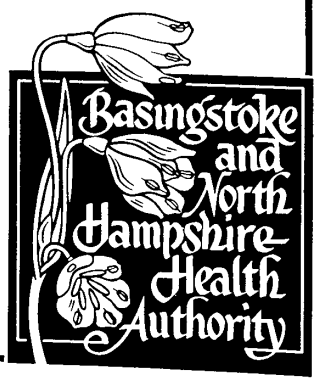
"GOING DUTCH"



BASINGSTOKE AND NORTH HAMPSHIRE HEALTH AUTHORITY

"GOING DUTCH"

JUNE 1986

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1. INTRODUCTION

The Netherlands is one of the most densely populated countries in the world, with 14.4 million inhabitants as at January 1st 1984. The population density is 424 persons per kilometre. Almost 12% of the population are now over 65 and the life expectancy of newly born children is now 79 for girls and 73 for boys.

Administrative and Executive powers in respect of Health Care are vested by legislation in both local and provincial Authorities. Accordingly, there are Municipal Medical Services and hospitals, and provincial hospitals and Mental Institutions; the State administers and runs seven of the teaching hospitals.

As in England, nearly everyone in the Netherlands is registered with a General Practitioner whom he usually consults in the first instance, for medical advice or treatment. The G.P. then decides, in consultation with the patient, whether to treat him or refer him to a medical or paramedical specialist. Since practically the whole of the Dutch population is medically insured, either with a Health Insurance Fund or a private Medical Insurance Company, patients in many cases have to obtain the approval of their insurers before consulting the Medical or Paramedical specialist. It is fair to say, though, that in emergencies such as many hospital admissions, approval may be granted retrospectively.

Clients with mental illness problems or emotional difficulties will usually also consult their General Practitioner in the first instance. Where the Doctor considers it necessary, they are referred to the appropriate services such as Child Guidance Clinics, Family Clinics or other Social Psychiatric Services. The more serious cases, of course, as in this country, may need to be admitted to Psychiatric Hospitals. It is interesting to note that, over the years, because there is a large number of Institutions in the Mental Health field in the Netherlands this led to confusion as to the service each is supposed to provide. Attempts are now being made to group them into Regional or Provincial Units known as RIAGG to which I will refer later in this report.

With almost the whole population of the Netherlands now insured against medical expenses, the sources of finance for health care can be divided into two main categories. They being the private medical insurance funds and the statutory schemes (under the Health Insurance Act and the Exceptional Medical Expenses Act). Although the part played by the State in financing Health Service Institutions is negligible, it does provide indirect financial assistance by its contributions to the statutory insurance funds. The system of insuring for health is covered by various Acts in the Netherlands and payments vary according to ones income.

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There are exceptions where long-term hospitalisation, especially in Psychiatric Hospitals, is required. A report of its own would be needed to explain this highly complicated system of financing. However, there is the Central Health Charges Board which is responsible for deciding whether to approve, reject or lay down charges and establishes guidelines concerning the level, structure and method of calculating scales of charges, and it advises the Dutch Minister of Health accordingly. There is also the Health Insurance Fund Council which supervises the work of the Executive bodies and controls the funds of the compulsory and old age Health Insurance Schemes and of the Exceptional Medical Expenses scheme which specifically covers people who need long-term care in Psychiatric Hospitals.

There is also a State Inspectorate of Health which was set up by an Act of Parliament in 1865 and has acquired an autonomous status. This is considered important as this political independence is essential for the performance of the Inspectorate's task which covers the Inspectorate of Mental Health Services.

The Dutch Health Service appears to have enjoyed a period of luxury as far as finance and staffing is concerned, but due to the constraints on finances that are now being experienced, they are currently undertaking an examination of the whole way the Health Service is financed and monies spent. They are also undertaking a "Griffiths exercise" as far as the management of the Service is concerned. It was interesting to note that in many places that I visited there were strong debates going on as to whether Doctors and Nurses, and not Administrators should manage hospitals.

2. ROTTERDAM

2.1 *The GGD (Municipal Medical and Health Service)*

The GGD is headed by a Director of the Municipal Health Service which includes Health Education, Preventive Medicine, the Development of Care, Planning, Epidermiology and Social Administration.

The catchment area for Rotterdam is 600,000 plus an extra 150,000 from some outlying villages. The river flows through the middle of Rotterdam and therefore divides it into two Care regions. In the South region there is 300,000 population and the Northern region is sub-divided into two areas, one with 150,000 population and the North East with 300,000 population. Each district has a RIAGG. There are two Psychiatric Hospitals, the Delta Ziekenhuis with 900 beds, and a second hospital

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with 600 beds near The Hague. It was interesting to note that this hospital is closing and in the Central and the North Eastern Region there will be new Psychiatric hospitals with 200-300 beds. As far as the Mentally Ill are concerned, there is one bed per 1000 population.

