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Assessing Parenting Competence in Child Protection Cases: A Clinical Practice Model

Karen S. Budd[1]

Evaluating parents in the context of possible abuse or neglect involves unique challenges. This paper describes a practice model for conducting clinical evaluations of parents' ability to care for young children (under age 8). Core features of the model include (a) a focus on parenting qualities and the parent–child relationship, (b) a functional approach emphasizing behaviors and skills in everyday performance, and (c) application of a minimal parenting standard. Several factors complicate the assessment task, namely, the absence of universally accepted standards of minimal parenting adequacy, the coercive context of the assessment, the scarcity of appropriate measures, difficulties predicting future behavior, and the likely use of the evaluation in legal proceedings. In the proposed model, the evaluator (a) clarifies specific referral questions in advance; (b) uses a multimethod, multisource, multisession approach; (c) organizes findings in terms of parent–child fit; (d) prepares an objective, behaviorally descriptive report that articulates the logic for the evaluator's clinical opinions regarding the referral questions; and (e) refrains from offering opinions regarding ultimate legal issues. The paper describes requisite skills needed to conduct parental fitness evaluations, sample methods, and a protocol for writing the evaluation report.

KEY WORDS: parenting evaluation; child abuse; parental fitness; assessment; forensic; child protection.

Psychologists and other mental health professionals often are asked to assess parents' caregiving abilities and children's safety while in their parents' care. The assessments are requested by child protection or legal authorities in cases of child abuse or neglect, in order to inform dispositional decisions such as placement, custody, visitation arrangements, or termination of parental rights, and to assist in intervention planning (Azar, Lauretti, & Loding, 1998; Barnum, 1997; Budd & Holdsworth, 1996). Assessments also are requested by social service agencies in cases of high-risk parenting practices that may fall short of documented maltreatment (Budd, Heilman, & Kane, 2000; Wolfe & McEachran, 1997). Various parent characteristics (e.g., cognitive delays, psychiatric problems, teenage status, substance abuse, chronic physical illness, or criminal behavior), child characteristics (e.g., unexplained injuries, nonorganic failure to thrive, or lead intoxication), and family conditions (e.g., homelessness, domestic violence, or social isolation) have been identified as risk factors for child abuse or neglect (cf. Ammerman, 1990; Belsky, 1980; Friedrich & Boriskin, 1976; Gelles & Straus, 1979; National Research Council, 1993; Starr, Dubowitz, & Bush, 1990). Although these risk conditions often exist in the absence of maltreatment or incompetent parenting (Wald & Woolverton, 1990), they signal areas of potential concern and may trigger further clinical assessment.

Evaluating parents in the context of possible abuse or neglect is notably different from evaluation that occurs as part of parent training or psychotherapy services, because of the high likelihood that the evaluation will be used in legal proceedings. Concomitant with increased attention to and reporting of child abuse and neglect in our society (U.S. Advisory Board on Child Abuse and Neglect, 1995), psychologists have become increasingly involved as evaluators in child protection matters. In view of

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this trend, the American Psychological Association (American Psychological Association Committee on Professional Practice and Standards, 1998) developed guidelines outlining professional competencies, procedures, and ethics of desired practice in child protection cases.

These guidelines recommend that, in assessing parenting capacity, clinicians examine the current and potential functional capabilities of the parent to meet the needs of the child, the relationship between the child and the parent, the psychological and developmental needs of the child, and specific recommendations for intervention. They advise clinicians to plan the scope and direction of the evaluation in response to referral questions and to use multiple sources and methods of data gathering, including whenever possible parent–child observations in natural settings. Given the gravity of decisions for which psychologists' findings are used, the guidelines call on evaluators to gain specialized competence and to take steps to avoid the interfering effects of personal and social biases on objectivity. Although the provisions are general in nature and are not mandatory, the attention given to parenting assessment in the child protection guidelines exceeds that in related professional guidelines (e.g., American Academy on Child and Adolescent Psychiatry, 1997; Committee on Ethical Guidelines for Forensic Psychologists, 1991). By providing an informed, objective perspective, clinical evaluations can contribute valuable information that enhances the fairness of child welfare decisions (American Psychological Association Committee on Professional Practice and Standards, 1998).

Although clinical evaluations are common in a child protection context, little empirical information exists about the characteristics of these evaluations in current practice. To address this gap, Budd, Poindexter, Felix, and Naik-Polan (2001) examined 190 mental health evaluation reports completed on parents in child abuse and neglect cases within a large urban setting. They reported numerous substantive limitations in the content and comprehensiveness of assessments. For example, evaluations on parents usually were completed in a single session, used few if any sources of information other than the parent, often cited no previous written reports, rarely included parent–child observation, and often neglected to describe the parent's caregiving qualities or the child's relationship with the parent. To the extent that these findings are representative of current clinical practice, they imply the need for education of providers and consumers of evaluations in order to achieve the American Psychological Association's (1998) aspirational goals.

This paper proposes a model for conducting clinical evaluations of parenting competence with young children (i.e., under age 8) in a child protection context. (The terms *competence*, *fitness*, and *adequacy* are used interchangeably to indicate professional judgments about parents' basic caregiving acceptability.) The model is designed for parents at risk for child maltreatment (physical abuse or neglect) or with substantiated child maltreatment. Several research and clinical reviews (e.g., Azar et al., 1998; Barnum, 1997; Budd & Holdsworth, 1996; Dyer, 1999; Grisso, 1986; Jacobsen, Miller, & Kirkwood, 1997; Kuehnle, Coulter, & Firestone, 2000; Melton, Petrila, Poythress, & Slobogin, 1997; Quinn & Nye, 1992; Reder & Lucey, 1995; Wolfe & McEachran, 1997) have addressed the topic of assessing parenting fitness; however, few provide specific directions for implementing clinical assessments in individual cases. The current model draws on the relevant literature as well as on the author's experiences assessing at-risk parents in child welfare and forensic (i.e., legal) settings. Subsequent sections of this paper cover core features of the model, challenges inherent in assessing parenting fitness, a framework for conceptualizing parental competence, and steps in conducting the evaluation.

CORE FEATURES OF PARENTAL FITNESS ASSESSMENT

What basic qualities underlie an informed, useful parenting assessment? The reviews on parental fitness cited earlier vary in theoretical orientation, disciplinary perspective, type of parenting problems discussed, and recommended evaluation components. However, they agree that assessments should include a focus on the parent's capabilities and deficits *as a parent* and on the *parent–child relationship*. Adult qualities and characteristics need to be linked to specific aspects of parental fitness or unfitness, by showing how they pose a protective factor or risk to the child, respectively, or how they enable or prevent the parent from profiting from rehabilitative services. Thus, a focus on parenting qualities and the parent–child relationship is a core feature of the current model.

