Chapter 1
Assessment of Children

Michael E. Woolley

Purpose: This chapter details and discusses the historical evolution and current trends in social work in the systematic, ecological, and evidenced-informed assessment of children. It includes the myriad struggles impacting children and the broad range of settings in which social workers serve children and their families.
Rationale: Whether in schools, child protective services, juvenile justice, family or community centers, mental-health agencies, or hospitals, social workers assume many roles in providing services for children. A critical part of providing effective services is a comprehensive assessment informed by social work values, ethics, interfacing with our evolving professional orientation, knowledge, skills, and tools.
How evidence-informed practice is presented: One current trend is the increasing use of quantitative survey instruments in child assessment, and there is an increasing number of such assessment tools being developed by social work researchers. A second trend is the increasingly widespread need for the evaluation of the effects of interventions. In order to offer such evaluations, valid and reliable assessment tools are needed that can show changes in the assessed struggles and targeted outcomes of those interventions.
Overarching questions: Within specific social work practice settings serving children, in order to complete an ecologically oriented and comprehensive assessment of a child and family, what information would be needed, from whom should that information be gathered, and by what means or methods should that information be collected?

Social workers are vital members of teams delivering services to children across a variety of settings, including, but not limited to, child welfare agencies, family service organizations, schools, health-care providers, and mental-health settings. The struggles and challenges faced by children served by those social workers covers a broad spectrum from day-to-day struggles to life-altering trauma. In all those settings and struggles, beginning the social work intervention process with a systematic and comprehensive effort to gather information about the child, the social contexts of the child, and the presenting struggle or challenge is a critical first step to providing professional, appropriate, and effective services to children who have been impacted by issues ranging from sexual abuse or mental illness to brain tumors or learning disabilities.

Social work has been increasingly called on, from both outside and inside the profession, to demonstrate the effectiveness of its practices. This

scrutiny provides the impetus to engage in research to develop evidence-based practice (EBP) strategies and approaches (Gambrill, 1999). The needs for quality assessment tools and strategies as a fundamental task within that effort are twofold. First, all practice activities should start with and be informed by an assessment process. Second, gathering evidence as to the effectiveness of an intervention requires assessing the target of that intervention before and after that intervention is delivered; therefore, reliable and valid assessment measures are a fundamental tool in the pursuit of evidence to support practice.

This chapter first defines what is involved in performing a systematic and comprehensive social work child-assessment process. The accumulated social work practice knowledge in the area of child assessment emerging across the first 100 years of professional social work is discussed. We then outline the current prevailing framework used to gather, organize, and present assessment information about children. More recent developments in the assessment of children are then added to that framework—for example, the necessity of gathering information from multiple informants and using multiple information-gathering tools when assessing children. Within that evolving assessment framework, a growing effort in social work (and other helping professions) is to strive to utilize evidence-based strategies and tools in practice. What is meant by evidence-based practice and how that effort can inform the most effective and efficient assessment of children is explored. The limitations to the evidence in support of our current assessment strategies with children, as well as promising ways to reduce those limitations, are detailed. Finally, current trends and developments in the assessment of children in social work practice settings, including child protection, schools, and mental health, are presented.

Defining Assessment

Assessment is used to describe an assortment of activities and processes in the social sciences and human services that involve gathering information about a client(s) and the presenting circumstances leading to an evaluation, determination, or plan of action focused on that client or client system. In social work practice, some aspects of assessment are driven by the practice setting, the population being served, and the practice model being applied by the social worker. However, this chapter offers a framework for social work assessment with children that, although embedded within the evolution of the social work perspective and the current effort to situate social work practice on an evidence base, can be applied by any direct practitioner regardless of setting, population, practice level, or model. In this chapter, a descriptive and evolving definition of assessment in the context of providing social work services to children is offered. As a starting framework, assessment in social work with children is defined as including three key components: (1) collecting data, (2) being informed by a contextual perspective, (3) leading to a prevention or intervention plan.

Data Collection

First, assessment of children is, in large part, defined by a range of activities used to gather information about a child, a struggle or challenge confronting that child, and relevant information about that child's social environments. Those activities can include but are not limited to (a) clinical interviews, (b) structured interviews, (c) self-report instruments, (d) direct observations, and (e) reviews of existing records. Those data-collection activities may elicit information from multiple informants, including the child, parents/guardians, other family members, key individuals in the child's life, and professionals who have direct experience with the child.

Contextual Perspective

The second component is illustrated by an enlightening distinction about assessment in social work practice made by Clifford (1998). He referred to ''social assessment,'' as opposed to psychological or medical assessment, in that social assessment ''is centered on a social explanation—and will draw on social research and social science concepts'' in identifying the service needs of an individual, small group, or community. Although social workers clearly also draw on and are informed by psychological and medical aspects of and explanations for client struggles, Clifford's focus on the social aspects of the client and his or her struggles distinguishes assessment in social work from assessment in other disciplines. This focus on contextual factors in social work can be seen in many assessment orientations in social work, such as the person-in-environment perspective, psychosocial models, the widespread use of ecological-systems thinking, and the pervasive structuring of assessment information into a biopsychosocial assessment document.

Prevention or Intervention Planning

Third, child assessment in social work is also defined as having as the central goal in gathering that information to inform the development of a social work prevention or intervention plan to help that child or group of children. Although systematic information about a child and his or her social environments may be gathered for other reasons—such as part of a research endeavor or eligibility evaluation—unless the ultimate goal is a formulation leading to the implementation of a social work service plan, the gathering of that information does not constitute an assessment as it is referred to in this chapter.

Thus, a social work assessment of a child includes (a) data collection, defined as a systematic gathering of information about the child, a struggle or challenge facing that child, and that child's multiple social environments; (b) data pursued from a contextual perspective oriented to how the child's social environments influence the child, the struggle or challenge, and efforts to resolve that struggle or challenge; and (c) development of an

intervention plan to assist that child with that struggle or challenge as the primary goal of that data-collection effort.

The application of systemic and comprehensive assessment strategies has become more important given profession-wide efforts to build an evidence-based approach to social work services (Gambrill, 1999). Because service-delivery activities start with and are built on the assessment process, reliable and valid assessment strategies and tools are fundamental to identifying, developing, evaluating, and providing evidence-based interventions. For example, reliable and valid assessments provide a vehicle to evaluate interventions, thereby establishing evidence as to when and with whom such interventions can be effective. Further, the application of interventions with already established bodies of evidence as to their effectiveness should only be utilized after the application of systematic, comprehensive, reliable, and valid assessment strategies and tools to inform the selection of interventions appropriate for a specific child in a specific situation. Additionally, the results of a systematic assessment should influence the provision of the interventions chosen, thereby following long-established social work practice principles, such as starting where the client is, treating each client as an individual, and providing individualized services (Hepworth, Rooney, & Larsen, 2002; Pilsecker, 1994).

The wide variety of settings in which social workers serve children, the larger array of struggles and challenges faced by those children, and the wide range of what and who social workers are actually assessing—for example, the child, a potential home placement, the risk of a caregiver to abuse or neglect, the appropriateness of a classroom setting—all make a truly comprehensive discussion of assessment of children in social work seem daunting. Therefore, one goal of this chapter is to set the current state of assessment of children in social work in a historical context that encompasses our collective professional knowledge informing the assessment of children as a framework on which to add recent advancements.

Historical Background

Mary Richmond, in her seminal book *Social Diagnosis* (1917), presents the first comprehensive treatise on the assessment process in social work. Although she uses the term *diagnosis*, which, for most social workers today means something quite different than assessment, what she is referring to as a social diagnosis 90 years ago meets the three criteria for social work assessment offered here. In fact, for those who have not read all or even parts of her book, it is truly worth the time, and you may find it contains surprisingly still-relevant insights on assessment, social casework, and prescient glimpses of things to come. For example, Richmond describes her preparation to write *Social Diagnosis* as including systematically reviewing social work case records and recording interviews with caseworkers across five different sites over the course of a year ''to bring to light the best

social work practice that could be found'' (p. 7). Is that not an effort to build a body of evidence about what works? Richmond further says of her efforts in the preparation of the book, ''the most difficult of all my problems has been to make a presentation on the handling of evidence'' (p. 9) in the assessment process. Richmond's book culminates in a series of structured interview protocols for the assessment of various clients and situations.

Assessment Informing Best and Evidence-Based Practices

The pursuit of providing clients with the best possible social work services available at a given point in time, basing assessment on gathering the best evidence possible, and collecting that evidence in a systematic manner are distinctly not new endeavors in the social work profession. In fact, social work has a rich history of professional knowledge development in the area of assessment.

Central to that accumulation of knowledge in the assessment of children has been the conceptual perspective of a child as embedded in a set of social contexts. Mary Richmond articulated that fundamental perspective 90 years ago. That perspective also guided Jane Addams and the Hull House staff. For example, in the area of juvenile delinquency, Hull House rejected dominant theories based on heredity and instead asserted that the most important factors leading to juvenile delinquency were environmental (Hart, 1990). With respect to assessment, that clearly means the gathering of information about, and analysis of, the social environment that a child inhabits in an effort to understand that child's development, struggles, and behavior.

The history of that perspective can be traced to today by examining social work textbooks over the decades detailing the state of the art and science of casework practices. For example, Hamilton (1951) states that assessment is an attempt to understand the client, the problem, and the situation; and such authors as Perlman (1957), Hollis (1964), and Pincus and Minahan (1973) iterate that triad of assessment. Hollis states this perspective succinctly when she points out that, in assessment, ''strengths as well as weaknesses in both the person and the situation are important considerations'' (p. 261). Hepworth et al. (2002) offer a similar triad. Assessment, they suggest, is a process ''to gather information and formulation of that information into a coherent picture of the client and his or her circumstances,'' leading to ''our inferences about the nature and causes of the client's difficulties'' (p. 187). They do, however, describe a meaningful shift in one aspect of that triad in that they stress the assessment of the *needs* and the *strengths* of the client as much as the *difficulties* of the client. This strengths perspective continues to guide the development of structured assessment instruments for practice, such as a strength-based and culturally informed reliable and valid assessment tool for practice with Native American youth, their families, and communities (Gilgun, 2004). This sort of melding of the long-evolving social work ecological strengths

and culturally informed orientation to helping clients with more recent and rigorous assessment methodology seems like a promising trajectory in social work assessment with children.

The focus on strengths has grown in part from the long-standing fundamental humanistic perspective in social work that all clients are doing their best and have resources and that, when clients struggle, it is because of a deficit in those available resources. Such resources can be both internal and environmental, and clients can call on those resources—social workers can likewise call on those resources in the assessment process—to help meet challenges and struggles clients face (McQuaide & Ehrenreich, 1997). Such a strengths perspective grows out of social work's values and ethical orientation to clients (a) as persons of worth, (b) as persons who have a fundamental right to choose their goals in the helping process and how they go about working on those goals, and (c) as persons who are capable of solving their own problems with appropriate support (Loewenberger & Dolgoff, 1985). The strengths perspective also stands in contrast to the still-pervasive medical model of diagnosing and labeling limitations, which is particularly prevalent in mental-health practice (Cox, 2006). The strengths perspective and the focus on the social environments of a client are reflected in the ubiquitous development of an ecological-systems orientation in social work practice.

