

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

3rd Edition

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.).

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/MR, 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 rise to 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.
- 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.
 - Other identified needs and concerns.

- C. *Family:*
- Family composition (including relevant extended family), family relationships, strengths/concerns.
 - For child in substitute care, foster family and natural family 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.
 - Results of prior or recent functional behavioral 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.
 - 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.
- F. *Peer Relationships:*
- Patterns of peer relationships in the neighborhood and in school, including similarities and differences between the two settings.
 - Predominant age of peers—same-aged, older, or younger—and gender of relationships.
 - Predominant activities with peers, formal and informal. Nature of peer culture.
- G. *Drug and Alcohol:*
- Child's current use/abuse of drugs & alcohol—type, frequency, severity. Cigarettes.
 - 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.
- 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. Stereotypical movements.
- Mental retardation, atypical development, autism/PDD.
- Medical illness, acute or chronic infection, physical limitation, serious accident or injury, sensory limitation, past surgery.
- 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 – bullying, sexual molestation or rape.
- Trauma in institutional care, including traumatic restraint experiences.
- Medical trauma.
- Other – refugee trauma, natural disaster, war, terrorism, 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, and effectiveness. Include all mental health services and levels of care, out-of-home placements (mental health and other), and services from other systems.
- Prior mental health diagnosis. Past psychiatric or psychological evaluations.
- 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.
- K. *Other:*
- Other domains as relevant, or added to earlier information.

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 suicidality. Identify child's goals, needs, requests, response & commitment to treatment, hopefulness, degree of understanding & insight, other individualized ideas, and ability to contract for safety, when relevant. Compare with previous contacts, when applicable.
- E. Key issues/themes addressed, and areas of 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: 5-Axis diagnosis.

VII. Recommendations:

- A. Response to specific questions and concerns that gave rise to evaluation request.
- B. Identification of each specific behavioral health service recommended, listing the amount, duration, and scope of each.
- 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.