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Dear TERM Provider:

Thank you for your commitment in becoming a TERM provider. Your role in the evaluation of parents and youth that are involved in Child Welfare Services (CWS) and Juvenile Probation is vital in case decision making to ensure the minors' receive appropriate care, ensure the minors' safety, as well as improve family functioning and community safety.

Given the forensic nature of CWS and Juvenile Probation evaluations, providers should ensure that the evaluation reports are factual, objective and clearly written for the Courts. This handbook serves as a resource for TERM providers who conduct psychological evaluations for CWS and Juvenile Probation and includes information relevant to TERM evaluations. The documents contained in this resource are for informational purposes and do not constitute legal/evaluative advice.

Please feel free to contact us at 877-824-8376 (Option 4) for any questions about TERM guidelines or processes. We also appreciate any ideas you may have to help us serve you better. Thank you for partnering with Optum TERM in serving the clients of the County of San Diego.

Respectfully,

Optum TERM Team

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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 contain all of the required elements.

Psychological Evaluation Report Quality Assurance Checklist

- The required format is followed.
- The required elements are all contained in the report.
- Report submitted according to required timelines (or extenuating circumstances for any delays are clearly documented).
- Collateral sources of information (e.g., background records, interviews with caregivers) have been consulted (or an explanation of the extenuating circumstances which precluded this is provided).
- 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).
- Test data is interpreted according to designated test publisher's manual and in keeping with professional standards.
- Diagnostic impressions and conclusions are supported by the evaluation data. Alternative hypotheses are considered.
- Recommendations are supported by the evaluation data and are 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 is made clear.
- Documentation of any mandated child abuse report made by the evaluator is included, if applicable.
- Report documentation is written in impartial and unbiased language.
- Report is signed by provider.

Psychological Evaluation Procedures

- A list of non-exhaustive objective measures is provided as a resource. Please note that Optum TERM does not endorse any specific measure(s).
- Providers are expected to ensure that the most updated measure(s) are used that are normed and validated for the population being evaluated and to be able to respond to referral questions adequately.

Psychological Evaluation Procedures

The following chart offers a non-exhaustive summary of possible psychological evaluation procedures by domain of functioning. Evaluators are expected to select assessment procedures that are relevant to the specific referral questions and empirically supported for the particular population being assessed.

Domain Of Functioning	Possible Evaluation Procedures	Age Range Appropriate for Test Administration
Cognitive/Intellectual Functioning	Bayley Scales of Infant and Toddler Development - Third Edition (Bayley-III)	1 – 42 months
	Wechsler Preschool & Primary Scale of Intelligence, Fourth Edition (WPPSI-IV)	2.6 – 7.7
	Differential Ability Scales-Second Edition (DAS-2)	2.6 – 17.11
	Wide Range Intelligence Test (WRIT)	4 – 85
	Kaufman Brief Intelligence Test, Second Edition	4 – 90
	Kaufman Assessment Battery for Children, Second Edition (KABC-II)	3 – 18
	Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV) (English and Spanish versions available)	6 – 16.11
	Test of Nonverbal Intelligence, Fourth Edition (TONI-4)	6 – 89
	Comprehensive Test of Nonverbal Intelligence, Second Edition (CTONI-2)	6 – 89.11
	Leiter International Performance Scale, Third Edition (Leiter-3)	3 – 75+
	Wechsler Abbreviated Scale of Intelligence (WASI)	6 – 89.11
	Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV) (English and Spanish versions available)	16 – 90.11
	Other standardized assessment measures with demonstrated reliability and validity	

Domain Of Functioning	Possible Evaluation Procedures	Age Range Appropriate for Test Administration
Neuropsychological Functioning	Beery-Buktenica Developmental Test of Visual Motor Integration, Sixth Edition (Beery-VMI)	2 – 100
	NEPSY, Second Edition (NEPSY-II)	3 – 16
	Bender Visual-Motor Gestalt Test, Second Edition (Bender-Gestalt II)	4 – 85
	Children’s Memory Scale (CMS)	5 – 16
	California Verbal Learning Test, Children’s Version (CVLT-C)	5 – 16.11
	Behavior Rating Inventory of Executive Functioning (BRIEF)	5 – 18
	Test Of Memory and Learning, Second Edition (TOMAL-2)	5 – 59.11
	Wide Range Assessment of Memory and Learning, Second Edition (WRAML-2)	5 – 90
	Trail Making Test (A&B)	5+
	Comprehensive Trail-Making Test (CTMT)	8 – 74
	Delis-Kaplin Executive Functioning System (D-KEFS)	8 – 89
	Conners Continuous Performance Test 3rd Edition (Conners CPT 3) (English and Spanish versions available)	8+
	Wisconsin Card Sorting Test (WCST)	7 – 89
	Kaufman Short Neuropsychological Assessment Procedure (K-SNAP)	11 – 85
	California Verbal Learning Test, Second Edition (CVLT-II)	16 – 89
	Wechsler Memory Scale, Fourth Edition (WMS-IV)	16 – 90.11
	Other standardized assessment measures with demonstrated reliability and validity	

Domain Of Functioning	Possible Evaluation Procedures	Age Range Appropriate for Test Administration
Academic Achievement	Batería III Woodcock-Muñoz (Spanish version of WJ-III)	2 – 90+
	Woodcock Johnson III Tests of Achievement Normative Update (NU) (WJ-NU-III)	2 – 90+
	Wechsler Individual Achievement Test, Third Edition (WIAT-III)	4 – 50.11
	Kaufman Test of Educational Achievement, Second Edition (KTEA-II)	4.6 – 90+
	Wide Range Achievement Test, Fourth Edition (WRAT-IV)	5 – 94
	Other standardized assessment measures with demonstrated reliability and validity	
Adaptive Functioning	Adaptive Behavior Assessment System, Second Edition (parent/teacher/adult forms) (ABAS-2) (English and Spanish versions available)	0 – 89
	Vineland Adaptive Behavior Scales, Second Edition (VABS-2) (English and Spanish versions available)	0 – 90
Drug/Alcohol Use	Review of all available collateral data, in conjunction with assessment measures	
	Substance Abuse Subtle Screening Inventory Adolescent and Adult Forms, Third Edition (SASSI-3)	12+
	Drug Abuse Screening Test (DAST)	Adolescents/Adults
	Michigan Alcohol Screening Test (MAST)	Adolescents/Adults
	Other standardized assessment measures with demonstrated reliability and validity	

Domain Of Functioning	Possible Evaluation Procedures	Age Range Appropriate for Test Administration
Personality & Psychopathology	Personality Inventory for Children, Second Edition (PIC-II) (English and Spanish versions available)	5 – 19
	Jessness Inventory-Revised (JI-R)	8+
	Million Pre-Adolescent Clinical Inventory (M-PACI)	9 – 12
	Personality Inventory for Youth (PIY)	9 – 19
	Manifestation of Symptomatology Scale (MOSS)	11 – 18
	Hare Psychopathy Checklist - Youth Version (PCL-YV)	12 – 18
	Personality Assessment Inventory - Adolescent (PAI-A)	12 – 18
	Adolescent Psychopathology Scale (APS)	12 – 19
	Million Adolescent Personality Inventory (MAPI)	13 – 18
	Million Adolescent Clinical Inventory (MACI) (English and Spanish versions available)	13 – 19
	Minnesota Multiphasic Personality Inventory - Adolescent (MMPI-A) (English and Spanish versions available)	14 – 18
	Hare Psychopathy Checklist-Revised (PCL- R)	18+
	Minnesota Multiphasic Personality Inventory- 2 (MMPI-2) and Minnesota Multiphasic Personality Inventory-2-RF (MMPI-2-RF) (English and Spanish versions available)	18+
	Personality Assessment Inventory (PAI) (English and Spanish versions available)	18+
	Other standardized assessment measures with demonstrated reliability and validity	

Domain Of Functioning	Possible Evaluation Procedures	Age Range Appropriate for Test Administration
Emotional & Behavioral Functioning	Achenbach Behavior Checklist (parent/teacher/self-report forms available) (CBCL/TRF/YSR) (English and Spanish versions available)	1.5 – Adult (depending on form utilized)
	Behavior Assessment System for Children-2 (BASC-2) (parent/teacher/self-report forms available); (English and Spanish versions available)	2 – 21 (depending on form utilized)
	Trauma Symptom Checklist for Young Children (TSCYC)	3 – 12
	Children’s Inventory of Anger (ChIA)	6 – 16
	Diagnostic Interview for Children and Adolescents – Revised (DICA-R)	6 – 17
	Conner’s Comprehensive Behavior Rating Scales (parent/teacher forms available) (Conner’s CBRS)	6 – 17.11
	Adult Manifest Anxiety Scale (AMAS)	19+
	Revised Children’s Manifest Anxiety Scale- Second Edition (RCMAS-2) (English and Spanish versions available)	6 – 19
	Children’s Depression Inventory, Second Edition (CDI-2)	7 – 17
	Child PTSD Symptom Scale (CPSS) (English and Spanish versions available)	7 – 18
	Beck Youth Inventories, Second Edition (BYI- II)	7 – 18
	Trauma Symptom Checklist for Children (TSCC)	8 – 16
	Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)	8 – 18
	Beck Depression Inventory, Second Edition (BDI-2) (English and Spanish versions available)	13 – 80
	Brief Symptom Inventory (BSI)	13+
	Symptom Assessment-45 (SA-45)	13+
	Beck Anxiety Inventory (BAI) (English and Spanish versions available)	17 – 80
	Empirically guided structured and semi-structured clinical interview, such as the Kiddie-SADS or NIMH DISC-IV	
	Other standardized assessment measures with demonstrated reliability and validity	

Domain Of Functioning	Possible Evaluation Procedures		Age Range Appropriate for Test Administration
Parenting	Review of all available collateral data, in conjunction with assessment measures		
	Adult-Adolescent Parent Inventory (AAPI)	Adolescents/Adults	
	Child Abuse Potential Inventory (CAPI)	Adults	
	Parenting Stress Index, Fourth Edition (PSI-4)	Adults	
	Other standardized assessment measures with demonstrated reliability and validity		
Domestic Violence Risk	Review of all available collateral data, in conjunction with assessment measures		
	Spousal Assault Risk Assessment (SARA)	Adults	
	Ontario Domestic Assault Risk Assessment (ODARA)	Adults	
	Domestic Violence Risk Appraisal Guide (DVRAG)	Adults	
	Other standardized assessment measures with demonstrated reliability and validity		
Sexual Behavior Problems	Review of all available collateral data and psychosexual history in conjunction with assessment measures		
	Child Sexual Behavior Inventory-III (CSBI-III)	2 – 12	
	Other standardized assessment measures with demonstrated reliability and validity <i>Note: Please refer to the online appendix Specialized Optum TERM Panel Evaluations for additional guidelines (located online on the Optum website under the TERM Manuals tab)</i>		

Domain Of Functioning	Possible Evaluation Procedures		Age Range Appropriate for Test Administration
Juvenile Firesetting Risk	Review of all available collateral data, in conjunction with assessment measures		
	Juvenile Firesetter Child and Family Risk Surveys (semi structured juvenile and family interview)	3 – 18	
	Comprehensive FireRisk Evaluation (semi-structured juvenile and family interview)	3 – 18	
	<p>Other standardized assessment measures with demonstrated reliability and validity</p> <p><i>Note: The highest degree of accuracy is achieved if the juvenile interview and interview with at least one caregiver are conducted.</i></p> <p><i>Please refer to the online appendix Specialized Optum TERM Panel Evaluations for additional guidelines (located online on the Optum website under the TERM Manuals tab)</i></p>		
Juvenile Competency to Stand Trial	<p>Review of all available collateral data in conjunction with appropriate assessment measures. Pursuant to WIC 709, the evaluator must assess whether the minor suffers from a mental disorder, developmental disability, or developmental immaturity and whether the condition impairs the minor’s competency.</p> <p>Formal psychological testing in domains of functioning relevant to assessment of competency as clinically indicated (e.g., IQ, academic achievement, personality and psychopathology)</p>		
	Juvenile Adjudicative Competence Interview (Semi-structured interview) (JACI)	Juveniles	
	<p>Other structured interview schedules or standardized competency assessment measures with demonstrated reliability and validity and developmental appropriateness/applicability to the Juvenile Court system.</p> <p><i>Note: Currently, all the available standardized competency assessment instruments are designed for use with adults and no juvenile norms have yet been published.</i></p> <p><i>Please refer to the online appendix Specialized Optum TERM Panel Evaluations for additional guidelines (located online on the Optum website under the TERM Manuals tab)</i></p>		

Child Welfare Psychological Evaluation Referral Questions

- Form 04-178 Request for TERM-Appointed Evaluator contains specific information regarding the case and includes name and contact information of Protective Service Worker (PSW), Protective Services Supervisor (PSS) and Regional Manager. The form also contains demographic information for the client, Court dates, case background and reason for referral. Providers should pay close attention to the Court dates and due dates on the form to ensure that they are able to accommodate the referral within the specified timeframe.
- Specific referral questions aimed to assist case decision making by San Diego Child Welfare Services and the Courts are included here as well. These are standard questions based on the type of referral (i.e. Parent- Family Code 7827/Diagnostic Clarification/Adoptive Parent or Child- Diagnostic Clarification/Adoption/Emotional Damage). Providers are expected to respond to all the questions or include extenuating circumstances/limitations prohibiting such.

Request for TERM-Appointed Evaluator

SW INFORMATION

Date:

SW Name: Phone #: Fax #:

SW Email: Region/Centralized Program: <select> Program: <select>

PSS Name: PSS Phone # PSS Email:

PSS Signature: _____ Date PSS signed: _____

Protective Services Program Manager (PSPM) Name: PSPM Phone #

PSPM Signature: _____ Date PSPM signed: _____

CLIENT/CASE

Name of Client: Gender: Male/Female DOB: State ID: Two Digit Person #:

San Diego Medi-Cal?: No Yes If yes, Medi-Cal# Medi-Cal Issue Date:

Language: <select> If client is a child/youth indicate language of their parent/caregiver:<select>
Ethnicity: <select> If "Other, please specify:

Client's/Caregiver's Name and Address (including facility name, if any):

Client's /Caregiver's Phone Number:

Voluntary Pre-jurisdiction Court-Ordered Next Court Date:

Optum makes every effort to assign a TERM psychologist who is a clinical match for the referred client. Please assist this process by providing the following information:

Safety Threats and Risk Factors (from SDM assessments):

Describe the incident that brought this family to CWS' attention (i.e. the safety concern that resulted in CWS involvement; the Harm Statement):

Date of the incident:

What is going on in the case right now (i.e. Case plan elements; Danger Statement and Safety Goals):

Why is this service being requested at this time (INCLUDE emotional, social, behavioral, developmental concerns for the child/adolescent OR specific mental health concerns about the parent):

CHECK ALL THAT APPLY:

A CHILD IN THIS CASE IS UNDER 3 YEARS OF AGE: For parents with children under 3, the statutory time limit for reunification services is 6 months. However, services can be extended up to 6 additional months if the parent makes substantive progress in court-ordered treatment and services prior to the review hearing.

Highly Vulnerable Child(ren) Case: A higher-than-average possibility exists of serious re-injury or death to a child. Case may include:

- severe physical abuse with serious non-accidental injuries to the head, face or torso in children age five years or younger, or children who are developmentally delayed at a functional level of five years or younger
- child's parent or guardian caused the death of another child through abuse or neglect
- infant born to parents currently involved with CWS or pas involvement with CWS and did not successfully reunify

Request for TERM-Appointed Evaluator

COMPLETE THIS SECTION FOR CHILD/ADOLESCENT REFERRAL

Requested Evaluation Due Date:

- Child at PCC, Juvenile Hall, or Adjunct bed **NOTE:** 10 day turnaround required for work product completion once authorization and case related records have been received by the provider.
- Parental rights have been legally terminated

REASON FOR REFERRAL (Check ONE):

- An adoption is finalizing for a child and an evaluation of the child's social, emotional, behavioral, and cognitive functioning is required as part of the adoption finalization process.
- A petition has been or will be filed under Section [300\(c\)](#) (Emotional Damage) and there is no therapist for the child who can evaluate and document emotional damage.
- Diagnostic Clarification and Treatment Recommendations are needed:** There are specific, **new** clinical reasons why the evaluation is being requested **at this particular time**. *(Please check the **ONE** box below that indicates the reason for the psychological evaluation):*
 - Client's behavior and/or symptoms have recently and severely escalated **AND** the treating **licensed** mental health professional has documented in writing the following information: description of specific changes in behavior and/or symptoms and why a psychological evaluation is necessary at this time to clarify diagnosis and appropriate interventions.
 - OR**
 - Progress in therapy has been minimal **AND** the treating **licensed** mental health professional has documented in writing the following information: why progress has been minimal and why a psychological evaluation is necessary at this time to clarify diagnosis and appropriate interventions.
 - OR**
 - CWS is requesting a psychological evaluation for diagnostic clarification and treatment purposes because the child is not making expected progress in current interventions and has not appeared to benefit from treatment e.g. talk therapy, art therapy, play therapy, behavioral interventions.
 - OR**
 - CWS is requesting a psychological evaluation for diagnostic clarification and treatment purposes because the child is showing symptoms of significant mental illness (e.g. appears to exhibit psychotic symptoms) and there are no records from current/past mental health professionals available to guide treatment decisions.

Request for TERM-Appointed Evaluator

COMPLETE THIS SECTION FOR PARENT REFERRAL

Requested Evaluation Due Date:

Date by which parent must demonstrate substantial progress in services (6 or 12 Month Review date):

Has the parent threatened CWS staff or others (Restraining Orders? Propensity for violence?): Client

(check all that apply):

- Is the offender Denies allegations/true finding
 Is the non-protecting parent (NPP) Accepts responsibility/true finding

REASON FOR REFERRAL (Check ONE– Evaluations can only be completed to answer ONE of the following):

Diagnostic Clarification and Treatment Recommendations are needed: There are specific, **new** clinical reasons why the evaluation is being requested **at this particular time.** *(Please check the **ONE** box below that indicates the reason for the psychological evaluation)*

Parent's behavior and/or symptoms have recently and severely escalated **AND** the treating **licensed** mental health professional has documented in writing the following information: the specific changes in the parent's behavior and/or symptoms and why a psychological evaluation is necessary at this time to clarify diagnosis and appropriate interventions.

OR

Progress in treatment has been minimal **AND** the treating **licensed** mental health professional has documented in writing the following information: why progress has been minimal as related to the mental health concerns of the client and why a psychological evaluation is necessary at this time to clarify diagnosis and appropriate interventions.

OR

CWS is requesting a comprehensive psychological evaluation for diagnostic clarification and treatment purposes because the parent is not making expected progress, due to a documented mental health concern in demonstrating acts of protection and ability to parent safely.

OR

CWS is requesting a comprehensive psychological evaluation for diagnostic clarification and treatment purposes because the parent is evidencing clear symptoms of significant mental illness and there are no records from current/past mental health professionals.