Evolving Ecological-Systems Perspective

A seminal application of the ecological perspective in social work is the introduction of the life model of practice by Germain and Gitterman in 1980. As they put it, ''the social purpose [of social work] calls for a practice method that is designed to engage people's strengths and the forces pushing them toward growth, and to influence organizational structures, other social systems, and physical settings so they will be more responsive to people's needs'' (p. 2). In the 1980s, the ecological perspective was increasingly used to articulate the social work approach to assessment and service delivery. Further, some authors started adding concepts from the general systems theory to that ecological perspective to create what was termed the *ecosystems perspective* (Greif & Lynch, 1983).

The adaptation of systems theory to practice endeavors introduced several helpful theoretical concepts into social work thinking. Those concepts are especially helpful in assessment, as they offer insights into how social systems—the interactions between a client and his or her environment—work. For example, *equilibrium* is a concept that states that human systems (read families) tend toward establishing a balance that can be maintained, whether that balance is good or not so good for the members of the system. *Boundaries*, such as between members of the family or between the family and other systems, such as the school or neighborhood, are critical in the flow of information, resources, and support within and among systems. Social work has long asserted that assessing and attending

to these dynamic processes are critical to effective assessment of a child and his or her social systems (Germain & Gitterman, 1980).

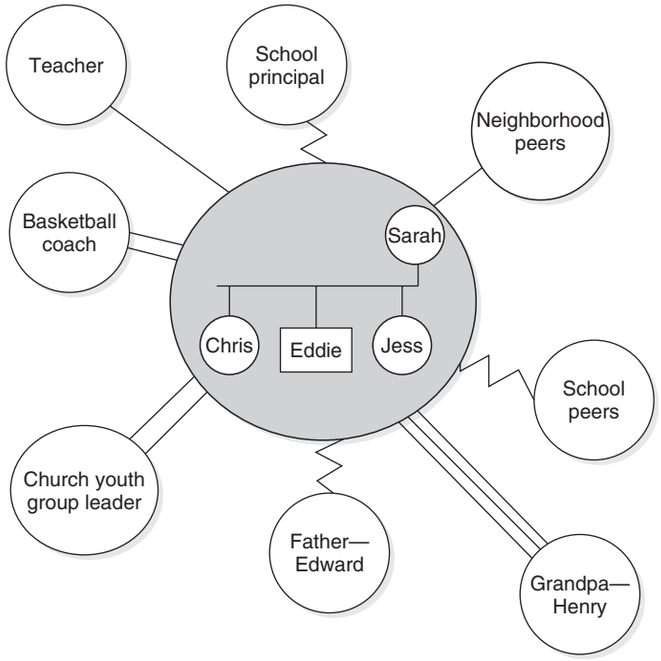
Another notable step in the evolution of the contextual orientation to assessment in social work is the person-in-environment (PIE) system, introduced by Karls and Wandrei (1992). The PIE system offers a common language and structure for social workers to use in formulating assessments from the unique orientation of social work. One goal in the development of the PIE system was to design an assessment structure that focuses on the ''social well-being'' of a client, which is identified as ''different than physical or mental well-being'' (p. 81), that assertion being supported by research about those three domains. The PIE assessment approach is systematic and comprehensive and includes information about the client, the problem, and the client's social environment, therefore possessing many of the characteristics described earlier for an effective assessment. It also introduces a coding system for client problems, with codes for duration, severity, and coping, as a way to quantify assessment information. The basic structure of the PIE system includes four factors: Factor 1–social role problems, Factor 2–environmental problems, Factor 3–mental disorders, and Factor 4–physical disorders. This system shares some structural characteristics with and foreshadows the multiaxial format of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) diagnostic format, and, although not widely used today, the PIE system represents an important development in social work's quest to build a professionally unique and uniform structure to assessment. Additionally, the PIE perspective continues to evolve; for example, the person-environment practice approach, as described by Kemp, Whittaker, and Tracy (1997), offers an ecological competence-oriented practice model that stresses the importance of ongoing assessment, social support, empowerment, and collective action.

Other developments in social assessment have also yielded systematic formats to gather and organize information. For example, there are two diagrammatic assessment tools that have seen widespread use in social work practice with children and families: the eco-map and the genogram (Hartman, 1995). Both tools grew out of the ecological-systems perspective and gained popularity in social work practice in the 1980s. Either or both can be drawn by a social worker in concert with a child and family during the assessment process and used as tools to elicit and synthesize information from the child and family as they help complete each diagram. Either can then be used to analyze family dynamics, gain a comprehensive picture of the family circumstances related to the struggle or challenge, or used to search for strengths, possible resources, and the ongoing collection of assessment information.

Hartman (1995), a social worker, first developed the eco-map for use in child welfare practice. An eco-map has, at its center, the child and family drawn as a circle (Figure 1.1). Then, surrounding the family and child is a system of circles representing other important people, resources, or activities, such as extended family; friends of the child and parents/guardians;

Figure 1.1

Example of an eco-map for Eddie, a 10-year-old boy with behavior problems



activities, such as recreation, sports, or hobbies; organizations, such as schools, churches, neighborhood groups, or workplaces; or other agencies, such as health-care providers, mental-health providers, or juvenile court. Care should be taken to include not just circles related to the presenting challenge or struggle but also those that represent strengths and resources to the child and family and other struggles or possible barriers to solving the presenting issue. Once all the needed circles have been drawn, various types of lines are drawn between the circles to represent the nature of the connection between the child and family and each particular circle. For example, a solid line depicts a strong relationship, and a dashed line represents a tenuous connection, whereas a line with hash marks across it suggests a stressful connection. Arrows are drawn along the connections to indicate the direction of flow of support, resources, and energy.

Murray Bowen (1978), a psychiatrist who was a pioneer in the field of family therapy, developed the genogram as an assessment tool. Carter and McGoldrick (1980), social workers who have been at the forefront of the evolution of family therapy over the past 25 years, particularly with respect to gender and ethnicity issues, introduced the use of genograms in social work. In drawing a genogram, three or even four generations of the family are depicted (Figure 1.2). Males are drawn as squares and females as circles, and a system of lines is utilized to connect family members and indicate the nature of their kinship. A genogram has levels for each generation, such that family members in the same generation are on the same level across the page. Once all the multigenerational members of

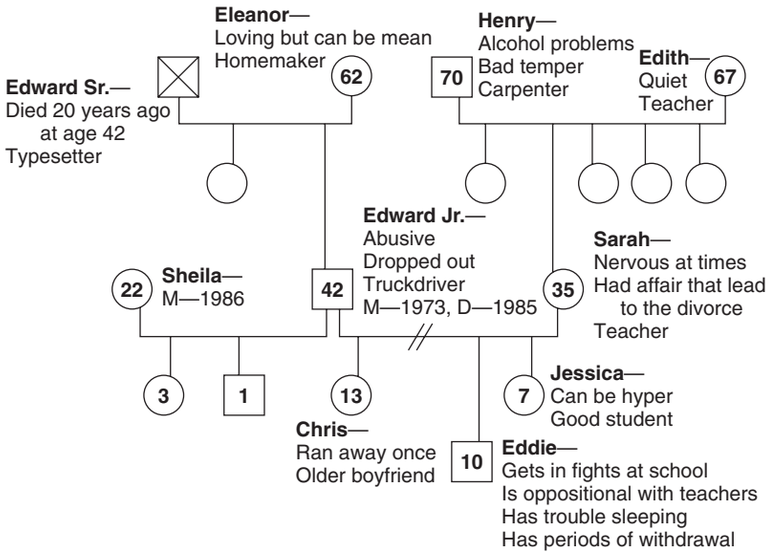


Figure 1.2

Example of a genogram for Eddie, a 10-year-old boy with behavior problems

the family are included and kinship lines are drawn, other aspects of the family dynamics and circumstances can be included, such as marriages and divorces, deaths and illnesses, alcohol or drug use, significant events in the family history, religion, occupation, education, mental-health problems, or any important events or family dynamics. Similar to the eco-map, various types of lines can also be added that characterize the nature of the relationships between family members. A genogram is used in practice not just as an assessment tool to identify family patterns, strengths and resources, and unresolved issues but also as an ongoing tool to identify strengths and resources in intervention planning and implementation. A comprehensive discussion of the use of genograms as an assessment and intervention tool is beyond this chapter; for more detail, see McGoldrick, Gerson, and Shellenberger (1999).

Another important step in the evolution of the ecological perspective in social work is the incorporation of a focus on risk and protective factors and the vulnerability or resilience to the impact of environmental stressors that such factors may offer (Fraser, Richman, & Galinsky, 1999). From this perspective, the characteristics of the physical environment and social relationships may act as risk or protective factors with respect to child and family functioning. Risk factors are environmental characteristics that predict undesirable developmental outcomes, whereas protective factors are promotive of positive developmental outcomes or may compensate for the negative impact of certain risk factors (Richman, Bowen, & Woolley, 2004). Central to this perspective is the concept of *resilience*, which has been defined as the dynamic interplay of environmental, social, and individual protective factors in the context of risk exposure, leading to positive adaptation and desirable developmental outcomes for youth (Luthar, Cicchetti, & Becker, 2000).

Related to the concept of resilience, it has become foundational in any assessment process in social work practice to assess client and client-system strengths (Saleebey, 2006). In the assessment of children, that means gathering information about the strengths of the child and the resources available to the child from his or her social environments. For example, Gleason (2007) details a strengths-based approach to completing a social developmental study in a school setting. That approach includes strategies for how to query children about strengths (for example, What are some things you have done that you are proud of?) and how to ask assessment interview questions from a strengths perspective (for example, When things are going well, what does that look like for you?). Then, the social worker frames intervention goals and objectives in positive ways and calls on assessed strengths and resources to achieve those objectives. Finally, a strengths perspective supports social workers striving to give children a voice in school meetings about their school service plans by preparing each child to speak and advocate for him- or herself in such meetings and making certain that time and space are made for the child to make those contributions to the process.

Bringing many of these concepts together in a manner that makes them applicable to assessment with children is the eco-interactional developmental (EID) perspective, as described by Richman et al. (2004). This framework is informed by (a) the ecological-systems perspective in terms of the centrality of the social environment, and (b) the risk and resilience perspective in how that environment influences children, all within (c) a developmental orientation whereby child functioning can only be meaningfully interpreted in the context of that child's developmental trajectory and current developmental level, needs, and struggles. Within this ecological framework, there are three key environmental contexts that must be assessed in social work practice with children: family, neighborhood, and school. As described by Bronfenbrenner (2005), these *microsystems* are the environmental settings that directly influence a child, whereas *mezzosystems* represent the connections among those key microsystems. Examples of mezzosystems include the nature of the relationship between a child's family and a teacher or the relationships between the family and neighborhood residents and organizations. The larger social, cultural, and political environments that children and their families inhabit and the characteristics of those systems constitute the *macrosystem*.

