Optum TERM

Writing Sample Packet

Evaluations

This packet is for new applicants or any current TERM evaluators requesting to add an evaluation specialty.

Prepared By:

Optum

Optum TERM

P.O. Box 601340
San Diego, CA 92108

Phone: 877-824-8376
Fax: 877-624-8376

PO Box 601340
San Diego, CA 92160-1340
P: 877-824-8376
F: 877-624-8376
www.optumsandiego.com

Re: Optum TERM Applicant Writing Sample Process

Dear TERMPanel Applicant/Provider:

Thank you for your interest in joining the Optum Treatment and Evaluation Resource Management (TERM) provider network. The Optum TERM mission is to improve the quality and appropriateness of mental health services provided to the clients of HHSA Child and Family Well-Being (CFWB) and Juvenile Probation.

Clients involved with CFWB are children who are current and/or past victims of child abuse or neglect and their families. Both children in the dependency system and their parents/caregivers may receive treatment and/or formal psychological and psychiatric evaluations. The Juvenile Probation Department may request psychological and psychiatric evaluations for youth with cases in Juvenile Justice Court. The Juvenile Court requires the providers of services in these cases to be pre-approved by Optum TERM as experts in abuse-related or delinquency issues. Data gathered through the evaluation process provides an additional source of information pertaining to the functioning of clients and can offer significant contributions to case decision making.

Given the forensic context and potential impact report documentation may have on legal proceedings and case decision making, applicants or current providers requesting to add evaluation specialties are required to submit a redacted evaluation report as part of the application process. The writing sample process is intended to ensure that documentation meets established quality standards for services rendered within this legal context. Please see the attached enclosures for specific writing sample instructions.

Please do not hesitate to contact us with any questions or concerns at 877-824-8376 option 1. We look forward to working with you in serving the clients of the County of San Diego.

Best Regards,

Optum TERM

PO Box 601340
San Diego, CA 92160-1340
P: 877-824-8376
F: 877-624-8376
www.optumsandiego.com

Table of Contents

PO Box 601340
San Diego, CA 92160-1340
P: 877-824-8376
F: 877-624-8376
www.optumsandiego.com

TERM Evaluation Writing Sample Instructions

Please submit a redacted and completely de-identified copy of an evaluation report you have completed with a client that best exemplifies your competence in assessing clients involved in the dependency or Juvenile Justice systems (depending on which services you would like to offer).

New Applicants

- ☞ If you are applying to evaluate **children**, you **must** submit a redacted evaluation of a youth.
- ☞ If you are applying for **specialized evaluations** (e.g. Neuropsychological, Juvenile Sexual Risk Assessment, Juvenile Threat Assessment, Autism Spectrum Disorder Evaluation, and/or Juvenile Mental Competency), you **must** submit a redacted evaluation reflecting the type of requested specialty. One redacted report per specialty is required.

Current TERM Evaluator

- ☞ If you are requesting to add a new **specialized evaluations** (e.g. Neuropsychological, Juvenile Sexual Risk Assessment, Juvenile Threat Assessment, Autism Spectrum Disorder Evaluation, and/or Juvenile Mental Competency), you **must** submit a redacted evaluation reflecting the type of requested specialty. One redacted report per specialty is required.

- ❗ The redacted evaluation report should include the required elements (see attached required reporting format and required elements) but does not have to be in the required TERM format.
- ❗ The sample report should be consistent with the evaluation requirements outlined in the TERM Provider Handbook located on the Optum website at www.optumsandiego.com: BHS Provider Resources > TERM Provider
- ❗ If additional documentation is needed to meet the specialty criteria, you will receive written communication from Optum requesting the additional information and/or submission of a different or updated redacted report.

Thank you for your time completing the TERM application and submitting the redacted evaluation. We are grateful for your shared commitment to delivering quality services to the clients of San Diego County Child and Family Well-Being (CFWB) and Juvenile Probation. Please do not hesitate to contact us with any questions or concerns at 877-824-8376 option 1.

PO Box 601340
San Diego, CA 92160-1340
P: 877-824-8376
F: 877-624-8376
www.optumsandiego.com

TERM Psychological Evaluation Quality Assurance Checklist

- The **Psychological Evaluation Quality Assurance Checklist** is a resource for providers to use to ensure that psychological evaluations follow TERM guidelines and contains all of the required elements.

Optum

PO Box 601340
San Diego, CA 92160-1340
P: 877-824-8376
F: 877-624-8376
www.optumsandiego.com

TERM Psychological Evaluation Quality Assurance Checklist

- ☐ Report submitted by provider within required time-frame.
- ☐ Report adheres to the Required Format and Elements.
- ☐ Collateral sources of information have been consulted (e.g. court records, background records, interviews with caregivers) and included. If not, an explanation is provided of the extenuating circumstances which precluded this.
- ☐ Testing measures are appropriate for the client's population, consistent with the rationale for testing, and with established validity and reliability. At least one objective measure of personality/psychopathology/emotional and behavioral functioning is utilized (or an explanation of the extenuating circumstances which precluded this is provided).
- ☐ Test data is included (i.e. available numerical scores such as standard scores or T-scores), if applicable.
- ☐ Test data is interpreted according to designated test publisher's manual and in keeping with professional standards, if applicable.
- ☐ Diagnostic impressions and conclusions are supported by the evaluation data and background information.
- ☐ Recommendations are appropriate, supported by the evaluation data, and within scope of licensure and role of a TERM provider.
- ☐ Referral questions are addressed with sufficient detail for the reader to follow the logic of the evaluator. The connection between data and opinions are made clear.
- ☐ Documentation of any mandated child abuse report is included, if applicable.
- ☐ Report documentation is written in impartial and unbiased language.
- ☐ Report is signed by provider.

