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LIFE DOMAIN FORMAT FOR PSYCHIATRIC/PSYCHOLOGICAL BEST PRACTICE EVALUATIONS: INITIAL AND CONTINUED CARE

Note: This format is applicable to both initial and continued care evaluations. However, when writing an evaluation for continued care, it is recommended that Section III, **Relevant Information,** begin with an additional subheading called *Brief Update* that identifies and briefly summarizes the key events and changes during the most recent service period. The remainder of Relevant Information then follows the usual format (e.g., *Strengths, Concerns,* etc.). The prescribing requirements in all regulations and bulletins must be followed for recommendations in the Best Practice Evaluation.

I. Identifying Information:

A. Places the child in individual, family, cultural, residential, and educational/vocational contexts (e.g., age, date of birth, gender, race, ethnicity, cultural/religious beliefs, name and grade in school, type of class setting).

B. Identifies family and household members, including each biological parent, stepparents, siblings/half-siblings. Identifies marital status of parents, and nature of child's contact with a non-custodial parent. Identifies employment status of current parental caregivers. Identifies custody of the child, and child's legal status (e.g., adjudicated or not).

C. Identifies other team members, including involved professional agencies/systems (e.g., MH/ID, C&Y, juvenile justice, case management, child psychiatrist, special education, etc.) and community supports.

II. Reason for Referral:

A. Identify if evaluation is for initial care or continued care.

B. Identify any specific questions and concerns giving that accompanied the evaluation request.

C. Identify sources of information.

III. Relevant Information (begin with *Brief Update if* a continued care request)**:**

A. Strengths:

- Child/adolescent strengths, in multiple domains.
- Special attention to motivation, plus ability to form relationships and use support.
- Areas of greatest interest, competence, and independence.
- Evidence of resilience.
- Family and community strengths.
- Symptom free period and how this was achieved.

B. Concerns:

- Clinical basis for current service request and recommended treatment.
- Nature, frequency, severity, and history of the child's behaviors/symptoms/serious emotional disturbance (SED) of concern.
- Identification of both externalized behaviors and internalized symptoms, comparing present to past.
- High-risk behaviors.
- Progression of concerns over time.
- Treatments that have worked in the past (if known)
- Other identified needs and concerns.

Adapted from Life Domains section of OMHSAS/CASSP: Guidelines for Best Practice in Child and Adolescent Mental Health Services 2001.

C. *Family:*

- Family composition (including relevant extended family), family relationships, strengths/concerns.
- For child that is in substitute care, information regarding foster family and biological family should be included.
- Family cultural and spiritual beliefs and practices, as relevant.
- Family history of psychiatric disorder and treatment.

D. *School/Vocational:*

- Prior school adaptation and placements.
- Characteristics of current school and specific class setting.
- Current academic, social, and behavioral adaptations, including relationships with school peers and with teachers and/or level of functioning in vocational programming.
- Efforts to date of school to address current problems.
- Current or past use of school-based services and results.
- Results of prior or recent functional behavior assessment, if completed.
- Results of current or past educational or IQ testing, CER, and IEP.
- Transition planning, for adolescents.

E. *Community:*

- Place of residence—family home or apartment, group home, RTF, etc.
- Community activities and attachments.
- Identification of community interests that can be initiated.
- Use of leisure time.
- Community employment, current and in past.
- Degree of church or spiritual involvement.
- Nature of neighborhood, in terms of resources and culture, safety, specific conditions.
- Specific stressors, as relevant.
- Social determinants that may be negatively impacting functioning such as food insecurity, inability to access community supports, stability of housing, economical concerns, etc.

F. *Peer Relationships:*

- Patterns of peer relationships in the community and school, including similarities and differences between the two settings.
- Predominant age of peers—same-aged, older, or younger.
- Predominant activities with peers, formal and informal. Nature of peer culture.

G. *Substance Use Disorder:*

- Child's current substance use, including tobacco use, including e-cigarettes and vaping—type, frequency, severity.
- Huffing or other dangerous substance use.
- Child's past history of substance use, and impact on functioning.
- Extent to which child views substance use as a concern.
- Child's past drug and alcohol treatment, response to treatment, involvement in self- help groups.
- Family substance abuse history, where relevant, including nature of use, type and effectiveness of treatment. Use of DAST/AUDIT/SBIRT.

