but are already therapeutically active in the USA. Finally, what role can the College take in all this? In order to supervise trainees in these methods, more consultants are needed with a background in general psychiatry *and* experience in BCPT. In order to provide these consultants for the future, senior registrar posts are urgently required with specialist training in BCPT if our profession is to move with the times.

Acknowledgements

I am grateful to the following for commenting on this manuscript: Drs M Crowe, M. Fernandez, L. Drummond, D. Veale and Professor J. Watson.

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Psychiatric Bulletin (1993), **17**, 4–7

The Social State

A proposed new element in the standard psychiatric assessment

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As psychiatry broadens its perspective beyond a predominantly hospital focus, the tools of its trade need some reshaping to serve the needs of an altered working environment. The instrument indispensable to every psychiatrist is the scheme for assessment, comprising history-taking and examination of the mental (and physical) state. Honed by long familiarity and usage, its employment is the fundamental skill demanded of aspirants to medical practice and to psychiatry.

In this article we identify one way in which the scheme for assessment falls short of present-day requirements, and we suggest a remedy. We aim to stimulate debate and, more ambitiously, to introduce modifications of sufficient value to be incorporated into everyday practice and teaching.

A need for change

Today, the most severe weakness of the assessment scheme is that it gives inadequate emphasis to the social dimension in history-taking and assessment. The inadequacy is particularly evident in domiciliary settings and in multidisciplinary team-work and rehabilitation, but it is becoming more evident in acute hospital psychiatry, too, with increasing awareness of the continuity of the patient's life outside hospital. The need for such awareness is emphasised in new directions in policy, such as the White Paper on community care (Department of Health, 1989) and the Royal College of Psychiatrists' (1989) guidelines for aftercare.

The present scheme is not well geared to the assessment of a person living within a continuing milieu of home and family: its focus is the assessment of a patient who is newly seen in a hospital or clinic, and its perspective implies assumptions that problems lie primarily within patients' mental and physical functioning rather than in their interactions with the environment.

We recognise an urgent need for an additional element within the assessment scheme, of similar status to the History, Mental State and Physical Examination, which we call, in order to give it a distinctive title, the Social State. Like the other three elements, it is clinically elicited, expansible and susceptible to revision over time. It, too, needs an agreed basic format, set out under a small number of main headings.

A difference from the other three components is that it contains both reported historical data and evaluative assessments, although these two types of record are kept separate to avoid confusion between reported fact and the assessor's opinion.

The aim is to give greater emphasis and depth to assessment of the patient's immediate social environment, the changes which may be associated with mental disorder, the needs which may exist and be met or unmet, and the possibilities for alleviation.

The choice of format

The development of psychiatry in the community and the closure of mental hospitals have fostered a profusion of schemes for evaluating aspects of social behaviour, functioning and quality of life. Carson (1991) has provided a valuable review of such instruments. Our aim is different, since the standard scheme for psychiatric assessment is not a rating-scale but a structured outline for descriptive reporting, which needs to be compact in form, generally applicable in all types of assessment, easily located in the case-notes, and wide-ranging in its outlook. We need a clinical instrument, a framework to help us organise and record our perceptions and evaluations.

The Social State provides a structure of five main headings, for each of which four main categories of information and assessment can be reported. These categories may be treated as columns in a matrix, as shown in Fig. 1. In practice, the information may be written in columnar form or sequentially down the page.

The structure is kept simple in order to emphasise that every psychiatric assessment should include a mention of at least the five main headings, and to avoid duplication with other parts of the History and Mental State. The four categories or columns will not all be needed if significant problems are absent. The format must allow for the possibility that only a very brief or highly distilled report will be required (or feasible) in some cases, while others may require a lot of detailed information.

The scheme is directed at the patient's usual residential and social environment. For an out-patient or acutely admitted in-patient the Social State refers to their normal home setting (even if it is a doorway in the street) rather than the place in which the patient is examined. For a long-stay hospital patient, the usual home environment will initially be the ward.

	Facts	Problems		Services	Strengths
		Subjective	*Objective*		
ACCOMMODATION					
FINANCES					
HOME ACTIVITIES					
OUTSIDE ACTIVITIES					
CARERS Informal					
Professional					

FIG. 1. The Social State: the basic matrix

https://doi.org/10.1192/pb.17.1.4 Published online by Cambridge University Press

The basic scheme is as follows:

The five main headings

Accommodation

Under this heading are described the physical nature of the patient's residence and the identity of the people who normally provide the immediate social environment. The aim is to assess the type and quality of physical resources available to the patient in the home and to name the people who share the accommodation.