Social work also has a rich history of stressing issues of cultural and ethnic diversity and historic and current forms of discrimination and oppression that emerge within a family's macrosystem and the various microsystems and mezzosystems surrounding a child and his or her family. Building on the ecological- and strengths-oriented PIE assessment system described earlier, Appleby, Colon, and Hamilton (2007) have comprehensively approached the effects of race, culture, and social class in the dynamics of oppression and discrimination (including racism, sexism, homophobia, ableism, and religious bigotry) on healthy development and social functioning. Because a fundamental goal in social work assessment

is to take a contextual perspective, it seems imperative to attend to the impact of such issues with respect to child clients and their families who may be members of currently or historically oppressed or discriminated groups. For example, the authors point out that culture is often seen as static, when, in fact, it is dynamic, changing as it develops, much like an individual develops and changes as the result of interactions with the environment and other cultures. Therefore, the culture in which the child client and his or her family are members is changing, as are the other cultures that child is surrounded by, and the dominant or majority culture, if that is different from the child's culture. Those multiple changing cultural contexts can at once serve as developmental settings for the child and family, sources of strengths and resources, mediators of struggles and challenges, or sources of oppression and discrimination, all potentially profoundly impacting child and family adaptation and functioning.

The pursuit of *social justice* has become an overarching framework in social work practice that refers to activities to reduce the causes and sequelae on clients, groups, and societies associated with oppression and discrimination. Finn and Jacobsen (2003) have offered a social work practice model that synthesizes well-established practice values, professional ethics, client engagement and professional relationship principles, and the PIE orientation to assessment while focusing on the impact of traditionally unjust structures and processes and the pursuit of socially just outcomes for clients. A comprehensive discussion of the impact on the child-assessment process of social justice issues associated with current or historical oppression and discrimination is beyond the scope of this chapter, so readers are encouraged to consult the literature starting with the references cited here. In fact, much research and intervention development and evaluation yet needs to be done related to the impact of issues of gender, race, ethnicity, culture, mental or physical ability, age, socioeconomic class, religion, family structure, sexual orientation, gender identity or expression, and citizenship status on clients and the social work helping process. However, a couple of examples may offer tangible reference points to illustrate that ambitious research and practice strategy development agenda.

In the context of working with Latino clients, Colon, Appleby, and Hamilton (2007) warn that traditional models of social work practice ''ignore the interdependent, mutually supportive aspects of Latino group norms and individual values'' (p. 302): for example, the centrality of familism (*familismo*) in the provision of social and economic support, and the importance of dignity (*dignidad*) and respect (*respeto*) in the dynamics of Latino families. Likewise, Colon et al. assert there are important practice implications to the historical racism experienced by African Americans, which today accounts for reduced access to socioeconomic resources, poor physical and mental-health outcomes, and limited access to social services, much of which is maintained by ongoing structural racism, particularly inequitable access to educational opportunity (Orfield, Losen, Wald, & Swanson, 2004). Finn and Jacobsen (2003) suggest that the application of the *empowerment* approach, an approach with a strong tradition in

social work with respect to helping oppressed groups (Gutierrez & Lewis, 1999; Simon, 1994), presents a significant addition to an ecologically PIE-oriented framework to assessment in the pursuit of socially just outcomes for clients.

Identifying and building evidence to support the understanding of the practice assessment implications of such cultural and social justice dynamics that impact children and families require ongoing research efforts. For example, researchers (Ogbu, 1991, 1998; Oyserman, Bybee, & Terry, 2006; Oyserman, Terry, & Bybee, 2002; Woolley & Bowen, 2007; Woolley & Grogan-Kaylor, 2006) have empirically studied and furthered our knowledge (evidence) base about why and how children who are members of historically oppressed and discriminated groups struggle in school and how to reduce long-standing gaps in school achievement for such groups. However, such efforts must find the balance between making broad, or even stereotypical, assertions about members of certain cultural or ethnicity groups and identifying and explicating important cultural patterns impacting social functioning, assessment, and service delivery. The task for individual social work practitioners is to actively seek and synthesize knowledge about the client groups they are serving, from understanding cultural practices and norms to emerging research informing evidence-based assessment and intervention activities.

In sum, an effective assessment of a child in need of social work services requires data about not only the child's struggles, challenges, and functioning and the social microsystems—family, neighborhood, and school—in which that child is embedded but also the mezzosystem cultural dynamics of that child and his or her family along with the current and historical implications of that culture within the wider macrosystemic cultural context. Once such data have been gathered, the information must be organized into a coherent format for analysis and synthesis in order to inform intervention planning. A biopsychosocial assessment offers a format for such organization and synthesis.

Biopsychosocial Assessment Report

Organizing the data collected in a systematic and comprehensive social work assessment of a child involves bringing together these various elements that have evolved with the accumulation of social work practice knowledge. Reflecting the pervasive impact of the ecological perspective in social work, an assessment report of a child is most frequently termed a *biopsychosocial assessment* (Lukas, 1993), although some authors have referred to it as a *psychosocial study* (Cooper & Lesser, 2002) or a *multidimensional assessment* (Hepworth et al., 2002). The outline of a biopsychosocial assessment reflects the social work ecological orientation, including information about various aspects of the child, the presenting challenge, and the child's environment, that need to be attended to in the developing an effective service plan. Table 1.1 is a suggested

Table 1.1 Biopsychosocial Assessment Outline

Identifying Information

Child's name, age, race/ethnicity, physical appearance, religion
Child's place of residence, school, other important settings
Referral source and referral information

Presenting Struggle(s)

Child's definition
Parent/guardian's definition
Social worker's definition

History of the Struggle(s)

When did it start, how frequently, with whom, and where does it occur?
What social, emotional, psychological, learning, or medical/physical risk factors contribute to or are key factors in this struggle?
What are the consequences of the struggle to the child and family?
Results from assessment instruments: child reports, adult reports, and structured interviews
What attempts have been made to resolve this struggle:
—By the child or family?
—With the assistance of professional helpers?

Safety Concerns

Abuse or neglect concerns
Suicide or homicide risk

Developmental History

Current developmental challenges
Previous developmental challenges
Role of developmental issues in the presenting challenge

Family History

Multigeneration background of child's family setting
Ethnocultural issues: Acculturation stressors, language concerns, immigration/refugee status
Genogram

Strengths and Resilience Factors

Child's talents, resources, skills, and protective factors
Family strengths, resources, and protective factors
Extended family resources
Communal resources: Neighborhood, religious organization, ethnocultural organizations
Eco-map

Results, Interpretations, and Implications of Structured Assessment Instruments

Self-report instruments
Adult-report instruments
Structured interviews

Child and Family Needs

Economic: Income, housing, food, clothing, transportation
Social/emotional: Peer interaction, recreation
Educational: Appropriate school services
Medical: Health care, medication
Sociocultural: Translator, cultural specific support, community, advocacy
Legal: Guardian ad litem, current court involvement, advocacy

(*continued overleaf*)

Table 1.1 (*Continued*)

Mental Status Exam

Snapshot of child's social, psychological, cognitive, and behavioral functioning
Most often used in mental-health settings (see Cooper & Lesser, 2002)

Mental Health Diagnosis

DSM-V Axis Diagnosis—most often used in mental-health and other clinical settings; see the DSM-IV-TR (American Psychiatric Association)
Results from mental-health assessment instruments

Initial Contacts with Child and Family

Brief description of first meetings and actions taken
Child's and family's orientation to the social worker and helping process

Summary Statement

A paragraph or two summing up the key information

Initial Service Plan

Identify focus of initial service efforts
Goals and objectives for those efforts
Who will be involved, how, when, and for what purpose?

Note: This outline was adapted from Cooper and Lesser; Fraser, Richman, and Galinsky; Hepworth, Rooney, and Larson; and Lukas.

biopsychosocial assessment outline that reflects the evolution of social work thinking over the past 100 years as it relates to assessment. Some sections will not be called for, depending on the setting for practice, the child's developmental stage, the presenting struggle, and a child's particular circumstances. Further, additional sections may be needed in some situations to address specific issues that are relevant to a comprehensive assessment study of a specific child.

We have reviewed the evolution of the ecosystems perspective informing assessment in social work over the past 100 years: assessment tools that have grown out of that perspective, such as the PIE system, genograms, and eco-maps; the recognition of the critical role of issues in assessment, such as cultural diversity and oppression; and the organization of ecological assessment information into a systematic and comprehensive biopsychosocial assessment. These accumulated forms of social work assessment knowledge and strategies with children are still useful today across the very wide range of settings in which social workers serve children. However, there are setting- and situation-specific assessment tools that have more recently evolved since social work adopted the application of measurement theory in the 1970s and sought to develop more valid and reliable assessment tools for practice and research (Hudson, 1997). In the sections that follow, some of those assessment strategies for use in such categories as child welfare, schools, mental health, and health are detailed. This brings us into the 1990s and the emergence of

the movement in social work toward evidence-based practice (Gambrill, 1999). This movement has been calling for increased practice evaluation and research efforts to build evidence supporting the effectiveness of social work practice. Fundamental tasks toward that end are the development and application of evidence-based assessment strategies.

Summary of Current Evidence-Based Assessment of Children

Since Mary Richmond reviewed case records and interviewed social workers more than 90 years ago, members of the social work profession have endeavored to identify, disseminate, and increase the widespread use of what we have evidence to believe works best for clients. Over those many decades, our methodological tools to measure (a) the struggles our clients face; (b) the functioning levels of children and families across social, emotional, and behavioral domains; and (c) the impact of our professional efforts to help have steadily advanced. Those advancements have increased the profession's ability to determine what works best for clients, and our expectations for the evidence in support of those determinations should, therefore, likewise progress. The pursuit of EBP is the latest effort toward that progression (Gambrill, 1999). However, efforts to move toward an evidence-based approach to the assessment of children are only just beginning; whereas there has been an increasing focus on evidence-based intervention approaches for use with children, less attention has been given to assessment (Mash & Hunsley, 2005). Although it does seem true that limited effort has gone into evaluating and synthesizing the assessment tools and strategies available for specific situations for children from an evidence-based perspective, there are many tools out there with supporting evidence that can be identified and applied. Next, a process to identify such tools and strategies is offered.

Defining what qualifies as *evidence* in support of child assessment tools and strategies evokes issues of epistemology, paradigmatic orientation, and research and practice methodologies, a comprehensive discussion of which is beyond the scope of this chapter. Social work has been historically epistemologically diverse, valuing different ways of knowing (Fraser, Taylor, Jackson, & O'Jack, 1991). Within that historical context, the paradigm of *pragmatism*, which supports the application of the research or practice methods that work best for a question or client, and a *mixed-methods* approach—combining quantitative and qualitative tools, which in the case of assessment means using both clinical interview techniques and empirically tested self-report instruments or structured interviews—provide the epistemological foundation for this chapter (Tashakkori & Teddlie, 2003).

