

*Psychiatric RESidential care Communities: Upgrading and Enhancing skills and competences for member of staff professional qualification”*

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## RESEARCH AND CONTEXT ANALYSIS

### NATIONAL REPORT FOR THE NETHERLANDS – EXECUTIVE SUMMARY

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Mental health care policy in The Netherlands proceeded gradually during the last decades. Instead of closing down psychiatric hospitals for long term patients, in The Netherlands the number of psychiatric hospital beds were only cut down by 15 to 20 per-cent during the last 25 years. At the same time an increase in sheltered housing took place. As a consequence we see an considerable increase in the number of people who are in permanent hands of mental health care. In 1980 about 30.000 people remained in mental hospitals or in any form of sheltered housing, in 2005 there were over 42.000.

Health care in The Netherlands has always been a mix of public and private enterprise. Legally spoken all hospitals and facilities are privately governed and privately managed. But laws and regulations restrict the freedom of the care entrepreneurs.

As one can understand from its historical background there is no clear separation between traditional and community care in The Netherlands. Traditional institutional hospital care developed very slowly toward a mix of psychiatric wards, ambulatory care, case management and outreach care, rehabilitation programmes and a range of long term housing

Formally there are no community based mental health services in the Netherlands, as the general practitioner is gate-keeper for all care where medical specialists are involved. So citizens can not enter a mental health care facility without a referral.

At the other hand, during the eighties and nineties most of the mental health care facilities were transferred into the communities. In these often multifunctional centers all kinds of treatment and care can be provided, from psychotherapy for depression diagnosed clients to admissions for psychotic patients.

The supplied psychiatric community care has the following aspects:

- crisis care: crisis intervention, clinical crisis admission, involuntary admission
- 'bed-on-receipt' 'time-out-bed' (voluntary crisis beds for short time-out periods)
- crisis card (not in every region): description of appointments between client, environment and caregivers in case of crisis
- case management
- all types of home care: intensive psychiatric home care, home support, assertive community treatment, meddling care etc.
- all forms of housing: sheltered housing, supported independent living, shelters for the homeless and roofless
- meeting centres, day activity centres
- working projects, adapted jobs, job coaching
- consumer run projects, run by volunteers or ex-clients (part time jobs)
- partner-groups, run by clients
- 'mates'-services (kind of buddy projects)
- sporting groups (i.c. walking and running)

The Dutch mental health care is staffed by 60.000 workers (46.000 fte), and this number is still growing. This means that there is 1 fte available for every 348 citizens, or 287 fte per 100.000 citizens.

There are 2.300 psychiatrists and 10.000 psychologists working, half of which are registered psychotherapists. We count over 15.000 psychiatric nurses, 6.000 social workers; 6.500 workers are 'lower' educated (social coaches etc.).

Of all the workers in the Dutch mental health care 52 % is high-educated (university and college with advanced training) and only 11 % is low-educated (intermediate vocational education).

There is no basic education for professionals working in the field of community based psychiatry or psychiatric community care. As we mentioned earlier, every professional is considered to be able to deliver community care.

Strong points of the Dutch mental health system in view of community care:

- In all catchment areas mental health care is available for all citizens
- In all catchment areas almost all necessary kinds of treatment and care are available
- The mental health care system is rather accessible, although referral by a GP is formally needed
- Client participation has developed well; many (consumer run) facilities support clients in their attempts to survive within the community
- Although complex the financing system is good
- Registration of treatment and care is relatively good. More and more figures ('production') are available
- Long term research about the mental health care situation of the population provide significant data
- Research on mental health (care) and support for MHC organisations and staff has developed well

Weak points:

- The division between 'cure' (treatment) and 'care' within the system is unclear and threatens to complicate the system
- Risk of psychiatrization (too many professionals?)
- Too slow development towards psychiatric community care
- Registration, control, staff meetings, quality systems etc. take more and more staff time at the expense of the available time for clients

- Although accessibility is rather good, the patients flow has blocked at many places within the system. Waiting lists for supported housing and specialised care are everywhere, despite or thanks to the relative richness of the system?
- Stepped care is often frustrated by waiting lists and bureaucracy.

Opportunities:

- Size and content of the sector. The sector is relatively rich, so shifts in funding must be possible
- Willingness to innovate among substantial parts of the working staff

Threats:

- Separation between cure and care, especially for long term patients
- Adoption of alternative facilities within the MHC-system often leads to encapsulation; facilities have to adapt to new regulations (in order to get money) that may kill all creativity.
- New financing laws and new bureaucracy