The RIAGGS which are the Mental Health Centres are co-ordinated by SAGG (Regional Board of Mental Health) which incidentally has no power platform as the RIAGGS get their money direct from the State.

RIBW which is the organisation for housing and hospitals are themselves co-ordinated by a RIGG (Regional Institute of Health Care) which is only a co-ordinating body.

The GDD plan, as far as housing is concerned, for 0.35 places per 1000 population and 0.7 - 1.1 places for hospital inpatients.

2.2 *RIAGGS (Community Centres for Ambulatory Health Care)*

Within the framework of the Health Service in The Netherlands various levels have been formed. Level zero comprises hygiene, the Police and schools. Level one includes the General Practitioner, Social work and District Nursing. Level two consists of specialised Health Care, (Psychiatric) hospitals, Nursing Homes, Addiction Centres and Regional Institutes for outpatient Mental Health Care (RIAGGS) etc.

The Central person, as in this country to whom clients turn to for help, is the General Practitioner. Although the Social Services also provide help for people with personal problems, there is a marked division between Social Work (which belongs in the first level) and Mental Health care (in the second level). They are separate services and organisations and also financed separately, and have similar problems to those experienced between Social Services and the Health Services in this country.

RIAGGS are foundations which have their own managements independent of the State, Church or Local Authority. They are funded under the Exceptional Medical Expenses Act and this Act insures the entire population against serious medical risks such as hospital care for chronic illness or physical or mental handicapped. Employers pay the premium for this insurance and every inhabitant of the Netherlands is entitled to free assistance from the RIAGGS.

Team work is the outstanding feature of the RIAGGS and they generally have separate teams for juveniles, adults and the elderly. Some have separate teams for

/psychotherapy....

psychotherapy and preventive medicine. All the teams are multi-disciplinary.

The RIAGGS operate for people of all ages and have three main tasks, which are assistance, prevention and service provision. Assistance includes intake, advice, short-term treatment, phsycho social support, social psychiatric guidance and treatment if necessary in conjunction with medication and psycho-therapy. They pay particular attention to the psychological, physical and social factors which influence the clients mental problems. The second of the main tasks is prevention and this I think is self-explanatory. Prevention is frequently directed at groups at risk which is established by using data from various social sources. The main task of service provision comprises various activities all aimed at supporting professional workers in other fields in their contacts with people troubled by mental health problems. The main principle is that the service provision should be as close to the environment of the people themselves in order to help them at the earliest possible stage in order to avoid specialised services being required at a later stage.

The RIAGGS which are Regional institutions cover the whole of the country and there are approximately 60. There are three RIAGGS in Rotterdam, one on the South Bank and two on the North Bank. They are split into three sections covering youths, adults and elderly. The adult section is divided into psychotherapy and social psychiatry.

2.2.1. <u>RIAGGS Rijnmond Noord-Oost</u>

In this RIAGG there is a population of 260,000 of which 20% are over 65. The norm for the Netherlands is 11.6%. In this RIAGG the elderly services are split into 6 districts. They receive 20 new referrals a week and most of these, that is 75%, come from General Practitioners, the remainder from hospitals or District Nurses.

The "in-take" procedure is that there is a domiciliary visit by a nurse for assessment which covers such things as psychiatric problems, physical situation and social help situation. The Nurse, incidentally, is a member of the RIAGGS team. This team consisting of a Doctor, a Psychologist, a Psychiatrist, a Nurse and a Social Worker. This team has the responsibility for setting up the patient plan which relates to the treatment programme.

/The Nurse....

The Nurse will try to see if support can be given in the natural setting to the clients by other District Nurses or Home Helps, or special Home Helps who are trained to cope with paranoia, depression and behaviour problems. There are also District Home Helps for the elderly who go and visit several houses a day and offer moral support, undertake shopping, washing, cooking and taking the client out for walks. These Social Workers also work in the Day Centre for the elderly and assist in its operation - there being a Day Centre in every district. The team for the elderly covering the six districts in this RIAGG consist of a Consultant Geriatrician, a Consultant Psychiatrist, a full-time Psychologist, seven full-time Nurses and two full-time Administrative staff. It is interesting to note that as far as the co-ordination of the Health Care in the neighbourhoods is concerned, this is undertaken by the General Practitioner who has a Physiotherapist and a Speech Therapist attached to his Practice.

Before a client can be admitted to a Psychogeriatric hospital - the average stay is two years - they have to be screened by the screening team from the RIAGG which includes a physical examination, a psychological examination, a social examination, as well as case history information. If assessments are required, these can be carried out in the Nursing Homes, and in fact one of the particular Nursing Homes I visited had a special assessment unit where these assessments are carried out over a 4-6 weeks period.

There are two types of waiting lists, one which is a priority list where people have to be admitted within a two month period.

