The case for catchment areas for mental health services

Graham Thornicroft, Geraldine Strathdee and Sonia Johnson

The establishment of mental health teams which take responsibility for small geographical catchment areas has been a fundamental element in the planning of community services in most Western European countries over the last decade. This idea is challenged in the companion paper in this issue of *Psychiatric Bulletin* which refers to catchment areas as a "relic of the past". The case is put for catchment areas in terms of their planning, service delivery and quality advantages for the development of comprehensive inter-agency mental health services. In brief, it is argued that community mental health services are still in many areas poorly developed (Audit Commission, 1994; Faulkner *et al*, 1994), and that catchment areas are necessary but not sufficient for their fuller realisation.

The development of catchment areas

The early proponents of community care concentrated less on specifying the components of care than on developing the organisational framework within which such services could effectively be delivered. Phillipe Paumelle, working in Paris in the 1950s, formulated three essential principles: that services should provide for continuity, co-ordination and integration of care. To fulfil these requirements, he wrote that the planning and operation of services should take place at a defined local level. The concept of a 'sector' as the demonimator in local planning evolved and has subsequently gained wide support. Tansella (1991), in recognition of the vital role of such an infrastructure, reiterates that "what is important in community care is not only the number and characteristics of various services but the way in which they are arranged and integrated".

The first sectors emerged in France in the 1960s. In the USA the Community Mental Health Centres Act (1963) introduced the principle of a catchment area for each CMHC. In the 1970s sectors of varied sizes developed in Europe, from Germany with sectors of 250,000 to Sweden with 25–50,000. Italy most comprehensively adapted the concept by virtue of Law 178 which established sectors of 50–200,000 population.

Sectors are not only a concept of health services. In each local area in Britain, housing, social services and the police have geographically defined areas of responsibility. In planning services for the severely mentally ill it is necessary to ensure improved outcomes by implementing effective interventions in the following key areas: housing, welfare benefits, physical health, daily living skills, work and education. This can best be achieved by

Table 1. Planning advantages of catchment areas

Agreed inter-agency definition of the priority group
High identification rates of the severely mentally ill
Integrated care programme approach and care management
Clinical and social needs assessment
Development of a directory of local resources
Appropriate services for local needs
Joint planning of hospital and community beds
Inter-agency development of local day care
Development of work with local employers
Agreed protocols with local sector police
Potential for better knowledge of cost issues
Greater budgetary clarity

Table 2. Service delivery advantages of catchment areas

Minimise patients lost to follow-up
Individually tailored inter-agency patient reviews
Less use of crisis and in-patient facilities
Facilitates home treatment
Improved identity of staff with locality
Clarity of functions of district teams
Improved inter-agency communication patterns
Improved knowledge and use of community resources
Increased morale and support to all community agencies
Allows comparative research and evaluation

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Table 3. Service quality advantages of catchment areas

Improved patient education and intervention
Less use of crisis and emergency services
Use of appropriate adult protocols
Greater support of relatives and carers
Defined responsibility for each patient
Improved communication for staff, patients and carers
Improved primary–secondary care communication

Table 4. Factors for consideration in defining catchment area boundaries

Socio-demographic composition of population
Social deprivation indices
Ethnic composition
Geographical characteristics
Age–sex structure
Social services boundaries and approved social worker structure
Health centre/group practice location
GP referral rates and patterns
Knowledge of psychiatric morbidity
Extent of sheltered housing
Number of old/new long-stay patients
Presence of a large institution
Local government planning regulations
Neighbourhood housing office and police sector boundaries

effective inter-agency working between primary and secondary health services, housing and social services.