PO Box 601340
San Diego, CA 92160-1340
P: 877-824-8376
F: 877-624-8376
www.optumsandiego.com

Child and Family Well-Being (CFWB) and Probation Psychological Evaluation Basic Requirements

- **Format and Required Elements**: Optum TERM requires consistent and specific format for all evaluation reports; please review The Format and Required Elements of a CFWB Psychological Evaluation. These documents represent the minimal requirements expected of CFWB and Probation psychological and psychiatric reports. These templates have been approved by County partners and it is expected that all providers use this format and include all required elements in the reports. Included are the templates below:
  - Format and Required Elements of a CFWB Psychological Evaluation
  - Format and Required Elements of a Probation Psychological Report
  - Format and Required Elements of a Juvenile Mental Competency Evaluation
  - Format and Required Elements of a Juvenile Threat Assessment
  - Format and Required Elements of a CFWB/Probation Psychiatric Evaluation

- **Specialized Optum TERM Panel Evaluation** is a resource that outlines the minimum guidelines for specialized evaluations. Optum TERM evaluators occasionally conduct evaluations that focus on specific concerns and referral needs. This section represents a description of quality standards for the different types of specialty evaluations.
  - Juvenile Fire Setting Risk Assessment (Juvenile Probation)
  - Adult Psychosexual Risk Assessment (CFWB)/Juvenile Sexual Offender/Behavior Problem Risk Assessment (Juvenile Probation)
  - Juvenile Competency to Stand Trial (Juvenile Probation)
  - Neuropsychological Evaluation (Juvenile Probation/CFWB)
  - Family Code 7827 Evaluation (CFWB)
  - Juvenile Threat Assessment (Juvenile Probation)

PLEASE NOTE:

- It is not a requirement for applicants to change their report format. However, it is expected that the submitted redacted report contains ALL the basic elements.
- If you are requesting any of the specialties, please submit a redacted evaluation report that reflects and aligns with the specialty requirements.

The Format and Required Elements of a CFWB Psychological Evaluation

The **Format** and **Elements** described represent the minimal requirements required of a CFWB Psychological Evaluation. The required "Elements" describes the information that should be addressed under each heading/section of the report. If an element is not included in the report, it is necessary to provide a valid reason. Additional relevant information may be included in the evaluation report.

Reports should be submitted with a professional letterhead on the first page of the report that includes contact information including the provider's office/mailing address and phone number. Please be advised that an attorney may release the evaluation report directly to the client or the parents/guardians of the client.

Name: Fill in the name of the client.

D.O.B.: ____ years, ____month

Gender/Ethnicity/Cultural/Religious Background: List relevant ethnic, cultural and/or religious identifiers.

Primary Language: List primary language used and any other languages that the client utilizes.

CFWB Case Number:

Protective Services Worker's Name:

Protective Services Worker's Phone Number:

Protective Services Worker's Fax Number:

Location of Evaluation: State where the evaluation took place.

Date of Evaluation: List all dates of when interviews and testing took place.

Date of Report: State the date the report was written.

Confidentiality Advisement: Confirm that the client has been advised that this evaluation is for purposes of writing a report for the Court and that any information obtained during this evaluation may appear in such a report. Indicate that the client understood/did not understand the nature of the evaluation and limits of confidentiality. The reader of the report should also be advised that the report contains sensitive information subject to misinterpretation by those untrained in interpreting psychological assessment data.

Referral Questions: Please list verbatim the referral questions that are being addressed in the report. If no specific referral questions were provided, please indicate and provide information regarding the purpose of the evaluation.

Reason for CFWB Involvement: Describe the reason that CFWB is involved in the case. Identify whether the case is High Risk, 300e, and/or High Profile, per PSW report.

Tests Administered: List each psychological, educational, neuropsychological, mental status exam and/or interview test/method that was administered. Document the reason if using an instrument that is unusual and/or specific to the special need(s) of the client.

Documents Reviewed: List each document that is reviewed, including the title, author, and date of each document.

Persons Interviewed: Collateral interviews or data collection must be conducted with relevant parties (e.g. Caregivers, Mental Health Providers, and Protective Service Workers). List the name, relationship to the client, and date of the interview. If no collateral sources were interviewed or provided additional data, please list here the extenuating circumstances that prevented this from occurring.

Family Constellation: List names and all ages of parents/guardians/siblings; identify the child's placement.

Background Information: Describe pertinent background information obtained from interviews and records. Indicate source(s) of information. Describe contradictions in the information when relevant. Elicit and describe examinee's reasons for involvement with CFWB. Address and describe history of childhood abuse and neglect. Include information about relevant medical history, mental health history/treatment, substance abuse, violent behavior, domestic violence, criminal record, sexual behaviors, school/grade level and social adjustment, work adjustment and history, and marital status/history. In general, this background information should be focused and relevant to the current protective issues and referral questions.

Mental Status/Behavioral Observations: Describe findings of the mental status examination and behavioral observations during testing and interview.

Tests Results/Interpretation of Findings: Describe results of each specific psychological/cognitive/educational test given. If a test is administered, the provider must describe the results of that test in the report, including available numerical test scores (e.g., standard scores, T scores). Describe the examinee's personality organization (including traits and features) using common, valid and reliable objective measures of personality. Integrate and summarize all test results, including collateral data, and provide a description of the client's cognitive, behavioral, and emotional functioning. Describe discrepant test findings or discrepancies among data sources if they exist. Comment on the impact of functioning on client's ability to parent or, if client is a child, on child's psychosocial functioning at home, school, and with peers.

Diagnoses: Provide diagnostic impressions according to the Diagnostic and Statistical Manual of Mental Disorders-5-TR (DSM-5-TR). Corresponding diagnostic codes from the ICD-10 (International Classification of Diseases) are required. The principal diagnosis should be listed first, with additional diagnoses listed thereafter, in order of significance. V codes are appropriate if they are the focus of clinical attention. Justification for all diagnostic impressions should be provided (e.g., criteria from the DSM-5-TR). Simply listing diagnostic rule-outs is not helpful, as the client was referred for a psychological evaluation specifically to rule-out competing diagnoses.

Summary and Conclusions: Summarize pertinent case identifiers, risk factors, and evaluation findings. Describe how the evaluation findings may impact the client's ability to parent or child's psychosocial functioning, the client's ability to engage in the reunification process, and potential for mitigation of identified risk factors. Explain diagnostic symptoms within the client's particular context, how these symptoms contributed to the process of differential diagnosis, and conceptual understanding of the client. List each referral question and provide an appropriate response to each of the questions that were to be addressed in the evaluation. If a referral question could not be answered, please indicate and explain why. This could be a qualified response to the question and/or a description of what information would be needed to answer the referral question(s) adequately.

Recommendations: Provide relevant treatment recommendations to address diagnoses if this is necessary for addressing the protective issues, amelioration of risk factors for parenting safely or healing from experiences of abuse and/or neglect, and the lowest level of care at which client can be safely treated. Remember that treatment recommendations must consider the legal timeline of the case and must specify whether a parent is likely to benefit from the recommended services within the legal timeline for that case.

Signature and Date: Please sign and date the report. Please do not use a computer-generated signature.

