

Housing Resource Center (HRC)

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INTRODUCTION TO THE MENTAL HEALTH REPORT

In order to complete the HRA 2010e supportive housing application, a comprehensive psychiatric evaluation and psychosocial summary are currently required. However, when you begin to file your HRA applications electronically, you may instead use the Comprehensive Mental Health Report (MHR), which provides psychiatric and psychosocial information on one form. You will be able to enter the required components of the psychiatric evaluation and psychosocial summary in a multi-tab form and have the data print in a report format. Referring agencies can elect to submit a Comprehensive Mental Health Report, or submit the psychiatric evaluation and psychosocial summary separately.

What are the benefits of using the Comprehensive Mental Health Report?

- Provides a template that guides you in documenting the necessary psychiatric and psychosocial information for a supportive housing application.
- Provides uniformed detailed psychiatric and psychosocial information to supportive housing providers.

Important Points about the Comprehensive Mental Health Report (MHR)

The MHR combines the different components contained in a psychiatric evaluation and psychosocial summary into a single page with multiple tabs that include: History; Mental Status; Diagnosis; Recommendation; Formulation; and Verification.

History Tab

The History tab contains psychiatric, medical, substance abuse and socioeconomic history for a client. To make it easier to provide the right amount of information in the related category, the History tab was separated into sub-categories and includes Presenting Problems; Psychiatric History; Substance Abuse; Medical; Family; Social Relations; Education/Employment; Legal/Criminal; Housing/Homeless.

Presenting Problems

Enter all known information regarding applicant's *Presenting Problems*.

Psychiatric History

Provide information regarding inpatient psychiatric hospitalizations; include name of medical center/clinic, length of stay, precipitating factors if known. Indicate any outpatient psychiatric treatment; include name of clinic and/or practitioner. Provide details regarding any present or historical of homicidal or suicidal ideation or behavior; include dates, precipitating factors. Provide current medication regimen; include compliance, current ability to manage medication. 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; if currently hospitalized also provide the reason for admission; clinical course. Describe motivation to follow through with psychiatric treatment. Indicate any changes in behavior and/or insight into treatment needs that supports placement in the community.

Substance Abuse

Detail history of use of alcohol/substances as well as any treatment; indicate length of abstinence. Indicate current level of functioning, specifying ability to perform activities of daily living. Describe motivation to follow through with substance abuse treatment. Indicate any changes in behavior and/or insight into treatment needs that supports placement in the community. If currently hospitalized, reason for admission; clinical course, clean time.

Medical History

Provide information regarding outstanding medical problems and treatment. Review current medication regimen; include compliance, current ability to manage medication. Describe motivation to follow through with medical treatment.

Family History

Provide background information on applicant: birthplace, structure of family at birth, who raised applicant, number of siblings, and any history of foster care, what life was like for the person as s/he was growing up. Identify any family problems experienced in family of origin and in own family.

Social Relations

Provide information regarding marital status and marital history including ages, whereabouts and legal status of any children.

Education and Employment

Indicate highest grade completed; indicate if special education classes; include vocational training. Provide a brief overview of employment history; including dates and nature of work. Specify any goals concerning further schooling or vocational training.

Legal and Criminal

Enter information on any past or present criminal justice system involvement and any legal actions pending.

Housing and Homeless

List prior housing, including independent housing, mental health placements and episodes and causes of homelessness (if known) including shelter and non-shelter homelessness

Mental Status Tab

The Mental Status tab contains information gathered during the formal examination process that describes a patient's behavior during the interview. The behavior that is documented includes Appearance, Motor Activity, Affect, Mood, Speech, Thought Form, Thought Content, Cognitive Testing, Insight, Judgment, and Impulse Control.

Diagnosis Tab

List all Clinical disorders and other conditions that may be a focus of clinical attention as defined in the DSM-IV-TR or DSM-5.

Recommendation Tab

The Recommendation tab contains relevant treatment and service recommendations that are needed to stabilize the patient. Include recommendation/assessment for model/type of housing where appropriate. This is especially important for individuals in institutions who may do well in an apartment (supported housing or apartment treatment) yet have been in a hospital/prison.

Formulation Tab

The Formulation tab contains information that addresses all relevant issues including but not limited to diagnosis, prognosis, current mental status, treatment compliance, and housing readiness.

Verification Tab

The Verification tab contains a statement confirming that your agency has a comprehensive mental health report completed or updated within the last 90 days and signed by a licensed psychiatrist, licensed psychiatric nurse practitioner, licensed psychologist, or a licensed clinical social worker.