A second core feature of the proposed model is the use of a *functional* approach (i.e., emphasizing behaviors and skills in everyday performance). Grisso (1986, p. 201) applied the term functional to

forensic evaluation of parenting competence, explaining that assessment of parents should center on "what the caregiver understands, believes, knows, does, and is capable of doing related to childrearing." Grisso further emphasized that parenting skills should be assessed in relation to individual children's needs. The goal of assessing functional competence influences the methods, principles, and scope of assessment (Haynes & O'Brien, 1999). Rather than concentrating on diagnostic and trait-based qualities, functional assessment focuses on direct measurement of parenting behaviors, capabilities, and practices. Functional assessment also embodies a constructive focus on identifying parenting strengths and areas of adequate performance, in contrast to a deficit-centered focus.

A third core feature of the current model is that it applies a *minimal* parenting standard. Rather than comparing parents to adaptive or nurturing parents or comparing the relative abilities among caregivers (as in divorce custody cases), a lower standard is appropriate. Minimal parenting competency is the "floor" of acceptable parenting that is sufficient to protect the safety and well being of the child. As discussed in the next section, the standards for evaluating parental fitness are not well defined or agreed upon, so applying a minimal parenting criterion can be difficult. However, several authors (e.g., Azar, Benjet, Fuhrmann, & Cavallero, 1995; Budd & Holdsworth, 1996; Jacobsen et al., 1997) recommend that evaluators strive to apply this criterion, given the lack of an empirical or legal basis for imposing a more stringent criterion. Research has found pervasive differences in parenting beliefs and practices associated with socioeconomic status, race, ethnicity, religion, and other human differences (cf. Garcia Coll, Meyer, & Brillon, 1995; Harkness & Super, 1995; Hoff-Ginsberg & Tardif, 1995). These factors do not exert direct effects on families resulting in "better" or "worse" parenting, but rather research suggests that people of different groups have different experiences that make them different people, both in their beliefs and values and in their behaviors (Hoff-Ginsberg & Tardif, 1995). Adherence to a minimal parenting threshold fits with psychologists' ethical responsibilities to respect individual differences with respect to culture, access to resources, and community practices of childrearing (American Psychological Association Committee on Professional Practice and Standards, 1998).

The three core features (focus on parenting, functional competence, and a minimal parenting standard) in the current model guide the psychologist in assessing a parent's capability as a caregiver. The referral questions also may address other topics, such as the parent's mental health diagnosis or therapy needs, the impact of maltreatment on the parent–child relationship, or the parent's progress in services. Methods of investigating these and other questions are discussed in later sections.

CHALLENGES IN ASSESSING PARENTAL FITNESS

Conducting evaluations of minimal parenting adequacy presents several challenges, which must be anticipated and addressed as part of the assessment. A fundamental issue complicating the task, as noted above, is the *absence of universally accepted standards* of minimal parenting adequacy. As Azar and Benjet (1994), Melton et al. (1997), and others have noted, the fields of child development, psychology, social welfare, and law lack universal models or standards of minimal parenting competence. Legal and child welfare criteria regarding minimal parenting vary from state to state and lack behavioral specificity (Melton et al., 1997). Social science research has identified numerous parenting qualities and behaviors associated with adaptive versus maladaptive parenting (cf. Bornstein, 1995; Maccoby, 1992); however, consensus has not been reached on the line demarcating "good enough" parenting (Budd & Holdsworth, 1996; Greene & Kilili, 1998). For example, practices such as spanking, cosleeping, and adult nudity in children's presence are viewed as inappropriate by some and as culturally normative by others (Craig, Amato, Dillinger, Hodgins, & Grignol, 2000). In the absence of consensus, clinicians are susceptible to employing vague and subjective criteria based on their personal experience. To guard against reliance on private assumptions, evaluators should articulate the specific findings that serve as a basis for their opinions about childrearing adequacy.

In addition to the lack of accepted standards of minimal parenting adequacy, the evaluation usually is conducted under a *coercive context* that affects the reliability and validity of the information obtained (Budd & Holdsworth, 1996; Wolfe, 1988). Parents often are mandated to participate, experience chronic stress relating to their involvement in the child welfare system, and are sensitive to the high stakes of the outcome. Under these conditions, it is understandable that parents would be less than candid, and that their responses may reflect a bias toward socially acceptable opinions. Professional guidelines

in child protection matters (American Psychological Association Committee on Professional Practice and Standards, 1998) discourage clinicians from providing ongoing therapy or intervention services to a parent for whom they conduct an assessment. Although this practice reduces role conflict, it limits clinicians' opportunity to develop rapport or refine their understanding about the parent. Parental fitness evaluations often require several sessions in order to gradually build sufficient information to formulate a reliable opinion.

Another set of challenges in evaluating parental fitness concerns the *dearth of appropriate measures*. Traditional psychological instruments were not designed to measure parenting adequacy. Tests of intelligence, academic functioning, and personality provide information on adult adjustment problems and capabilities, and they contribute to diagnostic determinations. However, they bear, at most, an indirect relationship to parenting issues (Brodzinsky, 1993; Grisso, 1986; Melton et al., 1997). Some instruments specific to parenting competency, with varying levels of psychometric soundness, have been developed; however, the majority were designed for families with a range of parent–child problems and are not specific to measuring childrearing attributes of parents at risk for maltreatment (Budd & Holdsworth, 1996). Further, the reference groups used to develop normative data on most psychological instruments do not match the populations evaluated for minimal parenting adequacy, which complicates interpretation of assessment findings (Azar, 1992; Brodzinsky, 1993; Milner, 1991). Thus, evaluators need to report the limitations of the assessment and conservatively interpret findings, in keeping with the strength of the evidence.

A related challenge in conducting assessments of minimal parenting adequacy concerns *difficulties in predicting future behavior*. Clinicians often are asked to assess the level of risk a parent poses to a child or the nature and relative efficacy of interventions that may increase the child's safety. Several authors (e.g., Caldwell, Bogat, & Davidson, 1988; Milner, 1991) have articulated the difficulties in predicting child abuse and neglect, including low base rates of the phenomena, imprecise criteria and assessment instruments, and multiple factors affecting the likelihood of maltreatment. Complicating the task of prediction is the fact that research on the effectiveness of interventions for child maltreatment is insufficient to guide the decisions of child protection professionals (National Research Council, 1993). Given these limitations, Melton et al. (1997, p. 465) urge clinicians to "have great humility in making predictions and offering other opinions."

A final challenge in conducting clinical evaluations of parents concerns the *potential use of the assessments as forensic (i.e., legal) evidence*. An evaluation takes on a "life of its own" once the report has been written. Whether or not evaluations of parents are initially requested for social service or legal reasons, they often end up serving as evidence in legal determinations. Forensic practice requires knowledge and skills more specialized than those developed in general training as a mental health professional (Committee on Ethical Guidelines for Forensic Psychologists, 1991; Melton et al., 1997; Schaefer, 1992). Clarification of the limits of confidentiality, accuracy of information, documentation of sources, clear specification of the basis for clinical opinions, and conservative interpretation of findings, which are recommended qualities of all mental health evaluations, are especially important in parental fitness assessments (Dyer, 1999).