Fitting within the definition of what can qualify as evidence, Gambrill (1999) has offered a hierarchy of possible evidence in support of interventions that can be adapted to assessment tools and strategies for use with

children. Gambrill describes six levels; however, the last two are cases of the evidence indicating that an intervention would not be beneficial or even harmful. Therefore, the top four levels of evidence are adapted here:

1. Evidence level one, rigorously developed structured assessment instruments, which, attended to the developmental and cognitive characteristics of children, with resulting strong evidence of validity and reliability, demonstrated with multiple samples including in-practice settings substantially similar to the targeted population.
2. Evidence level two, well-developed assessment tools or strategies with some evidence of reliability and validity with at least one sample similar to the targeted population.
3. Evidence level three, child assessment tools or strategies with reliability and validity evidence from samples somewhat similar to the targeted population, or assessment tools with anecdotal or clinical evidence of utility with clients similar to the targeted population.
4. Evidence level four, tools or strategies that appear promising but for which no evidence exists about their utility with the targeted population.

However, locating the practice approach for any given situation with the best supporting evidence requires some effort. Applying EBP is more of a process or goal than a destination. A five-step process emerging from the medical field to locate the best evidence has been applied to child welfare practice (see Shlonsky & Wagner, 2005). Applying that five-step process to the various social work practice contexts in which assessment of children is needed can inform a systematic approach to deciding which assessment approaches would be best in a given setting with a specific population of children who are experiencing a certain range of struggles or challenges:

1. State the assessment needs in the situation of interest as a question that can be answered. For example, what is the best approach to assess depression in elementary-aged children in schools?
2. Search for the best evidence with which to answer that question. In the current example, that process might start with searching the literature for assessment tools and strategies that have been shown to be reliable and valid—see the following section for a discussion of the reliability and validity of assessment instruments—with latency-aged children, that are accessible to school social workers, and that would effectively and efficiently assess potentially large numbers of children.
3. Evaluate the tools and strategies found in light of the available evidence in support of their utility, in this case, comparing reliability and validity results and evaluating descriptions of their application in elementary school settings.

4. Relying on the clinical experience and judgment of the practitioners involved, integrate the results of the evaluation of the available tools and strategies with the specific characteristics and needs of the clients who will be assessed.
5. Appraise the performance of the previous four steps with the goal of making the next search for needed assessment tools and strategies more streamlined and effective.

With the state of our knowledge and evidence in support of our practices ever advancing, this process may need to be done with some regularity so current practices in an agency or utilized by a social worker do not fall significantly behind the current state of the evidence. That process points out that one of the advantages of EBP is the constant pursuit of providing the best services to clients, which is in sync with the ethical values of social work. Other advantages include encouragement of ongoing professional development and transparency of the effectiveness of social work services that maximize practitioners' providing clients with the opportunity to make informed consent about services (Gambrill & Shlonsky, 2001). Although such a process is needed to find the best currently available assessment tools for a specific situation, some general principles of an evidenced-based approach to the assessment of children can be gleaned from our accumulating knowledge. One is the use of multiple informants in the assessment of children.

Multiple Informants

As asserted earlier, the central goal in the assessment of a child is the formulation of an intervention plan. To effectively inform that intervention, an evidence-based assessment uses the best available tools and strategies to gather information about the child, the presenting struggle or challenge, and the critical microsystems that child inhabits, such as his or her family, school, and neighborhood. The accumulating evidence supports the conclusion that the most effective strategy is to collect that information from multiple informants who know and interact with that child (N. K. Bowen, Bowen, & Woolley, 2004; Pelham, Fabiano, & Massetti, 2005). Multiple informants (such as the child, parents/guardians, and teachers) typically do not agree on important aspects of the child's functioning, because those multiple informants will have different perspectives emerging from different settings, all of which may hold ''truths'' about the child (Bidaut-Russell, Valla, Thomas, Bergeron, & Lawson, 1998; Ivens & Rehm, 1988; March, Parker, Sullivan, Stallings, & Conners, 1997; Montgomery, 1994; Tinsley & Holtgrave, 1997; Wright-Strawdermann & Watson, 1992; Yugar & Shapiro, 2001). This is a very important point; no reporter providing assessment data about a child the child, parent, foster parent, sibling, teacher, police officer, probation officer, and so on—should be seen either as the gold standard or without merit. The type of data sought, the knowledge and experiences of the possible reporters pertaining to the

child, the apparent veracity of those reporters, any complicating factors impacting the data provided by those reporters, and myriad other possible situational factors must be included in the evaluation and utilization of assessment data collected. Still, the most effective strategy is to gather assessment data about a child from multiple informants.

Child

Children have often been assessed by gathering information only from adults, such as parents/guardians and teachers. However, research has found that children often report higher rates or severity of social or emotional problems than adult informants—for example, depression—which is experienced internally and not easily observed (Breton, Bergeron, Valla, Berthiaume, & Gaudet, 1999; Wood, Kroll, Moore, & Harrington, 1995). Further, it has been found that children as young as 6 provide assessment data that can be more predictive of future functioning than adult-report assessment data (Ialongo, Edelsohn, & Kellam, 2001). These findings should lead clinicians and researchers to discontinue assessing children solely or even primarily by adult reports. Clearly, assessing a child should include gathering data directly from that child.

Parent/Guardian

There are many important aspects of the child's functioning for which the caregiving adults can provide vital information. It also seems self-evident that parents/guardians can provide important information about the family situation, information that is not appropriately gathered from the child, such as financial issues, parent/guardian health, mental health, substance abuse struggles, or marital conflicts negatively impacting parenting behaviors. Parents/guardians may also observe improvements, such as in behavior, mood, or other functioning, before the child does.

Other Family

Informed by the ecological-systems perspective, family therapists have long observed that other family members may provide valuable assessment information about a presenting challenge or struggle with a child (Haley, 1987). For example, a sibling may have a perspective on a child's problem or functioning that is not available to the child or parents/guardians. Similarly, cultures with strong extended families, such as extended family caregiving networks, may mean that grandparents, aunts, uncles, or even cousins may be vital participants in a child's life and provide important assessment data (Paniagua, 2005).

Teachers

How a child functions at school is an important question in any assessment of a child, because school performance is a vital developmental outcome for children (Woolley & Grogan-Kaylor, 2006). Teacher input is a valuable source of data about the child's school functioning, and that is why

teachers are important reporters in several well-validated child assessment instruments for elementary school-aged children (e.g., N. K. Bowen et al., 2004; Essex et al., 2002).

Multiple Data Collection Strategies

Clinical Interviews

Assessment interviews are the traditional method of collecting assessment data in social work with children and their families. This is still a foundation strategy for assessing and intervening with children and likely always will be. A clinical interview is required as a starting point to determine what other assessment tools and strategies may be appropriate. Although the more structured assessment tools described next can collect reliable and valid data about children, the interpretation of those tools, their application to the presenting struggle or challenge, and the formulation of a plan for intervention are still tasks that can only be accomplished with the skills, experience, and judgment of a trained social worker. Additionally, once more structured assessment tools have been administered and scored, a social worker can use his or her clinical skills to gather more information from the child and family about what the scores may mean.

Structured Survey Instruments

Self-report instruments are completed by the child or other informant and mathematically represent the child's or informant's—parent/guardian, other family, teacher—perception about the extent or level of a struggle or challenge by assigning it a number. In the case of a child self-report instrument assessing depression for example, each question or item measures the presence and/or extent of a depression-related symptom. Therefore, a depression self-report measure relies on a child or other reporter to accurately answer questions about the child's behaviors, thoughts, beliefs, feelings, attitudes, and/or perceptions. Self-report assessment instruments typically consist of multiple questions or items with two or more response options. Most instruments include subgroups of items designed to measure different underlying symptoms impacting the child. Each such group of items constitutes a *scale*, and an assessment instrument may contain one or multiple scales (DeVellis, 2003). As discussed previously, the quality of such an instrument is a function of the evidence in support of its reliability and validity.

Reliability is the extent to which an assessment tool is consistent. When an instrument is consistent across time, it will result in similar depression scores at two different points in time with the same child (assuming the level of depression has not changed). That type of reliability is referred to as *test-retest* reliability. When an instrument is consistent across items in a scale, groups of items designed to measure the same underlying depression construct will show a pattern of similar answers within any given report. That type of reliability is known as *internal consistency reliability*, which is the most often reported form of instrument

reliability and is usually estimated with Cronbach's formula for alpha (Cronbach, 1990).

Reliability coefficients range from 0.0 to 1.00. The closer to 1.00 the coefficient is, the more consistent the instrument is from administration to administration or among the items in the scale. A reliability coefficient can also be interpreted as revealing the percentage of an individual score that is attributable to the true score. In other words, if an instrument has an alpha of 0.80, 80% of the score is attributable to the child's level of depression, and 20% is attributable to something other than depression—in other words, sources of error. The reliabilities of child-report instruments are typically lower than for adult instruments. In general, reliabilities above 0.80 are considered good, with above 0.70 considered acceptable. However, given that an instrument with a reliability of 0.70 includes 30% error, then scores with such an instrument must be interpreted in that light. For example, if an intervention is anticipated to have a 30% effect on a struggle or challenge, and the assessment tool used to measure change in the client before and after that intervention has a 30% proportion of measurement error, then the assessment tool being used will be limited in its ability to consistently detect true change. Reliability is the most often reported characteristic of instrument quality, and although good reliability is a necessary characteristic of a quality instrument, it is not by itself sufficient to evaluate an instrument. For an instrument to be judged to have level one or two evidence as defined previously, evidence about its validity must also be available.

Validity is the extent to which an assessment tool measures what it is supposed to measure for a given individual at a given point in time. An instrument can be shown to be valid if it is shown to result in scores similar to a previously validated instrument or is predictive of outcomes or other variables with known relationships to the measured struggle or challenge. If an assessment tool is shown to result in similar scores to other tools that are known to be valid, it is said to have *criterion validity*. If an assessment tool is shown to be associated with related constructs in the predicted manner, the assessment tool is said to have *construct validity*. Assessing the validity of child-depression instruments can be difficult because there are often a limited number of quality instruments available for use with children for a given purpose. Developing reliable and valid assessment tools requires careful and rigorous research. When developing assessment tools for use with children, the combination of the developmental level and limited cognitive ability of children makes that process even more difficult.

In terms of the example of assessing depression in children, such an assessment tool would be the Mood and Feelings Questionnaire (MFQ), a 33-question self-report instrument designed for children ages 8 to 18. The child rates statements describing depressive symptoms within the past 2 weeks on a 3-point scale. In addition to the child form, there is also a parent form to collect multi-informant data. Studies have shown good reliability for both the child (alpha = 0.90 to 0.94) and parent (alpha = 0.90 to 0.92) forms of the MFQ (Angold et al., 1995; Wood et al., 1995). The

correlation between the child and parent forms has been found to range from 0.51 to 0.65, which represents higher inter-reporter correlation than typically found (Kent, Vostanis, & Feehan, 1997; Wood et al., 1995). The child form has been shown to have significantly higher diagnostic validity (Wood et al., 1995). Efforts to merge child and parent data have failed, because no combination was more valid than the child data alone, which emphasizes the importance of gathering assessment information directly from children.