A number of advantages have been claimed for sectorised services (Strathdee & Thornicroft, 1992). The three primary arguments for catchment areas are that they fix responsibility for care with named staff, and that they encourage continuity of care and that they facilitate effective inter-agency working. Responsibility for each patient requiring a service is allocated to a specified team, which can make population and patient needs assessments, so minimising the number of patients lost to follow-up (Wing, 1992). In addition, the development of alternative types of sector team allows empirical investigation of their cost-effectiveness and acceptability. Where staff in the community agencies know each other and meet face to face, working to a common agenda services development is likely to proceed faster.

Where evaluations of sectorisation have been reported, the findings are favourable. In Nottingham, for example, Tyrer et al (1989) found reductions in the number of admissions

(5%), duration of admissions (4%), and use of in-patient beds (38%). Similarly in Sweden, Hansson (1989) recorded falls in the number of admissions (20%), beds days used (40%), and compulsory admissions (25%). The Mental Health Task Force London Study (Cochrane et al, 1994) highlighted the difficulties in planning community services where there were not co-terminous boundaries between the three key agencies (health, housing and social services).

Small geographical catchment areas are now the norm for adult mental health services in England and Wales. In a recent survey, 199 district health authorities were contacted. Most (87%) responded and of these 81% (n=140) reported that they had sectorised their mental health services (Johnson & Thornicroft, 1993). Sectorisation had started in 1959, with 1985 as the median year. In 63% (n=86) of sectorised districts, a single team in each sector provides both continuing care and acute services, while in 10% (n=13) the sector has two teams for these separate functions. The median sector population was 60,000, with a mean of 70,600.

Factors influencing catchment area boundaries

The division of a district into smaller catchment areas is influenced by many considerations (Table 4). The most important issues are the rural or urban nature of the area, the presence of a river or other natural structure which impairs access; the need to achieve co-terminosity with either a social services boundary or general practice locations; and the division of the total district into areas which are manageable for the local mental health teams.

The primary–secondary care interface

The most serious arguments against rigid catchment areas arise where primary and secondary care boundaries are not co-terminous. In this case there may be concern from family doctors, patients and their carers that a sectorised service may reduce their choice for a preferred local psychiatrist, and may promote generalist rather than specialist services. Primary care attachments of specialist staff can go some way towards addressing this dilemma by assessing all patients referred by practice staff, and only

referring on to other catchment area teams those few patients who require ongoing specialist care. Indeed, a flexible application of catchment area boundaries is necessary for the system to work for the advantage of patients. In some cases the importance of an individual staff-patient relationship is such that it should override the strict application of what is an administrative convenience designed to improve the quality of service to most but not all patients.

In some rural areas and in smaller towns the ideal arrangement of co-terminous social services, and primary and secondary health services may occur. But in many metropolitan areas borough and primary care boundaries inter-weave. To rely on a primary care list alone for secondary care teams would potentially render some patients who are homeless, unregistered or who do not attend their GPs lost to contact, and this is more likely to occur for the more severely mentally ill (Harrison *et al*, 1994).

Current trends in British mental health services are clear: progressive reductions of long-term beds in hospital (Davidge *et al*, 1993), policies which guide staff to target services on the most severely mentally ill (Department of Health, 1993), and continuing widespread concern about cases in which continuity between services and across time has been inadequate (North East Thames and South East Thames Regional Health Authorities, 1994). One fundamental building block of the NHS, which has allowed a public health perspective to guide health services, has been the catchment area. Without this, a mosaic of smaller service providers may together fail to provide any service to many patients, as the example of some parts of the USA shows. It is therefore reasonable, at this stage of the development of mental health services, to target as the first priority the most severely disabled patients by using mental health catchment area teams, and, as a second priority, to support, through GP practice attachments, primary care staff with the other 90% of mentally ill patients who are not referred on to specialist teams.

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Graham Thornicroft, *Director;* Geraldine Strathdee, *Consultant Community Psychiatrist;* and Sonia Johnson, *Project Co-ordinator for the Maudsley Continuing Care Study and Honorary Senior Registrar, PRiSM, Institute of Psychiatry, De Crespigny Park, London SE5 8AZ*