



**MONTANA STATE HOSPITAL
FORENSIC MENTAL HEALTH FACILITY
POLICY AND PROCEDURE**

**SOCIAL ASSESSMENT FOR THE
FORENSIC MENTAL HEALTH FACILITY**

Effective Date: February 1, 2016

Policy #: MSH FMHF-11

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- I. PURPOSE:** To clarify policies, standards, and procedures for social assessments of patients at the Montana State Hospital (MSH) Forensic Mental Health Facility (FMHF).
- II. POLICY:**
 - A. MSH social workers are organized under the Social Services Department and supervised by the Social Work Manager, who is a licensed master's level social worker.
 - B. In the provision of routine care, social workers obtain written authorization for the release of confidential information from the patient or guardian. In emergency situations, when the patient's health and safety are critical, the social worker may release essential information without written authorization in order to guide or secure emergency care. Social workers may obtain information from sources that spontaneously offer information about the patient, but will avoid acknowledging whether the patient is at the hospital or not until a written authorization for the release of confidential information is obtained.
 - C. Patients have the right to refuse interviews and social assessment procedures. Social workers will explain the purpose of social assessments and the potential use of the information collected. Social workers will attempt to obtain informed consent for the social assessment. Refusal of social assessment interviews and procedures will be documented in the medical record.
 - D. Social workers attempt to collect social information from multiple sources, assess the reliability of the information received, and document the perceived reliability in order to develop effective treatment, discharge, and aftercare plans.
 - E. Social workers provide social assessments in a timely manner.
 - F. Social workers adhere to federal, state, and professional standards for social assessments.

- G. Social assessments are documented in a timely manner and become part of the patient's paper or electronic health record.
- H. MSH treatment teams incorporate a patient's social history and assessment results into the treatment, discharge, and aftercare plan.
- I. Social workers will document new or more accurate information as it becomes available. New information will be documented in the medical record and reported to the treatment team.
- J. Upon a patient's readmission, social workers may access prior social assessments but must update the information and reassess the patient's current status, functioning, and needs.
- K. The Director of Quality Improvement collaborates with the Social Work Manager to develop, implement, and monitor a program of quality assurance and performance improvement related to social assessments.

III. DEFINITIONS:

- A. Social Assessment – the process of assessing the social condition and functioning of a patient. The process includes standard methods of obtaining information, interviewing patients, interviewing others, and documenting the results.

IV. RESPONSIBILITIES:

- A. Social Worker – initiate the social assessment process; interview the patient; obtain authorization for the release of confidential information; interview the guardian, family members, or significant others; complete social assessment reports; consult with treatment teams about the social assessment and identified patient needs; and update assessments as indicated.
- B. Social Work Manager – understands standards for social assessments; trains and supervises social workers who conduct social assessments; monitor timeliness and quality of social assessments; assists social workers with performance improvement, and consults with the Director of Quality Improvement.

V. PROCEDURE:

- A. Social Assessment:
 - 1. The FMHF Unit Program Manager, or designee, will assign each patient a social worker upon admission.

2. The assigned social worker will immediately initiate the social assessment procedure, which will include:
 - a. Reviewing social information obtained in the petition for commitment, legal proceedings, preadmission screening, nursing assessment, health assessment, and psychiatric assessments.
 - b. Meeting with and attempting to interview the patient in order to:
 - i. Introduce themselves to the patient.
 - ii. Clarify the social work role and responsibilities.
 - iii. Notify them of patient rights.
 - iv. Notify them of the grievance process.
 - v. Describe the social assessment process, assessment procedures, and potential uses of the social information and assessment results.
 - vi. Attempt to obtain informed consent for the social assessment. A patient has the right to refuse assessment procedures.
 - vii. Obtain social information necessary for treatment, discharge, and aftercare planning.
 - c. Identifying potential sources of information. These may include, but are not limited to patient, guardians, family members/significant others, close personal friends, community treatment providers, courts, criminal justice officials, or others as indicated.
 - d. Obtaining written authorization for the release of confidential information from the patient or guardian in order to enable the sharing of relevant information with others involved in the patient's life, treatment, and aftercare.
 - e. With authorization, calling or writing potential sources of information to request information necessary for the social assessment.
 - f. Collecting factual and historical information in all of the following categories:
 - i. Identifying information
 - ii. Date and reason for admission
 - iii. Date and type of commitment
 - iv. Guardianship
 - v. Advanced directives
 - vi. Sources of information
 - vii. Current and recent living situation, social supports, and mental health services
 - viii. Current and recent high risk psychosocial issues
 - ix. Reported strengths, assets, resources, supports
 - x. Reported deficits, disabilities, limitations
 - xi. Family history
 - xii. Ethnic and cultural history