Structured Interview Instruments

Structured interview instruments consist of a set of scripted assessment questions that are asked of an informant by the social worker, with the responses to the questions indicated on the instrument form. The answers to the questions lead to a score, which will quantify specific struggles or symptoms that the child may be experiencing. Structured interview instruments are evaluated utilizing the same reliability and validity criteria used to evaluate the evidence in support of survey instruments. An example of such a tool is the Diagnostic Interview Schedule for Children (DISC), which is designed to assess for 30 different mental disorders in children. The DISC includes both a child and parent interview form and has been shown to have good reliability and validity in the assessment of mental disorders in children, from disruptive behavior disorders to anxiety and depressive disorders (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). However, few such structured interview instruments have been developed for social work practice settings, despite being a potentially reliable and valid strategy to collect assessment data while utilizing the interview skills of a social worker and interactions embedded within the social work relationship with a child and family.

Direct Observation

In many social work practice settings, such as schools, residential-treatment facilities, and inpatient psychiatric hospitals, social workers can directly observe children being assessed. Such observations can be made in various settings, structured and unstructured, and in interactions with various significant others, such as peers, teachers, parents/guardians, and other family. This allows the social worker to collect data about child functioning not filtered through the perceptual process of the child or other reporter. Such observation can be done in a systematic and structured manner utilizing observation protocols that can quantify the frequency and extent of targeted behaviors. For example, in the assessment of school behavioral struggles—referred to as a functional behavioral assessment—it is standard procedure for the social worker to observe the child in multiple circumstances at school, chosen in light of the behavioral struggles (Gresham, Watson, & Skinner, 2001). The data collected in those observations are vital to identifying the child and contextual factors that lead to and emerge from the behavior, informing strategies to create behavioral change.

Limitations of the Evidence

One limitation to the application of assessment tools with supporting evidence is the limited number of such tools for use with children. For example, in Corcoran and Fischer's (2000) widely used sourcebook of assessment tools for use in social work practice and research, there are 265 instruments listed for use with adults, whereas only 49 are listed for use with children. On closer examination of the instruments listed for children, 21 are for use exclusively with adolescents, 5 are completed by adults about youth, and 2 do not specify an age range or age information about the normative sample. This leaves only 21 child-report assessment tools presented as appropriate for use with children.

In terms of using the instruments that are available for use with children, significant limitations to the collection of reliable and valid assessment data can be seen as a function of three factors: first, children's cognitive ability is limited according to their age and developmental level to provide such assessment data, although they are still often the best, or only, source of assessment data about many childhood struggles and challenges; second, although adults can provide assessment data about many important targets of assessment, their reports are limited to their observations of the child and are filtered through their own perceptual processes, which are subject to distortion and bias; third, the quality of research methods applied to develop assessment tools to collect valid and reliable data directly from children varies. Next we discuss the limitations of children to provide assessment data followed by emerging and promising methods to develop better assessment tools for use with children.

Childhood can be separated into three phases: infancy, early childhood, and middle childhood (Ashford, LeCroy, & Lortie, 2001). Gathering assessment data about infants is limited to adult-report and observation of the infant. Children under the age of 6—early childhood—present cognitive limitations that severely constrain providing assessment information, and the reliability of such information can be difficult to determine. Therefore, for children in early childhood, assessment is largely limited to adult reports and observational data. However, as our methods improve and our understanding of child cognitive capacity continues to advance, we may yet develop tools to collect reliable and valid assessment data from children under 6.

In middle childhood (6–12 years), children develop their own culture, characterized by social rules, familiar games, interpersonal reciprocity, and attention to fairness (Ashford et al., 2001). This is a critical time in development when physical skills, social skills, and academic skills are acquired at a rapid rate. It is in this phase that children first have the cognitive ability to reliably and validly self-report perceptions, feelings, beliefs, and experiences. However, the cognitive ability of children in middle childhood is still much lower than adults, and careful attention to developmental issues is necessary in order to gather quality information (Chorpita, Albano, & Barlow, 1998; Garbarino, Stott, & Faculty of the

Erikson Institute, 1989). Still, recent research indicates that children have a mostly positive reaction to providing assessment data, such as filling out self-report assessment instruments, more positive than adolescents, and that girls are also more positive than boys (Saldana & DuBois, 2006).

However, the quality of evidence in support of assessment tools and strategies for use with children 6 to 12 is limited. The tools that are available typically have lower levels of reliability and validity evidence than seen for adult instruments. Childhood is a time of rapid growth, and children, as a function of their age and emerging cognitive ability, have limitations in their capacity to reliably and validly self-report perceptions, feelings, beliefs, experiences, and behaviors (N. K. Bowen et al., 2004; Chorpita et al., 1998; Woolley, Bowen, & Bowen, 2004).

Clearly, the cognitive demands of self-report instruments for children in middle childhood, including format and wording, are critical features in the development and selection of valid self-report instruments for children (N. K. Bowen et al., 2004). Instruments that meet these criteria are considered developmentally valid, which has been defined as the cognitive demands of an instrument—vocabulary, length and complexity of items, level of abstraction, nature of measured concepts—falling within the cognitive ability of children in the targeted age range (Woolley et al., 2004). These developmental issues impact the reliability and validity of child self-report instruments. However, the emerging use of *cognitive methods* to assess and advance the validity of assessment tools for use with children holds great promise to advance the validity of such instruments.

Emerging Trends in Child Assessment

Child struggles and challenges that are the attention of social work services can be measured with self-report assessment instruments. However, for the development of such instruments to lead to reliable and valid tools, that development process must follow consistent and rigorous methods. DeVellis (2003) has detailed a step-by-step procedure to construct reliable and valid assessment tools (Table 1.2).

Table 1.2 Assessment Instrument Development Procedure

Step	Task
1	Identify what struggle or challenge you want to assess.
2	Generate a pool of questions.
3	Determine the format for the assessment tool.
4	Seek review of question pool by experts in the specific area of practice.
5	Administer the assessment tool to a pilot sample.
6	Statistically evaluate questions and overall assessment-tool performance.
7	Optimize assessment-tool length.

Based on *Scale Development: Theory and Applications* (pp. 51–86), by R. F. DeVellis, 2003, Thousand Oaks, CA: Sage.

Such a procedure outlines the typical assessment-tool development process; however, such a procedure does not take into account the developmental level of children and the associated cognitive limitations of children to provide assessment data about themselves. *Cognitive methods* are a group of strategies used in the development of self-report questions used to assess the validity of assessment questions by collecting data directly from respondents about how they interpret and respond to such questions.

Cognitive methods emerged from a seminar held in 1983 that included cognitive psychologists and survey methodologists. The goal of that meeting was to develop a methodology to increase the validity of self-report questions through the application of theories of human cognition. Since that meeting, cognitive methods have been applied with adults (Jabine, Straf, Tanur, & Tourangeau, 1984; Jobe & Mingay, 1989), and only more recently with children (N. K. Bowen et al., 2004; Woolley et al., 2004). Cognitive interviewing is the cognitive method that is most applicable with children and involves interviewing a child while he or she reads and responds to an assessment question in order to collect data about four steps in the self-report process: (1) comprehension (reading and interpreting the item accurately), (2) retrieval (adopting the appropriate perspective for the item), (3) judgment (understanding the response continuum and the response options within the context of the item), and (4) response (providing an answer and demonstrating an ability to provide a rationale for the answer; DeMaio & Rothgeb, 1996; Jobe & Mingay, 1989; Tourangeau, Rips, & Rasinski, 2000). Table 1.3 details an example of an interview procedure to collect such data from children. Those data are used to evaluate the validity of the information gathered from children with respect to the intent of the self-report questions tested and to inform changes to the questions in order to increase the validity of child responses.

Once cognitive interview data have been collected about an assessment tool under development from children who are members of the

Table 1.3 Cognitive Interview Procedure

Step	Ask the Child
1	To read the assessment question out loud.
2	To describe what he or she thinks the question is trying to find out and/or what reading the question made the child think about.
3	To read the answer options out loud.
4	To pick the best answer option to the question for him or her.
5	To explain his or her answer.
6	If he or she can give an example of why he or she chose that answer.

Based on ''Constructing and Validating Assessment Tools for School-Based Practitioners: The Elementary School Success Profile'' (pp. 509–517), by N. K. Bowen, G. L. Bowen, and M. E. Woolley, in *Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services*, A. R. Roberts and K. Y. Yeager (Eds.), 2004, New York: Oxford University Press; and ''Cognitive Pretesting and the Developmental Validity of Child Self-Report Instruments: Theory and Applications,'' by M. E. Woolley, G. L. Bowen, and N. K. Bowen, 2004, *Research on Social Work Practice, 14*, pp. 191–200.

targeted population, that data can be analyzed to determine the validity of the interpretation of assessment-question meanings and chosen answers by that sample of children. That analysis is best guided by the construction of a validity codebook, which defines the acceptable ranges of question interpretations and rationale for chosen responses (Woolley, Bowen, & Bowen, 2006).

This approach has been used with promising results in the development of an assessment tool for use with children in school settings, the Elementary School Success Profile (N. K. Bowen et al., 2004; Woolley et al., 2006). N. K. Bowen and colleagues found that the methodology revealed significant validity problems in assessment questions for children that would not have otherwise been identified and that the methodology could be applied systematically and with reliable results (Woolley et al., 2006). This line of research suggests that the application of cognitive methods, specifically cognitive interviewing, in the development of assessment tools for use with children will result in more reliable and valid instruments and better evidence to support those qualities. More widespread application of this method will lead to better assessment tools available to social workers for practice purposes in the varied settings in which children are served.

Implications for Social Work on Micro-, Mezzo-, and Macrolevels

Child Protection

Few practice settings involve the level of potential consequences for the decisions made at the end of the assessment process than in child protection work. Although correct decisions can save children's lives, literally and metaphorically, wrong decisions can lead to death or long-term damage from traumatically removing children from their families when not necessary. Therefore, in the practice of child protection today, the primary goal is to assess *risk*. That risk comes from the behavior of the caretakers of that child, but, as in all areas of child assessment, assessment should include assessing the child, the caretakers, the social environment, and how those three interact. The risk being assessed can take on two forms: the child's being seriously mistreated in the immediate future or the cumulative negative impact on that child's developmental outcomes. However, much as in other areas of child assessment, there is tension between the two assessment strategies—clinical interview or structured instrument—in this context referred to as ''actuarial and clinical'' (Munro, 2002). Traditionally, assessment in child protection was clinical in nature and relied on the experience, judgment, and evolving practice wisdom of caseworkers. Over the past 20 years, that evolving practice wisdom has informed the development and empirical evaluation of risk-assessment actuarial instruments, which have consistently demonstrated higher predictive validity (Baird & Wagner, 2000). Table 1.4 lists factors often included in child-maltreatment risk-assessment instruments.

