Measuring Success in Child Welfare

A NATIONAL STUDY OF OUTCOME MEASUREMENT IN PUBLIC CHILD WELFARE SERVICES: RESULTS AND RECOMMENDATIONS

Measuring Child and Family Functioning

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Measuring Child and Family Functioning

Many child welfare agencies use risk assessment devices to assess child and family problems. While these devices are useful in structuring the assessment and focusing the assessment on specific risk factors, these tools are not adequate for measuring child or family functioning over time. Client progress during and after services may be difficult to assess without the assistance of tools that measure the intended outcomes of service. In some cases integration of clinical measures into an agency's outcome measurement package can provide practitioners with the additional information they need to make safety and permanency decisions more confidently. For instance, a worker may visit a family and observe family functioning. Based on the limited amount of time the worker has available for this observation, functioning may appear normal. If the worker has the advantage of combining the observation with a clinical measurement, he or she may be able to target specific risk factors that otherwise would go undetected, address these risks with the family, and build appropriate services into the case plan.

Selecting Clinical Measures

Selecting clinical measures for use in child welfare settings requires an awareness of specific measurement issues that require careful consideration. To assist managers in this process, the following section presents several child and family functioning measures identified through the Center's review of the research literature, conference presentations, PsycInfo, a searchable database maintained by the American Psychological Association, and results from the National Study. Thirty-five states and nine localities participated in the National Study by completing a survey concerning their outcome measurement activities or returning related documents (see *The National Study* for more details). The Center identified more than one hundred measures from these sources and analyzed them using the following criteria to determine their appropriateness for use in child welfare. Managers may find these criteria useful in reviewing new measures that come to their attention as they develop and implement outcome measurement plans.

1. **Is the measure sensitive to clinical change?** Many instruments are designed to detect the existence of a given condition, not to measure improvement in a child or family's functioning over time. Only instruments sensitive enough to detect client change can reliably measure it, a distinction many users are unaware of. Usually measures provide no research based information regarding sensitivity to change as these studies are a relatively recent addition to the psychometric literature. The importance of sensitivity to change cannot be emphasized enough, since child welfare decisions are often made when there appears to be a "lack of progress" on the part of a client. For purposes of this review, the Center selected only measures that indicated clinical sensitivity to change.

2. **What outcomes are measured?** Measures of the condition of children and families cover a wide array of constructs, from tangible outcomes such as academic performance, to less concrete concepts such as self-esteem. It will be important for agencies and programs to clearly identify the goals and desired outcomes of service for children and families before selecting measures. The Center identified measures that fit into core sets of child functioning domains, including physical health, emotional functioning, behavioral health,

cognitive and academic functioning, and self sufficiency (older children), and family functioning domains, including parental functioning, parental behavioral health, quality of home environment and conflict management.

3. **How long does it take to administer the measure?** Child welfare workers generally have limited time to spend with clients, therefore, the less time absorbed by measurement administration, the better. According to Evaluating the Outcome of Children's Mental Health Services: A Guide for the Use of Available Child and Family Outcome Measures, Second Edition (Cross, McDonald, and Lyons, 1997), ten minutes or less is an optimal guideline. For purposes of the review, the Center selected measures requiring 20 minutes or less to administer, ruling out several instruments that otherwise might be excellent measures but would not be practical for use in child welfare. Managers will also want to consider the time it takes to train workers to use the measure and the length of time required to interpret results.

4. **What is the developmental stage or age focus of the measure?** The broad range of ages of children served by the child welfare system will require agencies to select multiple measures in most cases. Age ranges are provided for each measure.

5. **Is it useful with the intended target group of clients?** For example, if an agency works primarily with Hispanic clients, knowing that a particular measure has been tested with Hispanic individuals will be a defining factor in selecting that particular measure. As most measures have been normed with Caucasian English speaking individuals in research settings, serious consideration will need to be given to the appropriateness of using instruments in practice that are not culturally validated. Managers will also need to consider how the measure is administered. If a client completes the form, consider the reading level the instrument was designed for and languages available.

6. **When is the measure administered?** Before and after treatment? Or periodically through the life of the case? Answers to these questions will help determine if the measure meets agency needs.

7. **What are the advantages and disadvantages of using this measure?** Certain clinical measures have the advantage of assessing a range of child or family functioning outcomes. Other measures are useful in that they can be used along with other tools as part of a "package." Any time an instrument can provide information on multiple outcomes, managers conserve resources. Several measures may only tap one aspect of an outcome, or are useful only with a particular population that may represent the agency's clientele. For example, some measures may be written for a higher reading level than would be sensible for use with an agency's client population.

8. **What does the measure tell a practitioner, administrator, or policy maker?** Decisions about measurement should be guided by a clear idea of what information is needed, how it will be used, and who will be using it. Other's experiences with clinical measures can help inform the selection process. Information about the usefulness of measurement information for different groups is provided where available.

9. **Is psychometric data available?** Reliability and validity indices establish the credibility of instruments. Without this information, various alternative explanations for the findings (e.g. examiner bias, chance, and effects of maturation) cannot be ruled out, which seriously restricts the usefulness of findings. Psychometric data availability is noted for each of the reviewed measures.

In addition to carefully reviewing measures for use in child welfare, it is important for managers to thoroughly assess agency resources necessary to add clinical measures to the repertoire of worker tools. For example, managers and administrators need to consider whether special staff or training will be needed for administration, interpretation, and analysis. Managers and administrators also need to consider the costs of purchasing copyrighted materials or reproducing other measures.

Finally, when using clinical measures in child welfare, it is important for management to articulate to staff "what's in it for us." Staff members need to be informed of the benefits that will be derived from clinical measurement and how the agency will support them in this process. Management must also be willing to adjust caseloads if necessary to effectively implement outcome measurement and to support staff through training, provision of necessary resources, active supervision and consultation.

Alternatives to Clinical Measures

In some cases clinical measures will be insufficient or inadvisable for use in child welfare for various reasons, such as lengthy administration times, unavailability of psychometric data, or inappropriateness for use with an agency's service population. As an alternative and/or supplement, administrative data can be used to track functional outcomes or measures of behaviors, actions, or life events (e.g., graduation from high school, incarceration, etc.). Functional outcome information is sometimes easier for staff to collect, use and maintain in a management information system and can be more concrete and easily understood, especially by those outside of child welfare. For example, a significant increase in graduation rates for children exiting foster care can be more meaningful to policy makers and the public than an increase in scores on a behavior rating scale. However, functional outcome data must be used and interpreted judiciously. An event such as high school graduation, while an important and wonderful accomplishment, suggests little about other major life issues such as family and interpersonal relationships, substance use issues, or plans for independent living. *Using Administrative Data* provides further measurement considerations.

To better control cost and level of difficulty, agencies can also design criterion-referenced measures to assess whether program participants have met specific criteria targeted by service interventions. Criterion-referenced measures are specific, concrete changes directly tied to the goals of intervention. For example, one goal of residential treatment might involve decreasing the number of adolescent runaway incidents. A criterion-referenced measure, therefore, might be an index of the number of times an adolescent had the opportunity to runaway but didn't.

*This section is excerpted from Cross T.P., McDonald E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services. (Second edition). Boston, MA: Judge Baker Children's Center. For copies contact The Technical Assistance Center for the Evaluation of Children's Mental Health Systems, Judge Baker Children's Center at (617) 232-8390.

Clinical and Administrative Measures of Child and Family Functioning

This section presents clinical measures of child and family functioning that appear appropriate for use in child welfare settings based on the Center's literature review and analysis. Several agencies participating in the *National Study* also reported using administrative data to track child and family functioning. These measures are also provided within each domain. Thirty-five states and nine localities participated in the *National Study* by completing a survey concerning their outcome measurement activities or returning related documents (see details of *The National Study* at the end of the document for more details).

Clinical measures developed for psychological or psychiatric settings are often not comprehensive enough or specific enough for child welfare purposes. Some states are able to tailor measures to meet their specific needs by using self- constructed measures or measures developed by researchers or academic units. While most of these measures have not been psychometrically validated, many states use them as an alternative to the limited number of options that have historically been available. These measures are also reported within each domain.

The measures are organized by target population, domain and ease of use in child welfare settings. The measures presented here have been screened with respect to their applicability in child welfare settings.

Level one measures are relevant to child welfare service goals, are relatively easy to administer and interpret, take less than 20 minutes to administer, and detect change over time. Level two measures meet some of these four criteria and may be appropriate for some agency purposes. Level three measures are either more complicated, more lengthy, more specialized or relatively little information was available about them at the time of the publication of this web page. In addition, child and family well-being measures reported in use by agencies surveyed are also listed here. Some agencies are not identified due to their request for confidentiality. Detailed ***descriptions of the measures for levels one and two*** are also provided.

Child and Family Functioning Domains	
Child Functioning	**Family Functioning**
Physical Health	*Parental Functioning*
Behavioral Health	*Parental Behavioral Health*
Cognitive and Academic Functioning	*Quality of Home Environment*
Self Sufficiency (older children)	*Conflict Management*

Resources

The Center reviewed several resources which managers may find useful in their work. The following items are highlighted with additional materials listed in the reference section that follows.

? ? The *Child Abuse and Neglect Database Instrument System* (CANDIS), developed by the National Crime Victims Research and Treatment Center at the Medical University of South Carolina in Charleston, contains numerous clinical measures used in child abuse and neglect research.

? ? Instruments Used to Measure Child and Family Functioning, Service Utilization, and Client Satisfaction in Family Preservation Services (1995), prepared by the Family Preservation Evaluation Project at the Department of Child Study at Tufts University, provides information about administration, age-appropriateness, whether the instrument has been used in research or practice, information on where the measure can be obtained, and authors that have used or recommended it.

? ? Evaluating the Outcome of Children's Mental Health Services: A Guide for the Use of Available Child and Family Outcome Measures, Second Edition, (Cross, McDonald, & Lyons, 1997) reviews several clinical measures used in mental health services, including information on outcome domains measured, applications, age group targeted, format and administration (including number of items, time needed to administer, and training required). The summaries also include reliability and validity information, population characteristics, a description of the measure's past use in evaluation, a short critique, and key contact information. Available from the Technical Assistance Center for the Evaluation of Children's Mental Health Systems, Judge Baker Children's Center at (617) 232-8390.

? ? Ours to Keep: A Guide for Building a Community Assessment Strategy for Child Protection (Day, Robinson, & Sheikh, 1998) provides brief descriptions of child and family functioning measures and references to several specialized tools to assess the presence of specific problems that frequently affect children and families that come to the attention of child welfare agencies, such as substance abuse, domestic violence and childhood sexual abuse. Available from the *Child Welfare League of America*.

? ? Healthy Families America: A Guide for Evaluating Healthy Families America Efforts (Daro, 1994) and the Parenting Program Evaluation Manual, Second Edition, (Daro, Adams, & Casey, 1990) contains information on clinical measures recommended for use in evaluating the outcomes of home visiting programs, including authors, sources, and summaries of each measure's utility. Available through *Prevent Child Abuse America's* publications department.

? ? Longitudinal Studies on Child Abuse and Neglect (*LONGSCAN*) is a consortium of research studies on outcomes for children who are at risk of child abuse and neglect

or are known to have been abused and neglected. This consortium has established common measurements for all participating studies. While these instruments have been used in research for these children and families there are also instruments that are relevant to clinical practice. In addition, these studies are resulting in findings regarding outcomes for children in a number of different settings across the country.

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Measures of Child Functioning

The following table lists reviewed clinical measures organized by domain and utility. The criteria used to determine the usefulness of measures to public child welfare services are: 1) Measure addresses specific domains relevant to child welfare; 2) Ease of administration and interpretation; 3) Measure takes less than 20 minutes to administer; and 4) Measure detects clinical change over time.

Level One Measures: meet all four criteria. These measures link to full summaries provided at this site.