Does this parent have a mental disability, as defined in Family Code Section 7827 as a “mental incapacity or disorder that renders the parent unable to care for and control the child adequately”? A request for this evaluation will assess whether the parent is capable of utilizing reunification services and their prognosis for benefiting from the services to safely parent the child(ren) within reunification time frames.

ADOPTIONS PROGRAM ONLY- Psychological Evaluation of a Prospective Adoptive Parent:

Diagnostic Clarification and Treatment Recommendations are needed: There are specific clinical reasons why the evaluation is being requested **at this particular time.** *(Please check the **ONE** box below that indicates the reason for the psychological evaluation)*

The client denies significant mental illness but CWS suspects that mental illness is contributing to the risk factors, protective concerns, or placement issues. The client presents with concerning behaviors: odd, labile, reactive. There may be a history of mental illness and/or significant family dysfunction in client's family of origin, and/or the client failed to protect her/his biological children in the past. For these reasons, CWS has concerns about the client's mental health and consequent ability to emotionally connect with, and safely parent, the adoptive child

Request for TERM-Appointed Evaluator

OR

- The client has a mental health diagnosis and may be on psychotropic medications, but is not functioning well. There may be additional medical conditions possibly impacting the client's functioning. There may be concerns that psychotropic or other prescribed medications are contributing to the client's poor functioning.

OR

- The client has significant criminal or drug history. Specific rule/out is requested for anti-social and/or narcissistic traits that, if present, could impact ability to safely parent.

ACTION REQUIRED

SW: Submit 04-178 to Regional JELS Staff to send to OptumTERM. OptumTERM will forward to provider with the CWS authorization once provider is confirmed.

Send case records to the provider once they have been confirmed as per the Policy Manual: [Mental Health Treatment](#)

Timelines for evaluators DO NOT begin until all case documents have been received.

FOR TERM PROGRAM USE ONLY

Date Received:	Processed by (OptumHealth Staff Name)	
Name of Provider Recommended:	Date Provider Accepted Referral:	
Provider's Address:	Provider's Phone:	
CWS SW Name:	Date and Mode of CWS Notification of Acceptance	Date:
		<input type="checkbox"/> Telephone <input type="checkbox"/> E-mail

Questions and Considerations for TERM Evaluations of a Child/Adolescent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on Optum TERM Website www.optumsandiego.com/

ALL EVALUATIONS OF A CHILD/ADOLESCENT

Please include the following elements in your evaluation:

- A. Review of educational and mental health records documenting child’s status prior to the abuse/neglect, if available, to obtain estimate of pre-morbid functioning.
- B. Review of CWS Jurisdiction/Disposition Report, other significant additional court reports i.e. those that document major changes in the child’s situation.
- C. Review of the History of Child Placements report, if child has not just become a dependent.
- D. Review of child’s most current Health and Education Passport.
- E. Collateral interviews with teacher(s), past mental health providers, extended family members or friends who knew the child prior to the abuse/neglect (if that is applicable).
- F. Clinical interview and behavioral observation of the child.
- G. General screen of the child’s cognitive/intellectual functioning using appropriate assessment instruments, paying special attention to assessment of impairment in attention and concentration.
- H. For evaluations of Emotional Damage (W&I Code 300c): Compare current cognitive functioning with pre-morbid level of functioning (if possible).
- I. Objective measures of personality and psychopathology, normed and validated with internal measures of validity/response bias, are required for all psychological evaluations, unless there is valid clinical justification for not doing so specified in the report (i.e., due to cognitive or psychiatric compromise, lack of age appropriate measures, literacy limitations, or significant defensiveness invalidating results). An appropriate alternative is to rely on other assessment components (behavioral observation, collateral reports, and clinical interview) and acknowledge potential consequent limitations in the report. The lack of normative data and objective scoring limit the usefulness of projective or “performance-based” instruments in the forensic context. Reliance on instruments that lack requisite scientific validity and/or reliability will not meet TERM standards for quality review.
- J. Objective, standardized instruments that assess trauma-related symptomatology also should be utilized whenever indicated and feasible based on the child’s age and cultural/linguistic background. Consider administration of trauma-specific instrument, such as Trauma Symptom Checklist for Children (TSCC; Briere, 1996).
- K. DSM diagnosis (full 5-Axis DSM-IV-TR diagnosis) including code specifiers.
- L. If DMS-5 diagnosis and/or diagnostic criteria more adequately describe the child’s presentation, please include and explain

Questions and Considerations for TERM Evaluations of a Child/Adolescent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on
Optum TERM Website www.optumsandiego.com/

ADOPTION EVALUATIONS OF A CHILD/ADOLESCENT

An adoption is finalizing for a child and an evaluation of the child’s social, emotional, behavioral, and cognitive functioning is required as part of the adoption finalization process.

Specific questions to address and document in the evaluation narrative include:

- A. What is the child’s cognitive/intellectual functioning?
- B. What is the child’s emotional and psychological functioning?
- C. What impact, if any, has this child’s history of abuse, neglect, and/or multiple placements had on the development of emotion and cognitive regulation?

If therapy and/or other interventions appear to be indicated at this time:

- A. What are the treatment recommendations?
- B. Are there specific cultural/linguistic considerations regarding intervention choice or approach?
- C. Is there a specific treatment modality or intervention that may be most appropriate?
- D. For a child with this clinical presentation, what is the typical required length of treatment to see a significant reduction in symptoms and/or increase in psychosocial functioning?

Questions and Considerations for TERM Evaluations of a Child/Adolescent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on Optum TERM Website www.optumsandiego.com/

ALL EVALUATIONS OF A CHILD/ADOLESCENT

Please include the following elements in your evaluation:

- A. Review of educational and mental health records documenting child’s status prior to the abuse/neglect, if available, to obtain estimate of pre-morbid functioning.
- B. Review of CWS Jurisdiction/Disposition Report, other significant additional court reports i.e. those that document major changes in the child’s situation.
- C. Review of the History of Child Placements report, if child has not just become a dependent.
- D. Review of child’s most current Health and Education Passport.
- E. Collateral interviews with teacher(s), past mental health providers, extended family members or friends who knew the child prior to the abuse/neglect (if that is applicable).
- F. Clinical interview and behavioral observation of the child.
- G. General screen of the child’s cognitive/intellectual functioning using appropriate assessment instruments, paying special attention to assessment of impairment in attention and concentration.
- H. For evaluations of Emotional Damage (W&I Code 300c): Compare current cognitive functioning with pre-morbid level of functioning (if possible).
- I. Objective measures of personality and psychopathology, normed and validated with internal measures of validity/response bias, are required for all psychological evaluations, unless there is valid clinical justification for not doing so specified in the report (i.e., due to cognitive or psychiatric compromise, lack of age appropriate measures, literacy limitations, or significant defensiveness invalidating results). An appropriate alternative is to rely on other assessment components (behavioral observation, collateral reports, clinical interview) and acknowledge potential consequent limitations in the report. The lack of normative data and objective scoring limit the usefulness of projective or “performance-based” instruments in the forensic context. Reliance on instruments that lack requisite scientific validity and/or reliability will not meet TERM standards for quality review.
- J. Objective, standardized instruments that assess trauma-related symptomatology also should be utilized whenever indicated and feasible based on the child’s age and cultural/linguistic background. Consider administration of trauma-specific instrument, such as Trauma Symptom Checklist for Children (TSCC; Briere, 1996).
- K. DSM diagnosis (full 5-Axis DSM-IV-TR diagnosis) including code specifiers.
- L. If DMS-5 diagnosis and/or diagnostic criteria more adequately describe the child’s presentation, please include and explain

Questions and Considerations for TERM Evaluations of a Child/Adolescent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on Optum TERM Website www.optumsandiego.com/

DIAGNOSTIC CLARIFICATION AND TREATMENT RECOMMENDATIONS - CHILD/ADOLESCENT

Diagnostic Clarification and Treatment Recommendations are needed.

Specific questions to address and document in the evaluation narrative include:

- A. Based on the documentation described in section above, what are the likely precipitants of the recent escalation symptoms (if relevant to the referral question checked above)?
- B. Based on the documentation described in section above, what might account for the youth’s failure to progress in treatment as expected (if relevant to the referral question checked above)?
- C. What is the child’s cognitive/intellectual functioning?
- D. What is the child’s emotional and psychological functioning?
 - I. What impact, if any, has this child’s history of abuse, neglect, and/or multiple placements had on the development of emotional and cognitive regulation?
 - II. If there has been an increase in symptoms or inappropriate behavior reported by the SW, caregiver, or the therapist, what are the apparent or suspected precipitants?
 - III. Do you suspect that the child has experienced any new abuse/trauma that has not been disclosed to CWS?
 - IV. For a child with this clinical presentation, what is the typical required length of treatment to see a significant reduction in symptoms and/or increase in psychosocial functioning?
 - V. Are there any current alcohol or other substance abuse issues? If so, how might these impact the child’s response to treatment?
- E. Is continuation of therapy appropriate at this time? If so, are there specific treatment recommendations? Are there specific cultural/linguistic considerations regarding intervention choice or approach? Is there a specific treatment modality that may be most appropriate?
- F. Should therapy be discontinued at this time? If so, please explain.

Questions and Considerations for TERM Evaluations of a Child/Adolescent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on Optum TERM Website www.optumsandiego.com/

ALL EVALUATIONS OF A CHILD/ADOLESCENT

Please include the following elements in your evaluation:

- A. Review of educational and mental health records documenting child’s status prior to the abuse/neglect, if available, to obtain estimate of pre-morbid functioning.
- B. Review of CWS Jurisdiction/Disposition Report, other significant additional court reports i.e. those that document major changes in the child’s situation.
- C. Review of the History of Child Placements report, if child has not just become a dependent.
- D. Review of child’s most current Health and Education Passport.
- E. Collateral interviews with teacher(s), past mental health providers, extended family members or friends who knew the child prior to the abuse/neglect (if that is applicable).
- F. Clinical interview and behavioral observation of the child.
- G. General screen of the child’s cognitive/intellectual functioning using appropriate assessment instruments, paying special attention to assessment of impairment in attention and concentration.
- H. For evaluations of Emotional Damage (W&I Code 300c): Compare current cognitive functioning with pre-morbid level of functioning (if possible).
- I. Objective measures of personality and psychopathology, normed and validated with internal measures of validity/response bias, are required for all psychological evaluations, unless there is valid clinical justification for not doing so specified in the report (i.e., due to cognitive or psychiatric compromise, lack of age appropriate measures, literacy limitations, or significant defensiveness invalidating results). An appropriate alternative is to rely on other assessment components (behavioral observation, collateral reports, clinical interview) and acknowledge potential consequent limitations in the report. The lack of normative data and objective scoring limit the usefulness of projective or “performance-based” instruments in the forensic context. Reliance on instruments that lack requisite scientific validity and/or reliability will not meet TERM standards for quality review.
- J. Objective, standardized instruments that assess trauma-related symptomatology also should be utilized whenever indicated and feasible based on the child’s age and cultural/linguistic background. Consider administration of trauma-specific instrument, such as Trauma Symptom Checklist for Children (TSCC; Briere, 1996).
- K. DSM diagnosis (full 5-Axis DSM-IV-TR diagnosis) including code specifiers.
- L. If DMS-5 diagnosis and/or diagnostic criteria more adequately describe the child’s presentation, please include and explain

Questions and Considerations for TERM Evaluations of a Child/Adolescent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on Optum TERM Website www.optumsandiego.com/

EMOTIONAL DAMAGE EVALUATIONS OF A CHILD/ADOLESCENT

A petition has been or will be filed under Section [300\(c\)](#) (Emotional Damage) and there is no therapist for the child who can evaluate and document emotional damage.

Specific questions to address and document in the evaluation narrative include:

- A. An opinion, based on documentation described in above section, regarding whether the child has been negatively impacted emotionally by the abuse and/or neglect that precipitated the current Child Welfare Services referral or case.
- B. The specific emotional and/or behavioral concerns that require intervention.
- C. Specific treatment or assessment recommendations, including:
 - I. Description of appropriate therapeutic milieu in which child can be optimally and safely treated.
 - II. Any additional testing or assessment (e.g. psychotropic medication evaluation) that would facilitate the child’s ability to reach optimal potential in psychosocial functioning.
 - III. Particular therapeutic approaches that may be most appropriate, given the child’s age, developmental level, cultural context, and clinical presentation.
 - IV. Estimated length of treatment, based on current presentation.

Questions and Considerations for TERM Evaluations of a Parent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on Optum TERM Website www.optumsandiego.com/

DIAGNOSTIC CLARIFICATION AND TREATMENT RECOMMENDATIONS EVALUATION - PARENT

Diagnostic Clarification and Treatment Recommendations are needed. Please see the accompanying Evaluation Request Form (04-178) to see if the client is already being seen by a licensed mental health professional and review all provided history from the provider and social worker to see why diagnostic clarification and treatment recommendations are needed at this time.

Evaluation narrative MUST include the following components:

- A. What is the parent’s cognitive/intellectual functioning? Is there evidence of impairments that would prevent parent from substantially benefiting from services within legal timelines for this case?
- B. What is the parent’s emotional and psychological functioning? Are criteria met for any Psychotic, Mood, or Anxiety Disorder (DSM-IV TR Axis I disorder) or Personality Disorder (DSM- IV TR Axis II disorder)? If so, would these disorders prevent parent from substantially benefiting from services within the legal timelines for this case?
- C. For a client with this clinical presentation, what is the typical required length of treatment to see a significant reduction in symptoms and/or increase in psychosocial functioning?
- D. Are there indications of personality pathology that do not meet full criteria for a diagnosis but that may negatively impact ability to safely parent? What is the parent’s level of insight, judgment, and motivation to participate in services? What are the implications regarding the parent’s ability to parent safely and/or benefit from reunification services, including therapy?
- E. Are there any other diagnostic considerations that may be impacting the parent’s motivation to participate in services or that may be impacting the parent’s insight, judgment, and/or ability to benefit from treatment?
- F. Are there any current alcohol or other substance abuse issues? If so, how might these impact the parent’s response to treatment and/or ability to safely parent?
- G. Is continuation of therapy appropriate at this time? If so, are there specific treatment recommendations? Are there specific cultural/linguistic considerations regarding intervention choice or approach? Is there a specific treatment modality that may be most appropriate.
- H. Objective measures of personality and psychopathology, normed and validated with internal measures of validity/response bias, are required for all psychological evaluations, unless there is valid clinical justification for not doing so specified in the report (i.e., due to cognitive or psychiatric compromise, lack of age appropriate measures, literacy limitations, or significant defensiveness invalidating results). An appropriate alternative is to rely on other assessment components (behavioral observation, collateral reports, clinical interview) and acknowledge potential consequent limitations in the report. The lack of normative data and objective scoring limit the usefulness of projective or “performance-based” instruments in the forensic context. Reliance on instruments that lack requisite scientific validity and/or reliability will not meet TERM standards for quality review.

Questions and Considerations for TERM Evaluations of a Parent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on Optum TERM Website www.optumsandiego.com/

MENTAL DISABILITY EVALUATION OF PARENT (FC 7827)

Does this parent have a mental disability, as defined in Family Code Section 7827? Mental disability is defined as a “mental incapacity or disorder that renders the parent unable to care for and control the child adequately”

Evaluation MUST answer questions a. and b. to meet Family Code Section 7827 criteria:

- A. If the parent does have a mental disability, does the disability render the parent incapable of utilizing reunification services?
- B. If the parent is capable of utilizing reunification services, what is the parent’s prognosis for ability to benefit from services and begin to safely parent this child within twelve months?

PLEASE NOTE: legal timeline for b. above is six (6) months (not twelve months) if child is under 3 years of age.

CHECK IN CLIENT/CASE INFORMATION TO DETERMINE IF CASE INCLUDES A CHILD UNDER 3 YEARS OF AGE. For parents with children under 3, the statutory time limit for reunification services is 6 months. However, services can be extended up to 6 additional months if the parent makes substantive progress in court-ordered treatment and services prior to the review hearing.

Evaluation narrative MUST address the following components:

Cognitive/Intellectual Functioning: What is the parent’s cognitive/intellectual functioning? Do these concerns render the parent incapable of utilizing reunification services? To what extent do these concerns affect the parent’s prognosis to benefit from services within the legal timelines?

Emotional/Psychological Functioning including Personality/Characterological Traits: Are diagnostic criteria met for any clinical disorders as described under DSM-IV-TR Axis I? Are criteria met for a personality disorder or mental retardation (DSM-IV-TR Axis II diagnoses) or are there are significant characterological traits?

Defensiveness/Level of Insight: How defensive is the parent regarding admission of the protective issues and/or mental health concerns? What level of insight does parent appear to have, based on this assessment, regarding the protective issue and/or mental health concerns?

Based on the assessment of all of the above factors, please answer Family Code Section 7827 criteria a. and b. above.

Treatment: What are the treatment recommendations, **if any**, that could promote this parent’s ability to safely parent **within the legal timelines**? Are there specific cultural/linguistic considerations regarding intervention choice or approach?

Questions and Considerations for TERM Evaluations of a Parent

See TERM Handbook sections on “Required Format and Elements of a CWS Psychological Evaluation” posted on Optum TERM Website www.optumsandiego.com/

ADOPTION EVALUATION OF PROSPECTIVE ADOPTIVE PARENT

Diagnostic Clarification and Treatment Recommendations are needed. Please see the accompanying Evaluation Request Form (04-178 and review all provided history from the social worker to see why diagnostic clarification and treatment recommendations are needed at this time.

Evaluation narrative MUST include the following components:

- A. What is the client’s cognitive/intellectual functioning?
- B. What is the client’s emotional and psychological functioning?
 - I. Concerns regarding a Psychotic, Mood, or Anxiety Disorder (DSM-IV TR Axis I mental health concerns): Are there indications of significant mental illness, such as psychotic symptoms or significant major depression? If so, please comment on the potential for impacting client’s ability to safely parent.
 - II. Concerns regarding a Personality Disorder (DSM-IV TR Axis II pathology): Are there indications of personality or character pathology? What is the client’s level of insight and judgment regarding parenting an abused and/or neglected child
 - III. What are the implications regarding the client’s ability to parent safely and/or benefit from services to facilitate a permanent adoption, including therapy?
- C. Are there any other diagnostic considerations that may be impacting the client’s motivation to participate in services or that may be impacting the client’s insight, judgment, and/or ability to safely parent?
- D. Are there any current alcohol or other substance abuse issues?
 - I. If so, what are your treatment recommendations?
 - II. How might substance abuse impact this client’s ability to safely parent?
- E. Are there specific cultural/linguistic considerations regarding intervention choice or approach?
 - I. If so, is there a specific treatment modality that may be most appropriate?



The Format and Required Elements of a CWS Psychological Evaluation

The **Format** and **Elements** described represent the minimal requirements required of a CWS 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.

