General Hospital Psychiatry in The Netherlands

Albert F.G. Leentjens, M.D., Ph.D., Consultant Psychiatrist

Chair of the Section of General Hospital Psychiatry of the Dutch Psychiatric Association

Department of Psychiatry

Maastricht University Hospital

P.O. Box 5800

6202 AZ Maastricht

The Netherlands

Phone: ++ 31 43 3877443

Fax ++ 31 43 3875444

Email: a.leentjens@np.unimaas.nl

Wordcount : 817 (references excluded)

Acknowledgement : The author would like to thank Dr. B. Verwey for his useful comments to an earlier version of this contribution.

From the beginnings of general hospital psychiatry (GHP) and consultation-liaison (CL) psychiatry in The Netherlands, in the 1970s, this field has attracted growing attention and interest. Political and social developments in the late 1980s and early 1990s however have resulted in a serious set-back for GHP from which it is only recently recovering.

Since the release of the new mental health act in 1984, mental health care policy was focussed at 'bringing psychiatry closer to society'. This was mainly done by striving towards integration of all psychiatric services into so called 'regional mental health centres'. This not only applied to psychiatric hospitals and social psychiatric services, but also to GHP and CL psychiatric services. Although in the beginning GHP was not much affected by this process, in later years new legislation put pressure on GHP wards and CL services to participate. This policy has had serious consequences for GHP. Perhaps the clearest example of this is the decree issued by the government in 1993 that in case of new building or renovation of psychiatric hospitals, they are *obliged* to form mental health centres and merge with psychiatric wards in general hospitals and CL services. In spite of the fact that psychiatric wards in general hospitals were the most efficient services, being responsible for 33 % of all acute admissions, while having only 7 % of clinical capacity[1], this efficiency was sacrificed for the bureaucratic idée fixe of integration and forced merger of services. Many psychiatric wards were moved out of the general hospital and re-allocated to these regional mental health centres, thus losing all the advantages of their location inside the hospital. Because of this, the number of independent psychiatric wards in general hospitals has declined more then 50% from 71 to 31 between 1993 and 2004 [2]. In order to provide better patient care, but also in order to secure their place in the general hospital, some GHP departments have redefined their core-business and transformed themselves into Psych-Med Units (PMUs). These units are

able to cope with more intensive somatic comorbidity than psychiatric wards. Another consequence of compulsory fusion of psychiatric wards in general hospitals with regional mental health centres is that many general hospitals lost their CL service. CL psychiatric services are now often provided on a transmural basis by CL psychiatrists employed by the mental health centres. In line with the government policy, a number of unpopular additional measures were taken. Budget-ceilings, irrespective of production, were set for the remaining GHP wards. In spite of continuous insistence, no reasonable tariffs were set for consultation and other general hospital psychiatric activities such as electroconvulsive therapy.

The report of the governmental 'Commission on General Hospital Psychiatry' in 1995 can be considered a first indication of a change of attitude towards GHP[3]. For the first time it was highlighted that the presence of GHP in general hospitals was important because it enables the provision of integrated care for patients with somatic and psychiatric comorbidity. Unfortunately this report did not lead to adjustments in policy. Only in the last five years has the situation begun to change. Different professional organisations in the field have joined forces and succeeded in forming a lobby to defend GHP interests. This 'Dutch Federation of General Hospital Psychiatry' (Nederlandse Federatie voor Ziekenhuispsychiatrie, NFZP) has regular consultations with the Ministry of Health, Well-being and Sport (VWS). They have successfully conveyed the importance of psychiatric departments located in general hospitals and as a result the policy of forced mergers with psychiatric hospitals was cancelled at the end of last year [4]. Another factor that will be beneficial for GHP is the change of reimbursement system for health care that was implemented in general hospitals in January 2005. The old system of budgeting will be replaced by a system of declarations on the basis of 'diagnosis-treatment-combinations' (so-called DBC's, similar to the 'diagnosis related groups' system in other countries). In this new system it becomes possible to bill not only admissions and

outpatient visits, but also consultations. Because of this, CL psychiatry may become a budget-generating instead of a budget-spending activity only.

The prospects for GHP and CL psychiatry in The Netherlands have clearly improved. Now that existential threats have subsided, professionals can focus more on scientific and clinical developments. The number of PMUs is growing and currently estimated at 7. The past few years have seen more symposia and congresses in the field of GHP and CL psychiatry than before. Taskforces and workgroups (such as the national workgroup on PMUs) have been formed. In the past year a comprehensive evidence-based multidisciplinary guideline on delirium has seen the light, and the first book on consultation-liaison psychiatry in The Netherlands in twenty years was published [5, 6]. The changed policy and renewed interest in scientific and care issues give impetus to the development of new GHP and CL initiatives that will be better adapted to the changing organization of the healthcare system.

References

1. Jabaaij L, Hutschemaekers G. Vraag en aanbod in de PAAZ. Een praktijkstudie vanuit het perspectief van patienten en behandelaars op de psychiatrische afdeling van algemene ziekenhuizen. Utrecht: Trimbos Instituut, 1998.
2. College Bouw Ziekenhuisvoorzieningen. Evaluatie regionale GGZ-centra. Utrecht: CBZ, 2000.
3. Commissie Ziekenhuispsychiatrie. Ziekenhuispsychiatrie, Over de grenzen heen. Speerpunt voor integratie van somatiek en psychiatrie; schakel tussen algemeen ziekenhuis en geestelijke gezondheidszorg. Rijswijk: Ministerie van WVC, 1995.

4. Hoogervorst H. Wijziging RGC-beleid. Den Haag: Ministerie van Volksgezondheid, Welzijn en Sport, 2004.
5. Van der Mast RC, Huyse FJ, Droogleever-Fortuijn HA, et al. Richtlijn delirium. Amsterdam: Nederlandse Vereniging voor Psychiatrie, 2004.
6. Leentjens AFG, Bannink M, Boenink AD, Huyse FJ. Consultatieve psychiatrie in de praktijk. Assen: Van Gorcum B.V., 2004.