Level Two Measures: meet several criteria and may be appropriate for some agency purposes.

Level Three Measures: Information necessary for criteria review was unavailable at the time of publication or measure may have some relevance but may have other limiting factors such as time or type of personnel required for administration.

Included in the reviewed clinical measures for each domain are measures reported to be in use; either by agencies participating in the *National Study of Outcome Measurement in Public Child Welfare Services* or by agencies reporting measurement activities at conferences or on the internet. These clinical measures include some which have been adapted by agencies for their own use (hybrids). Contact information is provided where available. As some of the measures reported to be in use by agencies span several domains, some duplication of measures occurs.

Descriptions of each measure, including population addressed, number of items, and time to administer (where information was available at the time of publication) are listed in the table entitled "Measuring Child and Family Functioning." In some instances agencies participating in the *National Study* requested confidentiality. In these cases only the number of agencies using the measure are listed, rather than the agency name(s).

CHILD FUNCTIONING

Child Physical Health and Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Reporting Use
Clinical Measures			
Level One	**Physical examination for foster children**		Reported use by three states
Level Two			
	(CYOS) The Casey Youth Outcomes Survey	Emotional health, family adjustment, cultural identification, competence and achievement, physical health, educational development, self-sufficiency, legal involvement, case history	
	(DDST) Denver Developmental Screening Test	Personal-social aspects, fine motor-adaptive behaviors, language, and gross motor coordination	
ADDITIONAL CHILD PHYSICAL HEALTH AND FUNCTIONING MEASURES REPORTED TO BE IN USE BY PUBLIC CHILD WELFARE AGENCIES			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Reporting Use
A. CLINICAL MEASURES			
	Creating a New System of Care: Building a Stronger Child and Family Partnership	Permanence/stability, safety, and physical well-being, additional indicators	Alabama
B. ADMINISTRATIVE DATA			
	Healthy Children and Youth (HCY) Early Period Screening, Diagnosis and Treatment	General physical health	Reported use by three states
	Physical and dental exams and treatment for children	General physical and dental health	Reported use by three states
	Sexually transmitted diseases among children	Child health and safety	Reported use by one state
	Preventable hospitalizations	Sustained health, delivery of preventive health care, and implementation of agency procedures	Reported use by one state
	Indicated reports of abuse or neglect	Child safety	Reported use by all states
	Incidence of substance abuse among children	Sustained health (drug free)	Reported use by one state

Child Behavioral, Social and Emotional Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Reporting Use
CLINICAL MEASURES			
Level One			
	(CAFAS) Child and Adolescent Functional Assessment Scale	**Role performance, thinking, behavior towards others/self, moods/emotions, substance abuse.**	**Ventura County, CA; Wheeling, WV; Lorain County, OH; two other counties**
	(CBCL 2-3) Child Behavior Checklist/2-3	Anxiety/depression, withdrawal, sleep problems, somatic problems, aggressive behavior, and destructive behavior.	
	(CBCL) Child Behavior Checklist	Behavioral problems and competencies	
	(CBCL) Child Behavior Checklist and Youth Self Report	Behavioral problems and competencies	Casey Family Program (long term foster care); Tennessee
	(CDI) Children's Depression Inventory	Emotions and behaviors	
	(DSMD) Devereux Scales of Mental Disorders	Conduct anxiety, depression, autism , acute problems, attention, and delinquency	
	(ISCS) Inferred Self-Concept Scale	Self-Esteem	
	(RADS) Reynolds Adolescent Depression Scale	Major depression and dysthymic disorder	
	(RCDS) Reynolds Child Depression Scale	Depression	
	(SEQ) Self-Esteem Questionnaire	Self-esteem and self-other	
	(SPPA) Self-Perception Profile for Adolescents	Global Self-worth: scholastic competence, athletic competence, social acceptance, physical appearance, behavioral conduct, close friendship, romantic appeal, and job competence	
	(SPPC) Self-Perception Profile for Children	Global self-worth: scholastic competence, athletic competence, social acceptance, physical appearance, and behavioral conduct	
	(TRF) Teacher's Report Form	Externalizing and internalizing; adaptive functioning; a global index of adaptive functioning; eight syndromes: anxious/depressed, withdrawn, social problems, somatic complaints, aggressive behavior, delinquent behavior, thought problems and attention problems	
	(WSDI) Wahler Self Description Inventory	Defensiveness, self-perception, values and methods of adaptation	

Child Behavioral, Social and Emotional Functioning (CONTINUED)			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Reporting Use
CLINICAL MEASURES (continued)			
Level Two			
	(BARS) Behavioral and Emotional Rating Scale	Interpersonal strengths, involvement with family, intrapersonal strengths, school functioning, and affective strength	
	(CGAS) Children's Global Assessment Scale	Severit y of disturbance	Hamilton County, Ohio
	(CFSEICA) Culture-Free Self-Esteem Inventories for Children and Adults	Child outcomes include: general self-esteem, social/peer-related self-esteem, academics/school related self-esteem and parents/home-related self-esteem; adults outcomes include: general self-esteem, social self-esteem and personal self-esteem	
	(CYOS) The Casey Youth Outcomes Survey	Emotional health, family adjustment, cultural identification, competence and achievement, physical health, educational development, self-sufficiency, legal involvement, case history	
	(DDST) Denver Developmental Screening Test	Personal-social aspects, fine motor-adaptive behaviors, language, and gross motor coordination	
	(PSPCSA) Pictorial Scale of Perceived Competence and Social Acceptance for Young Children	General Competence: cognitive competence and physical competence; and Social Acceptance: maternal acceptance and peer acceptance	
	(RBPC) Revised Behavioral Problem Checklist	Conduct disorder, socialized aggression, attention problems-immaturity, anxiety-withdrawal, psychotic behavior, motor tension excess	
	(VABS) Vineland Adaptive Behavior Scales, Survey Form	Adaptive behaviors in communication, daily living skills, socialization, and motor skills	
	(VSTCP) Vermont System for Tracking Client Progress	Physical aggression, sexual acting out, substance abuse, verbal abuse, self-confidence, compliance, school attendance, and parent contact	Vermont
Level Three			
	(DSRS) Depression Self-Rating Scale	Depression	
	(TISS) Teenage Inventory of Social Skills	Positive and negative behaviors	

ADDITIONAL CHILD BEHAVIORAL, SOCIAL AND EMOTIONAL FUNCTIONING MEASURES REPORTED TO BE IN USE BY PUBLIC CHILD WELFARE AGENCIES			
A. CLINICAL MEASURES			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Reporting Use
	Level of Care Change (under development)	Improvement in child functioning/decrease in maladaptive behavior; improvement in mental/emotional status	Texas Department of Protective and Regulatory Services
	Child Well-Being Scales (CWLA)	Child capacities, child role performance, familial capacities, parenting role performance (reduction in out-of –home placements, reduction in subsequent abuse/neglect reports, increase in educational functioning [household adequacy, parental disposition, child performance])	Reported by one state
	Client satisfaction (under development)	Personal satisfaction with life	Texas Department of Protective and Regulatory Services
B. ADMINISTRATIVE DATA			
	Children participating in community activities	Social functioning	Reported use by one state
	School attendance	Social and academic functioning	Reported use by one state
	Sexually transmitted diseases among children	Sexually transmitted disease, sexual functioning	Reported use by one state
	Incidence of substance abuse among children	Drug abuse	Reported use by one state

Child Cognitive and Academic Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Reporting Use
Clinical Measures			
Level One			
	(CAFAS) Child and Adolescent Functional Assessment Scale	**Role performance, thinking, behavior towards others/self, moods/emotions, substance abuse.**	**Ventura County, CA; Wheeling, WV; Lorain County, OH; two other counties**
Level Two			
	(ACLSA) Ansell-Casey Life Skills Assessment	Knowledge and behavior in 18 life skill areas	
	(CYOS) The Casey Youth Outcomes Survey	Emotional health, family adjustment, cultural identification, competence and achievement, physical health, educational development, self-sufficiency, legal involvement, case history	
	(SIT) Slosson Intelligence Test for Children and Adults	Intelligence	
	(VABS) Vineland Adaptive Behavior Scales, Survey Form	Adaptive behaviors in communication, daily living skills, socialization, and motor skills	
ADDITIONAL CHILD COGNITIVE AND ACADEMIC FUNCTIONING MEASURES REPORTED TO BE IN USE BY PUBLIC CHILD WELFARE AGENCIES			
A. CLINICAL MEASURES			
	SCANS (Secretary's Commission on Achieving Necessary Skills, 1991)	Key skill areas that the U.S. Department of Education is recommending all youth in America acquire; personal qualities, interpersonal skills, thinking skills, resource and technology skills	Casey Family Program (long term foster care)
	Iowa Test of Basic Skills		Casey Family Program (long term foster care)
	Comprehensive Test of Basic Skills		Casey Family Program (long term foster care)
	Woodcock-Johnson Achievement Test (requires psychologist to administer)		Casey Family Program (long term foster care)
B. ADMINISTRATIVE DATA			
	School attendance	Social and academic functioning	Reported use by one state

Child Self Sufficiency			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Reporting Use
Clinical Measures			
Level One			
	(SPPA) Self-Perception Profile for Adolescents	Global Self-worth: scholastic competence, athletic competence, social acceptance, physical appearance, behavioral conduct, close friendship, romantic appeal, and job competence	
Level Two			
	(ACLSA) Ansell-Casey Life Skills Assessment	Self-sufficiency: Social/physical development, self-care, educational and vocational development, community and housing issues, moral development	Casey Family Program (long term foster care)
	(CYOS) The Casey Youth Outcomes Survey	Emotional health, family adjustment, cultural identification, competence and achievement, physical health, educational development, self-sufficiency, legal involvement, case history	
	(VABS) Vineland Adaptive Behavior Scales, Survey Form	Adaptive behaviors in communication, daily living skills, socialization, and motor skills	

DESCRIPTION OF LEVEL ONE MEASURES						
(CAFAS) Child and Adolescent Functional Assessment Scale						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Includes: ? Role performance ? Cognitions ? Behaviors toward others and self ? Moods and emotions ? Substance use	Children grades 1-12	Majority of children and youth in the Fort Bragg Evaluation Project were male, with a mean age of 11 years, from intact families with incomes above 20,000.	A case-worker knowledgeable of the child and family's functioning rates the youth Administration time approximately 10 minutes If information provided is inadequate, two supplements exists: 1. 30 min. telephone interview 2. Life-functioning data sheet	Captures case-workers' judgments about child's level of functioning. Time and cost efficient. No gender or racial/ethnic differences observed on total CAFAS score when comparing Caucasians, African-Americans and Hispanics. Useful in assessing outcome over time (although measure does not detect improvements past "average" functioning) and for directing case management services	Open to case-workers' subjective biases. Lacks detail needed to explore specific areas of functioning thoroughly. Because measure does not detect changes above the "average" level, measure is not appropriate for a strengths-based approach.	Internal consistency reliability ranged from .63 to .68. Test-retest reliability measure indicated good reliability. Inter-rater reliability measured at .92 for total CAFAS score. High content validity. Construct-related validity significant, yet only moderate. The psychometric data relies on ratings of case vignettes, not real cases.
Contact Information	Dr. Kay Hodges, 537 Mark Jefferson Bldg., Psychology Dept., Eastern Michigan University, Ypsilanti, MI 48197, Phone: (313) 769-9725					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for use of available child and family outcome measures (2nd edition). Boston, MA: Judge Baker Children's Center. Hodges, K. (1996). Summary of Psychometric Data on the CAFAS. Fax Hodges, K. & Wong, M.M. (1996). Psychometric characteristics of a multidimensional measure to assess impairment: The child and adolescent functional assessment scale. Journal of Child & Family Studies, 5, 445-467.					