Optum

The Format and Required Elements of a Probation Psychological Evaluation

The **Format** and **Elements** described represent the minimal requirements required of a Probation Psychological Evaluation. The required "Elements" describes the information that should be addressed under each heading/section of the report. If an element is not included in the report, it is necessary to provide a valid reason. Additional relevant information may be included in the evaluation report.

Reports should be submitted with a professional letterhead on the first page of the report that includes contact information including the provider's office/mailing address and phone number. Please be advised that an attorney may release the evaluation report directly to the client or the parents/guardians of the client.

Name: Fill in the name of the client.

D.O.B.: ____ years, ____month

Gender/Ethnicity/Cultural/Religious Background: List relevant ethnic, cultural and/or religious identifiers.

Primary Language: List primary language used and any other languages that the client utilizes.

Probation Regis Number:

Probation Officer's Name:

Probation Officer's Phone Number:

Probation Officer's Fax Number:

Minor's Attorney's Name:

Minor's Attorney's Phone Number:

Minor's Attorney's Fax Number:

Location of Evaluation: State where the evaluation took place.

Date of Evaluation: List all dates of when interviews and testing took place

Date of Report: State the date the report was written.

Confidentiality Advisement: Confirm that the client has been advised that this evaluation is for purposes of writing a report for the Court and that any information obtained during this evaluation may appear in such a report. Indicate that the minor understood/did not understand the nature of the evaluation and limits of confidentiality. The reader of the report should also be advised that the report contains sensitive information subject to misinterpretation by those untrained in interpreting psychological assessment data.

Referral Questions: Please list verbatim the referral questions that are being addressed in the report. If no specific referral questions were provided, please indicate and provide information regarding the purpose of the evaluation.

Reason for Probation Involvement: Describe the reason that Probation is involved in the case.

Tests Administered: List each psychological, educational, neuropsychological, mental status exam and/or interview test/method that was administered. Document the reason if using an instrument that is unusual and/or specific to the special need(s) of the client. List the scoring method utilized when appropriate.

Documents Reviewed: List each document that is reviewed, including the title, author, and date of each document.

Persons Interviewed: Collateral interviews or data collection must be conducted with relevant parties (e.g. Caregivers, Mental Health Providers, and Probation Officers). List the name, relationship to the child, and date of the interview. If no collateral sources were interviewed or provided additional data, please list here the extenuating circumstances that prevented this from occurring.

Family Constellation: List names and all ages of parents/guardians/siblings; identify the child's placement.

Background Information: Describe pertinent background information obtained from interviews and records. Indicate source(s) of information. Describe contradictions in the information when relevant. Describe reasons for involvement with law enforcement and/or Probation. Address and describe history of delinquent behavior and previous consequences/rehabilitative efforts. As appropriate, include information about substance abuse, violent behavior, history of fire-setting, child abuse and neglect, domestic violence, sexual behaviors, school/grade level, work, marital/parental status, and mental health/medical history. In general, this background information should be focused and relevant to the current mental health issues, safety issues, placement concerns and referral questions.

Mental Status/Behavioral Observations: Describe findings of the mental status examination and behavioral observations during testing and interview.

Tests Results/Interpretation of Findings: Describe results of each specific psychological/cognitive/educational test given. If a test is administered, the provider must describe the results of that test in the report, including available numerical test scores (e.g., standard scores, T scores). Describe discrepant findings when indicated. Describe the client's cognitive, behavioral, and emotional functioning. Describe the examinee's personality organization (including traits and features) using common, valid and reliable objective measures of personality. Provide an integrated interpretation of all the available data including interview(s), collateral data, observations, and test results.

Diagnoses: Provide diagnostic impressions according to the Diagnostic and Statistical Manual of Mental Disorders-5-TR (DSM-5-TR). Corresponding diagnostic codes from the ICD-10 (International Classification of Diseases) are required. The principal diagnosis should be listed first, with additional diagnoses listed thereafter, in order of significance. V codes are appropriate if they are the focus of clinical attention. Justification for all diagnostic impressions should be provided (e.g., criteria from the DSM-5-TR). Simply listing diagnostic rule-outs is not helpful, as the client was referred for a psychological evaluation specifically to rule-out competing diagnoses.

Summary and Conclusions: Summarize pertinent case identifiers, victim/community safety, risk factors, recidivism, and evaluation findings. Describe how the evaluation findings may impact the rehabilitation process and amelioration of identified risk factors. Explain diagnostic symptoms within the client's particular context, how these symptoms contributed to the process of differential diagnosis, and conceptual understanding of the client. List each referral question and provide an appropriate response to each of the questions that were to be addressed in the evaluation. If a referral question could not be answered, please indicate and explain the reason(s). This could be a qualified response to the question and/or a description of what information would be needed to answer the referral question(s) adequately.

Recommendations: Provide relevant recommendations to address diagnoses, amelioration of risk factors, placement concerns, victim/community safety, recidivism, and evaluation findings.

Signature and Date: Please sign and date the report. Please do not use a computer-generated signature.

The Format and Required Elements of a Juvenile Mental Competency Evaluation

The **Format** and **Elements** described represent the minimal requirements required of a Juvenile Mental Competency Evaluation. The required "Elements" describes the information that should be addressed under each heading/section of the report. If an element is not included in the report, it is necessary to provide a valid reason. Additional relevant information may be included in the evaluation report.

Reports should be submitted with a professional letterhead on the first page of the report that includes contact information including the provider's office/mailing address and phone number. Please be advised that an attorney may release the evaluation report directly to the client or the parents/guardians of the client.

Name:

Date of Birth:

Age: ____ years, ____month

Gender:

Race/Ethnicity:

Primary Language:

Court Number:

Requested By:

Minor's Attorney's Name:

Minor's Attorney's Phone Number:

Minor's Attorney's Fax Number:

Date of Evaluation:

Location of Evaluation:

Date of Report:

Confidentiality Advisement: Confirm that the client has been advised that this evaluation is for purposes of writing a report for the Court and that any information obtained during this evaluation may appear in such a report. Indicate that the minor understood/did not understand the nature of the evaluation and limits of confidentiality. The reader of the report should also be advised that the report contains sensitive information subject to misinterpretation by those untrained in interpreting psychological assessment data.

Reason for Referral: Indicate the reason for referral specified by the referral source. Provide a factual summary of the circumstances that led to the minor's referral to Juvenile Court (i.e., date of arrest, specific charges).

Tests Administered: List each psychological test and mental competency interview/assessment that was administered. All psychological tests utilized should be standardized, empirically supported for the minor's population, and directly relevant to the assessment of competency.

