Chapter 11

The Mental Health Services: more than Psychiatry alone

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1 A CENTURY OF CHANGE OVERBRIDGED

At first sight, it is possible to imagine that in the year 2000, Dutch mental health care will look very much the way it did in the year 1900. Thirty to forty institutions spread throughout the country are responsible for providing the better part of the care, as well as a number of private practices and facilities for people who mainly need nursing care. However, a closer look at the system reveals that the differences between then and now outweigh the similarities. In the course of the century, the total number of patients has increased hundredfold and the major institutions and hospitals, which were either new or in the process of being built in 1900, have now primarily become organizations for mental health care.

Over the last hundred years, mental health care has undergone an enormous process of development. In the first half of the century, the development of hospital care and the psychiatric hospitals themselves saw a particularly striking change, while in the second half, partly due to the introduction of the first psychopharmacological drugs and new forms of psychotherapy, the change has been seen with the introduction of community care, partial hospitalization and sheltered living facilities. Up to the Second World War it was German psychiatry that predominated but after the war, American psychiatry became the most influential. The century has seen the emphasis on mental health care undergo a gradual shift from providing an asylum and custodial care to one of providing assessment, treatment and possibly a cure to one of assessing and treating. At the same time, psychiatry has extended its boundaries in order to provide the mental health services of today. Apart from patients with typical psychiatric problems, more and more people with psychological and psychosocial problems are being treated. Minders become carers in the broader sense of the word and psychiatry is growing toward being the largest medical specialism. Furthermore, with the introduction of psychotherapy, psychologists have in big numbers entered into the picture.

All this, however, is not just typical for the Netherlands alone. The development has manifested itself in more or less the same way in all Western countries. Nevertheless, there are a number of aspects which undeniably distinguish the Dutch mental health services from others. For example, the solid foundations of funding for mental health services are better in the Netherlands compared to the surrounding countries and while psychiatric hospitals do

undergo change, they are seldom closed down. Furthermore, on an organizational level, the distinction between various patient categories (psychiatric patients; psychogeriatric patients; mentally handicapped) goes considerably further in the Netherlands compared to other countries.

In this chapter, the uniqueness of the Dutch mental health services, regarding problems pertaining to patients and the provision of health care facilities, will be accentuated within a framework that is customary both to Western Europe and North America (Grove 1994). In the Netherlands, the term 'mental health care services' encompasses a whole range of organizations and practising professionals, all pursuing the common aim of treating mental health problems. The administration of treatment also falls under this term and applies to each individual case. Mental health problems only fall under the category 'psychiatric' when they have been diagnostically included in one of the leading psychiatric classification systems, such as the American DSM-III and/or DSM-IV systems. Psychosocial problems can be defined as such when the problems of the person involved concern his social standing or when his psychological and social problems are so interwoven that no differentiation can be made in his perception of them.

2 THE EPIDEMIOLOGY OF MENTAL DISORDERS

Mental health problems are relatively common and in the past, many attempts have been made to estimate the scope of these problems among the population. However, the outcomes and conclusions of research conducted in this area remain extremely unreliable, due to a lack of unity in the definitions of and criteria for mental health problems. Some researchers found that as little as 1% of the population were affected, whereas other estimates rose to more than 60%. The first reliable measuring tools in the field of mental health were developed in the seventies, but the real breakthrough came only in the eighties when a new classification system for psychiatric disorders (the so-called DSM-III, Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, APA 1980; DSM-IV 1994) was introduced on an international level. For the first time in the history of psychiatry there was unity of language based on clear agreements concerning the criteria for defining definite syndromes. This nomenclature has greatly furthered the processes of epidemiological and clinical research in the field of psychiatry.