DESCRIPTION OF LEVEL ONE MEASURES						
(CBCL) Child Behavior Checklist						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
The CBCL provides: ?? Total Problem Score ?? Two broad problem scales ?? Externalizing ?? Internalizing ?? Withdrawn ?? Somatic complaints ?? Anxious/Depressed ?? Social Problems ?? Thought Problems ?? Attention Problems ?? Delinquent Behavior ?? Aggressive Behavior ?? Sex Problems ?? Social Competence ?? Total Competence ?? 3 scale scores: ??Activities ??Social ??School	Children aged 4-18 years	2,368 children: 73% white; 16% African-American; 7% Hispanic; 4% other; 81% from middle to upper socioeconomic class	Informants are parents or other caregivers Self administered 138 item checklist; can also be administered by an interviewer Approximately 15-17 minutes to complete, may take longer Computerized scoring is available	The CBCL is the most thoroughly developed checklist for assessing children's behavior problems, has been used in numerous treatment outcome studies and program evaluations, and in studies in 15 different cultures. The CBCL is relatively easy to administer, detects change, may be used with a wide range of outpatient children, and is supported by data on very large samples. The scoring system enables children to be compared with appropriate age and sex group norms. Clinically, the CBCL can provide a research-based system for assessing and classifying children's problems and social competence	May potentially misrepresent the capability of such groups as children with chronic illness. It is rarely sufficient by itself as either a clinical or program evaluation tool. As it measures parents' perceptions, it is not objective and may be distorted in situations where parents exaggerate or minimize children's' problems. The complex format may result in substantial amounts of staff time devoted to helping parents complete the measure, especially if parents have limited reading skills. Its measurement of social competence may not be broad enough for many users.	There is considerable evidence for the reliability of the CBCL. Internal consistency is very high for the Total, Internalizing, and Externalizing scores and reasonably good for most of the scale scores. Internal consistency of the social competence scores is noticeably lower. Short-term test-retest reliability was high for both the problem and social competence scales. Inter-rater reliability between parents was reasonably high. A large body of research supports the validity of the CBCL for a number of different applications. In research studies, both the problem scales and social competence scales have discriminated between a number of different childhood problem groups and their respective comparison groups. Both of these scales have been used successfully to measure the effects of many different types of

						interventions
Contact Information	Achenbach, T.M. University Associates in Psychiatry, One South Prospect Street, Burlington, VT 05401-3456 Phone (801) 656-3270.					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (Second Edition). Boston, MA: Judge Baker Children's Center. Chapter 5…Questionnaires and Checklists. Steven Beck, Dept of Psych, OSU 79-106 Daugherty, T.K. & Shapiro, S.K. Behavior checklists and rating forms. In T.H. Ollendick, N.J. King, and W. Yule (Ed.), International Handbook of Phobic and Anxiety Disorders in Children and Adolescents (pp. 331-347). New York, NY: Plenum Press. Elliot, S.N., Busse, R.T., & Gresham, F.M. (1993). Behavior rating scales: issues of use and development. School Psychology Review, 22, 313-321. Emerson, E.N., Crowley, S.L., & Merrell, K.W. (1994). Convergent validity of the schools social behavior scales with the child behavior checklist and teacher's report form. Journal of Psychoeducational Assessment, 12, 372-380. Fagot, B.I. (1995). Classification of problem behaviors in young children: a comparison of four systems. Journal of Applied Developmental Psychology, 16, 95-106. Henning-Stout, M. (1998). Assessing the Behavior of Girls: What we see and what we miss. Journal of School Psychology, 36, 433-455. McConaughy, S.H. (1985). Using the child behavior checklist and related instruments in school-based assessment of children. School Psychology Review, 14, 479-494. McConaughy, S.H. (1993). Advances in empirically based assessment of children's behavioral and emotional problems. School Psychology Review, 22, 285-307. Lowe, L. (1998). Using the child behavior checklist in assessing conduct disorder. Research on Social Work Practice, 8, 286-301.					

DESCRIPTION OF LEVEL ONE MEASURES						
(CBCL 2-3) Child Behavior Checklist 2-3						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Includes: 1. Total Problem Score ? Internalizing problems ? Externalizing problems 2. Other Problem Score ? Anxiety and depression ? Withdrawal ? Sleep problems ? Somatic problems ? Aggressive behaviors	2-3 year-olds	183 younger siblings, ages 2-3, of the children used to establish previous national norms. An additional 185 children were randomly selected from communities in MA. 76% Caucasian 16% African-American 16% Latino 5% Other 29% upper-income level 37% middle-income level 34% low-income level	Self-administered. Parents are informants	Translated into Japanese, Korean and Spanish. Written at approximately a 5th grade reading level. Provides profiles for comparison with same age and gender children. Useful for assessment and measuring practitioner effectiveness.	Although the authors cite examples of its use, published studies using the CBCL 2-3 were not found.	Test-retest reliability moderate to high. .85 for 1 week, .64 for 1 year. Inter-parent agreement ranged from low to adequate. Convergent validity supported by significant correlations with the Behavior Checklist. Discriminant validity supported by non-significant correlations with several developmental scales. Discriminates between referred and non-referred children.
Contact Information	Achenback, T.M., University Medical Education, One South Prospect Street, Burlington, VT 05401-3456. Phone: (802) 656-8313 Fax: (802) 656-2602					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (2nd edition). Boston, MA: Judge Baker Children's Center.					

DESCRIPTION OF LEVEL ONE MEASURES						
(CDI) Children's Depression Inventory						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Depression	Children aged 8-13	1,266 children and young adolescents from Florida. No information is available on age-specific normative groups, nor on the ethnic/racial makeup of the sample.	Self-report instrument, consisting of 27 groups of sentences. Administrator reads each item aloud, gives the child time to choose and mark the sentence that best describes their thought/feelings for the past two weeks. Can be administered on an individual or group basis.	The instrument can be administered on an individual or group basis. Even though the CDI is not designed as a diagnostic measure it is useful in assessing the severity of depressive symptomatology	Although the CDI is a good indicator of self-reported distress in children, studies have demonstrated that it does not have adequate sensitivity and specificity to diagnose depression Lack of normative information	Research has shown that the CDI has an internal consistency that ranges from the lower to upper .80's. The test-retest had a mean score of .60 with a range between .38 and .87
Contact Information	Kovacs, Maria (1982)					
Citation(s)	Chapter 5…Questionnaires and Checklists. Steven Beck, Dept of Psych, OSU 79-106 Costello, E.J. & Angold, A. (1988). Scales to assess child and adolescent depression: checklists, screens, and nets. Journal of American Academy of Child and Adolescent Psychiatry, 27, 726-737. Crowley, S.L., Worchel, F.F., & Ash, M.J. (1992). Self-report, peer-report, and teacher-report measures of childhood depression: An analysis by item. Journal of Personality Assessment, 59, 1992. Daro, D. (1994). Healthy families America: A guide for evaluating healthy families America efforts. National Committee to Prevent Child Abuse. Fristad, M.A., Emery, B.L., & Beck, S.J. (1997). Use and abuse of the children's depression inventory. Journal of Consulting & Clinical Psychology, 65, 699-702. Reynolds, William M. (Ed); Johnston, Hugh F. (Ed); et al. (1994) Handbook of depression in children and adolescents. Issues in clinical child psychology. (pp.290-234). New York, NY, USA: Plenum Press. 616pp.					

DESCRIPTION OF LEVEL ONE MEASURES						
(CFEICA) Culture-Free Self-Esteem Inventories for Children						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Child Outcomes: ?? General self-esteem ?? Social/Peer-Related self-esteem ?? Academics/School Related self-esteem ?? Parent/Home-Related self-esteem ?? Lie items Adults Outcomes: ?? General self-esteem ?? Social self-esteem ?? Personal self-esteem ?? Lie items	Children and Adults	Students in elementary, junior high, and high school	Clinicians or teachers can administer the inventory, individually or in groups. However, group administration is not recommended for children below 3rd grade. It can be given orally or written There are 3 forms: A, B, and AD. A (60 items) and B (30 items) are for children, AD (40 items) is for adults All items are short statements with "yes" or "no" response options	CFEICA is a quick and easy-to-administer measure of self-esteem for children and adults that can be administered by clinicians, teachers and adults Measure has been used extensively for both research and clinical purposes Measure may also be helpful for identifying those in need of counseling or other psychotherapeutic services Instrument also measures therapeutic change and improvement	Systematic norming has not been conducted to determine if measure is truly "culture free"	Test-Retest reliability, content validity and concurrent validity have been demonstrated with all three forms of the inventory Internal consistency coefficients range from .66-.76 for Form A and .54-.78 for Form AD
Contact Information	James Battle, Ph.D. J.B. Preston Special Child Publications, P.O. Box 33548, Seattle, WA 98133					
Citation(s)	Daro, D. (1994). Healthy families America: A guide for evaluating healthy families America efforts. National Committee to Prevent Child Abuse. Chiu, L. (1988) . Measures of self-esteem for school-age children. Journal of Counseling and Development, 66, 298-301.					

DESCRIPTION OF LEVEL ONE MEASURES						
(DBRS: School Form) Devereux Behavior Rating Scale: School Form						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Includes: 1. Total Score 2. 4 Subscale Scores ? Interpersonal Problems ? Inappropriate Behaviors/Feelings ? Depression ? Physical/Fears	Age groups: 5-12 13-18	3,153 children aged 5-18 years and representative of US population in terms of ethnicity, race and education.	Teacher or home observer who has known child for at least 4 weeks is the informant. 40-item measure that contains separate levels of questions for both age groups, yet each level contains the four subscales.	Short length (takes approximately 10-15 minutes to administer) and versatility. The measure is considerably shorter than the Teacher Report Form (TRF), yet they share the same degree of reliability. Assesses changes in behavior over time as a function of educational placement and intervention.	Validity of scales for specific racial, ethnic and/or socioeconomic groups not yet established. Has never been used in outcome studies.	Internal reliability of total score ranged from .92 to .97. Test-retest reliability moderate to high. Intervals included 24 hours, 1, 2, and 3 weeks on both a clinical and regular education sample that ranged from .52 to .85. Inter-rater reliabilities moderate, ranging from .40 to .78. 6 validation studies concluded DBRS: School Form is comparable to other behavior rating scales in that it accurately distinguishing between children with and without disturbances.
Contact Information	The Psychological Corporation. Harcourt Brace & Company. 555 Academic Court, San Antonio, TX 78204-2498. Phone: 1-800-211-8378					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997) Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (2nd edition). Boston, MA: Judge Baker Children's Center.					

DESCRIPTION OF LEVEL ONE MEASURES						
(DSMD) Devereux Scales of Mental Disorders						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Identification of behaviors associated with psychopathology. The DSMD yields: ?? Six Subscales: ?? Conduct ?? Anxiety ?? Depression ?? Autism ?? Acute Problems ?? Attention (children aged 5-12 only) ?? Delinquency (youths aged 13-18 only) ?? Three Composite Scores: ?? Externalizing ?? Internalizing ?? Critical Pathology ?? A Total Scale Score	Children (age 5 -12) Youths (age 13-18)	Normed with sample of 3,153 children aged 5-18 years; 49% were males. The sample was chosen to be representative of the US population, and closely resembled the US population in terms of ethnicity, race and education. Actual statistics were unavailable.	111-item questionnaire; there are separate forms for ages 5-12 and 13-18. The form takes approximately 20-30 minutes to complete. Informants can be people who observe the child in home-like settings, and should be familiar with the child's behavior for at least four weeks prior to completing the form.	The form is designed at a sixth grade reading level. Its application is straightforward and could be useful to researchers investigating change in children's behavior over time in both specific areas as well as in the more general areas	No published studies were found that used this scale as an outcome measure for the evaluation of children's mental health. The DSMD does not have specific scales for somatic complaints and thought problems	The internal reliability of the total scale ranged from .97 to .98; reliabilities for the three composites ranged from .88 to .98. Test-retest reliability was high; at 24 hour and one week intervals the score ranged from .64 to .96. Inter-rater reliabilities ranged from .44 to .66. Studies provide evidence that the DSMS is reasonably accurate in identifying children with disturbances, compared to other measures, and very accurate in identifying children whose behavior falls within the normal range.
Contact Information	The Psychological Corporation. Harcourt Brace & Company. 555 Academic Court, San Antonio, TX 78204-2498. 1-800-211-8378					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (Second Edition). Boston, MA: Judge Baker Children's Center.					

