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Mental Health Analysis
Profiles (MhAPs):
Netherlands

**Alessia Forti,
Chris Nas,
Alex van Geldrop,
Gerdien Franx,
Ionela Petrea,
Ype van Strien,
Patrick Jeurissen**

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 Netherlands**

**Alessia Forti, Chris Nas, Alex van Geldrop, Gerdien Franx, Ionela Petrea, Ype van Strien,
 Patrick Jeurissen***

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*Alessia Forti, OECD
 Chris Nas, MSc, Dutch Association of Mental Health and Addiction Care (GGZ Nederland)
 Alex van Geldrop, MSc, Dutch Association of Mental Health and Addiction Care (GGZ Nederland)
 Gerdien Franx, Ph.D., Trimbos Institute, Netherlands Institution of Mental Health and Addiction;
 the Commonwealth Fund's Harkness Fellowships
 Ionela Petrea, Ph.D., Trimbos Institute; Netherlands Institution of Mental Health and Addiction
 Ype van Strien, MSc, Ministry of Health, Welfare and Sport, Netherlands
 Patrick Jeurissen, Ph.D. Radboud University Medical Center, Nijmegen*

Authorised for publication by Stefano Scarpetta, Director, Directorate for Employment, Labour and Social Affairs

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SUMMARY

As part of a wider project on mental health in OECD countries, a series of descriptive profiles have been prepared, intended to provide descriptive, easily comprehensible, highly informative accounts of the mental health systems of OECD countries. These profiles, entitled ‘Mental Health Analysis Profiles’ (MHAPs), will be able to inform discussion and reflection and provide an introduction to and a synthesised account of mental health in a given country. Each MHAP follows the same template, and whilst the MhAPs are stand-alone profiles, loose cross-country comparison using the MhAPs is possible and encouraged.

The Dutch mental health system is highly institutionalised and has a large number of psychiatric beds compared to other OECD countries. Nonetheless, government reforms have aimed at shifting the axis of the system from bed-based hospital services to more integrated mental health services and community-based services. Structural changes to the Dutch mental health system, together with recent government policies that aim to improve access to mental health services, have led to decreasing the treatment gap for mental disorders but also to increasing the expenditures associated with mental health care up until 2011.

RÉSUMÉ

Lancée dans le cadre d’un projet plus vaste consacré à la santé mentale dans les pays de l’OCDE, la série de profils « Santé mentale : profils d’analyse » (*Mental Health Analysis Profiles* - MHAP) vise à décrire de manière simple et détaillée les systèmes de santé mentale des pays de l’OCDE. Ces profils, qui étayeront les examens et les réflexions qui seront menés, feront le point sur la situation d’un pays donné dans le domaine de la santé mentale. Les profils MHAP sont indépendants les uns des autres mais suivent le même modèle : il est donc possible, et recommandé, de les utiliser pour procéder à des comparaisons entre pays.

Le système de santé mentale néerlandais s’appuie en grande partie sur les soins en établissement et compte un grand nombre de lits de psychiatrie par rapport à d’autres pays de l’OCDE. Néanmoins, les réformes entreprises par le gouvernement visent à réorienter le système de santé mentale des services hospitaliers vers des services spécialisés et des services de proximité plus intégrés. Les réformes structurelles qui ont été menées, ainsi que les récentes mesures visant à améliorer l’accès aux services de santé mentale, ont permis de réduire les lacunes en matière de traitement des troubles mentaux, mais elles ont aussi fait augmenter les dépenses liées aux soins de santé mentale jusqu’en 2011.

