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Dutch Psychiatry after World War II: An Overview

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Life as Usual

As in many other areas of social and political life in the Netherlands, Dutch psychiatry resumed its pace after World War II as if nothing had happened in those five dreadful years. Of what really *had* happened, there was nothing left to see: the deportation of patients and staff of the 'Apeldoornsche Bosch', the psychiatric hospital of the Jewish community in the Netherlands, to Auschwitz in 1943. On arrival, most of them were immediately killed. On the site of the Apeldoornsche Bosch there is now an institution for the mentally handicapped. The name has been changed and the rather austere buildings of the old hospital have all been replaced by friendly low-rise buildings and family-home type dwellings.

For most of the other Dutch psychiatric hospitals – still called 'gestichten' at the time, a word that in Dutch social life exactly conveys the meaning Erving Goffman tried to encompass in his concept of the 'total institution' – the war had simply meant hardship and sometimes evacuation to another mental hospital in a safer area. After the war, many buildings were in bad shape and most wards were overcrowded. Generally, there was a severe shortage of staff – doctors and nurses – and a persistent lack of money. But in practice this was the case throughout the health care system, and psychiatry was understandably not a priority in the first years after the war (the same low priority can be witnessed now in the countries of Eastern Europe). It took more than 20 years before building work could start on the first new mental hospital. Its buildings still bear the modernist touch of the sixties, but the whole concept of the institution, its remote location and its rather traditional layout, is considered now to be completely obsolete. This

last 'old' psychiatric hospital (St. Franciscushof, Raalte) is now, together with the first 'new' hospital of the nineteenth century (Santpoort, near Haarlem, founded in 1849), one of the first to close its doors for good.

Major Developments in the Provision of Mental Health Care since 1945

Of course, as elsewhere in the fifties, Dutch psychiatry eagerly took up the new treatment possibilities offered by the first psychotropic agents: antipsychotic drugs like Largactil, followed later by the first antidepressants, anxiolytica, sedatives and antimanic agents (lithium carbonate). The so-called somatic therapies, desperate attempts in the pre-war years to disguise the psychiatrist in the surgeon's gown and mask, were soon forgotten. Only ECT (electro-convulsive therapy) survived to become the target of anti-psychiatric attention in the seventies. Now ECT is accepted again as a treatment of last resort in severe depression, administered to a few hundred patients each year under strict conditions.

Between 1953 and 1963, medical (i.e. pharmacological) interventions for a broad spectrum of mental disorders became generally available, and on this solid base all kinds of new social and psychological therapies could flourish. For many patients, even those with the most severe mental illnesses, life outside the institutions became a real option. However, more than a decade would pass before this option became a real alternative to hospitalization for a growing number of patients.

Psychotherapy was introduced in the Netherlands before the turn of the century, at about the same time as the first chair in psychiatry was established at Utrecht University (1890) and the first psychiatrists took up private practice. Of course, since there were no possibilities as yet for reimbursing health care costs, access to this type of care was strictly reserved for the more affluent layers of society. Psychotherapy turned into psychoanalysis and it would take another fifty years before behavioral therapy or Carl Rogers' ideas put an end to this monopoly. At present more than 2,200 licensed psychotherapists (mainly psychologists) and about 1,700 psychiatrists provide mental health care. Most of them are employed by the regular mental health institutions, but a growing number are (full-time or part-time) in private practice. Although traditional psychoanalysis has become rare as a treatment modality (between 50 and 100 new patients each year), the psychodynamic approach still dominates the field, followed by the behavioral and cognitive

therapies, the Rogerian approach and systems theory. The existential therapies are quite popular, but not acknowledged by the professional bodies and not eligible for third party payment.

Social psychiatric and psychosocial services (providing care for children, alcohol abusers, the demented elderly, people with disrupted marriages etc.) began offering outpatient care in the years before the Second World War. Many of them were part of the 'pillarization' system so typical for the structure of Dutch society up to 1975. So the same types of social psychiatric services were offered through separate institutions to Roman Catholic, Protestant or 'non-confessional' clients and patients. In 1982 all ties with the religious denominations were severed: outpatient services for social psychiatry, psychosocial counselling and psychotherapy were integrated in the new RIAGG ('Regional Institute of Ambulatory Mental Health Care'), the Dutch equivalent of the American Community Mental Health Centers. Each RIAGG was responsible for mental health care delivery in a designated catchment area and financed by an annual budget based on the number of inhabitants (about 40 guilders – then equivalent to 10 pounds or so – per person per year). Services providing for alcohol- and drug-addicts were organised separately.