Collateral Records Reviewed: List each document that was reviewed, including the title, author, and date of each document. Make note of any data that was not available for review.

Persons Interviewed: List all of the interviews that were conducted, including the name of the interviewee, relationship to the minor, and date of the interview. If no collateral interview was obtained, list the extenuating circumstances that prevented this from occurring and attempts that were made even if unsuccessful. Note: Collateral informants must be advised of limitations to confidentiality.

Relevant Background Information: Describe pertinent background information obtained from interviews and records and indicate source(s) of information. In general, this background information should be focused and relevant to adjudicative competency. Describe contradictions in the information when relevant.

Past Legal History:

Developmental/Medical History:

Family History:

Mental Health History: Include any legal psychiatric findings, such as past evaluations of competency.

Substance Abuse History:

Academic History:

Psychosocial History/Peer Relationships:

Mental Status/Behavioral Observations: Describe findings of the mental status examination and behavioral observations during testing and interview. Describe client's approach to the evaluation and any barriers to the client's ability to engage and overall performance, along with consequent limitations to the validity of the evaluation. Include client's orientation, appearance, motivation, mood, thought content/process, communication, motor functioning, mental capacities (i.e., memory, concentration, abstraction, fund of information).

Tests Results/Interpretation of Findings: Please evaluate whether the minor suffers from a mental disorder, developmental disability, developmental immaturity, or other condition and, if so, whether the condition or conditions impair the minor's competency (Welf. & Inst. Code, § 709).

Psychological Test Data: A brief explanation of the nature and purpose of each test administered should be provided, and results should be explained in a straightforward manner avoiding (or defining) clinical jargon.

Competency Abilities: Describe results from the Juvenile Adjudicative Competence Interview (JACI), including relevant functional strengths and deficits; inclusion of quotes offered by the minor or specific behaviors observed is helpful to the reader. Information about competency functioning obtained from other sources should also be discussed (i.e., relating test findings, collateral data, and mental status results to competency abilities to provide insight into how minor will interact with attorney and in court hearings). Explain how any identified deficits can be expected to impact the minor's functioning in the actual case.

Diagnostic Impressions Relevant to Competency: Provide diagnostic impressions relevant to adjudicative competency according to the Diagnostic and Statistical Manual of Mental Disorders-5-TR (DSM-5-TR). Corresponding diagnostic codes from the ICD-10 (International Classification of Diseases) are required. Justification for all diagnostic impressions should be provided (e.g., criteria from the DSM-5TR). Diagnostic rule-outs should be used sparingly and only when there is insufficient information in the available data to clearly identify a diagnosis.

Response to Referral Questions: List each referral question followed by your response (either "yes" or "no" is required, along with a more detailed response that synthesizes history, mental status, collateral data, and testing results). If a referral question could not be answered, please indicate and explain the reason(s). This could ˙ qualified response to the question and/or a description of what information would be needed to answer the question(s) adequately.

1) *In the opinion of the evaluator, does the minor have a mental disorder? Is there a DSM disorder that affects the minor's competency?*
2) *In the opinion of the evaluator, does the minor have a developmental disability? Is there a developmental disability that affects the minor's competency ("Developmental disability" means a disability which originates before an individual attains age 18; continues or can be expected to continue indefinitely, and constitutes a substantial disability for that individual. The term includes autism, mental retardation, cerebral palsy, epilepsy, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation)?*
3) *In the opinion of the evaluator, is the minor developmentally immature? Is the minor incompetent due to developmental immaturity (See Timothy J. v. Superior Ct. (2007) 58 Cal. Rptr. 3d 746)?*
4) *Is the minor able to understand the nature of the proceedings? Does the minor lack a rational as well as factual understanding of the nature of the charges or proceedings against him or her?*
5) *Is the minor able to assist his/her attorney in the conduct of a defense in a rational manner? Does the minor lack sufficient present ability to consult with counsel and assist in preparing his or her defense with a reasonable degree of rational understanding?*
6) *In the opinion of the evaluator, is the minor competent to stand trial? If no, is the minor likely to benefit from attempts at restoration? If the minor is not found to be competent, is the minor likely to benefit from remediation? What modalities of intervention are recommended for remediation; are there any relevant treatment recommendations?*
7) *Does the evaluator have any information to suggest the minor is a danger to himself/ herself or to others or is gravely disabled?*

Careful discussion of the reasons supporting your conclusions is critical. For example, if you conclude that the minor is not competent your report must clearly state the reasons for your conclusion along with discussion of the supporting data. Note: Competency evaluations for juveniles should be made in light of juvenile rather than adult norms. With regard to the question of developmental immaturity, you should describe the minor being examined in comparison to average children of the same age.

Signature and Date: Please sign and date the report. Please do not use a computer-generated signature.

The Format and Required Elements of a Juvenile Threat Assessment

The **Format** and **Elements** described represent the minimal requirements for a Juvenile Threat Assessment. The required "Elements" describes the information that should be addressed under each heading/section of the report. If an element is not included in the report, it is necessary to provide a valid reason. Additional relevant information may be included in the evaluation report.

Reports should be submitted with a professional letterhead on the first page of the report that includes contact information including the provider's office/mailing address and phone number. Please be advised that an attorney may release the evaluation report directly to the client or the parents/guardians of the client.

Name: Fill in the name of the client.

DOB: ____yeas, ____month

Gender/Ethnicity/Cultural/Religious Background: List relevant ethnic, cultural and/or religious identifiers.

Primary Language: List primary language used and any other languages that the client utilizes.

Probation Regis Number:

Probation Officer's Name:

Probation Officer's Phone Number:

Probation Officer's Fax Number:

Minor's Attorney's Name:

Minor's Attorney's Phone Number:

Minor's Attorney's Fax Number:

Location of Evaluation: State where the evaluation took place.

Date of Evaluation: List all dates of when interviews and testing took place.

Date of Report: State the date the report was written.

Confidentiality Advisement: Confirm that the client has been advised that this evaluation is for purposes of writing a report for the Court and that any information obtained during this evaluation may appear in such a report. Indicate that the minor understood/did not understand the nature of the evaluation and limits of confidentiality. The reader of the report should also be advised that the report contains sensitive information subject to misinterpretation by those untrained in interpreting psychological assessment data.

Referral Questions: Please list verbatim the referral questions that are being addressed in the report. If no specific referral questions were provided, please indicate and provide information regarding the purpose of the evaluation.