CWS 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 CWS Involvement: Describe the reason that CWS 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. List the scoring method utilized when appropriate (e.g., Rorschach, Bender).

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 CWS. 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-IV-TR (DSM-IV-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. If an Axis II diagnosis is the principal diagnosis, please use the qualifying phrase "(Principal Diagnosis)" following the listing of the diagnosis on Axis II. V codes are appropriate if criteria for an Axis I or Axis II diagnosis are not met. Justification for all diagnostic impressions should be provided (e.g., criteria from the DSM-IV-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.

Medi-Cal Funded CWS Psychological Evaluations

- Pre-authorization is required for all Medi-Cal funded cases, even if the referral originated from Child Welfare Services. Optum Public Sector San Diego Psychological Testing Guidelines is included to assist providers in understanding general requirements for Medi-Cal funded psychological evaluations, reasons for possible denials and process for appeals.
- Pre-Authorization Request Form for Medi-Cal Psychological Testing and a completed sample is included for reference.



Optum Public Sector San Diego Psychological Testing Guidelines

Introduction

Psychological testing is a set of formal procedures utilizing current reliable and valid tests designed to measure the areas of intellectual, cognitive, emotional and behavioral functioning in addition to identifying psychopathology, personality style, interpersonal processes, and adaptive skills. Psychological testing is considered a Specialty Mental Health Service that requires pre-authorization.

General Requirements for Psychological Testing

- A. Psychological testing benefits may be available to active Medi-Cal beneficiaries. The following are examples of potential limitations or exclusions:
 - I. Services for the primary purpose of evaluating an excluded mental health diagnosis.
 - II. Services required for purposes of school, sports or camp, travel, career, employment, insurance, or marriage.
 - III. Services required for purposes of adoption that do not otherwise meet medical necessity criteria.
 - IV. Services related to judicial or administrative proceedings or orders that do not otherwise meet medical necessity criteria.
 - V. Services conducted for purposes of medical research.
 - VI. Services required obtaining or maintaining a license of any type.
 - VII. Services not consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines.
- B. Prior to testing, a clinical evaluation of the client must be completed either by the requesting psychologist or a qualified referring mental health professional. The evaluation must be comprehensive and complete enough to:
 - I. Identify specific, outstanding clinical questions that must be answered by psychological testing in order to establish the client's diagnosis or inform the treatment plan; and
 - II. Guide development of an appropriate testing battery.
- C. The provider must be an independently doctoral-level psychologist licensed and practicing within the scope of licensure and competence.
- D. The tests and number of hours requested must be appropriate to answer specific clinical questions that could not be answered by the clinical evaluation. The following are also considered:
 - I. Whether there are any role conflicts that would impact the provider's objectivity (e.g. previous or ongoing therapeutic relationship with the client or client's family members);
 - II. Whether testing was completed within the last 6 months and if so, the rationale for re- testing;
 - III. Whether the client has abstained from abusing alcohol or drugs for at least 6 weeks prior to testing.
- E. The number of hours requested and approved must include the total time necessary to complete face-to-face test administration, scoring, interpretation, and report writing. The number of hours that may be approved is typically based on standards published in test publications and will not exceed 150% of published test administration time. Additional time for the initial diagnostic interview and for a subsequent feedback session may also be requested.
- F. A testing request may be submitted by fax or mail using the Psychological Testing Request Form. Providers may access the form on <https://www.optumsandiego.com>.



Psychological Testing (96101)

Any of the following criteria must be met:

- A. A clinical evaluation was inconclusive and additional information which can be derived from psychological testing is needed to establish the client's behavioral health diagnosis. Examples include, but are not limited to:
 - I. The client presents with symptoms that could be indicative of more than one behavioral health condition, and a differential diagnosis could not be made.
 - II. The client presents with atypical symptoms.
- B. A clinical evaluation was inconclusive and additional information which can be derived from psychological testing is needed to inform the treatment plan. Examples include, but are not limited to:
 - I. Outstanding questions about the client's level of functioning must be answered in order to gauge the client's capacity to participate in behavioral health treatment.
 - II. Outstanding questions about a change in the client's presenting symptoms must be answered in order to gauge the adequacy of the treatment plan.
 - III. There are outstanding questions about why a client's response to treatment has not been as expected.

Authorization Determination Turnaround Time

Reviewers comply with specific determination turnaround time requirements for reviewing and reaching coverage determinations, as outlined in Medi-Cal Title 9 Medical Necessity criteria. Turnaround time is 14 calendar days.

Peer Review

Peer Reviewers are doctoral-level licensed psychologists. The Peer Reviewer will possess at least the same level of licensure as the provider requesting coverage, have competency in the same or similar specialty area, and hold an active, unrestricted license. The Peer Reviewer will offer to conduct telephonic peer-to-peer review with the requesting provider should the requested number of hours of testing service exceed the number of hours that may be approved. A Peer Reviewer will be available to conduct a peer review of any testing request prior to issuing a modification or full denial. The exception to this is situations where the adverse determination is based on an administrative reason (e.g. client not active to Medi-Cal, excluded mental health diagnosis), which may be issued by the Clinical Director or designee.



Denials of Psychological Testing Requests

The following are examples of types of denials that may be issued:

- A. **Service is a Coverage Exclusion Based on Medi-Cal Title 9 Criteria:** Testing is excluded from coverage when it is for school/educational purposes. Additional common types of testing requests for which denials may be issued include but are not limited to: testing for court-ordered or otherwise legally required purposes that does not otherwise meet medical necessity criteria; testing for purposes related to child custody determination, licensure/certification or career or workplace behaviors, and testing related to non-DSM diagnostic conditions or non-Covered diagnostic conditions.
- B. **Service Not Meeting Optum Public Sector San Diego Testing Guideline Criteria for Authorization:** Testing may not be approved if the testing request does not meet Optum Public Sector San Diego FFS Medi-Cal Psychological Testing Guidelines. Common types of testing requests for which denials may be issued include but are not limited to: situations where number of hours requested exceed established reimbursable timeframe guidelines, requested tests in a battery are redundant or duplicative, and use of measures that do not meet professional standards.

Client Appeals and Provider Disputes of Denials

A client or authorized client representative or provider acting on behalf of a client has the right to request an appeal of a modified or denied request. The written Notification of Action (NOA) will include a description of the client appeal process, and the Letter of Determination will include a description of the provider dispute process. Questions about the appeal/dispute process may be addressed by contacting the FFS Provider Line at 1-800-798-2254, or by consulting the www.optumsandiego.com website and/or the FFS Provider Handbook.



**Pre-Authorization Request Form
For Medi-Cal Psychological Testing**

Please fax completed form to (866) 220-4495

Name of Client to Receive Testing:		Client's DOB:	
Client's Medi-Cal #:		Testing Dates of Service Requested:	
Psychologist Name:	Degree:	Start:	
		End:	
Psychologist's Address:		NPI #:	
Street:		Phone:	
City:	State:	Zip:	Fax:
Has a Diagnostic Interview (90791) Taken Place?		Date Diagnostic Interview Completed:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Referred by Child Welfare Services: <input type="checkbox"/> Yes <input type="checkbox"/> No		Court-Ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Professional Who Referred Client to Psychologist for Testing:			
Name:		Degree:	
		Specialty:	
		Phone:	
Case Background:			
(Include current level of care, specific behaviors and symptoms of concern and impact on current functioning, risk factors, assessment/testing history including dates and types of prior evaluation, co-existing medical, psychiatric, substance abuse conditions, etc.)			
Purpose of Testing:			
(Specify referral questions, outstanding issues related to differential diagnosis, contributions to the clinical treatment plan.)			
ICD Diagnostic Code Number and DSM Diagnostic Label:			
(If no diagnosis exists, write "None")			
Rule-Out Diagnostic Code Numbers and Names to be Evaluated			
ICD Diagnostic Code Number:		DSM Diagnostic Label:	
List All Tests Required:			
(Please spell out names of tests. Indicate if administering select or supplementary subtests.)			
Total Hours of Authorization for Testing Requested:			
Diagnostic Interview: 90791 =			
Psychological Testing Hours: : 96101 (Maximum hours allowed = 10)			
Feedback Session (please specify modality requested:90834/90847/90846):			
Total Hours Requested:			

Note: Psychological testing must be pre-authorized. Information may be submitted to the fax number above or by mail. Requests will be processed within 14 calendar days from date of receipt. An incomplete form may delay processing. Authorizations are based on the client's Medi-Cal eligibility, Optum Policies & Procedures, and Psychological and Neuropsychological Testing Guidelines.



Pre-Authorization Request Form For Medi-Cal Psychological Testing

Please fax completed form to (866) 220-4495

Name of Client to Receive Testing: Jannie Adoptions		Client's DOB: 05/25/20
Client's Medi-Cal #: XXXXXXXXX		Testing Dates of Service Requested: Start: 02/01/16 End: 08/01/16
Psychologist Name: Joe Evaluator	Degree: Ph.D.	
Psychologist's Address: Street: 1234 Forensic Ave City: San Diego State: CA Zip: 99999		NPI #: 987654321
		Phone: (619) 555-1234
		Fax: (619) 555-4321
Has a Diagnostic Interview (90791) Taken Place? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Date Diagnostic Interview Completed:
Referred by Child Welfare Services: Yes <input type="checkbox"/> No <input type="checkbox"/>		Court-Ordered: Yes <input type="checkbox"/> No <input type="checkbox"/>
Professional Who Referred Client to Psychologist for Testing: Name: Suzy Social Worker Degree: MSW Specialty: Social Work Phone: (858) 555-1111		
Case Background: (Include current level of care, specific behaviors and symptoms of concern and impact on current functioning, risk factors, assessment/testing history including dates and types of prior evaluation, co-existing medical, psychiatric, substance abuse conditions, etc.) Referred by CWS for pre-adoption evaluation.		
Purpose of Testing: (Specify referral questions, outstanding issues related to differential diagnosis, contributions to the clinical treatment plan.) Assessment of cognitive, emotional, and psychological functioning; treatment planning recommendations		
ICD Diagnostic Code Number and DSM Diagnostic Label: None (If no diagnosis exists, write "None")		
Rule-Out Diagnostic Code Numbers and Names to be Evaluated		
ICD Diagnostic Code Number:		DSM Diagnostic Label:
List All Tests Required: (Please spell out names of tests. Indicate if administering select or supplementary subtests.) K-BIT2 BASC-2 BESS Trauma Symptom Checklist for Young Children		
Total Hours of Authorization for Testing Requested: 11		
Diagnostic Interview: 90791 = 1		
Psychological Testing Hours: : 96101 (Maximum hours allowed = 10) 10		
Feedback Session (please specify modality requested:90834/90847/90846): 0		
Total Hours Requested: 11		

Note: Psychological testing must be pre-authorized. Information may be submitted to the fax number above or by mail. Requests will be processed within 14 calendar days from date of receipt. An incomplete form may delay processing. Authorizations are based on the client's Medi-Cal eligibility, Optum Policies & Procedures, and Psychological and Neuropsychological Testing Guidelines.

**Pre-Authorization Request Form
For Medi-Cal Psychological Testing**

Please fax completed form to (866) 220-4495

Juvenile Probation Referral Questions

- Probation Psychological and Neuropsychological Evaluation Referral form contains demographic information for the minor in question, due date of the report, date of Court Order, guidelines for probation evaluations and specific referral questions.
- Please note that on occasion, a specialized referral question may be requested. It is the responsibility and ethical obligation of the provider to ensure that accepting such an evaluation is within their scope of practice.
- Guidelines for Specialized Optum TERM Panel Evaluation referrals are available for review and as a resource.
- Psychological Evaluation Templates for Mental Competency evaluations and for standard psychological evaluations are provided to ensure standardized reporting of information and to assist the reader to efficiently obtain the information needed for case decision making. These templates have been approved by Juvenile Probation and it is expected that all providers use this format and include all required elements in the reports.

Probation Psychological and Neuropsychological Evaluation Referral

Minor's Name: _____

ID #: _____

Minor's DOB: _____

Probation Officer: _____

PO Telephone: _____

Date of Court Order: _____

Report Due to Optum (no later than 2 days prior to court): _____

Accepting Evaluator: _____

Date Accepted: _____

Optum Fax Number: 877-624-8376

Guidelines for Probation Psychological and Neuropsychological Evaluations

- **Psychological evaluations** are indicated when the Court suspects that the juvenile presents with a mental health or substance abuse problem. This type of evaluation should address the psychological factors related to the delinquency issues. **Note to evaluator:** Please utilize standardized and empirically validated procedures for assessment of intellectual functioning, academic achievement, personality and psychopathology, and risk factors.
- **Neuropsychological evaluations** are indicated *after* a comprehensive psychological evaluation has been completed and a neuropsychological evaluation has been recommended. This type of evaluation should identify neuropsychological deficit(s), if present, and recommend appropriate treatment, rehabilitation and educational remediation for a minor.
- Please note, psychological evaluations and neuropsychological evaluations are completed by evaluators with a PhD or PsyD. Evaluators with an MD or DO and who are approved to conduct psychiatric evaluations are not to accept psychological or neuropsychological evaluations.

Specialized Referral Questions:

Family Violence Evaluations Only (In addition to questions 1-7 below, please respond to the following):

- What level of risk does the minor present to him or herself or to family members if placed back in the family home? What placement is recommended if the family home is not feasible?

Fire Setting Evaluations Only (In addition to questions 1-7 below, please respond to the following):

- What level of risk does the minor present for fire setting?

Sexual Offender Evaluations Only (In addition to questions 1-7 below, please respond to the following):

- What level of risk does the minor present for sexual acting out/sexual assaultive behaviors?

Neuropsychological Evaluations Only:

- Please address the following specific behaviors or issues with a suspected neuropsychological cause:

Required Referral Questions for All Cases:

- 1) Briefly summarize the minor's current behavioral and emotional functioning. Include strengths as well as weaknesses. Relevant risk factors such as antisocial attitudes and associations, dysfunctional family dynamics (including history of abuse and/or domestic violence), or trauma history should be included.
- 2) Describe the minor's intellectual functioning (IQ), current educational achievement, and any learning disabilities.
- 3) Does the minor have a mental health diagnosis?
- 4) Does the minor have a substance abuse or dependence diagnosis?
- 5) Is there any history or evidence of self-harming behaviors, aggressive or assaultive behaviors, sexual acting out, fire setting, or participation in gangs?
- 6) What interventions and treatment services are recommended to address the mental health or substance abuse issues identified? Is a referral for psychiatric evaluation for medications advised?
- 7) What, if any, additional case specific questions should this report address?



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-IV-TR (DSM-IV-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. If an Axis II diagnosis is the principal diagnosis, please use the qualifying phrase "(Principal Diagnosis)" following the listing of the diagnosis on Axis II. V codes are appropriate if criteria for an Axis I or Axis II diagnosis are not met. Justification for all diagnostic impressions should be provided (e.g., criteria from the DSM-IV-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.



Specialized Optum TERM Panel Evaluations

The following chart summarizes minimum standards for specialized CWS and Juvenile Probation evaluations (to be used in conjunction with Optum TERM Evaluation Guidelines):

Juvenile Fire Setting Risk Assessment (Juvenile Probation)
Methods of Evaluation
<p>The assessment should be based on the integration and synthesis of multiple sources of information, including:</p> <ul style="list-style-type: none"> ● 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. <ul style="list-style-type: none"> ○ 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) ● 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 <p>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.</p>
Relevant Resources
<p>Office of Juvenile Justice and Delinquency Prevention http://www.ojjdp.gov/</p> <p>National Association of State Fire Marshals Juvenile Fire setters Program http://www.firemarshals.org/programs/juvenile-firesetters-program</p>



**Adult Psychosexual Risk Evaluation (CWS*) and Juvenile Sexual Behavior Problem Risk Assessment
(Juvenile Probation)**

*For CWS 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
- Psychological tools designed for the evaluation of sexual behavior problems as applicable (such as the Child Sexual Behavior Inventory-III for ages 2-12, or Child Sexual Behavior Checklist-2nd Revision 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](#)
- [State Sex Offender Management Board Center for Sex Offender Management](#)
- [San Diego County Sex Offender Management Council](#)



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
- Assessment of functional abilities related to the legal standard of competence to stand trial (e.g. factual and rational understanding, competence 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.
- Other standardized assessment measures with demonstrated reliability and validity to assess developmental maturity, cognitive functioning, personality and psychopathology, history of trauma and the impact on the client, social, emotional and behavioral functioning and other domains of functioning as indicated by referral questions and relevance to assessment of competence
- The impact of self-presentation on the validity of psychological tools should be recognized and assessed
- Evaluators should be familiar with local competence 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 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. Note: Competency evaluations for juveniles should be made in light of juvenile rather than adult norms. Developmental immaturity should be discussed in terms of deviations from what is expected of children of the same age.



Juvenile Competency to Stand Trial

(Juvenile Probation)

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Relevant Resources

American Academy of Psychiatry and the Law (2007). AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competency to Stand Trial. http://www.jaapl.org/cgi/reprint/35/Supplement_4/S3

California Welfare and Institutions Code- WIC § 709 (2012)

http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=2.&title=&part=1.&chapter=2.&article=17

Grisso, T. (2005). *Evaluating juveniles' adjudicative competence: A guide to clinical practice*. Sarasota, FL: Professional Resource Press.

Kruh, I. & Grisso, T. (2009). *Evaluation of juveniles' competence to stand trial*. New York: Oxford University Press.

Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin, C. (2007). Chapter 14: Juvenile Delinquency, pp. 465-493, *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers (3rd ed.)*. New York: Guilford.



Neuropsychological Evaluation (CWS, Juvenile Probation)
Methods of Evaluation
<p>The assessment should be based on the integration and synthesis of multiple sources of information, including:</p> <ul style="list-style-type: none">• 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• 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 <p>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.</p>
Relevant Resources
<p>American Academy of Clinical Neuropsychology Practice Guidelines for Neuropsychological Assessment and Consultation (2007). http://pdfserve.informaworld.com/756085_776051288.pdf</p> <p>National Academy of Neuropsychology (2003). Official Statement on Independent and Court-Ordered Forensic Neuropsychological Evaluations. http://www.nanonline.org/NAN/Files/PAIC/PDFs/NANIMEpaper.pdf</p>



**Family Code 7827 Evaluations
(CWS)**

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
- 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 CWS 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.



Family Code 7827 Evaluations

(CWS)

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Relevant Resources

American Psychological Association (2013). Guidelines for psychological evaluations in child protection matters. *American Psychologist*, 68, 20-31.

<http://www.apa.org/practice/guidelines/child-protection.pdf>

Budd, K.S., Connell, M., & Clark, J.R. (2011). *Evaluation of Parenting Capacity in Child Protection*. New York: Oxford University Press.

California Family Code 7827 (2003)

http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=FAM&division=12.&title=&part=4.&chapter=2.&article=

Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin, C. (2007). Chapter 15: Child Abuse and Neglect, pp. 494-538, *Psychological Evaluations for the courts: A handbook for mental health professionals and lawyers* (3rd ed.). New York: Guilford.



