Geriatric Mental Health Care 1 (2013) 3–6

Contents lists available at SciVerse ScienceDirect

Geriatric Mental Health Care

journal homepage: www.elsevier.com/locate/gmhc

Review

Mental health in long-term care settings: The Dutch approach

Raymond T.C.M. Koopmans *

Department of Primary and Community Care, Centre for Family Medicine, Geriatric Care and Public Health, Radboud University Nijmegen, Medical Centre, P.O. Box 9101, 117 ELG, 6500 HB Nijmegen, Netherlands

ARTICLE INFO

Article history:
Received 15 September 2012
Received in revised form
1 November 2012
Accepted 8 November 2012
Available online 22 November 2012

Keywords:
Elderly care physicians
Dementia
Depression
Emotion-oriented care
Snoezelen
The Netherlands

ABSTRACT

Like many other countries in the world, the Netherlands faces the challenges of the rising numbers of frail elderly resulting in high rates of institutionalization. This paper gives an overview of the specific Dutch approach in long-term care settings with a focus on people with mental health problems like dementia, depression and a combination of physical and psychiatric problems. The Netherlands is the only country in the world with specially trained Elderly Care Physicians (ECP's), which specialty has a long academic tradition and therefore has academic networks to establish an infrastructure for teaching purposes, but also for multicenter research and development of best practices. The paper further emphasizes on dementia care and different care concepts like emotion oriented care and snoezelen with their evidence of effectiveness and ends with care for people with depression.

Contents

1. Introduction

All over the world governments are searching for answers to meet the health care demands of the growing amount of elderly people. Most elderly people prefer to live in their own homes and to postpone institutionalization as long as possible. That is the main reason why the Dutch long-term care-sector is transforming. Large care homes split up in smaller units, situated in the neighborhoods of where elderly people live. New housing concepts are created, like small-scale housing or group living especially for people with dementia. These changes also reflect the debate whether the focus of care for the elderly should be on quality of life and well-fare or on the traditional 'medical model' focusing on diseases and impairments. As a result, traditional Dutch care homes, gradually transform to more specialized, intermediate and high care, institutes for people that (temporarily) are not able to live in the community anymore, such as (young onset) dementia patients with severe behavioral problems, people who need terminal palliative care, people with advanced stage of Huntingtons' disease or Parkinsons' disease and so on. But also people, who need short-term geriatric rehabilitation, are multidisciplinary treated in these institutions and discharged after rehabilitation.

Every Dutch citizen is insured for health care expenses by a national health insurance system. Additionally, every Dutch citizen is insured under the Exceptional Medical Expenses Act (AWBZ), which covers admission to care homes, costs of home care, and psychiatric treatment. Since 2010 long-term care is reimbursed by so called 'care dependency packages'. Depending on the levels of

* Tel.: +31 243655307.
E-mail address: R.Koopmans@elg.umcn.nl

2212-9693/$ - see front matter © 2012 Published by Elsevier GmbH.
http://dx.doi.org/10.1016/j.gmhc.2012.11.004

dependency of specific patient categories for instance patients who are in need for palliative care or geriatric rehabilitation, different amounts of money are reimbursed.

2. Nursing home physician specialist

In search for possible new specialties for elderly people, a Dutch Health Management Forum issued a study on new medical professions for elderly people. They suggested three types of specialists: (1) a primary care expert in geriatric medicine, providing special attention to elderly patients visiting a general practice, (2) a basic specialist with expertise in geriatric medicine, and (3) a medical specialist in geriatric medicine that can manage complex medical problems. Working in care homes makes unique demands on: (1) problem oriented working methods, (2) medical knowledge of chronic diseases and the presentation of illness in the elderly, (3) communication skills, multidisciplinary cooperation, organization, and (4) skills to deal with complex medical–ethical dilemma's and moral problems. Against this background, the new specialist Elderly Care Physician (ECP) has arisen (Koopmans et al., 2010). The ECP can be seen as a combination of a primary care expert in geriatric medicine and a basic specialist with expertise in geriatric medicine. So the Netherlands move beyond the concept of the nursing home physician specialist as is described by Katz et al. (2009). Over the past 20 years, unique working methods have been developed, based on the Chronic Care Model (www.improvingchroniccare.org), and problem orientated methods that have been described elsewhere (Hertogh et al., 1996; Hertogh, 1999; Hoek et al., 2003, 2001). Moreover, Dutch care homes employee their own multidisciplinary teams consisting of an ECP, and many other professionals like nurses, nurse practitioners, psychologists, physiotherapists, speech therapists and so on. Because the Netherlands can serve as an example in that respect, the curriculum of the three-year specialist-training program of the ECP is described in more detail.

