and Youth (CSCY; Brodzinsky et al., 1992)	C,A				X
11. Kidcope (Spirito et al., 1988)	C,A				X
12. Kohn Social Competence Scale (Kohn & Rosman, 1972)	C				X
13. Loneliness and Social Dissatisfaction Questionnaire (LSDS; Asher et al., 1984)	C				X

14. Penn Interactive Peer Play Scale (PIPPS; Fantuzzo et al., 1995)	C				X
15. Self-Esteem Inventory – Revised (SEI; Coopersmith, 2002)	A	X			
16. Self-Esteem Index (SEI; Brown & Alexander, 1991)	C,A				X
17. Social Skills Rating System (SSRS; Gresham & Elliott, 1990)	C,A		X		X
18. Clinical Assessment Package for Assessing Client Risks and Strengths (CASPARS; Gilgun, 1999)	C,A		X		X
19. Matson Evaluation of Social Skills for Youngsters (MESSY; Matson et al., 1983)	C				X
20. Social Adjustment Inventory for Children & Adolescents (SAICA; John et al., 1987)	C,A				X
21. Elementary School Success Profile (ESSP; Bowen, 2006)	C				X
22. Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998)	C,A				X
23. Multidimensional Student’s Life Satisfaction Scale (MSLSS; Huebner, 1994)	C,A				X
24. Strengths & Difficulties Questionnaire (SDQ; Goodman, 2001)	C,A				X
25. School Social Behavior Scales, 2 nd Edition (SSBS-2; Merrell, 1993)	C				X
26. Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992)	I/P,C,A				X

Appendix E
Adolescent Instruments

	<i>Age Group</i> I/P= Infant/Preschool C= Child A= Adolescent	Self-Esteem/Self-Concept	Self-Efficacy	Life Satisfaction	Social Competence/ Communication Skills	Perceived Social Support	Perceived Academic/ General Achievement	Problem-Solving/Decision- Making
1. Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1989)	A	X						
2. Self-Esteem Questionnaire (SEQ; DuBois et al., 1996)	C,A	X						
3. Bledsoe Self-Concept Scale (BSCS; Bledsoe, 1967)	A	X						
4. Multidimensional Self-Concept Scale (MSCS; Bracken, 1992)	A	X			X			
5. Self-Perception Profile for Adolescents (SPPA; Harter, 1988)	A	X			X		X	
6. Self-Description Questionnaire (SDQII; SDQIII; Marsh 1990, 1992)	A	X			X		X	
7. Tennessee Self-Concept Scale (TSCS; Fitts, 1965)	A	X		X	X			
8. Career Decision-Making Self-Efficacy Scale (CDMSES; Taylor & Betz, 1983)	A		X					X
9. Self-Efficacy Questionnaire for Children (SEQ-C; Muris, 2001)	A		X					
10. Student's Life Satisfaction Scale (SLSS; Huebner, 1991)	C,A			X				
11. Perceived Life Satisfaction Scale (PLSS; Adelman et al., 1989)	A			X				
12. Assertiveness Scale for Adolescents (ASA; Lee, 1985)	A				X			
13. Teenage Inventory of Social Skills (TISS; Inderbitzen & Foster, 1992)	A				X			

14. Child and Adolescent Social Support Scale (CASSS; Malecki et al., 1999)	C					X		
15. Social Support Scale for Children (SSSC; Harter, 1985)	C,A					X		
16. Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988)	A					X		
17. Perceived Social Support from Family and Friends (PSS-FA & PSS-FR; Procidano & Heller, 1983)	A					X		
18. Achievement Goal Questionnaire (AGQ; Finney et al., 2004)	A						X	
19. Inventory of School Motivation (ISM; McInerney & Sinclair, 1991)	A						X	
20. Problem-Solving Inventory (PSI; Heppner & Peterson, 1992)	A							X
21. 4-D: Strengths-Based Assessment Tools for Youth in Care (4-D; Gilgun, 2004)	A		X		X	X	X	X
22. Family, Friend, and Self Form (FFS; Simpson & McBride, 1992)	A	X		X	X	X	X	
23. Child and Adolescent Social and Adaptive Functioning Scale (CASAFS; Price et al., 2002)	A		X		X	X	X	
24. Adolescent-Coping Orientation for Problem Experiences (A-COPE; Patterson & McCubbin, 1987)	A		X	X	X	X	X	X
25. Resiliency Scale (Jew et al., 1999)	A		X	X	X	X		X
26. Resilience Scale (Wagnild & Young, 1993)	A		X	X				X
27. Ansell-Casey Life Skills Assessment (ACLSA; Casey Family Programs, 2005)	C,A		X		X	X	X	X

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