Within a few years, the almost 60 RIAGGs developed into the main providers of outpatient mental health care in the country. They now deal with about 500,000 patients each year. As the waiting lists for the RIAGGs have come to be long, a growing number of people prefer to look for therapy in the private sector, in many cases at their own expense. There are indications that the so-called 'alternative therapists' – many of them of a distinct 'New Age' orientation – enjoy a fast-growing clientèle. Of course, the differentiation in healing practices between problems of the mind and problems of the body is here less relevant.

Facts and Figures

At first, the only external indication that the situation inside the hospitals was changing was the diminishing growth in the number of 'real' hospital beds. Admittedly, the actual number of beds in use for the care of psychiatric patients rose in the fifties and sixties, as ever more mentally handicapped patients could be transferred to their 'own' institutions. Between 1970 and the present the number of places increased threefold and now stands at 43,000. In the seventies the newly-built nursing homes for the demented elderly also took over part of the function of the traditional psychiatric

hospitals: today, these comprise more than 31,000 beds.

The general psychiatric hospitals (current bed capacity about 23,000) gradually came to focus on the care of psychiatric patients alone, and at the same time a process of internal differentiation led to the development of new therapeutic régimes for specific subgroups of patients. Beginning in the sixties, most psychiatric hospitals witnessed an astounding proliferation of all kinds of therapeutic communities, rehabilitation units, short and long term treatment programs, substance abuse clinics and services for people with behavioral problems and personality disorders. Hardly any of these new developments brought relief to the group of the chronically mentally ill. Approximately half of the total number of hospital beds was (and still is) taken up by the more than 10,000 chronic patients already hospitalized for at least two consecutive years. Even today the psychiatric hospitals provide accommodation for more than 5,000 patients staying there for at least 10 and up to more than 65 years, i.e. their whole life as an adult.

Most of the long-stay patients are now people who have grown old in the hospital. For those who still remain there, the chances of successful reintegration in society are virtually non-existent. Their living conditions in hospital, however, are now generally more in line with the standard considered acceptable in the wider society. Many of them have their own room in one of the sheltered housing projects developed by the psychiatric hospitals as part of a nationwide scheme for the renovation of old psychiatric institutions. In 1978 less than 8,000 of the psychiatric beds were rated as 'good' and 9,000 as 'bad', in terms of quality of the buildings they were located in. In 1991 the number of beds rated 'good' had been doubled and less than 2,000 beds earned the label 'bad'.

The majority of people in psychiatric care remain outside the psychiatric hospitals. Most new chronic patients are only intermittently hospitalized, if at all. Even in situations where it is quite clear that they have great difficulty managing their own life, most of them prefer to stay outside hospital. The RIAGGs, outpatient clinics of psychiatric and general hospitals, psychiatrists or psychologists in private practice and general practitioners, provide 'extramural' (outpatient, ambulatory) care for their problems. Short-term hospitalization is possible in the PAAZ, the psychiatric department of the general hospital, and partial hospitalization programs ('semimural care') are available in many places. The whole gamut of psychiatric, psychotherapeutic and psychosocial services is provided for by the present mental health system. In 1996 the

intramural services in mental health accounted for 140,000 patient episodes, the semimural services for 50,000 episodes and the extramural services – the general practitioner and social worker not included – for more than 750,000 patient episodes. As many patients make use of the services of more than one institution every year, with a population of 15.5 million inhabitants these nearly 950,000 patient episodes relate to about 4% of the population.

Only recently, a national survey made it clear that in the adult population the 12-month prevalence of all mental disorders is about 23.5%; the prevalence 'ever' is 41.2%. Thus, the majority of people with mental disorders are not referred to specialized mental health care institutions. Many of them (especially in cases of depression or anxiety) are seen by general practitioners, but epidemiological studies have revealed that in many cases – alcohol abuse and dependence is an obvious example – neither the services of the general practitioner, nor those of the mental health system are sought. Sometimes patients, like their doctors, fail to recognize their somatic symptoms as indicators of an underlying mental disorder.