Whilst talking to the Head of the Elderly Service for this RIAGG it was interesting to note that he was concerned with the lack of tolerance by the general public because they did not understand what a confused old person suffering from paranoia and who was probably refusing help, was all about. He believed that they needed to undertake a public education programme.

The Psychiatric Service in this RIAGG is split into three sections. This covers Social Psychiatry, Acute Psychiatry (emergency)

/and.....

and Poli Clinics - which deal specifically with depot injections. This particular RIAGG operated specifically a revolving door syndrome and provided facilities for people to receive short-term care whilst in an acute state and were quickly moved back into the Community where they were supported either in sheltered workshops or Group Homes.

The Psychiatric Services had a Consultant Psychiatrist heading the team, and Psychiatric Social Workers acting as the support staff who have an average of 50 - 60 cases on their books.

RIAGG Rijnmond Noord-Oost

2.2.2 RIAGG Zuid

This RIAGG covered a population of 300,000 and included Nursing Homes for Psychogeriatrics, Nursing Homes for the elderly and Nursing Homes for the Mentally Ill.

They were currently examining how they could use their Nursing Homes to provide Meals on Wheels services and to have alarms installed in local houses occupied by the elderly and linked to these Nursing Homes.

In this RIAGG there are 170 staff, of whom over 100 are Nurses and Doctors. RIAGGS operate similarly to the plans which Basingstoke have for their own Mental Health Centres. This RIAGG operated very much in the same mode as the RIAGG North East.

2.2.3 RIAGG Centrum West

This RIAGG covered an area of 150,000 population and had a total staffing of 3,200 man-hours per week.

They had a Day Care Treatment Centre and a Poli Clinic. The latter was staffed by a full-time Psychiatrist and a full-time Nurse and they basically provided medical care.

The Day Clinic had 24 places and catered for 60 people per week. It operated as far as possible on a therapeutic care programme and was split into six groups. Two of a psychotherapeutic nature, three of Social activity nature, and one which dealt specifically with migrant groups. They also had a Crisis Centre nearby which had 12 beds, of which 6 were for social admissions.

There are 14 Social Psychiatric Nurses which is equivalent to our CPNs attached to this RIAGG, and they each had a caseload of 40.

The Day Clinic in the RIAGG always has on duty every day a Psychiatrist from 10.00hrs to 12.00hrs to examine the clients who are then directed to one of the six groups covering Social Psychiatry, short therapy, poli clinic, day clinic, psychotherapy and ethnic groups. This Psychiatrist acted as a filter and is an approach which could be considered for our Mental Health Centres.

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2.3 *Department of Psychiatry*

Within the RIAGG Noord-Oost there is a Department of Psychiatry similar to those in other RIAGGS.

The Head of the Department is a Consultant Psychiatrist. The Psychiatric Department is split into three sections. This covers Social Psychiatry, Acute Psychiatry (emergency) and Poli Clinics, the latter which deals with depot injections.

Some clients come to the Department of Psychiatry for their medication, but the majority are supported either in sheltered workshops or group homes. In the Netherlands they have based their philosophy on the thoughts of Professor Giel's book on Social Psychiatry which covers the problem of moving residents to Community from Institutions.

They specifically operate the revolving door syndrome.

Within the Department of Psychiatry there is the Community Psychiatric Nursing Service (Acute) who besides being involved in emergency psychiatry, also operated within what is described as a Social Psychiatric field.

They also have working in this area Social Workers who carry about 50-60 clients on their books.

It is interesting to note that prior to 1970 the Psychiatric Institutions and the Social Workers involved in social psychiatry did not communicate with each other in the same way as our Social Services and Health Services. Now due to Management changes they have started to become a more integrated service.

2.4 *A Psychiatric Hospital*

Delta Ziekenhuis is a Psychiatric hospital covering Rotterdam.

The hospital is managed by two Chief Executives. The Principal Chief Executive is a General Administrator who is assisted by a Chief Executive who is a Clinician and the latter also having responsibility for the paramedics.

The hospital Services are split into four sections, each with a Head of the Section.

Section 1

Ambulent client, poli clinics, day treatment and liaison psychiatry.

/Section 2....

Section 2

Patients under 65 years of age, acute psychiatry, short-term stays, (no longer than 2 years). Within this section there are 250 beds which equates to one bed to 2,800 population.

Section 3

Longer treatment, long-stay rehabilitation. Within this Section, there are 225 beds which equates to one bed per 3,111 population.

Section 4

Over 65s, psychiatry for the elderly, acute psychiatry, short and long-stay rehabilitation. This Section has 440 beds which equates to one bed to 1,750 population.

There are 870 beds in all in this Psychiatric hospital for a catchment area of 700,000 people covering an area of approximately 40 kilometres by 20 kilometres.

The hospital is managed by a Hospital Management Team consisting of both of the Chief Executives, the Managers who manage Sections 1 and 3, and the Manager for Section 2, the Manager for Section 4, plus a Financial Adviser and a Personnel Adviser. This equates to the Psychiatric Division's Management Board.

