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

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.

5. Information that social workers receive after the completion of the Social Assessment report will be documented in the progress notes or in an addendum to the Social Assessment.

6. Social workers will reassess a patient's functioning, needs, and plans during the treatment plan review periods specified in policy (MSH FMHF # TX-12). The results of the reassessment will be documented in the medical record.

B. Forensic Social Assessments: The assigned social worker will work closely with the forensic psychiatrist and psychologist to obtain the comprehensive background information necessary for a forensic evaluation. The forensic social assessment will include similar information as the social assessment described above, but will also include additional information as requested by forensic evaluators. The forensic social worker will prepare assessments and documents with the understanding they may be called to court to testify about their opinions, assessment, or documentation.

VI. REFERENCES: Federal standards: 42 CFR 482.61; 42 CFR 482.62; State standards: §53-21-162; §53-21-165; §53-21-180. Professional standards: National Association of Social Workers (Ethical standards). Administrative Rule of Montana 37.106.1915 and 37.106.1621.

VII. COLLABORATED WITH: Hospital Administrator, Medical Director; Director of Clinical Services; Social Work Manager.

VIII. RESCISSIONS: None, new MSH FMHF policy.

IX. DISTRIBUTION: All MSH FMHF policy manuals.

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: MSH Social Work Program Manager.

XII. ATTACHMENTS: For internal use only.

A. Social Assessment

Signatures:

John W. Glueckert
Hospital Administrator

Thomas Gray, M.D.
Medical Director