

NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER <u>Health Services</u> STATEMENT NUMBER <u>6.04</u>
SUBJECT: SOCIAL HISTORY – SECURE PSYCHIATRIC UNIT PROPONENT: <u>Robert MacLeod, Administrative Dir.</u> <i>Name/Title</i> <u>Medical/Forensic Services 271-3707</u> <i>Office Phone #</i>	EFFECTIVE DATE <u>03/01/08</u> REVIEW DATE <u>03/01/09</u> SUPERSEDES PPD# <u>6.04</u> DATED <u>02/01/06</u>
ISSUING OFFICER: <hr/> <i>William Wrenn, Commissioner</i>	DIRECTOR'S INITIALS _____ DATE _____ APPENDIX ATTACHED: YES _____ NO _____
REFERENCE NO: See reference section on last page of PPD.	

I. **PURPOSE:**

To provide guidelines governing the social assessment of persons admitted to the Secure Psychiatric Unit.

II. **APPLICABILITY:**

To all Social Workers and residents of the **SECURE PSYCHIATRIC UNIT**

III. **POLICY:**

It is the policy of the Secure Psychiatric Unit to require the preparation of a summary admission report for all new admissions to the unit. The report shall include but not be limited to:

- A. Account of the legal aspects of the case
- B. Summary of criminal history
- C. Social history
- D. Medical, dental, and mental health history
- E. Occupational interests and experience
- F. Educational status and interests
- G. Recreational preference and needs assessment
- H. Psychological evaluation
- I. Staff recommendation
- J. Pre-institutional assessment information

IV. **PROCEDURES:**

- A. A social history shall be conducted and reported in the medical record within ten (10) days of the resident's admission. In the event of lack of resident cooperation in providing psychosocial data adequate to allow assessment, a progress note should be entered describing the circumstance and the plan for follow-up. If the resident is discharged within the first ten (10) days and no history has been obtained, justification for lack of the history shall be documented.
- B. A social history shall be conducted and reported by personnel privileged to provide this service. Authentication of reports shall be by the clinician conducting the history and

- assessment process and shall include co-signature by the supervising clinician if conducted and reported by an individual acting in the capacity of a social worker.
- C. In the event of the re-admission of a resident within 12 months or less since the previous admission, an interim assessment shall record the psychosocial aspects of the resident's life since the last discharge and shall update the psychosocial dynamics (e.g. changes of employment, living conditions and habits, marital status) that have transpired also since the last discharge. A copy of the previous history shall be included with the interim assessment.
 - D. Updated histories shall be performed and recorded every year.
 - E. A social history shall be filed in the Psychosocial Assessment section of the ward chart. All interim assessments including yearly updates, shall be filed on top of the most recent history. Everything else in the chart is filed in book order, not most recent on top.
 - F. In all cases, other than for an interim assessment, it is suggested that the following format and content guide shall be followed in documenting the social history and assessment.
 1. Legal aspect rationale, or reason for gathering history
 2. Identification information to include:
 - a. Age
 - b. Sex
 - c. Ethnic/cultural background
 - d. Marital status
 - e. Living arrangements
 - f. Environment and home
 - g. Religion
 - h. Present family situation
 - i. Physical appearance
 - j. Level of functioning
 3. Childhood history
 4. Military service history
 5. Sources of information (informants) and their attitudes toward the resident
 6. Review of systems to include:
 - a. Pre-natal history
 - b. Post-natal development
 - c. Childhood history
 - d. Medical status to include history of any recent or past head trauma
 - e. Social status
 - f. Educational status
 - g. Vocational status
 - h. Familial status
 - i. Socio-economic status
 - j. Financial status
 - k. Legal and criminal history
 7. Drug and alcohol abuse by the resident and among other members of the individual's family or household; include history of prescribed and over-the-counter drug usage.
 8. Evaluation of the characteristics of the social, peer-group and environmental settings from which the resident comes.
 9. Evaluation of the resident's family circumstances to include:
 - a. The constellation of the family group
 - b. The family's current living situation
 - c. Social, religious, ethnic, cultural, financial, emotional and health factors
 10. Evaluation of the family's expectations regarding the resident's treatment, the degree to which they expect to be involved, and their expectations of the type of treatment required.
 11. Summary, including impressions.
 12. Recommendations.

G. Notations shall be made in the progress notes when the social history has been completed.

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition Standards

Standards for Adult Correctional Institutions
Fourth Edition Standards

Standards for Adult Community Residential Services
Fourth Edition Standards

Standards for Adult Probation and Parole Field Services
Third Edition Standards

Other

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