A controversial area related to forensic assessment concerns the role of clinical evaluators in offering definitive opinions on legal questions (Grisso, 1986; Melton et al., 1997). Examples of such "ultimate legal issues" in a the child protection context are whether or not to grant unsupervised visitation to a parent, whether a parent's rights should be terminated, and whether a parent should be reunified with his or her child. Several commentators (e.g., Grisso, 1986; Melton et al., 1997; Schultz, Dixon, Lindenberger, & Ruther, 1989) recommend against having psychologists offer such opinions, arguing that psychologists possess no particular expertise in legal decision-making. Rather, psychologists are trained to assess human behavior, precipitating and maintaining factors associated with parenting problems, skills and behaviors in need of change, and interventions that are likely to meet the needs of the family (Melton et al., 1997). By offering relevant, objective, and behaviorally descriptive accounts and anchoring interpretations in data, evaluators provide a basis for informed legal decisions (American Psychological Association Committee on Professional Practice and Standards, 1998). The difference between recommending a specific legal decision and reporting information pertinent to the decision is sometimes a matter of language, such as providing information in terms of risks and protective factors rather than as a definite opinion. However, given the uncertainties inherent in parenting fitness evaluations, a conservative

approach regarding offering conclusions or opinions is warranted.

FRAMEWORK FOR CONCEPTUALIZING MINIMAL PARENTING COMPETENCE

Parenting has been conceptualized in numerous ways in an attempt to describe the continuum of adaptive to maladaptive childrearing patterns (e.g., Belsky, 1984; Maccoby, 1992; Patterson, 1982). Parenting conceptualizations inform the assessment of minimal parenting competence by guiding evaluators toward relevant dimensions of inquiry. However, given the lack of consensus regarding minimally adequate parenting and the wide variety of concerns that give rise to parenting evaluations, no standard conceptualization exists for assessing minimal parenting competence. Azar et al. (1998) outline five broad functional domains of parenting (parenting skills, social cognition skills, self-control skills, stress management, and social skills), deficits in which are presumed to increase the risk of child maltreatment. Grisso (1986) lists parenting tasks to be assessed, based on consideration of children's developmental needs. Reder and Lucey (1995) propose a wide-ranging inquiry into the parent's interactions in the role of parent, the relationship with the child, family influences, interactions in the external world, and the potential for change. Each of these approaches is useful in focusing the clinician on pertinent dimensions, although many of the dimensions have yet to be operationalized in behavioral terms amenable to functional assessment.

The current model conceptualizes parenting adequacy in terms of the fit between the parent's functioning and the child's needs. Two aspects of parent–child fit are pertinent: (a) the nexus between a child's developmental needs and the parent's caregiving skills, and (b) the nexus between the parent's competence to care for his or her own needs and for the child's needs. The top half of Table I illustrates a framework for considering the basic needs of the child in the three broad domains of physical, cognitive, and social/emotional development, in relation to the parent's functional skills and deficits in meeting these needs. The specific skills relevant to any child or family would vary with the ages, developmental levels, previous history of maltreatment, and special needs of the child (Azar & Bober, 1999). The second part of the framework (displayed in the bottom half of Table I) considers the parent's personal and adaptive competencies and deficits in three domains (physical, cognitive, and social/emotional) as they impact the parent's childrearing practices. This matrix focuses on the link between the parent's independent functioning in particular domains and his/her competence in caregiving functioning. Deficits in a parent's adaptive skills in, for example, the cognitive domain may affect childcare abilities in the same domain (e.g., ability to teach the child) or in another domain (e.g., ability to read medicine labels and care for child when ill).

The framework proposed here provides a heuristic means of conceptualizing the interface between a parent's overall functioning, his/her childrearing skills, and the child(ren)'s developmental needs. Rather than dictating standard topic areas or skills to be assessed, it allows the clinician to tailor the assessment to the individual case. The practical nature of the framework also lends itself to communicating assessment findings with persons outside the mental health field (e.g., attorneys, caseworkers, and parents). Thus, the framework offers a working model for organizing and integrating information about parenting functioning and parent–child fit, which the evaluator uses in formulating summary statements and opinions relating to minimal parenting adequacy.

STEPS IN CONDUCTING A PARENTAL FITNESS EVALUATION

Because most psychologists are not trained in forensic assessment, conducting a parental fitness evaluation that may be used as evidence in a child protection proceeding can be a daunting task. Training in clinical assessment, child development, and child maltreatment is necessary but insufficient. Psychologists also need to become familiar with relevant ethical and professional guidelines (e.g., American Academy on Child and Adolescent Psychiatry, 1997; American Psychological Association Committee on Professional Practice and Standards, 1998; Committee on Ethical Guidelines for Forensic Psychologists, 1991), prevailing agency and legal standards regarding child protection issues (e.g., The Adoption and Safe Families Act, 1997 [Public Law 105-89]), culturally sensitive assessment methods (e.g., Dana, 1993; Edwards & Kumru, 1999; Maitra, 1995), and forensic assessment practices (cf. Barnum, 1997; Heilbrun, 1992; Melton et al., 1997). With this knowledge base, psychologists will be better equipped to deal with the complex issues involved in parenting assessments.

Table I. Framework for Viewing Parent–Child Fit

Areas of child needs	Examples of functional parenting skills	Examples of functional parenting deficits
	Parent's competence to meet child's needs	
Physical care	Provides regular, nutritious meals	Dilutes infant formula with water
	Protects home from hazards	Leaves young child unsupervised
	Takes child for immunizations regularly	Fails to get child medical treatment for head lice
Cognitive	Gets child to and from school regularly	Provides little structure and variety in child's experiences
	Teaches child basic concepts (e.g., colors, self-care)	Fails to seek services for a child with special needs
	Provides toys and activities to foster child's development	Keeps child alone in crib for long periods during the day
Social/emotional	Disciplines child fairly and realistically for age	Gets angry and loses temper with child for minor infractions
	Shows warmth and affection toward child	Makes fun of child for mistakes or accidents
	Is emotionally responsive to child's needs	Interacts with child to meet own needs rather than child's needs
Areas of competence	Examples of adaptive skills/deficits in parent's independent functioning	Examples of how deficits in independent functioning may impact childrearing
	Adult's personal competence relevant to parenting	
Physical/self-care	Shops for and prepares regular meals/often goes hungry or eats on haphazard schedule	Feeds child irregularly because of lack of food in house
	Cares for personal hygiene and health/disregards grooming and health needs when on drugs	Fails to dress child appropriately or ensure that child is bathed regularly
	Maintains stable housing/has transient and unstable housing	Exposes child to dangerous living conditions
Cognitive	Exercises reasonable judgment/fails to consider the consequences of actions	Has unrealistic childrearing beliefs
	Has basic reading and math skills/cannot read or do simple arithmetic	Cannot read instructions for delivering medications to child
	Understands and remembers information/has short-term memory loss	Forgets about child when distracted by television
Social/emotional	Handles conflicts in a nonaggressive manner/becomes angry and hostile when provoked	Swears and demeans child for developmentally normative infractions
	Shows concern for the feelings of others/does not empathize with others' perspective	Ignores or rebuffs child's initiations when parent is angry or depressed
	Has a social support network/isolated and mistrustful of people	Prevents child from having social contact with peers or others

The process of conducting a parental fitness evaluation entails several steps, which can be organized into three phases: planning the evaluation, carrying out data-gathering activities, and preparing the report. These steps are discussed next and outlined in Table II, along with common obstacles that can complicate assessment.

