Thesis summary

Deinstitutionalisation of mental health care in the Netherlands from 1993–2004

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[S.l.: s.n.], 2005, pp.137,
Thesis University of Utrecht,
ISBN 90 9019167 4

The results presented in this review are based on my thesis presented at the University of Utrecht, the Netherlands on 4 March 2006. The main aim of the research was to study the deinstitutionalisation of Dutch mental health care from 1993 to 2004.

The number of psychiatric patients in asylums in the West increased to 3,000 per asylum in the middle of the 20th century in Europe and 10,000 in the USA. These increases were due to increasing psychiatric illnesses and to the way society dealt with psychiatric patients. The need for more humane circumstances and the availability of better therapies was the basis for changes in the second half of the 20th century. In certain regions and countries in the West, another policy was developed and implemented, varying from gradually diminishing the number of admitted patients and the number of asylums to the abolishment of psychiatric institutions. In the Netherlands, after 1955, only a gradual and slow decline of 20% is seen until 1990. In 1993 a new period started with integration between ambulatory and clinical general mental hospitals (asylums).

The overall research question in this thesis is how Dutch mental health care developed specifically toward deinstitutionalisation from 1993–2004. This question is worked out in four research questions that have the country, regional, institutional and programme level as their subject. The research was based on questionnaires and data published by mental health care organisations and the regional and national Dutch government. Special attention was paid to definitions, selection of questions, representability of the respondents, neutrality of the interviewers, checks on data and use of different sources of information for verification and interpretation. Dropout rates in the four studies were respectively 1, 0, 3 and 29%.

The results show a massive merger process of ambulatory and clinical mental health facilities. This process is aimed at building integrated regional mental health care centres, integrated regional care networks and integrated care programmes instead of the formerly divided clinical and ambulant services. These new integrated mental health centres are mostly located in sub regions (80–400,000 inhabitants), improving continuity of care, reducing clinical care by ambulatory alternatives, providing care at a shorter distance and with greater differentiation and providing less overlap and fewer gaps in care provision. Consequences are substitution of clinical facilities by day care treatment, home care and sheltered ambulatory housing. Only a slight positive effect was measured on the quality of care programmes. More than just merging institutions and wards are necessary for implementing evidence based care, especially toolkits for a specific diagnostic group, like patients with schizophrenia. A massive reduction and reallocation of the original psychiatric hospital beds was prognosticated between 5 to 10 years, reducing the total asylum capacity by 50% to 6,000 beds.

For the readers of the IJIC it is of special interest to learn that, by integrating ambulatory and clinical psychiatric care, clear estimates are necessary for the minimal capacity of short-term and long-term clinical beds especially in closed wards and seclusion rooms in sub regions. This process also has effects on the wards that are 'left-behind' and the reduced general psychiatric hospitals, especially the capacity of the asylum function.

A further observation is that insufficient attention has been paid to reinstitutionalisation processes that are seen in other Western countries. Reinstitutionalisation is due to the increase in mental disorders in the elderly, increases in psychiatric disorders in detention populations and the desired capacity for young chronic patients. In these countries, deinstitutionalisation processes started earlier than in the Netherlands and became more prominent. The desired changes in Dutch law to treat non-compliant patients and changing attitudes in Dutch society, and the need for more safety in the society, are extra reasons to expect a period of reinstitutionalisation in the Netherlands. Therefore, it is possible that the prognosticated deinstitutionalisation in the Netherlands will not take place.

Conclusions relevant for integrated care: the deinstitutionalisation process in mental health care in the Netherlands should address the capacity and cooperation of mental health care in the new sub regional catchment areas. The same goes for the capacity and

quality of mental health care in the old general psychiatric hospitals. National mental health care policy items are relevant to the de- or reinstitutionalisation balance. These items are the desired treatment options for uncooperative patients who are a danger to themselves, the fate of psychiatric patients in detention, how to cope with the increasing need for psychiatric help and, last but not least, the financing of mental health care.

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