3. The training program

The first and only specialist training program for Nursing Home Physicians in the world started in 1989 (Hoek et al., 2003; Hoek and Ribbe, 2001). The practical part of the curriculum was particularly on somatic and psychogeriatric wards of care homes. The trainees participated 1 day a week in the theoretical course at the University. In September 2007, the first trainees started with a new three-year curriculum. The program is based on competencies, formulated in 2002, according to the CANMEDS-framework. Compared with the former nursing home physician program, it trains the physicians in achieving new and extended competencies, especially concerning knowledge and skills for people with complex medical problems who live at home. The entrustable professional activities are categorized in six themes: acute care, chronic somatic care, rehabilitation, palliative care, institutional psychogeriatric/mental health care, and community psychogeriatric/mental health care.

After 1 year in a teaching care home, trainees work 6 months fulltime on one or two of the following hospital-wards: hospital geriatrics, internal medicine, neurology, surgery or orthopedics. Furthermore, there is a community part, in which trainees work 6–12 months with psychogeriatric patients (mainly dementia) or patients with mental health problems who live at home. Institutions for Mental Health Care (GGz) offer this part, or in combination with care homes with a day clinic or outpatient services. Finally, there is a 3 months internship of choice, for example in a rehabilitation hospital, a hospice, or in a practice of a General Practitioner (GP). Another possibility is to carry out a research project. Trainees can combine two learning periods and create individual, tailor-made learning trajectories.

A problem-oriented theoretical course of 40 days a year supports the learning process in practice. A day starts with a session in which trainees exchange their recent experiences from practice and discuss their personal learning objectives by linking theory and practice. Educational programs basically consist of an introduction, learning objectives, didactic learning methods and preparation tasks. Examples of the former are research papers, guidelines, and study tasks particularly linked to the theme, for instance drawing up an inventory of patients with depression. Most of the theoretical course is offered at the University. About a quarter is offered in the regions of the teaching care homes, with a focus on topics like the regional organization of care or disease-management programs for patients with stroke, dementia or Parkinson's disease. Up to 10% consists of national teaching days for all trainees and up to 5% is in preparation to be given by E-learning.

The University Medical Centers of Amsterdam, Nijmegen, and Leiden offer the training program. Since 2009 they cooperate in a national foundation, called SOON (www.soon.nl). Trainees are employed by an organization financed by the Ministry of Health. The specialist training program can be followed fulltime (36 h per week) or part-time. The registration committee of the Royal Dutch Medical Association authorizes all institutions and supervisors involved in the training program. Supervisors who guide trainees in practice are contracted to participate at least 8 days per year in a training program at the University Medical Center.

4. Academic networks

Dutch Elderly Care Medicine (formerly named Nursing Home Medicine) has a long academic tradition. The first professor in Nursing Home Medicine in the world was Prof. drs. J. Michels. To date four ECP's have a chair in Elderly Care Medicine, and there are three emeriti. The universities of Nijmegen, Leiden, Amsterdam en Maastricht have established academic networks and the university of Groningen is setting up such a network.

Basically the network is a close cooperation between care-home organizations and the University Medical Centre. The goals of the networks are: (1) the development of an infrastructure for teaching in medical school and the postgraduate specialist training program, (2) the development of an infrastructure for research projects in long-term care in order to improve quality of care, and (3) the development of best-practices in long-term care. Many multicentre research projects (PhD projects) take place in these networks sometimes financed by one of the care-home organizations.

5. Care for people with dementia

Since more than 30 years, Dutch care homes make a difference in patient categories. This means that patients with mainly physical (somatic) impairments like stroke, Parkinson's disease, live on different wards than those with dementia. Traditionally, patients with dementia live on dementia special care units. On these wards, many different care concepts, are used. For instance many care-homes group patients with dementia on behalf of their severity of dementia. This means that patients with mild dementia live on different wards than patients who have advanced dementia or are in the final phase of dementia. The consequence of this concept is that once dementia progresses, the patient has to move to another ward, where care is more tailored to his/her specific needs and impairments. Some care-homes established specialized wards for patients with very high levels of problem behaviors. One of the concepts that is scientifically studied is