Despite the rapid development of psychiatric epidemiology, there is still no clear-cut picture of the spread or the course of mental disorders within the population. Nonetheless, there is some certainty, based on research conducted on random samples of the Dutch population (Vermande & Bijl 1995) and in the United States, that the monthly prevalence of mental disorders (all clinically relevant new and existing cases for that time span) is approximately 80 per 1,000 inhabitants, and that the yearly prevalence is approximately 250 per 1,000 inhabitants (Robins & Regier 1991; Hodiamont 1986). Approximately 32% of the population will, at some time in their life, show signs of mental disturbances which can be diagnosed according to DSM criteria. On the basis of monthly,

yearly and lifespan prevalence, it appears that mental disorders are not arbitrarily distributed among the population. The majority of the population will never suffer from serious mental disorders, a small number will experience some problems, maybe once or twice in their lives, and for an even smaller minority, the condition will be chronic. A yearly prevalence of 250 per 1,000 inhabitants therefore means that significantly fewer than 250 people per 1,000 suffer from mental problems. While some people experience more than one problem per year, others have multiple problems simultaneously. Expressed in numbers of people who suffer from one or more mental problem in a given year, the number will more likely be 150 per 1,000 than 250 per 1,000.

American research has shown that about 7% of the adult population have suffered from a mental disorder for more than a year and 9% of the population indicate a serious disfunctioning both on personal and social levels, due to a mental disorder. Each year, approximately 2% of the adult population suffer from extremely serious mental problems, such as psychosis or major depression while another 2-3% suffer from serious problems. The other instances mainly consist of serious anxiety and mood disturbances, adjustmental and behavioral problems, addictions and personality disorders. In countries like the Netherlands and Great Britain, the majority of people (75-80%) suffering from mental disorders will consult their general practitioner (GP) but do not always present the problem as psychological in nature. This means that GPs do not always recognize mental problems as such, although this does happen in 75-80% of the cases (Verhaak 1995). In the majority of cases (75-80%) where the GP himself does recognize the problems, he also becomes the treating physician. Ultimately, about 20-25% of all treatable mental health problems reach the mental health services. On estimate, only half of these have been referred by primary health care professionals (GPs) and only a small number will eventually be treated intramurally.

Based on the English model (Goldberg & Huxley 1980) overviews have been made in the Netherlands which show the relationship between the prevalence of mental health problems and the consumption of health care facilities (STG 1992; Sytema 1994; RIVM 1994). The quantitative filling-in of this so-called *filtermodel* differs from author to author and from year to year, but the ratio between the various levels shown in the filter and the nature of the sequence of those filters does not differ. Based on a summary of the outcomes of various population surveys and on the most recent data concerning the consumption of mental health facilities, the filtermodel for 1996 will look as in Table 1.

The year 2000 will see at least 900,000 treatment episodes in the Dutch mental health care services as opposed to 9,000 in 1900. Of these, a little more than 130,000 will take the form of admissions, compared to 8,000 in 1900. It should be noted, however, that the production figures of mental health care have risen sharply over the last few years but that this rise in production does not reflect the increase in the number of patients who are offered help. An increasing number of people undergo various relatively short periods of treatment in different mental health care institutions with each episode being counted separately. The yearly prevalence figures should therefore not be

Table 1 'Filtermodel' yearly prevalence of psychiatric, psychological and psychosocial morbidity in the Netherlands, 1996, per 1,000 inhabitants and per type of facility, not including the mentally handicapped

Level 1	mental health problems of the population consulting the GP	250
Level 2	mental health problems among GP patients recognition of problems by GP	180
Level 3	diagnosis by GP GP referral – forwarding to mental health services	140
Level 4	total reaching mental health services decision about admission	60
Level 5	intramural mental health care	9

interpreted as 60 mental health patients per 1,000 inhabitants, but rather as 60 mental health episodes per 1,000 inhabitants. When converted to the number of patients, this number is perhaps only 40.

