include a critical review of a research paper. There is at the present time appropriate emphasis within the examination on understanding research methodology and having an adequate grasp of theory which underpins clinical work.

The authors will no doubt be disappointed that the Short Answer Question Paper is being discontinued after 1996 because if failed to discriminate satisfactorily between candidates.

John Cox, *Dean, Royal College of Psychiatrists*

Catchment areas: a model for the future or a relic of the past?

John M. Kellett

The shift of power from specialist services to the primary care teams has forced the former to examine the value of their hallowed traditions. In psychiatry, and geriatric medicine, the catchment area is a favoured restrictive practice, enabling demand to be regulated to suit the resources of each team. It is time to decide whether this is a practice to be defended and retained or whether, like many other restrictive practices, it is harmful to the consumer.

Origins

In the days of the workhouse it was appropriate to limit its use to the poor of the parish whose members subscribed to its upkeep. Generous parishes needed to be defended against the destitute vagrant from another area. So grew the notion of a catchment area, a notion that was promoted by the services which later occupied the poor law institutions. These services were under-funded as they were often regarded as of low priority and a device to limit demand was necessary if a service was not to be swamped.

Potential benefits and harm

Benefits

Responsibility for the difficult patient is clear.

Coterminosity promotes close liaison and cooperation with other services.

Each consultant team is guaranteed an adequate work-load.

Prevents over-specialisation.

Ensures contact with same team over time.

Harm

Prevents GP matching the specialist to the patient.

Reduces competition between consultants, thereby encouraging mediocrity.

Geographical boundaries do not fit with practice boundaries, thus preventing close liaison with a single general practice.

Discourages necessary specialisation.

Blocks opportunity to change specialist after bad experience.

Enforces change of specialist when moving house.

The above lists are clearly open to debate. Some would regard further specialisation as an inevitable consequence of the increasing sophistication of psychiatry, while others might regard this as a process which would accelerate burn-out. What cannot be denied is that the greater flexibility of open referral systems leaves more choice for the consumer.

https://doi.org/10.1192/pb.19.6.340 Published online by Cambridge University Press

Table 1. Use of catchment areas in Europe

Speciality	Country								
	B	D	F	H	L	N	R	S	Y
Child	3	1	1	3	3	1	1.5	3	2
Adult	3	1	1	2	3	1	2	3	2
Old age	3	1	2	2	3	1	1	3	3
Forensic	3	1	3		2	3	1	2	1
Eating	3	1	3	3	3	2	3	3	3
Sex	3	1	3	3	3	2	3	3	3
Psychotherapy	3	1	3	3	3	1	2	3	3
Rehabilitation	3	1	2	3	3	1	1	2	2
Liaison	2	1	1		1	1	1	3	1

Key: 1 fixed and rigid catchment area; 2 less defined catchment area; 3 no restriction of choice of specialist based on area of residence. B=Belgium, D=Denmark, F=France, H=Hungary, L=Luxembourg, N=Norway, R=Rumania, S=Switzerland, Y=Yugoslavia.

The current position

Although many academic units such as those at the Maudsley Hospital operate an open system, the vast majority of NHS services are organised on the basis of geographical areas. If such a system is essential to the effective organisation of psychiatric services, it is likely to be used elsewhere in Europe. A questionnaire was therefore sent to psychiatrists in the 17 countries listed by the Royal College of Psychiatrists (1992). Replies were received from Belgium, Denmark, France, Hungary, Luxembourg, Norway, Rumania, Switzerland, and Yugoslavia. As in the UK, in some specialities there is universal open referral (eating disorders, sexual dysfunction). In general adult psychiatry only two countries, Norway and Denmark, operate a scheme like our own while three (Belgium, Luxembourg and Switzerland) place no restrictions. France has a mixed system in which a team must see patients from its area but patients have no restriction of choice (Table 1).

