Structure for the Psychosocial Assessment and Written Report

Source: Rich, P. (2003). *Understanding juvenile sexual offenders: Assessment, treatment, and rehabilitation*. New York, John Wiley & Sons.

1. Purpose, describing the reason for the assessment.
2. Explanations of Process, explaining the use and process of the assessment, as well as noting that there is no way to fully ascertain future risk and that risk assessment is based upon a combination of current and past behaviors exhibited by the juvenile, that place him at a particular level of risk.
3. Consent, documenting that the process and purpose of the assessment was described to the juvenile (and legal guardians, if a minor), that the limits of confidentiality were discussed, and consent was given for the assessment.
4. Informants, identifying those individuals interviewed during the course of the assessment.
5. Records Reviewed, noting documents reviewed for the assessment.
6. Reason for Referral, explaining the specific reason the juvenile is being referred for assessment, and usually providing a brief recap of the sexual charges or allegations.
7. Identifying Information, including information such as age, grade, race, religion, physical appearance, and other information that helps identity the juvenile or by which he identifies himself.
8. Placement and Treatment History, including current or former placement such as home, foster care, or residential placement, and current or former treatment including outpatient, day treatment, inpatient, or residential treatment and the general dates and reason(s) for treatment.
9. Presentation and Cooperation , explaining the juvenile's level of participation and engagement in the evaluation.
10. Legal Status and State Agency Involvement, explaining current legal standing, custody and guardianship, pending charges, court dates, and the like, and state agency involvement, if any.
11. Significant Life Events, presenting a basic chronology of significant life events from birth to current evaluation.
12. Family History (may include several sub-headings), includes family structure and relationships (genogram), current family environment and living arrangements, family trauma, family stability, significant history of other family members, and other important family dynamics.
13. Family Mental Health and Substance Abuse History, includes all significant use of alcohol or drugs by immediate or other significant family members.
14. Developmental History, including birth, developmental milestones, early health issues, behaviors and interactions in infancy, preschool, and elementary school, and other early behaviors or difficulties.
15. Relevant Medical Information, including significant or notable medical or health conditions, including enuresis and encopresis.
16. Past Psychiatric Medications, including reasons and dates.
17. Current Medical and Psychiatric Medications, including reasons for current medications.
18. Cognitive Functioning and Psychological Evaluations, including IQ score and history of prior or current psychological testing, dates, and general results.
19. School Functioning, including current grade level and any grade retentions, general academic functioning, learning disabilities, history of special education and reasons, behaviors and difficulties in school and the development of problem behaviors, excessive tardiness or absence, school disciplinary action, and so forth.
20. Social Functioning, including peer and adult relationships outside of the school environment, and social relationships and functioning in general.
21. Problematic Non-Sexual Behaviors, providing a general overview of the development and history of *non-sexual* behavioral or emotional problems, including age of onset, extent and frequency of problems, and most recent occurrence of conduct disorder and oppositionality, violence and aggression, arrests and /or legal problems, school problems or difficulties, fire setting, running away, and other significant behavioral concerns.
22. History of Substance Use, including current or prior history of substance use/abuse, with special emphasis on whether alcohol or drugs were involved in problem behaviors or sexual offending behaviors.
23. Victimization or Trauma History, including physical or sexual victimization or abuse, and/or trauma or life transforming events experienced by the juvenile.
24. Psychiatric Co-Morbidity and Diagnostic History, including current or prior significant co-existing psychiatric conditions, and generally includes a review of the major categories of mental disorders notated and defined in DSM-IV-TR (American Psychiatric Association, 2000).
25. Psychiatric Assessment, noting outcome and significant details of psychiatric evaluation (with psychiatrist), if conducted.
26. Sexual Development and Non-Offending Sexual Interests and Behaviors, including all prior *non-offending* sexual experiences and encounters, early interest in sexual activities, exposure to sexual activities, history of masturbation, sexual interests and fantasies, and use of pornography or other sexual materials.

27. Sexual Offending History, including description of offenses, the juvenile's description of and attitude towards the offenses, and the family's response to offenses.
28. Risk for Re-Offending, in which a risk level is assigned based upon either a clinical assessment of risk developed through the psychosocial assessment, a companion risk assessment instrument (as proposed by this book), or an actuarial-like assessment, if one is available; if a risk assessment tool is used, the completed instrument should be attached to or accompany the broad assessment report, and the risk assignment explained in this written report.
29. Current Diagnosis, if following a clinical model that utilizes DSM-IV-TR diagnoses.
30. Diagnostic/Clinical Formulation, representing the simple, concise, and condensed version of the clinician's visualization of the diagnosis, the factors leading to it, and the client profile; it is a formulaic reduction of the history, facts, symptoms, and presentation that reduces the entire complex picture into a brief summary that provides meaning, conjectures causes, outlines current issues, and informs prognosis.
31. Recommendations, providing recommendations for treatment goals and interventions to be provided or considered further over the course of treatment; these are not treatment goals, which will result from the first treatment plan that will later be developed for the juvenile if he continues in treatment.
32. Signature, Credential, and Date.