Section 4 is split into five units. These are:-

Aanloop Ward

72 beds for the Acute.

Buitenzorg Ward

34 beds for dementia.

ZE Ward

62 beds long-stay.

Maaszicht Ward

57 beds long-stay.

Brink Ward

154 beds long-stay.

In order for a patient to be admitted they have to be visited at home by their General Practitioner who then asks one of the RIAGG Psychiatrists to visit the patients before the patient can be admitted to the Delta Ziekenhuis.

/Aanloop Ward....

Aanloop Ward, which is an Acute Admission Ward, is divided into three sections which are themselves sub-divided into two sections - there being 12 beds in each section.

This ward has a co-ordinator who is a full-time Nurse, a full-time psychiatrist, psychologist, social worker, G.P. and a full-time assistant psychiatrist.

There are three nurses in each of the six sections on duty from 0.730 - 16.30 hrs. Two nurses from 16.30 hrs. to 22.30 hrs. and one nurse from 22.30 to 07.30 hrs.

The ward costs £486,486 per annum for staffing, which works out at £18.51p per bed. This cost does not include food and drugs etc.

Buitenzorg Ward is a psychogeriatric ward which has 34 beds. This is split into two units of 17 beds and the ward is specifically a screening ward. The staffing is 0.74WTE Psychiatrists, 0.52WTE General Practitioners, 0.52WTE Psychologists, 0.52WTE Social Workers, and a full-time Nurse Co-ordinator On the first shift there are four nurses, second shift, three nurses, and the third shift, one nurse.

This ward costs £343,783 per annum to run for staffing, which works out at £27.70p per bed per day.

The budget for the hospital per year is £17,837,837 which works out at a daily bed cost of £57.49p.

At the Delta Ziekenhuis there are about 160 new admissions in each year and this is rising at the current point in time. Only about 5 or 6 patients are admitted under order. It is in fact very difficult for someone to be admitted under an order for psychiatric treatment and these orders can only be used if they are a danger to themselves or a danger to others, and the order has to be signed either by a judge or by the Mayor of Rotterdam.

Delta Ziekenhuis is a large hospital in its own grounds and is somewhat remote in its situation. Like Park Prewett, it has a regular bus service and there are hairdressing saloons and all the therapy units similar to ours. They also have a licensed bar for the patients.

External picture of a ward at Delta Zeikenhuis

Rear of a ward at Delta Ziekenhuis

2.5 A Psychogeriatric Nursing Home

Rustenburg Psychogeriatric Nursing Home is quite isolated and was built in 1979 to house 180 patients who live in four wards which are built around patios. One of the wards holds 20 patients which is a ward specifically for those who are terminally ill, or are dying. Each ward has its own specific dependancy level and their dependancy levels are not mixed.

There is a multi-disciplinary approach at Rustenburg in designing the programme for every day's occurrences. This includes physiotherapists, social workers, physicians, nurses who are specially trained for nursing the elderly. In fact, the Nursing Home has its own training school for training nurses for Rotterdam for nursing the elderly which is, in itself, a special 2½ year training course. The Nursing Home is a misnomer because it really is a small psychogeriatric hospital with all usual facilities including catering, domestic, hairdressing, chiropody services.

Each ward is manned by two teams and there is a nursing establishment of 20 persons for each ward who are led by a Head Nurse, assisted by an Assistant Head Nurse. There are approximately 200 staff working in the Nursing Home covering all disciplines.

They average about 60 new patients a year.

They have a resident Medical Practitioner for the Nursing Home who is responsible for the physical well-being of all of the patients which consists of 40 patients with psychiatric problems, 120 psychogeriatrics, and 20 elderly severely mentally infirm.

The patients are grouped into 4 groups, those who are bed-bound, those who need first-aid nursing, those who function fairly well on their own, and those who live there as their own home.

The resident Medical Practitioner has two other functions besides looking after the physical well-being of the patients, and one is to carry out all the physical investigations (screening) for new intakes of which there are two per week, and he involves the psychologists and the nurses from the Social Psychiatry Department in this screening, and it is from that that they decide what are the accommodation needs and treatment programmes for the client. The screening does, incidentally, include physical investigations. The other part of his role is to assist in the 7-placed Day Centre which operates 5 days a week and has 15 clients on its books.

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It is interesting to note that the General Practitioners undertake the domiciliary work, and if they think their patients need screening, the G.P. then notifies the psychiatric nurse who arranges to do a home visit and then brings the patient if necessary, into Rustenburg for screening. This is the only Nursing Home in the area where screening takes place and it is fair to say that the relatives are involved in the screening process and the devising of the treatment programme.

There are three part-time physiotherapists in the Centre and an Occupational Therapy Department.