Reason for Probation Involvement: Describe the reason that Probation is involved in the case.

Tests Administered: The evaluator shall conduct an evidence-based risk assessment utilizing standardized and empirically validated procedures for assessment of risk factors. List each psychological, educational, neuropsychological, risk assessment tool, mental status exam that was administered.

Documents Reviewed: List each document that was reviewed, including the title, author, and date of each document. If any information is unavailable to the provider, he or she shall document in the report efforts to obtain that information and any consequent limitations to the evaluation.

Persons Interviewed: Collateral interviews or data collection must be conducted with relevant parties (e.g. Client, Caregivers, Mental Health Providers, Probation Officers, Teachers, Attorney). List the name, relationship to the child, and date of the interview. If no collateral sources were interviewed or provided additional data, please list here the extenuating circumstances that prevented this from occurring and any consequent limitations to evaluation conclusions.

Family Constellation: List names and all ages of parents/guardians/siblings; identify the child's placement.

Background Information: Describe pertinent background information obtained from interviews and records, including review of history, risk and need factors. Describe reasons for involvement with law enforcement and/or Probation. Address and describe history of delinquent behavior and previous consequences/rehabilitative efforts. As relevant, include information about substance abuse, social isolation/loneliness, violent behavior, history of firesetting, child abuse and neglect and other adverse childhood experiences, domestic violence, sexual behaviors, school/grade level, work, parental status, mental health/medical history, and any history of threat posturing/preparatory behaviors/rehearsal fantasies or actions. Evaluator shall inquire about youth's internet and social media usage and shall seek information about digital devices owned, used or borrowed. Evaluator shall note source(s) of information for these inquiries. Describe contradictions in the information when relevant.

Mental Status/Behavioral Observations: Describe findings of the mental status examination and behavioral observations during testing and interview.

Tests Results/Interpretation of Findings: Describe results of each specific psychological/cognitive/educational test/risk assessment tool administered. Document the reason if using an instrument that is unusual and/or specific to the special need(s) of the client. List the scoring method utilized when appropriate. If a test is administered, the provider must describe the results of that test in the report, including available numerical test scores (e.g., standard scores, T- scores). Describe discrepant findings when indicated. Describe the client's cognitive, behavioral, and emotional functioning. Provide an integrated interpretation of all the available data including interview(s), collateral data, observations, and test results. Any limitations to the selected tools and measures and their interpretation should be documented and discussed in the report. The impact of self-presentation and response style on the validity of the assessment should be assessed and discussed.

Diagnoses: Provide diagnostic impressions according to the Diagnostic and Statistical Manual of Mental Disorders-5-TR (DSM-5-TR). Corresponding diagnostic codes from the ICD-10 (International Classification of Diseases) are required. The principal diagnosis should be listed first, with additional diagnoses listed thereafter, in order of significance. V codes are appropriate if they are the focus of clinical attention. Justification for all diagnostic impressions should be provided (e.g., criteria from the DSM-5-TR). Simply listing diagnostic rule-outs is not helpful, as the client was referred for a psychological evaluation specifically to rule-out competing diagnoses.

Summary and Conclusions: Summarize evaluation findings and explain the basis of your risk assessment, following ethical and professional guidelines for communicating risk predictions. List each referral question and provide an appropriate response to each of the questions that were to be addressed in the evaluation, including discussion of the basis for your clinical conclusions along with any relevant limitations. If a referral question could not be answered, please indicate and explain the reason(s). This could be a qualified response to the question and/or a description of what information would be needed to answer the referral question(s) adequately.
Recommendations: Provide relevant recommendations to address diagnoses, amelioration of risk factors, placement concerns, victim/community safety, recidivism, and evaluation findings.

Signature and Date: Please sign and date the report and include license number. Please do not use a computer generated signature.

The Format and Required Elements of a CFWB/Probation Psychiatric Evaluation

The **Format** and **Elements** described represent the minimal requirements required of a CFWB or Probation Psychiatric Evaluation. The required "Elements" describes the information that should be addressed under each heading/section of the report. If an element is not included in the report, it is necessary to provide a valid reason. Additional relevant information may be included in the evaluation report.

Reports should be submitted with a professional letterhead on the first page of the report that includes contact information including the provider's office/mailing address and phone number. Please be advised that an attorney may release the evaluation report directly to the client or the parents/guardians of the client. An asterisk (*) indicates that this element is required. If it is not included in report, the report will not be accepted.

***Client's Name**: Fill in the name of the client.

***D.O.B.**: ___ years, ___month

***Gender/Ethnicity/Cultural/Religious Background**: List relevant ethnic, cultural and/or religious identifiers.

***Primary Language**: List primary language used and any other languages that the client utilizes.

***Location of Evaluation**: List location where the evaluation took place.

***Date of Evaluation**: List all the dates of when interviews and evaluation took place.

***Date of Report**: List the date the report was written.

***CFWB Case Number/Probation Regis Number**:

***Protective Worker/Probation Officer's Name**:

***Protective Worker/Probation Officer's Phone Number**:

***Protective Worker/Probation Officer's Fax Number**:

***Minor's Attorney's Name (for use in Probation cases only)**:

***Minor's Attorney's Phone Number (for use in Probation cases only)**:

***Minor's Attorney's Fax Number (for use in Probation cases only)**:

***Referral Questions**: Please list verbatim the specific questions posed by the requestor (i.e., PSW, PO, and Judge). Protective issues in CFWB cases and dangerousness (if pertinent) in Probation cases should be addressed.

***Sources of Information**: List all sources of information reviewed or used in the development of the resulting opinion and report. Include phone conversations, other clinicians' reports, psychological testing reports, and people interviewed or who completed standardized questionnaires as collateral data. If no collateral data were

obtained via interview or data collection, please list here the extenuating circumstances that prevented this from occurring.

***Confidentiality Advisement**: Confirm that the client has been advised that this evaluation is for purposes of writing a report for the Court and that any information obtained during this evaluation may appear in such a report. Indicate that the client understood/did not understand the nature of the evaluation and limits of confidentiality. The reader of the report should also be advised that the report contains sensitive information subject to misinterpretation by those untrained in interpreting psychiatric evaluation data.

***Background Information**: Include how the client came to the attention of the Court, how CFWB/Probation is involved in the case, police involvement, prior Court actions, and information about the client's placement. Briefly include results from previous evaluations.

***History of Present Illness**: Incorporate details of signs and symptoms of current psychiatric illness, time course, stresses and contributing events, current and past medications and their effects/side effects.