In 'Public Health Status and Forecasts' (RIVM 1993) the following ranking is given to mental health problems concerning their relevance for public health as a whole and divided into three 'top tens':

- most common diseases and disorders
  5 depression (major depression 250,000-300,000 cases)
  10 dementia (over 100,000 now, over 140,000 in 2010)
- most frequently occurring annual diseases and disorders (short duration)
  9 depression (150,000 new cases per year)
- most important causes of death in terms of potential years of life lost
  8 suicide (45,000 years lost, a mean of 30 years per case).

None of the three top tens shows a complete picture of the most serious and incapacitating mental health problems. Most striking is the absence of schizophrenia. On a lifetime basis, the chances of having a schizophrenic episode are estimated to be about 1%, but the yearly incidence of new cases is only 0.2-0.3%. Moreover, none of the top tens take substance users or addictions into account.

There is a substantial psychological co-morbidity with physical diseases, as well as the other way round. Of the people suffering from serious somatic complaints, 9% on average also have psychiatric problems and a total of 25% suffer from relatively serious mental problems. For those people who suffer from chronic physical disorders, approximately 30% have mental problems as a direct result of the disease or its consequences.

3 THE UNIQUE ROLE OF THE GOVERNMENT

Mental health care distinguishes itself even more than general health care by a distinctive and direct relationship with the government. The oldest institutions (the psychiatric hospitals of Den Bosch and Utrecht) have a history stretching back over 500 years. They operated at that time under the direct supervision of the local authorities. After the unification of the provinces, and the

establishment of the Kingdom of the Netherlands in 1813, care for the psychiatric patient became almost naturally the responsibility of national and provincial government. Although the government acknowledged its role as supervisor, it was not until the middle of the nineteenth century that this responsibility was put into practice.

Up to the beginning of the twentieth century, a psychiatric admission was by definition an involuntary commitment. Because of the infringement on freedom of movement of citizens, this required the state to take on a specific responsibility in the form of legislation. In 1841 the first law on the insane was passed, followed in 1884 by the second one which remained in use for over a century. In 1992, a period of 25 years of parliamentary and public debate finally ended with the introduction of the law for Special Admissions to Psychiatric Hospitals (*Wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen*, BOPZ) which placed involuntary admissions under strict danger criteria. An involuntary admission is now only possible under the following criteria: if a significant and demonstrable danger threatens the patient or others; the patient's mental disturbances will result in danger and the only way to remedy this is to admit the patient who is obviously against the admission. The 'special' admission can be carried out in one of two ways. The patient can be secured (immediately and for short duration on intervention of the mayor) or a judicial authorization can be granted (for longer duration). In both cases, the final decision will be made by the judge.

The interest concerning psychiatric patients' rights has increased dramatically in a period of less than 25 years and now manifests itself extensively in legal measures. Some of these measures specifically relate to mental health care such as the mandatory presence of independent trusted patient representatives in the psychiatric hospital or the possibility of allowing the mentally incompetent patient to have his immaterial well-being taken care of by a mentor. Other measures pertain to all patients of all health institutions and include complaints committees, the right to examine one's medical file at all times and the right to receive full information according to the stipulations of the new Medical Treatment Agreement Act. Nowadays, most institutions also have patient councils or patient representatives on the executive board. Throughout the country, there is also a rapid increase in the amount of influence which the organization of family members of the patient has.

4 THE FUNDING OF THE MENTAL HEALTH CARE SERVICES

Of the patients who were admitted to the new and renovated institutions in the nineteenth century, 90% were poor. It would therefore be fair to say that the history of hospital psychiatry can largely be considered a part of the history of poor relief in the Netherlands. With this fact in mind, the local authorities of the past became increasingly involved with mental health care because they were the administrators of the most significant coffers for poor relief. In the nineteen-thirties, the attempts of the social psychiatrist Querido, who was a local health authority official, to reduce the number of psychiatric admissions