- xiii. Educational history
 - xiv. Religious and spiritual history
 - xv. Marital history
 - xvi. Vocational and employment history
 - xvii. Military history
 - xviii. Medical history
 - xix. Psychiatric history
 - xx. Trauma history
 - xxi. Substance use history
 - xxii. Legal history
 - xxiii. Family history of physical, mental, substance-related, and other heritable disorders or conditions
- g. Assessing the patient in all of the following categories:
- i. Level of participation and cooperation with the social assessment
 - ii. Reliability of the information provided, for each source of information
 - iii. Patient's perceived strengths, assets, resources, supports
 - iv. Patient's perceived deficits, disabilities, and limitations
 - v. High risk psychosocial issues requiring immediate intervention
 - vi. Anticipated steps necessary for discharge to occur
 - vii. Adequacy of available community treatment providers, supports, resources, insurance, housing, income
 - viii. Anticipated needs for social services and recommended interventions (assistance with treatment, discharge, and aftercare planning and implementation)
3. The social worker will document the social history and assessment using the Social Assessment report format (Attachment A).
4. The social worker will complete the Social Assessment report, in a paper or electronic document within fourteen (14) days of the patient's admission in order to assist the treatment team with the development of treatment, discharge, and aftercare plans.
- a. The social assessment document is divided into sections which move logically from identifying current information, through historical patient and family data, to assessment conclusions, and finally, to recommendations for treatment and discharge planning.
 - b. Sections devoted to current and historical information present facts as objectively as possible and will avoid subjective opinions or commentary.
 - c. Perceptions, opinions, and comments should be documented in the assessment, conclusions, and recommendations section.

SOCIAL ASSESSMENT
MONTANA STATE HOSPITAL

SECTION 1: IDENTIFYING INFORMATION, DIRECTIVES, NOTIFICATIONS, AND AUTHORIZATIONS

A. Identifying Information:

Name: _____
MSH Number: _____
Birth date: _____
Date of Admission: _____
Type of Commitment: _____
Legal Guardian/phone number: _____
Payee/phone number: _____

B. Advance Directives:

C. Notification of Patient Rights and the Grievance Process:

D. Sources of Information:

E. Preferences for Releases of Information:

Signed release date:

SECTION 2: FACTUAL AND HISTORICAL INFORMATION:

A. Reason for Admission, Presenting Problems, and Reported Problems:

B. Current or Recent Living Situation:

C. Current or Recent Social Supports and Resources:

D. Current or Recent Mental Health Services and Care Providers:

E. Current or Recent High-Risk Psychosocial Issues Needing Immediate Attention:

F. Reported Individual Strengths and Assets:

G. Reported Deficits, Disabilities, and Limitations:

H. Family History:

I. Ethnic and Cultural History:

J. Educational History:

K. Religious and Spiritual History:

L. Marital History:

M. Vocational and Employment History:

N. Military History:

O. Medical History:

P. Psychiatric History:

Q. Trauma History:

R. Substance Use History:

S. Legal History:

T. Family History of Physical, Mental, Substance-Related, and Other Heritable Disorders or Conditions:

SECTION 3: SOCIAL ASSESSMENT, CONCLUSIONS, AND RECOMMENDATIONS

A. Level of Participation and Cooperation with Social Assessment:

B. Reliability of Information by Source:

C. Patient's Strengths, Assets, Resources, and Supports:

D. Patient's Deficits, Disabilities, and Limitations:

E. High Risk Psychosocial Issues Requiring Immediate Intervention:

F. Anticipated Steps Necessary for Discharge:

G. Adequacy of Available Community Treatment Providers, Supports, Resources, Housing, Insurance, and Income:

H. Anticipated Need for Social Services and Recommended Interventions

1. Treatment Plans

2. Discharge Plans

3. Aftercare Plans

(Insert name) _____, (insert degree)

Social Worker

(Insert unit)

Montana State Hospital

Signature:

Date/Time:

