MINNESOTA JUDICIAL BRANCH

CHAPTER 37

ESSENTIAL CONCEPTS OF CHILD DEVELOPMENT, ATTACHMENT FORMATION, AND ASSESSING PARENTING CAPACITY

TABLE OF CONTENTS

DEVELOPMENTAL STAGES: COGNITIVE AND PSYCHOLOGICAL

A GUIDE TO ASSESS FACTORS IN ATTACHMENT FORMATIONS

A GUIDE TO ASSESS EVIDENCE IN PARENTAL CAPACITY ASSESSMENTS

A special thank you to Deena McMahon for writing this chapter of the Benchbook.

McMahon Counseling & Consultation
1026 Portland Ave.
St. Paul, MN 55104
651-210-0335

DEVELOPMENTAL STAGES: COGNITIVE AND PSYCHOLOGICAL

- Children's needs vary significantly, depending on the age and developmental stage of the child. In terms of attachment and brain development, the first years are the most critical. It during those years that changes happen most rapidly.

- Successful and optimal development of the child depends on the health and strength of the relationship the child has with his/her caregivers, especially in the early years.

- Children with special needs, attachment wounds, or who have experienced abuse or neglect progress through the developmental stages, but often do so in a delayed time frame.

- The range of "normal" is wide and diverse. Cultural components of parenting and community mores must be considered when evaluating children and parents.

- There are global risk factors for children and caregivers that can affect children of every age. There are also risk factors specific to each developmental stage. The degree of harm the child experiences will depend upon their vulnerabilities and the resiliency features they have, as they progress through their developmental milestones.

GLOBAL RISK AND RESILIENCY FACTORS

The following checklist provides a list of global risk and resiliency factors for children, regardless of age.

Characteristics of caregivers that present as risk factors for children:

- □ Mental illness
- □ Chemical dependency
- □ Domestic violence
- □ Lack of support system
- □ Developmentally disabled
- □ Poverty
- □ Lack of education/learning disabilities

Global risk factors for children:

- □ Loss of caregiver or attachment figure
- □ Multiple caregivers or moves
- □ Exposure to domestic violence
- □ Prenatal exposure to alcohol or drugs
- □ Physical health concerns

Global resiliency factors for children:

- □ Age of the child
- □ Cognitive abilities and neurological health
- □ Previous attachment history
- □ Consistent caregiver

GLOBAL QUESTIONS REGARDING EVERY CHILD

The following questions should be considered for every child as they are paired with the child's developmental stage, risk factors for the specific child and suggested services.

- ✓ How often has this child been moved?
- ✓ Has this child received consistent care from one or two adults?
- ✓ What special physical or mental health needs does the child have?
- ✓ Does the caregiver have mental health or addiction issues?
- ✓ Has the child been prenatally exposed to alcohol or other drugs?
- ✓ Has the child experience trauma? By whom? Frequency?
- ✓ Has this child been neglected or abused, and at what age?
- ✓ Is the child in a concurrent home?
- ✓ Is the child separated from siblings? Why?
- ✓ What sorts of visits happen with parents and/or siblings?
- ✓ Has the child witnessed domestic violence?
- ✓ Has the child or adult received mental health case management?

DEVELOPMENTAL STAGES

Trust vs. Mistrust – The Baby (0 to 18 months)

THE DEVELOPMENTAL TASK: The child learns to trust and rely on an adult.

TYPCIAL: The child will allow others to provide comfort, will accept and seek nurture from a preferred caregiver, will be soothed, and will have the ability to relax. The child eats when hungry and stops when full. The child learns to roll, sit, grasp, make sounds, crawl, and walk. The child typically learns to sleep all night and has regular naps.

- These skills are not lost when the child moves from home to home, as long as the primary caregiver remains with the child.
- These skills do not necessarily transfer from one caregiver to another caregiver. A change in primary caregiver can easily cause regression and require the child to start over.
- The baby begins to understand object permanence — that is, people do not cease to exist even when they are out of sight.
- The baby develops expectations of adults and situations. He develops strong preferences. He has difficulty with separation from the caregiver and experiences moves and changes as anxiety-producing.

ATYPICAL: The child does not have a sense of security with the caregiver. The child is difficult to soothe. The child may have eating difficulties with digestive concerns, acid reflux, and intolerance of changes to formula or milk. The child may not have established sleeping patterns and be overly sensitive to changes in routine.

- The child may have an exaggerated startle response and cry for extended periods of time, sometimes with a high pitched wail and appear inconsolable.
- The child may fail to learn to roll over, sit, or crawl. The child does not appear interested in interacting with the adults or environment and become listless, avoidant, or overly fussy.
- The child may avert his face rather than gaze at the person holding them and arch his back when held.

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
▪ See GLOBAL RISK and RESILIENCY FACTORS, p. 36-4	▪ See GLOBAL QUESTIONS FOR EVERY CHILD, p. 36-5	
▪ Loss of caregiver or attachment figure. ▪ Multiple caregivers or moves from one home to another that create chaos for the parent. Lack of stability for the parent transfers directly to the lack of stability for the child.	▪ How often has this child been moved? ▪ Has this child received consistent care from one or two adults?	▪ Intensive intervention to support the parent. ▪ Parent Child Interaction Therapy, which provides the parent frequent and hands-on coaching about managing their baby.
▪ Parent who has unrealistic expectations of a child's ability to understand and control their responses.	▪ Does the parent understand their child's developmental tasks?	▪ In-home family skills training for the parent and child to support good parenting practices (attunement, child-centered parenting, behavior management). ▪ Parent support and education groups or classes.
▪ Exposure to domestic violence, either prenatally or after birth.	▪ Has this child experienced trauma? By whom? Frequency? ▪ Is the child witnessing domestic violence?	▪ In-home family skills services to educate the parent about the needs of the child, teach the adult the necessity of good care and typical child development tasks, and monitor for safety. ▪ Individual/couple/family therapy in a domestic violence program.
▪ Exposure to alcohol or other drugs.	▪ Has the child been prenatally exposed to alcohol or other drugs?	▪ Evaluation from Early Childhood Screening services, such as head start or learning readiness programs, provided by school district at no cost to parent. ▪ Neuropsychological evaluation. ▪ DC-03 evaluation for the child. ▪ Services from Early Childhood Special Education, often provided in the family home.