by means of preventive measures known as: 'The Amsterdam Model', originally came from the Amsterdam local authorities. The authorities wanted to limit expenditure for the large numbers of the Amsterdam population in psychiatric hospitals. In this model, the local health authority psychiatrist determined during a home call whether an admission for the patient was indicated. After the Second World War, two Acts in particular, heralded the permanent transition toward the funding of psychiatric and mental health care from the national insurance funds for medical expenses. The first of these was the Social Health Insurance Act (*Ziekenfondswet*), which was introduced by the German occupying forces in 1942 and later, the Exceptional Medical Expenses Act (AWBZ). These steps also allowed the transition from a local regime to a national regime to take place, which would increasingly consider mental health care as a provision to which every citizen had a right (providing an indication had been given). Government policy took as its starting point the provision of equal quality and availability of care and based on a national level. It is only a few years ago that the decision was taken to incorporate the whole of the mental health care services, including hospital, semi-residential and community care into the Exceptional Medical Expenses Act. While it does not look as if this will still be the case in the year 2000, just which differentiations in the form of funding will ultimately receive preference by the world of politics is not clear at the present time. However, people assume that long-term psychiatric care will remain covered by the Exceptional Medical Expenses Act but that in time, this will no longer be the case for most of the ambulatory psychotherapy sector. In addition, the care offered by psychiatrists and psychotherapists in private practice will probably be subject to new forms of insurance cover.

Compared internationally, the Dutch funding system for mental health care is still unique because the whole population is eligible for almost all forms of mental health care through national insurance. Hardly any restrictions are imposed on either the nature or the duration of the treatment. Furthermore, even a significant part of the voluminous circuit of psychiatrists and psychotherapists in private practice is paid from the funds of the Exceptional Medical Expenses Act and, as far as hospital care is concerned, the whole range of provisions and facilities has become completely classless. All psychiatric hospitals and psycho-geriatric nursing homes work on a 'private not for profit' basis within a district allocated to them. Nowhere in the Dutch hospital sector are services provided on a 'private for profit' basis.

A large amount of money is spent on Dutch mental health care. By far the largest portion of this money is related to labour costs. Increasing productivity is only marginally possible despite the fact that, at the same time, the increasing tendency toward individual treatment and caring for people in small groups calls for an increase both in deployment of labour and the qualification levels of staff. The price attached to mental health care is therefore largely determined by the time factor.

In 1997, the costs of hospital mental health care will amount to well over 3.7 milliard guilders of which 2.8 milliard will be for psychiatric hospitals (hospital charges amounting to approximately 350 guilders per day) and 0.4 milliard guilders for the psychiatric departments of general and university hospitals. In

the same year, 0.7 milliard guilders will be spend on the Regional Institutes for outpatient Mental Health Care (RIAGGs) and 0.1 milliard guilders for services provided by independently established psychiatrists and psychotherapists. The costs of outpatient psychiatric treatment amount to 0.15 milliard guilders while more than 0.2 milliard guilders will be spend on sheltered housing schemes. For the care and treatment of drug addicts within the mental health care sector, approximately 0.2 milliard guilders will be available. All things considered, the costs pertaining to mental health care amounted to more than 5 milliard guilders, which is approximately 8% of the total costs of health care in the Netherlands for that year. These figures do not take into account the costs pertaining to psycho-geriatric nursing homes, which will be approximately be 3.0 milliard guilders for that year, and approximately 5 milliard guilders for institutions which cater for the mentally handicapped. Almost all of these costs are funded by the Exceptional Medical Expenses Act.

5 AN ACTIVE GOVERNMENT

In the years following 1974, the national government became actively involved in laying down specifications for and the development of mental health care services in the Netherlands. It would hardly be exaggerating to say that the Dutch Government even played the most important role in determining these specifications. It was in fact the government that decided that both the architectural quality of the buildings and the living conditions within psychiatric hospitals were, to a large extent, below standard and therefore unacceptable. From the second half of the seventies, the campaign for housing in the psychiatric sector led to strong improvements of the situation concerning both the above-mentioned points. The development of the RIAGG concept (the Dutch equivalent of the Community Mental Health Centers) would almost certainly have come to a standstill without the interference of the government. Other sectors such as sheltered housing for part-time treatment programmes and employment rehabilitation profited strongly from government support. This support includes an interest in improving the rights of the patient, regulation of the profession of psychotherapist and finally, striving toward prevention of mental health problems. The foundations of all these developments were laid down by government bills and in many cases, acting on the government's instructions, insurance revenues as well as tax revenues have been invested in the realization of new policy aims.