Plan the Evaluation

1. *Identify referral questions.* A crucial first step in preparing for an evaluation is to clarify the assessment objectives. Although the reasons for referral may seem obvious, vague or global referral purposes (e.g., "to evaluate this mother's parenting ability," "to provide recommendations for service planning," or "to assess the parent's cognitive and emotional functioning") are likely to produce vague and global reports. As Beyer (1993) states, an assessment is only as useful as the questions presented to the evaluator. Thus, Beyer recommends that the evaluator clarify (a) what specifically the referral source wants to know about the parent's functioning, (b) what problems or events gave rise to the concerns, and (c) what specific outcomes or options will be affected by the findings. By consulting with the referral source to articulate specific questions, the clinician can determine whether an evaluation is necessary, whether the questions can realistically be answered by an evaluation, and whether the clinician possesses the skills and resources to conduct the assessment (Dyer, 1999; Melton et al., 1997). Budd et al. (2001) found that most evaluations of parents in their empirical analysis failed to describe

Table II. Steps in Conducting Parental Fitness Evaluation and Common Obstacles Encountered

Steps	Common obstacles
Plan the evaluation	
1. Identify referral questions.	1. Referral source fails to clarify clinical concerns.
2. Review background records.	2. Referral source provides minimal prior records.
3. Begin conceptualization of parent–child fit.	3. Information on child or parent is vague.
4. Develop assessment agenda.	4. Agency or referral source dictates inadequate assessment protocol.
Carry out assessment activities	
1. Interview the parent.	1. Parent is uncooperative.
2. Administer relevant tests or inventories.	2. Measures are not available, or norms relate to populations dissimilar to client.
3. Observe parent–child interactions.	3. Parent–child observation is not feasible.
4. Interview collateral sources.	4. Parent refuses to consent to clinician's contact with collateral sources.
5. Administer child measures, if indicated.	5. Access to child is limited.
Integrate findings and write the report	
1. Review and interpret assessment data.	1. Assessment gaps remain in areas of conceptual framework.
2. Construct a report that responds to the referral questions.	2. Agency or referral source dictates an inappropriate format for report.

specific referral purposes, which contributed to the limited usefulness of the reports.

Translating vague requests (e.g., "What is the potential of this couple as custodial parents for their children?") into specific referral questions requires a dialogue about the reasons for clinical concern, the circumstances that make the questions pertinent at the present time, and how the answers will be used. More specific referral questions might be the following: (a) "What strengths and deficits do this couple have in terms of the parents' ability to adequately care for their three young children?" (b) "If specific concerns exist about the parents' readiness to resume custody of their children, are there services that would prepare them for reunification?" and (c) "If services are needed, what types of services are necessary to address the concerns, and what is the prognosis for achieving readiness for reunification within the next 12 months?"

Dyer (1999) describes several common referral questions in child protection cases and the dilemmas psychologists face when they fail to ascertain specific referral questions before accepting a case. He notes that issues related to the history of the case, agency expectations, or timelines for reunification may not be conveyed to clinicians, yet failure to understand these issues can severely hamper the usefulness and comprehensiveness of evaluations. Formulating specific referral questions in advance increases the likelihood that the clinician will be apprised of key facts and expectations relating to the case.

Once the referral questions have been determined, they form the basis for planning the scope and direction of the evaluation. Pragmatic considerations often restrict evaluators from comprehensively assessing all the potentially relevant areas of functioning, so priority areas need to be delineated. Because relevance is a primary criterion for admissibility of legal evidence (Heilbrun, 1992), forensic assessments typically have a narrower focus on the identified referral questions than assessments in a therapy context (Melton et al. 1997).

2. *Review background records.* Prior records (i.e., child abuse or neglect allegations, progress reports in child welfare services, mental health history, medical history, police contacts, and court proceedings) may provide crucial information relevant to the case. By reading prior records before conducting an evaluation, the clinician has the opportunity to add to, correct, and clarify existing information as part of the evaluation rather than simply duplicate what is already known. However, prior documents may contain erroneous information or bias the evaluator's objectivity, so some evaluators choose to meet with a client once before reading background records. The clinician should evaluate the reliability of information in the records and remain vigilant to detecting discrepancies.

Obtaining prior records often is difficult, and the records received may be incomplete. When access to records is precluded, the clinician may be able to gather some information by interviewing

caseworkers, therapists, or other collateral sources. In the report, it is important to state precisely which records were reviewed as part of the evaluation, and to describe how the current findings corroborate or contradict prior reports.

3. *Begin conceptualization of parent–child fit.* Based on information gained from the referral source and prior records, the clinician begins to identify what is known about the child's developmental needs and the parent's skills and deficits. Reported concerns (such as parental drug use or substantiated abuse or neglect incidents) and areas of adequate functioning (such as the child's attainment of developmental milestones or a positive parent–child relationship during visitation sessions) are noted. This process helps the clinician clarify what information to obtain or confirm as part of the evaluation.

4. *Develop an assessment agenda.* The clinician tentatively outlines areas to be assessed and possible methods for obtaining the information. The selection of assessment areas and strategies is dictated by the referral questions, as well as by personal or background issues relevant to the case. For example, if the evaluation purpose is to assess the feasibility of unsupervised visits between a father and child, the clinician would need to identify potential risk factors (e.g., safety threats or special needs of the child) and protective factors (e.g., parent skills, strengths, and resources), assess the father's ability to independently manage the child for limited time periods, determine if a stable setting is available for the visits, and assess the potential effect of the new visitation plan on the child. Assessment methods for this case would most likely include a clinical interview, review of records, interviews with caseworker and other collateral informants (e.g., persons who can provide information on the topics just noted), and observation of the father and child together. Standardized tests or inventories may be appropriate, if concerns exist about the father's mental health status or other aspects of the father's functioning. Similarly, screening of the child's functioning could be appropriate, if questions exist that bear on the advisability of unsupervised visits. Often, however, information that can inform these issues is already available in previous evaluations or case records.

Carry Out Assessment Activities

1. *Interview the parent.* An assessment typically begins with a detailed clinical interview of the parent (or parents, if a couple is referred), in order to obtain the parent's perspective on the referral issues, gather background information, and inquire into areas of personal and parenting functioning. Several hours, which may be divided into two to three sessions, usually are needed to complete the interview. Table III lists common topics the author covers in the interview (i.e., purpose and confidentiality limitations of the session, the history of allegations or parenting concerns, services the family has received, current living situation, personal background, descriptions of children and parent–child relationship, and expectations regarding outcomes). The nature of interview questions naturally depends on the individual case. The clinician should be sensitive to cultural and background differences, and develop rapport by asking questions in a respectful manner, responding in a nonjudgmental manner, and attempting to understand the parent's point of view (Maitra, 1995). If the parent is of a different race, ethnicity, or cultural background than the psychologist, it may be beneficial to seek consultation from a knowledgeable professional (e.g., regarding nonverbal cues, common parenting practices, idiomatic expressions, or other culturally specific patterns) before or during the assessment. Dyer (1999) provides suggestions for inquiring about sensitive topics such as the parent's use of drugs and alcohol, exposure to physical or sexual abuse, and criminal history during the parent interview.