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
▪ Inconsistent caregiving: parent is unavailable. ▪ A depressed parent. ▪ A chemically dependent parent.	▪ Does the caregiver have mental health or addiction problems? ▪ Has this child been neglected?	▪ Participation of parent and child in Early Childhood Family Education (ECFE) events and programs geared towards positive parent/child interaction and parent education.
▪ Mental illness and chemical dependency in the caregiver.	▪ Has the parent used services before? ▪ What is the nature and prognosis for this illness and is it a lifelong illness or addiction?	▪ Mental health screening and/or chemical dependency screening and treatment for the parent, if indicated.
▪ Lack of pediatric follow up. ▪ Lack of access to health care. ▪ Physical health concerns causing persistent physical pain or discomfort.	▪ What special needs does the child have?	▪ Public Health nursing, at no cost to the family, will monitor the progress of the child and offer support and information to the parent. Provided in the family home, this may include teaching the parent how to address the physical cares of the child in terms of bathing, feeding, and providing routine care. ▪ Physical examination by a pediatrician to assess any physical health concerns and to monitor immunizations and weight gain.
▪ A developmentally disabled parent.	▪ Does the parent understand and prioritize the child's needs?	▪ In-home family skills training or in-home family therapy to strengthen parent/child relationship, address parenting deficits, and teach developmentally appropriate ways of child rearing. ▪ After-school activities and programming.
▪ Child temperament and the parent perception of the child is a critical feature for safety. ▪ A parent who becomes angry at the child's daily needs creates a risk feature for the child.	▪ Does the adult have basic parenting skills? ▪ Are the needs of the child a bad fit with the skills/temperament of the parent? ▪ Does the parent use shaking or corporal punishment?	▪ Early Childhood Family Education classes or in-home parenting skills. ▪ Possible psychological evaluation for the parent. ▪ Possible parenting assessment (see "Assessing Parental Capacity).

Autonomy vs. Shame and Guilt – The Toddler (18 months to 3 years)

THE DEVELOPMENTAL TASK: The child develops a sense of independence and self-control.

TYPICAL: The child takes some risks, gains confidence, and enjoys being given choices. The child learns through exploration and trial and error, with guidance. The child requires supervision, enjoys the company of others, and learns that there is pleasure in play. The child learns to use language to communicate and can usually make themselves understood. The child is willing to tackle potty training, falling asleep on their own, and transitioning to day care, preschool, or a babysitter. The child can climb, jump, go up stairs, and stand on one foot. The child enjoys ritual and routine.

- The child wants to assert himself.
- The child learns to rebel and say NO; as he gains confidence, self-esteem is developed.
- The child learns he has an impact on the world and the people around him.
- The child's capacity to regulate his mood and emotions increases.

ATYPICAL: The neglected child may form very rigid boundaries and reject their caregiver. The child will attempt to fend for himself and not understand the risk factors inherent in this. The child can develop diffuse boundaries and approach strangers to have their needs met. The child may become overly defiant and seek to be in control at all times. Temper tantrums may be frequent and extreme in nature.

- The child may fail to develop language skills or appear delayed in indentifying shapes, colors, animals, or body parts.
- The child does not play with other children well and may not be able to play independently.
- The child may be overly fearful and anxious, clingy, whiny, or become a bully with aggressive behaviors.

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
▪ See GLOBAL RISK and RESILIENCY FACTORS, p. 36-4	▪ See GLOBAL QUESTIONS FOR EVERY CHILD, p. 36-5	
▪ Overly-controlling/rigid or permissive parenting styles. The parent may punish a child for a toileting accident or for being defiant, which is a task the child has not yet mastered. ▪ Lack of adult supervision.	▪ Is the child receiving good supervision? ▪ Does the parent use corporal punishment or have a history of abuse with other children?	• In-home family skills training for the parent and child to support good parenting practices (attunement, child-centered parenting, behavior management).
▪ A parent who has unrealistic expectations of a child's ability to understand and control their responses. Ex: Has a 3-yr old care for a baby or leaves a preschooler unattended. ▪ Insistence on toilet training and obedience before the child is ready.	▪ Does the parent understand their child's developmental tasks?	▪ In-home family skills training for the parent and child to support good parenting practices (attunement, child-centered parenting, behavior management). ▪ Parent support and education groups or classes.
▪ Separation from the attachment figure harms the child's sense of security and trust. ▪ Child will go to anyone.	▪ Does the child have a secure attachment with a primary caregiver? ▪ How many times has the parent/child care giver	▪ Attachment-focused parenting which teaches attunement, boundaries, and using the parent as a secure base.

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
	relationship changed, such as moves from one foster home to another?	
▪ Exposure to drugs, violence; impaired mental health of parent.	▪ Is there violence or sexual victimization in the family? ▪ Has this child experienced the trauma of neglect or abuse?	▪ Physical examination of the child to ensure the child is healthy, has positive nutrition, and is current on immunizations and dental care. ▪ In-patient or out-patient counseling for the parent.
▪ Lack of routine and structure in the home. The child does not know who to count on or how to prepare. ▪ Expectations are unclear.	▪ How many times has the parent/child care giver relationship changed, such as moves from one foster home to another? ▪ Does the parent/home provide a predictable/safe routine?	▪ In-home family skills training for the parent and child to support good parenting practices (attunement, child-centered parenting, behavior management).
▪ A parent who lacks understanding of normal behaviors such as tantrums or refusal and becomes punitive.	▪ Does the parent understand their child's developmental tasks?	▪ Early Childhood Family Education (ECFE) classes.
▪ A parent with impaired mental health or chemical dependency issues.	▪ Does the parent have mental health or addiction problems that have been assessed, and has the parent used services?	▪ Assessment of mental health concerns for the parent and/or child with interventions geared toward improving the relationship and addressing the most concerning symptoms. If it is the parent/child relationship that is most impaired, then services need to include the parent and the child. If there are serious concerns about the parent's mental health or chemical health, services need to be focused on the adult with an emphasis on how the problem and interventions impact parenting.
▪ Possible special needs in learning, communicating, and physical development of the child.	▪ What, if any, are the child's special needs or developmental delays? ▪ How severe is the delay? ▪ As a result, is the child unable to meet his or her developmental milestones?	▪ Early childhood screening from Early Childhood Special Education or Early Childhood Family Education (ECFE) to address developmental delays in the child and to provide education and support to the parent. ▪ Positive, enriched daycare that can provide a routine of daily care for the child outside of the parent's home, if the parent is

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
		unable to provide this.