DESCRIPTION OF LEVEL ONE MEASURES						
(ISCS) Inferred Self-Concept Scale						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Self-Esteem	Children in grades 1-6	180 children from 90 different classrooms.	30 items; informant is a teacher or counselor	The ISCS is easy to administer and score, and it is a relatively reliable instrument	Evidence of its validity is inadequate. It is unclear whether the instrument measures inferred concepts of self or behavior observations, because the items are a mixture of both.	Extensive data on reliability are presented in the manual. Evidence substantiating the scale's validity has not been presented
Contact Information	McDaniel, E.L. Western Psychological Services					
Citation(s)	Chiu, L. (1988). Testing the Test: Measures of Self-Esteem for School-Age Children. Journal of Counseling and Development, 66, 298-301.					

DESCRIPTION OF LEVEL ONE MEASURES						
(RADS) Reynolds Adolescent Depression Scale						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Evaluates the severity of depressive symptoms in adolescents by looking at five components of depression: ?? somatic ?? motivational ?? cognitive ?? mood ?? vegetative	Adolescents aged 12-18 years	Ethnically diverse sample of 2460 adolescents in grades 7 to 12	30 items rated on a 4 point scale Self-report Approximately 5-10 minute administration time	Scale requires only a 3rd grade reading level Hand scorable for individual and group adminstration There is evidence that it can be used as an outcome measure of treatment efficacy (measures change over time)	The standardization sample primarily consists of Caucasian and African American students from the midwest. Lack of independent, published studies replicating the research reported in the author's professional manual.	Reliability is high with both normal and depressed adolescents. Studies have shown internal consistencies of .87 and .88 Test-retest reliability was .80 within a six seek interval. Validity has been established in a number of studies, which show strong correlations with other self-report measures of depression
Contact Information	Reynolds (1986)					
Citation(s)	Reynolds, William M. (Ed); Johnston, Hugh F. (Ed); et al. (1994) Handbook of depression in children and adolescents. Issues in clinical child psychology. (pp. 290-234). New York, NY, USA: Plenum Press. 616pp. Davis, N. L. F. (1990) . The reynold's adolescent depression scale. Measurement & Evaluation in Counseling & Development, 23(2), 88-92.					

DESCRIPTION OF LEVEL ONE MEASURES						
(RCDS) Reynolds Child Depression Scale						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Depression	Children aged 8-13 years	1600+ children from diverse ethnic and socioeconomic backgrounds	30 items rated on a 4 point scale Self-report Approximately 10 minute administration time	Written at a 2nd grade reading level Data was normed on a diverse population Measures change over time; can be used as a treatment outcome Hand scorable for individual and group administration	There are not identified subscales for the instrument.	Internal consistency reported as .90, ranges from .88 to .92. Spanish language version used with sample of children from Puerto Rico had internal consistency of .83. Test-retest reliability was .85 within a four-week interval. Measure has high correlations with other self-report and clinical interview measures of childhood depression
Contact Information	Reynolds (1989)					
Citation(s)	Reynolds, William M. (Ed); Johnston, Hugh F. (Ed); et al. (1994) Handbook of depression in children and adolescents. Issues in clinical child psychology. (pp290-234). New York, NY, USA: Plenum Press. 616pp.					

DESCRIPTION OF LEVEL ONE MEASURES						
(SEQ-3) Self-Esteem Questionnaire						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
?? Self-esteem: Indicates feelings of success or importance. ?? Self-other satisfaction: Indicates the level to which the individual is satisfied with the degree of self-esteem attained	4th grade through adulthood	Not available	21 item self-report. Can be administered individually or in a group.	It has been successfully used as a diagnostic tool with elementary and secondary school children, and with potential child abusers. In its diagnostic capacity it can be used as an outcome measure of the effectiveness of treatments, or as an indicator of an individual's need for psychological services.	Does not measure domain-specific self-esteem.	The SEQ-3 has been shown to be a valid and appropriate instrument for psychologically normal or neurotic populations with normal intelligence.
Contact Information	Hoffmeister, J.K., Test Analysis and Development Corporation. 2400 Park Lake Drive, Boulder, CO 80301					
Citation(s)	Daro, D. (1994). Healthy families America: A guide for evaluating healthy families America efforts. National Committee to Prevent Child Abuse					

DESCRIPTION OF LEVEL ONE MEASURES						
(SPPA) Self-Perception Profile for Adolescents						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
?? Global Self-worth ?? Domain Specific Self-worth: ?? Scholastic Competence ?? Athletic Competence ?? Social Acceptance ?? Physical Appearance ?? Behavioral Conduct ?? Close Friendship ?? Romantic Appeal ?? Job Competence	Adolescents aged 14-18 years	651 students from Colorado, grades 8-11, from lower middle to upper middle class families, 90% white	45 item self-report. Each item presents two types of kids, respondents must choose which is most like him/her and whether this is "sort of" or "really" true of him/her	There is much overlap between the SPPA and the SPPC (Self-Perception Profile for Children), which allows for a comfortable switch between the two when children reach adolescence. If the additional subscales of the SPPA are not relevant to the adolescent, the SPPC can be used in it's place	There is still limited evidence of the scale's psychometric value	Internal consistency ranged from .55 to .92 with a mean of .89. No test-retest reliability has been reported. Factor analysis has yielded a relatively clear eight factor structure
Contact Information	Harter (1988). The Self-Perception Profile for Adolescents. University of Denver, CO. Department of Psychology, 2155 S. Race Street, Denver, CO 80208-0204					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (Second Edition). Boston, MA: Judge Baker Children's Center					

DESCRIPTION OF LEVEL ONE MEASURES						
(SPPC) Self-Perception Profile for Children						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
?? Global Self-Worth ?? Domain specific Self-Worth ?? Scholastic Competence ?? Athletic Competence ?? Social Acceptance ?? Physical Appearance ?? Behavioral Conduct	Children and adolescents aged 8-13 years, most appropriate for grades 3-6 (Separate forms are available for younger children)	1,543 students from Colorado, grades 3-8, from lower middle to upper middle class families, 90% white	36-item self-report questionnaire Children in grades 5 and above can fill out the form with little assistance; younger children may need the questionnaire read aloud Each item presents two types of children; respondents must choose which is most like him/her and whether this is "sort of" or "really" true of him/her Individual scores are directly influenced by the child's reference group (who the child compares her/himself to when filling out the form). As the instrument uses an unspecified reference group, administrators should obtain information on the group the child is comparing him/herself to	It has been used with diverse cultures: African-Americans, Hispanic, Dutch, French-Canadian, and Irish children Can be used for program evaluation and for individual clinical and diagnostic purposes	Appropriateness for use in special populations has yet to be demonstrated. There is evidence that the factor structure is different for mentally retarded and learning disabled children The instrument uses an unspecified reference group (see administration column)	Acceptable levels of internal consistency were reported for all six subscales across a large number of 3rd to 8th graders. The alpha ranged from .71 to .90. Test-retest correlations ranged from .40 to .83 Factor analysis suggests the measure is successfully tapping discrete areas of self-esteem. Adequate to good predictive, convergent, discriminant and construct validity are reported
Contact Information	Harter, S. (1985) University of Denver, CO. Department of Psychology, 2155 S. Race Street, Denver, CO 80208-0204 (303) 871-2478					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (Second Edition). Boston, MA: Judge Baker Children's Center					

DESCRIPTION OF LEVEL ONE MEASURES						
(TRF) Teacher's Report Form						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
This measure produces: ?? A Total Problem Score ?? Two broad problem scale scores: ?? Externalizing ?? Internalizing ?? Scores for: ?? Academic Performance ?? Adaptive Functioning (four characteristics) ?? Global Index of Adaptive Functioning ?? Eight Syndromes: ?? Anxious/ Depressed ?? Withdrawn ?? Social Problems ?? Somatic Complaints ?? Aggressive behavior ?? Delinquent Behavior ?? Thought Problems ?? Attention Problems	Children and adolescents age 5-18 years	1,391 children; 54% female; 76% White, 14% African-American, 7% Latino, and 3% other; 39% upper income, 43% middle income, and 18% lower income families	Self Administered (by teachers) 124 items Approximately 10 minutes to complete, may take longer depending on how extensive comments are Discriminates successfully between referred and non-referred children	Relatively quick to administer The TRF is useful and can supplement other sources of child behavior.	There is a need to use additional measures, given the limited range of behaviors that teachers observe and the low inter-teacher agreements. For the same reasons, users need to be very thoughtful about which teacher(s) should complete the measure for a given child. An item content review reveals potential limitations of these systems when used to assess preadolescent and adolescent girls	Test-retest reliability was high (.90 for adaptive scales; .92 for problem scales) over an interval of 15 days for all but one syndrome scale in girls: Thought Problems (.43). Inter-rater agreement between teachers ranges from low to adequate, with most scores in the mid .50's. Validity for this scale is evidenced by correlations with the Conners Revised Teacher Rating Scale, and correlations with ratings of school behavior made by classroom observers. Successfully discriminates between referred and non-referred children
Contact Information	Achenbach, T.M. University medical Education, One South Prospect Street, Burlington, VT 05401-3456 Phone (802) 656-8313. Fax (802) 656-2602.					

Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (Second Edition). Boston, MA: Judge Baker Children's Center. Chapter 5…Questionnaires and Checklists. Steven Beck, Dept of Psych, OSU 79-106 Elliot, S.N., Busse, R.T., & Gresham, F.M. (1993). Behavior rating scales: issues of use and development. School Psychology Review, 22, 313-321. Emerson, E.N., Crowley, S.L., & Merrell, K.W. (1994). Convergent validity of the schools social behavior scales with the child behavior checklist and teacher's report form. Journal of Psychoeducational Assessment, 12, 372-380. Fagot, B.I. (1995). Classification of problem behaviors in young children: a comparison of four systems. Journal of Applied Developmental Psychology, 16, 95-106. Henning-Stout, M. (1998). Assessing the Behavior of Girls: What we see and what we miss. Journal of School Psychology, 36, 433-455. Lowe, L. (1998). Using the child behavior checklist in assessing conduct disorder. Research on Social Work Practice, 8, 286-301. McConaughy, S.H. (1985). Using the child behavior checklist and related instruments in school-based assessment of children. School Psychology Review, 14, 479-494. McConaughy, S.H. (1993). Advances in empirically based assessment of children's behavioral and emotional problems . School Psychology Review, 22, 285-307.
Agencies Using	Casey Family Program

DESCRIPTION OF LEVEL ONE MEASURES						
(WSDI) Wahler Self Description Inventory						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Assesses quality of individuals' self-evaluations. Outcomes include: ? Individual's problems ? Defensiveness ? Self-perception ? Values ? Methods of adaptation.	High school students	Not Available	66 item self-evaluation. 10-15 minutes to administer. No other information available.	Used widely with subpopulations including mental health clients, hospitalized psychiatric patients, rehabilitation patients, social security claimants, and high school/college students. Requires only a 6th grade reading level. Sensitive to one's potential for change and attainment of therapeutic change.	Need a definition of different types of rehabilitation patients.	Internal consistency, concurrent validity and stability of the WSDI have been empirically documented
Contact Information	H.J. Wahler, Ph.D. Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025					
Citation(s)	Western Psychological Services					

DESCRIPTION OF LEVEL ONE MEASURES						
(YSQ) Youth Satisfaction Questionnaire						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Outcomes include general satisfaction with quality of care, a rating of the quality of each service received, and single questions about whether adolescents received too much or too little help.	Children and youths aged 9-18 years	Sample was predominantly white (68%) and male (72%), who were receiving services within the community	Self-report. Respondents are asked five questions concerning care and amount of help received. They are then asked to list the services received and to give each a grade.	Unique in measuring youth's opinions, it has the added benefit of being flexible for use with the specific set of services children receive.	The instrument does not measure specific components of quality of care. It gives limited information about how to develop care. The issue of positive bias of satisfaction measures must be considered for this measure as well.	The only information available is about internal consistency of the three item general satisfaction score, which is adequate. Information is needed on the stability and validity of this measure, although this is admittedly difficult to assess with client satisfaction measures. The client's bias toward positive or negative responses should be assessed.
Contact Information	Regional Research Institute for Human Services, Oregon Partners Project Evaluation, Portland State University, P.O. Box 751, Portland, OR 97297, Phone (503) 725-4040					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (Second Edition). Boston, MA: Judge Baker Children's Center. Lowe, L. (1998). Using the child behavior checklist in assessing conduct disorder. Research on Social Work Practice, 8, 286-301.					
Agencies Using	The Youth Satisfaction Questionnaire is one of the measures required of states participating in the federally funded Comprehensive Community Mental Health Services Program for Children with Serious Emotional Disturbances.					