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-IV-TR (DSM- IV-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-IV-TR).

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 be a qualified response to the question and/or a description of what information would be needed to answer the referral 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.

Additional Resources

- American Psychological Association (APA) Forensic Specialty Guidelines and Psychological Evaluations in Child Protective Matters are provided as a resource. Providers are expected to be familiar with these guidelines to ensure standards of practice are met.

Specialty Guidelines for Forensic Psychology

American Psychological Association

In the past 50 years forensic psychological practice has expanded dramatically. The American Psychological Association (APA) has a division devoted to matters of law and psychology (APA Division 41, the American Psychology–Law Society), a number of scientific journals devoted to interactions between psychology and the law exist (e.g., *Law and Human Behavior*; *Psychology, Public Policy, and Law*; *Behavioral Sciences & the Law*), and a number of key texts have been published and undergone multiple revisions (e.g., Grisso, 1986, 2003; Melton, Pettila, Poythress, & Slobogin, 1987, 1997, 2007; Rogers, 1988, 1997, 2008). In addition, training in forensic psychology is available in predoctoral, internship, and post-doctoral settings, and APA recognized forensic psychology as a specialty in 2001, with subsequent recertification in 2008.

Because the practice of forensic psychology differs in important ways from more traditional practice areas (Monahan, 1980) the “Specialty Guidelines for Forensic Psychologists” were developed and published in 1991 (Committee on Ethical Guidelines for Forensic Psychologists, 1991). Because of continued developments in the field in the ensuing 20 years, forensic practitioners’ ongoing need for guidance, and policy requirements of APA, the 1991 “Specialty Guidelines for Forensic Psychologists” were revised, with the intent of benefiting forensic practitioners and recipients of their services alike.

The goals of these Specialty Guidelines for Forensic Psychology (“the Guidelines”) are to improve the quality of forensic psychological services; enhance the practice and facilitate the systematic development of forensic psychology; encourage a high level of quality in professional practice; and encourage forensic practitioners to acknowledge and respect the rights of those they serve. These Guidelines are intended for use by psychologists when engaged in the practice of forensic psychology as described below and may also provide guidance on professional conduct to the legal system and other organizations and professions.

For the purposes of these Guidelines, *forensic psychology* refers to professional practice by any psychologist working within any sub discipline of psychology (e.g., clinical, developmental, social, cognitive) when applying the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual, and administrative matters. Application of the Guidelines does not depend on the practitioner’s typical areas of practice or expertise, but rather, on the service provided in the case at hand. These Guidelines apply in all matters in which psychologists provide expertise to judicial, administrative, and

educational systems including, but not limited to, examining or treating persons in anticipation of or subsequent to legal, contractual, or administrative proceedings; offering expert opinion about psychological issues in the form of amicus briefs or testimony to judicial, legislative, or administrative bodies; acting in an adjudicative capacity; serving as a trial consultant or otherwise offering expertise to attorneys, the courts, or others; conducting research in connection with, or in the anticipation of, litigation; or involvement in educational activities of a forensic nature. Psychological practice is not considered forensic solely because the conduct takes place in, or the product is presented in, a tribunal or other judicial, legislative, or administrative forum. For example, when a party (such as a civilly or criminally detained individual) or another individual (such as a child whose parents are involved in divorce proceedings) is ordered into treatment with a practitioner, that treatment is not necessarily the practice of forensic psychology. In addition, psychological testimony that is solely based on the provision of psychotherapy and does not include psych legal opinions is not ordinarily considered forensic practice.

For the purposes of these Guidelines, *forensic practitioner* refers to a psychologist when engaged in the practice of forensic psychology as described above. Such professional conduct is considered forensic from the time the practitioner reasonably expects to, agrees to, or is legally mandated to provide expertise on an explicitly psych legal issue.

The provision of forensic services may include a wide variety of psych legal roles and functions. For example, as

This article was published Online First October 1, 2012.

These Specialty Guidelines for Forensic Psychology were developed by the American Psychology–Law Society (Division 41 of the American Psychological Association [APA]) and the American Academy of Forensic Psychology. They were adopted by the APA Council of Representatives on August 3, 2011.

The previous version of the Guidelines (“Specialty Guidelines for Forensic Psychologists”; Committee on Ethical Guidelines for Forensic Psychologists, 1991) was approved by the American Psychology–Law Society (Division 41 of APA) and the American Academy of Forensic Psychology in 1991. The current revision, now called the “Specialty Guidelines for Forensic Psychology” (referred to as “the Guidelines” throughout this document), replaces the 1991 “Specialty Guidelines for Forensic Psychologists.”

These guidelines are scheduled to expire August 3, 2021. After this date, users are encouraged to contact the American Psychological Association Practice Directorate to confirm that this document remains in effect.

Correspondence concerning these guidelines should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

researchers, forensic practitioners may participate in the collection and dissemination of data that are relevant to various legal issues. As advisors, forensic practitioners may provide an attorney with an informed understanding of the role that psychology can play in the case at hand. As consultants, forensic practitioners may explain the practical implications of relevant research, examination findings, and the opinions of other psych legal experts. As examiners, forensic practitioners may assess an individual's functioning and report findings and opinions to the attorney, a legal tribunal, an employer, an insurer, or others (APA, 2010b, 2011a). As treatment providers, forensic practitioners may provide therapeutic services tailored to the issues and context of a legal proceeding. As mediators or negotiators, forensic practitioners may serve in a third-party neutral role and assist parties in resolving disputes. As arbiters, special masters, or case managers with decision-making authority, forensic practitioners may serve parties, attorneys, and the courts (APA, 2011b).

These Guidelines are informed by APA's "Ethical Principles of Psychologists and Code of Conduct" (hereinafter referred to as the EPPCC; APA, 2010a). The term *guidelines* refer to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and facilitate a high level of practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive, and they are not intended to take precedence over the judgment of psychologists.

As such, the Guidelines are advisory in areas in which the forensic practitioner has discretion to exercise professional judgment that is not prohibited or mandated by the EPPCC or applicable law, rules, or regulations. The Guidelines neither add obligations to nor eliminate obligations from the EPPCC but provide additional guidance for psychologists. The modifiers used in the Guidelines (e.g., *reasonably*, *appropriate*, *potentially*) are included in recognition of the need for professional judgment on the part of forensic practitioners; ensure applicability across the broad range of activities conducted by forensic practitioners; and reduce the likelihood of enacting an inflexible set of guidelines that might be inapplicable as forensic practice evolves. The use of these modifiers, and the recognition of the role of professional discretion and judgment, also reflects that forensic practitioners are likely to encounter facts and circumstances not anticipated by the Guidelines and they may have to act upon uncertain or incomplete evidence. The Guidelines may provide general or conceptual guidance in such circumstances. The Guidelines do not, however, exhaust the legal, professional, moral, and ethical considerations that inform forensic practitioners, for no complex activity can be completely defined by legal rules, codes of conduct, and aspirational guidelines.

The Guidelines are not intended to serve as a basis for disciplinary action or civil or criminal liability. The standard of care is established by a competent authority, not by the Guidelines. No ethical, licensure, or other administrative action or remedy, nor any other cause of action, should be taken *solely* on the basis of a forensic practitioner acting in a manner consistent or inconsistent with these Guidelines.

In cases in which a competent authority references the Guidelines when formulating standards, the authority should consider that the Guidelines attempt to identify a high level of quality in forensic practice. Competent practice is defined as the conduct of a reasonably prudent forensic practitioner engaged in similar activities in similar circumstances. Professional conduct evolves and may be viewed along a continuum of adequacy, and "minimally competent" and "best possible" are usually different points along that continuum.

The Guidelines are designed to be national in scope and are intended to be consistent with state and federal law. In cases in which a conflict between legal and professional obligations occurs, forensic practitioners make known their commitment to the EPPCC and the Guidelines and take steps to achieve an appropriate resolution consistent with the EPPCC and the Guidelines.

The format of the Guidelines is different from most other practice guidelines developed under the auspices of APA. This reflects the history of the Guidelines as well as the fact that the Guidelines are considerably broader in scope than any other APA-developed guidelines. Indeed, these are the only APA-approved guidelines that address a complete specialty practice area. Despite this difference in format, the Guidelines function as all other APA guideline documents.

This document replaces the 1991 "Specialty Guidelines for Forensic Psychologists," which were approved by the American Psychology-Law Society (Division 41 of APA) and the American Board of Forensic Psychology. The current revision has also been approved by the Council of Representatives of APA. Appendix A includes a discussion of the revision process, enactment, and current status of these Guidelines. Appendix B includes definitions and terminology as used for the purposes of these Guidelines.

1. Responsibilities

Guideline 1.01: Integrity

Forensic practitioners strive for accuracy, honesty, and truthfulness in the science, teaching, and practice of forensic psychology and they strive to resist partisan pressures to provide services in any ways that might tend to be misleading or inaccurate.

Guideline 1.02: Impartiality and Fairness

When offering expert opinion to be relied upon by a decision maker, providing forensic therapeutic services, or teaching or conducting research, forensic practitioners strive for accuracy, impartiality, fairness, and independence (EPPCC Standard 2.01). Forensic practitioners recognize the adversarial nature of the legal

system and strive to treat all participants and weigh all data, opinions, and rival hypotheses impartially.

When conducting forensic examinations, forensic practitioners strive to be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact. This guideline does not preclude forceful presentation of the data and reasoning upon which a conclusion or professional product is based.

When providing educational services, forensic practitioners seek to represent alternative perspectives, including data, studies, or evidence on both sides of the question, in an accurate, fair and professional manner, and strive to weigh and present all views, facts, or opinions impartially.

When conducting research, forensic practitioners seek to represent results in a fair and impartial manner. Forensic practitioners strive to utilize research designs and scientific methods that adequately and fairly test the questions at hand, and they attempt to resist partisan pressures to develop designs or report results in ways that might be misleading or unfairly bias the results of a test, study, or evaluation.

Guideline 1.03: Avoiding Conflicts of Interest

Forensic practitioners refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to impair their impartiality, competence, or effectiveness, or expose others with whom a professional relationship exists to harm (EPPCC Standard 3.06).

Forensic practitioners are encouraged to identify, make known, and address real or apparent conflicts of interest in an attempt to maintain the public confidence and trust, discharge professional obligations, and maintain responsibility, impartiality, and accountability (EPPCC Standard 3.06). Whenever possible, such conflicts are revealed to all parties as soon as they become known to the psychologist. Forensic practitioners consider whether a prudent and competent forensic practitioner engaged in similar circumstances would determine that the ability to make a proper decision is likely to become impaired under the immediate circumstances.

When a conflict of interest is determined to be manageable, continuing services are provided and documented in a way to manage the conflict, maintain accountability, and preserve the trust of relevant others (also see Guideline 4.02 below).

2. Competence

Guideline 2.01: Scope of Competence

When determining one's competence to provide services in a particular matter, forensic practitioners may consider a variety of factors including the relative complexity and specialized nature of the service, relevant training and experience, the preparation and study they are able to devote to the matter, and the opportunity for consultation with a professional of established competence in the

subject matter in question. Even with regard to subjects in whom they are expert, forensic practitioners may choose to consult with colleagues.

Guideline 2.02: Gaining and Maintaining Competence

Competence can be acquired through various combinations of education, training, supervised experience, consultation, study, and professional experience. Forensic practitioners planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies that are new to them are encouraged to undertake relevant education, training, supervised experience, consultation, or study.

Forensic practitioners make ongoing efforts to develop and maintain their competencies (EPPCC Standard 2.03). To maintain the requisite knowledge and skill, forensic practitioners keep abreast of developments in the fields of psychology and the law.

Guideline 2.03: Representing Competencies

Consistent with the EPPCC, forensic practitioners adequately and accurately inform all recipients of their services (e.g., attorneys, tribunals) about relevant aspects of the nature and extent of their experience, training, credentials, and qualified and how they were obtained (EPPCC Standard 5.01).

Guideline 2.04: Knowledge of the Legal System and the Legal Rights of Individuals

Forensic practitioners recognize the importance of obtaining a fundamental and reasonable level of knowledge and understanding of the legal and professional standards, laws, rules, and precedents that govern their participation in legal proceedings and that guide the impact of their services on service recipients (EPPCC Standard 2.01).

Forensic practitioners aspire to manage their professional conduct in a manner that does not threaten or impair the rights of affected individuals. They may consult with, and refer others to, legal counsel on matters of law. Although they do not provide formal legal advice or opinions, forensic practitioners may provide information about the legal process to others based on their knowledge and experience. They strive to distinguish this from legal opinions, however, and encourage consultation with attorneys as appropriate.

Guideline 2.05: Knowledge of the Scientific Foundation for Opinions and Testimony

Forensic practitioners seek to provide opinions and testimony that are sufficiently based upon adequate scientific foundation, and reliable and valid principles and methods that have been applied appropriately to the facts of the case.

When providing opinions and testimony that are based on novel or emerging principles and methods, forensic practitioners seek to make known the status and limitations of these principles and methods.

Guideline 2.06: Knowledge of the Scientific Foundation for Teaching and Research

Forensic practitioners engage in teaching and research activities in which they have adequate knowledge, experience, and education (EPPCC Standard 2.01), and they acknowledge relevant limitations and caveats inherent in procedures and conclusions (EPPCC Standard 5.01).

Guideline 2.07: Considering the Impact of Personal Beliefs and Experience

Forensic practitioners recognize that their own cultures, attitudes, values, beliefs, opinions, or biases may affect their ability to practice in a competent and impartial manner. When such factors may diminish their ability to practice in a competent and impartial manner, forensic practitioners may take steps to correct or limit such effects, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations.

Guideline 2.08: Appreciation of Individual and Group Differences

When scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, or other relevant individual and cultural differences affects implementation or use of their services or research, forensic practitioners consider the boundaries of their expertise, make an appropriate referral if indicated, or gain the necessary training, experience, consultation, or supervision (EPPCC Standard 2.01; APA, 2003, 2004, 2011c, 2011d, 2011e).

Forensic practitioners strive to understand how factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, or other relevant individual and cultural differences may affect and be related to the basis for people's contact and involvement with the legal system.

Forensic practitioners do not engage in unfair discrimination based on such factors or on any basis proscribed by law (EPPCC Standard 3.01). They strive to take steps to correct or limit the effects of such factors on their work, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations.

Guideline 2.09: Appropriate Use of Services and Products

Forensic practitioners are encouraged to make reasonable efforts to guard against misuse of their services and exercise professional discretion in addressing such misuses.

3. Diligence

Guideline 3.01: Provision of Services

Forensic practitioners are encouraged to seek explicit agreements that define the scope of, time-frame of, and

compensation for their services. In the event that a client breaches the contract or acts in a way that would require the practitioner to violate ethical, legal or professional obligations, the forensic practitioner may terminate the relationship.

Forensic practitioners strive to act with reasonable diligence and promptness in providing agreed-upon and reasonably anticipated services. Forensic practitioners are not bound, however, to provide services not reasonably anticipated when retained, nor to provide every possible aspect or variation of service. Instead, forensic practitioners may exercise professional discretion in determining the extent and means by which services are provided and agreements are fulfilled.

Guideline 3.02: Responsiveness

Forensic practitioners seek to manage their workloads so that services can be provided thoroughly, competently, and promptly. They recognize that acting with reasonable promptness, however, does not require the forensic practitioner to acquiesce to service demands not reasonably anticipated at the time the service was requested, nor does it require the forensic practitioner to provide services if the client has not acted in a manner consistent with existing agreements, including payment of fees.

Guideline 3.03: Communication

Forensic practitioners strive to keep their clients reasonably informed about the status of their services, comply with their clients' reasonable requests for information, and consult with their clients about any substantial limitation on their conduct or performance that may arise when they reasonably believe that their clients expect a service that is not consistent with their professional obligations. Forensic practitioners attempt to keep their clients reasonably informed regarding new facts, opinions, or other potential evidence that may be relevant and applicable.

Guideline 3.04: Termination of Services

The forensic practitioner seeks to carry through to conclusion all matters undertaken for a client unless the forensic practitioner– client relationship is terminated. When a forensic practitioner's employment is limited to a specific matter, the relationship may terminate when the matter has been resolved, anticipated services have been completed, or the agreement has been violated.

4. Relationships

Whether a forensic practitioner– client relationship exists depends on the circumstances and is determined by a number of factors which may include the information exchanged between the potential client and the forensic practitioner prior to, or at the initiation of, any contact or service, the nature of the interaction, and the purpose of the interaction.

In their work, forensic practitioners recognize that relationships are established with those who retain their services (e.g., retaining parties, employers, insurers, the

court) and those with whom they interact (e.g., examinees, collateral contacts, research participants, students). Forensic practitioners recognize that associated obligations and duties vary as a function of the nature of the relationship.

Guideline 4.01: Responsibilities to Retaining Parties

Most responsibilities to the retaining party attach only after the retaining party has requested and the forensic practitioner has agreed to render professional services and an agreement regarding compensation has been reached. Forensic practitioners are aware that there are some responsibilities, such as privacy, confidentiality, and privilege that may attach when the forensic practitioner agrees to consider whether a forensic practitioner–retaining party relationship shall be established. Forensic practitioners, prior to entering into a contract, may direct the potential retaining party not to reveal any confidential or privileged information as a way of protecting the retaining party’s interest in case a conflict exists as a result of pre-existing relationships.

At the initiation of any request for service, forensic practitioners seek to clarify the nature of the relationship and the services to be provided including the role of the forensic practitioner (e.g., trial consultant, forensic examiner, treatment provider, expert witness, research consultant); which person or entity is the client; the probable uses of the services provided or information obtained; and any limitations to privacy, confidentiality, or privilege.

Guideline 4.02: Multiple Relationships

A multiple relationship occurs when a forensic practitioner is in a professional role with a person and, at the same time or at a subsequent time, is in a different role with the same person; is involved in a personal, fiscal, or other relationship with an adverse party; at the same time is in a relationship with a person closely associated with or related to the person with whom the forensic practitioner has the professional relationship; or offers or agrees to enter into another relationship in the future with the person or a person closely associated with or related to the person (EPPCC Standard 3.05).

Forensic practitioners strive to recognize the potential conflicts of interest and threats to objectivity inherent in multiple relationships. Forensic practitioners are encouraged to recognize that some personal and professional relationships may interfere with their ability to practice in a competent and impartial manner and they seek to minimize any detrimental effects by avoiding involvement in such matters whenever feasible or limiting their assistance in a manner that is consistent with professional obligations.

Guideline 4.02.01: Therapeutic–Forensic Role Conflicts

Providing forensic and therapeutic psychological services to the same individual or closely related individuals involves multiple relationships that may impair objectivity and/or cause exploitation or other harm. Therefore, when requested or ordered to provide either concurrent or

sequential forensic and therapeutic services, forensic practitioners are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another qualified provider. If referral is not possible, the forensic practitioner is encouraged to consider the risks and benefits to all parties and to the legal system or entity likely to be impacted, the possibility of separating each service widely in time, seeking judicial review and direction, and consulting with knowledgeable colleagues. When providing both forensic and therapeutic services, forensic practitioners seek to minimize the potential negative effects of this circumstance (EPPCC Standard 3.05).