The initial interview should begin with a discussion of the purpose of the evaluation (e.g., who referred the parent and for what reason) and the limits of confidentiality (e.g., who will receive or have access to the report). It is useful to ask the parent about his or her understanding of the reason for the evaluation. After the clinician clarifies the purpose and limits of confidentiality, it is advisable to have the parent restate these points in his or her own words. When in doubt about a parent's comprehension or memory, this discussion should be repeated at the beginning of each assessment session.

In order for the interview to be productive, the parent must cooperate in providing information. Given the important decisions for which the evaluation results will be used, parental caution and skepticism are understandable. Some parents become more spontaneous and relaxed as the interview proceeds, whereas others remain guarded throughout the evaluation. The clinician should explain the parent's right to decline to answer sensitive questions or to refuse to participate, but that the clinician is obliged to report the results of the assessment in any event. Parents who

Table III. Potential Content Areas for Interviewing Parents in an Assessment of Parental Fitness

I. Purpose of evaluation and limitations of confidentiality
II. History of child maltreatment allegations or parenting concerns
  A. Parent's version of events
  B. Parent's view of credibility of concerns and personal responsibility for events
  C. Parent's view of how events have impacted his/her own life
III. Services received relating to allegations or parenting concerns
  A. Helpful services and why
  B. Unhelpful services and why
IV. Parent's current living situation
  A. Nature, stability, and environmental setting of residence
  B. Persons in home and special needs present
  C. Employment or school status
  D. Physical health
  E. Substance use
  F. Mental health
  G. Relationship status
  H. Social support network
V. Parent's personal background
  A. Nuclear family—continuity or discontinuity of relationships and why
  B. Early health and development
  C. Childrearing and disciplinary experiences growing up
  D. Educational history
  E. Significant life events (e.g., trauma, abuse or neglect, moves, criminal involvement, substance use)
  F. Cultural and religious identity
  G. Significant partner relationships and breakups
VI. Children and parent–child relationship
  A. First experiences as a parent
  B. Pre- and postnatal history of children
  C. Early development and health of children
  D. Individual characteristics of children
  E. Time parent spent as caregiver
  F. Strengths and weaknesses as a parent
  G. Current relationship with children
  H. Special needs, fears, or considerations about children's well-being
  I. Current visitation schedule and contact, if children are not in parent's custody
  J. View of how children are doing now
  K. Things parent would like to do for children and ability to provide these things
VII. Hopes and expectations for dealing with current allegations or parenting concerns
  A. What would parent like to see happen?
  B. What would be best for children?
  C. What would the children like to have happen?
  D. What services or changes are needed to help parent achieve desired outcomes?
  E. Likelihood of being able and willing to make needed changes?
  F. Barriers to achieving desired outcomes?
  G. What would happen if desired outcomes were not achieved?

refuse to cooperate may benefit from an opportunity to take a break, to speak to someone they trust (e.g., their attorney, a friend), or to reschedule the session.

2. *Administer relevant psychological tests or inventories.* After the interview is underway, the clinician often administers relevant psychological measures to complement the interview data. Table IV lists topics and examples of assessment measures potentially relevant to parental fitness assessments. (For more detailed reviews and examples of potential assessment measures, see Budd & Holdsworth, 1996; Dyer, 1999; Lutzker, 1998; Wolfe & McEachran, 1997). Listed measures cover the content areas of emotional distress and adjustment, childrearing beliefs and attitudes, social support, marital and family adjustment, cognitive and adaptive functioning, personality functioning, and academic achievement. These measures presume an examinee reading level of between the third and eighth grade, depending on the test. It is important to consider the parent's reading level and, if in doubt, to present items orally.

An important caveat in using psychological instruments is that, with the exception of the measures of childrearing beliefs and attitudes, they were not designed to assess parenting capability and have not been empirically investigated in this context. Interpretation of the measures is difficult, because of problems discussed earlier with reliability, validity, and appropriate normative comparisons. Dyer (1999) advocates the usefulness of personality measures for assessing psychopathology and providing psychiatric diagnoses. Others (e.g., Jacobsen et al., 1997; Melton et al., 1997), however, caution that misleading conclusions can be drawn if the instruments are used out of the contexts in which they have been validated. In view of the limitations of psychological measures for parental fitness evaluations, the clinician should select measures with care based on their appropriateness to the client and their relationship to referral questions. In interpreting findings, the psychologist should apply a conservative approach and seek corroboration across data sources (Heilbrun, 1992).

In the author's experience, a few specific measures are frequently useful in parental fitness assessments. Four measures, indicated by an asterisk in Table IV, provide information on the parent's emotional distress and adjustment, childrearing beliefs and attitudes, and social support network. The author included three of the four measures in a standardized protocol for psychosocial assessment of disadvantaged teenage mothers (Budd et al., 2000), and previous research supports their applicability to parents

Table IV. Psychological Instruments for Assessing Parent Functioning and Parent–Child Relationship

Content areas	Instruments
	Parent functioning
Emotional distress and adjustment	Brief Symptom Inventory (BSI; Derogatis, 1993)*
	Symptom Checklist 90-Revised (SCL-90R; Derogatis, 1983)
	Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996)
	Parenting Stress Index-Short Form (PSI-SF; Abidin, 1990)
Childrearing beliefs and attitudes	Child Abuse Potential (CAP) Inventory (Milner, 1986)*
	Parent Opinion Questionnaire (POQ; Azar et al., 1984)*
	Parental Problem-Solving Measure (PPSM; Hanson, Pallotta, Christopher, Conaway, & Lundquist, 1995).
Social Support	Arizona Social Support Interview Schedule (ASSIS; Barrera, 1981)*
	Perceived Social Support Questionnaire (Procidano & Heller, 1983)
	Family Support Scale (FSS; Dunst, Trivette, & Hamby, 1996)
Marital and family adjustment	Dyadic Adjustment Scale (DAS; Spanier, 1989)
	Conflict Tactics Scale (CTS; Straus, 1979; Straus, Hamby, Boney-McCoy, & Sugarman, 1996)
Cognitive and adaptive functioning	Wechsler Adult Intelligence Scale-III (WAIS-III; Wechsler, 1997)
	Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1984)
Personality functioning	Minnesota Multiphasic Personality Inventory-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989)
	Millon Clinical Multiaxial Inventory (MCMI-II and -III; Millon, 1987, 1994)
Academic achievement	Wide Range Achievement Test 3 (Wilkinson, 1993)
	Observation of parent–child relationship
Parent–Child interactions	Dyadic Parent–child Interaction Coding System II (DPICS II; Eyberg et al., 1994)
	Home Observation for the Measurement of the Environment (HOME) Inventory (Caldwell & Bradley, 1984)

*Denotes measures of parental functioning discussed in text.

at risk for child abuse and neglect. The four measures are now described briefly.