Initiative vs. Guilt – Preschool to Kindergarten (3 to 6 years)

THE DEVELOPMENTAL TASK: The child gains a sense of self-awareness and initiative about who he is going to be. The child learns to like himself and to feel pride.

TYPCIAL: The child begins to understand right from wrong and can feel guilt, remorse, and even shame. The child models after grownups and pays close attention to what grownups are saying and doing. The child's ability to articulate is better, and he moves into a learning environment that requires more discipline and structure.

- The child develops a sense of imagination, fantasy, and creative play, with strong talents, preferences, and skills emerging.
- The child can follow simple verbal instructions, make plans, and demonstrate some follow through.
- The child becomes aware they are sexual people and are interested in learning more.

ATYPCIAL: This child may be fearful of asking questions, exploring new territory, or knowing his limits. Parents who expect more than is safe or reasonable place the child in an overly responsible position. When this happens, failure experiences make the child feel ashamed. The child begins to feel bad or stupid, and his behaviors demonstrate this lack of self-esteem.

- Lying and stealing appear; sleep and eating patterns may be affected.
- Night terrors and poor academic performance may emerge, as the child does not feel he is a competent learner or is fearful of leaving the parent at home alone.
- The child may become incontinent, or fail to become potty trained.
- The child may appear rebellious to teachers and bossy and over bearing with peers.
- Failure to make friends or enjoy social activities appears.

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
▪ See GLOBAL RISK and RESILIENCY FACTORS, p. 36-4	▪ See GLOBAL QUESTIONS FOR EVERY CHILD, p. 36-5	
▪ The parent who expects the child can eat, cook or babysit, and who does not require supervision.	▪ Does the parent have realistic expectations? ▪ Does the parent have the cognitive capacity to parent?	▪ Parenting skills training for the caregiver, with an emphasis on providing continuity of care from the foster home to the birth parent, in terms of rules, expectations, and parenting styles.
▪ The child can become a sexual abuse victim, as they are interested and eager to please. This is especially true in homes where drug addiction is present.	▪ Does the parent provide safety at home from alcohol, addicts, or sexually inappropriate adults or children?	▪ The child will need intensive therapy with a skilled professional. ▪ The child and parent (non-offending) need to do attachment repair focused on trust and safety. ▪ The adult caregiver needs therapy to learn how to attend to the child.
▪ Children exposed to violence, addiction and family chaos have trouble understanding how they fit into the world and what their responsibility is to fix the problems—the child blames themselves for being abused or molested.	▪ Has the child been evaluated for trauma or abuse?	▪ Assessment for addiction and/or violence in the home and a plan for treatment that includes teaching the parent how to manage differently and to address safety and past mistakes, in a way the child can understand. ▪ Therapy for the child and parent to reestablish safety and trust.
▪ Lack of social supports, such as babysitter, grandparents, teachers or neighbors, increase vulnerability.	▪ Are there social or emotional supports for the child outside of the home?	▪ Use of respite, use of family conferencing or family group decision making to find and implement support. ▪ Use of daycare.
▪ If the child has a learning disability or is developmentally behind or unprepared for a school class room, the child struggles to learn and to fit in. ▪ Physical health problems become more problematic.	▪ Does the child have special needs? ▪ Is the parent responsible in regards to the child's health—is the child current on immunizations; does the parent keep medical appointments, etc.?	▪ Early Childhood Screening to flag any developmental delays and address them with an III-EP or an early individualized educational plan that can be implemented in day care, in preschool and kindergarten, and with an early childhood specialist in the home with the parent/caregiver. ▪ Physical by a pediatrician to assess for nutrition, exercise and immunizations.
▪ Mental health concerns for the parent.	▪ Has the parent had a psychiatric evaluation? Are they	▪ Assessments for mental health for the adults and for the child,

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
	compliant with medicines?	if needed, with a treatment plan that emphasizes the parent/child relationship. ▪ Group or individual therapy for the adult.

Industry vs. inferiority – Elementary School (6 to 12 years)

THE DEVELOPMENTAL TASK: The child develops a sense of industry or hard work and learns the skills of survival. The child feels competent (safe) as he can achieve a certain outcome with a certain amount of work or focus.

TYPICAL: Social relationships and membership are vital and the child enjoys participation in group activities. Healthy competition is fun as is cooperation with children and adults. Social skill development is essential and the child looks to other adults in addition to the parent to establish fair rules and provide support.

- The child learns there are payoffs to hard work and following rules.
- The child may experiment with assertiveness and be disrespectful or challenging towards the parent's rules.

ATYPICAL: The child begins to feel like they are stupid and not likeable. They avoid interaction with peers and tend to isolate or avoid competitive or challenging situations. They are overly fearful of failure and thus avoid new skill development.

- The child may begin to engage in drug or alcohol use, sexual activities, or other high risk behaviors to "fit in" and to feel better.
- The child may feel responsible for the parent or for younger siblings. The child views activities their peers participate in as childish.

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
▪ See GLOBAL RISK and RESILIENCY FACTORS, p. 36-4	▪ See GLOBAL QUESTIONS FOR EVERY CHILD, p. 36-5	
▪ Parents who are not involved or engaged in the social or education activities of a child teach the child their interests do not matter.	▪ Does the parent understand and prioritize the child's needs?	▪ A strong emphasis on attachment repair needs to be implemented with parent-child therapy to address damages as a result of lack of good care in the past.
▪ A parent who is developmentally disabled.	▪ Does the parent understand and prioritize the child's needs?	▪ In-home family skills services or in-home family therapy to strengthen the parent/child relationship, address parenting deficits and teach developmentally appropriate ways of child rearing. ▪ After-school activities and