The government has also played a specific role in the regionalization of mental health care services. In almost all sectors of the Dutch health care services, attempts to integrate provisions which meet the needs of the population within a regional system have failed. However, in the mental health care sector, RIAGGs as well as psychiatric hospitals and sheltered housing schemes have taken on a regional character. They carry the responsibility for the psychiatric and psycho-social care of the population for a specified catchment area. It is partly on this basis that their budget is fixed and that agreements concerning productivity are made with insurance companies in view of the fact that they are the executors of the Exceptional Medical Expenses Act.

However, there is an increase in the cooperation now taking place between these various provisions per district and in such a way that as far as mental health care is concerned, more and more districts are having only to deal with one regional provider. The government no longer plays a role in the current process of combining the forces of autonomous institutions into integrated regional institutions. However, the government does stimulate the growing tendency for concerted action and steps which have been taken in this direction are being rewarded. It is to be expected that in view of the way in which this development is now taking place, the year 2000 will see a single regional institution for mental health care in the majority of the 29 health care districts. This institution will be capable of providing an almost complete range of assistance and care services to a population of approximately 500,000 people. The mental health care institution will no longer be first and foremost a large building complex, but a complex organization of services. The 'total institution' which Erving Goffman investigated and described in the fifties, in the United States of America, has become an 'institutional totality'.

6 THE SUPPLY OF MENTAL HEALTH CARE PROVISIONS

Within the structure of the Dutch health care system, mental health care is a provision operating at what is known in the Netherlands as the second level or echelon. This means that it is a specialized form of care which, in principle, is only accessible to those who have been referred by their GP. This principle, which is based on medical specialisms within the body of the health care system, has never been successfully maintained by the mental health care services without being abridged. In both acute and crisis situations, a direct appeal is made to the mental health care services for assistance. Sometimes this appeal is made by a family member but quite often it is forthcoming from the local police department. A reasonable number of referrals are also made through the social services and schools and occasionally it is the patients themselves who appeal directly to the specialized help services. In addition, the institutions often confer among themselves, as a result of which referrals are made.

The advancement from less toward more specialized is also visible in the structure of the mental health services themselves, especially in the way in which the care is divided on a scale ranging from less to more specialized. Community mental health care is structured by the provisions which are offered for the purposes of diagnostics, treatment and supervision, but without providing care or nursing care. In the community we encounter: approximately 55 regional institutions for ambulatory mental health care (the Regional Institutes for Outpatient Mental Health Care), more than 70 outpatient clinics attached to psychiatric hospitals, almost 70 psychiatric outpatient clinics attached to general and university hospitals, 16 health centers for drug and alcohol abuse (CAD) and hundreds of private practices run by independently established psychiatrists and psychotherapists. Between 85 and 90% of all occurring patient episodes in the mental health care services, are taken care of by the community or ambulatory sectors.

Semi-residential mental health care consists mainly of two categories of facilities which are completely different from each other in nature. On the one hand, there are the sheltered housing schemes which provide accommodation possibilities for the chronic psychiatric patients for whom there is no further treatment programme open to them. On the other hand, there are part-time treatment programmes which concentrate on intensifying therapeutic contacts. The medical day-care centers for pre-schoolers (almost 50 in number) form their own sector within the semi-residential mental health care services and only came into their own right as a separate sector after the year 1975. The sheltered housing schemes are usually a part of a regional institute (RIBW) which offers a whole range of accommodation and supervised accommodation.