At Rustenburg there is now established a board of relatives which has its own constitution and meets every month to discuss the Home and its running, and twice a year, the Management Board which consists of the Nursing Sister, the Clinician and the Financial and personal Directors.

The full-time Social Workers who are attached to the unit principally are there to support the family and to assist the relatives, not to support or assist the client. This involves assisting and supporting the relatives to maintain their client at home, and in fact they have an involvement in the Day Centre where the relatives also attend.

The Nursing Home has about 40 volunteers currently coming to help in the Home, who are all females, and come from the local villages and the local church.

The psychologist told me that the screening was undertaken in the Nursing Home and not in the client's home for historical and financial reasons and because the expertise was in the Nursing Home. After the clients had been screened there was generally a meeting a couple of weeks later with the Community Psychiatric Nurse who would assist in discussing the diagnosis and deciding what accommodation requirements there were and the treatment programme for the clients. The psychologist explained that the concept of psychology with the elderly was new in Holland, and she was still in the process of trying to build up acceptability. She was currently establishing groups specifically to help the clients who were resident to communicate with their relatives, the nursing staff and each other, and was looking at how to get them to express their emotional feelings to understand non-verbal communication, and was also considering how to deal with reality orientation.

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It was pleasing to note that one of the philosophies within the Nursing Home was in the care of the dying. They believe people should be allowed to die in their natural surroundings, and were opposed to the maintaining of life when people are becoming ill and consider they should be allowed to die naturally and gracefully.

Rustenburg Nursing Home

2.6 *Sheltered Housing*

There are 172 places in the centre sector of Rotterdam, and as in England these are viewed as an alternative to having people in psychiatric hospitals.

The Rotterdam approach to people who have problems is to look at their living needs, their housing needs, their contact needs, their social time and communication needs before one considers their medical problems, and thus they have managed to maintain a lot of people in the Community.

/The Dutch.....

The Dutch approach, therefore, is that it is better to keep people out of hospital, because once they have been put into hospital they then have problems because they are described as psychiatric, and are considered sick. Therefore as treatment helps them, they then have to be rehabilitated so their first approach is to stop people being put into hospital.

Their houses, as in Basingstoke, cater for a wide range of clients, that is elderly ex-patients, or potential patients. In none of the houses were there staff at night. Some of the houses are specificall rehabilitation houses, where after a two-year stay, a client is expected to move on.

I visited a sheltered Group Home for the elderly and also visited six houses which cater for 22 young clients. Within these six houses there are 280 man-hours per week, which includes 20 hours social work, and 20 hours domestic work, but again, there is no night cover. This system is very much like the Core and Cluster system which we are going to establish in Basingstoke.

Bergweg 183 - a sheltered house for the elderly

3. UTRECHT

Utrecht is situated on the old Rhine and is a University city with a cathedral. It has chemical and cigar factories and is a major transport and financial centre.

It is a beautiful little city, with a population of approximately 230,000, of which 13% are unemployed.

3.1 *The GGD (Municipal Medical and Health Service)*

The Director of the Municipal Medical and Health Service is the overall chief of all the Medical Services and has specific responsibilities for the ambulance service, health education, advice (social and medical), child health, (4-18yr. olds), occupational health, epidermiology, environmental health, including profilaxis, and housing places for the elderly for the city of Utrecht. Each Department has a Head and under the Directorship of the Municipal Director, they form a Management Team and are responsible to the Mayor of Utrecht.

The problems of health care in Utrecht are similar but on a smaller base to those in Rotterdam, but it was of concern to find that there is a major problem of drugs in Utrecht and they are currently trying to set up a system for the registration of addicts. They now have a bus going around the town giving Methadone treatment.

3.2 *The Crisis Centre*

The Crisis Centre in Utrecht is in a small area within a very large Psychiatric hospital. This project within the Netherlands is unique. They provide outpatient medical health services for the acute mentally ill and their service covers two RIAGGS.

There are no beds within the Crisis Centre and therefore they have to work closely with the hospital. They undertake all the screening at the Centre and consider that they form the link with both inpatients and outpatients.

Their main tasks are:-

1. Crisis intervention (first-aid).

2. Intense programmes for helping people, using the Outreach system. The Centre offers a full 24-hour service.

3. Visiting the Police or the G.P.s when clients are in need.

/4. Offering....

4. Offering a complete treatment service for people to prevent admission. This treatment can last for two or three months and if it is not possible within that period to treat the person they then are passed on to the Psychiatric services for prolonged treatment. Their treatment involves psychology and medical approach, but they do not use ECT in any of their treatments. They usually have 150 compulsory admissions per year. They do not deal with psychopaths.

5. To undertake assessments. This Crisis Centre which covers two RIAGGS looks after a population of 600,000, which includes the city of Utrecht and the environs.

