which drug and alcohol problems are perceived, and how they are approached (Feltham, 1989). We found a considerable interest on the part of the people we met to learn how we tackled these problems and a willingness to discuss critically their traditional approaches. There is certainly scope for continuing exchange with Soviet colleagues.

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Letter from . . .

Sittard (The Netherlands)

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The Psychiatric Department of the General Hospital (PDGH) Sittard/Geleen has a catchment area of about 160,000 people. As a PDGH we have 42 beds and five seclusion rooms available. Besides this we offer day-treatment (16 places), run an out-patient department, provide psychiatric consultation and training facilities.

At the moment there are 65 similar PDGHs in the Netherlands. This does not include departments, generally small, which do not meet the required criteria to be officially recognised. The total number of PDGH-psychiatrists is estimated at 160. There are 15,000 admissions annually, accounting for 34% of the total number of psychiatric admissions in the Netherlands.

It might be interesting to give a short review of the history of the PDGH in the Netherlands.

The oldest PDGH has been in existence since 1931. In the '60s and '70s the number of PDGHs increased rapidly. Also around this time, the majority of combined neurology/psychiatry departments were split up. At the beginning of the '70s a series of articles, reports and papers began to shed more light on the subject of PDGHs.

A characteristic description might be that PDGHs are small-scale, low threshold departments evenly distributed throughout the country, in which a clear inter-relationship exists with both the other specialties and the partners within the regional mental health care system. Their aim is to provide primary, non-stigmatising and relatively short-term psychiatric intervention for a fairly large and differentiated population. The emphasis lies on integral diagnosis in parallel with a modest range of therapeutic possibilities.

At present, consideration is being given to functionally oriented management and organisation of mental health care facilities with classification according to target group (youth, adults, the elderly, addicts, etc.) and type of care (preventive, curative, etc.).

Mental health care in the Netherlands has been sub-divided into approximately 40 regions, so called Regional Institutes for Mental Health Care (RIMCH). In these we find:

intramural (General Psychiatric Hospitals [GPHs], PDGHs, Psychiatric University Clinics [PUCs] and Specialised Psychiatric Hospitals)
semi-institutionalised (day-treatment in Psychiatric Hospitals, PDGHs, PUCs, sheltered residence units and crisis intervention centres) and
extramural facilities (Regional Institutes for Ambulant Mental Health Care [RIAMHCs], psychiatric out-patient departments of Psychiatric Hospitals, PDGHs and PUCs as well as independently established psychiatrists and psychotherapists.

Part of the General Hospital and the PDGH, Sittard.

The degree of cooperation within these RIMCHs is far from uniform. Its improvement is a special point of interest of our PDGH within our region.

Regarding the differences between the intramural facilities, the PDGH in general is relatively small (28 beds compared with 72 for PUC and 302 for GPH). The PDGH has a low level of stigmatisation, high accessibility, a good interaction with other medical specialties, good availability of consultation and somewhat lesser availability of treatment. The PUC (total of 507 beds) scores best on the availability of consultation and treatment. The most available beds are at the GPHs (24,132).

As mentioned before, it seems necessary for intervention and treatment facilities to be better harmonised within the regional cooperation framework of mental health provision. The functions should play a more pivotal role than the institutions.

The PDGHs would, in view of their typical characteristics and particular suitability for integral diagnoses, be especially appropriate for patients requiring psychiatric admission for the first time. Because small departments can offer only a restricted range of facilities, a minimum department size is essential. Much is to be said, therefore, for regionally centralised PDGHs with, for example, 24–40 beds, a day-treatment capacity of 8–16 and, where possible, other specialist functions such as medium term resocialisation.

Every general hospital should at least have access to a psychiatric consultant and this implies that the number of psychiatrists employed in this sector will have to be increased.

Finally, we would like to make some additional remarks. In the near future, largely as a result of the de-institutionalisation of psychiatric hospitals and the increase in the number of psycho-geriatric disorders, a greater number of patients, including those of a more difficult nature, is, as in the USA, expected to be making calls upon the provisions of the PDGHs. Consequently, the capacity and expertise of the PDGHs will have to increase. It would seem advisable that planning be influenced by the results of research into the functioning of PDGHs. More research into general hospital psychiatry is necessary.

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