Measures of Family Functioning

The following table lists reviewed clinical measures organized by domain and utility. The criteria used to determine the usefulness of measures to public child welfare services are: 1) Measure addresses specific domains relevant to child welfare; 2) Ease of administration and interpretation; 3) Measure takes less than 20 minutes to administer; and 4) Measure detects clinical change over time.

Level One Measures: meet all four criteria. These measures link to full summaries provided at this site.

Level Two Measures: Meet several criteria and may be appropriate for some agency purposes.

Level Three Measures: Information necessary for criteria review was unavailable at the time of publication or measure may have some relevance but may have other limiting factors such as time or type of personnel required for administration.

Included in the reviewed clinical measures for each domain are measures reported to be in use; either by agencies participating in the *National Study of Outcome Measurement in Public Child Welfare Services* or by agencies reporting measurement activities at conferences or on the internet. These clinical measures include some which have been adapted by agencies for their own use (hybrids). Contact information is provided where available. As some of the measures reported to be in use by agencies span several domains, some duplication of measures occurs. Descriptions of each measure, including population addressed, number of items, and time to administer (where information was available at the time of publication) are listed in the table entitled "Measuring Child and Family Functioning." In some instances agencies participating in the *National Study* requested confidentiality. In these cases only the number of agencies using the measure are listed, rather than the agency name(s).

FAMILY FUNCTIONING

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
Quality of Home Environment			
Level One			
	(FES) Family Environmental Scale	Cohesion, expressiveness, conflict, independence, achievement, intellectual orientation, active/recreational orientation, moral/religious orientation, organization, control	Ventura County, CA; Schuykill County, PA
	(FRS) Family Resources Scale	8 subscales of need: Growth/Support, Health/Necessities, Nutrition/Protection, Physical Shelter, Intrafamily Support, Communication/Employment, Childcare, Income	Pennsylvania
Level Two			
	(BCQ) Burden of Care Questionnaire	Disruption of family life and relationships, demands on time, negative mental and physical health effects for family members, financial strain, disruption of social/community life for family members and worry, emotional strain, and embarrassment	
	Child Well-Being and Family Risk Scales (CWLA)	Child capacities, child role performance, familial capacities, parenting role performance. Reduction in out-of-home placements; reduction in subsequent abuse/neglect reports; increase in educational functioning (Household adequacy, parental disposition, child performance)	Reported use by one county and one state
	(CLL) Childhood Level of Living Scale	Care of the child, physical and emotional; cognitive development of the child	

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
Quality of Home Environment (con't.)			
	(CYOS) The Casey Youth Outcomes Survey	Emotional health, family adjustment, cultural identification, competence and achievement, physical health, educational development, self-sufficiency, legal involvement, case history	Casey Family Program (long term foster care)
	(VABS) Vineland Adaptive Behavior Scales, Survey Form	Adaptive behaviors in communication, daily living skills, socialization, and motor skills	
	(VSTCP) Vermont System for Tracking Client Progress	Physical aggression, sexual acting out, substance abuse, verbal abuse, self-confidence, compliance, school attendance, and parent contact	
Level Three			
	(FCAM) Family Concept Assessment Method	Family congruence, family satisfaction, and family effectiveness	
	(FEF) Family Evaluation Form	Interpersonal relationships, child's adjustments to their environment, marital satisfaction, and child-rearing practices	
	(FFFS) Feetham Family Functioning Survey	Relationship between the family and the subsystem; and the relationship between the family and the broader community	
	(FFS) Family Functioning Scale	Cohesion, expressiveness, conflict, intellectual-culture orientation, active-recreational orientation, religious emphasis, organization, family sociability, external locus of control, family idealization, disengagement, demographic family style, laissez-faire family style, authoritarian family style, and enmeshment	
	(FFSS) Family Functioning Style Scale	Commitment; appreciation; time together; sense of purpose; sense of congruence; ability to communicate; family rules, values, and beliefs; coping strategies; problem-solving; positivism; flexibility and adaptability; and balance	
	(FHI) Family Hardiness Index	Stressors, family types, resources, and outcomes for both acute and long-term stressors	

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
ADDITIONAL QUALITY OF HOME ENVIRONMENT MEASURES REPORTED TO BE IN USE BY AGENCIES			
	NORTH CAROLINA SUPPORT OUTCOME SCALE		NORTH CAROLINA
	North Carolina Family Assessment Scale (NCFAS)	Environment, social support, family interactions	Reported use by one state and two counties
	TNFAS (Tennessee Children's Mental Health Services Research Center)	Social isolation, family cohesion, problem solving skills, parent child interaction, family resources, family stability	Tennessee Department of Children's Services
	Family Assessment Measure (FAM)		Ventura County, CA
	Creating a New System of Care: Building a Stronger Child and Family Partnership	Indicators listed in questionnaire and safety, permanence/stability, and physical well-being	Alabama

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
Conflict Management			
Level One	(FES) Family Environmental Scale	Cohesion, expressiveness, conflict, independence, achievement, intellectual orientation, active/recreational orientation, moral/religious orientation, organization, control	Ventura County, CA; Schuykill County, PA
	(SFI) Self-Report Family Inventory	Health, conflict, communication, cohesion, leadership, and expressiveness	
Level Two			
	Child Well-Being and Family Risk Scales (CWLA)	Child capacities, child role performance, familial capacities, parenting role performance. Reduction in out-of-home placements; reduction in subsequent abuse/neglect reports; increase in educational functioning (Household adequacy, parental disposition, child performance)	Reported use by one county and one state
	Family Adaptability and Cohesion Scales (FACES)	Cohesion, adaptability and change	Ventura County, CA
	(FAD) Family Assessment Device	Problem solving, communications, roles, affective responsiveness, affective involvement, behavior control, general functioning	Pennsylvania
	(FAF) Family Assessment Form	Assess family functioning to develop treatment plans and evaluate outcomes	Philadelphia, PA (In home services, family foster care, congregate care, and other service types)
Level Three			
	(FEF) Family Evaluation Form	Interpersonal relationships, child's adjustments to their environment, marital satisfaction, and child-rearing practices	
	(FFS) Family Functioning Scale	Cohesion, expressiveness, conflict, intellectual-culture orientation, active-recreational orientation, religious emphasis, organization, family sociability, external locus of control, family idealization, disengagement, demographic family style, laissez-faire family style, authoritarian family style, and enmeshment	
	(FFSS) Family Functioning Style Scale	Commitment; appreciation; time together; sense of purpose; sense of congruence; ability to communicate; family rules, values, and beliefs; coping strategies; problem-solving; positivism; flexibility and adaptability; and balance	
	(FHI) Family Hardiness Index	Stressors, family types, resources, and outcomes for both acute and long-term stressors	

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
ADDITIONAL CONFLICT MANAGEMENT MEASURES REPORTED TO BE IN USE BY AGENCIES			
	TNFAS (Tennessee Children's Mental Health Services Research Center)	Social isolation, family cohesion, problem solving skills, parent child interaction, family resources, family stability	Tennessee Department of Children's Services
	Brief Family Assessment Scale (BFAS)	Family strengths, resources, and problem areas	Arizona
	Family Crisis Oriented Personal Evaluation Scales		Ventura County, CA

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
Parental Behavior al Health			
Level One			
	(PSI) Parenting Stress Index	Child characteristics: adaptability, acceptability, mood, and hyperactivity. Parent characteristics: depression, attachment, restriction of role, sense of competence, social isolation, relationship with spouse, and parental health	
	(SFI) Self-Report Family Inventory	Health,conflict, communication, cohesion, leadership, and expressiveness	
Level Two			
	(BCQ) Burden of Care Questionnaire	Disruption of family life and relationships, demands on time, negative mental and physical health effects for family members, financial strain, disruption of social/community life for family members and worry, emotional strain, and embarrassment	
	Child Well-Being and Family Risk Scales (CWLA)	Child capacities, child role performance, familial capacities, parenting role performance. Reduction in out-of-home placements; reduction in subsequent abuse/neglect reports; increase in educational functioning (Household adequacy, parental disposition, child performance)	Reported use by one county and one state
	(FAD) Family Assessment Device	Problem solving, communications, roles, affective responsiveness, affective involvement, behavior control, general functioning	Philadelphia, PA (In home services, family foster care, congregate care, and other service types)
	(FAF) Family Assessment Form	Assess family functioning to develop treatment plans and evaluate outcomes	Pennsylvania
Level Three	There are various scales/measures developed for adult mental health and drug use. Two examples are offered below.		
	(BDI) Beck Depression Inventory	Depression	
	(CES-DS) Center for Epidemiological Studies-Depression Scale	Depression	
ADDITIONAL PARENTAL BEHAVIORAL HEALTH MEASURES REPORTED TO BE IN USED BY AGENCIES			
	Alcohol and drug use in parents preceding and following substitute care for child	Substance use/abuse of parents	Reported use by one state
	Incarcerations/arrests	Criminal activity	Reported use by one state

Family Functioning

Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
Parental Functioning			
Level One			
	(CAP) Child Abuse Inventory	Distress, rigidity, unhappiness, problems with the child and oneself, with the family, and with others	
	(CFSEICA) Culture-Free Self-Esteem Inventories for Children and Adults	Child outcomes include: general self-esteem, social/peer-related self-esteem, academics/school related self-esteem and parents/home-related self-esteem; adults outcomes include: general self-esteem, social self-esteem and personal self-esteem	
	Family Environmental Scale (FES)	Cohesion, expressiveness, conflict, independence, achievement, intellectual orientation, active/recreational orientation, moral/religious orientation, organization, control	Ventura County, CA; Schuykill County, PA
	(FRS) Family Resources Scale	8 subscales of need: Growth/Support, Health/Necessities, Nutrition/Protection, Physical Shelter, Intrafamily Support, Communication/Employment, Childcare, Income	Pennsylvania
	(FSS) Family Support Scale	Number of social supports, satisfaction with existing support, and degree of perceived helpfulness	
	Index of Family Relations	Measures the degree or severity of a problem in family relationships	
	Index of Parental Attitudes	Measures the degree, severity or magnitude of a problem in a parent-child relationship	
	(PCRI) Parent-Child relationship Inventory	Parental support, satisfaction with parenting, involvement, communication, limit setting, autonomy, and role orientation	
	(PSI) Parenting Stress Index	Child characteristics: adaptability, acceptability, mood, and hyperactivity. Parent characteristics: depression, attachment, restriction of role, sense of competence, social isolation, relationship with spouse, and parental health	
	(SFI) Self-Report Family Inventory	Health, conflict, communication, cohesion, leadership, and expressiveness	
	(WSDI) Self-Report Family Inventory	Defensiveness, self-perception, values and methods of adaptation	