In the Netherlands, as far as compulsory admissions are concerned, they depend on a 19th century law. If the consultant considers that the client needs urgent admission, he contacts the Mayor, who will sign the paper, and if it is verified by a judge within 3 days, the detention can remain. There is an appeal procedure, but I was unable to ascertain what it is, therefore one may assume that no-one ever appeals.

At the Crisis Centre in 1985 they had 2,100 new referrals and the number of client visits averaged at 2.7 per client. There were 8,000 outpatients in total, and each lasted on average 76 minutes.

The staffing level is high and during the day there are 28 crisis interventors on duty, plus a Consultant Psychiatrist, Consultant Psychotherapist, Consultant Psychologist, the Co-ordinator and his assistant and four secretaries. Of the Crisis interventors on duty, half are social workers without psychiatric training and the other half are psychiatric nurses. In the evenings and at night time there are 14 people on duty and one of the consultants is on call.

The Crisis Centre quite clearly had problems of accountability and problems about who deals with inpatient and outpatient treatment, as once a patient is discharged from the hospital, the Crisis Centre is very rarely informed and therefore they don't know what after-care is being provided.

I think there are lessons to be learned from the way this Crisis Centre is managed, and certainly from its environment as far as the establishment of Mental Health Centres in Basingstoke is concerned.

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Crisis Centre

3.3 *A Psychiatric Hospital*

Zon en Schild is a psychiatric hospital with 800 beds and is organised in different sections, there being five in number. I specifically looked at the section which dealt with the cure and care of the elderly. One of the sections had 48 beds which undertook the admission and treatment of the elderly with psychiatric problems, and the other section had 130 beds, and dealt with the long-stay. There were between 80 and 90 new admissions per annum of the over 65s, of which 70% were discharged within 5-6 months back to their own place. Of the remaining 30%, 20% go to Nursing Homes and 10% become long-term admissions or die.

They are building a new section to the hospital which will be split into six groups of 12 patients.

/Two groups....

Two groups will be long-stay and four groups will be acute, of which one of these groups will specialise in admission of diagnosis procedures. The other three groups will deal specifically with re-socialisation, functional problems, including psychotherapy and a structure group including music and drama therapy and physiotherapy.

They do not have any respite beds within Zon en Schild and they do not undertake ECT treatment.

The hospital has a catchment area of 600,000 which covers two RIAGGS.

Within the two RIAGGS there were four private nursing homes which are co-ordinated by one RIAGG. The licensing of Nursing HJomes is undertaken by three separate Ministries. There are, therefore, similar problems regarding planning as we have with Social Services and again, they have the same problems we have with regard to getting base information.

The mean age of the in-patients in the elderly care unit at Zon en Schild was 71.

Zon en Schild Hospital new Ward

developments

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3.4 *Lisidunahof Psychogeriatric Nursing Home*

Lisidunahof Psychogeriatric Nursing Home has 168 beds, a 17-placed Day Hospital which has about 45 clients attending.

This Nursing Home covers Leusden and Amersfoort which together have a population of about 75,000.

There are 176.9 staff for this Nursing Home, of which 131.8 are nurses (all grades), and 2.60 physiotherapists. There are two Doctors, one of them is part-time - 0.7WTE. The Medical Director/General Manager is also a Doctor and now only spends 10% of his time as a Doctor, the rest as an Administrator, which means that they are under-staffed for Doctors, as the norm is one per 100 patients.

In 1985 there were 40 admissions for long-stay to Lisidunahof, of which the average age was 84. The average in-patient age currently is 84.7. Interesting to note that they have 40 deaths per year, which equates to their admission rate.

The average stay of patients who died in 1985 varied between three months and ten years; the average worked out at 3.6 years. They do have social admissions which are looked after for a period of 14-21 days.

There are currently 49,000 places in Holland for geriatrics and psychogeriatrics. With a population of 14,000,000 this equates to 0.35 beds per patient. There are currently 55,000 general hospital beds which equates to 0.39 beds per thousand. The concern in Holland is that they believe that within the next five years they will need another 32,500 beds for geriatrics.

The annual budget for Lisidunahof Nursing Home was £3,212,000. The average cost per day is about £52. This compares to between £119.36p and £132.62p for inpatient stay in a hospital. The cost on the budget of personnel is 68½%.

This Nursing Home is privately owned and is one of five Nursing Homes with 800 beds in total, which are owned by a private company. 11% of the over 65s in Holland are psychogeriatric, which equates to about 250,000 people.

/The Nursing Home...

The Nursing Home itself is split into different wings, one caring for those who are terminally ill, to those who are able to live with minimum support. The standard of care and the standard of building were extremely high and the physiotherapy and occupational departments were excellent. They don't, however, undertake any outreach work which is a failing and they did hope to change this in the year's to come.

Day Centre at Leusden

(attached to the Nursing Home)

3.5 *RIAGG (Community Centre for Ambulatory Health Care)*

I met the Doctor who is a General Practitioner working for the RIAGG and specifically looks after the elderly.

