As a UK family doctor, I was particularly struck by how seldom Tobago's Health Centre patients 'medicalised' emotional distress, in contrast to my UK experience, where 'minor' psychological disorders are a significant part of every GP's daily work.

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Detention under Section 3 of the Mental Health Act and home security

Sir: When a patient is admitted to hospital under Section 3 of the Mental Health Act, the approved social worker is required to ensure that their residence is made secure. However, once this is done there is no requirement to continue to maintain security at the site. We have recently had experience of a patient whose entire belongings were stolen while receiving treatment as an in-patient. This was not only extremely distressing to the patient, but also delayed rehabilitation and discharge. Discussion with colleagues suggests that this is not an uncommon experience.

Patients detained under Section 3 usually have chronic psychotic illnesses and frequently live alone in housing that is less than ideal. They may be well-known in the neighbourhood and prolonged absence is clearly noted and acted on. As their detention is at the instigation of the psychiatric services, we feel that those services should carry some responsibility for maintaining the security of our patients' property. Especially as we usually justify compulsory detention as being in their interest.

We suggest that the team involved in the care instigate arrangements for regular (weekly) visits to the home to ensure it remains secure. Perhaps it would even be appropriate to make this aspect of patient care and support statutory. It is unfortunate that sometimes this aspect of a patient's social care is not considered, especially as it is obviously very important to them.

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Catchment areas

Sir: Kellett (*Psychiatric Bulletin*, June 1995, **19**, 240–342) and Thornicroft *et al* (*Psychiatric Bulletin*, June 1995, **19** 343–345) present arguments for and against the geographical catchment area. No system is perfect but having been a consultant operating within and without the catchment area I have to vote in favour. I think Kellett is wrong in saying there are no longer valid reasons for a catchment area, particularly when his own perceived benefits of the system seem to encompass many of the fundamentals of good psychiatric practice while his list of 'harms' contains little to do with patients.

At the request of our purchasers we have transferred from geographical catchment areas to consultants being linked to named general practitioners (GPs) who are grouped to produce 'neighbourhoods'. This was introduced as a purchasing strategy to allow groups of GPs (neighbourhoods) working in similar areas and experiencing similar problems to identify local service need in their dialogue with purchasers and providers. But these problems are very strongly geographically linked and this is demonstrated by our annual public health reports. The majority of GPs' patients reside in a local area but GPs are not geographically confined and can have patients widely dispersed. They tell me they have to keep patients living further away to maintain their list size and stay solvent. Our neighbourhood arrangement means the consultant seeing the patient is determined by the GP's name though the GP has a choice of two consultants. Consequently, consultant patients are now spread over a larger geographic area than before.

While working with geographical areas I was able to establish community out-patient clinics where patients are reviewed in their own home. This system will only work if the population served generates a manageable caseload but more importantly is sufficiently concentrated in a geographical area to minimise time lost travelling between houses. Now that I track GPs I have to travel further, the number of patients I can see in a session will inevitably drop and the cost of the clinic will rise. The clinics may become non-viable.

The community clinic is exceptionally popular with patients, does away with tedious ambulance arrangements, dramatically reduces non-attendance and meets the needs of elderly people with high levels of physical and mental disability in the inner city who cannot easily use traditional services. Would it be progress to abandon a development of this sort?

I still believe the geographical catchment area provides a good basis for the delivery of mental health services. It facilitates the identification of local needs, close liaison between disciplines and the development of service and expertise relevant to a locality. Kellett is quite wrong in suggesting the purpose of locality-based services is to take over complete care of the patient. On the contrary, detailed knowledge of the locality

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