Mental Health Care as Part of Welfare Policy

The present level of service provision and the meticulously planned distribution of services by way of regional mental health networks is the outcome of a specific welfare policy on the national level. This could be implemented only through the allocation of a comparatively generous budget specifically for mental health. Traditionally, care for the mentally ill was subsumed under a city council's obligation to take care of the needs of its own poor. In that respect, a mental hospital was not so much a medical institution as an asylum for the poor with a mental illness, a mental handicap, a dementia or a substance disorder. It was only in the fifties that the last battle was resolved between psychiatrists and hospital managements – many still run by religious orders – as to who was primarily responsible for the patients. The doctors won, and with them a medical model that would soon be contested by the proponents of a more socially-oriented model and by the first patient advocates. Nobody, however, contested the by then practically complete coverage of a stay in a psychiatric hospital by the Sickness Fund, the national health insurance scheme.

Attempts in the twenties and the thirties to introduce a national system of compulsory insurance for health care costs always failed. The Germans introduced their own system during the war in an attempt to gain the support of the working population, and at the

same time to prevent Dutch industries from working at a lower level of labour cost than their German counterparts. Essentially the same system was continued after the war. In the early fifties, short-term psychiatric hospitalization was made eligible for coverage by the Sickness Fund Act (ZFW). Gradually, the number of days reimbursed was increased. From 1968 onward, through the new Exceptional Medical Expenses Act (AWBZ) – an additional compulsory health insurance system for the population as a whole – much more money became available for the care of the chronically mentally ill than could ever have been provided by the city councils. The first year of stay in a mental hospital was covered by the ZFW; thereafter, the AWBZ took over.

The extramural or ambulatory services, many of them founded back in the thirties, always had difficulty making ends meet. Their budget was meagre and very insecure, highly dependent from year to year on fluctuating state subsidies, additional grants from private foundations and the scant fees they could impose on (some of) their patients. To stimulate the development of the RIAGGs the government decided in 1982 to allocate additional AWBZ funds for the new ambulatory services. An initially generous budget system (based on capitation) fuelled the development of over 60 RIAGGs all over the country and provided the basis for sustainable growth of the ambulatory services over a number of years.

In 1989 all services provided by mental hospitals, ambulatory services and private practitioners became eligible for reimbursing from AWBZ funds. Thereby the mental health sector as a whole could benefit from the same advantages as the institutions for the mentally handicapped and the nursing homes for the demented elderly had enjoyed since the inception of the AWBZ in 1968. In 1996 the total cost for the mentally handicapped amounted to six billion guilders, for the services for the demented elderly about three billion guilders had to be spent, while five billion guilders was needed for mental health care (about 8% of the total health care bill and 0.8% of the national income).

Money – or to be more precise, the funds allocated for psychiatry by the AWBZ – is the fertilizer of the soil on which Dutch psychiatry blooms. As the AWBZ was introduced long after the Sickness Funds were established, the moment of take-off for the development of psychiatry and mental health care in the modern sense of the word came rather late: at the end of the sixties for the psychiatric hospitals, at the end of the seventies for the predecessors of the RIAGGs. Many developments in care provision were in

themselves not that new: what was new was above all the availability of the means to *implement* new ideas – or, for that matter, old ones – on a relatively grand scale.

Public Funds, Private Providers

Interestingly enough, successive increases in the funding of the mental health services (in 1950, 1986 and 1989) were not the consequence of a major political change in the public-private mix of funding. Admittedly, the contribution of private out-of-pocket payments to the budget of mental health institutions has become less and less significant, to the point where it is today marginal; yet the main locus of change is to be found in the mode of public funding. Poor relief, paid for by local authorities out of their own budgets, made way for a national health insurance system entitling every citizen to access to services of good quality and guaranteeing budgetary continuity for the service providers. Health insurance money cannot be used for other purposes than the provision of health care and this provision is only possible if its delivery can be guaranteed over time. The insurance system makes health care relatively immune to the vicissitudes of rapidly changing political priorities: the entitlements of patients can only be restricted by law, and it is not easy to find a political majority willing to do that.