LIST OF ACRONYMS

ADHD: Attention deficit-hyperactivity disorder
AIA: Provincial Councils for Public Health
AWBZ: Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*)
BIG: Professions in Individual Health care Act (*Wet op de beroepen in de Individuele gezondheidszorg*)
BOPZ: Psychiatric Hospitals Compulsory Admissions Act (*Wet bijzondere opnemingen in Psychiatrische Ziekenhuizen*)
CCBH: Central Commission on the Treatment of Heroin Addicts (*Centrale Commissie Behandeling Heroïneverslaafden*)
CIZ: National Care Assessment Centre (*Centrum Indicatiestelling Zorg*)
CO: Court Order
CQ-index: Consumer Quality Index
CVZ: Health Care Insurance Board (*College voor Zorgverzekeringen*, currently *Zorginstituut Nederland*)
DBC: Diagnosis Treatment Combinations (*Diagnose Behandel Combinaties*)
EBRO: Evidence Based Guideline Development platform
EHCI: Euro Health Consumer Index
EPA: Serious or severe (and persistent) mental illness (*Ernstige Psychische Aandoening*)
FACT: Flexible Assertive Community Treatment
FPA: General providers of mental health care with a Forensic Psychiatric Department
FPC: Forensic Psychiatric Centres
FPK: Forensic Psychiatric Clinics
GGZ Nederland: Dutch Association of Mental Health and Addiction Care
Gnw: Medicines Act (*Geneesmiddelenwet*)
IGZ: Health Care Inspectorate
IGZ: Health Care Inspectorate (*Inspectie voor de Gezondheidszorg*)
Kwz: Quality of Health Facilities Act (*Kwaliteitswet zorginstellingen*)
LHV: National Association of General Practitioners (*Landelijke Huisartsen Vereniging*)
LPGGZ: Umbrella organisation for user and family groups in mental health care
LVG: National Association of Organised Primary Care (*Landelijke Vereniging Georganiseerde Eerste Lijn*, currently *InEen*)
Meer GGZ: Platform for mental health institutions
MoH: Ministry of Health, Welfare and Sport
NCCMH: National Collaborating Centre for Mental Health
NGSG: National Steering Group for Multidisciplinary Guideline
NICE: National Institute for Health and Clinical Excellence
NIP: Dutch Association of Psychologists (*Nederlands Instituut van Psychologen*)
NMa: Dutch Competition Authority (*Nederlandse Mededingingsautoriteit*, currently *Autoriteit Consument & Markt*)
NVVP: Dutch Association of Independent Psychologists & Psychotherapists (*Nederlandse Vereniging voor Vrijgevestigde Psychologen & Psychotherapeuten*)
NVvP: Dutch Psychiatric Association (*Nederlandse Vereniging voor Psychiatrie*)
NZa: Dutch Health Care Authority (*Nederlandse Zorgautoriteit*)
PPC: Penitentiary Psychiatric Centres

PZG: Psychiatry by self-employed professionals (*Psychiatrie door Zelfstandig Gevestigden*)
QIC: Breakthrough Quality Collaborative
RCT: Randomised Control Trial
RIVM: Dutch Public Health Institute (*Rijksinstituut voor Volksgezondheid en Milieu*)
ROM: routine outcome monitoring
RVZ: Council for Public Health and Health Care (*Raad voor de Volksgezondheid en Zorg*)
SBG: Mental Health Care Benchmark Foundation (*Stichting Benchmark GGZ*)
TBS: Placement at the disposal of the Government (*Terbeschikkingstelling*)
UWV: Employee Insurance Agency (*Uitvoeringsinstituut Werknemersverzekeringen*)
V&VN: Dutch Nurses' Association (*Verpleegkundigen & Verzorgenden Nederland*)
VHI: Voluntary Health Insurance
SHI: Social Health Insurance
WGBO: Act on Medical Treatment Agreement (*Wet op de Geneeskundige Behandelovereenkomst*)
WKCZ: Health care Complaints Act (*Wet Klachtrecht Cliënten Zorgsector*)
Wkkgz: Act on Quality, Complaints and Disputes in Health care (*Wet kwaliteit, klachten en geschillen zorg*)
WMCZ: Client Representation Act (*Wet Medezeggenschap Cliënten Zorginstellingen*)
Wmg: Health Care Market Regulation Act (*Wet marktordening gezondheidszorg*)
Wmo: Social Support Act (*Wet maatschappelijke ondersteuning*)
Wpg: Public Health Act (*Wet Publieke gezondheid*)
WTZi: Care Institutions Act (*Wet Toelating van Zorginstellingen*)
WVG: Services for Disabled People Act (*Wet Voorzieningen Gehandicapten*)
ZATs: Special Care and Advice Teams (*Zorgadvies Teams*)
ZonMw: Netherlands Organisation for Health Research and Development
Zvw: Health Insurance Act (*Zorgverzekeringswet*)

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1. INTRODUCTION

1. This report is part of a series of descriptive profiles – Mental Health Analysis Profiles (MhAPs), produced by the OECD to give key insights into the mental health systems of select OECD countries. Following a set framework, these profiles give a detailed introduction to the history, mental health needs, and organisation and payment of care in select mental health systems. Countries have been selected so as to give an overview of different ways of approaching mental health care system organisation across the OECD, as well as to highlight examples of particularly innovative practice.

2. The organisation and the structure of the mental health system in the Netherlands have changed considerably in recent years. Government reforms have aimed at shifting the axis of the system from bed-based hospital services to more integrated mental health services and community-based services. Programmes to increase co-ordination across different sectors (*e.g.* education, social care, employment services) as well as e-Mental health initiatives to promote self-management have been proliferating in recent years in the Netherlands. Nonetheless, this shift towards care in the community is still under way, as the Dutch mental health system remains highly institutionalised and has a large number of psychiatric beds compared to other OECD countries. In parallel with these structural changes, most recent reforms have aimed at introducing more competition in the health market, which has resulted in substantial changes in a number of areas: in the way mental health services are now organised and financed; in the role and responsibilities of the Ministry of Health, Welfare and Sport; in the processes for negotiating price and quality across providers and health insurers; and in the role of consumer groups vis-à-vis policy-makers and mental health care providers. These structural changes, together with recent government policies that aim to improve access to mental health services, have led to decreasing the treatment gap for mental disorders but also to increasing the expenditures associated with mental health care up until 2011.

