

CREATING A COMPREHENSIVE PSYCHOSOCIAL: A GUIDE

This suggested psychosocial format concisely relates the information that HRA's Customized Assistance Services needs to determine eligibility on the HRA 2010e, or for the SPOA Case Management/ACT program to determine an individual's eligibility for services on the Universal Referral Form. Remember to keep the original and send *readable* copies of all documents.

PARAGRAPH ONE: Identifying data.

- Full name, age, race, marital status
- Length of time in current shelter, program, or hospital
- Usual appearance including physical build, dress, neatness, any distinctive points
- Type of financial and medical benefits; indicate whether current or pending

PARAGRAPH TWO: Brief Social History.

- Background information on applicant: birthplace, structure of family at birth, who raised applicant, number of siblings, history of foster care, what life was like for the person as s/he was growing up
- Identification of any family problems experienced in family of origin and in own family
- Marital status and marital history including ages, whereabouts and legal status of any children
- Legal Actions Pending

PARAGRAPH THREE: Education and Work History.

- Highest grade completed; indicate if special education classes; include vocational training
- Brief overview of employment history; including dates and nature of work
- Specify any goals concerning further schooling or vocational training

PARAGRAPH FOUR: Psychiatric, Medical and Substance History.

- In-patient psychiatric hospitalizations; include name of medical center/clinic, length of stay, precipitating factors if known
- Indicate any out-patient psychiatric treatment; include name of clinic and/or practitioner
- History of homicidal or suicidal ideation or behavior; include dates, precipitating factors
- History of use of alcohol/substances as well as any treatment; indicate length of abstinence
- Current medication regimen; include compliance, current ability to manage medication
- Outstanding medical problems and treatment

PARAGRAPH FIVE: Housing History

- List prior housing, including independent housing, mental health placements and episodes and causes of homelessness (if known) including shelter and non-shelter homelessness. Use dates/lengths of stay in housing and shelters. If non-shelter using homeless (parks/streets/public places) provide any specific details including dates, locations and source of information.

PARAGRAPH SIX: Current Situation.

- Indicate current level of functioning, specifying ability to perform activities of daily living
- If on an inpatient unit, describe applicant's behavior, compliance with routines and willingness to accept treatment
- Describe motivation to follow through with psychiatric, medical and substance abuse treatment
- Indicate any changes in behavior and/or insight into treatment needs that supports placement in the community
- Include level of assistance applicant will need once housed

PARAGRAPH SEVEN: Summary and Recommendations

- Highlight applicant's outstanding features, i.e., pleasant, cooperative, motivated, etc.
- If applying for supportive housing, a summary of why client is a good candidate

SOME CONSIDERATIONS WHEN DOING A HOUSING PSYCHOSOCIAL

- Try to find a place where you and the applicant can talk without being overheard by others, and where you will not be interrupted. Because shelters may offer little privacy, you may wish to arrange to talk outside, such as in a park or in a coffee shop.
- Remember the information for a psychosocial comes ideally over time with trust and comfort with the worker. Don't try to get it all in one sitting
- It is strongly recommended that the applicant be involved in the creation of the psychosocial. It's his/her life and he/she will make the ultimate choice as to where and how to live, or which services they choose to receive. You are participating in this process together. Where possible, let the applicant participate in the construction and editing. It is also recommended that the applicant see the psychosocial before it is sent out.
- Try to remain judgment free. The applicant is going to be checking your responses to what is being said and how he/she is being evaluated. If you indicate negative attitudes about what is being related, the person is going to be less likely to give accurate or complete information.
- Respect the person's pain and privacy. We probe some very personal areas of their lives as a pre-requisite to creating a psychosocial. Some people may find these questions invasive or too upsetting to deal with. Pay attention to body language. Are you getting too many "I don't know's"? You may have gone far enough on the topic and may well switch to a more neutral tone, or stop altogether.
- Some people are poor historians, and this can be problematic. Some applicants can't or won't remember some details, areas of discussion, or whole decades of time. This may be conscious or unconscious, plain resistance or genuine absence of memory. You may not be able to get certain pieces of information that any housing or service provider will ask. Refrain from pushing too much in certain areas, or guessing. As workers, we gather information from charts, from the applicant and, again, from our own observations and work with the individual. It is important to note where information came from especially if there is a discrepancy between the views or statements of different parties. Some examples of ways to word discrepancies or gaps in information are:
 - Applicant states that...It is the author's observation that...
 - There is no information available on...
 - The applicant is a poor historian on specific dates but it can be determined that...
 - According to past reports...Applicant denies (or disagrees with) this, however...
- For some people, putting together a time line or other visual aid is very helpful to help piece together missing information.