The acceptance of mental health care as an integral part of the health care system, as a medical enterprise, typically meant a rise in status and budget to a middle-class level. Compared to the social sector, salaries in the medical sector are higher, the buildings better in style and decoration, the level of care more professional and there is more differentiation in the services offered. In psychiatry just as in the medical sector as a whole, there is – certainly at the hospital level – no demand for an extended private service system. As the majority of the Dutch population considers itself to be 'middle class', the level, style and layout of the medical sector is completely in accordance with their expectations. It not only reflects middle-class values; it *is* middle-class. The main reason why quite a few people prefer to go to a private practitioner, and are even willing to pay for his or her services out of their own pocket, is that in this way they can avoid the waiting lists for psychotherapy and counselling which confront them at many RIAGGs. Due to the emphasis now placed on public mental health and social psychiatric services for chronic patients, the centers can no longer sustain their original balance between psychosocial and social psychiatric services, at least not without a substantial rise in their yearly budget. At present, this

budget is only allowed to grow by a very limited amount each year.

Mental health care institutions – be they hospitals, RIAGGs, or sheltered housing projects – are typically private not-for-profit organisations. The few state institutions in this sector have now all been privatized. However, the autonomy of these institutions is not unrestricted. The Ministry of Health issues quite detailed guidelines and the Sickness Fund Council – responsible for the execution of the provisions of the AWBZ Act – is a formidable controller of the money spent. The regional sickness funds are responsible for contracting the services to be provided to the population and they also have influence, albeit limited, on the budgets of the different institutions. The planning of services (new sites, number of beds and places) is a major responsibility of the government. All in all, the growing diversity of checks and balances, the mix of autonomy and dependence, the interface between private and public, have made the (mental) health care system extremely complex. As with many Dutch welfare state arrangements one might say that it functions relatively well and works rather smoothly, but even the single most important agent, the Ministry of Health, would not be able to say precisely by what rules and in what way.

Mental Health as Public Health.

More than in other areas of health care the Ministry of Health is directly involved in mental health. Inevitably, mental health contains a strong element of public health: involuntary admission to mental hospital (certification) is a judicial and not a medical decision; the care for the homeless with a mental illness is a responsibility of local government; the civil rights of psychiatric patients have to be safeguarded; mental health prevention is dependent on government subsidies; and so on. In the days when mental health care was paid for out of the social services budgets of the city councils, one might say that nearly all psychiatry belonged to the area of public health. Now this area is confined to the responsibility for the safeness and well-being of the community, the collection of epidemiological data and the development of community-oriented prevention programmes for mental health.

Public mental health has long been neglected, but as it became more and more clear that mental health care is more than just providing cure and care, there arose a new interest in the custodial and preventive functions of mental health care. The Ministry of Health is now developing new policies to stimulate city councils to

become more active in these areas. Proposals are even in preparation to change the new law on involuntary admission (BOPZ). The present 'lunacy act' is just three years old and is the unhappy outcome of a parliamentary debate that took more than 20 years. At present, the only criterion for involuntary admission is imminent danger to others or the patient, occasioned by the patient as a direct consequence of his or her mental illness. Even then, it has to be made plausible that only placing the patient in a mental institution will remove the danger. To make matters even more complicated, involuntary admission does not entitle the psychiatrist to use force in treatment: patients may refuse drugs or any other kind of treatment. About 15% of all admissions in psychiatric hospitals take place under the BOPZ Act.

However, most patients in need of treatment but refusing it are not at all dangerous and there is now a strong lobby in favour of reinstating the old 'for your own good' clause in the new law. In modern psychiatric institutions, strongly treatment-oriented as they are, the right to refuse treatment is experienced as a real dilemma in cases of involuntary commitment, especially when the patient is psychotic and violent at the same time. In most of these cases there is hardly any doubt that it is possible to relieve the patient of his or her symptoms. It is not at all easy to get around the strict stipulations of the law, for in every hospital the patients' 'ombudsman' (an independent patient advocate working in the hospital, but employed by a national authority) closely watches over the rights of patients. By law, medical treatment is (with very few exceptions) only possible by informed consent of the patient; the use of force and isolation cells, or any curtailment of a patient's civil rights, is kept under strict surveillance.

At the other end of the public mental health spectrum, we find the preventive programmes in mental health, sometimes organized by the municipal health authority (GG&GD), but in most cases by the (private) RIAGGs. Typical areas of prevention and mental health education are support for people taking care of a demented parent, psycho-education for families with a schizophrenic son or daughter, community work with depressed patients, or prevention of bullying in schools. Characteristic of mental health prevention is a strong orientation to people at risk and secondary prevention. The ideas of the mental health movement of the fifties and sixties (primary prevention, even societal change) have lost their appeal due to lack of empirical data and an appropriate technology to back up the lofty humanistic ideals. As a sector within the health care

system, mental health chose for a future of professionalization (especially in the area of psychotherapy) and medicalization. Very soon after its introduction in 1980 the new DSM system of classification became generally accepted, and in the present decade we witness the emergence of an 'evidence-based medicine' movement with a plethora of protocols, standards and consensus statements.

