

in treatment of the same; (5) using a variety of psychological methods in treatment of the same; (6) re-introducing (rehabilitating) sufferers into normal daily life. It is a waste of time and training for me to act as a careers adviser, marriage counsellor, or be friendly to people who are not ill but facing one of the hardships that crop up in every normal life from time to time. The fact that people are willing to pay me for my advice, counselling, or friendship is neither here nor there; but some other facts are more relevant.

Psychiatrists are in short supply for the amount of illness and disability that exists in the world. A given population can only produce a finite (rather small) number of trained psychiatrists, because only a limited number of people have the requisite abilities, and some of them must become engineers, scientists, lawyers, administrators, etc. and not doctors, let alone psychiatrists (and student vacancies for the long training are limited also). However, the population may also produce professional and voluntary counsellors of various sorts, some requiring only very short training, and tapping to some extent a different range of abilities.

In Britain (even before the National Health Service began) general practitioners guided patients to the appropriate specialist, and the specialist psychiatrist sees only patients selected by GPs, and then works with the GPs in treating them. This seems to me a more efficient use of the specialist and a better service to the patient than the Canadian open door, where each doctor works independently and the patient can shop around as he fancies and can afford. This also involves the old debate: does psychiatry touch all aspects of life, or is its function limited? Which kind of work do you most enjoy doing?

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### **Competition in mental health care**

DEAR SIRS

In the *Bulletin* of October 1986 (10, 262–265) you published an article by Dr M. Peet, entitled 'Network Community Mental Health Care in North-West Derbyshire'. I would like to compare the experience in The Netherlands with the network system as described by Peet.

Although the network system in the Netherlands was already operating in the thirties, it was composed of small institutions working separately from each other, offering services for different patient populations—adult psychiatric patients, alcohol and drug addicts, patients with psychosomatic disorders, the demented elderly and psychiatrically ill children.

In this system there were also small institutions offering different services for the same populations for instance, crisis intervention, rehabilitation services, psychotherapy and marital counselling.

Since January 1982 these services have been integrated into one institution per health care region for a population

of  $\pm 200,000$ . These services are founded by means of a population-wide social security law. At the same time two mental health case registers were in operation, one in the North and one in South of The Netherlands.

With these instruments it will be possible to enter census data for a geographically defined area and compare different areas. Our experience from these data is that the total amount of mental health care consumption does not differ much between regions but that the difference between regions is primarily made up by a difference in services offered and used. In our opinion, this indicates that it is quite possible to use alternatives in mental health care services, as Peet indicates.

In The Netherlands the effect on hospital admission is not as striking as mentioned in Peet's article. This is mainly because in The Netherlands the two broad conceptual models of community care, 'the hive system' (representing the hospital as the centre of activities) and the 'network system' (emphasising the development of a network of community services), are working separately from each other in each health care region. This provokes competition in keeping patients: a part of the patients referred from the 'network system' into the 'hive system' do not return to the network system, and this was found in the Northern region as well as the Southern region. The net loss of the network system in a year is 75 patients.

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### **Human beings and knowledge**

DEAR SIRS

I wonder if any of your readers would be interested in ancient Eastern comments on the relationship between human beings and knowledge. The following are quotations from Chuang Tsu, a follower of Lao Tsu the founder of Taoism, who lived in the fourth century B.C.

"Life has a limit, but knowledge is without limit. For the limited to pursue the unlimited is futile".<sup>1</sup>

"Great knowledge is all encompassing; small knowledge is limited. Great words are inspiring; small words are chatter. When we are asleep, we are in touch with our souls. When we are awake, our senses open. We get involved with our activities and our minds are distracted. Sometimes we are hesitant, sometimes underhanded, and sometimes secretive. Little fears cause anxiety, and great fears cause panic. Our words fly off like arrows, as though