3. This report is designed to describe how mental health care is provided across the Dutch population, from service provision for children and young people to available mental health care for older people. Attention is also paid to any groups in the population who may have difficulties accessing appropriate mental health care, for example minority ethnic groups. The report begins with a short history of the evolution of the Dutch mental health system alongside a summary of the mental health characteristics of the population. The report goes on to describe the design of the Dutch mental health system, recent mental health policy and legislation and a detailed examination of the mental health services and financing in the country.

1.1. History and development of the mental health system

4. Mental health services in the Netherlands have long been dominated by inpatient bed-based care. The first notable reforms came about in the early 1980s, with the integration of ambulatory services and the establishment of community mental health centres. Intervention was increasingly customised so as to take account of the needs of various groups of service users, and the focus shifted to the discharge of patients and the scaling-up of shelter homes. These types of services were subsequently integrated into regional mental health care organisations (Schene and Faber, 2001).

5. Despite all the early efforts to reduce the role of mental hospitals, up to the mid-1990s the rates of psychiatric beds in the Netherlands remained quite high, and well above European levels generally. But the process of change underwent a marked acceleration in the 1990s. The focus was now on the assessment and treatment of patients, and the concepts of recovery and reintegration became increasingly recognised (Höppener and Nolen, 2001). Over the last 15 years, the mental health system with its institution-based care was progressively transformed, and specialised outpatient mental health services for people with

severe and enduring mental health problems became widely available, alongside a whole range of community-based services, such as home treatment, crisis care and supported living arrangements. The case management model of care was introduced and soon became standard practice. All these developments were made possible by a strong national incentive plan (now expired). In terms of organisation, specialist mental health services are now largely concentrated in 31 regional integrated mental health care organisations, with only a few stand-alone mental hospitals and community services still in existence (van Hoof *et al.*, 2011). These mental health organisations also incorporate about half of non-psychiatric residential facilities, and overall provide an estimated 85% of all mental health care services in the Netherlands. More recently, Flexible Assertive Community Treatment or FACT teams have gradually begun to provide community mental health services (Veldhuizen, 2007) (see section 4 for further information on FACT teams).

6. Following the introduction of a comprehensive health reform package in 2006, the organisation of the health care system in the Netherlands has significantly changed. Universal health care coverage has now been achieved through a private health insurance and provision market that is regulated and supervised by the Dutch government (Schäfer *et al.*, 2010). The Health Insurance Act (*Zorgverzekeringswet*, Zvw) and the Health Care Market Regulation Act (*Wet marktordening gezondheidszorg*, Wmg), in force since January and July 2006 respectively, changed the organisation of the health system in the Netherlands that had been in place since World War Two. Although the Zvw introduced free-market principles in health care organisation – shifting the axis from supply- to demand-side control (Muiser, 2007) – the 2006 Act also contains provisions ensuring the social character of the private health insurance system, *i.e.* an obligation to insure all citizens, and shared employer and employee contributions/premiums (Schäfer *et al.*, 2010). Moreover, several reimbursement mechanisms are currently in play to refund the health care costs of illegal immigrants who are unable to pay for care (Klazinga, 2008). Previous to the aforementioned 2006 reforms, public sickness funds constituted the majority of the insurance offer in the Netherlands, and the government had direct control over the volume, price and productive capacity of the health system. As a result of the 2006 reforms, health insurers are now allowed to negotiate with providers on the volume, price and quality of care, to make a profit, and to operate under private legislation. The government also shifted its role from the direct management of the health care system towards monitoring. In other words, after 2006 the organisation of the health care system began to operate under the credo, “less government, more market” (Eyssen *et al.*, 2010).

1.2. Mental health legislation

7. According to the Dutch Constitution, the government is tasked with improving the population’s health and developing goals, instruments and policies that contribute to this. The Netherlands has a range of health legislation, partly impacting on the care process and partly on the health care system (RIVM, 2013).

8. There is no single overarching mental health care act, and mental health regulation is mostly integrated into general health care legislation, with the exception of the Psychiatric Hospitals Compulsory Admissions Act (*Wet bijzondere opnemingen in Psychiatrische Ziekenhuizen*, BOPZ). This Act regulates the involuntary hospitalisation and treatment of patients in psychiatric care. The most important legislation affecting the care of patients with mental health disorders is described hereafter. Some of these laws are being revised or in the process of being replaced (see section 6.2 for further detail).