The origins of the concept of mental health care services came from the general psychiatric hospitals (now about 50 in number and known as APZ), which even now constitute the core of hospital mental health care. A whole catalogue of possibilities for assistance is hidden under the common denominator of the term 'psychiatric hospital'. These vary from outpatient clinics to accommodation units for long-term residents, from geropsychiatric departments to therapeutic communities, from admission wards to specialized units for special needs groups such as addicts or forensic patients. More than fifty per cent of the national capacity of 23,000 beds are occupied by chronic patients who remain admitted for more than two years and of this group, more than a quarter are taken up by patients who have been in care for more than 25 years. There are even a few patients known to the services who have been in care without interruption for more than 65 years.

The 66 psychiatric departments of general hospitals (PAAZ) and university hospitals (PUK) are in the main not very large (approximately about 30 beds each) and the average length of stay is also relatively short, on average 5-6 weeks. The number of admissions for these departments is put at approximately 45% of the number which applies to admissions for psychiatric hospitals.

Included in the category of hospital mental health care are: the child and youth psychiatric clinics, the centers for care and treatment of drug addicts, the convalescent homes catering for those with serious problems of neurotic exhaustion and the TBS clinics for forensic psychiatry. In general, the overall capacity of these facilities is small. In order to complete the picture of mental hospital care, we should take into account the number of beds in psychiatric nursing homes, amounting to more than 25,000, (see also Schrijvers et al., Chapter 9) and include these in the count. There is however an increasing tendency for nursing homes to consider themselves as an independent sector, within the framework of the health care services.

In the Netherlands, the facilities as provided by the mental health services are mostly in the form of autonomous institutions with both their own budget responsibilities and management. The division between first and second line health care and the continuation of a levelled structure in the second line has meant that the transfer of patients between institutions has inevitably been accompanied by the usual difficulties and that close collaboration between these institutions has, to some extent, been given a low profile. Regionalization has however brought the various institutions within one working district closer

together and the uniformization of funding has in turn made working together in the area of patient care more possible. The government has greatly stimulated concerted actions of working together in the mental health services and has especially emphasised the importance of looking for ways to let the patient remain in their own environment for as long as possible or in any case enable them to return home as soon as possible. Nowadays, in the majority of districts, there is a gradual change taking place from the traditional levelled structure towards a new network structure in which patients can make relatively easy use of care facilities of varying intensity, whether intramural, semi-residential or community based. Such networks exist for the sectors: children and youth, addicts, the elderly and chronic and acute psychiatric patients.

A network which also includes admission possibilities is unnecessary for the majority of the community patients but is exceptionally important for those psychiatric patients who alternately need one or more of the following: help in crisis situations, treatment, supervision and rehabilitation. In these cases the central point is formed by the multifunctional unit which offers all assistance programmes available for short-term psychiatric problems. Within the multifunctional unit, the general psychiatric hospitals, the psychiatric departments of general hospitals and the Regional Institutes for Outpatient Mental Health Care all work together in a way which invites further integration of activities and also in the end a merger. This has, in fact, already taken place in a few districts in the Netherlands and in many other districts people are moving in the right direction towards this concept.

Approximately 45,000 full-time jobs are filled by the Dutch mental health services. Because many people work part-time within the services, the total number of people working for the mental health services can with some certainty be estimated at approximately 60,000. This figure actually amounts to nearly 1% of the Dutch working population. The majority of the full-time jobs (34,000) are found in the hospital sector but in comparison, by far the greater number of the more than 5,000 places in the regional institutions (more than half) is taken up at academic level. On average, in one regional mental health care institution, the number of professionals in full-time employment amount to: 6 psychiatrists, 10 psychotherapists and 10 psychologists. In the whole of the mental health care services an estimated number of 1,700 psychiatrists, 2,000 psychologists and over 2,000 registered psychotherapists are employed.