***Past Psychiatric History**: Include prior episodes of mental illness, hospitalizations, medications taken, treatments, and placements.

Past Medical History: Include prior or existing medical conditions, medications, operations, and hospitalizations.

Family History: Include psychiatric, medical, and school function history.

Developmental History: Include pregnancy/prenatal history, delivery and postnatal events, highlights of early development, and ongoing developmental difficulties.

Substance Abuse History: Include substances used, treatment received, and ongoing symptoms or disability related to substance use/abuse including the use/abuse of prescription medications.

Sexual History: Include information on gender identity, sexual activity, signs or symptoms of dysfunction, and ongoing issues.

School History: Include current school placement, school functioning, presence of an Individualized Education Plan (IEP), and current remediation.

Social/Cultural/Family Events History: Include major family events like divorces, moves, immigration.

Legal/Social Services History: Include information about arrests, convictions, probation requirements, placements, CFWB contacts, etc.

***Mental Status Exam**: Include information about overview (level of consciousness, appearance, dress and hygiene, attitude, motor behavior); speech and language (fluency, rate, quantity, loudness, clarity, receptive or expressive abnormalities, vocabulary); mood and affect (including suicidal ideation and behavior, homicidal ideation and behavior); thought processes (form, content, and perceptions); obsessions and rituals; cognitive functioning including short term memory, long term memory/memory consolidation, abstract reasoning, and cognitive flexibility; insight and judgment, and interpersonal style as manifested during the evaluation.

***Case Formulation/Summary**: Provide a relatively brief biopsychosocial summary of the client. Explain diagnostic symptoms within the client's particular context, how these symptoms contributed to the process of differential diagnosis, and conceptual understanding of the client.

***Diagnoses**: Provide diagnostic impressions according to the Diagnostic and Statistical Manual of Mental Disorders-5-TR (DSM-5-TR). Corresponding diagnostic codes from the ICD-10 (International Classification of Diseases) are required. The principal diagnosis should be listed first, with additional diagnoses listed thereafter, in order of significance. V codes are appropriate if they are the focus of clinical attention. Justification for all diagnostic impressions should be provided (e.g., criteria from the DSM-5-TR). Simply listing diagnostic rule-outs is not helpful, as the client was referred for a psychological evaluation specifically to rule-out competing diagnoses.

***Recommendations**: Answer the specific referral questions using information related to the diagnoses and/or case summary and conceptualization. Offer treatment recommendations that are supported by the evaluation documentation, including types of medications as well as other therapeutic interventions to address the psychiatric and/or physical health concerns. Provide prognosis regarding psychiatric functioning; ensure prognosis addresses the legal time limits of the case if this is a CFWB referral. If asked to address placement issues, discuss lowest level of placement needed to safely treat client without specifically naming a particular program. Opinions about protective issues or dangerousness in the community are helpful if pertinent.

***Signature and Title**: Please sign and date the report. Please do not use a computer-generated signature.

Specialized Optum TERM Panel Evaluations

The following chart summarizes minimum standards for specialized CFWB and Juvenile Probation evaluations (to be used in conjunction with Optum TERM Provider Handbook and TERM Clinical Specialty Criteria for Evaluators):

Juvenile Fire Setting Risk Assessment (Juvenile Probation)
Methods of Evaluation

The assessment should be based on the integration and synthesis of multiple sources of information, including:
• Empirically guided comprehensive clinical interview, to include details of fire setting history, frequency of incidents, method, motive, consequences, family and environmental factors, and review of known associated risk factors. An independent history of the minor's fire setting behaviors should also be obtained from collateral sources.
  ○ Examples of published structured interviews include the Juvenile Fire setter Child and Family Risk Surveys, Fire setting Risk Interview and the Child Fire setting Interview, as well as, the Comprehensive Fire Risk Evaluation
  ○ The highest degree of accuracy is achieved with these measures if both the juvenile interview schedule and interview with at least one caregiver are conducted
• Behavioral observations and formal mental status exam
• Collateral interviews and review of all available collateral data, including fire or police incident report(s)
• If any information is unavailable to the provider, he or she shall note in the report the efforts to obtain that information
• Use of empirically guided inventories or tools for assessment of fire setting behavior as applicable
• Other standardized assessment measures with demonstrated reliability and validity to assess cognitive functioning, achievement abilities, personality and psychopathology, social, emotional and behavioral functioning, history of trauma and its impact on the client, as well as other domains of functioning as specified by referral questions
• The impact of self-presentation on the validity of psychological tools should be recognized and assessed
Estimation of risk level, community safety, and identification of treatment needs should be the immediate focus. The evaluation should be guided by available best practice guidelines. Any psychological tests utilized should be relevant to understanding risk, empirically supported, and appropriate to the minor's age, clinical status, and ethnicity. Use of unstructured clinical judgment with regard to risk estimation will NOT meet quality review standards.

Relevant Resources
Office of Juvenile Justice and Delinquency Prevention US Fire Administration: Youth Firesetting

Specialized Optum TERM Panel Evaluations

The following chart summarizes minimum standards for specialized CFWB and Juvenile Probation evaluations (to be used in conjunction with Optum TERM Provider Handbook and TERM Clinical Specialty Criteria for Evaluators):

Adult Psychosexual Risk Evaluation (CFWB)

Juvenile Sexual Behavior Problem Risk Assessment (Juvenile Probation)

*For CFWB evaluations, the provider must be approved by the California Sex Offender Management Board

Methods of Evaluation

The assessment should be based on the integration and synthesis of multiple sources of information, including:

- Empirically guided comprehensive clinical interview, to include psychosexual history and review of: past trauma history, deviance and paraphilia's, sexual and non-sexual offense history, known associated dynamic and historical risk factors, situations or circumstances under which sexual behavior problems occur, current perceptions about offense, interpersonal relationships, motivation for treatment, and response to prior interventions
- Behavioral observations and formal mental status exam
- Collateral interviews and review of all available collateral data, including victim statements and arrest records for all offenses
- If any information is unavailable to the provider, he or she shall note in the report the efforts to obtain that information
- Psychological tools designed for the evaluation of sexual behavior problems as applicable (such as the Child Sexual Behavior Inventory for ages 2-12, or Child Sexual Behavior Checklist for ages 12 years and younger) and other empirically guided risk assessment strategies as applicable if supported by current literature and appropriate to clinical circumstances
- Other standardized assessment measures with demonstrated reliability and validity to assess cognitive functioning, achievement abilities, personality and psychopathology (including psychopathy in adults), as well as other domains of functioning as specified by referral questions
- The impact of positive self-presentation on the validity of psychological tools should be recognized. Assessment of response style/bias is required for all evaluations

Risk appraisal, victim/community safety, and identification of treatment needs should be the immediate focus of the evaluation. Evaluations should be guided by available best practice guidelines. Any psychological tests utilized should be relevant to understanding risk, empirically supported, and appropriate to the client's age, clinical status, and ethnicity. Use of unstructured clinical judgment with regard to risk estimation will NOT meet quality review standards.