Guideline 4.02.02: Expert Testimony by Practitioners Providing Therapeutic Services

Providing expert testimony about a patient who is a participant in a legal matter does not necessarily involve the practice of forensic psychology even when that testimony is relevant to a psych legal issue before the decision maker. For example, providing testimony on matters such as a patient’s reported history or other statements, mental status, diagnosis, progress, prognosis, and treatment would not ordinarily be considered forensic practice even when the testimony is related to a psych legal issue before the decision maker. In contrast, rendering opinions and providing testimony about a person on psych legal issues (e.g., criminal responsibility, legal causation, proximate cause, trial competence, testamentary capacity, the relative merits of parenting arrangements) would ordinarily be considered the practice of forensic psychology.

Consistent with their ethical obligations to base their opinions on information and techniques sufficient to substantiate their findings (EPPCC Standards 2.04, 9.01), forensic practitioners are encouraged to provide testimony only on those issues for which they have adequate foundation and only when a reasonable forensic practitioner engaged in similar circumstances would determine that the ability to make a proper decision is unlikely to be impaired. As with testimony regarding forensic examinees, the forensic practitioner strives to identify any substantive limitations that may affect the reliability and validity of the facts or opinions offered, and communicates these to the decision maker.

Guideline 4.02.03: Provision of Forensic Therapeutic Services

Although some therapeutic services can be considered forensic in nature, the fact that therapeutic services are ordered by the court does not necessarily make them forensic. In determining whether a therapeutic service should be considered the practice of forensic psychology, psychologists are encouraged to consider the potential impact of the legal context on treatment, the potential for treatment to impact the psych legal issues involved in the case, and whether another reasonable psychologist in a similar position would consider the service to be forensic and these Guidelines to be applicable.

Therapeutic services can have significant effects on current or future legal proceedings. Forensic practitioners

are encouraged to consider these effects and minimize any unintended or negative effects on such proceedings or therapy when they provide therapeutic services in forensic contexts.

Guideline 4.03: Provision of Emergency Mental Health Services to Forensic Examinees

When providing forensic examination services an emergency may arise that requires the practitioner to provide short-term therapeutic services to the examinee in order to prevent imminent harm to the examinee or others. In such cases the forensic practitioner is encouraged to limit disclosure of information and inform the retaining attorney, legal representative, or the court in an appropriate manner. Upon providing emergency treatment to examinees, forensic practitioners consider whether they can continue in a forensic role with that individual so that potential for harm to the recipient of services is avoided (EPPCC Standard 3.04).

5. Fees

Guideline 5.01: Determining Fees

When determining fees forensic practitioners may consider salient factors such as their experience providing the service, the time and labor required, the novelty and difficulty of the questions involved, the skill required to perform the service, the fee customarily charged for similar forensic services, the likelihood that the acceptance of the particular employment will preclude other employment, the time limitations imposed by the client or circumstances, the nature and length of the professional relationship with the client, the client's ability to pay for the service, and any legal requirements.

Guideline 5.02: Fee Arrangements

Forensic practitioners are encouraged to make clear to the client the likely cost of services whenever it is feasible, and make appropriate provisions in those cases in which the costs of services is greater than anticipated or the client's ability to pay for services changes in some way.

Forensic practitioners seek to avoid undue influence that might result from financial compensation or other gains. Because of the threat to impartiality presented by the acceptance of contingent fees and associated legal prohibitions, forensic practitioners strive to avoid providing professional services on the basis of contingent fees. Letters of protection, financial guarantees, and other security for payment of fees in the future are not considered contingent fees unless payment is dependent on the outcome of the matter.

Guideline 5.03: Pro Bono Services

Forensic psychologists recognize that some persons may have limited access to legal services as a function of financial disadvantage and strive to contribute a portion of their professional time for little or no compensation or personal advantage (EPPCC Principle E).

6. Informed Consent, Notification, and Assent

Because substantial rights, liberties, and properties are often at risk in forensic matters, and because the methods and procedures of forensic practitioners are complex and may not be accurately anticipated by the recipients of forensic services, forensic practitioners strive to inform service recipients about the nature and parameters of the services to be provided (EPPCC Standards 3.04, 3.10).

Guideline 6.01: Timing and Substance

Forensic practitioners strive to inform clients, examinees, and others who are the recipients of forensic services as soon as is feasible about the nature and extent of reasonably anticipated forensic services.

In determining what information to impart, forensic practitioners are encouraged to consider a variety of factors including the person's experience or training in psychological and legal matters of the type involved and whether the person is represented by counsel. When questions or uncertainties remain after they have made the effort to explain the necessary information, forensic practitioners may recommend that the person seeks legal advice.

Guideline 6.02: Communication With Those Seeking to Retain a Forensic Practitioner

As part of the initial process of being retained or as soon thereafter as previously unknown information becomes available, forensic practitioners strive to disclose to the retaining party information that would reasonably be anticipated to affect a decision to retain or continue the services of the forensic practitioner.

This disclosure may include, but is not limited to, the fee structure for anticipated services; prior and current personal or professional activities, obligations, and relationships that would reasonably lead to the fact or the appearance of a conflict of interest; the forensic practitioner's knowledge, skill, experience, and education relevant to the forensic services being considered, including any significant limitations; and the scientific bases and limitations of the methods and procedures which are expected to be employed.

Guideline 6.03: Communication with Forensic Examinees

Forensic practitioners inform examinees about the nature and purpose of the examination (EPPCC Standard 9.03; American Educational Research Association, American Psychological Association, & National Council on Measurement in Education [AERA, APA, & NCME], in press). Such information may include the purpose, nature, and anticipated use of the examination; who will have access to the information; associated limitations on privacy, confidentiality, and privilege including who is authorized to release or access the information contained in the forensic practitioner's records; the voluntary or involuntary nature of participation, including potential consequences of participation or nonparticipation, if

known; and, if the cost of the service is the responsibility of the examinee, the anticipated cost.

Guideline 6.03.01: Persons Not Ordered or Mandated to Undergo Examination

If the examinee is not ordered by the court to participate in a forensic examination, the forensic practitioner seeks his or her informed consent (EPPCC Standards 3.10, 9.03). If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee's unwillingness to proceed.

Guideline 6.03.02: Persons Ordered or Mandated to Undergo Examination or Treatment

If the examinee is ordered by the court to participate, the forensic practitioner can conduct the examination over the objection, and without the consent, of the examinee (EPPCC Standards 3.10, 9.03). If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider a variety of options including postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee's unwillingness to proceed.

When an individual is ordered to undergo treatment but the goals of treatment are determined by a legal authority rather than the individual receiving services, the forensic practitioner informs the service recipient of the nature and purpose of treatment, and any limitations on confidentiality and privilege (EPPCC Standards 3.10, 10.01).

Guideline 6.03.03: Persons Lacking Capacity to Provide Informed Consent

Forensic practitioners appreciate that the very conditions that precipitate psychological examination of individuals involved in legal proceedings can impair their functioning in a variety of important ways, including their ability to understand and consent to the evaluation process.

For examinees adjudicated or presumed by law to lack the capacity to provide informed consent for the anticipated forensic service, the forensic practitioner nevertheless provides an appropriate explanation, seeks the examinee's assent, and obtains appropriate permission from a legally authorized person, as permitted or required by law (EPPCC Standards 3.10, 9.03).

For examinees whom the forensic practitioner has concluded lack capacity to provide informed consent to a proposed, non-court-ordered service, but who have not been adjudicated as lacking such capacity, the forensic practitioner strives to take reasonable steps to protect their rights and welfare (EPPCC Standard 3.10). In such cases, the forensic practitioner may consider suspending the

proposed service or notifying the examinee's attorney or the retaining party.

Guideline 6.03.04: Evaluation of Persons Not Represented by Counsel

Because of the significant rights that may be at issue in a legal proceeding, forensic practitioners carefully consider the appropriateness of conducting a forensic evaluation of an individual who is not represented by counsel. Forensic practitioners may consider conducting such evaluations or delaying the evaluation so as to provide the examinee with the opportunity to consult with counsel.

Guideline 6.04: Communication With Collateral Sources of Information

Forensic practitioners disclose to potential collateral sources information that might reasonably be expected to inform their decisions about participating that may include, but may not be limited to, who has retained the forensic practitioner; the nature, purpose, and intended use of the examination or other procedure; the nature of and any limits on privacy, confidentiality, and privilege; and whether their participation is voluntary (EPPCC Standard 3.10).

Guideline 6.05: Communication in Research Contexts

When engaging in research or scholarly activities conducted as a service to a client in a legal proceeding, forensic practitioners attempt to clarify any anticipated use of the research or scholarly product, disclose their role in the resulting research or scholarly products, and obtain whatever consent or agreement is required.

In advance of any scientific study, forensic practitioners seek to negotiate with the client the circumstances under and manner in which the results may be made known to others. Forensic practitioners strive to balance the potentially competing rights and interests of the retaining party with the inappropriateness of suppressing data, for example, by agreeing to report the data without identifying the jurisdiction in which the study took place. Forensic practitioners represent the results of research in an accurate manner (EPPCC Standard 5.01).

7. Conflicts in Practice

In forensic psychology practice, conflicting responsibilities and demands may be encountered. When conflicts occur, forensic practitioners seek to make the conflict known to the relevant parties or agencies, and consider the rights and interests of the relevant parties or agencies in their attempts to resolve the conflict.

Guideline 7.01: Conflicts With Legal Authority

When their responsibilities conflict with law, regulations, or other governing legal authority, forensic practitioners make known their commitment to the EPPCC, and take steps to resolve the conflict. In situations in which the

EPPCC or the Guidelines are in conflict with the law, attempts to resolve the conflict are made in accordance with the EPPCC (EPPCC Standard 1.02).

When the conflict cannot be resolved by such means, forensic practitioners may adhere to the requirements of the law, regulations, or other governing legal authority, but only to the extent required and not in any way that violates a person's human rights (EPPCC Standard 1.03).

Forensic practitioners are encouraged to consider the appropriateness of complying with court orders when such compliance creates potential conflicts with professional standards of practice.

Guideline 7.02: Conflicts With Organizational Demands

When the demands of an organization with which they are affiliated or for whom they are working conflict with their professional responsibilities and obligations, forensic practitioners strive to clarify the nature of the conflict and, to the extent feasible, resolve the conflict in a way consistent with professional obligations and responsibility (EPPCC Standard 1.03).

Guideline 7.03: Resolving Ethical Issues With Fellow Professionals

When an apparent or potential ethical violation has caused, or is likely to cause, substantial harm, forensic practitioners are encouraged to take action appropriate to the situation and consider a number of factors including the nature and the immediacy of the potential harm; applicable privacy, confidentiality, and privilege; how the rights of the relevant parties may be affected by a particular course of action; and any other legal or ethical obligations (EPPCC Standard 1.04). Steps to resolve perceived ethical conflicts may include, but are not limited to, obtaining the consultation of knowledgeable colleagues, obtaining the advice of independent counsel, and conferring directly with the client.

When forensic practitioners believe there may have been an ethical violation by another professional, an attempt is made to resolve the issue by bringing it to the attention of that individual, if that attempt does not violate any rights or privileges that may be involved, and if an informal resolution appears appropriate (EPPCC Standard 1.04). If this does not result in a satisfactory resolution, the forensic practitioner may have to take further action appropriate to the situation, including making a report to third parties of the perceived ethical violation (EPPCC Standard 1.05). In most instances, in order to minimize unforeseen risks to the party's rights in the legal matter, forensic practitioners consider consulting with the client before attempting to resolve a perceived ethical violation with another professional.

8. Privacy, Confidentiality, and Privilege

Forensic practitioners recognize their ethical obligations to maintain the confidentiality of information relating to a client or retaining party, except in so far as disclosure is

Consented to by the client or retaining party, or required or permitted by law (EPPCC Standard 4.01).

Guideline 8.01: Release of Information

Forensic practitioners are encouraged to recognize the importance of complying with properly noticed and served subpoenas or court orders directing release of information, or other legally proper consent from duly authorized persons, unless there is a legally valid reason to offer an objection. When in doubt about an appropriate response or course of action, forensic practitioners may seek assistance from the retaining client, retain and seek legal advice from their own attorney, or formally notify the drafter of the subpoena or order of their uncertainty.

Guideline 8.02: Access to Information

If requested, forensic practitioners seek to provide the retaining party access to, and a meaningful explanation of, all information that is in their records for the matter at hand, consistent with the relevant law, applicable codes of ethics and professional standards, and institutional rules and regulations. Forensic examinees typically are not provided access to the forensic practitioner's records without the consent of the retaining party. Access to records by anyone other than the retaining party is governed by legal process, usually subpoena or court order, or by explicit consent of the retaining party. Forensic practitioners may charge a reasonable fee for the costs associated with the storage, reproduction, review, and provision of records.

Guideline 8.03: Acquiring Collateral and Third Party Information

Forensic practitioners strive to access information or records from collateral sources with the consent of the relevant attorney or the relevant party, or when otherwise authorized by law or court order.

Guideline 8.04: Use of Case Materials in Teaching, Continuing Education, and Other Scholarly Activities

Forensic practitioners using case materials for purposes of teaching, training, or research strive to present such information in a fair, balanced, and respectful manner. They attempt to protect the privacy of persons by disguising the confidential, personally identifiable information of all persons and entities who would reasonably claim a privacy interest; using only those aspects of the case available in the public domain; or obtaining consent from the relevant clients, parties, participants, and organizations to use the materials for such purposes (EPPCC Standard 4.07; also see Guidelines 11.06 and 11.07 of these Guidelines).

9. Methods and Procedures

Guideline 9.01: Use of Appropriate Methods

Forensic practitioners strive to utilize appropriate methods and procedures in their work. When performing examinations, treatment, consultation, educational activities, or scholarly investigations, forensic practitioners seek to

maintain integrity by examining the issue or problem at hand from all reasonable perspectives and seek information that will differentially test plausible rival hypotheses.

Guideline 9.02: Use of Multiple Sources of Information

Forensic practitioners ordinarily avoid relying solely on one source of data, and corroborate important data whenever feasible (AERA, APA, & NCME, in press). When relying upon data that have not been corroborated, forensic practitioners seek to make known the uncorroborated status of the data, any associated strengths and limitations, and the reasons for relying upon the data.

Guideline 9.03: Opinions Regarding Persons Not Examined

Forensic practitioners recognize their obligations to only provide written or oral evidence about the psychological characteristics of particular individuals when they have sufficient information or data to form an adequate foundation for those opinions or to substantiate their findings (EPPCC Standard 9.01). Forensic practitioners seek to make reasonable efforts to obtain such information or data, and they document their efforts to obtain it. When it is not possible or feasible to examine individuals about whom they are offering an opinion, forensic practitioners strive to make clear the impact of such limitations on the reliability and validity of their professional products, opinions, or testimony.

When conducting a record review or providing consultation or supervision that does not warrant an individual examination, forensic practitioners seek to identify the sources of information on which they are basing their opinions and recommendations, including any substantial limitations to their opinions and recommendations.

10. Assessment

Guideline 10.01: Focus on Legally Relevant Factors

Forensic examiners seek to assist the trier of fact to understand evidence or determine a fact in issue, and they provide information that is most relevant to the psych legal issue. In reports and testimony, forensic practitioners typically provide information about examinees' functional abilities, capacities, knowledge, and beliefs, and address their opinions and recommendations to the identified psych legal issues (American Bar Association & American Psychological Association, 2008; Grisso, 1986, 2003; Heilbrun, Marczyk, DeMatteo, & Mack-Allen, 2007).

Forensic practitioners are encouraged to consider the problems that may arise by using a clinical diagnosis in some forensic contexts, and consider and qualify their opinions and testimony appropriately.

Guideline 10.02: Selection and Use of Assessment Procedures

Forensic practitioners use assessment procedures in the manner and for the purposes that are appropriate in light of

the research on or evidence of their usefulness and proper application (EPPCC Standard 9.02; AERA, APA, & NCME, in press). This includes assessment techniques, interviews, tests, instruments, and other procedures and their administration, adaptation, scoring, and interpretation, including computerized scoring and interpretation systems. Forensic practitioners use assessment instruments whose validity and reliability have been established for use with members of the population assessed. When such validity and reliability have not been established, forensic practitioners consider and describe the strengths and limitations of their findings. Forensic practitioners use assessment methods that are appropriate to an examinee's language preference and competence, unless the use of an alternative language is relevant to the assessment issues (EPPCC Standard 9.02).

Assessment in forensic contexts differs from assessment in therapeutic contexts in important ways that forensic practitioners strive to take into account when conducting forensic examinations. Forensic practitioners seek to consider the strengths and limitations of employing traditional assessment procedures in forensic examinations (AERA, APA, & NCME, in press). Given the stakes involved in forensic contexts, forensic practitioners strive to ensure the integrity and security of test materials and results (AERA, APA, & NCME, in press).

When the validity of an assessment technique has not been established in the forensic context or setting in which it is being used, the forensic practitioner seeks to describe the strengths and limitations of any test results and explain the extrapolation of these data to the forensic context. Because of the many differences between forensic and therapeutic contexts, forensic practitioners consider and seek to make known that some examination results may warrant substantially different interpretation when administered in forensic contexts (AERA, APA, & NCME, in press).

Forensic practitioners consider and seek to make known that forensic examination results can be affected by factors unique to, or differentially present in, forensic contexts including response style, voluntariness of participation, and situational stress associated with involvement in forensic or legal matters (AERA, APA, & NCME, in press).

Guideline 10.03: Appreciation of Individual Differences

When interpreting assessment results, forensic practitioners consider the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences that might affect their judgments or reduce the accuracy of their interpretations (EPPCC Standard 9.06). Forensic practitioners strive to identify any significant strengths and limitations of their procedures and interpretations.

Forensic practitioners are encouraged to consider how the assessment process may be impacted by any disability an examinee is experiencing, make accommodations as

possible, and consider such when interpreting and communicating the results of the assessment (APA, 2011d).

Guideline 10.04: Consideration of Assessment Settings

In order to maximize the validity of assessment results, forensic practitioners strive to conduct evaluations in settings that provide adequate comfort, safety, and privacy.

Guideline 10.05: Provision of Assessment Feedback

Forensic practitioners take reasonable steps to explain assessment results to the examinee or a designated representative in language they can understand (EPPCC Standard 9.10). In those circumstances in which communication about assessment results is precluded, the forensic practitioner explains this to the examinee in advance (EPPCC Standard 9.10).

Forensic practitioners seek to provide information about professional work in a manner consistent with professional and legal standards for the disclosure of test data or results, interpretation of data, and the factual bases for conclusions.