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
		programming.
▪ The child who has disruptions of school settings and peer relationships is at-risk.	▪ Does the child have a positive learning environment at school with consistent attendance?	▪ A school based assessment to flag any delays ▪ Development of an individual education plan ▪ Increased communication between the school and the parent.
▪ Inconsistent rules and expectations confuse and anger the child. Parents who do not tolerate back talk may be overly punitive and harsh.	▪ What services are being used to support the child?	▪ In-home family skills services or in-home family therapy to strengthen the parent/child relationship, address parenting deficits and teach developmentally appropriate ways of child rearing.
▪ A child's lack of academic or social success. ▪ Children who have learning disabilities may be abused by the parent for poor grades.	▪ Does the child have special needs—cognitive, physical or emotional—which the parent can address effectively?	▪ School assessments to address learning lags, learning disabilities or presence of developmental delays, with an individualized education plan to be developed and implemented by the school.
▪ Children with neurological challenges such as hyperactivity, autism or Fetal Alcohol Syndrome Disorder are more vulnerable.	▪ If necessary, has the child been assessed for special needs, mental health, academic concerns, etc?	▪ Assessments for mental health for the parent and/or child to determine what level of intervention is required. ▪ Parent-child therapy. ▪ Use of a personal care attendant for the child if their behaviors are so unmanageable they cannot function without one-on-one for periods in the day.
▪ Exposure to media which depicts violence, sex, drugs. Adult themed media, with little adult supervision exposes the child to behaviors and feelings they have not learned to master. ▪ Precocious sexual behavior.	▪ Is the home safe from predators, violence and alcohol/drugs?	▪ Outpatient mental health services for the adult, as needed or chemical dependency assessment and treatment. ▪ If family violence or addiction is present, parents and children need to attend family sessions. This is true for children of almost any age. This is secondary to the adult completing an intense course of individualized treatment.

Identify vs. Role Confusion – Middle and High School (12 to 18 years)

THE DEVELOPMENTAL TASK: The child takes his social skills, talents, sense of morality/values, and social relationships to create a sense of who they are. The child will either mimic or reject their adult role models.

TYPCAL: This child changes rapidly, his body grows, his hormones change, and his interest in sexuality increases while his reliance on and pleasure in his parents diminish. He pushes away and rejects in order to find the person he wants to be. Peer relationships become primary.

- The child may not want to be with his/her family.
- The child's eating habits, sleeping habits, and manner of dress emerge and change dramatically.
- The child challenges who is in charge and who sets the limits.

ATYPICAL: This child may fail to launch (has not developed basic survival skills), with highly enmeshed or highly conflicted relationships at home. The child may seek to break social rules as a way to leave home, or he may use these behaviors as a form of retaliation for past hurts. Self-esteem and confidence are replaced with insecurity and false bravado. Goals, dreams and pleasure in daily activities are absent. Depression in adolescents is common.

- This child will fight back and may be arrested.
- The child breaks rules and hurts others with little or no remorse.
- If the child has failed to develop a primary attachment with an adult earlier in life, he will demonstrate unhealthy boundaries and seek attention and acceptance from poor role models.

RISK FACTORS	QUESTIONS FROM THE BENCH	SERVICES FOR AT-RISK CHILDREN
▪ See GLOBAL RISK and RESILIENCY FACTORS, p. 36-4	▪ See GLOBAL QUESTIONS FOR EVERY CHILD, p. 36-5	
▪ An inflexible parent who values compliance or who sees the child as a reflection of themselves. ▪ A parent who needs to be in control will struggle and may either reject or abuse the child. ▪ A parent who views acting out behavior as typical or normalize breaking social mores.	▪ Does the parent understand adolescent social norms and have resources to parent?	▪ Parenting education for the adult to assist in developing positive skills to address their adolescent child. ▪ Parent/child therapy to address the relationship, past hurts and shared goals.
▪ Physical abuse, sexual abuse and emotional abuse continue to be significant risk factors.	▪ Has the child been abused?	▪ Individual or group therapy for child to address trauma. ▪ Parent/child therapy to address the relationship, past hurts, and shared goals.
▪ Children with little supervision or positive role models will struggle. ▪ The child who has failed to find an arena of competency such as good friends, sports, academics or employment, will be at-risk. WHY?	▪ Is there trouble in community or social involvement?	▪ Mentoring for the child, to provide a positive role model for competency. ▪ If services for the child are required to enhance social skills, to cope with family stressors or to address addictions, group work with

		peers is often the most effective venue.
▪ Children who experiment with sex, drugs and truancy may be harshly punished, neglected or left to make their own choices with no guidance.	▪ Does the child have positive resources outside the home?	▪ Social and life skills training for the older adolescent, to help them prepare for independence. This can be done through individual skills training, with an in-home skills worker, or with a school-based group. ▪ After-school activities, community service, social group settings, employment, use of restorative justice program.
▪ Anxiety and depression are common in this age group and possibly life-threatening if left unattended.	▪ Do the parent and/or child suffer from mental health problems? ▪ Has the child/parent been screened for chemical use?	▪ Mental health and chemical health assessments for parent/child, as indicated.
▪ Continual school truancy.	▪ Have assessments and services—mental health, academic, etc.—been offered?	▪ School assessment to address any learning lags with a plan to provide support to the child so they can feel successful.

GLOSSARY OF TERMS

Concrete Services	Housing, transportation, employment, accessibility to health care, phone, etc.
DC-03	Diagnostic Criteria for Children Ages 0-3, it is an evaluation that flags developmental and mental health concerns. The clinician needs specific training.
DA	Diagnostic Assessment – provides a diagnosis, does not include psychometric or personality testing. The clinician must be a licensed mental health professional, LMFT, LICSW, Ph.D.
DBT	Dialectical Behavioral Therapy
Diffuse Boundaries	Willing to seek attention and affection from anyone. Lack of discrimination in who meets their needs.
ECFE	Early Childhood Family Education
ECSE	Early Childhood Special Education
EMDR	Eye Movement Desensitization Reprocessing
IEP	Individual Education Plan
III-EP	Individual Education Plan for children prior to first grade
Neuropsychological Evaluation	Comprehensive psychological assessment of cognitive and behavioral functions using a set of standardized tests and/or procedures.
Psychological Evaluation	Examination by a psychiatrist or psychologist used to establish a diagnosis, treatment plan, and medication, if needed.
Rigid Boundaries	Rejection of caregivers or inflexibility in allowing others to provide care

SOURCES

"AAP Policy Redirect." AMERICAN ACADEMY OF PEDIATRICS WEB SITE. http://www.aap.org/policy/re0012.html .

Brazelton, T. Berry. Touchpoints the Essential Reference: Your Child's Emotional and Behavioral Development. New York: Perseus Books, 1992, 1992.