Table 1.4 Child-Protection Risk-Assessment Factors

Adult Factors

- Number and severity of previous child-maltreatment events
- Developmental history
  - Instability
    - Childhood—frequent moves, change in household members, parental absences
    - Adolescence—substance abuse, mental illness, criminal behavior
    - Inadequate parental nurturing or supervision
  - Abuse history
    - Victim of coercive, hostile, or neglectful parenting
    - Was he or she a victim or witness of abuse as a child
    - Nature, duration, frequency of that abuse
  - Alcohol or drug abuse
    - Currently using
    - Failed attempts at treatment
  - Mental-health or cognitive problems
    - Mood disorder or personality disorder
    - Insecure adult attachment style (ambivalent or avoidant)
    - Low self-esteem
    - Violent behavior toward others or suicide attempts
    - Learning disability
    - Low intellectual functioning
    - Cognitive distortions in terms of the use of violence
    - Noncompliance with treatment or medications
  - Poor problem-solving skills
- Age 20 or younger at birth of first child
  - Gender—males at higher risk of reoccurrence
  - Single parent
  - Partner not biological parent of child
  - Lack of social support
    - Lack of knowledge about parenting or child development
    - Lack of insight into or failure to anticipate child's needs
    - Unrealistic expectations for child behavior
    - Lack of or poor supervision of child
  - Placing own needs above the needs of the child
  - External locus of control
  - Chronic illness
  - Previous use and availability of weapons
  - Previous service contacts

Family-Situation Factors

- History of family violence
- Attachment difficulties
  - Lack of concern or warmth toward the child
  - Negative attitude toward pregnancy
  - Prolonged separation(s) of mother and child
- Fewer than 18 months between births of children
- High levels of family stress
- Family feels isolated

(*continued*)

Table 1.4 (*Continued*)

Family-Situation Factors
Family targeted or exploited by local community
Family members emotionally supportive of each other
Is the house dirty, cluttered, or disorganized
Have other professional helpers felt intimidated or had needed services rejected
Any children under 18 not living at home
Previously found abuse or neglect
Economic struggles
Unemployment
Poor housing—unsafe, lack of privacy, residential instability
Parental discipline
Coercive parenting
Yelling, shouting, or criticizing
Hostile or threatening
Random punishment
Few positive strategies used to reinforce or change behavior
Child Factors
Unplanned child
History of attachment difficulties
Being younger (especially under age 5)
Adopted, foster child, or stepchild
Being premature, low birth weight, or currently underweight
Chronic illness, developmental delay, or birth defect
Difficult to comfort, cries frequently, or difficult temperament
Mental or physical disability
Gender
Girls more likely to be sexually abused
Boys more likely to be seriously physically abused
Poor school attendance or frequent tardiness
Appearance
Inappropriately dressed
Looks tired, unkempt, or neglected
Child complaining about care or treatment at home

Note: This list of risk factors was adapted from Corby (2000); Fowler (2003); Munro (2002); and Righthand, Kerr, and Drach (2003).

The tension between clinical and actuarial risk assessment has spawned a debate in the literature that has been referred to as the ''risk assessment wars'' (Johnson, 2006). However, such an either/or debate about the relative merits of clinical versus actuarial assessment represents a false dichotomy leading to a pointless turf war—a false dichotomy because it implies the need to chose one or the other while ignoring the differential and complementary merits of each. It also ignores the fact that neither by itself has proven to be reliably effective in assessing risk

for maltreatment so far, defined as both high rates of sensitivity and specificity (Munro, 2002). In fact, still-quite-limited research has examined the predictive validity of risk-assessment instruments for child protection, and some have shown marginal performance (Camasso & Jagannathan, 2000; Rittner, 2002). Such research has offered suggestions about how to improve the validity and utility of risk assessments, including making them shorter, easier to score and interpret, multilevel risk classification as opposed to binary in nature, better training of caseworkers in the science informing their development and use, and more input of clinical wisdom to their design (Baird & Wagner, 2000; Baumann, Law, Sheets, Grant, & Graham, 2005; Camasso & Jagannathan, 2000). Still, actuarial approaches have shown clear utility, and it is reasonable to anticipate that ongoing research will continue to advance their utility and predictive validity in the years to come. Alternatively, it seems illogical to remove the benefits of clinical information gathering and judgment informed by experience from the important work of protecting children while assessing and helping the huge diversity of families confronted by child-protection systems with respect and dignity.

In the general discussion of evidence-based assessment with children, the use of both multiple information sources and data-gathering strategies was advocated. Shlonsky and Wagner (2005) have called for just such an integrated approach in child-protection assessment. They assert that actuarial risk assessment has the best potential to predict future reoccurrence of child maltreatment, whereas clinical or contextual assessment of child and family functioning, as they call it, is the most effective way to identify treatment factors that need to be addressed and the services that would most benefit the family. The authors describe this *structured decision-making* process, which integrates actuarial risk assessment combined with clinical judgment. In this approach, an actuarial risk assessment determines the initial response, and clinical assessment of the child and family determines the case planning and services provided. That clinical assessment includes gathering information about family struggles as well as strengths in such areas as family relationships, social support, health, mental health, substance abuse, and housing. Other sections of this chapter and volume can be consulted for guidelines to assess these areas of child and family functioning and needs.

Forty states have adopted the use of structured risk-assessment instruments at various points in the child-protection service process, which may include many points from deciding to open a case, removing a child from the home, returning a child, or closing a case (Camasso & Jagannathan, 2000). Still, the process to gather the information and fill out the risk-assessment instrument, as well as to assess the current situation and functioning of the child and family, relies on the clinical skills, judgment, and experience of caseworkers. The future of assessment in child protection hopefully will bring the development of more predictive and utilitarian risk-assessment instruments and integration of those instruments with clinical

skills and judgment, informing a more evidence-based approach to the vital work of child protection.

Schools

Schools are one of the few settings in which social workers can practice on micro-, mezzo-, and macrolevels. For example, a child who is being teased and bullied can be addressed on a microlevel to increase that child's ability to cope and respond when bullied, on a mezzolevel to reduce bullying in a classroom, or on a macrolevel to implement a program to change the social climate of a school system to reduce teasing and bullying throughout the district (Woolley, 2006). Because schools serve all children, including those in need of services from child protection, mental health, and health-care providers, school social workers provide assessment, referral, and intervention services literally to the whole population of children in a given area. Therefore, the assessment tools and strategies needed by school social workers bridge the needs of social workers from many other settings that serve children, and the trends discussed in other sections of this chapter may also be informative to school practice.

However, school social workers also have the unique task of completing an ecologically oriented systematic and comprehensive assessment of a child or groups of children, the findings of which can inform prevention or intervention planning to reduce the impact of specific struggles or challenges that negatively impact school success. To that end, there are assessment tools that have been rigorously developed and have level one or two evidence to support their use with children in schools. One such tool is the School Success Profile (SSP; G. L. Bowen, Woolley, Richman, & Bowen, 2001) for use with middle and high school students, and another is the Elementary School Success Profile (ESSP; N. K. Bowen et al., 2004) for use with children in third through fifth grades.

The SSP is an ecologically oriented self-report assessment instrument for use in school-based practice that includes 220 questions. Those questions gather assessment information about the risk and protective factors in a child's life across five domains affecting school outcomes, including school, family, peers, neighborhood, and health and well-being. The SSP has gone through multiple revisions over more than 10 years of research and practice use, and its reliability and validity have been demonstrated (G. L. Bowen, Rose, & Bowen, 2005). The SSP can be used to inform micro-, mezzo-, or macrolevel practice, because scoring the instrument can result in both individual student and group (classroom, grade, school) results that can then be used to inform prevention and intervention planning for students at risk of school failure.

Emerging from the development and use of the SSP, the ESSP includes three forms—child, parent/guardian, and teacher—and so fits within the use of multiple informants of information about children suggested earlier. Cognitive interviewing methods were applied in the rigorous development

of the ESSP, and the child form is computerized and animated to appeal to younger children and hold their attention. For more information about the SSP or ESSP, please go to www.schoolsuccessprofile.org

Mental Health

The area of mental-health practice with children has the benefit of the most attention in terms of developing assessment tools. Partly as a benefit of the medical model, which is built on arriving at a diagnosis for the purpose of insurance and publicly funded health care, there are assessment instruments for many childhood mental-health problems. Such instruments have varied levels of evidence about their reliability and validity and include assessment tools to measure childhood depression (Angold et al., 1995), anxiety (Silverman & Ollenbeck, 2005), behavior problems (Macgowan, Nash, & Fraser, 2002), thought disorders (Kaufman et al., 1997), attention problems (Pelham et al., 2005), suicide risk (Reynolds & Mazza, 1999), trauma (Balaban, 2006), and multiple mental-health struggles (Shaffer et al., 2000). Social workers practicing in mental-health settings with children should have success in finding assessment tools with level one or two evidence for most mental-health issues with children by following the procedures outlined previously. However, professionals from other disciplines, such as psychology or psychiatry, have developed many of those instruments, with few being developed from the unique perspective of social work practice. That is also the case, although less so, in other areas of social work practice. In order for social work to develop its own assessment tools and strategies informed by a social work perspective that have supporting evidence, more social work researchers and practitioners need to engage in the work of developing assessment tools.

An example of a social work–constructed assessment tool is the Carolina Child Checklist, developed by Fraser et al. (2005) as part of an overall intervention research project to prevent aggression and behavior problems in children aged 8 to 12. This teacher-report instrument was developed utilizing rigorous methods, has demonstrated reliability and validity, identifies both male and female forms of aggression in children, and was developed not just as an assessment tool but also as a research tool to be sensitive enough to provide evidence about the effectiveness of a manualized preventive intervention for use with third-grade children and their families (Macgowan et al., 2002). Fraser and colleagues' work, from the construction of assessment tools to intervention development, implementation, and evaluation, presents a meritorious model for the pursuit of evidence-based practice in social work.

Child Struggles That Cross Settings

Research in social work across these various settings in which children are served has made it increasingly clear that assessment processes in one setting overlap with and should include the assessment of needs and

struggles traditionally seen as the practice domain of other child-serving settings.

For example, Shannon and Tappan (2011) examine the practices of social workers in child protective services (CPS) with regard to the prevalence and implications of children served by CPS who have developmental disabilities. Their findings support a call for widespread systematic assessment of developmental disabilities among children served by CPS and the training of CPS workers in such assessment. Not only do a large percentage of children served by CPS have such disabilities, but such disabilities impact the capacity of such children to verbally report on their potential experiences of abuse or neglect. Further, CPS workers need training in understanding such disabilities and the treatment and service needs of such children, with the goal being CPS workers who no longer see a developmental disability as simply one more risk factor but as a parallel and interrelated issue needing specialized interventions and services.

Similarly, increasingly schools are seen as an ideal setting to provide mental-health services for children and screen children for mental-health struggles or needs. For example, Woolley and Curtis (2007), after discussing the natural fit of providing mental-health services in schools and the increasing frequency at which schools are becoming the site of mental-health delivery for children, then provide information for social workers on how to identify valid and reliable assessment tools, in particular for the assessment of depression in elementary-aged children. Similarly, Caselman and Self (2008) detail the importance in social work practice of early identification and intervention with young children with emerging educational or mental-health struggles. To that end, they review nine available adult—teacher and parent—report instruments to assess social, emotional, and behavioral development and struggles in children. They, too, point out how school social workers are uniquely positioned to complete such vital assessments.