H. *Medical/Developmental:*

- Pregnancy, including medical or psychological complications, maternal smoking, and maternal drug or alcohol use.
- Prenatal care.
- Delivery, including any complications and neonatal distress.
- Neonatal period.
- Developmental milestones – motor, speech and language, cognitive, emotional, adaptive.
- Relational capacity.
- Lead or other toxicity.
- Specific sensory idiosyncrasies and/or stereotypical movements.
- Intellectual disabilities, below average cognitive functioning, atypical development, autism, or other developmental delay.
- Medical illness, acute or chronic infection, physical limitation, serious accident or injury, sensory limitation, past surgery that may impact current functioning.
- Neurological disorder: seizures, loss of consciousness, traumatic brain injury.
- Medications for physical health or neurological disorders.
- Medication for allergies.
- Past pregnancy, for females.
- Gender preference and gender identity, when relevant and with consent of the child, and other issues of sexuality.

I. *Trauma History:*

- Physical abuse.
- Sexual abuse.
- Psychological abuse.
- Neglect.
- Witnessing of domestic violence or other violence.
- Traumatic loss.
- Multiple separations from primary caregivers.
- Victimization in community such as bullying.
- Trauma in institutional care, including traumatic restraint experiences.
- Medical trauma.
- Other adverse events– refugee trauma, natural disaster, war, terrorism, sex trafficking, etc.

J. *Legal:*

- Custody – with biological parents, other relatives, child welfare, adoptive parents, or emancipated youth.
- Adjudication as delinquent or dependent.
- Prior arrests.
- Other delinquent status indicators: probation, placement in juvenile facility, incarceration.
- Outstanding legal issues: pending charges, community service requirement, other.

K. *Services:*

Service History:

- Services used in past, reason, level of participation (both Member and family/guardian), and effectiveness. Include all mental health services and levels of care, out-of-home placements (mental health and other), and services from other systems. Please include strategies that Member/family seemed most receptive to and techniques that positively impacted behavior or symptoms.
- Prior mental health diagnosis. Results of past psychiatric or psychological evaluations.

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- Psychotropic medication history – rationale for each, duration, degree of effectiveness, medication adherence, significant side effects.

Service Update:

- Current services—including hours and locations—with summary of recent service history.
- Impact of services:
  - Role of service providers and of family.
  - Progress/degree of attainment of treatment goals and objectives. Identify effective and ineffective interventions.
  - Receptivity of the child and family to services, and level of participation.
- Nature of planned modifications of goals and services.
- Specific indications for, and use of, psychotropic medication. Include names and dosages and, where applicable, blood levels. Indicate medication adherence and effectiveness of medication, when in use.
- Nature of regular clinical updates to prescriber by involved mental health staff, during most recent service period.

L. *Other:*

- Other domains as relevant or added to earlier information. Include specific information, if available, such as clinician insight and experience with Member that can positively impact future treatment efforts.

IV. Interview:

A. Identification of participants.
B. The child/adolescent's appearance, hygiene, self-care.
C. The child/adolescent's manner of relating to the interviewer and other identified adults present. Emphasis on level of engagement, cooperation, and openness to input.
D. The child/adolescent's formal mental status, including reality testing and comprehensive risk assessment include suicidal and homicidal ideation/intent.
E. Assessment of Member's goals, needs, requests, response & commitment to treatment, feelings of hopefulness, degree of understanding & insight, other individualized areas that can assist clinicians. Compare with previous informants if this information is available.
F. Key issues/themes addressed, and areas of treatment agreement/consensus.

V. Discussion:

A. Overview/summary.
B. Hypothesis/formulation: What appears to be the basis for child's symptoms/behaviors?
C. Diagnostic considerations.
D. Rationale for recommended services and interventions.
E. Nature of consensus and agreements with the child/adolescent, family if present, and others.
F. Prognosis.

VI. Diagnosis: Follow current version of DSM or ICD.

VII. Recommendations:

A. Response to specific questions and concerns relating to the evaluation request.

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B. Identification of each specific behavioral health service recommended, listing the amount, duration, and scope of each. (Recommendations need to be written per regulation and bulletin requirements for each service/level of care.)
C. Recommendations to guide treatment (e.g., interventions for team to consider; other or alternative services; psychotropic medication referral or recommendation; additional assessment(s); community referral(s); education and/or vocational recommendations; consultation with primary care physician; other).
D. Use and expansion of natural supports.
E. Recommended criteria for service tapering, termination, or modification of level of care.