The Brief Symptom Inventory (BSI; Derogatis, 1993) provides an index of emotional adjustment. The BSI consists of 53 items on which the parent rates how much he or she was distressed during the past week by various symptoms (e.g., trouble remembering things, feeling lonely, difficulty making decisions). Parents respond to items on a 5-point scale from "*not at all*" to "*extremely*." Items are scored on a standardized key and compared to normative levels for persons of the same gender and psychiatric history. The BSI yields a Global Severity Index summary scale, as well as nine individual scales. It is based on the well-researched Symptom Checklist 90-Revised (SCL 90-R; Derogatis, 1983), which has been shown to have strong psychometric properties (Cyr, McKenna-Foley, & Peacock, 1985; Derogatis, 1983). Research demonstrates the usefulness of the SCL-90R with at-risk parents (Ammerman & Patz, 1996; Budd et al., 2000; Haskett, Scott, & Fann, 1995); however, little research specific to parental fitness has been conducted to date with the BSI.

Two self-report instruments, the Child Abuse Potential (CAP) Inventory (Milner, 1986) and the Parent Opinion Questionnaire (POQ; Azar, Robinson, Hekimian, & Twentyman, 1984), are useful for assessing childrearing beliefs and attitudes. The CAP Inventory, Form VI, is a 160-item questionnaire to screen characteristics and attitudes associated with physical child abuse. Items are answered in a forced-choice, agree–disagree format. The measure yields a primary clinical scale, the 77-item abuse scale, and six factor scales: distress, rigidity, unhappiness, problems with child and self, problems with family, and problems from others. In addition, the CAP Inventory produces three validity indexes (faking good, faking bad, and random response). Extensive research on the psychometric properties of the CAP Inventory supports its concurrent and criterion validity (Milner, 1986, 1990, 1994). Elevated scores on the CAP Inventory signal an increased risk of physical child abuse, and individual scales suggest areas of potential clinical concern; however, the results need to be interpreted cautiously, because limited information is available on predictive validity of the measure (Milner, Gold, Ayuob, & Jacewitz, 1984). Some parents in a child protection context respond in a socially desirable manner, resulting in an invalid profile due to an elevated faking good index. Milner (1986) recommends that, if both

the abuse score and the faking good index are elevated, the abuse score may still be used, based on the assumption that the abuse score might have been even higher if the parent were not attempting to respond to items in a socially desirable manner.

The POQ (Azar et al., 1984) is an 80-item measure of unrealistic parental expectations regarding appropriate child behavior. Items are answered in a forced-choice, agree–disagree format, with high scores indicating greater levels of unrealistic expectations. Six subscales (self-care, family responsibility and care of siblings, help and affection to parents, leaving children alone, proper behavior and feelings, punishment) relate to specific content areas of unrealistic expectations. POQ scores have been found to distinguish between maltreating and nonmaltreating parents (Azar et al., 1984), and to differentiate parents who perpetrate abuse from nonperpetrating parents in a family (Azar & Rohrbeck, 1986). Budd et al. (2000) found only modest associations between POQ and CAP Inventory scores, which suggests that the measures tap different aspects of parenting risk. Normative levels have not been established for the POQ, and further research is needed on its psychometric properties.

The Arizona Social Support Interview Schedule (ASSIS; Barrera, 1981) is used to assess a parent's social support network. This measure, as modified slightly by Mitchell (1989), asks the parent to identify persons who provide support in four functional areas (emotional, material, positive feedback, and social participation), as well as persons with whom the parent has conflict. The parent then identifies whether he or she actually had contact with these individuals in the past month, and rates satisfaction with the amount of support received in each of the four areas. Norms have not been established for the ASSIS, so it is useful mainly as a source of qualitative information. The ASSIS has been used with at-risk parents in various applied research investigations (e.g., Barrera 1980, 1981; Nitz, Ketterlinus, & Brandt, 1995). Budd et al. (2000) found that adolescent mothers' dissatisfaction with their social support was significantly associated with greater child abuse risk.

3. *Observe parent–child interactions.* Observation of the parent and child together serves two assessment functions: it provides an index of behavior when the parent presumably is attempting to use his/her best caregiving skills, and it offers the opportunity to observe a range of parent and child behavior under different conditions. The examiner can observe parent–child interactions in a free-play, unstructured context as well as under various structured conditions, such as when the child is asked to clean up toys, when the parent is asked to teach the child a challenging task, or during a typical childcare routine (such as mealtime). Ideally, the evaluation includes more than one observation session, so the clinician can observe parent–child interactions across occasions. Observations in the family's home provide an opportunity to observe the physical setting, toys and learning materials, structure provided by parent, and routines of the family. The American Psychological Association's child protection guidelines (American Psychological Association Committee on Professional Practice and Standards, 1998) recommend observation in natural settings when possible. If circumstances preclude home observation, the clinician can observe the parent and child during a visitation session, at a clinic, or at a social service agency.

As Wolfe and McEachran (1997) note, there are no unique behavior categories for maltreating or high-risk families, so the clinician can consider using one of several research-based observation systems, two of which are listed in Table IV. The Dyadic Parent–child Interaction Coding System II (DPICS II; Eyberg, Bessmer, Newcomb, Edward, & Robinson, 1994) was designed to assess parents and their young children referred clinically for behavior problems. The DPICS II measures parent and child behaviors during a child-directed and a parent-directed activity and provides objective scoring criteria for the evaluator. Although not initially developed for use with families in the child protection system, selected categories in the DPICS II have been used to assess treatment effectiveness in programs with at-risk and abusive families (Borrego, Urquiza, Rasmussen, & Zebell, 1999; Funderburk, Balachova, Chaffin, & Silovsky, 2000).

The HOME Inventory (Caldwell & Bradley, 1984) is a combination observation and interview procedure that assesses the quality and quantity of social, emotional, and cognitive support available to a young child in the home. The observer scores the presence or absence of specific behaviors and routines organized into topics such as the parent's emotional responsivity, acceptance of the child's behavior, the presence of learning materials, and the child's opportunities for involvement in social activities and variety in experiences. Research (e.g., Garcia Coll, Hoffman, & Oh, 1987; Luster & Rhoades, 1989) with at-risk families supports the HOME's usefulness in identifying more or less optimal home environments.

Any standardized observation system is limited in its applicability and requires substantial training

prior to reliable use. Because of the individualized circumstances giving rise to parental fitness assessments, it often is not feasible to employ standardized observational formats. For example, observation sessions may occur at a social service agency or in a public setting, multiple children may participate, and the children may range in age from infancy to adolescence. When standardized coding is not practical, the clinician can informally observe and record interactions of interest. Informal coding could involve recording instances of specific behaviors (e.g., the parent's positive attention, criticism, and responses to child initiations) or describing examples of the sequence of parent–child interactions across the session. Table V lists questions regarding parent and child behavior patterns for the clinician to consider during the observation session. Informal observation methods maximize the flexibility of the observational assessment but preclude systematic analysis or comparison of findings across or within families (Mash & Terdal, 1997).

