



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

INITIAL AND ANNUAL SOCIAL ASSESSMENTS

Effective Date: April 13, 2016

Policy #: SS-01

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- I. PURPOSE:** To clarify policies, standards, and procedures for social assessments of patients at Montana State Hospital (MSH).
- II. POLICY:**
 - A. MSH social workers are organized under the Social Services Department and supervised by the Social Work Manager, who is a licensed clinical social worker and/or 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 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. (covered in F below) Social workers adhere to federal, state, and professional standards for social assessments.
 - F. Social assessments are documented in a timely manner and become part of the patient's paper or electronic health record.
 - G. MSH treatment teams incorporate a patient's social history and assessment results into the treatment, discharge, and aftercare plan.

- H. 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.
- I. 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.
- J. 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 Treatment 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 categories noted in Attachment A:
3. The social worker will document the social history and assessment using the Initial Social Assessment report format (Attachment A).
4. The social worker will complete the Initial Social Assessment report, in a paper or electronic document within seven (7) 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 Initial Social Assessment report will be documented in the progress notes or in an addendum to the Initial Social Assessment.
6. Social workers will reassess a patient's functioning, needs, and plans during the treatment plan review periods specified in MSH policy TX-12. The results of the reassessment will be documented in the medical record.

**Montana State Hospital
Initial Social Assessment**

Identifying Information

Name:

MSH Number:

Birthdate:

Admit Date:

Commitment Type:

Guardianship & or POA Contact:

Payee Contact:

Advance Directives:

Notification of Patient Rights and Grievance Process:

Sources of Information & Reliability:

FACTUAL & HISTORICAL INFORMATION

Reason for Admission:

Past and Present Summary of Functioning:

Developmental, Family & Marital History:

Religious/Cultural History:

History of Physical, Emotional or Sexual Abuse:

Psychiatric History:

Medical History:

Alcohol/Substance Use History:

Education & Employment History:

Military History:

Criminal History:

Past & Present Community Resources Utilized:

Past & Present Living Situation/Environmental Needs:

Financial History/Environmental Needs:

FAMILY MEDICAL HISTORY

Medical History

Psychiatric History

Substance Abuse History

Incarceration History

SOCIAL EVALUATION

Identified Strengths & Challenges:

Identified High Risk Psychosocial Issues and follow up:

CONCLUSIONS & RECOMMENDATIONS

Anticipated steps for discharge to occur from MSH:

Community Resources and Support Systems to use in Discharge Planning:

Anticipated SW role in Treatment Planning and Discharge Planning:

Signature/Credentials

Date

Montana State Hospital Annual Social Assessment

Identifying Information

Name:

MSH Number:

Birthdate:

Admit Date:

Commitment Type:

Guardianship & or POA Contact:

Payee Contact:

Advance Directives:

Notification of Patient Rights and Grievance Process:

Sources of Information & Reliability:

FACTUAL & HISTORICAL INFORMATION

Reason for Admission:

Brief Summary of Functioning over past year:

Developmental, Family & Marital History:

Religious/Cultural History:

History of Physical, Emotional or Sexual Abuse:

Psychiatric History:

Medical History:

Alcohol/Substance Use History:

Education & Employment History:

Military History:

Criminal History:

Past & Present Community Resources Utilized:

Past & Present Living Situation/Environmental Needs:

Financial History/Environmental Needs:

FAMILY MEDICAL HISTORY

Medical History

Psychiatric History

Substance Abuse History

Incarceration History

SOCIAL EVALUATION

Identified Strengths & Challenges:

Identified High Risk Psychosocial Issues and follow up:

CONCLUSIONS & RECOMMENDATIONS

Anticipated steps for discharge to occur from MSH:

Community Resources and Support Systems to use in Discharge Planning:

Anticipated SW role in Treatment Planning and Discharge Planning: