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MENTAL HEALTH PLANNING FOR ROTTERDAM

Report on a WHO Meeting

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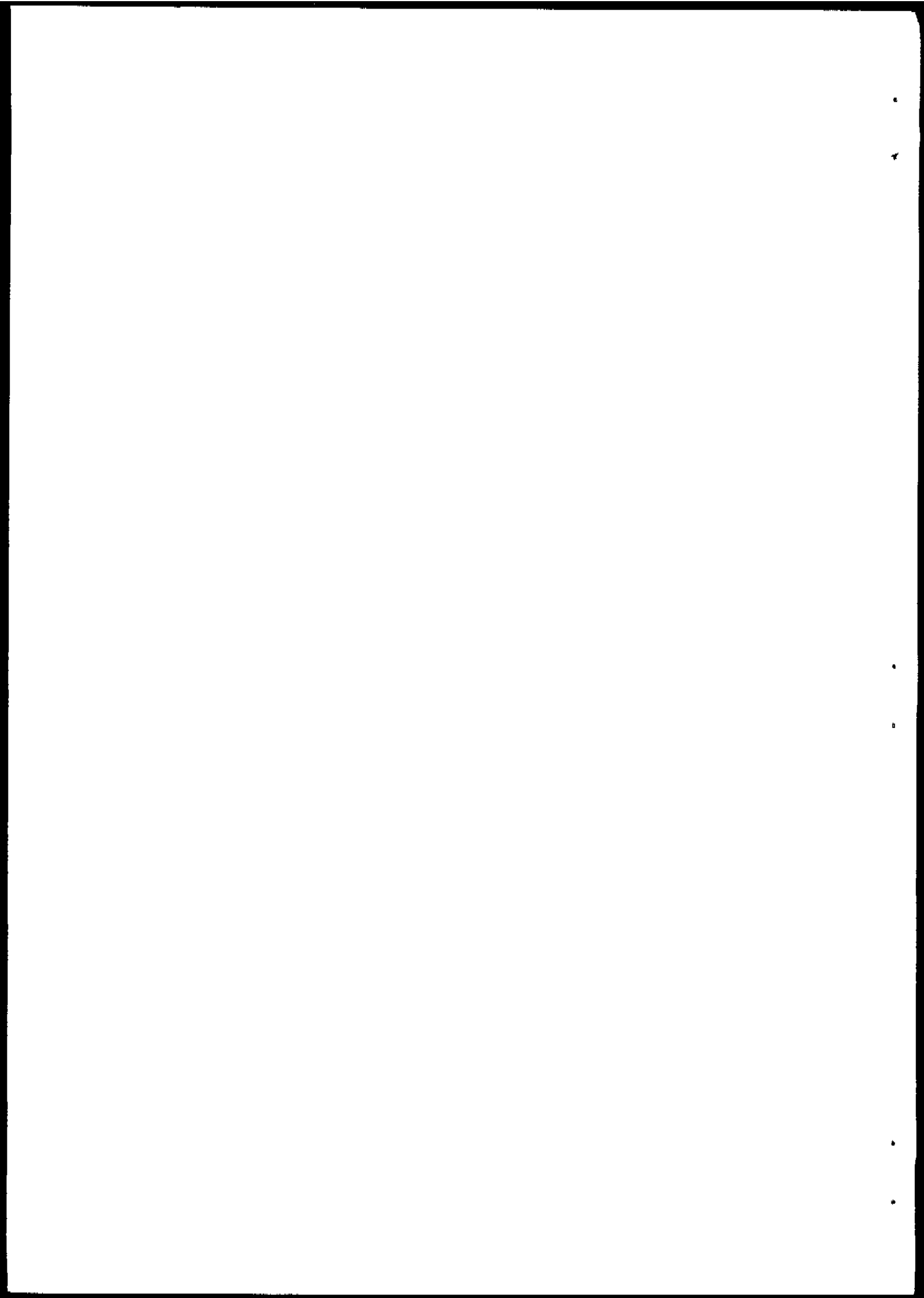
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1. Introduction

1.1 Organization of the Workshop

The Workshop on Mental Health Planning for Rotterdam was held at the WHO Regional Office for Europe, Copenhagen, from 24 to 29 August 1980. It was convened by the Regional Office in response to a request from the Netherlands Ministry of Public Health, with financial support from the Municipality of Rotterdam.

The Workshop was attended by 22 leading mental health specialists from the Netherlands (including 10 from the Rotterdam area), together with 6 experts from other countries, appointed as WHO temporary advisers, and 3 members of the Regional Office secretariat (see Annex 1). Dr P. Mason was elected as Chairman of the meeting and Professor B. Cooper as Rapporteur, while Dr A.E. Baert acted as Secretary and Dr H.J. Schneider as Co-secretary.

The participants were greeted by Dr Leo A. Kaprio, WHO Regional Director for Europe, who welcomed the official request from the Netherlands for the Workshop as an opportunity for WHO to apply the principles of mental health care and planning, developed over a number of years by successive WHO working groups, to a current situation in a highly industrialized developed country.

1.2 Scope and purpose

The main aims of the Workshop were defined at the outset as follows:

- to review the current situation of mental health care in Rotterdam;
- to agree on principles governing the future provision of mental health care for the area;
- to establish long-term planning targets in accordance with these principles;
- to establish priorities and to stipulate transitional stages in moving towards long-term goals;
- to suggest mechanisms for implementation.

It was agreed that, in pursuit of these aims, the problems of provision of mental health care should be considered from the respective standpoints of administration and service function, but above all of the needs of patients and clients.

While the theme and content of the Workshop were focused on the problems of Rotterdam, it was thought that its conclusions might well be of much wider interest. This point was emphasized by the Netherlands Secretary of State for Health, who in a letter of authorization to the WHO Regional Office for Europe declared that:

"The problem is how, in the present situation in respect to manpower and budget, and with the existing structure of the facilities, the duties of the mental health care services can best be carried out at regional level under a cohesive and anticipatory policy. The solution to this problem affects not only the Rotterdam municipal authorities, but could also be useful to other regional authorities. This conference could also be of interest to the Joint Committee on Domiciliary Mental Health Care, particularly with a view to obtaining information from the various European countries."

1.3 Background information

Available to the participants was a report prepared by Direkteurenoverleg Geestelijke Gezondheidszorg (DOGG) (1), the mental health consultative body, together with a number of information and background papers prepared by individual participants. Also important in this context were the reports of the WHO working groups on constraints in mental health services development (2) the future of mental hospitals (3) and changing patterns in mental health care (4).

2. The nature of the problem

2.1 Deficiencies in the existing services

There appears to be a broad consensus of opinion, among those engaged in the field, that the current situation as regards provision of mental health care in the Rotterdam area is seriously unsatisfactory in a number of respects.

(1) Inpatient care is provided by a number of large psychiatric hospitals, only one of which is situated within the Rotterdam area, while some are a long distance away from the city. There are, as yet, insufficient psychiatric beds within the city itself. (These are confined

to 88 beds in the University Psychiatric Clinic and 14 child psychiatric beds in the Sophia Childrens' Hospital). Most persons requiring psychiatric inpatient care must, therefore, be admitted to large institutions, which are more or less remote from the patients' own homes or local communities, and in some cases offer a poor standard of accommodation.

- (2) An unduly high proportion of all inpatient admissions result directly from crises or acute emergencies, some of which are seen as potentially preventable.
- (3) Facilities for after-care or rehabilitation of discharged hospital patients are either inadequate or are not functioning effectively.
- (4) There is a lack of "half-way" and daycare facilities for the chronic mentally ill and handicapped.
- (5) Services for disturbed children and adolescents are generally inadequate to meet the existing level of demand.
- (6) Communication and coordination between the various mental health agencies is generally poor, a point which applies equally to liaison between inpatient and extramural services.
- (7) In consequence of these difficulties, staff morale has been adversely affected in some agencies and there are many tensions and conflicts arising in the relationships between groups of professional workers.
- (8) The general standard of registration and documentation of patients or clients is poor, resulting in a lack of basic information and statistical data required for the effective management and planning of services.

Developments already planned for 1980 (in particular for a redistribution of inpatient facilities) should result in alleviation of some of these problems, but so far it has not proved possible to produce an overall plan with agreed long-term objectives, covering both inpatient and extramural care.

2.2 Origins of the present situation

The deficiencies outlined above are in no way unique to Rotterdam. It would be misleading, therefore, to try to account for them in terms specific for that area - or, indeed, for the Netherlands as a whole. There are nonetheless a number of regional and national factors which must be understood if effective remedies are to be applied. Chief among those linked with the organization and structure of services is the lack of any effective links between the psychiatric hospitals and the community-based services. Until 1951 there existed an integrated system of services - albeit of a somewhat rudimentary nature - based on the hospitals. The setting up of a separate "social psychiatric" service for Rotterdam in that year, influenced by the work of QUERIDO in Amsterdam, resulted in a basic division between the extramural services (including pre-admission and after-care on the one hand and mental hospital inpatient care on the other), and since that time has tended to perpetuate the division.

Over the same period, the number of neuropsychiatrists engaged in free practice in Rotterdam has dwindled steadily. Earlier, these physicians relied for their incomes largely on their neurological practices, their psychiatric work being far from lucrative. Demand for psychotherapy, for example, appears always to have been much lower in Rotterdam than in some other cities of the Netherlands, notably in Amsterdam.

Attitudes and priorities in extramural care have changed since the 1960s, leading in some instances to anti-institutional and even antipsychiatric tendencies. The same trends have to some extent been reflected in a diminution of interest in the problems of the more chronic, severely ill and handicapped groups of patients, in favour of psychotherapeutic work and a theoretical preoccupation with mental health in the broad sense, as opposed to mental illness. Underlying this tendency can be detected an assumption that extramural services should concern themselves primarily with the effects upon mental health of the social environment, whereas it is the business of inpatient services to concentrate on the treatment of endogenous disease processes.

There is some indication that the social psychiatric service for Rotterdam, which is administered by the municipality, has suffered from a conflict of aims and priorities arising from its dual role: on the one hand as a psychiatric service with direct responsibility for crisis intervention, pre-admission care and after-care, and on the other hand as a municipal administrative agency which is an instrument of political policy. The lack of a clearly defined

role for the social psychiatric service has tended to create some mistrust and anxiety in the area, concerning the ultimate aims of the municipal authority.

There has been only slow development, amounting at times to stagnation in the psychiatric inpatient services for Rotterdam. In Delta Mental Hospital, for example, the largest single inpatient unit serving the area, scarcely any new developments took place during the 1960s and early 1970s - a period of great innovation and rapidly changing concepts of mental health care in many European countries. Since 1975 a new start has been made and a number of new developments are now in progress.

Finally, ideological and political conflicts with respect to the balance of private and public responsibility for mental health care have led to some extent to the identification of different models and philosophies of care with different political parties.

To these problems, intrinsic to the services and their structure, must be added a number of extrinsic problems, connected with the changing demographic, socioeconomic and cultural characteristics of Rotterdam, which are now leading to a growth in demand for mental health care and hence to an increasing pressure on the already overstrained, malfunctioning services.

3. Rotterdam: the area and its mental health services

3.1 Demographic and social structure

Rotterdam is a relatively young city. As recently as 1850 it had only 90 000 inhabitants. Population growth has occurred mainly in the past 100 years. Many labourers from the surrounding agricultural areas settled in the town with the coming of industry. By the beginning of this century, the numbers had risen to 320 000. At that time housing conditions were still generally poor, compared with Amsterdam and The Hague. Health standards were generally low and morbidity rates high: in the first quarter of this century tuberculosis was still the most important single cause of death. Rotterdam had 600 000 inhabitants by 1940 and reached its maximum population of 740 000 in 1964.

The bombing of the inner city in 1940 had many long-term consequences: old Rotterdam disappeared, the inner city population moved to the new outlying suburbs and the different population groups became much more intermingled. Post-war developments have accelerated these trends. The population size has declined slowly from its peak in 1964, due to a low birth rate and a high rate of outward migration - mainly to neighbouring municipalities. Table 1 illustrates this change.

Table 1

Birth, death and migration rates for 100 000
inhabitants, Rotterdam, 1975 and 1978

Year	Birth rate	Death rate	Migration	
			Outward	Inward
1975	9.0	11.5	54.8	46.9
1978	10.1	11.6	45.6	33.9

Source: CBS Regional Statistical Notebooks, 1977 and 1980

Currently, the population stands at about 590 000. A further decrease is forecast, to 548 000 in 1985 and 535 000 in 1990. This reduction in the city population will not, however, be reflected in the figures for the area of Rotterdam as a whole.

At present the population of the city is relatively old: 16% of the inhabitants are over 65 years, compared with the national average of 11%. Table 2 shows the age-sex distribution at the beginning of 1978. Demographic trends indicate that the proportion of elderly inhabitants will continue to rise for some time to come, especially in the city of Rotterdam itself and in the area

of IJsselmonde. A corresponding fall in the proportion of young persons is foreseen, the age group 12-16 years in particular being expected to diminish by as much as 50% over the next decade. These trends are summarized in Table 3.

Rotterdam has a registered immigrant population of 65 000, the largest groups being Surinamese from the former Dutch East Indies (19 000), Turkish (14 000), Moroccan (5 600), Yugoslav (4 300), Spanish (3 700) and Portuguese (3 600). These immigrant groups are at present made up largely of young single males, and live for the most part in the older central districts of the city.

The immigrant population is expected to increase to 90 000 by 1987 and by then will comprise 19% of the total population. An increase is also predicted in the numbers of unemployed (at present about 15 000) of handicapped persons and of single-person and two-person households. Already over 100 000 inhabitants of Rotterdam are dependent on social security.

In summary, the following trends are expected to become increasingly prominent over the next decade:

- a continuing drift of population from the older, central parts of the city to outlying suburbs and neighbouring municipalities;
- increase in the numbers of old people generally and, in particular, in the number of old persons in need of care and supervision;
- increase in the concentration of immigrants, with a corresponding rise in the frequency of associated social problems such as illiteracy (30-80% of immigrants) and difficulties of communication;
- increase in the numbers of the unemployed, mostly notably of the long-term unemployed;
- a rise in the numbers of handicapped persons with needs for rehabilitation and care;
- increase in the proportion of single-person and two-person households and consequently in the proportion of socially isolated persons.

These demographic and social trends are likely to lead to increasing difficulty, for many persons in the area population, in finding and maintaining a useful role in society and in participating in mutually supportive social networks. The resulting psychosocial stresses may be expected to give rise to an increased demand for help and support from mental health agencies.

So far, because of the lack of a psychiatric case register or any effective system for record-linkage, it has not been possible to monitor such developments in an effective way. Isolated statistics, such as the rising suicide rate for Rotterdam (increased from 8.4 per 100 000 in 1975 to 11.3 per 100 000 three years later) suggest an increase in mental and social pathology, but the existing indicators are relatively weak and unreliable. Much more accurate and detailed information will be required in future.

3.2 Present situation of the mental health services

3.2.1 Psychiatric inpatient facilities

Of all persons living in the Rotterdam area who must be admitted to a psychiatric inpatient facility, only 50% can be placed within the area itself. The remainder must be admitted to institutions situated at a greater or lesser distance outside the city, none of which have units or wards designated for Rotterdam patients. These hospital facilities cannot therefore be regarded as forming part of a network of mental health service for a defined area population.

Only an approximate estimate can be made of the number of psychiatric beds occupied at any point in time, or during any one year, by patients drawn from the Rotterdam area. On the basis of percentages shown in Table 4, the notional figure of 1911 psychiatric beds has been estimated. In addition, there are 162 beds in teaching and general hospitals - making a total of 2073 beds - as well as 64 day-treatment places.

From Table 4 it can be seen that the three psychiatric hospitals of greatest importance to Rotterdam, in terms of numbers of beds available for patients from the area, are:

- (1) Delta Mental Hospital in the southern part of the area, providing some 900 beds;
- (2) St. Bavo Hospital north of Rotterdam, providing nearly 400 beds (or approximately 50% of its total number of beds) for Rotterdam patients;
- (3) St. Joris Hospital north of Rotterdam, providing some 300 beds (also approximately 50% of its total number of beds) for Rotterdam patients.

Table 2
Distribution of city population by age and sex,
Rotterdam, 1 January 1978

Age-group	Male %	Female %	Both sexes %
0-14	18.5	16.8	17.6
15-19	8.3	7.8	8.0
20-29	17.5	15.2	16.3
30-39	13.1	11.2	12.1
40-49	11.5	10.8	11.2
50-64	17.4	18.9	18.2
65+	13.7	19.3	16.6
Total	100.0	100.0	100.0
No. of persons	287 264	303 048	590 312

Source: CBS Regional Statistical Notebook 1980

Table 3
Projected development of city population by age and sex,
Rotterdam, 1985 and 1990 (in thousands)

Age-group	Males		Females	
	1985	1990	1985	1990
0-19	62.4	61.5	60.0	59.0
20-64	164.5	159.2	161.9	154.2
65+	39.2	39.3	60.5	62.3
Total	266.1	260.0	282.4	275.5

Source: Provincial Planning Service of the Province Zuid - Holland.
Prognosis: AV 12R/AVHB 78

In addition, about 240 beds are available at the Bloemendaal Psychiatric Centre in the Hague and Schakenbosch Mental Hospital in Leidschendam, both situated well outside the Rotterdam area.

Apart from Bloemendaal, all these hospitals have a majority of beds occupied by chronic, long-stay patients. In three of them the number of patients admitted annually is still lower than the total number of beds; in Delta Hospital the number of admissions is just higher than the bed total and in Bloemendaal it is about 40% higher. Of all beds available for Rotterdam patients, approximately 60% are occupied by "chronic" patients (mentally retarded, psychogeriatric or mentally ill with over two years' duration of stay). This situation appears to be improving only slowly: in 1970 the proportion of "care" beds (i.e. beds occupied by patients hospitalized for over two years) in the five main psychiatric hospitals serving Rotterdam was 67.6%, and by 1977 it had fallen to 59.3% (see Table 5).

Each of the five main psychiatric hospitals has in recent years undergone its own development, independently of the others and with no coordinated plan for Rotterdam. Each can still take patients from any part of the area, according to the current availability of beds. There are major differences in organization, structure and staffing among these hospitals. St. Bavo, for example, has only 2.0 doctors and 7.0 paramedical staff per 100 beds, whereas Bloemendaal has 6.7 doctors and 14.7 paramedical staff per 100 beds.

The present provision of psychiatric hospital beds is generally considered to be inadequate in numbers as well as unfortunate in distribution, and plans have been approved for extensive redevelopment over the next 10-15 years (see section 4.3).

There are as yet only a limited number of psychiatric beds in teaching and general hospitals. The University Psychiatric Clinic, situated in the Rotterdam general hospital (AZR) has 88 beds for adults, of which 36 are used to provide a service to the Rotterdam area. In addition, there are 14 psychiatric beds for children and young persons in the Sophia Children's Hospital, which form part of the Clinic. Apart from these "academic" beds, there are two general hospitals in the western suburb of Schiedam, which each have 30 psychiatric beds at their disposal.

3.2.2 Psychogeriatric homes

The shortage of admission facilities for mentally disordered old people is seen as one of the most urgent problems of mental health care in the Rotterdam area. For many years there has been a need for additional psychogeriatric beds, estimated at about 200. This deficiency is reflected in long waiting-lists and prolonged waiting times for admission. In 1979 an average of over 500 old people were waiting admission to psychogeriatric units. The mean waiting time is estimated at about six months, but in many instances this waiting period stretches to over one year. A back-pressure is thus set up on the outpatient and primary health care services, which must devote a disproportionate amount of time and energy to dealing with the problems of severely demented old people and their families, though scarcely equipped to do so.

Apart from the overall shortage of psychogeriatric beds, there is also a problem of the quality and standard of care provided, since conditions in the homes do not always satisfy modern requirements. In Rotterdam, old people are still being admitted to three nonrecognized homes which do not fulfil acceptable criteria in any way. The two municipal psychogeriatric homes, with a total of over 300 beds, are themselves very antiquated. An additional home with 200 beds in Beekbergen (Gelderland), purchased by the Municipality of Rotterdam, is at a distance of 140km from the city and also offers only outmoded accommodation.

3.2.3 Facilities for alcoholic and drug dependent patients

The most important inpatient treatment agency for alcoholic and drug dependent patients from Rotterdam is the Dr K.H. Bouman Foundation, which has a total of 153 beds distributed among five intramural facilities as follows:

Alcoholic patients

- crisis and detoxification unit in Rotterdam (15 beds)
- observation ward in Rotterdam (45 beds for therapeutic treatment in groups)
- treatment ward at Schiedam (34 beds for individual therapy)

Other drug dependent patients

- crisis and detoxification unit in Rotterdam (15 beds)
- Clinic for drug dependent patients at Schiedam (35 beds)

Table 4

Present situation of psychiatric hospital facilities
serving the Rotterdam area: bed numbers and admissions^a

Hospital	Total No. of regist- ered beds	No. of beds actually available patients	Beds occupied by Rotterdam	Total No. of admiss- ions area	Admissions from Rotterdam
Delta	1 170	1 019	920	1 080	975
St. Bavo	880	757	370	430	225
St. Joris	650	600	290	515	270
Schakenbosch	485	475	160	410	145
Bloemendaal	662	656	80	899	120
Other	1 809	± 1 800	± 180	± 4 200	± 380

^a Based on 1978 figures

Source: DOGG Survey of Mental Health Services in the Rotterdam Area, 1980

Table 5

Numbers of "treatment" and "care" beds in the five main
psychiatric hospitals serving Rotterdam, 1970-77

Year	Treatment beds (2 year)	Care beds (2 year)
1970	1 225	2 770
1971	1 255	2 704
1972	1 305	2 582
1973	1 378	2 401
1974	1 393	2 256
1975	1 386	2 132
1976	1 352	2 064
1977	1 359	1 982

Source: Provincial Health Council of the Province
Zuid-Holland

These facilities together provide an important service for the area, taking approximately 1400 admissions annually. In addition, 45 beds for drug dependent patients are available in the Emiliehoeve, a unit of the Bioemendaal Psychiatric Centre, and a smaller proportion of Rotterdam patients are admitted for treatment there.

Many patients treated in the crisis and detoxification centres are subsequently referred to outpatient mental health care facilities; so far, however, there is no systematic cooperation with outpatient agencies in Rotterdam.

3.2.4 Homes and hostels for the adult mentally ill

About 350 beds for mentally ill and handicapped persons are available in a variety of homes and hostels in and around Rotterdam. These institutions are not controlled by any single authority and do not form part of an integrated service. About two-thirds are under the control of agencies represented on DOGG and about one-third are organizationally linked with psychiatric inpatient facilities. Fifty-three of the beds are situated in homes run on a private basis. No exact information is to hand concerning the extent of psychiatric, general medical or trained nursing supervision of patients or expatients residing in this heterogeneous collection of hostels, homes and boarding houses. Table 6 gives some information on the numbers of beds in the most important agencies and shows that about 60% are designated as psychiatric treatment or rehabilitation places; however, by no means all these places are filled and the different agencies are known to apply differing admission criteria. Moreover, there are many more "unofficial" places in small hotels, boarding houses, etc., where mentally deviant persons are tolerated but receive no active treatment.

Table 6

Distribution of beds in intermediate facilities (homes and hostels)
for the mentally ill in the Rotterdam area

Agency facilities	No. of of beds	Total No. treatment/ rehabilitation	Psychiatric
Dr J.H. Pameijer Stichting	9	165	+
Stichting Centrum St. Bavo	1	24	+
Zuidbuurthoeve St. Joris	1	20	+
Stichting De Rustenburg	3	70	-
Stichting Hilleviet	1	15	-
Huize Eben-Haëzer	1	20	-
Private homes	3	53	-

Source: DOGG Survey of Mental Health Services in the Rotterdam area.

3.2.5 Outpatient mental health services

The available basic information on psychiatric outpatient and related extramural services for the Rotterdam area is set out in Table 7.

Because these various agencies do not form parts of an integrated mental health service for a defined population, but have grown up largely independently of one another, there is no clearly defined differentiation of function and no firm allocation of responsibility. In practice, however, a small number of agencies are responsible for most of the general outpatient services for the mentally ill. Of the 13 agencies listed in Table 7, two are concerned only with child guidance and child psychotherapy, a third only with alcoholic and drug dependent patients and a fourth only with the mentally retarded. If in addition those agencies are excluded which are not mainly concerned with Rotterdam patients, a total of six agencies is left out, of which four provide a general psychiatric outpatient service.

Table 7
Outpatient mental health services for
the Rotterdam area

Agency	Type of care provided				
	a	b	c	d	e
1. Social psychiatric service GG & GD	+	+	+	+	-
2. Institute for mental health care IKS	+	+	+	+	-
3. Institute for mental health care NWN	+	+	+	+	-
4. Institute for mental health care ZHE	+	+	+	+	-
5. Institute for mental health care Gouda	+	+	+	+	-
6. Institute for mental health care Dordrecht	+	+	+	+	-
7. Outpatient service of the Institute for mental health care Waterweg Noord	-	-	+	+	-
8. Outpatient services of the main psychiatric hospitals serving Rotterdam	-	+	-	-	-
9. Institute for psychotherapy IMP	-	-	+	-	-
10. Outpatient service of the University Psychiatric Clinic	+	-	+	-	-
11. Sophia Children's Hospital of the University Psychiatric Clinic	+	-	+	+	-
12. Child guidance service Mathenesserlaan	-	-	+	+	-
13. Child guidance service Gunning Society	-	-	+	+	-
14. Institute for help with existential problems Mathenesserlaan	-	-	+	-	-
15. Ambulatory service of the Dr K.H. Bouman Foundation	-	-	-	-	+
16. Drugs and alcohol GG & GD	-	-	-	-	+

Source: DOGG Survey of Mental Health Services in the Rotterdam area.

a = Emergency psychiatric care

b = General ("social") psychiatric outpatient care

c = Psychotherapeutic care

d = Child guidance

e = Restricted to special patient groups (drug dependent, mentally retarded)

The task performed by the various agencies may be summarized as follows:

- (1) Five institutions provide "social" psychiatric treatment, two of them specifically for Rotterdam patients.
- (2) All outpatient services except those with highly specialized functions offer psychotherapy, although there are differences between them as regards the target-groups to which treatment is directed and the settings in which it is given.
- (3) Only one agency explicitly lists "family guidance" in its tasks, though some of the others in practice offer a similar approach.
- (4) Ambulant care for the mentally retarded and for drug dependent persons is provided in each instance by a single central agency, that for the drug dependent being part of a supra-regional service with a catchment area much larger than that of Rotterdam.
- (5) Outpatient psychogeriatric care is limited in the main to screening procedures and arrangement of admission in cooperation with the municipal social psychiatric service and the psychogeriatric homes.

Total professional manpower for the outpatient mental health services has been estimated at 312 full-time equivalents, of which slightly more than one-quarter are in services for the mentally retarded or drug dependent patients. The remaining 225 full-time equivalent posts carry responsibility for the full range of ambulant care for the mentally ill in an area population of 1.3 million. This is the equivalent of one professional worker - irrespective of type of training or qualifications - for 5700 inhabitants.

Table 8 summarizes the distribution of established posts among the 13 outpatient mental health agencies listed in Table 7. It must be emphasized that this table refers to numbers of established posts, rather than to the numbers of professional workers in post at any point in time. A proportion of these posts are vacant, so that the available manpower is actually less than the table appears to indicate.

Manpower statistics for the outpatient services alone are clearly inadequate as an index of the present situation, since they tell us nothing about the balance between the extramural and inpatient services. However, some strong inferences may be drawn from the table. First of all, the outpatient services of the psychiatric hospitals are grossly underequipped to carry the burden of after-care for discharged hospital patients; in particular, for those with schizophrenia and other chronic, severely handicapping conditions. Secondly, there are at present very large disparities in the distribution of the different professional groups among the various agencies. It is highly improbable that these differences can be explained simply in terms of the different types of patient-clientele dealt with by the agencies. Finally, taken as a whole, the manpower statistics serve to emphasize that care of the mentally ill and handicapped in the community cannot be administered by mental health professionals alone: in Rotterdam as elsewhere, a large part of the total burden of care must inevitably be carried by general practitioners, social workers, community nurses and other "front line" professional workers, as well as a number of voluntary agencies.

4. Existing plans and policies for mental health care

In recent years there has been in the Netherlands, at national and at regional level, a growing concern with the state of the mental health services, reflected both in new legislation and in the development of official planning. Long-term planning has become indispensable in the mental health field, particularly in view of the antiquated nature of hospital facilities in most developed countries and the large capital expenditure involved in rebuilding or renovation. The Netherlands presents no exception in this respect.

4.1 Legislation and planning at national level

The principle of regionalization is now an accepted part of government policy on health care. The Health Care Master Plan (1974) marks the beginning of a new phase in government policy, in which for the first time an official concept is presented of the direction in which in future health care should develop. The plan aims at making health services more effective by means of:

- regionalization of health care;
- division of health regions into so-called echelons;
- clear differentiation and combination of functions of the different services;
- cost control.

Table 8

Established posts^a for the different professional groups in Rotterdam outpatient mental health agencies

Agency	Medical ologist	Psych- ing	Nurs- work	Social	Other	Total
1. Social psychiatric service GG & GD	18.7	13.4	27.4	13.4	8	80.9
2. Institute for mental health care IKS	5.1	6.7	3.6	14.4	3.4	33.2
3. Institute for mental health care NWN	1.6	3.9	3	3	-	11.5
4. Institute for mental health care ZHE	3	3.8	5.1	2	-	13.9
5. Institute for mental health care Gouda	0.5	1.3	1.8	0.2	-	3.8
6. Institute for mental health Dordrecht	0.4	0.9	1.9	0.2	-	3.4
7. Outpatient service of the Institute for mental health care Waterweg Noord	2.5	4	-	5	-	11.5
8. Outpatient services of the main psychiatric hospitals serving Rotterdam	1.4	0.2	3.3	-	0.2	5.1
9. Institute for psychotherapy IMP	6.4	8.6	-	1	0.5	16.5
10. Outpatient service of the University psychiatric clinic	8	2.5	-	1	-	11.5
11. Sophia children's hospital (university psychiatric clinic)	11	3	-	4.5	1.5	20
12. Child guidance service Mathenesserlaan	0.5	1.3	-	4.1	1.7	7.6
13. Child guidance service Gunning Society	0.5	2.8	-	5.2	2.7	11.2
14. Institute for help with existential problems Mathenesselaan	0.1	-	-	6	-	6.1
15. Ambulatory service of the Dr K.H. Bouman Foundation	3	7.3	50.7	-	3.5	64.5
16. Drugs and alcohol GG & GD	1	-	2	2	-	5
Total	63.7	59.7	98.8	52	21.5	305.7

^a Full-time equivalents

Source: DOGG Survey of Mental Health Services in the Rotterdam Area

In the mental health field, the Plan aims ultimately at the setting-up of "regional institutes for mental health" (RIGG), in which inpatient and extramural facilities will be closely integrated.

The alteration of the Public Assistance Act, effective from the beginning of 1979, regulates the "indirect financing" of hostels, homes and other residential facilities for the mentally ill and handicapped, and may be considered a first step on the road to official recognition of such institutions. An official working group on protected forms of living for the mentally ill has recently completed its task and has submitted recommendations for the creation of adequate policy instruments to promote and regulate the after-care and rehabilitation services.

A departmental investigating committee established that about 9000 of the country's current total of 23 000 psychiatric beds were located in hospital wards that should be demolished, since they could no longer be renovated adequately to fulfil modern standards of hospital accommodation. Accordingly, a target was set for the replacement of some 6000 beds in obsolete wards by new units due to be under construction by the end of 1980.

In a discussion paper, the Government has outlined the tasks and functions of a psychiatric hospital, encompassing outpatient and day-patient care, provision of evening, night and weekend emergency cover, observation and short-term treatment facilities, continuing clinical treatment and long-term care and rehabilitation. In addition, the following option functions are listed:

- a psychiatric unit for children;
- a ward for patients who are aggressive or severely disturbed in behaviour;
- a unit for assessment and short-term treatment of psychogeriatric patients;
- a ward for mentally retarded patients with psychiatric disturbances;
- a psychiatric hostel.

A further expansion of the psychiatric outpatient services has high priority in official government policy on mental health care. The current curtailment of public spending, resulting from the economic situation, will not affect this field, for which a 6% annual growth rate is guaranteed.

The Netherlands Association for Ambulatory Mental Health Care (NVAGG) has proposed a target for the setting-up of comprehensive regional outpatient services throughout the country by 1982; this target, however, has not been accepted by the Government.

Since 1976, a special subvention has gone to outpatient services to promote consultative activities with general practitioners, social workers and community nurses. It is hoped that the effectiveness of these primary care-givers in the mental health field will be increased and that referral of the milder forms of emotional and mental disturbance to specialist agencies may be diminished. The effectiveness of these consultative activities will be evaluated.

In 1975, the Secretary of State for Public Health set up a committee to advise on the rights of patients in psychiatric hospitals. A Bill on formal admissions to psychiatric hospitals intended to replace the Lunacy Act, was presented to Parliament in 1979 and is now undergoing revision.

4.2 The trend towards regionalized services

The trend towards regionalization called for in the Health Care Master Plan is at present more evident in certain other areas of the Netherlands than in Rotterdam. The Hague may be taken as an example in this respect. Here, an association of 16 participating mental health agencies was set up in 1975 to promote cooperation among the agencies, with a view to their integration into a regional institute. So far as outpatient services are concerned, the decision was taken early in 1980 to join together in a single body under public control. The greater area of the Hague (700 735 inhabitants) will in future be served by a single regional institute of outpatient services with the following functions:

- provision of a 24-hour, seven days a week service for psychiatric emergencies and crisis intervention;
- disposal and admission to psychiatric hospitals, homes and hostels, etc.;
- provision of psychotherapeutic outpatient treatment;
- provision of services for alcoholic and drug dependent patients;

- preventive and consultative work;
- postgraduate professional training;
- documentation and collation of statistical data.

The greater area of the Hague will be divided into 4 sections, each with 200 000-250 000 inhabitants. It is also planned that the individual sections will be subdivided into smaller districts of 20 000 to 40 000 inhabitants, each having a mental health team for "intake", short-term outpatient treatment and consultive work with general practitioners and other primary care-givers.

Though there are still a number of unresolved problems in relation to budgeting, the assimilation of some denominational agencies, etc., the way now seems open to the creation of a truly integrated outpatient service for the mentally ill in this region. The next, more difficult step, will be to incorporate psychiatric inpatient facilities into this system: in particular the four psychiatric hospitals and the inpatient unit for drug dependent patients which serve the Hague.

4.3 Plans for the Rotterdam area

The mental health services for Rotterdam are also undergoing change. Here, however, there is as yet no unifying concept; planning so far has been related to particular agencies or types of care rather than to a comprehensive service for the area as a whole.

Three plans exist for the further development of inpatient facilities for the area, namely:

- establishment of a new psychiatric hospital in the eastern suburb Capelle an den IJssel, by the St Bavo Foundation;
- establishment of an annex of the St Joris Hospital in one of the western suburbs, to provide beds as well as outpatient and day-patient care;
- reshaping the clinical care provision by the Delta Mental Hospital, by dividing the present 900 bedded institution into 2 autonomous units and relocating of one of these units more centrally in the Rotterdam area.

Planning for the future provision of inpatient facilities is based on the official national target of 1.6 psychiatric beds per 1000 inhabitants. It is, however, accepted that there must be considerable variation around this norm, according to regional variations in need. Moreover, there is still some uncertainty about the definition of a "psychiatric bed" on which this target figure is based, and about the extent to which norms of this kind are intended to include, for example, places in psychogeriatric homes and after-care hostels.

Following the recommendations of a report on the planning of nursing homes in Rotterdam, published early in 1980, a phased plan has been drawn up by a working group appointed to examine the problems of rebuilding and new building in this field.

The setting up of the DOGG as a consultative body representing many of the mental health agencies in Rotterdam may be seen as the initial formal step towards the creation of unified outpatient services and, in the longer term, towards complete integration along the lines currently being pursued in the Hague and elsewhere.

In conclusion, it appears that the present situation in Rotterdam is by no means one of stagnation; nevertheless, progress has been slow and the area is lagging behind other parts of the Netherlands. There is still no general agreement as to what changes are required or how to proceed with reorganization.

5. Principles and objectives of mental health care

5.1 Basic principles of care provision

A major obstacle to progress in the Rotterdam services has been the lack of clearly defined principles and objectives of mental health care. One important task of the Workshop, therefore, was to formulate a set of basic principles which would act as a guideline in planning future developments. Fortunately, there is a broad consensus of informed opinion as to the nature of these principles, based on experience of the development of community mental health care in many countries over the past 25-30 years and backed up to some extent by the findings of scientific research. Many of the principles have been explicitly stated in the reports of national commissions and have thus had an influence on legislation and official policy on mental health

care. They have also been categorically endorsed in the reports of WHO expert committees and working groups, including those cited in paragraph 1.3 above. The most important of these principles can be summarized in the following way.

- (1) Services should be accessible to the local population. In particular, treatment facilities should be situated within easy reach of patients and their families.
- (2) They should be comprehensive in the sense of providing a range of facilities to meet the special needs represented by the different kinds of mental disorder and mental health problem existing in the service population.
- (3) They should maintain close and effective links with the local communities they serve and should be responsive both to the needs of individuals and to the changing patterns of need within these communities.
- (4) The service agencies should be effectively coordinated to create a network of mental health care, able to provide for patients at all stages of their illness from the initial onset to the point of complete recovery and independence.
- (5) The services should be equitable, i.e. they should be available to all sections of the population irrespective of financial considerations or any other form of discrimination.
- (6) They should provide for all patients therapeutic and supportive care of a quality acceptable in the light of modern knowledge and consistent with the wellbeing, rights and dignity of the individual patient.
- (7) The scope and responsibilities of the service system as a whole, as well as of its component parts, should be clearly defined in terms of the population served, the types of conditions and problems accepted for care and the therapeutic, supportive, preventive, teaching and research functions to be fulfilled.

The practical value of such a set of principles is that they supply criteria for judging not only the adequacy and quality of existing services, but also the extent to which innovations and new developments are successful in bringing about change in the desired direction. In short, they offer a basis for the evaluation of mental health services.

5.2 Functions of a comprehensive mental health service

Definition of the basic principles of care provision leads on naturally to a consideration of the functions and priorities of a comprehensive mental health service. Functions are most readily classifiable in terms of the various types of activity involved and of service offered. The following short list is compiled from information papers made available to the Workshop:

- (1) psychiatric emergency care and acute psychiatric treatment;
- (2) continuing clinical treatment;
- (3) rehabilitation and resettlement;
- (4) long-term residential care;
- (5) long-term ambulant supervision in the community;
- (6) consultation services, including specialist consultation to other medical and social agencies, counselling to self-help groups, etc.;
- (7) preventive work - in particular, screening and early detection of mental disorder in the community;
- (8) staff training and further education;
- (9) documentation; collation and analysis of statistical data;
- (10) participation in applied research.

Many additions could be made to this list and, moreover, it is obvious that the various functions overlap with one another to a great extent. In the last analysis, all the other items could be subsumed under the single heading of prevention, since, as has been rightly commented, a comprehensive mental health service is fundamentally an attempt to realize the primary, secondary and tertiary stages of prevention of mental disorder. Nevertheless, a list of this kind is helpful in checking to what extent an existing service is fulfilling its proper functions.

Such a list by itself cannot provide an adequate basis for evaluation. For this purpose it is also necessary to specify the target groups of patients and clients to whom the services in question should be delivered, and to establish a system of priorities. The consensus of opinion in

the Workshop was that first priority should be accorded to the treatment of those members of the community who are suffering from severe, florid mental disorders (schizophrenia, organic psychosyndromes, chronic alcoholism, acute depression, etc.), but that the psychiatric specialist resources should also continue to play an active part in the treatment and care of patients with milder forms of mental disturbance (milder depressive reactions, neurosis and psychosomatic disorders), and of high-risk subgroups of the population, working in close conjunction and collaboration with primary health care agencies. In particular, the need for a much closer cooperation between psychiatric services and the general practitioners was strongly emphasized.

5.3 Practical implications for the Rotterdam services

What are the implications for the mental services in Rotterdam of an acceptance of these broad principles and priorities? First of all, the need for services to be acceptable to the communities they serve, and to be responsive to the needs of these communities, implies that the service area must be limited in size and, equally, that the population served must be limited in numbers. There are no generally accepted guidelines laying down the size of population to be covered by a mental health service: in the United Kingdom and the Federal Republic of Germany, expert opinion favours an area service for 200 000-300 000 inhabitants, because most types of specialized facility (day-hospitals, sheltered workshops, services for alcoholics, etc.) can be provided within such an area; in some other countries, "sectors" with populations of 40 000-60 000 are preferred, because these offer the possibility of closer working links with primary care-givers and community agencies.

Secondly, if an area mental health service is to be comprehensive, it must be in a position to provide inpatient, day-patient, outpatient, intermediary and rehabilitation facilities for persons suffering from a wide range of mental disorders, with many of them requiring special forms of care. Moreover, if these various agencies are to be effectively coordinated with one another, they must be linked together in a network controlled by an effectively functioning administrative body, which also takes responsibility for short- and medium-term planning. These requirements call for the setting up in each defined service area of an administrative body with full executive powers.

Finally, the principles relating to equitability and quality of care imply a unified system of regional budgeting and financing, controlled by central long-term planning and with the eventual aim of direct comparability with general health care costs.

5.4 Constraints on future development

Progress towards these objectives is hampered by a number of constraints and obstacles, some material, but others arising for less tangible reasons. Many, as has been noted, have a historical background and cannot be expected to yield easily to any rapid solution. But pinpointing these obstacles is the first step towards overcoming them.

Constraints in mental health services development relate to problems of material resources, manpower, coordination, information, administration and policy and, finally, professional and public attitudes.(2) The Workshop identified the following factors as being of major importance in the Rotterdam situation (though not necessarily in this order of importance):

- (a) shortage of skilled manpower and an imbalance in the distribution of trained professionals;
- (b) lack of trust between the various agencies and authorities: fear of loss of autonomy and of being swallowed up in a bureaucratic system;
- (c) reluctance of the various authorities to coordinate or to agree about joint-user arrangements and sharing of responsibilities;
- (d) lack of mutual exchange of information between the different agencies and services;
- (e) lack of agreement about policy and objectives, partly due to differing philosophies of mental health care and to conflicting ideologies;
- (f) the diversity of sources and channels of funding;
- (g) the differing salary grades and conditions of work for members of staff of different agencies - for example, those who are civil servants and those who are not;
- (h) lack of a clear national policy with regard to the development of comprehensive, integrated mental health care;
- (i) professional conservatism and reluctance to accept change;
- (j) public reluctance to accept and to tolerate the presence of mentally handicapped and behaviourally deviant persons in the wider community.

It will be noted that one major factor - shortages of material and economic resources - is missing from this list. Of course such shortages exist, and act as a major constraint on the

development of mental health services in Rotterdam, as elsewhere. But the Workshop was not of the opinion that the development of an integrated, community-based type of service must necessarily entail greater capital and running costs than would in any case be required in future to rebuild the existing antiquated institutions and to maintain the present, highly inefficient service system. From this viewpoint, an integrated regional service was considered to offer the "best buy" solution for the future.

In view of the formidable list of constraints set out above, it seems evident that Rotterdam cannot achieve the goal of a comprehensive, community-based service overnight. Nevertheless, many of the factors specified in this list lie to some extent within the control of the agencies and professional groups directly concerned, so that there are possibilities for initiating change in the desired direction quite quickly, if appropriate strategies can be applied.

6. Conclusions and recommendations

The Workshop was strongly of the opinion that the Rotterdam services should not wait for a solution to be imposed from outside - as, sooner or later it must be if the situation does not improve - but that they should now actively pursue ways and means of implementing change through the setting up of a joint programme of planned innovation. This will call for a much closer and more active collaboration than hitherto between the various agencies concerned.

The first step must be seen as agreement on common goals and objectives. The group considered that the report of the Workshop should be seen as providing a possible basis for such agreement and tried to formulate its conclusions and recommendations accordingly.

6.1 Establishing medium- and long-term planning targets

Work should begin as soon as possible on the planning and development of regionalized (sectorized) mental health services for the area of Rotterdam. While detailed planning proposals were thought to lie outside the scope of the Workshop, some general guidelines were agreed as a basis for follow-up discussions. It was considered that 3 levels of organization should be established.

- (1) A mental health region covering the 1.3 million inhabitants of the Rotterdam area. At this level, a board should be set up, responsible for long-term planning in close collaboration with the municipalities and province.
- (2) Mental health care areas each for a service population of 200 000-500 000 (preferably 200 000-350 000). At this level, all services should be administered by an executive body with responsibility for management and finances, including short- and medium-term planning.
- (3) Mental health care districts with service populations between 30 000 and 60 000. At this level, the specialist mental health services should be organized to provide local community-based care and to cooperate closely with the primary care-givers, such as general practitioners, social workers and public health nurses.

Both at the area and at the regional level, the newly created executive bodies should include representatives of both inpatient and extramural services, the first line care-givers, the municipalities, financing bodies and the service "consumers" (patients or clients and their families).

To ensure accessibility of care, it was thought essential that appropriate facilities should be available within each area for all forms of mental disorder, except those requiring a high degree of specialization. The area services should therefore include facilities for (though not necessarily limited to) the following:

- psychiatric emergencies, acute and short-term treatment;
- chronic mental illness and handicap (including day-care, hostels, rehabilitation and sheltered workshops);
- psychogeriatric services;
- chronic alcoholism and drug dependence;
- extramural care of disturbed children and adolescents;
- psychotherapeutic and supportive care of ambulant patients.

Certain forms of specialized treatment and care, in particular inpatient services for children and adolescents and units for violent, aggressive patients, should be provided at the regional

rather than the area level. At this level there should also be effective links with university departments and training institutes.

The Workshop emphasized that an effective system of registration and basic documentation is an essential prerequisite for planning both at the area and at the regional level. This aspect of planning is regarded as especially urgent because of the need for an adequate data base at the outset to enable the effects of planned change in the services to be effectively monitored and evaluated.

6.2 The transitional period: progress and priorities

The establishment of a set of priorities governing the transition to a comprehensive, community-based system of mental health care presented the most difficult single problem considered in the Workshop, since it is above all on this issue that all attempts so far made to initiate a radical change have come to grief. Perhaps not surprisingly, therefore, the Workshop did not succeed, in the short time available, in establishing a detailed list of priorities or in stipulating in a precise way the transitional goals to be achieved in moving towards a fully integrated type of service.

A consensus of opinion was, nonetheless, reached with regard to a number of fundamentally important issues. First of all, it was agreed that the initial steps in implementing change should be taken without waiting for any additional funds to become available, other than the relatively modest amounts required to cover the costs of setting up an effective liaison and communication service for the various agencies. The most urgent and immediate problem, in respect of financing, was seen not as the size of the total available budget, but rather the diversity of sources and channels of funding and the resulting disparities between different agencies.

Secondly, it was considered important that the first steps towards "sectorization" within the psychiatric hospitals serving Rotterdam should begin as soon as possible. There has been a widespread tendency to assume that the difficulties to be faced in implementing a policy of regionalization will arise mainly or even exclusively from problems of integration - as, indeed, so far as outpatient services are concerned, they probably will. But it must be borne in mind that for the hospital services the problem will be largely one of differentiation: that is, of the setting up of clinically autonomous units within the hospitals, with their own psychiatric teams, each carrying responsibility for a defined regional population. This latter development will pose its own administrative and political problems. It is therefore urged that the two lines of development - outpatient service integration and hospital sectorization - should both begin as soon as possible and should proceed in parallel, with the maximum of coordination and exchange of information.

Finally, it was considered neither feasible nor desirable that area executive bodies, whether under the name of mental health "institutes" or in any other form, should be established in Rotterdam in the immediate future. For the transitional period, some form of coordinating body will be required for each area, on which all mental health agencies providing services to the local population are represented. In order to function effectively, these coordinating bodies, or "consortia", will each require the services of a small staff responsible for liaison work and for the collation and exchange of information.

6.3 Implementing change: a programme for action

The Workshop decided that their recommendations should be put forward in the form of a programme for action, as follows:

1. The summary report of the Workshop should be adopted as a statement of policy by the mental health community of Rotterdam as a whole.
2. The DOGG is recommended to adopt this report as a basis for future action;
3. All mental health agencies and professional groups serving the Rotterdam area who were not represented at the Workshop should be informed as soon as possible and should be brought into the further discussion and planning process.
4. The draft final report of the Workshop should be brought to the attention of local provincial and national government, of professional bodies, the press and the public.
5. As a first step in the planning process, local and provincial government should be brought into the DOGG and the representation of mental health agencies serving the area of Rotterdam should be made complete.

6. Mental health care areas covering Rotterdam should be geographically demarcated and their links with all mental health services, including those outside the urban limits which provide a service for Rotterdam, should be specified.
7. In parallel with this development, a policy of "sectorization" should be implemented within the psychiatric hospitals concerned, in order to create well defined inpatient facilities within these hospitals for patients from the different sectors of Rotterdam.
8. Working committees should be set up by the enlarged DOGG to examine various aspects of the process of regionalization, and should appoint liaison officers to work in close collaboration with the mental health agencies in each area. High priority should be given to the setting up of a working committee on registration and documentaton.
9. As an initial step towards regionalization, a "consortium" should be set up in each area, representing the various mental health agencies and professional groups involved, together with a proportion of professional, administrative and lay members from outside the mental health field (including representatives of the "consumers").
10. Plans for the implementation of comprehensive, integrated mental health care services in each area, corresponding to its needs, should be drawn up by the area consortia in collaboration with the working committees. Each plan should set out a specific time-table for the implementation of proposed changes and new developments. Time-tables for the plans of the different areas should be coordinated at regional level.

Finally, it should again be stressed that changes in the organization and structure of services will only succeed if they are accepted by the professional groups most closely involved. If proposals for change are to be seen as representing an opportunity, rather than a threat, they must be fully discussed with all the affected groups, including those who could not be represented at the Workshop, as well as with the medical profession, social services, the various authorities and other interested bodies.

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