I discovered that he thought, like I did, that there was a lack of control and co-ordination in some of the services in Holland. They have a very similar problem to that which we experience between the Health Service and Social Services.

/He explained....

He explained to me that Utrecht was suffering some severe problems of violence, drug and alcohol addiction which took place mainly in the shopping centre. In the evening it is becoming quite a threatening and frightening place and the local citizens feel in fear in entering that area.

At the moment the service is, to some degree, institutionalised and he is hoping to change some of the thinking to a more community orientated approach.

We also discussed the problem of Senior Managers in the Dutch Health Service. Many of them are about 35 years of age and have reached the top of their disciplines and therefore will remain in those positions for the next 20-35 years, which will create its own problems, as well as creating a promotion block for junior executives. I feel there is some similarity to our Health Service in this.

In order to maintain the interest of Managers who are unlikely to reach the top of their disciplines because of the blockage, consideration is being given in Holland, and needs to be given by us, to develop Managers' skills in other areas in order to maintain their interest and commitment.

The Health Service in Utrecht has established a specific four year project to look at female patients only and this is being financed by an environmental feminist group. There are seven workers in this group, of whom two are research workers. The cost for the four years is two million guilders.

3.6 *Sheltered Housing*

The house shown in the picture overleaf was started eight years ago and was the first house to open and had 15 residents. There are now a number of other houses in Utrecht which house old people, both short-stay and long-stay and have within them particular work programmes.

Within this house there are 10 staff, including a cleaner, student, a warden and other workers and the staffing is on a 24 hour basis.

/I spent....

I spent a long time talking with the residents on their views of having been in a psychiatric hospital and how they felt about the lost years of their lives. They felt very strongly that Doctors and Nurses would not listen to them or accept their point of view, and they had to "break out" in order to move to the sheltered housing where they were now surviving very well. I felt their points of view about not being involved, and not being listened to, were very deeply felt.

Having the previous day spent some time talking to members of a patients council in Rotterdam who also expressed very deep heart-felt views at being ignored by their carers, I consider that we, in Basingstoke must seriously examine how we involve the consumers in targeting our service provisions for the future correctly.

Bogermanhius, Utrecht

3.7 *Community Work*

The Netherlands Health Authorities and Social Services believe that work is a natural part of a clients daily routine.

I visited a farm in the middle of the countryside which has 10 patients there. The patients can stay for two years and have to accept responsibility for the running of the farm with the farmer and his wife. It is a proper farm of over 60 acres with a cow, 500 hens, 200 goats and fields of vegetables.

The project has been going for 10 years and more than 100 chronically ill clients have been successfully rehabilitated and resettled through this project.

It was started by the farmer and his wife helping drug addicts, the philosophy being that patients who lived on the farm had to accept responsibility for running parts of the farm, including looking after animals from day one, and this gave them confidence and responsibility and they eventually got better. They only have the most chronically ill clients in this farm and their response to being able to be treated as a whole person and given responsibility was quite rewarding and the success rate has been 100%.

In Zeist there is a building which is rented from the Local Authority. It is full of cottage industries. Some of the cottage industries are run by a Manager for those people who have mental illness problems, and is in effect, a sheltered workshop. Other projects are run by ordinary people who rent some of the space in the building for their own cottage industry work. This mixture of having cottage industries specifically run for those with mental illness problems and for others who want to run their own projects, was a very exciting approach to a sheltered workshop concept and certainly expressed clearly how Community Care can work.

This approach to providing work in the community for people who have had mental illness problems needs to be developed further within Basingstoke and also with the involvement of the Manpower Services Commission Enterprise Scheme.

/4. PATIENTS COUNCILS

4. PATIENTS COUNCILS

In Rotterdam I visited an address which is occupied by an Ombudsman and a member of the Clients Association. The Ombudsman has a role which is very similar to that of a Community Health Council Secretary.

In Holland there is a Clients Council organisation, of which Rotterdam is just one of their branches. It is a Client Support Group and they have befriending schemes and they meet in Rotterdam every two weeks to discuss local and provincial policy and to try to influence the planners. They are all volunteers and they are financed by the National organisation which is, in itself, financed by the Government. Unfortunately, the local branch only receives £500 per year from the National organisation. They have 100 paid up members in Rotterdam. Their main problem being a volunteer organisation, is that they are only consulted on issues in a voluntary capacity.

There is also a separate Client's group representing inpatients, and they meet bi-weekly.

The executives of the Patients Council (Clients organisation) feel that they have an important role to play within the Netherlands to ensure that because patients are people, and have their own views about the service they receive, they should have both the right and the ability to influence these services. They also consider that there is sometimes a conflict of interest between service users and service providers, and that professionals cannot always represent users views effectively, so there is a need for a Client Group.