7 CARE CONSUMPTION

Although the number of people with mental health problems is growing from year to year, it is only a relatively small number who make use of the facilities offered by the mental health care services. In the majority of cases, this is limited to community care and in particular that which is offered by the regional institutions. In 1993 the regional institutions recorded a total number of 240,000 new registrations indicating a growing trend which, when put together with the already existing number of 250,000 registrations brings the total number of clients to nearly half a million. Not all registrations are active in the sense that

they also actually make use of the services offered and in many cases (27%) the contact between client and the services is a once-only occurrence. However, if this group is not included in the count, the average number of contacts per client amounts to 13, spread over a period of on average 10 months. Furthermore, 80% of the contacts are taken up by 20% of the clients.

Of the new registrations with the regional institutions, the following percentages can be found: 40% adult care departments, 10% crisis services, 35% youth care services and 15% care for the elderly. More than 25% of the contacts made in the adult care sectors are offered psychotherapy although this percentage is smaller in the other sectors. Other services offered by the regional institutions include those of: supervision and advice, crisis intervention and home calls, assessing and mediating prior to admission, diagnostics and consultations and further, group work and pharmacotherapy. Apart from all this, the regional institutions are also actively involved in the areas of preventive measures for mental health problems. Their advisory services are extended to other professionals including the primary health care and educational sectors.

The other significant provider of help for mental health problems is the psychiatric hospital itself. However, this provision is particularly limited to dealing with psychiatric problems which require admission to an institution. In 1993 this involved more than 35,000 new admissions to psychiatric hospitals, demonstrating a growing trend which has been taking place for many years and from which more than 11,000 are repeated admissions. Most admissions will be released from hospital within one year. A little fewer than 15% of the admissions are judicially imposed and therefore involuntary. Additionally, although only 15% of the admissions occur due to the diagnosis of schizophrenia, because the percentage of schizophrenic patients is rather high – particularly among in-hospital patients – at any given moment, one out of every three patients in a psychiatric hospital can be regarded as schizophrenic. Table 2 gives a general summary of the consumption of mental health facilities in 1993.

Table 2 Number of clients of the mental health care services, 1993

	Per 1-1-93	*New 1993*
Community mental health care		
RIAGG	250,000	240,000
psychiatric outpatient clinics	-	88,000
consultations private practices	45,000	38,000
Centre for Alcohol and Drugs Abuse (CAD)	29,000	25,000
Semi-residential care		
part-time treatment	6,000	12,000
sheltered housing schemes	4,000	1,200
Intramural care		
psychiatric hospitals	22,000	35,500
psychiatric departments of general hospitals	1,700	16,500
drug addiction clinics	700	6,500
Total number of clients	*358,400*	*462,700*

Source: Ten Have et al.1995.

8 THE DEVELOPMENT PROCESS OF MENTAL HEALTH CARE

The last quarter of this century has seen the Dutch mental health care services undergoing rapid development both in quantitative and qualitative terms. In addition, there is extensive political and social interest for what is happening within the mental health services and what they stand for. The mass media regularly play a part in this process of development by going into the possibilities of obtaining professional assistance for mental health problems and usually approaches these issues with the necessary care and concern. But they do not leave it at that, they also explore the existing problems in the mental health services especially concerning the problems involved in providing help both adequately and on a highly professional basis.

There are some ambiguities existing in the mental health care services. While on the one hand there is a question of enormous growth concerning the problem areas which are eligible for mental health care, on the other hand, increasing attention is paid to the problems pertaining to chronic psychiatric patients taking place in many aspects of life, such as: work, housing accommodation, leisure time, contacts, which now present themselves even when the patient resides within the society. Furthermore, on the one hand, psychotherapy has expanded enormously while on the other hand, there is an increasing interest in the still limited area of biological psychiatry. Finally, on the one hand, there is the political ideology to provide quality mental health care for everyone who needs it, but on the other hand, there is always the fear that people will call on the services too quickly and too readily. This ambivalence concerning mental health care in the Netherlands will certainly still be with us many years after the year 2000.

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