Conclusion

To paraphrase Shakespeare, for something to go well, it must start well. Assessment is the starting point of all social work practice activities. Social workers provide services in a multitude of settings to children and their families who are facing a broad range of struggles and challenges. To serve children in the most ethical and effective manner, social workers must identify and apply the best assessment tools and strategies available. That goal is best accomplished by identifying the assessment tools and strategies with the best available evidence supporting their use and quality. This chapter reviews the history of the social work orientation to the assessment of children over the past 100 years. The wisdom accumulated over that century informs the current approach to such assessment offered here, including the format for organizing that assessment information into

a biopsychosocial assessment report and the best available current tools and strategies to collect that information.

The approach to child assessment offered in this chapter includes an ecological-systems framework, which means (a) collecting data from the child, parents/guardians, and others, such as teachers; (b) using multiple data collection tools, such as clinical interviews, self-report instruments, and structured-interview instruments; and (c) direct observations of the child. The significant limitations—in number and quality—of the currently available assessment tools for use with children is described, and a process to identify what is available and how good the evidence for specific practice applications is offered. Emerging assessment-tool development methods are reviewed that promise to lead to more reliable and valid child-assessment tools in the future. Finally, social work practice setting-specific assessment issues in the arenas of child protection, school, and mental-health practice are reviewed.

In closing, social work has much work to do to develop more reliable and valid tools and strategies to assess children across all practice settings. If we are to move toward more EBP, then the need for assessment tools that start those services well and can effectively be used to measure the efficacy of prevention and intervention activities must be a primary focus of ongoing research and practice efforts.

Key Terms

Children	Biopsychosocial	Evidenced-based
Assessment	Ecological perspective	

Review Questions for Critical Thinking

1. What assessment information should be collected in social work practice in any assessment of a child and family across a wide range of social work service settings and child-presenting struggles?
2. Within the varying practice settings of school, mental health, child welfare, health, and juvenile justice, what are the advantages of taking a multi-informant and multiple data-collection methods approach?
3. Given that an ecologically informed comprehensive assessment of a child, family, and presenting struggle(s) should include clinical interviews, structured interviews, self-report instruments, direct observations, and reviews of existing records, in what order would you complete those varying data-collection methods? What are the advantages or disadvantages, for example, of reading the prior records first or last? Would the setting or presenting struggle impact your decision on that order, and how would that be a factor?

4. Discuss social work values and practice ethics as they relate to the assessment of strengths and environmental resources and the use of genograms and eco-maps in direct practice with children and their families.
5. What are the importance and implications of the reliability and validity of self-report assessment instruments for use in both practice and research activities?

Online Resources

http://csmh.umaryland.edu/ ***The Center for School Mental Health*** at the University of Maryland. This site has information for school practitioners, school leaders, and families. Note that on the right under the ''Practice'' link, click ''Tools for Clinicians,'' and you will find a link to a list of mental-health assessment tools and instruments for use in schools that are all free of charge.

http://www.cebc4cw.org/ ***The California Evidenced-Based Clearinghouse for Child Welfare*** is funded by the California Department of Social Services. Note that in the links down the left side is ''Assessment Tools,'' which brings you to a lengthy list of both child and family assessment instruments and tools, for which the quality of the validity and reliability of each instrument are listed along with how to access the instruments.

http://www.childwelfare.gov/famcentered/casework/assessment.cfm This is the ***Family-Centered Assessment*** page of the ***Child Welfare Information Gateway*** sponsored by the U.S. Department of Health and Human Services. Multiple assessment tools are listed and described for use with children and their families in child-welfare settings. See this page as an introduction to the organized and synthesized information available from the U.S. government on social work practice in general and assessment of children in particular. Try http://www.childwelfare.gov/systemwide/assessment/family_assess/childneeds/mental.cfm for information on assessment of child mental-health issues. Spend some time looking around this site and its links and see what useful assessment tools you may find for your practice.

http://www.modelsforchange.net/publications/328 This is a link to a report from the site ***Models for Change: Systems Reform in Juvenile Justice*** funded by the MacArthur Foundation. This report details assessments used in evidence-based juvenile justice practice, from assessing mental-health struggles of adjudicated children to assessing risk for reoffending. Also note, go to the ''Home'' of this site and plug ''assessment'' into the search function, and you will find many other links to assessment informations, tools, and strategies in juvenile justice practice.

http://smhp.psych.ucla.edu/pdfdocs/assessment/assessment.pdf This is a link to a report on assessment indicators and tools for mental-health practice in schools from the ***Mental Health in Schools Center*** at the University of California Los Angeles. Look at the whole website—home is http://smhp.psych.ucla.edu/—for a wide range of information about mental-health practice with children, and practice in school settings in particular.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Angold, A., Costello, E. J., Messer, S. C., Pickles, A., Winder, F., & Silver, D. (1995). Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents. *International Journal of Methods in Psychiatric Research*, *5*, 237–249.

Appleby, G. A., Colon, E., & Hamilton, J. (2007). *Diversity, oppression, and social functioning: Person-in-environment assessment and intervention* (2nd ed.). Boston, MA: Allyn & Bacon.

Ashford, J. B., LeCroy, C. W., & Lortie, K. L. (2001). *Human behavior in the social environment: A multidimensional perspective*. Belmont, CA: Wadsworth.

Baird, C., & Wagner, D. (2000). The relative validity of actuarial- and consensus-based risk assessment systems. *Children and Youth Services Review*, *22*, 839–871.

Balaban, V. (2006). Psychological assessment of children in disasters and emergencies. *Disasters*, *30*, 178–198.

Baumann, D. J., Law, J. R., Sheets, J., Grant, R., & Graham, C. (2005). Evaluating the effectiveness of actuarial risk assessment models. *Children and Youth Services Review*, *27*, 465–490.

Bidaut-Russell, M., Valla, J.-P., Thomas, J. M., Bergeron, L., & Lawson, E. (1998). Reliability for the terry: A mental health cartoon-like screener for African American children. *Child Psychiatry and Human Development*, *28*, 249–263.

Bowen, G. L., Rose, R. A., & Bowen, N. K. (2005). *The reliability and validity of the school success profile*. Philadelphia, PA: Xlibris Press.

Bowen, G. L., Woolley, M. E., Richman, J. M., & Bowen, N. K. (2001). Brief intervention in schools: The school success profile. *Brief Treatment and Crisis Intervention*, *1*, 43–54.

Bowen, M. (1978). *Family therapy in clinical practice*. New York, NY: Aronson.

Bowen, N. K., Bowen, G. L., & Woolley, M. E. (2004). Constructing and validating assessment tools for school-based practitioners: The elementary school success profile. In A. R. Roberts & K. Y. Yeager (Eds.), *Evidence-based practice manual: Research and outcome measures in health and human services* (pp. 509–517). New York, NY: Oxford University Press.

Breton, J.-J., Bergeron, L., Valla, J.-P., Berthiaume, C., & Gaudet, N. (1999). Quebec Child Mental Health Survey: Prevalence of DSM-III-R mental health disorders. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *40*, 375–384.

Bronfenbrenner, U. (Ed.). (2005). *Making human beings human: Bioecological perspectives on human development*. Thousand Oaks, CA: Sage.

Camasso, M. J., & Jagannathan, R. (2000). Modeling the reliability and predictive validity of risk assessment in child protection services. *Children and Youth Services Review*, *22*, 873–896.

Carter, B., & McGoldrick, M. (1980). *The family life cycle*. New York, NY: Gardner Press.

Caselman, T. D., & Self, P. A. (2008). Assessment instruments for measuring young children's social-emotional behavioral development. *Children & Schools*, *30*, 103–115.

Chorpita, B. F., Albano, A. M., & Barlow, D. H. (1998). The structure of negative emotions in a clinical sample of children and adolescents. *Journal of Abnormal Psychology*, *107*, 74–85.

Clifford, D. (1998). *Social assessment theory and practice: A multidisciplinary framework*. Brookfield, VT: Ashgate.

Colon, E., Appleby, G. A., & Hamilton, J. (2007). Affirmative practice with people who are culturally diverse and oppressed. In G. A. Appleby, E. Colon, & J. Hamilton (Eds.), *Diversity, oppression, and social functioning: Person-in environment assessment and intervention* (pp. 294–311). Boston, MA: Allyn & Bacon.

Cooper, M. G., & Lesser, J. G. (2002). *Clinical social work practice*. Boston, MA: Allyn & Bacon.

Corby, B. (2000). *Child abuse: Towards a knowledge base* (2nd ed.). Philadelphia, PA: Open University Press.

Corcoran, K. J., & Fischer, J. (2000). *Measures for clinical practice: A sourcebook*. New York, NY: Free Press.

Cox, K. F. (2006). Investigating the impact of strength-based assessment on youth with emotional or behavioral disorders. *Journal of Child and Family Studies*, *15*, 287–301.

Cronbach, L. J. (1990). *Essentials of psychological testing* (5th ed.). New York, NY: HarperCollins.

DeMaio, T. J., & Rothgeb, J. M. (1996). Cognitive interviewing techniques: In the lab and in the field. In N. Schwartz & S. Sudman (Eds.), *Answering questions: Methodology for cognitive and communicative processes in survey research* (pp. 177–196). San Francisco, CA: Jossey-Bass.

DeVellis, R. F. (2003). *Scale development: Theory and applications*. Thousand Oaks, CA: Sage.

Essex, M. J., Boyce, W. T., Goldstein, L. H., Armstrong, J. M., Kraemer, H. C., & Kupfer, D. J. (2002). The confluence of mental, physical, social, and academic difficulties in middle childhood: Developing the MacArthur Health and Behavior Questionnaire. *Journal of the Academy of Child and Adolescent Psychiatry*, *41*, 588–603.

Finn, J. L., & Jacobsen, M. (2003). *Just practice*. Peosta, IA: Eddie Bowers.

Fowler, J. (2003). *A practitioners' tool for child protection and the assessment of parents*. Philadelphia, PA: Jessica Kingsley.

Fraser, M. W., Galinsky, M. J., Smokowski, P. R., Day, S. H., Terzian, M. A., Rose, R. A., & Guo, S. (2005). Social information-processing skills training to promote social competence and prevent aggressive behavior in third grade. *Journal of Consulting and Clinical Psychology*, *73*, 1045–1055.

Fraser, M. W., Richman, J. M., & Galinsky, M. J. (1999). Risk, protection, and resilience: Toward a conceptual framework for social work practice. *Social Work Research*, *23*(3), 131–143.

Fraser, M. W., Taylor, M. J., Jackson, R., & O'Jack, J. (1991). Social work and science: Many ways of knowing. *Social Work Research and Abstracts*, *27*(4), 5–15.

Gambrill, E. (1999). Evidence-based practice: An alternative to authority based practice. *Families in Society: Journal of Contemporary Human Services*, *80*, 341–350.

Gambrill, E., & Shlonsky, A. (2001). The need for comprehensive risk management systems in child welfare. *Children and Youth Services Review*, *23*, 79–107.

Garbarino, J., Stott, F. M., & Faculty of the Erikson Institute. (1989). *What children can tell us: Eliciting, interpreting, and evaluating information from children*. San Francisco, CA: Jossey-Bass.

Germain, C. B., & Gitterman, A. (1980). *The life model of social work practice*. New York, NY: Columbia University Press.