The Welfare State: Idea and Ideal

The Dutch welfare state was modelled after the English example, but retained some of the traditional Bismarckian traits that prevailed in most West European countries. The economic growth and the discovery of huge natural gas reserves in the early sixties provided the funds necessary for the creation of a welfare state of hitherto unforeseen dimensions. In fact, the development of a fully-fledged welfare state became for the first time a political goal in itself. Political parties were looking for gaps to be filled and the idea of the perfection of society by way of a skilful combination of political will, unlimited means and professional knowledge gained a remarkable popularity. The major political parties all more or less endorsed this idea in the years between 1965 and 1975.

In this attempt to end history by establishing a complete and all-encompassing welfare state, it was unavoidable that politicians, journalists and activists would at some point stumble on the mental hospitals and their population. It was a shock to the public eye to find them in such a poor state. Mental health was quickly discovered as a domain too long forgotten. At the same time that the government tried to gain control over the skyrocketing costs of the health care system in general, it decided to invest in mental health care. Building schemes for the renewal of psychiatric hospitals were developed and psychotherapy became the object of great expectations.

In 1974 the State Secretary of Health, J.H. Hendriks, presented his "Structuurnota Gezondheidszorg" (Plan for a new structure in the health care system), the first policy document ever on the organisation of the health care system. In this White Paper he endorsed, among many other changes, a mental health care system that would provide all citizens with high quality mental health care in their own community and on all necessary levels: outpatient, part-time, inpatient. What he envisaged was a system of regionalized mental health care with the general practitioner as a gatekeeper, the

RIAGG as community mental health center for outpatient care, the psychiatric hospital as a major treatment facility and the psychogeriatric nursing home as a facility for the care of the demented elderly.

More than twenty years later we can say that a major part of his plan has become reality. In a country with a multiparty system (about 12 parties!) and a notoriously difficult coalition system that allows a government to survive only as long as it is prepared to look for compromise, this is rather astonishing. In fact, outside the field of mental health practically none of Hendriks' great plans to restructure the health care system have been realised. The same fate was suffered by most of the grand designs of his successors, Veder-Smit, Gardeniers-Berendsen, Van der Reijden, Dees, and Simons. Perhaps one has to include in this list Borst-Eilers, the present Minister of Health and the first to deny any penchant for thinking in grand designs ('Dutch health care is nearly perfect', she likes to say while trying to push a major change through parliament in the guise of a minor adjustment!)

The welfare state ideology is not only interesting in relation to its effects on the place allotted to mental health services, but also in its influence on the definition of mental health. The psychiatric hospital had always been considered to be a marginal place for marginal people. The rise of ambulatory services outside the hospital and without direct connections to the hospital was a first step towards a more socially integrated position for mental health. It has something to offer to people who were obviously not 'mad', but suffered nonetheless as victims of enduring and painful problems in living. Previously, neurotic, disturbed or unhappy people with sufficient financial means could rely on a highly individualized 'talking cure', i.e. psychotherapy (until 1960 mainly psychoanalysis), but for the majority of the population psychotherapy or even psychosocial counselling was hardly available and certainly not something they could pay for themselves.

The welfare state combined these different types of services under the heading 'mental health' and declared this area of care to be guided by the same principles as health care in general: available, accessible and acceptable to every citizen who might benefit from the services. A national insurance scheme would secure a safe financial basis for the care providers, independent of the income of the individual clients. Under these circumstances, psychiatry was quite willing to join forces with other professions under the aegis of mental health.

By way of spoiling this rosy picture I would like to add the hypothesis that in psychiatry, as in society in general, the sudden positive acceptance of mental illness and psychological problems was greatly enhanced by the growing tendency in the sixties to deny the harsh reality of mental illness, in particular its stubborn resistance to easy cures and good intentions. The rising popularity of psychotherapy and all kinds of experiential therapies was an important second factor. Looking back, it is difficult to grasp now the exceptionally high status awarded in those days to psychotherapists. Without any empirical evidence, their work was considered to be highly effective, even in the most difficult cases. A third factor that gave the new mental health its sudden upswing was the growing popularity of the labelling theory of mental illness and the romantic fervour of the antipsychiatric movement. Together they provided the ideological underpinning.