Although no speciality is likely to be satisfied with its level of provision, the increase in numbers of psychiatrists over the past 50 years (from 520 in England and Wales in 1950 to well over three times that number today) (Department of Health, 1994, personal communication) has altered the nature of the service. No longer is it limited to severely psychotic patients who are unlikely to make an informed choice of team, but it is able to work closely with general practitioners to treat neurotic disorders in the community. The conditions which favoured the catchment area have passed.

The needs of general practice

We are all familiar with the criticism of the local doctor who is not sympathetic to psychiatry and is far more interested in doing sessions in the family planning clinic. When attempting to rehabilitate an apathetic patient we accept the importance of hands-on experience to stimulate interest, and of encouraging the patient to develop autonomy. We treat our colleagues as different species subject to different paradigms of learning. Much of the purpose of a locality-based service lies in its ability to take over complete care of the patient, kidnapping the sufferer from the family doctor. Instead of helping the GPs to care for their patients we deprive them of any control of their psychiatric service and imagine we are improving the psychiatric expertise of primary care.

Clearly there is a contrast between the needs of the GP and the expectations of the psychiatrist. Many of the old school are used to absolute autonomy, the patient remaining under the care of the specialist until he/she is returned to the GP, and the GP with an antipathy to psychiatry may well prefer such a system. Unfortunately the expense of calling in the multidisciplinary team is more likely to reduce referrals (Fear & Cattell, 1994), the GP either treating the patient directly or, more alarmingly, ignoring the problem. At no time has it been more important for the psychiatrist to share his/her skills with the primary team.

There are parts of the country where this debate is of little consequence. If one lives in Jersey or Orkney the local psychiatric service is unlikely to be able to offer much choice. However, when the highway to a more

https://doi.org/10.1192/pb.19.6.340 Published online by Cambridge University Press

equitable and efficient service of unchained GP referral is cleared, a herd of sacred cows is allowed to wander onto the road and graze on the central reservation, a herd with the label 'multidisciplinary team'.

Multidisciplinary team

There is no intrinsic reason why a multidisciplinary team should favour one or other system of referral. In my experience, however, the opposition to dropping the catchment area concept is deeply rooted within such teams. They involve the welding of different professions, all conscious of their professional hierarchies, independence, and work-load. Instead of the team uniting to compete to provide a better service, they find it easier to limit their objectives to a geographical concept. This avoids the issue of having a team leader to direct resources and reduces the fear of overwhelming demands. It also neutralises the fear of inter-team rivalry and conflict. The creation of subspecialties might lead to a split in the choice of objective. A team welded by specialisation would demand dynamic leadership.

The social worker is in a particularly ambiguous position, being like the workhouse manager employed by a locality-led employer. However, the majority of social workers are based in their community and hospital social workers already refer many of their patients to colleagues outside the hospital. Whether the patient is within or without the borough would seem to be of little import. Community care depends on team members visiting patients at home and there are advantages in reducing the amount of travelling, enabling staff to liaise regularly with local facilities, such as day centres and hostels. Again, people imagine that the loss of rigidity would lead to a free-floating service with no commitment to the locality. In practice the competition for trade would compel the team to improve local liaison services. As far as inter-team competition is concerned, our medical colleagues can cope with this without conflict. As always, the local team would take the majority of local referrals but those with special expertise could expand their clientele to the benefit of their trust, the patients themselves, and the morale of the team.

Comment

In the past the use of the catchment area to structure psychiatric services had considerable justification. There are no longer valid reasons for continuing this system. The catchment area concept is a restrictive practice which it behoves us to abolish, a shibboleth of community psychiatry which can no longer be justified, a relic of a previous era.

References

FEAR, C. F. & CATTELL, H. R. (1994) Fund-holding general practices and old age psychiatry. *Psychiatric Bulletin*, **18**, 263–265.

ROYAL COLLEGE OF PSYCHIATRISTS (1992) *Psychiatric Associations of the World*. Occasional paper no 14.

John M. Kellett, *Consultant Psychiatrist, Division of Geriatric Medicine, St George's Hospital Medical School, Jenner Wing, Cranmer Terrace, Tooting, London SW17 0RE*

https://doi.org/10.1192/pb.19.6.340 Published online by Cambridge University Press