Table V. Potential Content Areas for Informally Observing Parent–Child Interactions in an Assessment of Parental Fitness

I. Parent behavior patterns
A. How does parent structure interactions through instructions, toys, or activities?
B. How does parent show understanding or misunderstanding of children's developmental levels?
C. How does parent convey acceptance or approval of children's behavior (praise, descriptive feedback, physical affection)?
D. How does parent convey disapproval of children's behavior (criticisms, negative commands, threats, physical roughness)?
E. Does parent notice and attend to children's physical needs (e.g., hunger, need to use bathroom, safety risks)?
F. Is parent responsive to children's initiations via verbalizations, facial expressions, and actions?
G. Does parent accept children's right to disagree or express their own opinions?
H. Does parent follow through with his/her instructions or rules?
I. Does parent spread attention fairly across children if more than one child is present?
J. Does parent appear distracted, withdrawn, or bored during session (e.g., ignoring children or watching television instead of interacting with children)?
K. Does parent make "troublesome" comments (e.g., asking children if they love parent, making negative comments about family members or foster parents, or swearing)?
II. Child behavior patterns
A. Are children at ease around parent (e.g., smiling, playing, and verbalizing vs. remaining distant, quiet, or fearful)?
B. Do children initiate interactions with parent?
C. Do children display developmental, emotional, or behavioral difficulties that require more skillful parenting strategies than the parent exhibits?
D. Do children respond to parent's initiations by showing interest and acceptance of parent's attention?
E. Do children disagree with parent or express own opinions?
F. How do children show affection and interest toward parent?
G. What topics do children bring up in conversations with parent (e.g., activities in foster family, desire to be with parent)?

Direct observation is not always possible (e.g., because the parent is not allowed access to the child, the child is hospitalized, or other complicating factors exist). In these cases, the clinician must avoid drawing conclusions about persons not directly observed.

4. *Interview collateral sources.* Persons who know the parent and child can provide valuable information. Caseworkers, therapists, substance abuse counselors, previous service providers, or other professionals can report on the parent's progress in services, problems, and strengths. Extended family, friends, the parent's partner, or a foster parent may offer pertinent information that confirms or disconfirms assertions by the parent. The child's teacher, babysitter, physician, or other provider also may have relevant information based on interactions with the family. The psychologist should request the parent's written permission to speak with these individuals and provide them the same notice regarding the limits on confidentiality of the evaluation as the parent receives. If parents refuse to give permission for the evaluator to speak with potential collateral sources, this fact should be noted in the report.

5. *Administer child measures, if indicated.* Depending on the referral concerns or issues that arise during the evaluation, assessment of the child's functioning may be appropriate (cf. Azar & Bober, 1999; Budd & Holdsworth, 1996; Wolfe & McEachran, 1997). To obtain information about the child's developmental functioning, the clinician could administer the Bayley Scales of Infant Development, 2nd edition (Bayley, 1993), the Wechsler Preschool and Primary Scale of Intelligence-Revised (Wechsler, 1989), the Wechsler Intelligence Scale for Children III (Wechsler, 1991) or the Denver Developmental Screening Test II (Frankenburg et al., 1992). Symptom checklists are available for screening behavioral, emotional, and social functioning (Mash & Terdal, 1997). Clinical interviews or diagnostic play could be used if the child has requisite verbal skills. Considering the young age range of the children (under age 8) and the fact that parental competence evaluations focus mainly on the parent and the parent–child relationship, extensive evaluation of the child is not routine.

Integrate Findings and Write the Report

1. *Review and interpret assessment data.* After assessment activities have been completed, the evaluator scores psychological instruments and reviews information gathered in the parent interview, observations, and collateral interviews. The clinician also reviews written records in light of the current findings. With the evaluation results in hand, the clinician then returns to the framework (described in Table I) for viewing the fit between the child's developmental needs, the parent's independent ability to meet his or her own needs, and the parent's caregiving skills and deficits in major domains of functioning (physical, cognitive, and social/emotional). This framework forms the basis for summarizing the assessment findings in terms of functional parenting skills and deficits. The clinician also organizes the findings in relation to the specific referral questions. The clinician considers consistencies and inconsistencies across data sources and methods, and identifies strengths and gaps in the evidence.

2. *Construct a report that responds to the referral questions.* Preparing a clear, well organized, and informative report of a parental fitness evaluation is a challenging task. It entails integrating multiple and often mixed findings, weighing the strength of data supporting various interpretations, judging whether the parent's functioning in various areas meets a minimally adequate threshold, and deciding which statements to make in summarizing the key results and conclusions. The psychologist needs to produce a report that is free of technical terms and assumptions, so persons outside the field of psychology can understand it. Further, because it is likely to be used as legal evidence in child protection matters, accuracy and sound logic are crucial.

Table VI displays a detailed outline of a report format for parental competency evaluations. This format is based on a protocol developed by the current author and colleagues for a project in the juvenile court system of Cook County, IL, which encompasses much of the city of Chicago. The project, conducted by the Clinical Evaluation and Services Initiative (CESI), is designed to reform the way clinical information is used in judicial decision-making (Clinical Evaluation and Services Initiative [CESI], 1999). The protocol outlined in Table VI is being used by clinicians as part of a pilot project, with the intent of addressing many of the substantive limitations identified in the empirical analysis of evaluations of parents in the Cook County court system (Budd et al., 2001).

The report format incorporates many of the recommendations described in the literature on assessment of parental competency (discussed earlier in this paper). For example, in a section on the reasons for referral, the psychologist enumerates the specific clinical questions to be answered, the reasons for the referral at this time, and the options or decisions under consideration. Separate sections are provided for summarizing information from relevant records and describing confidentiality issues. Findings from assessment activities are presented descriptively, not interpretively, with individual sections devoted to different types of information (interviews, psychological measures, observations, etc.). In the clinical summary that follows, the psychologist responds to each referral question, summarizing the data used to formulate an opinion and delineating the logical inferences that link the findings to the interpretations. The psychologist also articulates the parent's functional skills and deficits as they relate to the referral questions. The protocol advises evaluators to avoid providing opinions on the ultimate legal issue, as recommended by several forensic experts. In the recommendations section, the psychologist lists clinical or legal recommendations following from the assessment and ties them to specific risk factors or deficits.

One particularly challenging aspect of preparing the report concerns judgments the clinician will need to make about whether the parent's caregiving repertoire meets a minimally adequate criterion. Psychologists are trained to evaluate parents with personal problems, chronic stressors, and troubled lives, but rarely does clinical training teach us to consider whether a parent's childrearing deficits are so pervasive that they fall below a minimal threshold of fitness. For example, does a home that is dirty, dark, and infested with insects constitute an unsafe living environment for a child? Is a mother who chronically maintains such a home environment unfit? Would it matter if the child were an infant versus a 4-year-old? Would the fact that the mother beams when she talks about her son, and caresses him gently as she feeds him, lead us to consider the seriousness of the home conditions differently? And, if the mother has just completed substance abuse rehabilitation after a 3-year cocaine addiction and has been clean for 6 months, would that portend adequate caregiving functioning?