Erikson, Erik H. Childhood and Society. New York: Vintage, 1995.

National Research Council Institute of Medicine. From Neurons to Neighborhoods, the Science of Early Childhood Development (National Research Council and Institute of Medicine). Washington D.C.: National Academy Press, 2000.

Piaget, Jean. The Language and Thought of the Child. Cleveland and New York: Meridian Books, 1955.

"Stages of Social - Emotional Development in Children and Adolescents." Child Development Institute - Parenting Info. <http://www.cdipage.com/erickson.shtml>.

Whaley, Lucille F. Nursing care of infants and children 3rd Edition. St Louis, Missouri: Mosby, 1987.

A GUIDE TO ASSESS FACTORS IN ATTACHMENT FORMATIONS

The parent's capacity to attend to the child; place the child first; and provide a safe, consistent, and nurturing home life is essential to the child's healthy development.

Attachment formation as a cultural norm is widely accepted. Parent-child attachments occur in virtually all communities, regardless of race or culture. Parenting practices do vary widely and are largely shaped by community cultural mores.

FACTS ABOUT ATTACHMENT

- Attachment theory is well-researched and scientifically based.
- All children need consistent, predictable, positive care in their early years, and the attachment formation the child develops with the primary care giver(s) is not culture-bound.
- Attachment is a brain-based process dependent upon the neurological growth and development of a child's central nervous system in response to the child's environment and early experiences.
- The child's first developmental task is to form a trusting relationship with the primary adult caregiver(s).
- Early in life, a child's brain forms neurobiological systems. This development creates resiliency features that serve as predictive factors for the child's positive adjustment and future relationship development. Without early positive experiences, the child will typically struggle to develop the internal template to facilitate secure attachment.
- This template or inner working model will provide the child a base on which all other relationships will be based. The child develops the capacity to trust and love adults based on positive, consistent care giving. The child understands her family is secure and predictable, and thus the child begins to trust and learn.
- A child with an attachment disorder has failed to develop a sense of trust in the adult caregiver to meet her needs. As that security is compromised, so is the child's sense of confidence in the world and in the people who are supposed to take care of her.
- Loss of an attachment relationship for a young child is interpreted as a message that adults have no staying power and continuity of care cannot be taken for granted. Hence, sense of worthiness and self esteem are compromised as a child interprets the parent's lack of constancy as being the child's own fault.
- It is common for children who experience abandonment or loss of their attachment figure to have significant acting out behaviors, to develop clinical depression, or to suffer from a long term sense of worthlessness and poor self esteem.
- Children who have had significant loss—who have truly been neglected or permanently left by their caregivers—not only lose the capacity to feel joy, to play, and to explore the world, but they also reject the comfort that they are offered when faced with a new caregiver. The lesson they have learned is that adults cannot be trusted to stay, so there is no use in engaging or reaching out.
- Reactive Attachment Disorder (or Disorganized Attachment Patterns) is considered the most extreme form of attachment problem. RAD is very easy to prevent, but difficult to treat.
- Sometimes, children who are removed from a positive care giving situation, and/or who have significant risk features, fail to develop a positive attachment relationship with their next caregiver, as they are too fearful to try again.

ESSENTIAL COMPONENTS OF ATTACHMENT

The following indicators of positive attachment are not meant to be an exclusive list, but do highlight the most critical features when assessing attachment.

Reciprocity

Reciprocity suggests both parent and child experience joy and pleasure in their relationship. Reciprocity in a parent child relationship demonstrates that not only can the parent meet the child's needs, but the child is willing to accept and receive comfort with a natural give and take between the two parties. It implies pleasure in meeting each other's needs and is mutually rewarding.

Indicators of Reciprocity

1. Are there any examples about the parent knowing how to be playful with the child?
2. When they are together, is there documentation that the parent finds pleasure with the child? Does the child enjoy the parent?
3. Does the parent understand that they are the main activity for the child, not the snack, the present, or the movie?
4. Does the parent ask questions, show interests in and want to know what the child has been doing and is interested in, or is the parent more focused on themselves?
5. Does the parent follow through with visits or services even when they are inconvenient to the parent?
6. Does the parent greet the child with joy or enthusiasm? How does the child react to the parent?
7. Does the parent choose age appropriate toys, activities, and conversation when with their child? Do they rely too heavily on others to plan for the visit? Do they become irritable when they can't use TV or video as an entertainment for the child? Are they on their phone during visits?

Empathy

Empathy enables the parent to understand how the child feels and to connect to the child on an emotional level. Later in life, it allows the child to develop conscience formation and sensitivity to others. Empathy is a critical component in a healthy parent child relationship. It is essential in forming a positive attachment, and is a strong indicator of a child's comfort and trust in their caregiver.

Indicators of Empathy

1. Can the parent correctly interpret the child's messages and feelings, and respond to them effectively?
2. Can the parent provide comfort and encouragement, and offer the correct interactions when the child is distressed or having trouble managing on their own?
3. Can the parent place the needs of the child ahead of their own on a consistent basis?
4. Has the parent placed relationships with another adult, drugs, or alcohol ahead of their child?
5. Can the parent feel the hurt, anguish, and joy of the child, and share the emotional experience? Does the parent take responsibility for the child's circumstances or do they blame others, including the child?

Attunement

Attuned caregiving means the adult can read the child's verbal and non verbal cues, correctly interpret the cues, and then attend to the emotional or physical needs of the child. Attunement is the sense a parent and child understands the inner life or emotional experience of each other. An attuned parent can read her child's cues, verbal and non verbal.

Indicators of Attunement

1. What will happen if this parent does not become more attuned to the child?
2. Does lack of attunement create or indicate safety issues for the child?
3. How hard does the child have to work to convey their feelings and needs to their parent?
4. How often does the parent correctly understand the child?
5. Who could teach the parent what the child is trying to communicate in terms of behaviors and emotions?
6. Are there addictions or mental health impairments that are so severe that the parent will never be able to understand what their child needs from them?

Nurture

Nurture is the component of attachment often called love. It is the caring and growing up of a young child done with compassion. It is tenderness. The parent demonstrates this by providing for the basic physical and emotional needs of the child, on a consistent basis.

