RECOMMENDED JUVENILE DIAGNOSTIC ASSESSMENT AND INTAKE REPORT CONTENTS

The following recommendations are made on behalf of the Youth Justice Oversight Committee (YJOC) Behavioral Health Workgroup. The purpose of this document is to suggest what should be included in an assessment and intake report. These suggestions do not override the clinical judgment of the evaluator.

General Instructions and Guidance

The general audience for this document will be court personnel who are not clinicians. As a result, avoid using clinical jargon. If clinical language must be used, then explain the terminology and give a concrete example (e.g., a direct quote from the child).

Due to Electronic Medical Records (EMRs) limitations, providers use different report formats. The format is provider determined, but the recommendations highlight content most useful to justice stakeholders.

Court personnel find quick access to treatment plans and recommendations helpful; consider placing them at the top of the report.

Recommendation(s)

What is/are the brief recommendation(s) of the evaluator (e.g. inpatient treatment, outpatient treatment, individual counseling, group counseling, etc.) taking into consideration all the information within this review and based on available resources and/or services.

Demographic/ Background Information

Identifying Information

This section should include the child's full name, date of birth and the date of the assessment, where the assessment occurred and who made the referral.

Purpose of Assessment

A brief explanation of the presenting problems or reason for referral should be included.

Collateral Information

This section should include the list of records reviewed including any records provided by the referral source, records of prior evaluations or assessments, prior and current mental or behavioral health treatment and education records. If records were not available or received this should be specifically noted.

This section should also include all interviews conducted as a part of the assessment including the date, time, location and length of interview of the child and any other collateral sources.

Clinical/Treatment Plan Summary

Relevant History to Include

- Child's current mental status (mood, affect, intellectual functioning by estimate, suicidal/homicidal ideation, etc.)
- Psychiatric history (medications, previous treatment, what was/was not helpful).
- Medical history (chronic issues, professional care, PCP status, exams, current meds, allergies, smoking history etc.)
- Family/social history (living situations, relationships, faith, abuse/neglect, cultural background, hobbies, trauma exposure, all Adverse Childhood Experiences (ACES))
- Developmental history (delays, ADL challenges)
- Substance use history (age of first use, frequency, route, last use, treatment details)
- Educational history
- History of self-harm, suicidal ideation or attempts
- History of violence towards others
- Any behavior considered to be risky or warrant clinical consideration
- Strengths/resilience factors presenting
- Diagnoses/ provisional diagnoses or possible rule out diagnoses

Behavioral Observations

Document notable behaviors or symptoms observed during assessment or reported by collateral sources throughout the case.

Assessments Administered with Results

This includes any available screenings (depression, anxiety, substance use), personality assessments, IQ assessments, any suicide assessments, etc.