NOTE: Caution should be taken when assessing children in this context; providers should guard against projecting adult constructs onto children.

Relevant Resources

Association for the Treatment of Sexual Abusers

California Coalition on Sexual Offending

California Sex Offender Management Board (CASOMB)

San Diego County District Attorney

Specialized Optum TERM Panel Evaluations

The following chart summarizes minimum standards for specialized CFWB and Juvenile Probation evaluations (to be used in conjunction with Optum TERM Provider Handbook and TERM Clinical Specialty Criteria for Evaluators):

Juvenile Competency to Stand Trial
(Juvenile Probation)

Methods of Evaluation

The assessment should be based on the integration and synthesis of multiple sources of information, including:

- Empirically guided comprehensive clinical interview, to include review of significant features of the minor's social, emotional, cognitive, and behavioral development, medical and mental health history, educational history, current developmental and clinical status, and family context
- Behavioral observations and formal mental status examination as it relates to the demands of the specific legal case
- Collateral interviews and review of all available collateral information, including but not limited to court records, Probation and CFWB records, and Regional Center records
- The provider shall consult with the minor's counsel and any other person who has provided information to the court regarding the minor's lack of competency
- If any information is unavailable to the provider, he or she shall note in the report the efforts to obtain that information
- Assessment of functional abilities related to the legal standard of competency to stand trial (e.g. factual and rational understanding, competency to assist counsel). Selection of competency assessment tools should be based on appropriateness for the minor's developmental and clinical status. Examples of competency assessment tools include:
  - Structured competency interview schedule (e.g., Juvenile Adjudicative Competence Interview; Grisso, 2005).
  - Standardized competency assessment instruments normed and validated for the juvenile population.

    Note: Currently, all the available standardized competency assessment instruments are designed for use with adults and no juvenile norms have yet been published at the time of this document.
- Other standardized assessment measures that are appropriate for the client's age, language proficiency, and cultural background and with demonstrated reliability and validity to assess domains of functioning as indicated by referral questions and relevance to assessment of competency (developmental maturity, cognitive functioning, personality and psychopathology, history of trauma and the impact on the client, social, emotional and behavioral functioning)
- The impact of self-presentation on the validity of psychological tools should be recognized and assessed
- Evaluators should be familiar with local competency remediation services to inform their recommendations, and should consider any legally mandated time parameters for remediation

Analysis of competency to stand trial and provision of a remediation opinion should be the immediate focus of the evaluation. The evaluation should be guided by available best practice guidelines. Any psychological tests or assessment tools utilized should be empirically supported, relevant to understanding competency, and appropriate to the minor's age, clinical status, and ethnicity. Use of unstructured clinical judgment with regard to competency assessment will NOT meet quality review standards.

Pursuant to California Welfare and Institutions Code 709, the evaluator must assess whether the minor suffers from a mental illness, mental disorder, developmental disability, or developmental immaturity and whether the condition impairs the minor's competency. A minor is incompetent to proceed if he or she lacks sufficient present ability to consult with counsel and assist in preparing his or her defense with a reasonable degree of rational understanding, or lacks a rational as well as factual understanding, of the nature of the charges or proceedings against him or her.

Specialized Optum TERM Panel Evaluations

The following chart summarizes minimum standards for specialized CFWB and Juvenile Probation evaluations (to be used in conjunction with Optum TERM Provider Handbook and TERM Clinical Specialty Criteria for Evaluators):

Juvenile Competency to Stand Trial (Juvenile Probation) - continued -
Relevant Resources
California Welfare and Institutions Code- WIC § 709 http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=709 Assembly Bill No. 1214 http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB1214 Grisso, T. (2005). *Evaluating juveniles' adjudicative competence: A guide to clinical practice.* Sarasota, FL: Professional Resource Press.

Neuropsychological Evaluation (CFWB, Juvenile Probation)
Methods of Evaluation
The assessment should be based on the integration and synthesis of multiple sources of information, including: • Empirically guided comprehensive clinical interview to include a complete neuropsychological history (e.g., presenting psychological and neuropsychological symptoms, developmental, medical and psychiatric history, medications, neurological tests) • Behavioral observations and formal mental status exam • Collateral interviews and review of all available collateral data • If any information is unavailable to the provider, he or she shall note in the report the efforts to obtain that information • Standardized neuropsychological measures with demonstrated reliability and validity to assess relevant domains of cognitive functioning (general intellect, higher level executive skills, attention and concentration, learning and memory, language, visual-spatial skills, motor and sensory skills) • Other standardized assessment measures with demonstrated reliability and validity to assess emotional, behavioral and adaptive functioning as specified by referral questions • The impact of self-presentation on the validity of psychological and neuropsychological tools should be recognized and assessed Neuropsychological status as it relates to the case plan should be the immediate focus of the evaluation. The evaluation should be guided by available best practice guidelines and any (neuro) psychological tests utilized should be empirically supported and appropriate to the client's age, clinical status, and ethnicity. If client has been referred for a comprehensive evaluation, neuropsychological screening will NOT meet quality review standards.
Relevant Resources
American Academy of Clinical Neuropsychology Practice Guidelines for Neuropsychological Assessment and Consultation National Academy of Neuropsychology. Official Statement on Independent and Court-Ordered Forensic Neuropsychological Evaluations.