Indicators of Nurture

1. Has the parent been able to keep safe and consistent housing for themselves and their child?
2. Can the parent provide for the needs of several children at once, or is the task beyond their capacity in terms of meeting many demands for affection and attention at once.
3. Has the parent been able to provide the child with consistent food and medical care?
4. Has the parent been able to ensure that the child is engaged in appropriate social and educational activities to assist in the child's over all well being?
5. Can the parent demonstrate an ability to be emotionally available, such as following through with their own mental health or medication requirements, so that they can attend to the needs of the child?
6. Does the child appear to feel loved by the parent?
7. When they are together during visits, is the child trying overly hard to be "good" for the parent?
8. Does the parent seem to be angered or irritated by difficult behaviors of the child?
9. Does the parent consistently keep visits, ask for more visits, and inquire about details of how their child is doing on a regular basis?
10. Does the parent demonstrate positive and healthy physical boundaries during contacts, such as respecting a child's desire to not kiss or hug, or responding to the child's need for affection when needed?

Parent as Secure Base

Parent as a secure base and emotional regulator means the child uses the parent to give them a sense of safety and security. It gives the child confidence to explore their world and also helps the child manage their moods and emotions. As the parent soothes, comforts, and calms a child, the child gradually internalizes this skill and can thus learn to master and manage their feelings.

Indicators of Secure Base

1. Does the child rely on the parent when they are together?
2. Does the child have a strong preference for the company and comfort of the parent?
3. Does the child seek out the parent when they are distressed?
4. Does the child manage new environments by relying on the security of their parent, such as the toddler exploring a room or finding a toy and bringing it back to the parent for praise or interest? Or, does the older child worry about leaving for school because they feel responsible for caring for younger siblings or for keeping their parent safe or sober?
5. Is there a truancy issue for school age children?

Health and Discriminating Boundaries

Positive and discriminating emotional boundaries suggest that a child knows who they can count on and whom they prefer for comfort and care. They avoid strangers and seek intimacy and interaction from a select few. It is a lifelong protective factor.

Indicators of Positive Boundaries

1. Does the child go to strangers for comfort?
2. Does the child reject the parent, even when the parent is available?
3. Does the child appear to be "parent shopping" and overly eager to call anyone mom or dad?
4. Does the child show almost no visible distress when greeting or leaving a visit with a parent?
5. Do the parent and the child demonstrate loyalty to each other?
6. Does the child demonstrate the capacity to discriminate and to know that someone may not be safe?
7. Is the child overly eager to please (Diffuse Boundaries), or are they reluctant to let down their guard with almost everyone (Rigid Boundaries)?

QUESTIONS FROM THE BENCH

Answers to the following questions will aid the judge in understanding the parent's capacity to attend to the child; place the child first; and provide a safe, consistent, and nurturing home life is essential to the child's healthy development.

1. How would you characterize this child's attachment formation? Secure? Insecure?
2. What are the implications for this child and their caregiver?
3. What services does this child/family need?
4. What sort of parenting does this child require?
5. If nothing changes, what is the prognosis for this child?

SOURCES

Crumbley, Joseph. *Transracial adoption and foster care: practice issues for professionals*. Washington, D.C.: CWLA Press, 1999.

Fletcher, Bart, and Claudia Fletcher. *Out of many, one family: how two adults claimed twelve children through adoption*. S.l.: B. Fletcher, 2009.

Forbes, Heather T., and B. Bryan Post. *Beyond consequences, logic, and control: a love-based approach to helping attachment-challenged children with severe behaviors*. Orlando, FL: Beyond Consequences Institute, 2006.

Gerard, Anthony. Parent-Child Relationship Inventory.

Gray, Deborah D. *Attaching in adoption: practical tools for today's parents*. Indianapolis, Ind.: Perspectives Press, 2002.

Hughes, Daniel A. *Building the bonds of attachment: awakening love in deeply troubled children*. Northvale, N.J.: Jason Aronson, 1998.

Marschack Interaction Method. Utilized by Family Attachment Center; Deephaven, MN.

National Resource Center for Permanency Planning. Hunter College of Social Work.

A GUIDE TO ASSESS EVIDENCE IN PARENTAL CAPACITY EVALUATIONS

There has been a great deal of research into determining what factors most reliably predict an individual's capacity to successfully parent. There are several primary life domains in the life and relationships of an adult that can and do point towards outcomes for parents and children.
There are conditions so serious that any one of them will make family reunification a very low probability; there are also those factors which outline family strengths and point out early reunification indicators. These are strengths and resources which can be called upon to help the family plan for timely reunification and to improve a child's well-being.

BEST PRACTICE FOR ASSESSING CAPACITY TO PARENT

A parenting assessment is most effectively used at the case planning stage to assist in identifying poor prognosis cases, to target any red flags for successful outcomes, and to offer services and recommendations for the family. The vast majority of child welfare cases do not require an assessment as comprehensive as this process typically is.

When assessing parental capacity, the prominent life domains of an adult must be reviewed for risk and resiliency features as they relate to safe parenting. There are numerous assessment tools that offer the assessor a structured format to do this. The Differential Assessment Tool, developed by Hunter School of Social Work and the National Resource Center for Permanency Planning is one such format. Appropriately used, it provides a complete assessment.

It is essential that the assessor observe the parent/child relationship and it would be considered best practice to have more than one observation, when possible, as the findings will be more reliable. A mental health evaluation, completed either by the same assessor or by a competent mental health professional, is critical in most cases. There are times when a chemical dependency evaluation should also be part of the assessment process.

CONTENT OF PARENTING CAPACITY ASSESSMENT

A successful parenting capacity assessment will address the following topics:

Brief Overview

1. Why has this assessment been asked for, and by whom?
2. Does the family have a history of involvement with child welfare agencies?
3. How long have the children been in care, or are they at risk of placement now?

Family Constellation

1. Who is in the family?
2. What are the dates of birth, ages, and relationships of family members involved in the assessment?

Assessment Format

1. How many contacts did the assessor have with the family?
2. How many times were the children observed with the parent or foster parent?
3. Where did it take place, who was present, and how long were the appointments?
4. Who did the assessor speak with and what records were reviewed?

Summary of Conclusions

1. The assessor's findings in an easy to read format with clearly stated conclusions.
2. All conclusions must have evidence in the document to support the findings.
3. Conclusions should be directly related to parenting.