At present, there is no validated formula for determining parental fitness. Instead, in analyzing assessment findings, the evaluator makes numerous clinical judgments about the parent's functioning and ability to meet the child's developmental needs. The

Table VI. Outline[a] of Report of Parental Fitness Evaluation

I. Identifying information
  A. List identifying information regarding the assessment
  B. Examples of identifiers: persons evaluated (including names, birthdates, and ages), referral source, date of referral, and date of report
II. Reason for referral
  A. Enumerate specific clinical questions to be answered
  B. State reasons for referral (e.g., problems that triggered the referral at this time)
  C. Describe legal or service options or decisions under consideration
III. Summary of assessment contacts and activities by date
  A. Chronologically list contacts (including date, type of activity, persons involved, and locations)
  B. Examples of contacts: interviews, observations, tests, and conversations with collateral sources
IV. Assessment measures administered
  A. List each psychological measure (full name) used
V. Records reviewed
  A. List relevant records reviewed, subdivided if lengthy into types or sources of records (including name and date of record, and noting if pages are missing)
  B. Examples of relevant subsections: court, child welfare agency, mental health, medical, police
VI. Information from relevant records
  A. Summarize pertinent background information, based on records reviewed (as just listed)
  B. If lengthy, divide into sections, such as allegations and child welfare involvement, children's placements and visitation arrangements, mental health history, child welfare services offered and received, and police involvement
  C. Describe relevant information, citing sources to clarify what information came from what source, noting discrepancies or consistencies across sources, and relevant documents not available for review
VII. Warning of limits on confidentiality
  A. Indicate notice to parent regarding assessment purpose and limits on confidentiality of the report
  B. State if parent appeared to understand the notice and how determined
  C. Indicate notice provided to collateral sources
VIII. Behavioral observations and mental status
  A. Describe parent's general behavior, presentation, coherence, mood, speech, thought pattern, responsiveness, and cooperation with the assessment
  B. Clarify whether evaluator judges that the results are or are not valid and the basis for this opinion
  C. List any factors (e.g., parent's comprehension of questions, time limits, cultural or language differences, gaps in assessment activities, or parent or child illness during assessment) that limit the generalizability of the assessment data
IX. Information from clinical interviews
  A. Describe pertinent information from interviews of parent and collateral sources (only persons interviewed in current assessment)
  B. If lengthy, divide into sections similar to those under record review, such as allegations and child welfare involvement, children's placements and visitation arrangements, mental health history, child welfare services offered and received, and police involvement
  C. Document the interviewee's actual words to convey some points
  D. Avoid offering opinions or interpretations in this section
X. Results of assessment measures
  A. Summarize performance on assessment measures by briefly describing purpose of each measure and results
  B. If lengthy, divide into sections by type of measure (e.g., intellectual functioning, parenting knowledge and beliefs, emotional and behavioral adjustment)
  C. State whether findings from individual measures are valid, clinician's basis for the judgment, and implications for interpreting results on the measures
XI. Observation of parent–child interactions
  A. Summarize performance during observations, by describing the setting, activities, persons involved, and relevant positive and negative aspects of the interactions
  B. Use behavioral examples to communicate points about qualities, skills, and patterns of interaction
  C. Examples of relevant dimensions of parent behavior: instances of parent observing and monitoring the child's behavior, providing affection, methods of disciplining (e.g., setting limits and following through), responsiveness to the child's initiations or cues, voice tone, nature of topics discussed with child, and signs of understanding or misunderstanding the child's behavior or intent
  D. Examples of relevant dimensions of child behavior: child's initiations to parent, responses to parent's initiations, sense of ease around parent, display of affection toward parent, cooperation with parent's requests or attempts to structure child, activity level, and topics raised with parent

(*Continued*)

Table VI. (*Continued*)

XII. Clinical summary
A. For each referral question, summarize the data used to form an opinion and the examiner's opinion (i.e., interpretation of the data), clearly delineating the logical inferences that link the findings to the interpretations
B. List the parent's strengths and deficits (or risks and protective factors) that bear on the referral questions and the parent's childrearing capacity, given the child's developmental needs
C. Avoid opinions regarding the ultimate legal issue (i.e., whether a parent's rights should be terminated, or if a parent should be granted unsupervised visits), but instead provide factual, behaviorally specific, and logical information that bears on the ultimate issue
D. Be cautious about describing and offering opinions on findings unrelated to the referral questions
XIII. Summary of recommendations
A. If appropriate, list clinical or legal recommendations following from the assessment (e.g., intervention, advocacy services, resources, or information needed)
B. If recommendations relate to the ultimate legal issue, state them in the alternative rather than giving a definitive recommendation (for example, "If it is determined that the child will return to the parent's custody, then specified transition services need to be put in place immediately.")
C. Link the recommendations to specific risk factors or deficits described in the clinical summary
D. Be cautious about making recommendations on topics unrelated to the referral questions
XIV. Signature
A. Provide full name, professional degree, license number, and signature of clinician (and supervisor, if any)

[a] This outline lists relevant sections (Roman numerals) of a sample report and potential content to include in each section.

assessment evidence often is disparate, and results from different methods may vary in strength, specificity, reliability, validity, and relevance. Each fact drawn from the assessment becomes a building block in developing an integrated picture of the parent's functioning, the risks and protective factors present, and the nature of the parent–child relationship, based on the clinician's professional training. By considering these building blocks in an objective, thoughtful manner, the clinician can address the specific referral questions and articulate the basis for his or her opinions.

CONCLUSIONS

This paper describes a clinical practice model for assessing parental fitness to care for young children in the context of alleged child maltreatment or high-risk parenting practices. Psychologists increasingly are asked to conduct evaluations of parents in a child protection context, yet the available evidence suggests that evaluations typically provided by clinicians fall short of recommended guidelines in many respects. The current model embodies three core features: (a) emphasis on the parent's functioning as a caregiver and on qualities of the parent–child relationship, (b) a focus on functional skills and deficits involved in everyday parenting patterns, and (c) measurement of parenting adequacy in light of what would be minimally necessary to protect the safety of the child. The task of parenting assessment is complicated by several factors, including the lack of universal standards of minimal parenting competency, the coercive conditions of the evaluation, the dearth of appropriate measures, difficulties predicting future behavior, and the high probability that the evaluation will be used in legal proceedings. To contend with these complications, the proposed assessment model involves conceptualizing parental fitness by examining the fit between the child's developmental needs, the parent's ability to care for his or her own needs, and the parent's ability to function as a caregiver. It recommends that psychologists clarify specific referral questions in advance; obtain data to address the referral questions through multiple methods, sources, and sessions; organize findings carefully; and develop an objective, behaviorally descriptive report that establishes a logical basis for clinical opinions regarding the referral questions. Further, it advises a conservative approach to offering opinions regarding ultimate legal issues, underscoring Melton et al.'s recommendation (Melton et al., 1997) that the clinician should have great humility about stating any opinions or predictions.

Psychologists who provide evaluations in a forensic context must approach the task with an open mind, tolerance for ambiguity, and confidence that full information enhances fair decision-making. Unfortunately, there is no index for measuring the correctness of the evaluator's opinion, but neither is there a right answer known to others. Parental fitness assessment can facilitate sound child protection decisions by applying psychological knowledge and skills

to important questions affecting the safety and well-being of children and families.

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