Subheadings include:

- type of accommodation
- physical amenities, personal space
- quality of accommodation
- identity of other people sharing the accommodation
- ease of access
- physical security
- nature and quality of neighbourhood.

Finances

This requires a description of the patient's financial status and use of welfare benefits, in order to assess income, monetary assets, liabilities and capacities to handle money.

Subheadings include:

- sources of income (including welfare benefits)
- capital
- expenditure (including special liabilities such as gambling)
- debts (including threats of punitive action such as withdrawal of services or eviction)
- budgeting capacity.

Home activities

The focus here is on daily events and activities within the home and the provision of both informal and professional support and services from people visiting the home.

Subheadings include:

- way of spending a typical day (includes waking and rising, daily routines)
- daily living skills (including personal hygiene, laundry, cooking, cleaning)
- recreational activities
- visitors
- relationships with immediate neighbours.

Outside activities

The patient is seen in relationship to the local and wider community outside the home residence.

Subheadings include:

- occupation
- social contacts (family, friends, others)
- shopping
- travel
- use of public amenities (e.g. pubs, cinema)
- other outside leisure activities
- religious observance
- holidays.

Carers

Under this heading are listed the people who are individually identifiable as accepting a special responsibility for promoting and sustaining the patient's welfare. They may include family members, friends, other informal contacts and members of professional agencies.

Subheadings include:

(a) Informal carers

- Caring relatives and friends
- relationships with other people within the home and local community
- attitudes to patient reported by others (or observed by assessor) within home.

(b) Professional carers

- Staff members of NHS agencies (GP, psychiatric services etc – and relationships with them)
- staff members of other statutory agencies (social services etc)
- members of voluntary bodies (including religious organisations, etc).

The four columns: FACTS – PROBLEMS – SERVICES – STRENGTHS

Each of the headings is to be reported under four categories, or columns in the matrix.

The first, entitled FACTS, aims to record the situation in terms of reported objective information from the patient or identified others (including the assessor).

The second, PROBLEMS, comprises two kinds of element, which may be reported separately: subjective difficulties reported by the patient and objective difficulties observed by others.

The third, SERVICES, reports provisions already made at the time of assessment to alleviate some, but not necessarily all, the problems identified. Inadequacies or overprovision may be commented on, but this area of the assessment report is not the place to record proposals about management.

The fourth, STRENGTHS, invites the assessor to report on positive features of the patient's social opportunities and functioning, which may serve to

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counterbalance the commonly prevailing negative tone of many psychiatric assessments by highlighting positive resources, relationships and potentialities.

The first four of the five main headings relate to different categories of service provision which may be needed, namely housing, finances, domiciliary services able to visit the patient and services outside the home to which the patient must travel. The fifth heading provides a summary of informal carers (such as family, partners and friends) and professional staff (including, if appropriate, a care manager and key-worker) who currently have a personal responsibility for the patient, together with details about their relationships with the patient and their views on the patient's situation, behaviour and problems.

Where should the Social State be reported?

The Social State should be recorded after the History and before the Mental State examination. In this position it supplants and extends the information which may at present be recorded in the history, partly under *previous personality* and partly under *social history* or *current circumstances*.

The Social State's incorporation of both reported data and observations made by the assessor makes it an appropriate bridge between the history and the examination of mental and physical state, and it also provides a suitable backdrop against which the mental state can be appraised.

Our scheme does not include management proposals within the Social State. They should be recorded later as part of a treatment plan, listing recommendations about social management under the same headings used in the Social State.

The way forward

The Social State provides an overdue enhancement, appropriate to the psychiatry of today. It offers a simple outline to a complex diversity of possible elements of information and assessment, which lends itself equally well to multidisciplinary teamwork, computerised data-entry or professional examinations.

We hope our colleagues will assist us in putting our proposals to practical test.

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Mental Health Nursing Review

The Review Team for the Mental Health Nursing Review is in the process of collecting evidence from all areas of mental health nursing in order to report on how best, in the interest of patient care, to equip and deploy valuable nursing resources. The team will also identify how mental health nursing is able to respond fully to the needs of individuals in a variety of settings.

The Review, which is being carried out by a multi-disciplinary team, reflecting the wide range of interests within the mental health field, will be concerned with all aspects of mental health and will examine practice, education, leadership, management, research, development, and consumer issues. It would be appreciated if readers wishing to draw any issues to the attention of the Review Team would send them to Clyde Lake Mental Health Nursing Review Team Secretariat, Room 533, Richmond House, 79 Whitehall, London SW1A 2NS not later than 29 January 1993. All information received will be treated in confidence.

https://doi.org/10.1192/pb.17.1.4 Published online by Cambridge University Press