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
Level Two			
	(BCQ) Burden of Care Questionnaire	Disruption of family life and relationships, demands on time, negative mental and physical health effects for family members, financial strain, disruption of social/commun ity life for family members and worry, emotional strain, and embarrassment	
	Child Well-Being and Family Risk Scales (CWLA)	Child capacities, child role performance, familial capacities, parenting role performance. Reduction in out-of-home placements; reduction in subsequent abuse/neglect reports; increase in educational functioning (Household adequacy, parental disposition, child performance)	Reported use by one county and one state
	(FACESII) Family Adaptability and Cohesion Evaluation Scales	Cohesion, adaptability and change	Ventura County, CA
	Family Assessment Device (FAD) (McMaster)	Problem solving, communications, roles, affective responsiveness, affective involvement, behavior control, general functioning	Pennsylvania
	Family Assessment Form (FAF) (Children's Bureau of Southern California and CWLA)	Assess family functioning to develop treatment plans and evaluate outcomes	Philadelphia, PA (In home services, family foster care, congregate care, and other service types)
	(FDM) The Family Dynamics Measure	Information processing and role structure	
	(FIRA-G) Family Index of Regenerativity and Adaptation-General	Family Stressors, Family Strains, Relative and Friend Support, Social Support, Family Coherence, Family Hardiness, and Family Distress	
Level Three	See parental behavioral health		
	(FCAM) Family Concept Assessment Method	Family congruence, family satisfaction, and family effectiveness	
	(F-COPES) The Family Crisis Oriented Personal Evaluation Scales	Ability to acquire social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal	
	(FEF) Family Evaluation Form	Interpersonal relationships, child's adjustments to their environment, marital satisfaction, and child-rearing practices	
	(FFFS) Feetham Family Functioning Survey	Relationship between the family and the subsystem; and the relationship between the family and the broader community	
	(FFI) Family Functioning Index	Intra-family communications, cohesiveness, decision-making, marital satisfaction, and general happiness and closeness of the family	

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
	(FFS) Family Functioning Scale	Cohesion, expressiveness, conflict, intellectual-culture orientation, active-recreational orientation, religious emphasis, organization, family sociability, external locus of control, family idealization, disengagement, demographic family style, laissez-faire family style, authoritarian family style, and enmeshment	
	(FFSS) Family Functioning Style Scale	Commitment; appreciation; time together; sense of purpose; sense of congruence; ability to communicate; family rules, values, and beliefs; coping strategies; problem-solving; positivism; flexibility and adaptability; and balance	
	(FHI) Family Hardiness Index	Stressors, family types, resources, and outcomes for both acute and long-term stressors	
	(ISEL) Interpersonal Support Evaluation List	Perceived availability of: tangible resources, appraisal, self-esteem, and a sense of belonging	
	(ISSB) The Inventory of Socially Supported Behaviors	Material aid, physical assistance, intimate interaction, guidance, feedback, and social participation	
	(MSSI) The Inventory of Socially Supported Behaviors	Help with daily tasks, satisfaction with visits from kin or relatives, help with crisis, emergency childcare, satisfaction with communication from a male support figure, satisfaction with communication from another adult, and community involvement	
	(MSPP) Michigan Screening Profile of Parenting	Parent's expectation of their child, relationship with their own parents, ability to cope, and degree of emotional support in interpersonal relationships	

Family Functioning			
Utility of Measure	Measure/Scale	Outcomes Measured	Public Agency Using Measure
ADDITIONAL PARENTAL FUNCTIONING MEASURES REPORTED TO BE IN USE BY AGENCIES			
	(NCFSOS) North Carolina Family Support Outcomes Scale	Child well-being, family interactions, social support, family's environment, responsibility of caregiver, overall child functioning, overall parental functioning, overall family functioning, and overall community functioning	
	CFFAS (NCFAS/CAFAS hybrid) (Mental Health Board of Lucas County, Toledo, OH)		Lucas County, OH
	Family Assessment Measure (FAM)		Ventura County, CA
	Family and Children's Scale		Shuykill County, PA
	Family Assessment of Needs (Children's Research Center, National council on Crime Delinquency, Madison, WI)		Reported use by two states
	Adolescent and Adult Parenting Inventory (Family Development Resources)	Reduction in out-of-home placements; reduction in subsequent abuse/neglect reports; increase in educational functioning	Reported use by one county
	TNFAS (Tennessee Children's Mental Health Services Research Center)	Social isolation, family cohesion, problem solving skills, parent child interaction, family resources, family stability	Tennessee Department of Children's Services
	Brief Family Assessment Scale (BFAS)	Family strengths, resources, and problem areas	Arizona

DESCRIPTION OF LEVEL TWO MEASURES						
(ACLSA) Ansell-Casey Life Skills Assessment						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Outcomes include knowledge and behavior in the following areas: ? Social development ? Educational and vocational development ? Money, housing, and transportation ? Physical development and self-care ? Moral development	Ages: 8-11 (ACLSA-I) 12-15 (ACLSA-II) 16-19 (ACLSA-III)	ACLSA II was field tested on 219 foster parents and youth (ages 12-15) in the Casey Family Program. ACLSA I and III similarly tested one year later.	Youth and caregivers complete, then agency either hand scores results or sends scores via the internet for analysis.	Youth and caregivers: Identifies youths' strengths and weaknesses Facilitates discussion about skills. Provides caregivers with methods for teaching self-sufficiency skills. Direct service provider: Involves both caregiver and youth in goal setting. Time-efficient but provides rich info. Programs/agencies: Identifies needs for program planning. Useful for setting and monitoring agency outcome goals. Provides useful information about youth life skills for funding purposes.	Only measures life skills. Additional measures must be utilized to obtain information about other competencies, such as emotional stability.	The majority of subscale reliabilities are greater than .65
Contact Information	Dorothy Ansell, The Casey Family Program, Research Department, 1300 Dexter Ave. North, Suite 400. Seattle, WA 98109-354. Phone: (206) 282-7300.					
Citation(s)	ACLSA order form Nollan, K. A., Wolf, M., Ansell, D., Burns, J., Barr, L., Copeland, W., & Paddock, G. (2000). Ready or not: Assessing youths' preparedness for independent living. Child Welfare, 79(2), 159-176.					

DESCRIPTION OF LEVEL TWO MEASURES						
(BCQ) Burden of Care Questionnaire						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Outcomes include: ? Disruption of family life and relationships ? Demands on time ? Negative mental and physical health effects ? Financial strain ? Disruption of social life ? Emotional strain, worry and embarrassment.	Parents of children aged 5-17 years.	Predominantly Caucasian (72%), military families with male (63%) children. 50% of children were between the ages of 12 and 18. 83% of parental respondents were female.	Parent reflects on previous 6 months and self-report.	Brief Easy to administer Captures caregivers' perceptions of burden.	Applicability to different populations has not yet been established. Additional information needed about scale's correlation with variables other then family functioning and parental mental health (i.e. child functioning).	Subscales and scale as a whole have good internal consistency. Factor analyses supports three distinct, but related dimensions of Objective, Internalized Subjective, and Externalized Subjective Burden. BCQ correlates with the Family Assessment Device and the Brief Symptom Inventory.
Contact Information	Resource Specialist, Center for Mental Health Policy, Vanderbilt Institute for Public Policy, Box 163 Peabody, Nashville, TN 37203 Phone: (615) 322-8925.					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (2nd Ed.). Boston, MA: Judge Baker Cihldren's Center.					

DESCRIPTION OF LEVEL ONE MEASURES						
(CAFAS) Child and Adolescent Functional Assessment Scale						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Includes Child's: ? Role performance ? Cognitions ? Behaviors toward others and self ? Moods and emotions ? Substance use Caregiver's: ? Capacity to provide for child's basic needs ? Social Support	Children grades 1-12	Majority of children and youth in the Fort Bragg Evaluation Project were male, with a mean age of 11 years, from intact families with incomes above 20,000.	A case-worker knowledgeable of the child and family's functioning administers scale. Administration time approximately 10 minutes If information provided is inadequate, two supplements exists: 3. 30 min. telephone interview 4. Life-functioning data sheet	Captures case-workers' judgements about child's level of functioning. Time and cost efficient. No gender or racial/ethnic differences observed on total CAFAS score when comparing Caucasians, African-Americans and Hispanics. Useful in assessing outcome over time (although measure does not detect improvements past "average" functioning) and for directing case management services	Open to case-workers' subjective biases. Lacks detail needed to explore specific areas of functioning thoroughly. Because measure does not detect changes above the "average" level, measure is not appropriate for a strengths-based approach.	Internal consistency reliability ranged from .63 to .68. Test-retest reliability measure indicated good reliability. Inter-rater reliability measured at .92 for total CAFAS score. High content validity. Construct-related validity significant, yet only moderate. The psychometric data relies on ratings of case vignettes, not real cases.
Contact Information	Dr. Kay Hodges, 537 Mark Jefferson Bldg., Psychology Dept., Eastern Michigan University, Ypsilanti, MI 48197. Phone: (313) 769-9725					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for use of available child and family outcome measures (2nd edition). Boston, MA: Judge Baker Children's Center. Hodges, K. (1996). Summary of Psychometric Data on the CAFAS. Fax Hodges, K. & Wong, M.M. (1996). Psychometric characteristics of a multidimensional measure to assess impairment: The child and adolescent functional assessment scale. Journal of Child & Family Studies, 5, 445-467.					

DESCRIPTION OF LEVEL ONE MEASURES						
(CAP) Child Abuse Potential Inventory						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Assesses parents' risk for physical child abuse. Outcomes include: ? Distress ? Rigidity ? Unhappiness ? Problems with child and oneself ? Family problems ? Problems with others	Parents	110 parents known to physically abuse their children were matched with demographically similar comparison subjects with no know history of physical abuse. Sample obtained from OK and NC. 50% of parents were high school educated and married. 67% were Caucasian.	Parents self-administer 160 items Forced choice format Approximately 10-20 minutes to complete	Written at a 3rd grade reading level. Spanish version exists. Useful in assessing current risk for child abuse. Sensitive to reductions in child abuse potential.	CAP is not intended to assess other parenting skills or abilities besides risk of parental physical abuse.	Internal consistency reliability ranged from .74 to .98. Split-half reliabilities of 1 day to 6 month intervals ranged from .75-.91. Evidence supports construct and criterion validity.
Contact Information	Milner, J.S.					
Citation(s)	Heinze, M.C., & Grisso, T. (1996). Review of instruments assessing parenting competencies used in child custody evaluations. Behavioral Sciences and the law, 14, 293-313.					

DESCRIPTION OF LEVEL ONE MEASURES						
(CFSEIC) Culture-Free Self-Esteem Inventories for Children						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
1. Child Outcomes ? General self-esteem ? Social self-esteem ? Academic self-esteem ? Home-related self-esteem 2. Parent Outcomes ? General self-esteem ? Social self-esteem ? Personal self-esteem	Children grades 3-9 Adults	Students in: Elementary school Junior high school High school	Clinicians or teachers can administer the inventory, individually or in groups. However, group administration is not recommended for children below 3rd grade. It can be given orally or written There are 3 forms: A, B, and AD. A (60 items) and B (30 items) are for children, AD (40 items) is for adults All items are short statements with "yes" or "no" response options	CFEICA is a quick and easy-to-administer measure of self-esteem for children and adults that can be administered by clinicians, teachers and adults Measure has been used extensively for both research and clinical purposes Measure may also be helpful for identifying those in need of counseling or other psychotherapeutic services Instrument also measures therapeutic change and improvement	Degree that measure is truly "culture-free" is questionable considering there have not been any systematic norming studies to confirm this assumption.	Test-retest reliability, content validity and concurrent validity have been demonstrated on all three forms of the inventory. Internal consistency coefficients range from .66-.76 for Form A and .54-.78 for Form AD
Contact Information	Dr. James Battle, J.B. Preston Special Child Publications, P.O Box 33548, Seattle, WA 98133					
Citation(s)	Daro, D. (1994). Healthy families American: A guide for evaluating healthy families America efforts. National Committee to Prevent Child Abuse.					