Specialized Optum TERM Panel Evaluations

The following chart summarizes minimum standards for specialized CFWB and Juvenile Probation evaluations (to be used in conjunction with Optum TERM Provider Handbook and TERM Clinical Specialty Criteria for Evaluators):

Family Code 7827 Evaluations (CFWB)
Methods of Evaluation
The assessment should be based on the integration and synthesis of multiple sources of information, including: • Empirically guided comprehensive clinical interview, to include review of significant historical information, such as family of origin, educational history, mental health and medical history, substance use history, marital history, work history, criminal history, current symptomatology, treatment history and parents' use of clinical intervention, sources of stress and support, interpersonal relationship history, history of parenting, parental acceptance of responsibility, capacity for empathy, and readiness to change • Behavioral observations and formal mental status exam • Collateral interviews and review of all available collateral data • If any information is unavailable to the provider, he or she shall note in the report the efforts to obtain that information • Standardized assessment measures with demonstrated reliability and validity to assess relevant aspects of parental functioning as specified by referral questions (cognitive functioning, parenting skills, personality and psychopathology, history of trauma and its impact on the client, emotional functioning, and adaptive functioning as appropriate • If symptoms of a particular Axis I or Axis II disorder are critical to case conceptualization, consideration should be given to use of focused measures of psychopathology as an adjunct to any broad based measures that have been administered (e.g., psychopathy, substance use disorders) • The impact of positive self-presentation on the validity of psychological tools should be recognized. Assessment of response style/bias is required for all evaluations • As most tests have not been adequately validated or normed for the child protection population, a conservative approach to interpretation of findings should be adopted (e.g., seeking corroboration across multiple information sources, clearly noting any limitations to the tests' use in the evaluation report) • Prognosis for remediation within the legal time limits specified for the case must be included. Note: The date by which parent must demonstrate substantial progress in services is listed on CFWB Form 04-178 and should be referenced when addressing prognosis. Any interventions proposed must be achievable within this timeframe The immediate focus of the evaluation should be the determination of ability to safely parent the child(ren), capacity to benefit from services within legal time parameters, and identification of specific interventions to restore functioning and/or assist the parent in gaining requisite parenting skills if capacity to benefit has been determined. The evaluation should be guided by available best practice guidelines and any psychological tests utilized should be relevant to understanding parenting capacity, empirically supported and appropriate to the client's age, clinical status, and ethnicity. Unstructured clinical judgment or failure to address legal timelines will NOT meet quality review standards. Pursuant to Family Code 7827, "mentally disabled" as used in this section means that a parent or parents suffer a mental incapacity or disorder that renders the parent or parents unable to care for and control the child adequately. A proceeding may be brought where the child is one whose parent or parents are mentally disabled and are likely to remain so in the foreseeable future.

Specialized Optum TERM Panel Evaluations

The following chart summarizes minimum standards for specialized CFWB and Juvenile Probation evaluations (to be used in conjunction with Optum TERM Provider Handbook and TERM Clinical Specialty Criteria for Evaluators):

Family Code 7827 Evaluations (CFWB) - continued -
Relevant Resources
American Psychological Association. Guidelines for psychological evaluations in child protection matters. California Family Code 7827

Juvenile Threat Assessment (Juvenile Probation)
Methods of Evaluation
The assessment should be based on the integration and synthesis of multiple sources of information, including: • Empirically guided comprehensive clinical interview • Review of history, risk and need factors to include individual, family, school-related, peer-related, and environmental risk and protective factors (i.e., history of aggressive conduct; adverse childhood experiences; family dynamics/parenting; antisocial peer associations; social isolation/loneliness; behavioral, cognitive and personality factors; antisocial attitudes/values/beliefs; substance abuse history; developmental/medical/psychiatric history; academic achievement/history; medication compliance; *threat posturing/preparatory behaviors/rehearsal fantasies or actions). Evaluator shall inquire about youth's internet and social media usage and shall seek information about digital devices owned, used or borrowed. Evaluator shall note sources for these inquiries (subject, parents, teachers, peers, etc…) • Behavioral observations and formal mental status exam • Collateral interviews and review of available collateral data • If any information is unavailable to the provider, he or she shall note in the report the efforts to obtain that information and any consequent limitations to the evaluation • Standardized psychological measures with demonstrated reliability and validity to assess relevant domains of functioning as specified by referral questions • Evidence-based risk assessment utilizing empirically validated risk assessment tools relevant to the purpose of the assessment, as appropriate to the context. • Any limitations to the selected tools and measures and their interpretation should be documented and discussed in the report • The impact of self-presentation and response style on the validity of psychological and neuropsychological tools should be recognized and assessed Estimation of risk level, community safety, and identification of treatment needs should be the immediate focus. The evaluation should be guided by available best practice guidelines. Any psychological tests utilized should be relevant to understanding risk, empirically supported, and appropriate to the minor's age, clinical status, and ethnicity. Use of unstructured clinical judgment with regard to risk estimation will NOT meet quality review standards.

Specialized Optum TERM Panel Evaluations

The following chart summarizes minimum standards for specialized CFWB and Juvenile Probation evaluations (to be used in conjunction with Optum TERM Provider Handbook and TERM Clinical Specialty Criteria for Evaluators):

Juvenile Threat Assessment (Juvenile Probation) -continued -
Relevant Resources
Association of Threat Assessment Professionals Risk Assessment Guideline Elements for Violence: Considerations for Assessing the Risk of Future Violent Behavior (2006). American Academy of Psychiatry and the Law. Ethics Guidelines for the Practice of Forensic Psychiatry. American Psychological Association. Ethical Principles of Psychologists and Code of Conduct. American Psychological Association. Specialty Guidelines for Forensic Psychology.
Definition of Key Terms
Threat posturing: Communication of a threat. Consider the following: 1) Has a threat been communicated? If so, was the communication direct or indirect, verbal, written, text message, social media posting? 2) Have there been hostile or aggressive behaviors upon a person? If so, were the behaviors verbal, physical, personal space intrusions, malicious glaring? 3) Have there been hostile aggressive behaviors upon objects such as vandalism, destruction of property, throwing/breaking objects, punching walls, pounding tables, slamming doors? 4) Is there a history of violent behaviors? 5) Have recent behaviors escalated in intensity, frequency and/or duration? 6) Has there been a narrowing of focus upon a target? **Preparatory behavior: Investing time & resources towards a malicious act.** Consider the following: 1) Researching & planning, developing checklists, & "how-to's" 2) Have any weapons, supplies, ammunition, or equipment been procured? 3) Have there been any predatory behaviors such as open source data searches of targets or surveillance? 4) Has there been any testing of security & responses or trial runs? 5) Has there been a ramping up of these behaviors? **Rehearsal fantasies and actions: Obsessions & fixations with malicious themes.** Consider the following: 1) Have there been any communications of what will transpire or leakage of malicious intent? 2) Is there evidence of romanticizing past incidences of violence? 3) Has there been any evidence of "costuming" of omnipotent characters or tactical gear? 4) Is there emotional/psychological investment into fantasies or increased risk of impelling one into action? **Reference: A Primer on Threat Assessments accessed at http://www.nothreat.com/primer.htm**