Guideline 10.06: Documentation and Compilation of Data Considered

Forensic practitioners are encouraged to recognize the importance of documenting all data they consider with enough detail and quality to allow for reasonable judicial scrutiny and adequate discovery by all parties. This documentation includes, but is not limited to, letters and consultations; notes, recordings, and transcriptions; assessment and test data, scoring reports and interpretations; and all other records in any form or medium that were created or exchanged in connection with a matter.

When contemplating third party observation or audio/video-recording of examinations, forensic practitioners strive to consider any law that may control such matters, the need for transparency and documentation, and the potential impact of observation or recording on the validity of the examination and test security (Committee on Psychological Tests and Assessment, American Psychological Association, 2007).

Guideline 10.07: Provision of Documentation

Pursuant to proper subpoenas or court orders, or other legally proper consent from authorized persons, forensic practitioners seek to make available all documentation described in Guideline 10.05, all financial records related to the matter, and any other records including reports (and draft reports if they have been provided to a party, attorney, or other entity for review), that might reasonably be related to the opinions to be expressed.

Guideline 10.08: Record Keeping

Forensic practitioners establish and maintain a system of record keeping and professional communication (EPPCC Standard 6.01; APA, 2007), and attend to relevant laws and rules. When indicated by the extent of the rights, liberties,

and properties that may be at risk, the complexity of the case, the amount and legal significance of unique evidence in the care and control of the forensic practitioner, and the likelihood of future appeal, forensic practitioners strive to inform the retaining party of the limits of record keeping times. If requested to do so, forensic practitioners consider maintaining such records until notified that all appeals in the matter have been exhausted, or sending a copy of any unique components/aspects of the record in their care and control to the retaining party before destruction of the record.

11. Professional and Other Public Communications

Guideline 11.01: Accuracy, Fairness, and Avoidance of Deception

Forensic practitioners make reasonable efforts to ensure that the products of their services, as well as their own public statements and professional reports and testimony, are communicated in ways that promote understanding and avoid deception (EPPCC Standard 5.01).

When in their role as expert to the court or other tribunals, the role of forensic practitioners is to facilitate understanding of the evidence or dispute. Consistent with legal and ethical requirements, forensic practitioners do not distort or withhold relevant evidence or opinion in reports or testimony. When responding to discovery requests and providing sworn testimony, forensic practitioners strive to have readily available for inspection all data which they considered, regardless of whether the data supports their opinion, subject to and consistent with court order, relevant rules of evidence, test security issues, and professional standards (AERA, APA, & NCME, in press; Committee on Legal Issues, American Psychological Association, 2006; Bank & Packer, 2007; Golding, 1990).

When providing reports and other sworn statements or testimony in any form, forensic practitioners strive to present their conclusions, evidence, opinions, or other professional products in a fair manner. Forensic practitioners do not, by either commission or omission, participate in misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny, or subvert the presentation of evidence contrary to their own position or opinion (EPPCC Standard 5.01). This does not preclude forensic practitioners from forcefully presenting the data and reasoning upon which a conclusion or professional product is based.

Guideline 11.02: Differentiating Observations, Inferences, and Conclusions

In their communications, forensic practitioners strive to distinguish observations, inferences, and conclusions. Forensic practitioners are encouraged to explain the relationship between their expert opinions and the legal issues and facts of the case at hand.

Guideline 11.03: Disclosing Sources of Information and Bases of Opinions

Forensic practitioners are encouraged to disclose all sources of information obtained in the course of their professional services, and to identify the source of each piece of information that was considered and relied upon in formulating a particular conclusion, opinion, or other professional product.

Guideline 11.04: Comprehensive and Accurate Presentation of Opinions in Reports and Testimony

Consistent with relevant law and rules of evidence, when providing professional reports and other sworn statements or testimony, forensic practitioners strive to offer a complete statement of all relevant opinions that they formed within the scope of their work on the case, the basis and reasoning underlying the opinions, the salient data or other information that was considered in forming the opinions, and an indication of any additional evidence that may be used in support of the opinions to be offered. The specific substance of forensic reports is determined by the type of psych legal issue at hand as well as relevant laws or rules in the jurisdiction in which the work is completed.

Forensic practitioners are encouraged to limit discussion of background information that does not bear directly upon the legal purpose of the examination or consultation. Forensic practitioners avoid offering information that is irrelevant and that does not provide a substantial basis of support for their opinions, except when required by law (EPPCC Standard 4.04).

Guideline 11.05: Commenting Upon Other Professionals and Participants in Legal Proceedings

When evaluating or commenting upon the work or qualifications of other professionals involved in legal proceedings, forensic practitioners seek to represent their disagreements in a professional and respectful tone, and base them on a fair examination of the data, theories, standards, and opinions of the other expert or party.

When describing or commenting upon clients, examinees, or other participants in legal proceedings, forensic practitioners strive to do so in a fair and impartial manner. Forensic practitioners strive to report the representations, opinions, and statements of clients, examinees, or other participants in a fair and impartial manner.

Guideline 11.06: Out of Court Statements

Ordinarily, forensic practitioners seek to avoid making detailed public (out-of-court) statements about legal proceedings in which they have been involved. However, sometimes public statements may serve important goals such as educating the public about the role of forensic practitioners in the legal system, the appropriate practice of forensic psychology, and psychological and legal issues that are relevant to the matter at hand. When making public statements, forensic practitioners refrain from releasing

private, confidential, or privileged information, and attempt to protect persons from harm, misuse, or misrepresentation as a result of their statements (EPPCC Standard 4.05).

Guideline 11.07: Commenting Upon Legal Proceedings

Forensic practitioners strive to address particular legal proceedings in publications or communications only to the extent that the information relied upon is part of a public record, or when consent for that use has been properly obtained from any party holding any relevant privilege (also see Guideline 8.04).

When offering public statements about specific cases in which they have not been involved, forensic practitioners offer opinions for which there is sufficient information or data and make clear the limitations of their statements and opinions resulting from having had no direct knowledge of or involvement with the case (EPPCC Standard 9.01).

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Appendix A

Revision Process of the Guidelines

This revision of the Guidelines was coordinated by the Committee for the Revision of the Specialty Guidelines for Forensic Psychology (“the Revisions Committee”), which was established by the American Academy, of Forensic Psychology and the American Psychology–Law Society (Division 41 of the American Psychological Association [APA]) in 2002 and which operated through 2011. This committee consisted of two representatives from each organization (Solomon Fulero, PhD, JD; Stephen Golding, PhD, ABPP; Lisa Piechowski, PhD, ABPP; Christina Studebaker, PhD), a chairperson (Randy Otto, PhD, ABPP), and a liaison from Division 42 (Psychologists in Independent Practice) of APA (Jeffrey Younggren, PhD, ABPP).

This document was revised in accordance with APA Rule 30.08 and the APA policy document “Criteria for Practice Guideline Development and Evaluation” (APA, 2002). The Revisions Committee posted announcements regarding the revision process to relevant electronic discussion lists and professional publications (i.e., the Psylaw-L e-mail listserv of the American Psychology–Law Society, the American Academy of Forensic Psychology listserv, the American Psychology–Law Society

Newsletter). In addition, an electronic discussion list devoted solely to issues concerning revision of the Guidelines was operated between December 2002 and July 2007, followed by establishment of an e-mail address in February 2008 (sgfp@yahoo.com). Individuals were invited to provide input and commentary on the existing Guidelines and proposed revisions via these means. In addition, two public meetings were held throughout the revision process at biennial meetings of the American Psychology–Law Society.

Upon development of a draft that the Revisions Committee deemed suitable, the revised Guidelines were submitted for review to the Executive Committee of the American Psychology–Law Society (Division 41 of APA) and the American Board of Forensic Psychology. Once the revised Guidelines were approved by these two organizations, they were submitted to APA for review, commentary, and acceptance, consistent with APA’s “Criteria for Practice Guideline Development and Evaluation” (APA, 2002) and APA Rule 30-8. They were subsequently revised by the Revisions Committee and were adopted by the APA Council of Representatives on August 3, 2011.

(Appendices continue)

Appendix B

Definitions and Terminology

For the purposes of these Guidelines:

Appropriate, when used in relation to conduct by a forensic practitioner means that, according to the prevailing professional judgment of competent forensic practitioners, the conduct is apt and pertinent and is considered befitting, suitable, and proper for a particular person, place, condition, or function. **Inappropriate** means that, according to the prevailing professional judgment of competent forensic practitioners, the conduct is not suitable, desirable or properly timed for a particular person, occasion, or purpose; and may also denote improper conduct, improprieties, or conduct that is discrepant for the circumstances.

Agreement refers to the objective and mutual understanding between the forensic practitioner and the person or persons seeking the professional service and/or agreeing to participate in the service. See also Assent, Consent, and Informed Consent.

Assent refers to the agreement, approval, or permission, especially regarding verbal or nonverbal conduct, that is reasonably intended and interpreted as expressing willingness, even in the absence of unmistakable consent. Forensic practitioners attempt to secure assent when consent and informed consent cannot be obtained or when, because of mental state, the examinee may not be able to consent.

Consent refers to agreement, approval, or permission as to some act or purpose.

Client refers to the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services.

Conflict of Interest refers to a situation or circumstance in which the forensic practitioner's objectivity, impartiality, or judgment may be jeopardized due to a relationship, financial, or any other interest that would reasonably be expected to substantially affect a forensic practitioner's professional judgment, impartiality, or decision making.

Decision Maker refers to the person or entity with the authority to make a judicial decision, agency determination, arbitration award, or other contractual determination after consideration of the facts and the law.

Examinee refers to a person who is the subject of a forensic examination for the purpose of informing a decision maker or attorney about the psychological functioning of that examinee.

Forensic Examiner refers to a psychologist who examines the psychological condition of a person whose psychological condition is in controversy or at issue.

Forensic Practice refers to the application of the scientific, technical, or specialized knowledge of

psychology to the law and the use of that knowledge to assist in resolving legal, contractual, and administrative disputes.

Forensic Practitioner refers to a psychologist when engaged in forensic practice.

Forensic Psychology refers to all forensic practice by any psychologist working within any sub discipline of psychology (e.g., clinical, developmental, social, cognitive).

Informed Consent denotes the knowledgeable, voluntary, and competent agreement by a person to a proposed course of conduct after the forensic practitioner has communicated adequate information and explanation about the material risks and benefits of, and reasonably available alternatives to, the proposed course of conduct.

Legal Representative refers to a person who has the legal authority to act on behalf of another.

Party refers to a person or entity named in litigation, or who is involved in, or is witness to, an activity or relationship that may be reasonably anticipated to result in litigation.

Reasonable or **Reasonably**, when used in relation to conduct by a forensic practitioner, denotes the conduct of a prudent and competent forensic practitioner who is engaged in similar activities in similar circumstances.

Record or **Written Record** refers to all notes, records, documents, memorialization's, and recordings of considerations and communications, be they in any form or on any media, tangible, electronic, handwritten, or mechanical, that are contained in, or are specifically related to, the forensic matter in question or the forensic service provided. **Retaining Party** refers to the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services.

Tribunal denotes a court or an arbitrator in an arbitration proceeding, or a legislative body, administrative agency, or other body acting in an adjudicative capacity. A legislative body, administrative agency, or other body acts in an adjudicative capacity when a neutral official, after the presentation of legal argument or evidence by a party or parties, renders a judgment directly affecting a party's interests in a particular matter.

Trier of Fact refers to a court or an arbitrator in an arbitration proceeding, or a legislative body, administrative agency, or other body acting in an adjudicative capacity. A legislative body, administrative agency, or other body acts in an adjudicative capacity when a neutral official, after the presentation of legal argument or evidence by a party or parties, renders a judgment directly affecting a party's interests in a particular matter.

Guidelines for Psychological Evaluations in Child Protection Matters

American Psychological Association

The problems of abused and neglected children are epidemic in our society (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, 2008) and create issues that psychologists may be called upon to address. Psychologists are positioned to contribute significantly to decision making in child protection matters. Psychological data and expertise may provide sources of information and a perspective not otherwise available to courts regarding the functioning of parties, and thus may increase the fairness of decisions by the court, state agency, or other party.

As the complexity of psychological practice increases and the reciprocal involvement between psychologists and the public broadens, the need for guidelines to educate the profession, the public, and the other interested parties regarding desirable professional practice in child protection matters continues to increase. Because psychologists may assume various roles and responsibilities in child protection matters, the following guidelines were developed primarily for psychologists conducting psychological evaluations in such matters.

These guidelines are a revision of the 1999 “Guidelines for Psychological Evaluations in Child Protection Matters” (American Psychological Association [APA], 1999). These guidelines are informed by APA’s “Ethical Principles of Psychologists and Code of Conduct” (“APA Ethics Code”; APA, 2002a, 2010). The term *guidelines* refer to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from *standards* in that standards are mandatory and may be accompanied by an enforcement mechanism.

Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help facilitate a high level of practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists. The specific goal of the guidelines is to promote proficiency in using psychological expertise when psychologists conduct psychological evaluations in child protection matters.

Child protection laws address three interests: the child’s, the parents’, and the states. Child protection laws emphasize that the child has a fundamental interest in being protected from abuse and neglect.

These laws also address parents’ interests in child protection matters. Parents enjoy important civil and constitutional rights regarding the care for their children. Public policy and practice developments in recent years have also acknowledged the role of extended family and kinship systems in child care matters, such as policies favoring child placement with grandparents or other family members rather than in foster care when such placement is consistent with safety of and care for the child. Although the term *parents* will be used in these guidelines for the sake of simplicity, this term is also intended to include persons other than the biological parents who are raising the child, that is, grandparents, other relatives, step-parents, guardians, and adoptive parents, among others.

In addition to the interests and rights of the child and parents, the state also has interests in child protection matters. All states have the right to investigate and to intervene in cases where a child has been harmed or there is a reasonable belief that a child is being harmed. The specific procedures guiding state intervention in child protection cases vary across jurisdictions but may be understood to involve different phases which may, in practice,

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These guidelines are a revision of the 1999 “Guidelines for Psychological Evaluations in Child Protection Matters” (American Psychological Association [APA], 1999) and were developed by the Committee on Professional Practice and Standards (COPPS). Members of COPPS during the development of this document were Mary Ann McCabe (chair, 2010), Lisa Drago Piechowski (chair, 2009), Eric Y. Drogin (chair, 2007–2008), Bonita Cade, Lois Condie, Nabil El-Ghoroury (Board of Professional Affairs [BPA] liaison, 2007–2008), Ruth Fassinger (BPA liaison, 2009 – 2010), Terry S. W. Gock, Robert Kinscherff, Stephen J. Lally, Gary D. Lovejoy, Julia Ramos-Grenier, Bonnie Spring, and John A. Zervopoulos. COPPS is grateful for the support and guidance of BPA, and particularly to BPA Chairs Judith Patterson (2010), Cynthia A. Sturm (2009), and Jaquelyn Liss Resnick (2008). COPPS wishes to thank the many APA colleagues and governance groups who offered comments on drafts of these guidelines. COPPS also acknowledges the APA Practice Directorate Legal and Regulatory Affairs staff: Shirley Higuchi, Stacey Larson, Alan Nessman, and Maureen Testoni. Finally, COPPS extends its sincere appreciation to the APA Practice Directorate staff members who facilitated the work of COPPS during this revision effort: Mary G. Hardiman, Lynn F. Bufka, Ronald S. Palomares, Ayobodun Bello, LeShawn Lumpkin, and Sheila Kerr.

These guidelines are scheduled to expire in February 2021, 10 years from the date of adoption by the APA Council of Representatives. After this date, users are encouraged to contact the APA Practice Directorate to determine whether these guidelines remain in effect.

Correspondence concerning these guidelines should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

overlap. Psychologists strive to be familiar with the relevant law, procedures, and practices in the jurisdiction(s) where they provide child protection evaluations.

In the first phase, an investigation by child welfare authorities may be triggered by a report of suspected child maltreatment, which may include involvement by parent(s), sibling(s), or others who have access to the child (U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2009). If the initial report suggests that urgent intervention is required to assure the safety of the child, child welfare authorities may seek court authorization to take emergency custody of the child pending further investigation.

In the second phase, if the results of investigation indicate that the child has been harmed or is at significant risk of harm, the child welfare authorities may offer voluntary services or seek court authorization to extend protective custody if it was obtained due to the urgency of the initial report. Child welfare authorities may also seek to obtain or extend protective custody of the child based on the investigation's findings. Typically, an initial strategy for further assessment and intervention for the family is developed and then is presented to the family for voluntary participation and/or is submitted to the court.

This process of resolving protective custody issues and determining an intervention strategy may require court hearings and a finding by the court that the parents have maltreated the child or have otherwise failed to care for or protect the child adequately, and a determination that circumstances warrant continued protective state custody of the child. During this phase, the court may periodically review interventions and other reunification efforts, and/or permanency planning for the child in the event that reunification cannot occur. At any point during this second phase, the court may order a variety of case-specific assessments relevant to the child protection issues, or a psychologist may be retained by another entity to conduct such assessments.

In the third phase, if efforts at reunification fail or if the court determines that the facts of the case relieve the state from making reasonable efforts to reunify the family, the case may move from child protection to termination of parental rights and permanency planning for the child (e.g., long-term kinship care, guardianship, adoption). During this phase, assessments commonly focus upon why clinical or social services interventions have failed in achieving family reunification, whether the state has made legally required reasonable efforts towards reunification, the likelihood that the parent(s) will ever be brought to adequate parenting or restored to an adequate parenting capacity they had earlier demonstrated, and/or the nature of any continuing risk of harm to the child due to parental maltreatment of the child or failures to provide the child adequate care and protection. Psychologists involved in child protection evaluations remain aware that the termination of parental rights has a finality prompting both due process protections and higher standards of proof than may be required in other phases of a child protection proceeding (Condie & Condie, 2007).

Child protection authorities are ordinarily required to make "reasonable efforts" to establish or re-establish parenting capacities sufficient to reunite the child with his/her parent(s). Typically, these "reasonable efforts" requirements must be met prior to a disposition of termination of parental rights. States may have different statutory or case law requirements regarding reunification efforts. In conducting an evaluation, psychologists become reasonably familiar with such statutes and case law (APA Ethics Code, Standard 2.01(f)).

During any phase of a child protection case, psychologists may be asked to evaluate different parties for different purposes. Psychologists may act as court-ordered evaluators, or may be retained by the state child protection agency or an organization providing contracted services to the state child protection agency. Psychologists may also be retained by a *guardian ad litem* or by an attorney for the child if one has been appointed to represent the child. Finally, psychologists may be retained by the parent(s) or counsel representing the parent(s).

As evaluators in child protection cases, psychologists are frequently asked to address the following questions:

1. What maltreatment of the child, if any, occurred in this case?
2. If maltreatment has occurred, how seriously has the child's psychological well-being been affected?
3. What therapeutic interventions would be recommended to assist the child?
4. Can the parent(s) be successfully treated to prevent harm to the child in the future? If so, how? If not, why not?
5. What would be the psychological effect upon the child if returned to the parent(s)?
6. What would be the psychological effect upon the child if separated from the parent(s) or if parental rights are terminated? (See Barnum, 1997, 2002.)