DESCRIPTION OF LEVEL TWO MEASURES						
(CLL) Childhood Level of Living Scale						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Care of child in the home measured with following outcomes: ? Part A: Physical care (food, shelter, clothing safety, health care) ? Part B: Emotional/ Cognitive care (discipline, affection, emotional support and cultural stimulation)	Children 4-7 years of age.	Originally developed for use in rural Appalachia and later revised for a low-income urban population.	Service provider administers. 99-items total. Part A: Physical Care, 47 items, 5 subscales Part B: Emotional/ Cognitive Care, 53 items, 4 subscales Specific, discrete statements requiring a "true or "false" response.	Avoids service providers' subjectivity and biases in assessment by requesting very specific, observable information. All items are weighted equally when scored.	Limited to families with young children.	Reliability and validity well established. Intercorrelations between subscales ranged from .63 to .88
Contact Information	Dr. Norman Polansky, School of Social Work, University of Georgia, Athens, GA 30602					
Citation(s)	Cabral, R. J. & Strang, M. (1984). Measuring Child Care: An examination of three assessment measures. Journal of Social Service Research, 6, 45-55.					

DESCRIPTION OF LEVEL TWO MEASURES						
(CYOS) Casey Youth Outcomes Survey						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Assess youth functioning in the following areas: ? Physical and emotional health ? Family adjustment and other relationships ? Cultural identification ? Competence and achievement ? Educational development ? Self-sufficiency ? Legal and case history	Youth ages 6 and older.	Not available at time of this publication.	Clinician administers the 154 item survey using the last 6 months as the time frame.	Useful for clinical research as well as practical program evaluation. Sensitive to clients' clinical change over time.	Must be administered by a clinician.	Not available at the time of this publication.
Contact Information	The Casey Family Program Corporate Headquarters, 1300 Dexter Avenue North, Seattle, WA 98109. Phone: (206) 282-7300.					
Citation(s)	Pecora, P., Adams, B., LeProhn, N.S., Paddock, G., and Wolf, M. (1998). Assessing Casey Youth Outcomes: A working Paper and List of Indicators. Seattle, WA: The Casey Family Program.					

DESCRIPTION OF LEVEL TWO MEASURES						
(DDST) Denver Developmental Screening Test						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Detects developmental delays in the following areas: ? Personal/social ? Fine motor-adaptive behaviors ? Language ? Gross motor coordination	Children 2 weeks to 6 years old.	A representative sample of 1036 developmentally normal male and female children.	Clinician administers the appropriate test items to parent and child. 65 items. Approximately 20 minutes to administer.	Administrators do not need training in psychological testing to administer the DDST. Easy to administer and score. Can be used in repeat evaluations of the same child. Proven effective in predicting later school learning problems	Lack of psychometric data. Fails to provide an in-depth assessment of intelligence, hearing or motor development. Interpretation of results requires considerable knowledge of child development.	Test-retest reliability at one-week intervals was calculated. Scores ranged from between .66 to .93. .
Contact Information	Frankenber, W.R., Dodd, J.B. and Fandal, A.W., Denver Developmental Material, Inc. P.O. Box 6919, Denver, CO 80206-0919					
Citation(s)	Daro, D. (1994). Healthy families America: A guide for evaluating healthy families America efforts. National Committee to Prevent Child Abuse.					

DESCRIPTION OF LEVEL TWO MEASURES						
(FACES II) Family Adaptability and Cohesion Evaluation Scales						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Families classified in one of three categories: 1. Balanced 2. Mid-range 3. Extreme Families further classified into one of four types: 1. Flexibly separated 2. Flexibly connected 3. Structurally separated 4. Structurally connected	Family members	1,140 couples/families, including 412 adolescents from across the nation.	Case-manager or primary caregiver administers the 30 item scale.	Measure has been used with diverse populations such as Hispanics, Czech, Japanese, Austrian, Australian, Italian, heterosexual and homosexuals.	Moderately difficult for clinician to determine how to analyze and use this scale in a practical way.	Cronbach's alpha is .87 for cohesion, .78 for adaptability, and .90 for the total score.
Contact Information	Dr. David N. Olson, Family Social Service, 290 McNeal Hall, University of Minnesota, St. Paul, MN 55108 Phone: (612) 625-7250 Fax: (612) 625-4227					

Citation(s)	Daro, D. (1994). Healthy families America: A guide for evaluating healthy families America efforts. National Committee to Prevent Child Abuse. Cross, T., McDonald, E., Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measure (2nd Edition). Boston, MA: Judge Baker Children's Center. Forman, B.D. & Hagan, B.J. (1983). A comparative review of total family functioning measures. American Journal of Family Therapy, 11, 25-40. Sawin, K.J. & Harrigan, M.P. (1995). Measuring of Family Functioning for Research and Practice. New York, NY: Springer Publishing Company. Schmid, K.D., Rosenthal, S.L., & Brown, E.D. (1988). A comparison of self-report measures of two family dimensions: Control and cohesion. American Journal of Family Therapy, 16, 73-77. Skinner, H.A. (1987). "Self-report Instruments for Family Assessment" -chapter- Jacob, T. (Ed); et al. (1987). Family interaction and psychopathology: Theories, methods and finding. Applied Clinical Psychology. 427-452. Tutty, L.M. (1995). Theoretical and practical issues in selecting a measure of family functioning. Research on Social Work Practice, 5, 80-106.

DESCRIPTION OF LEVEL TWO MEASURES						
(FDM) Family Dynamics Measure						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Outcomes for a healthy family include: ? Identity process ? Change ? Information processing ? Role structure	Family members.	Not available at time of this publication.	Family members self-report.	Written at a 3rd grade reading level. The FDM has extensive cross-cultural use. It has been translated for use in Iceland, Denmark, Sweden, Finland, Estonia and Norway.	Lack of extensive data on validity and reliability. Questionable reliability on select scales.	Internal consistency varied considerably across the three initial samples. Some of the subscales were correlated rather highly and it is undetermined if they are considered distinct scales. Test-retest data not available.
Contact Information	A family interest group of nurse researchers who were affiliated with the Midwest Nursing Research Society.					
Citation(s)	Sawin, K. J. & Harrigan, M.P. (1995). Measures of Family Functioning for Research and Practice. New York, NY: Springer Publishing Company.					

DESCRIPTION OF LEVEL TWO MEASURES						
(FIRA-G) Family Index of Regenerativity and Adaptation-General						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
? Family stressors ? Family strains ? Relative and friend support ? Social support ? Family coherence ? Family hardiness ? Family distress	Comparative data across 4 states of the family cycle: 1. Couple stage 2. Preschool/school age stage 3. Adolescent launching stage 4. Empty nest/ Retirement stage	Varies for each of the seven instruments comprising the FIRA-G.	Adult family members are the informants.	The seven instruments cover a broad range of outcomes. Specific outcomes can be selected to meet particular agency performance goals.	Few, if any, published studies that have used the FIRA-G. Because it is a compilation of 7 instruments, there is not a concise way to summarize each population.	Test-retest reliability high ranging from .80-.86. Internal consistency moderate to high ranging from .69-.82. Most subscales are moderately to highly valid. Correlations range from .60-.99.
Contact Information	McCubbin, H.I. (1987). Family Index of Regenerativity and Adaptation-General (FIRA-G). In H.I. McCubbin, A.I. Thompson, & M.A. McCubbin (1996). Family Assessment: Resiliency, coping and adaption-Inventories for research and practice (pp.823-842). Madison: University of Wisconsin System.					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (2nd Edition). Boston, MA: Judge Baker Children's Center.					

DESCRIPTION OF LEVEL ONE MEASURES						
(FRS) Family Resource Scale						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Measures adequacy of resources in households for young children, including: ? Growth/support ? Health/necessities ? Nutrition/protection ? Physical shelter ? Intrafamily support ? Communication/ employment ? Childcare ? Income	Households with preschool aged children	45 mothers with retarded, handicapped and/or developmentally at-risk preschool aged children. Mothers' mean age was 28 and mean education was 12th grade. All mothers had a low to middle SES.	Parents self-report. 30 items Approximately 5 minutes to complete	The FRS is useful for both assessment and intervention purposes. Scale is particularly useful with families of children enrolled in early intervention or other educational or therapeutic programs. The FRS represents a broad-based approach to child welfare.	May not be as relevant for households with teens and adolescents.	High internal consistency and split-half reliability coefficients reported. Test-retest reliability over 2-3 months was .52 An eight factor solution indicates that the FRS taps independent dimensions of needs and resources. A significant, positive correlation exists between both well-being and commitment to child-level interventions.
Contact Information	Dr. Carl J. Dunst, Family, Infant and Preschool Program, Western Carolina Center, 300 Enola Road, Morganton, NC 28655-4602					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (2nd edition). Boston, MA: Judge Baker Children's Center. Dunst, C. J., & Leet, H. E. (1987). Measuring the adequacy of resource in households with young children. Child Care, Health and Development, 13, 111-125.					

DESCRIPTION OF LEVEL ONE MEASURES						
(FSS) Family Support Scale						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
? Number of social supports ? Satisfaction with existing support ? Degree of perceived helpfulness	Child-rearing families	139 parents of mentally retarded, physically handicapped or developmentally at-risk preschool children. 60% were from low SES All parents participated in an early intervention program.	Family members self-report. 18 items	Valuable as an assessment and intervention tool. Effectively taps into a broad range of social supports. Sensitive to individuals' differing levels of stress and coping.	May not be relevant for families without at-risk children.	Internal consistency, split-half, and test-retest reliability coefficients determined to be quite high.
Contact Information	Dr. Carl J. Dunst, Family, Infant and Preschool Program, Western Carolina Center, 300 Enola Rd., Morganton, NC 28655-4602					
Citation(s)	Daro, D. (1994). Healthy families America: A guide for evaluating healthy families America efforts. National Committee to Prevent Child Abuse.					

DESCRIPTION OF LEVEL ONE MEASURES						
(PCRI) Parent-Child Relationship Inventory						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Assesses parents' attitudes towards parenting and their children. Outcomes include: ? Parental support ? Satisfaction with parenting ? Involvement ? Communication ? Limit setting ? Role orientation ? Autonomy	Parents of 3-15 year old children	1,139 parents were recruited from schools and day-care centers. Sample was diverse, but weighted towards middle SES, better educated subjects. Parents over 54 years of age were excluded.	Parents self-report.	Written at a 4th grade reading level. According to Western Psychological Services, instrument is designed for use in child custody evaluations, family therapy, parent training and child abuse assessments. Computer analysis and interpretation of scores available along with hand-scoring option. Separate norms provided for mother and father .	Validity issues need to be clarified with future research.	Internal consistency reliability coefficients ranged from .70 to .88. 1 week test-retest reliabilities ranged from .44 to .79. Patterns of correlations were consistent with the constructs implied by the scale names.
Contact Information	Gerard, A.B., Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025					
Citation(s)	Heinze, M. C. & Grisso, T. Review of instruments assessing parenting competencies used in child custody evaluations. Behavioral Sciences and the Law, 14, 293-313.					