Gilgun, J. F. (2004). The 4-d: Assessment instruments for youth, their families, and communities. *Journal of Human Behavior in the Social Environment*, *10*, 51–73.

Gleason, E. T. (2007). A strengths-based approach to the social developmental study. *Children & Schools*, *29*, 51–59.

Greif, G. L., & Lynch, A. A. (1983). The eco-systems perspective. In C. H. Meyer (Ed.), *Clinical social work in the eco-systems perspective* (pp. 35–71). New York, NY: Columbia University Press.

Gresham, F. M., Watson, T. S., & Skinner, C. H. (2001). Functional behavioral assessment: Principles, procedures, and future directions. *School Psychology Review*, *30*, 156–172.

Gutierrez, L., & Lewis, E. (1999). Working with women of color: An empowerment perspective. *Social Work*, *35*, 149–153.

Haley, J. (1987). *Problem-solving therapy* (2nd ed.). San Francisco, CA: Jossey-Bass.

Hamilton, G. (1951). *Theory and practice of social casework*. NY: Columbia University Press.

Hart, S. L. (1990). Working with the juvenile delinquent. In M. L. M. Bryan & A. F. Davis (Eds.), *100 years at Hull House* (pp. 145–150). Bloomington: Indiana University Press.

Hartman, A. (1995). Diagrammatic assessment of family relationships. *Families in Society*, *76*(2), 111–122.

Hepworth, D. H., Rooney, R. H., & Larsen, J. A. (2002). *Direct social work practice: Theory and skills* (6th ed.). Pacific Grove, CA: Brooks/Cole.

Hollis, F. (1964). *Casework: A psychosocial therapy*. New York, NY: Random House.

Hudson, W. W. (1997). Assessment tools as outcome measures in social work. In E. J. Mullen & J. Magnabosco (Eds.), *Outcome measures in the human services: Cross-cutting issues and methods* (pp. 68–80). Washington, DC: National Association of Social Workers Press.

Ialongo, N. S., Edelsohn, G., & Kellam, S. G. (2001). A further look at the prognostic power of young children's reports of depressed mood and feelings. *Child Development*, *72*, 736–747.

Ivens, C., & Rehm, L. P. (1988). Assessment of childhood depression: Correspondence between reports by child, mother, and father. *Journal of American Academy of Child and Adolescent Psychiatry*, *27*, 738–741.

Jabine, T. B., Straf, M. L., Tanur, J. M., & Tourangeau, R. (1984). *Cognitive aspects of survey methodology: Building a bridge between disciplines*. Washington, DC: National Academy Press.

Jobe, J. B., & Mingay, D. J. (1989). Cognitive research improves questionnaires. *American Journal of Public Health*, *79*, 1053–1055.

Johnson, W. (2006). The risk assessment wars: A commentary response to ''evaluating the effectiveness of actuarial risk assessment models.'' *Children and Youth Services Review*, *28*, 704–714.

Karls, J. M., & Wandrei, K. E. (1992). Pie: A new language for social work. *Social Work*, *37*, 80–85.

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., . . . Ryan, N. (1997). Schedule for affective disorders and schizophrenia for school-age children-present and lifetime (K-SADS-PL): Initial reliability and validity. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 980–988.

Kemp, S. P., Whittaker, J. K., & Tracy, E. M. (1997). *Person-environment practice: The social ecology of interpersonal helping*. New York, NY: Aldine de Gruyter.

Kent, L., Vostanis, P., & Feehan, C. (1997). Detection of major and minor depression in children and adolescents: Evaluation of the Mood and Feelings Questionnaire. *Journal of Child Psychology and Psychiatry*, *38*, 565–573.

Loewenberger, F., & Dolgoff, R. (1985). *Ethical decisions for social work practice*. Itasca, IL: Peacock.

Lukas, S. R. (1993). *Where to start and what to ask: An assessment handbook*. New York, NY: Norton.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*, 543–562.

Macgowan, M. J., Nash, J. K., & Fraser, M. W. (2002). The Carolina Child Checklist of risk and protective factors for aggression. *Research on Social Work Practice*, *12*, 253–276.

March, J. S., Parker, J. D. A., Sullivan, K., Stallings, P., & Conners, C. K. (1997). The Multidimensional Anxiety Scale for Children (MASC): Factor structure, reliability, and validity. *Journal of the Academy of Child and Adolescent Psychiatry*, *36*, 554–565.

Mash, E. J., & Hunsley, J. (2005). Evidence-based assessment of child and adolescent disorders: Issues and challenges. *Journal of Clinical Child and Adolescent Psychology*, *34*, 362–379.

McGoldrick, M., Gerson, R., & Shellenberger, S. (1999). *Genograms: Assessment and intervention*. New York, NY: Norton.

McQuaide, S., & Ehrenreich, J. H. (1997). Assessing client strengths. *Families in Society*, *78*, 201–212.

Montgomery, M. S. (1994). Self-concept and children with learning disabilities: Observer-child concordance across six context-dependent domains. *Journal of Learning Disabilities*, *27*, 254–262.

Munro, E. (2002). *Effective child protection*. Thousand Oaks, CA: Sage.

Ogbu, J. U. (1991). Low school performance as an adaptation: The case of Blacks in Stockton, California. In M. A. Gibson & J. U. Ogbu (Eds.), *Minority status and schooling: A comparative study of immigrant and involuntary minorities* (pp. 249–285). New York, NY: Garland Press.

Ogbu, J. U. (1998). Voluntary and involuntary minorities: A cultural-ecological theory of school performance with some implications for education. *Anthropology and Education Quarterly*, *29*, 155–188.

Orfield, G., Losen, D., Wald, J., & Swanson, C. B. (2004). *Losing our future: How minority youth are being left behind by the graduation rate crisis*. Cambridge, MA: Civil Rights Project at Harvard University and the Urban Institute. Accessed at www.urban.org/url.cfm?ID=410936/

Oyserman, D., Bybee, D., & Terry, K. (2006). Possible selves and academic outcomes: How and when possible selves impel action. *Journal of Personality and Social Psychology*, *91*, 188–204.

Oyserman, D., Terry, K., & Bybee, D. (2002). A possible selves intervention to enhance school involvement. *Journal of Adolescence*, *25*, 313–326.

Paniagua, F. A. (2005). *Assessing and treating culturally diverse clients: A practical guide*. Thousand Oaks, CA: Sage.

Pelham, W. E., Fabiano, G. A., & Massetti, G. M. (2005). Evidence-based assessment of attention deficit hyperactivity disorder in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, *34*, 449–476.

Perlman, H. H. (1957). *Social casework: A problem solving approach*. Chicago: University of Chicago Press.

Pilsecker, C. (1994). Starting where the client is. *Families in Society*, *75*, 447–452.

Pincus, A., & Minahan, A. (1973). *Social work practice: Model and method*. Itasca, IL: Peacock.

Reynolds, W., & Mazza, J. (1999). Assessment of suicidal ideation in inner-city children and young adolescents: Reliability and validity of the Suicidal Ideation Questionnaire—JR. *School Psychology Review*, *28*, 17–30.

Richman, J. M., Bowen, G. L., & Woolley, M. E. (2004). School failure: An eco-interactional developmental perspective. In M. W. Fraser (Ed.), *Risk and resilience in childhood: An ecological perspective* (2nd ed., pp. 133–160). Washington, DC: National Association of Social Workers Press.

Richmond, M. E. (1917). *Social diagnosis*. New York, NY: Sage.

Righthand, S., Kerr, B., & Drach, K. (2003). *Child maltreatment risk assessments*. Binghamton, NY: Haworth Press.

Rittner, B. (2002). The use of risk assessment instruments in child protection services case planning and closures. *Children and Youth Services Review*, *24*, 189–207.

Saldana, L., & DuBois, D. L. (2006). Youth reactions to participation in psychological assessment procedures. *Journal of Clinical Child and Adolescent Psychology*, *35*, 155–161.

Saleebey, D. (2006). *The stengths perspective in social work practice* (4th ed.). Boston, MA: Allyn & Bacon.

Shaffer, D., Fisher, P., Lucas, C. P., Dulcan, M. K., & Schwab-Stone, M. E. (2000). NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry*, *39*, 28–38.

Shlonsky, A., & Wagner, D. (2005). The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management. *Children and Youth Services Review*, *27*, 409–427.

Shannon, P., & Tappan, C. (2011). Identification and assessment of children with developmental disabilities in child welfare. *Social Work*, *56*, 297–305.

Silverman, W. K., & Ollenbeck, T. H. (2005). Evidence-based assessment of anxiety and its disorders in children and adolescents. *Journal of Child and Adolescent Psychology*, *34*, 380–411.

Simon, B. L. (1994). *The empowerment tradition in American social work: A history*. New York, NY: Columbia University Press.

Tashakkori, A., & Teddlie, C. (2003). Major issues and controversies in the use of mixed methods in the social and behavioral sciences. In A. Tashakkori &

C. Teddlie (Eds.), *Handbook of mixed methods in the social and behavioral sciences* (pp. 3–50). Thousand Oaks, CA: Sage.

Tinsley, B. J., & Holtgrave, D. R. (1997). A multimethod analysis of risk perceptions and health behaviors in children. *Educational and Psychological Measurement*, *57*, 197–209.

Tourangeau, R., Rips, L. J., & Rasinski, K. (2000). *The psychology of survey response*. Cambridge, UK: Cambridge University Press.

Wood, A., Kroll, L., Moore, A., & Harrington, R. (1995). Proper ties of the Mood and Feelings Questionnaire in adolescent psychiatric outpatients: A research note. *Journal of Child Psychology and Psychiatry*, *36*, 327–334.

Woolley, M. E. (2006). Advancing a positive school climate for students, families, and staff. In C. Franklin, M. B. Harris, & P. Allen-Meares (Eds.), *The school services sourcebook* (pp. 777–784). New York, NY: Oxford University Press.

Woolley, M. E., & Bowen, G. L. (2007). In the context of risk: Supportive adults and the school engagement of middle school students. *Family Relations*, *56*, 92–104.

Woolley, M. E., Bowen, G. L., & Bowen, N. K. (2004). Cognitive pretesting and the developmental validity of child self-report instruments: Theory and applications. *Research on Social Work Practice*, *14*, 191–200.

Woolley, M. E., Bowen, G. L., & Bowen, N. K. (2006). The development and evaluation of procedures to assess child self-report item validity. *Educational and Psychological Measurement*, *66*, 687–700.

Woolley, M. E., & Curtis, H. W. (2007). Assessing depression in latency age children: A guide for school social workers. *Children & Schools*, *29*, 209–218.

Woolley, M. E., & Grogan-Kaylor, A. (2006). Protective family factors in the context of neighborhood: Promoting positive school outcomes. *Family Relations*, *55*, 95–106.

Wright-Strawdermann, C., & Watson, B. L. (1992). The prevalence of depressive symptoms in children with disabilities. *Journal of Learning Disabilities*, *25*, 258–264.

Yugar, J. M., & Shapiro, E. S. (2001). Elementary children's school friendship: A comparison of peer assessment methodologies. *School Psychology Review*, *30*, 568–587.