In the course of their evaluations, and depending upon the specific needs of a given case, psychologists are frequently asked to evaluate the parent(s) and/or the child individually or together. Psychologists seek to gather information on family history, assess relevant personality functioning, assess developmental needs of the child, explore the nature and quality of the parent-child relationship and assess evidence of trauma. Psychologists typically also consider specific risk factors such as substance abuse or chemical dependency, domestic violence, health status of family members, and the entire family context. In addition, psychologists review information from other sources, including assessments of cultural, educational, religious, and community factors (APA Ethics Code, Standard 9.06).

Particular competencies and knowledge are necessary to perform psychological evaluations in child protection matters so that adequate and appropriate psychological services can be provided to the court, state agencies, or other parties (APA Ethics Code, Standard 2.01(f)). For example, in cases involving physical disability, such as hearing impairments, orthopedic handicaps, etc.,

psychologists strive to seek consultation from experts in these areas. This need for consultation may also apply to other aspects of human diversity, such as, but not limited to, ethnic minority status, sexual orientation, and socioeconomic status (Condie, 2003).

Conducting psychological evaluations in child protection matters can be professionally demanding and personally stressful. The demands and stresses of such evaluations may intensify because the evaluation issues may include child abuse, neglect, and/or family violence. Psychologists remain alert to how these issues may personally affect them and, when appropriate, seek peer or other personal support, and undertake relevant study, training, supervision and/or consultation (APA Ethics Code, Standard 2.06).

I. Orienting Guidelines

Guideline 1. The primary purpose of the evaluation is to provide relevant, professionally sound results or opinions in matters where a child's health and welfare may have been and/or may be harmed.

Rationale. Government agencies and courts rely on psychological evaluations in child protection matters to become further informed about the welfare and safety of a child in whose life the state has intervened and to make decisions to ensure the child's welfare and safety. As a result, opinions and recommendations of such evaluations must have a reliable basis in the knowledge and experience of psychology—a standard based in psychology's professional ethics and in legal case law (APA Ethics Code, Standard 2.04; *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993).

Application. Psychologists seek to determine the specific nature of the child protection proceeding; to identify the issues and questions to be addressed that are relevant to the specific investigation or legal proceeding; and to design and implement an evaluation process based upon established scientific and professional knowledge in psychology that sufficiently addresses these issues or questions (APA Ethics Code, Standard 2.04; see Budd, Felix, Sweet, Saul, & Carlton, 2006).

Guideline 2. When psychologists conduct evaluations in child protection matters to address specific referral questions, they are aware that the interests of the parties in the case may differ from one another.

Rationale. In all child protection matters, the state has intervened because of concerns that the child's physical and/or psychological well-being has been endangered. Nevertheless, psychologists who conduct child protection evaluations are aware that the interests of the child, the child's parent(s), and the state—each represented separately in the legal system—may not always coincide. As a result, evaluation recommendations may affect each of these interests differently.

Application. Psychologists, mindful of the different interests represented in child protection matters, strive

to conduct impartial and competent evaluations. When conducting their evaluations, psychologists consider the developmental and functional impact on the child of past parental abuse or neglect, as well as the risks to the child's well-being from any reasonably anticipated parental maltreatment or from parental failures to provide the child with sufficient care or protection. Psychologists also seek to address the following risks to the child: multiple substitute care placements; maltreatment while in substitute care; inadequate supports or interventions from poorly resourced child welfare systems; prolonged separation from parents, kin, or other primary caregivers who may be adequate caregivers; unwarranted or poor quality institutional care; or other inadvertent but potentially negative consequences of state intervention.

Guideline 3. When the referral question in the evaluation addresses concerns about the parent/caretaker and child relationship, psychologists are mindful of: the parent/caretaker's parenting capacities, including circumstances or factors relevant to maltreatment of the child; the child's well-being and psychological needs; and the resulting fit.

Rationale. Although some referral questions may direct psychologists to address specific concerns involving only the child or parent(s), psychologists are aware that recommendations about the child ordinarily cannot be separated from broader considerations about the fit between the child and parent(s) that have given rise to the child protection concerns, interventions, and/or legal proceedings. As a result, psychologists remain mindful of those broader "fit" considerations as well as of the limits of their evaluative role and of the evaluation information that they consider when they address the parent-child fit in a given case. Where the information and opinions or recommendations arising from a family member's evaluation have potential implications for the fit between a child's developmental needs and the parenting capacities of the child's caretakers, psychologists strive to communicate those implications thoughtfully and fairly, within the limits of their data and of the evaluation's referral questions and scope (APA Ethics Code, Standards 2.04, 9.01(a)).

Application. Evaluation of the parent/caretaker and child relationship in child protection matters may include the following assessments: (a) the adult's capacities for parenting, including those attributes, skills, and abilities most relevant to abuse and/or neglect concerns;

(b) the psychological functioning and developmental needs of the child, particularly with regard to vulnerabilities and special needs, including any disabilities, of the child as well as the strength of the child's attachment to the parent(s) and the possible detrimental effects of separation from the parent(s); (c) the current and potential functional abilities of the parent(s) to meet the needs of the child, including an evaluation of the relationship between the child and the parent(s); and (d) the need for

and likelihood of success of clinical interventions for observed problems, which may include recommendations regarding treatment focus, frequency of sessions, specialized kinds of intervention, parent education, and placement (see Grisso, 2002).

II. General Guidelines: Preparing for a Child Protection Evaluation

Guideline 4. The role of psychologists who conduct child protection evaluations is that of a professional expert who strives to maintain an unbiased, impartial approach to the evaluation.

Rationale. Government agencies and courts may use psychologists' findings to support consequential decisions involving the child and his or her family, including determination of whether a child was abused or neglected, parental access to the child, psychological treatment recommendations, or termination of parental rights. The gravity of these decisions highlights the ethical mandate that the psychologist conduct the evaluation from an unbiased, impartial stance (APA Ethics Code, Standards 9.01(a), 9.06). Further, if the psychologist will testify as an expert about his or her findings, the psychologist can only "assist the court" if his or her opinions arise from evaluation data gathered impartially from reliable methods that reflect the knowledge and experience of psychology (APA Ethics Code, Standard 2.04; *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993).

Application. Psychologists rely on scientifically and professionally derived knowledge when conducting child protection evaluations (APA Ethics Code, Standard 2.04). Psychologists strive to describe fairly the data they gather and develop in their evaluations and the inferences they draw from the data upon which they base the conclusions and recommendations. Psychologists are not precluded from assertively presenting their final opinions, or recommendations. But psychologists strive to base their final opinions, and/or recommendations upon generally accepted methods and procedures, an unbiased assessment of the relevant data, active consideration and discussion of all plausible alternative explanations of the data, and fair disclosure of any significant limitations upon the final opinions, and/or recommendations offered (APA Ethics Code, Standard 2.04; Heilbrun, 2001). Psychologists unable to accept this unbiased impartial approach ordinarily decline to participate in the case or withdraw from the case. If not permitted to decline the case or withdraw from the case, psychologists make known their commitment to the APA Ethics Code, disclose to the court or to entities that retain them the factors that may bias or compromise the objectivity and reliability of the evaluation final and take steps to resolve the conflict consistent with the APA Ethics Code (APA Ethics Code, Standard 1.02; APA, 2010).

Guideline 5. Psychologists strive to gain competence sufficient to provide effective and ethical forensic services when conducting child protection evaluations and when addressing case-specific issues that may require specialized professional knowledge, training, or skills.

Rationale. Competence to conduct child protection evaluations and to address case-specific issues is ethically demanded and legally required for reliable, admissible expert testimony. Ethically, "Psychologists provide services . . . in areas only within the boundaries of their competence" (APA Ethics Code, Standard 2.01). Legally, trial courts must ensure "that those who purport to be experts truly have expertise concerning the actual subject about which they are offering an opinion" (*Broders v. Heise*, 1996; *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993).

Application. Psychologists consider what specific competencies are required for each child protection evaluation and strive to ensure either that they have the necessary competencies to conduct the evaluation or that they can adequately conduct the evaluation under either supervision or in a consulting relationship with a colleague who maintains the necessary competencies. Professional competence in performing psychological assessments of children, adults, and families is necessary but often insufficient to address, competently and ethically, many referral questions in child protection matters. For example, because child protection proceedings specifically focus upon allegations or findings of abuse and/or neglect of a child, psychologists conducting assessment in these matters seek to develop sufficient expertise in assessment of child maltreatment that is often beyond the scope of general clinical psychology practice (APA Ethics Code, Standard 2.01(c)). Because a broad range of potential professional skills and competencies may be required to conduct competent child protection evaluations, it may be unreasonable to expect a psychologist to possess the clinical, forensic, cultural, linguistic, or other skills necessary to address every potential referral issue or question prompting a child protection evaluation. For example, psychologists involved in cases where children present with specific disabilities strive to rely upon information about the particular vulnerabilities and risks of maltreatment associated with the child's specific disabilities. When the psychologist's competencies are insufficient to conduct a competent evaluation, the psychologist seeks appropriate supervision or consultation, or declines or refers the case (APA Ethics Code, Standard 2.01(b)).

Psychologists strive to consider the various professional competencies called upon to conduct evaluations with specific child protection concerns. Child protection evaluations may call upon specialized education, training, experience, and/or supervision in the following areas: forensic psychology practice; law and child welfare practices relevant to the jurisdictions where child protection evaluations are provided; policies and resources that may be relevant to the specific case; risk and

and protective factors in child maltreatment; the dynamics and potential impacts of various forms of child abuse and neglect; other forms of family violence; family development and dynamics; adult, child, and family adaptation and psychopathology; identification of potential strengths or resources within the family or extended family; the potential impact of familial separation; the potential impact of kinship-based care, community-based foster or congregate care, or institutional care upon a child; and the role of human and cultural differences.

Some cases may also require specialized training or experience with specific cultural or linguistic concerns, particular diversity populations, familiarity with unusual patterns or types of maltreatment, needs arising from medical conditions, the functional impact of specific disabilities of the parent(s) and/or child upon the care and protection of the child, or other essential case-specific competencies. Careful consideration of the specific professional competencies required in each case will enable psychologists to determine if they have sufficient skills to conduct the evaluation, if they should seek appropriate supervision or consultation, or if they should decline or refer the matter. Psychologists rely upon current research and professional best practices in selecting and using evaluation methods and procedures (APA Ethics Code, Standards 2.04, 9.02(a)). Psychologists strive to communicate any relevant limitations upon the use, findings, or interpretations of psychological assessment procedures, tools, and/or tests to persons who rely upon their reports or professional opinions/recommendations for guidance or decision making (APA Ethics Code, Standard 9.06).

Psychologists become familiar with applicable legal and regulatory standards and procedures, including state and federal law governing child protection issues (APA Ethics Code, Standard 2.01(f)). Thus, psychologists seek to become familiar with local child welfare policies, practices, and resources relevant to the cases in which they provide professional services, and to be familiar with the procedures and practices of local courts, government agencies, or organizations that provide potentially relevant social or clinical services to persons involved in child protection proceedings. These may include laws and regulations addressing child abuse, neglect, and termination of parental rights (see, e.g., Adoption and Safe Families Act of 1997; Indian Child Welfare Act of 1978).

Guideline 6. Psychologists strive to be aware of personal biases and societal prejudices and seek to engage in nondiscriminatory practice.

Rationale. Unrecognized personal biases may compromise the ethical integrity and legal reliability of evaluation conclusions and recommendations. Such biases include those related to age, gender, gender identity, gender expression, race, ethnicity, national origin, religion, sexual orientation, disability, language, culture and socioeconomic status, and immigration status (APA Ethics Code, Standard 3.01). Societal prejudices, just as perniciously,

may lead to discriminatory, unfair use of evaluation methods and reasoning that are disrespectful of the examinee's rights and dignity and undermine the scientific and professional bases of the child protection evaluation (APA Ethics Code, Standards 2.04 and 9.06, Principles C, D, and E).

Application. A psychologist recognizes and strives to overcome any personal biases that could reasonably be expected to impair his or her objectivity, competence, or effectiveness when functioning as an evaluator in child protection matters (APA Ethics Code, Standard 9.06). If any of the psychologist's biases will impair his or her functioning in such matters, the psychologist must withdraw from the evaluation. When developing and interpreting evaluation results, psychologists strive to be aware of diverse cultural and community methods of child rearing, and consider these in the context of existing state and federal law. Psychologists also seek to remain aware of the stigma associated with disabilities often found in child protection cases such as intellectual disabilities and psychiatric disabilities (including substance use disorders), and they ensure that they have sufficient professional competencies to provide an objective and accurate evaluation of persons presenting with these disabilities (APA Ethics Code, Standard 2.01). In addition, psychologists seek to address aspects of the disability that are relevant to parenting, and remain mindful of the potential impact of stigma or bias in their own professional work and that of others involved in the case. Also, psychologists use, whenever available, tests and norms based on populations similar to those evaluated (APA Ethics Code, Standard 9.02).

Guideline 7. Psychologists providing child protection evaluations strive to avoid role conflicts and multiple relationships that may compromise their objectivity, competence, or effectiveness, or that may otherwise risk harm or exploitation to the person or identified client (e.g., court, state child protection agency) with whom the professional relationship exists.

Rationale. Inappropriate role conflicts and multiple relationships impair psychologists' abilities to conduct impartial and competent evaluations. As a result, opinions and recommendations from such evaluations will be unable to provide useful information or guidance to entities intervening in the family on the child's behalf and may not provide the basis for reliable testimony that will assist the court to make decisions that address the child's best interests (APA Ethics Code, Standards 3.05, 3.06).

Application. Psychologists seek to manage ethically the role conflicts that may arise when they consider or conduct child protection evaluations. Psychologists generally do not conduct psychological evaluations in child protection matters in which they serve in a therapeutic role for the child or the immediate family or have had other involvements that may compromise their objectivity. Standard 3.05 of the APA Ethics Code states, "A psychologist refrains from entering into a multiple relationship if the multiple relationships could reasonably be expected to impair the psychologist's objectivity,

competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.” This does not, however, preclude psychologists from testifying in cases as fact or expert witnesses concerning therapeutic treatment of the children, parents, or families (Greenberg & Gould, 2001). In addition, during the course of conducting a psychological evaluation in child protection matters or during the pendency of a legal matter in which the evaluation is considered or relied upon by the judge or other legal decision-maker, psychologists do not accept any of the participants involved in the evaluation as therapy clients (APA Ethics Code, Standard 3.05(a)). Therapeutic contact with the child or involved participants following a child protection evaluation is discouraged and when done, is undertaken with caution. When psychologists face extraordinary circumstances, such as when they are serving rural populations or persons with specialized needs for which adequate alternative services are not available, psychologists seek to resolve the situation consistent with APA Ethics Code Standard 3.05(c).

Psychologists asked to testify regarding a therapy client who is involved in a child protection case are encouraged to become aware of the limitations and possible biases inherent in such a role and the possible impact on ongoing therapeutic relationships (APA Ethics Code, Standard 3.05(a)). Although the court may order psychologists to testify beyond their role as fact witnesses to become expert witnesses, psychologists appreciate the difference in roles and methods between being psychotherapists, child protection evaluators, and expert witnesses, and strive to make these distinctions clear to the court (Greenberg & Shuman, 1997, 2007).

Psychologists appreciate that persons seeking or receiving their evaluation services in child protection cases may not always reliably distinguish between clinical and forensic roles, or recognize other potential role conflicts or multiple relationships that may arise in the context of these cases. For example, family members may not clearly distinguish whether a psychologist is acting in a clinical capacity or a forensic capacity, or understand when a court or state child welfare agency may be the psychologist’s client. Similarly, state child welfare agencies or courts may not appreciate the difference between providing clinical assessment or therapy services and providing forensic assessment and/or expert witness services. Therefore, psychologists strive to communicate with referring parties and family members in a manner that prevents misperceptions of their role.

III. Procedural Guidelines: Conducting a Psychological Evaluation in Child Protection Matters

Child protection matters present situations that reflect a variety of legal and/or ethical considerations. The appropriate procedure or response in one case may be inappropriate in another. Psychologists seek to educate themselves

about laws that govern the evaluation, as well as other applicable sections of the APA Ethics Code, particularly those that address confidentiality and informed consent (APA Ethics Code, Standards 2.01(f), 4.01, 9.03). In addition, psychologists appreciate the need for timeliness in their involvements in child protection matters, including responding to the evaluation referral, scheduling evaluation appointments, and completing the report. Inattention to court-imposed timelines may delay the case’s legal disposition and negatively impact the child and parent(s) involved in the case.

Guideline 8. Based on the nature of referral issues or questions that define the focus and scope of the evaluation, psychologists determine the methods that are appropriate to address the referral issues or questions.

Rationale. Psychologists, based on their training, their experience, and their knowledge of research and professional literature, are best able to determine the methods to address evaluation referral issues and questions appropriately.

Application. In child protection matters, psychologists are frequently asked to address: past, current, or foreseeable child protection issues; parenting capacities; and/or the fit between parenting capacities and the needs of a child for care and protection. From these questions, psychologists may propose interventions designed to provide parents with parenting skills and supports sufficient to provide adequate care and protection for a child, may describe why previous attempts at intervention or support have failed, and/or may offer an opinion about the likelihood that a parent’s deficiencies may be adequately remedied by further interventions or supports.

Although the scope of the psychologist’s involvement in child protection matters is ordinarily defined by the issues or questions prompting referral for an evaluation, the scope may sometimes be reasonably inferred by the situation prompting the referral when specific questions do not accompany the referral. Nonetheless, in cases where the issues, questions, or circumstances prompting the referral are unclear, the psychologist seeks to clarify the scope of the child protection evaluation being requested.

A psychologist strives to address evaluation referral questions with appropriate methodology that is based upon established scientific and professional knowledge (APA Ethics Code, Standard 2.04). If the psychologist is unable to address the referral question in full, the psychologist strives to communicate the limitations of the evaluation procedures and declines to offer opinions or recommendations beyond the scope of the assessment or his or her expertise (APA Ethics Code, Standards 2.01, 9.01(a)).