I. PRIMARY LIFE DOMAINS (See Appendix A for complete guide)

A. Parent Child Relationships

This portion of the assessment examines the relationships the child has with his adult caregivers and the degree of empathy, reciprocity, and comfort observed in the relationship. It evaluates a parent's sense of responsibility for the situation and if they believe they have been able to meet the needs of the child. It also assesses the parent's understanding of their child's development. Can the parent empathize with the child?

Indicators for Parenting

1. Can the parent consistently place the needs of the child ahead of their own, especially during times of stress or crisis?
2. Does the parent accept some responsibility for why the child is in foster care?
3. What sort of attachment relationship does this parent/child demonstrate; is it a risk or resiliency factor?
4. Has the parent kept visits and asked for more contact?
5. Do the parent and child find joy and pleasure in the company of the other?

B. Parent System Supports, Past and Present

Parent support systems are essential. Having a positive, healthy support system is significant both in terms of capacity and attachment. Parents who lack essential supports have little or nothing to pass on to their vulnerable child. When a parent is scrambling just to get their basic survival needs met, the process of attachment is often impaired or overlooked in their relationships with their children. Having a strong support system often prevents a reentry into foster care for a child during times of relapse of emotional stress, especially for parents who have cognitive impairments, chemical abuse issues, or significant mental health problems.

Indicators for Parenting

1. Does the parent have evidence of a positive and reliable support system?
2. Are the people the parent relies on free from illegal activity or addiction?
3. Is there more than one person the parent can count on for support?
4. Will the support system assist in times of crisis to ensure safety for the child?
5. Is the support system new or one that has been reliable over time?

C. Family History

This portion of the assessment looks at the long term health and stability of a parent's own immediate family. It looks at who the parent had as a positive role model for attachment and parenting and evaluates if the parent had their own needs met as a child.

Indicators for Parenting

1. Does the parent have a good role model for parenting?
2. Are there family members able and willing to serve as a safety net in times of crisis?
3. Did the parent have their own needs met as a child?
4. Did the parent experience out of home placement as a child?
5. Does the parent show a healthy continuity of relationships over time?

D. Parent's Self-Care and Maturity

This portion of the assessment examines an individual's capacity to meet the broader demands of life and self-care. In order to provide the essentials of child rearing, a parent must have the ability to address—in some fashion—basic necessities such as food, clothing, medical care, and shelter. If the essentials are not

covered, the attachment formations are typically sacrificed. Stressed, anxious parents who lack the time or energy to be attentive often form an anxious-ambivalent attachment relationship with their child or are viewed as dismissive of the child's needs.

Indicators for Parenting

1. Does the parent have a history of safe and stable housing?
2. Does the parent have a stable employment history or the capacity to consistently find resources to meet the basic needs of the child?
3. Has the parent used medical care for themselves as needed and/or have the resources to do so?
4. Is the parent able to safely attend to their own basic needs for daily living?

E. Child Development

The parent needs to understand what is typical for their child. This is an indicator for safety. It helps guide what they think is safe, given their child's age, and to know how much to expect from their child.

Indicators for Parenting

1. Has the child been assessed for any special needs?
2. Does the parent have an understanding of their child's needs and can they parent to those needs or have the resources to get the help they need?
3. Are there any special needs that have developed as a result of trauma or neglect?

F. Significant Child Welfare History

This portion of the assessment tries to determine poor prognostic indicators, such as chronic mental health problems, relationship stability, drug use/addiction, illegal behavior, and previous child protection interventions.

1. Has the parent ever abandoned this or another child?
2. Has the parent lost custody of another child? Why?
3. Have there been charges of abuse or neglect of this child or others?
4. Does the parent have a history of domestic violence? If so, have they been able to establish a more positive pattern of interacting? Can they keep themselves safe from others?
5. Does the parent demonstrate relationship stability?
6. Does the parent have a history of being able to live free of an alcohol or other drug addiction?
7. Has the parent successfully completed chemical dependency treatment? Do they need to? Have they acknowledged it has been a problem for them?
8. Is the parent free of a history of serious criminal activity and has a support system that is as well?
9. Was the parent physically or sexually abused or neglected as a child?

G. Inherent Developmental Problems

This portion of the assessment summarizes the parent's mental health. Histories, duration of problems, and services utilized are looked at in terms of the impact on child rearing and the child's well being. Risk and safety factors are heavily considered.

1. Has the parent been diagnosed with a serious mental health problem?
2. Has the parent demonstrated an interest or commitment to securing services?
3. Has the parent followed recommendations for services?
4. Has the parent been compliant with medications?
5. What are the short and long term prognoses for the mental health problems? Timeframe for treatment?

II. RECOMMENDATIONS

1. The recommendations need to be realistic.
2. Services should offer some explanation, if not obvious.
3. If red flags or indicators for poor prognosis are identified, services should address them specifically.
4. Recommendations for services should be clear, in keeping with the cultural and parenting norms of the family, and available in the community.

III. LEGAL CONSIDERATIONS

The factors listed below are identified as problematic for reunification in the "Concurrent Planning Guide[1]," which is included as Appendix A to this chapter. Agency assessment of the parent should address these factors. When any of these factors are present, especially if not countered by significant positive factors in the parent-child relationship or in the parent's history and functioning[2], a court order for a parenting capacity assessment to help with planning for services to the parent may be necessary. Note that some of the factors below constitute egregious harm or another case type that permits the agency to by-pass reunification efforts and proceed to expedited permanency under Minnesota Statutes § 260.012.

[1] *Concurrent Planning: From Permanency Planning to Permanency Action*, Lutheran Social Services of Washington and Idaho (Katz, Spoonemore and Robinson). See Appendix A.

[2] Positive factors for reunification are also listed in the "Concurrent Permanency Planning Guide." Id. at Note 1.