Psychiatry Then and Now

In 1974, Dutch mental health care was a fragmented system, consisting of about 40 mental hospitals (400 – 1200 beds), several hundred mainly small and autonomous ambulatory services, and a limited number of psychiatrists in private practice, some of them heading the psychiatric department (PAAZ) of a general hospital. In some places there were facilities for sheltered living and part-time treatment and there was an exciting proliferation noticeable in the area of psychotherapy, especially in the big cities and the university towns. Psychiatry was certainly not a popular choice for medical doctors wishing to become a medical specialist; the resulting shortage of psychiatrists opened the door to clinical psychologists and non-medical psychotherapists. The whole idea of a catchment area or of regionalization of care was unheard of. Cities like Amsterdam and Utrecht were very well equipped with all kind of services and practitioners, in Rotterdam there was next to nothing and in many areas of the country it would have been very difficult to find a psychotherapist or psychiatrist at all. Psychiatric hospitals were very unevenly distributed over the country and mainly situated in wooded areas far from the big cities. Many of them still cherished their confessional identity, but all of them arbitrarily accepted (and refused) patients of any denomination from every corner of the country. The divide between inpatient and outpatient services was practically unsurmountable.

The picture today is quite different. In this chapter I have set

out the changes which have been brought about, but it may still be useful to ask again what made these changes possible. The answer is quite simple: money. The mental health sector was impoverished and the Ministry of Health offered the possibility of renewing long derelict buildings, attracting more and better staff, getting more permanent funding, differentiating between patient categories, and specializing within the array of services provided. The bottom line, sometimes very implicit, was always the same: adherence to the new principles of the organization of mental health care as *an integrated system providing comprehensive care to a community in a circumscribed area.*

Even today, with the regionalization of services entering a new phase (one regional provider instead of a number of autonomous organizations in the different echelons), money is again the catalyst of the new developments. Several years ago, a small part of the budget of the psychiatric hospitals was placed in the 'Zorgvernieuwingsfonds' (a regional budget for the renewal of mental health care). To get hold of this money again, the different mental health care providers in a region had to devise new projects, in collaboration with each other and with a strong component of de-institutionalisation. Literally hundreds of these projects landed on the doormat at the offices of the regional Sickness Funds. In many regions this was the final impetus needed to bring the partners together in a new comprehensive organisation for mental health care.

Today, the danger of regional monopolies of care would seem to be imminent. Superficially, it may even seem that at the end of the century just as at its beginning, psychiatry will be the domain of some 40 large institutions; and in the eyes of some critics, the word institution is synonymous with 'psychiatric hospital'. However, even if one labels the institutions in this way, in reality they bear no resemblance to the old psychiatric hospital. They are 'virtual' organizations, coordinating structures governing a loose network of small, highly differentiated and socially integrated centres of care. Most patients will live in society permanently, making use of the services they need to continue doing just that.

Notes

There is a rich and extensive literature in Dutch on mental health and mental health care in this country and although Dutch researchers regularly publish in international journals, they hardly ever do so on specifically 'Dutch' topics such as the organisation of mental health care. Readers who

would like to have access to the references in Dutch relating to this article can contact the author for a bibliography. English readers are advised to consult the following books:

1. A.J.P. Schrijvers (ed.), *Health and Health Care in the Netherlands. A Critical Self-Assessment by Dutch Experts in the Medical and Health Sciences* (Utrecht: De Tijdstroom, 1997). This book provides the most up-to-date overview of developments in all areas of health and health care.
2. G.H. Okma, *Studies on Dutch Health Politics, Policies and Laws* (Utrecht University: Ph.D. thesis, 1997).
3. A. de Swaan, *In Care of the State. Health Care, Education and Welfare in Europe and the USA in the Modern Era* (Cambridge: Polity Press, 1988).
4. J. Goudsblom, *Dutch Society* (New York: Random House, 1967).

The Dutch Ministry of Health, Welfare and Sport regularly publishes in English informative brochures and fact sheets on Dutch health (care) issues (P.O. Box 5406, NL 2280 HK Rijswijk). The national library on mental health is at the Trimbos Instituut, the Netherlands Institute of Mental Health and Addiction, P.O. Box 725, NL 3500 AS Utrecht).