Whilst talking with some of the executives, I found, quite clearly, that they feel that they are not listened to by the service providers, and there does need to be a forum for users to feed back. They consider that when they are involved, they facilitate the most effective planning and delivery of services.

I spent 2½ hours talking to one lady who was so angry at her 14 years of lost life in a psychiatric hospital. She now lives independently and manages perfectly adequately, is quite articulate, and is a member of the Executive of the Clients Council. She felt strongly that she had not been listened to by the service providers and felt distressed about having been labelled mentally ill and no longer able to participate in life.

She feels that her experiences and experiences of other consumers are so relevant, that unless the planners listen to them, they will target their services in such a way that the full benefits will not be received by those needing them.

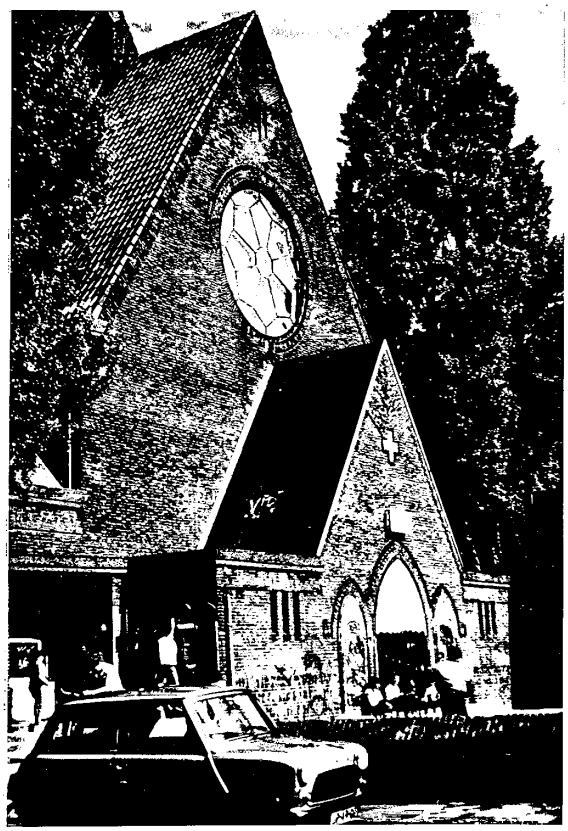
/I felt....

I felt very clearly that we, in Basingstoke, must ensure that the consumers, both the inpatient consumers and those who have used the service, or been through the service, should be involved in the planning process.

The Patients Council representatives found that one of the major difficulties is that many clients who have been in hospital a long time, are severely damaged by their many years of institutionalisation. They see their role also as offering some guidance and acting as advocates on behalf of those clients to ensure that they are able to have some influence over decisions made about their lives and their futures.

Perhaps the establishment of user groups using an ex-patient as an advocate should be considered, so that those who aren't able, themselves, to put forward their thoughts are helped by others who can.

When I left the meeting of the Patients Council, the lady who was so angry at having lost 14 years of her life, pleaded with me that I ensure that this didn't happen in our country. I promised I would.



Church Hall used in Rotterdam

by the Patients Council

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5. RECOMMENDATIONS

5.1 *Sector Management*

Consideration should be given to see if the organising of the Management of each of the 4 Basingstoke sectors on a similar pattern established by the Dutch RIAGGS is advantageous.

5.2 *Therapist Aids*

An examination should be undertaken into the role of "therapist aids" in supporting the elderly and those with mental illness problems in their own neighbourhood.

5.3 *Consultant Psychiatrists*

In the Management of the Mental Health Centres, consideration should be given to having a set time in each Centre for an attendance by a Consultant Psychiatrist every day.

5.4 *Care Groups*

The establishing of a structure which will identify a Manager directly accountable for services provided for each Care Group in order to ensure that the interests of that Group are kept in the forefront, should be considered.

5.5 *Support Groups*

Properly constituted relative support groups should be established for the elderly care wards who should meet at least twice a year with the Management Board.

5.6 *Community Support*

Priority should be given to the establishing of proper Community Support environments.

5.7 *Operational Policies*

Clearly defined Operational Policies for each Mental Health Centre which will have to spell out accountability, and the relationship between the Mental Health Centre and the hospital, need to be written.

5.8 *Development Programmes*

Individual development programmes need to be drawn up for each Manager in order to maintain their initiative and commitment.

5.9 *Work Environments*

Sheltered work environments in the Community are an essential part of supporting clients and a Cottage industry approach should be considered.

/5.10.....

5.10 *Relocation of Services*

It is essential that in the contraction of Park Prewett Hospital and in the reduction of services in the hospital, that they should not take place until those appropriate services have been re-provided within the Community.

5.11 *Consumer Views*

A Clients organisation which should have two groups, the first group dealing with inpatient issues, and the second group with the creation of a Community Service, properly constituted, should be established within the Basingstoke and North Hampshire Health Authority.

6. ACKNOWLEDGEMENTS

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