1. The abuse or neglect of the child has been very serious such as:

- Serious physical abuse: burns fractures, poisoning
- Sexual abuse by a parent
- Failure to thrive infant
- Child born drug or alcohol exposed
- Multiple forms of abuse
- Abuse or neglect over a long period of time
- Significant neglect

2. The parent demonstrates ambivalence about parenting as demonstrated by behaviors such as such as:

- Previous placement of the child or other children
- Previous consideration of placing this child for adoption; previous children placed for adoption
- Pattern of uncertainty about desire to parent
- Inconsistent contact or visits with the child
- Lack of emotional commitment to the child, such as disliking the child due to paternity
- Parent mental illness not historically or currently well-controlled
- Consistently acknowledging ongoing problems with parenting

3. The parent has a significant history of impaired personal or social functioning such as parent:

- Continues to reside with someone dangerous to the child
- Raised in foster care
- History of recent or perpetual criminal involvement
- Previous reunification disruption
- Intergenerational abuse with lack of historical change in family dynamics
- Previous interventions or treatment unsuccessful; uncooperative with treatment plans
- Restricted ability due to developmental disabilities
- Lifestyle and support system choices place child at risk of inappropriate caregivers
- Criminal lifestyle used to provide financial support
- Failure to respond to different forms of treatment/intervention despite acceptable participation levels

QUESTIONS FROM THE BENCH

Answers to the following questions will aid the judge in understanding the parent's capacity to parent the child:

1. What are the implications for parenting, given the evidence in this assessment?
2. What is the prognosis for change?
3. What is the "fit" between the children's needs and the parent's skill set?
4. What could be tried that has not already been offered?
5. Are there barriers the parent has already overcome that, with more time, suggest the parent will continue to make sufficient progress to parent safely?
6. What are the best possible outcomes for the children?

SOURCES

Bavolek, Stephen J. Adult-Adolescent Parenting Inventory.

Budd, Karen. "Assessing parenting capacity in a child welfare context". Chicago, IL: DePaul University, 2004.

Gerard, Anthony. Parent-Child Relationship Inventory.

Katz, Linda. Concurrent Planning Curriculum: Module II Differential Assessment Tool. Child Welfare League of America.

Marschack Interaction Method. Utilized by Family Attachment Center; Deephaven, MN.

Millon, Theodore and Carrie Millon, Roger Davis, and Seth Grossman. Million Clinical Multiaxial Inventory-III.

Minnesota Multiphasic Personality Inventory-2. Restandardization Committee: James Butcher, Grant Dahlstrom, John Graham, Auke Tellegen, and Beverly Kaemmer.

National Resource Center for Permanency Planning. Hunter College of Social Work.

CONCURRENT PLANNING GUIDE (Appendix A)

This tool is designed to identify children in need of a concurrent planning placement based on a family assessment. The Guide should be completed within 60 days of case opening. This tool seeks to balance a child's need for permanency with recognition that the parents have the capacity for growth and change, and that reunification efforts continue in earnest. It is expected that some children living in concurrent planning resource families will reunify. The tool is ideal for team decision-making, as well as supervisory conferences.

SECTION I – EARLY REUNIFICATION PROGNOSIS INDICATORS
Prognosis indicators for early reunification – concurrent planning not needed

PARENT-CHILD RELATIONSHIP
The parent(s) demonstrate:
- ☐ Ability to respond to child's cues.
- ☐ Empathy for child; balance between own needs and needs of child.
- ☐ Ability to accept appropriate responsibility for problems that lead to abuse/neglect.
- ☐ Ability and willingness to modify parenting.
- ☐ Having raised the child for a significant period of time.
- ☐ Ability to meet child's special needs (medical, educational, social, cognitive, etc.).
- ☐ Evidence of previous effective parenting observed through child's development (age appropriate cognitive & social skills; conscience development; minimal behavior issues).

PARENTAL HISTORY AND FUNCTIONING
The parent(s) demonstrate:
- ☐ Stable physical health.
- ☐ Stable emotional/mental health; any mental illness well-controlled.
- ☐ Economic stability (employment, housing, and/or ability to live independently).
- ☐ Freedom from addiction/s (substances, gambling, violence, etc.).
- ☐ Consistent contact with child (visitation, parenting time, telephone contacts).
- ☐ Historical ability to meet child's needs despite impaired mental function.
- ☐ Problems leading to placement are of recent origin and situational rather than chronic in nature.

SUPPORT SYSTEMS
The parent(s) demonstrate:
- ☐ Positive relationships supportive of safe parenting.
- ☐ Kin system providing mutual caretaking and shared parenting.
- ☐ Proximity of support system practical to family needs.
- ☐ A support system that recognizes strengths and limitations of parents/family.

SECTION II – POOR PROGNOSIS INDICATORS
Prognosis indicators for concurrent planning – develop alternative plan (alternative placement as appropriate.)

PARENT-CHILD RELATIONSHIP
Factors Related To Abuse or Neglect
- ☐ Serious physical abuse, such as burns, fractures, poisoning.
- ☐ Non-third party sexual abuse of child; prognosis likely to require lengthy foster care.
- ☐ Diagnosed failure to thrive infant.
- ☐ Child drug-exposed at time of birth (cocaine, crack, heroin, alcohol, etc).
- ☐ Child has been victim of more than one form of abuse.
- ☐ Significant neglect.

Factors Related To Ambivalence
- ☐ Previous placement of this child or other child(ren).
- ☐ Previous consideration of relinquishing this child; previous relinquishments of a child.
- ☐ Repeated pattern of uncertainty as to desire to parent.
- ☐ Inconsistent contacts with child.
- ☐ Lack of emotional commitment to child; parent dislikes child due to child's paternity.
- ☐ Parental mental illness not historically and/or currently well controlled.
- ☐ Parent(s) consistently acknowledge ongoing problems with parenting.

PARENTAL HISTORY AND FUNCTIONING
- ☐ Parent continues to reside with someone dangerous to the child.
- ☐ Parent(s) raised in foster care.
- ☐ Recent or perpetual history of parental criminal involvement.
- ☐ Documented history of domestic violence.
- ☐ Parent has degenerative or terminal illness.
- ☐ Previous reunification has disrupted.
- ☐ Intergenerational abuse with lack of historical change in family dynamics.
- ☐ Parent(s) engage in high-risk relationships (drugs, criminal activity, alcohol).
- ☐ Progressive signs of family deterioration due to personality disorder(s).
- ☐ Previous interventions and/or treatment unsuccessful; uncooperative with treatment plan.
- ☐ Parent(s) restricted in ability to parent due to developmental disabilities.
- ☐ Lifestyle and support system choices place child at risk through inappropriate caregivers.
- ☐ Visible means of financial support derived from prostitution, drugs, or other crime.
- ☐ Failure to respond to multiple forms of treatment/intervention despite acceptable participation levels.