For example, if the referral is for a child protection evaluation of only a parent or only a child, psychologists ordinarily refrain from offering opinions or recommendations regarding the specific fit between the person evaluated and the child or a parent who was not evaluated. In such cases, psychologists may describe findings (e.g., cognitive disability, substance dependence, likelihood that a

particular form of maltreatment has occurred, attitudes justifying intimate partner violence) and the potential implications for parenting and/or child safety or well-being. But where the psychologist lacks a sufficient foundation on which to base case-specific opinions or recommendations, the psychologist acknowledges the limitations of the foundation and refrains from offering opinions or recommendations (APA Ethics Code, Standard 9.01(a)). In cases where basic facts are contested and remain uninvestigated or unresolved, psychologists ordinarily avoid offering opinions regarding the personal credibility of evaluation participants or asserting that the psychologist can determine the truthfulness of statements made by evaluation participants. Psychologists may report relevant consistencies or inconsistencies of information that are found in documents reviewed, that are provided by persons interviewed as evaluation subjects or collateral sources, that are developed through assessment procedures, or that are found in other information sources. Similarly, psychologists asked only to critique the child protection assessments of another mental health professional in a particular case may do so but then refrain from making case-specific recommendations about the parent(s) and child because they did not evaluate the parents or child (APA Ethics Code, Standards 9.01(a), 9.01(b)).

Psychologists strive to inform those making referrals for child protection evaluation and, as appropriate, those making decisions in these cases, of any relevant limitations upon their evaluations, opinions, or recommendations. When psychologists begin a child protection evaluation but then identify relevant issues not anticipated in the referral questions that could enlarge the scope of the evaluation, psychologists ordinarily notify the identified client for the child protection assessment of the unanticipated relevant issues, notify the identified client of any mandated reports or any previously unanticipated limitations upon confidentiality or testimonial privilege, and, unless urgent action is required to maintain the safety of persons consistent with professional practice and law, seek authorization from the identified client before conducting further evaluation of those newly identified issues (APA Ethics Code, Standard 9.03(a)).

Guideline 9. In accordance with the APA Ethics Code, psychologists performing psychological evaluations in child protection matters obtain appropriate informed consent or assent from all adult participants, and as appropriate, inform the child participant.

Rationale. Psychologists seek to be aware of informed consent issues with examinees because of the intrusive nature of child protection matters on the privacy of family members, the complexity of the legal issues involved in such cases, and the potential serious legal consequences of the evaluation for the family (APA Ethics Code, Standard 9.03).

Application. Psychologists seek to establish the identified client for purposes of the child protection evaluation. For example, in court-ordered evaluations, the court may be the identified client. In other circumstances, a referring state child protection agency or an attorney

may be the identified client. Psychologists seek to inform the identified client and others who are involved in the referral and evaluation process, including the evaluation participant(s), about the psychologist's role, the nature of the relationship between the psychologist and the identified client and/or the referring party, the nature and purpose of the evaluation, any limitations on confidentiality and privilege, who might foreseeably have access to the evaluation's results, who is paying for the evaluation, and any other material facts regarding the evaluation process and reporting. This information should be conveyed in language understandable to those receiving the information. Persons who will receive the information should be afforded the opportunity to ask questions about the referral context and/or the evaluation process (APA Ethics Code, Standard 9.03(a)).

Persons referred for a child protection evaluation may feel compelled to consent to the evaluation, particularly when the evaluation is court-ordered or referred by child protection authorities. As a result, prior to beginning the evaluation, psychologists seek to determine whether informed consent by the evaluation's prospective examinees or assent by the prospective examinees to an evaluation "mandated by law or governmental regulations" (APA Ethics Code, Standard 9.03) is required. Psychologists also offer minors unable to legally provide their own informed consent an opportunity to assent to the evaluation (APA Ethics Code, Standard 3.10(b)). Psychologists providing child protection evaluations are mindful of requirements for informed consent or assent relevant to the context or jurisdiction in which the professional service is provided. Before beginning the evaluation process, psychologists seek to obtain from the participants in the evaluation confirmation of sufficient understanding of the evaluation and its referral context, and their agreement to participate in the evaluation whether by their informed consent or assent (APA Ethics Code, Standards 9.03(a), 9.03(b)). When psychologists doubt the capacity of an evaluation participant to offer a meaningful informed consent or assent, psychologists ordinarily do not proceed with evaluation until receiving clarification about whether or not to proceed from a court, attorney representing the individual, a guardian, or other source with appropriate authority. When persons referred under court order or by their counsel decline to participate, psychologists typically refer such persons back to the attorneys who represent them in the child protection matter or seek the court's guidance before proceeding. In circumstances where there is not yet a court case filed or the persons declining participation in the evaluation are not yet represented by counsel, psychologists seek to be aware of whether or not another referring party (e.g., governmental child protection agency) has the authority to require participation over the objections of persons referred, or to authorize the psychologist to proceed despite the objections.

Psychologists providing child protection evaluations understand issues of confidentiality and testimonial privilege and seek to inform themselves of the relevant laws and professional practices regarding these issues in the jurisdiction in which the evaluation is provided (APA Ethics Code, Standards 2.01(f), 4.01).

Psychologists are aware that confidentiality and/or testimonial privilege issues may be shaped by the specific characteristics or procedural posture of the case, the specific nature of the evaluation requested or the assessment procedures relied upon, as well as factors such as legal requirements, court orders, or agency regulations. Standard 3.07 of the APA Ethics Code states, “When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality.”

Psychologists strive to provide to the child information regarding the nature, purposes and procedures of the child protection evaluation in a developmentally and culturally appropriate manner, and seek to obtain the child’s assent if the child cannot legally provide their own informed consent (APA Ethics Code, Standard 3.10 (b)). Psychologists strive to explain to the child the nature of the evaluation procedures and attempt to make it clear to the child that information from the evaluation will be shared with other persons. When those persons are reasonably foreseeable and it is developmentally appropriate to do so, the psychologist strives to identify key persons with whom the information will be shared (e.g., judge, case worker, and attorney). Psychologists seek to allow time for questions by the child and answer them in developmentally and culturally appropriate manners.

Guideline 10. Psychologists use multiple methods of data gathering.

Rationale. Multiple methods of data gathering serves three ends: It broadens the information base upon which evaluators will base their opinions and recommendations; it provides information to challenge biases that may compromise evaluators’ opinions and recommendations; and it contributes to building a quality evaluation that will support ethical and legally reliable expert opinions.

Application. Psychologists strive to use multiple methods of data gathering, including but not limited to, clinical interviews, interviews with collateral contact, clinical observations, and/or psychological testing that are sufficient to provide appropriate substantiation for their findings. Psychologists ordinarily review relevant reports (e.g., from child protection agencies, social service providers, law enforcement agencies, health care providers, child care providers, schools, and institutions). When conducting child protection evaluations, psychologists are mindful of child welfare system issues that may affect their interactions with the system, including: case records or other documents of varying levels of detail, accessibility, or reliability; the potential or explicit advocacy stance of persons working professionally

within the system (e.g., attorneys, case workers, guardians ad litem); the potential impact of turnover or caseloads among child welfare staff or service providers to the family; and the potential range of responses of parents and children to investigation and/or court involvement.

Psychologists appreciate that preconceptions and biases may significantly impact their work, particularly in circumstances when they may prematurely believe a particular conclusion is obvious or a case is clear cut—an example of confirmatory bias. This underscores the importance of using consistent multimodal evaluation approaches and procedures across cases, and of utilizing multiple sources of information to actively explore plausible alternative explanations of the evaluation data (Brun, 2001).

In evaluating parental capacity to care for a particular child or assessing the child–parent interaction, psychologists make efforts to observe the child together with the parent in natural settings as well as structured settings. However, in cases where the safety of the child is in jeopardy or where the court has prohibited parental contact with the child, this may not always be possible. Psychologists understand that parent–child observations in safe, structured settings may be of limited predictive value for assessing the safety of parent–child interactions outside of such observations. Psychologists may also attempt to interview extended family members and other individuals when appropriate (e.g., caretakers, grandparents, clinical and social services providers, and teachers). If information gathered from a third party is used as a basis for conclusions or recommendations, psychologists seek to identify the source of the information, corroborate the information from at least one other source when possible, and, if obtained, document the corroboration in the report. If the information cannot be corroborated but is nonetheless relied upon to support conclusions or recommendations, the psychologist acknowledges that the information is uncorroborated.

Guideline 11. Psychologists seek to properly interpret clinical or assessment data that inform or support their conclusions.

Rationale. Properly interpreting clinical or assessment data in an evaluation—neither over interpreting nor inappropriately interpreting or applying the data—conforms with the ethical requirement that psychologists base their work upon established scientific and professional knowledge of the discipline (APA Ethics Code, Standard 2.04).

Application. Psychologists seek to refrain from drawing conclusions that are inadequately supported by the evaluation data. Psychologists strive to rely on scientific and professional knowledge in the field to interpret data from interviews or assessment measures, aiming to avoid over interpreting or under interpreting the data. Psychologists also become knowledgeable about the influence of social and cultural factors in the different evaluation phases: when generating data, when drawing inferences from available data, and when offering

able data, and when offering conclusions, opinions, or recommendations (APA Ethics Code, Standards 9.02(a), 9.06, 9.10).

When reporting findings from a child protection evaluation, psychologists seek to present their evaluations' substance and conclusions in a form that is understandable to the recipient of a written report or oral testimony. Recipients typically include persons without extensive training in psychology or evaluation methods. Therefore, psychologists in their written reports and testimony seek to distinguish among data, inferences, and conclusions or opinions so that recipients can understand the bases of psychologists' work in the case (APA Ethics Code, Standard 9.01(a)).

Psychologists strive to be knowledgeable about cultural norms. For example, to avoid overstating or understating child protection concerns, psychologists seek to understand relevant cultural variations in the use of physical or verbal methods of discipline, child care given by adults in the extended family, or contributions to child care or family finances by older siblings (APA, 2002b).

Psychologists also strive to acknowledge to the court any limitations in methods or data used (APA Ethics Code, Standard 9.06). In addition, given the potentially serious consequences of a court's finding that is adverse to an examinee's wishes, psychologists are aware that the examinee's responses in a court-ordered evaluation may reflect a defensive posture towards the evaluation.

Guideline 12. Psychologists conducting a psychological evaluation in child protection matters strive to provide opinions only when they have obtained sufficient data to support those opinions.

Rationale. Opinions from evaluations that are unsupported by sufficient data do not reflect the established scientific and professional knowledge of the discipline (APA Ethics Code, Standards 2.04, 9.01(a)). Rather, those opinions are likely to be based on biases that will compromise the evaluation's professional quality and legal reliability.

Application. Psychologists conducting evaluations seek to withhold communicating opinions and recommendations to any entity in child protection matters until they have obtained sufficient data to support those opinions and recommendations. If required to communicate opinions and recommendations before completing an evaluation, psychologists strive to appropriately limit the nature and extent of their opinions and recommendations.

In addition, the APA Ethics Code requires that psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an evaluation of individuals adequate to support their opinions. If, despite reasonable efforts, such an evaluation is not practical, psychologists seek to clarify the probable impact of the evaluations absent information on the reliability and validity of their opinions and limit

the nature and extent of their opinions and recommendations to the referring entity (APA Ethics Code, Standard 9.01(b)).

Guideline 13. Recommendations, if offered, address the evaluation's specific referral questions, which may encompass various concerns related to the child's welfare and health in a child protection matter.

Rationale. Referral questions orient and direct evaluations. As a result, recommendations address the referral questions. Recommendations unconnected to referral questions may not meet the concerns of the referral entity and may not be deemed relevant in court. Similarly, consistent with Guideline 8, psychologists may have to inform judges and court officials about the evaluation methods they will use to address specific referral questions effectively.

Application. Recommendations are based on sound psychological data, such as clinical data, interpretations and inferences founded on generally accepted psychological theory and practice, especially when these are well-supported by evidence-based research (APA Ethics Code, Standards 2.04, 9.01(a)). Particular attention may be given to outcomes research on interventions with abusive families if relevant to the scope of the evaluation as defined by the referral issues or questions. Psychologists strive to communicate relevant information and clinical data pertaining to the issues being evaluated while also maintaining an awareness of and communicating scientific limitations in predicting behavior. Psychologists also seek to explain the reasoning behind their conclusions.

The profession has not reached consensus about whether psychologists should offer opinions regarding the "ultimate issues" before the court—for example, whether psychologists should offer opinions about child placement, termination of parental rights, or the best interests of the child. Some in psychology hold that psychologists may aid judges and other decision makers by offering opinions on these "ultimate issues"; others in psychology hold that such opinions are essentially social and moral decisions for which psychologists have no particular mandate or expertise and which are beyond the purview of psychological practice. Psychologists conducting child protection evaluations are advised to be aware of the arguments on both sides of this issue and to be able to explain the logic of their position concerning their own practice (APA, 2009, Guide-line 13).

If psychologists providing child protection evaluations choose to offer opinions on "ultimate issues" before the court or for other decision makers (e.g., state child welfare authorities), the recommendations should be based on articulated assumptions, data, interpretations, and inferences based upon established professional and scientific standards (APA Ethics Code, Standard 2.04; APA, 2009, Guideline 13).

Guideline 14. Psychologists create and maintain records in accordance with ethical and legal standards.

Rationale. Legal and ethical standards describe requirements for the appropriate development, maintenance, and disposal of professional records (APA Ethics Code, Standard 6.01). Further, records developed during an evaluation provide underlying professional and legal support for the evaluation's opinions and recommendations.

Application. All data obtained in the process of conducting a child protection evaluation are properly maintained and stored in accordance with APA's "Record Keeping Guidelines" (APA, 2007). Psychologists recognize that when engaging in forensic work, it is particularly important to maintain complete, legible, and accurate documentation of all their work. All records, including raw data and interview information, are recorded with the understanding that they may be reviewed by other psychologists, the court, or the referring party.

Psychologists understand from statutes, case law, or professional ethics that managing records from a child protection evaluation referred from an agency, a lawyer, or a court, including conditions for the records' release, may be handled differently than records developed in a psychotherapy setting (APA Ethics Code, Standard 2.01(f)).

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(Appendix follows)

Appendix

Glossary of Terms

The following definitions are written generally and are intended solely to familiarize readers with some common terms used in child protection matters.^{A1} These are not to be construed as uniformly accepted legal definitions or applied in specific legal matters. Readers wishing to use these terms as part of their evaluations are encouraged to confer with a licensed attorney in the state in which they are providing the evaluation.

Abuse, emotional: also referred to as “psychological maltreatment”; generally defined as a repeated pattern of behavior that conveys to children that they are worthless, unwanted, or only of value in meeting another’s needs; may include serious threats of physical or psychological violence.

Abuse, neglect: see **Neglect**.

Abuse, physical: generally defined as the suffering by a child, or substantial risk that a child will imminently suffer, a physical harm, inflicted upon accidentally upon him or her by his or her parents or caretaker.

Abuse, sexual (child): generally defined as contacts between a child and an adult or other person significantly older or in a position of power or control over the child, where the child is being used for sexual stimulation of the adult or other person.

Child Protective Services (CPS): the social service agency (in most states) designated to receive reports, investigate, and provide rehabilitation services to children and families with problems of child maltreatment. Frequently, this agency is located within a large public entity, such as a department of social services or human services.

Disposition hearing: held by the Juvenile/Family Court to determine the disposition of children after cases have been adjudicated; includes determinations regarding placement of the child in out-of-home care when necessary and services needed by the children and family to reduce the risks and address the effects of maltreatment.

Evidence: any form of proof presented by a party for the purpose of supporting its factual allegation or arguments before the court.

Expert witness: an individual who by reason of education or specialized experience possesses superior knowledge respecting a subject about which persons having no particular training are incapable of forming an accurate opinion or deducing correct conclusions. A witness who has been qualified as an expert will be allowed (through his or her answers to questions posed) to assist the jury in understanding complicated and technical subjects not within the understanding of the average lay person. Experts are also allowed to provide testimony based on “hypothetical” scenarios or information/opinions which are not specifically related to the parties in particular legal action.

Fact witness: generally defined as an individual who, by being present, personally sees or perceives a thing; a beholder, spectator, or eyewitness. One who testifies to what he or she has seen, heard, or otherwise observed regarding a circumstance, event, or occurrence as it actually took place or a physical object or appearance as it usually

exists or existed. Fact witnesses are generally not allowed to offer opinion, address issues that they do not have personal knowledge of, or respond to hypothetical situations.

Family/juvenile court: courts specifically established to hear cases concerning minors and related domestic matters such as child abuse, neglect, child support, and determination of paternity, termination of parental rights, juvenile delinquency, and family domestic offenses.

Family preservation/reunification: the philosophical belief of social service agencies, established in law and policy, that children and families should be maintained together if the safety of the children can be ensured.

Guardian ad litem: generally defined as an adult appointed by the court to represent and make decisions for someone (such as a minor) legally incapable of doing so on his or her own in a civil legal proceeding. The guardian ad litem can be any adult with a demonstrated interest.

Guardianship: legal right given to a person to be responsible for the necessities (e.g., food, shelter, health care) of another person legally deemed incapable of providing these necessities for himself or herself.

Maltreatment: generally defined as actions that are abusive, neglectful, or otherwise threatening to a child’s welfare. Commonly used as a general term for child abuse and neglect.

Neglect: generally defined as an act of omission, specifically the failure of a parent or other person legally responsible for a child’s welfare to provide for the child’s basic needs and proper level of care with respect to food, shelter, hygiene, medical attention, or supervision.

1. **Emotional:** generally defined as the passive or passive-aggressive inattention to a child’s emotional needs, nurturing, or emotional well-being. Also referred to as psychological unavailability to a child.
2. **Physical:** generally defined as a child suffering, or in substantial risk of imminently suffering, physical harm causing disfigurement, impairment of bodily functioning, or other serious physical injury as a result of conditions created by a parent or other person legally responsible for the child’s welfare, or by the failure of a parent or person legally responsible for the child’s welfare to adequately supervise or protect him or her.

^{A1} Many of the terms in this Glossary of Terms appeared in the original 1999 “Guidelines for Psychological Evaluations in Child Protection Matters” (APA, 1999). As noted in those Guidelines, many definitions contained in this glossary were taken from *Working With Courts in Child Protection* (National Center on Child Abuse and Neglect, 1995).

(Appendix continues)

Out-of-home care: child care, foster care, or residential care provided by persons, organizations, and institutions to children who are placed outside of their families, usually under the jurisdiction of Juvenile/Family Court.

Petition: a formal written application to the court requesting judicial action on a particular matter.

Protection order: may be ordered by the judge to restrain or control the conduct of the alleged maltreating adult or any other person who might harm the child or interfere with the disposition.

Review hearing: held by the Juvenile/Family Court to review dispositions (usually every 6 months) and to determine the need to maintain placement in out-of-home care and/or court jurisdiction of a child. Every state requires state courts, agency panels, or

citizen review boards to hold periodic reviews to reevaluate the child's circumstances if s/he has been placed in out-of-home care. Federal law requires, as a condition of federal funding eligibility, that a review hearing be held within at least 18 months from disposition, and continue to be held at regular intervals to determine the ultimate resolution of the case (i.e., whether the child will be returned home, continued in out-of-home care for a specified period, placed for adoption, or continued in long-term foster care).

Termination of parental rights hearing: formal judicial proceeding where the legal rights and responsibility for a child are permanently or indefinitely severed and no longer legally recognized and where the state assumes legal responsibility for the care and welfare of the child.