DESCRIPTION OF LEVEL ONE MEASURES						
(PSI) Parenting Stress Index						
Outcomes measured	Target population	Population the measure was normed wit h--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Designed to assess sources and levels of stress and competence in parents. Outcomes include: 1.Child Traits ? Adaptability ? Acceptability ? Mood ? Hyperactivity 2. Parent Traits ? Depression ? Attachment ? Restriction of role ? Sense of competence ? Social isolation ? Relationship with spouse ? Parental health	Parents of children between the ages of 1 month and 11 years.	2,633 parents of non-clinical children and children with behavioral or health problems. The majority of the children were under 5 years of age. 95% of sample was Caucasian. 28% of parents were college graduates.	Parents self-report. 101 items	Index discriminates well between clinical and non-clinical populations. Used frequently in mental and medical health centers, research, and child welfare programs. Useful in assessing the effectiveness of interventions. PSI is available in eight languages. Written at the 5th grade reading level.	Practitioners cautioned when using PSI with low-income families until additional research has been conducted about this population. Items in assessment are deficit-oriented. Hence, child and parent strengths may not be fully identified.	Studies have established validity of PSI. Concurrent validity demonstrated. Alpha reliability coefficients derived for each subscale.
Contact Information	Richard R. Abidin, Curry Programs in Clinical and Social Psychology, 405 Emmet Street, Charlottesville, VA 22903-249. Phone: (804) 924-7472.					
Citation(s)	Daro, D. (1994). Healthy families America: A guide for evaluating healthy families America efforts. National Committee to Prevent Child Abuse. Heinze, M.C., Grisso, T. (1996). Review of instruments assessing parenting competencies used in child custody evaluations. Behavioral Sciences and the Law, 14, 293-313.					

DESCRIPTION OF LEVEL TWO MEASURES						
(PSPCSA) Pictorial Scale of Perceived Competence and Social Acceptance for Young Children						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Designed as a precursor to the SPPC evaluating the following outcomes: ? Cognitive competence ? Physical competence ? Social acceptance (including maternal acceptance and peer acceptance)	Preschool through 2nd grader children ages 4-7.	90 preschoolers 56 kindergartners 65 1st graders 44 2nd graders Boys and girls represented equally. Students were 96% Caucasian from middle class homes.	Children self-report. 24 items	Pictorial style of instrument benefits young children by engaging them long enough to complete the test.	Psychometric soundness is yet to be demonstrated. Only gives an index of one's perceived competence and social acceptance, not general self-worth.	Internal consistency is moderate to good, ranging from .52 to .87. Convergent, predictive and discriminant validity reported acceptable from small samples. Two-factor solution suggests measure taps the distinct domains of competence and social acceptance.
Contact Information	Harter, S. & Pike, R. (1983). The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children, University of Denver, CO, Department of Psychology, 2155 S. Race Street, Denver, CO, 80208-0204. Phone (303) 871-2478.					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (2nd Ed.). Boston, MA: Judge Baker Children's Center.					

DESCRIPTION OF LEVEL TWO MEASURES						
(RBPC) Revised Behavioral Problem Checklist						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Outcomes include: ? Conduct disorder ? Socialized aggression ? Attention problems/ immaturity ? Anxiety/withdrawal ? Psychotic behavior ? Motor tension excess	Youth ages 5 through young adults	Data was obtained from several diverse samples including: Clinical settings A camp for children with diabetes Two public schools	An adult (usually parents or teachers) who knows youth well. Uses a 3-point scale : 1) No knowledge or opportunity to observe 2) Mild problem 3) Severe problem	Useful for both clinical and research applications for phobia and anxiety disorders, to screen for behavior disorders in K-12 students, to classify juvenile offenders and to evaluate psychological and pharmacological interventions.	Lack of national norms. Paucity of information regarding the samples with which the measure was normed, and an absence of statistical analyses by age and gender.	Internal consistency of subscale scores ranged from .90-.95 Inter-rater reliability ranged from mediocre to good depending on the subscale. Two month test-retest reliability was moderate to good, except for a lower coefficient for socialized aggression. RBPC correlated with the Child Behavior Checklist Discriminated between clinical and nonclinical samples.
Contact Information	Psychological Assessment Resources, Inc., P.O. Box 998, Odessa, FL 33556-9901. Phone: 1-800-331-8378.					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (2nd Ed.). Boston, MA: Judge Baker Children's Center. Simpson, R. G. (1989) . Revised behavior problem checklist (RBPC). Diagnostique, 15(1-4), 161-173.					

DESCRIPTION OF LEVEL ONE MEASURES						
(SFI) Self-Report Family Inventory						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Designed to assess health of family functioning by measuring: ? Health ? Conflict ? Communication ? Cohesion ? Leadership ? Expressiveness	Families	Both clinical and non-clinical families including families with adolescents, seriously ill, mentally ill, or mentally retarded members, foster families, and African American and Latino families.	Family members self-report. 36 items	Subscales result in rich clinical data. SFI is short and easy to administer and score.	Normative data needs to be determined along with more external validation. Additional research also needed to establish its discriminative and clinical validity.	Internal consistency has average alpha of .84-.88 in diverse clinical and non-clinical samples. Test-retest reliability correlates across 30-90 day intervals supporting the temporal stability of the scale. Possesses face validity. Estimates of concurrent criterion validity are encouraging.
Contact Information	Robert Beavers (1983), staff of the Southwest Family Institute in Dallas, TX.					
Citation(s)	Green, R. G. (1987). Self-report measures of family competence. The American Journal of Family Therapy, 15, 163-168. Halvorsen, J. G. (1991). Self-report family assessment instruments: An evaluative review. Family Practice Research Journal, 11, 21-55. Tutty, L. M. (1995). Theoretical and practical issues in selecting a measure of family functioning. Research on Social Work Practice, 5, 80-106.					

DESCRIPTION OF LEVEL TWO MEASURES						
(VABS) Vineland Adaptive Behavior Scales: Survey Form						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
? Communication ? Daily living skills ? Socialization ? Motor skills	Individuals birth to 18 years of age, as well as low functioning adults.	3,000 individuals stratified by sex, race, community size, region of country and parents' level of education.	Primary caregivers are informants for clinicians trained in interviewing and assessment.	Supplementary norms provided by mentally retarded, emotionally disturbed, visually handicapped and hearing impaired children. Used in intervention and training program evaluation.	Administration requires training, a professional interviewer, and a 20-60 minute interview.	Test-retest reliability and split-half reliability moderate to high. Inter-rater reliability ranges from low to adequate. Correlates significantly with several other behavior inventories. Discriminant validity evidenced by its lack of relationship with tests such as the Peabody Picture Vocabulary.
Contact Information	Sparrow, S.S., Balla, D.A. & Cicchetti, D.V. (1984). Vineland Adaptive Behavior Scales, Interview Edition, Survey Form Manual. American Guidance Service, Circle Pines, Minnesota 55014-1796					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997) Evaluating the outcome of children's mental health services. A guide for the use of available child and family outcome measures (2nd Edition). Boston, MA: Judge Baker Children's Center.					

DESCRIPTION OF LEVEL TWO MEASURES						
(VSTCP) Vermont System for Tracking Client Progress						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
1.Negative Behaviors ? Physical aggression ? Sexual acting out ? Substance abuse ? Verbal abuse 2. Positive Behaviors ? Self-confidence ? Compliance ? School attendance ? Parent contact	Both children and adolescents.	Exclusively Caucasian and predominantly male subjects in the state of Vermont.	Case-manager or primary caregiver administers the 22 item scale at numerous time points in order to track client changes.	Useful for program evaluation because it measures outcomes of children with serious emotional disturbances and generates individualized client reports to assist in their treatment planning. User-friendly and comprehensive.	Subject to case-managers' biases and interpretations of improvement. Normed with a limited population and lacks psychometric data needed to establish generalization.	Factor analysis, comparison to the Child Behavior Checklist (CBCL) scores and restrictiveness of living and cost outcomes provide evidence for validity of VSTCP. Additional research needed to assess the validity for a range of applications and settings.
Contact Information	Dr. John D. Burchard, Department of Psychology, University of Vermont, John Dewey Hall, Burlington, VT 05405. Phone: (802) 656-2670.					
Citation(s)	Cross, T., McDonald, E., & Lyons, H. (1997). Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures (2nd Edition). Boston, MA: Judge Baker Children's Center.					

DESCRIPTION OF LEVEL ONE MEASURES						
(WSDI) Wahler Self-Description Inventory						
Outcomes measured	Target population	Population the measure was normed with--is it useful with our clients	Administration of instrument	Advantages of this measure for use in child welfare (i.e. normed with special pop. or reading level?)	Disadvantages	Psychometric Analysis
Assesses quality of individuals' self-evaluations. Outcomes include: ? Indivual's problems ? Defensiveness ? Self-perception ? Values ? Methods of adaptation	Adults, including high school students.	Not available at time of publicat ion.	66 item self-evaluation. 10-15 minutes to administer.	Used widely with subpopulations including mental health clients, hospitalized psychiatric patients, rehabilitation clients social security claimants, and high school/college students. Requires a 6th grade reading level. Sensitive to one's potential for change and attainment of therapeutic change.	Need a definition of different types of rehabilitation patients.	Internal consistency and concurrent validity have been empirically documented.
Contact Information	Dr. H. J. Wahler, Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025					
Citation(s)	Dr. H. J. Wahler, Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025					

The National Study of Outcome Measurement

The *National Study of Outcome Measurement in Public Child Welfare Services* was funded by the Illinois Department of Children and Family Services (DCFS). It was conducted in coordination with the American Humane Association's Children's Division (AHA) and the Child Welfare League of America's (CWLA) Managed Care Institute to describe the current state of outcome measurement in child welfare, identify successful outcome measurement strategies, and understand barriers to success. The information collected includes:

? ? Agency characteristics
? ? Agency outcome measurement initiatives
? ? Administrative data agencies use to measure outcomes
? ? Clinical or functional measures agencies use to measure outcomes
? ? Agency management information system capacity
? ? Indicators that agencies use to assess program success
? ? Examples of innovative outcome measurement systems
? ? Barriers to successful outcome measurement system implementation
? ? Future outcome measurement plans

Study Method

Public child welfare agencies in 50 states, the District of Columbia, and 14 localities were invited to participate in the study. Localities with the largest child population in county/city administered states were identified using 1990 U.S. Census data. Agency staff who knew the most about their agency's experience in outcome reporting were first identified using contact information from AHA Outcomes Roundtable participant lists and the *1997-1998 APWA Public Welfare Directory*. Through subsequent telephone interviews with agency staff, Center researchers were usually referred to agency data analysts or departments of quality assurance. Larger agencies often contained outcome reporting divisions.

The study instrument was developed in coordination with the CWLA Managed Care Institute, AHA, and DCFS' Office of the Research Director. Several response categories for measures were developed from *1997 CWLA Managed Care Survey* results. The survey was piloted in two states before national administration.

Response Rate

Thirty-five states and nine localities participated in the study by completing the survey or returning documents related to their outcome measurement plans. Both states and localities participated in seven states. The responses from the participating states and localities represent 83% of the nation's children age 0-17 (U.S. Census, 1990). Respondents were given the option of reporting publicly on their agency's outcome measurement activities. Some agencies chose to maintain confidentiality. Therefore all data is presented in the aggregate.

Participating States

The 32 states that returned questionnaires are listed below.

States in the National Survey of Outcome Measures in Public Child Welfare

Alaska	Iowa	Maine	Ohio
Alabama	Idaho	Minnesota	Oregon
Arkansas	Illinois	Missouri	Rhode Island
Arizona	Indiana	Mississippi	Tennessee
Connecticut	Kentucky	Montana	Texas
Delaware	Louisiana	North Carolina	Utah
Florida	Massachusetts	New Hampshire	Virginia
Georgia	Maryland	New Jersey	Wyoming

Results

Results from the National Survey can be found in *Recommended, Mandated and State Implemented Measures, State Administrative Data Measures,* and *Measuring Child and Family Functioning*.