Legislation impacting on the health care system

- *Zorgverzekeringswet* (Zvw), Health Insurance Act
- *Algemene Wet Bijzondere Ziektekosten* (AWBZ), Exceptional Medical Expenses Act

- *Wet marktordening gezondheidszorg* (Wmg), Health Care Market Regulation Act
- *Wet maatschappelijke ondersteuning* (Wmo), Social Support Act
- *Wet publieke gezondheid* (Wpg), Public Health Act
- *Wet toelating zorginstellingen* (WTZi), Care Institutions Act
- *Gezondheidswet*, Health Care Act

9. These acts are directed at the financing and organization of care provision, and also provide a framework for the content of the care and community support delivered.

10. The Zvw and the AWBZ are health insurance acts that regulate short-term care and long-term care, respectively (for further information, see section 5.1 on Financing). The Health Care Market Regulation Act (Wmg) permits more room for patient choice and increased competition among insurers and providers (Schäfer *et al.*, 2010). In particular, the Wmg sets rules for the development, organisation and supervision of health care markets in the Netherlands. The Act inaugurated and set the tasks and responsibilities of the Dutch Health Care Authority (*Nederlandse Zorgautoriteit*, NZa) as an independent administrative body concerned with the surveillance of market forces in health care. The aim of this Act is to create an efficient and effective health care system, to control costs, and to protect and improve the position of the health care consumer.

11. The Wmo and the Wpg regulate the public health tasks and community support provided by municipalities. The Wmo covers nine performance areas to be handled by local municipalities. These include public mental health, addiction care and support services for people with chronic mental health conditions in order to improve their functioning and participation in society. The Wpg regulates the organisation of all public health care. The Wpg also addresses the management of crises due to infectious diseases and the isolation of persons who can pose a danger to the health of others internationally. The WTZi regulates health institutions with regard to *e.g.* governance and transparency, and also regulates the licensing of providers who want to deliver care reimbursed through the Zvw or the AWBZ. The WTZi also defines the rules on the administration and profitability of these organisations. The aim of the Act is to gradually give more freedom and responsibility to health care organisations.

12. The Health Care Act (*Gezondheidswet*) is one of the (many) acts that provides the Dutch Health Inspectorate with some its tasks, duties and mandate. This Act was first enacted in 1901 and then revised several times. Since 1956, it has set the rules for the organisation of the Dutch health care system. The Health Care Inspectorate (*Inspectie voor de Gezondheidszorg*, IGZ) promotes public health through the enforcement of the quality of health services, prevention measures and medical products and the Provincial Councils for Public Health (*de Provinciale raden voor de volksgezondheid*) provide independent advice on a broad range of health care-related issues to provincial administrations and others.

Legislation impacting on the care process:

- *Kwaliteitswet zorginstellingen* (Kwz), Quality of Health Facilities Act
- *Wet op de geneeskundige behandelingsovereenkomst* (WGBO), Act on Medical Treatment Agreement
- *Geneesmiddelenwet* (Gnw), Medicines Act

- *Wet op de beroepen in de individuele gezondheidszorg (BIG)*, Professions in Individual Health care Act
- *Wet bijzondere opnemingen in psychiatrische ziekenhuizen (BOPZ)*, Psychiatric Hospitals Compulsory Admissions Act

13. Legislation impacting the care process itself obviously also concerns the quality of care. This legislation imposes quality standards on health care organisations, including those providing mental health services, or on the relationship between the health care provider and the patient. The Kwz for instance requires that organisations assess, control and improve the quality of service delivery. It also requires the publication of a yearly public quality report to account for the quality of care on a range of quality indicators (see also sections 3.5 and 6.1). The WGBO describes the right to give informed consent, the right to receive or refuse to receive appropriate information, the requirement that providers establish and keep a patient record for at least fifteen years, the right of patients to see their record, and privacy regulations concerning the patient record. In case of the treatment of children under the age of 12, the parents who hold custody should be involved in decisions about the treatment plan. Youngsters aged 12 to 16 share this right with their parents, whereas after that age the involvement of parents is no longer required, unless the minor has to be admitted into a hospital for 24-hour care. At age 18 parental authority expires, although parents still have a duty to care for their children until the age of 21. The Medicines Act (Gnw) regulates all issues regarding the production, trade, prescription and provision of pharmaceuticals, including regulations to enhance their safe use.

14. Another important piece of legislation regulates the quality of the individual practitioner. The BIG, for instance, states that doctors, psychologists, nurses, dentists and midwives can only perform specific treatments (with a certain risk for patients) if they are competent and authorised to do so. If they are, they need to be registered in the BIG register and to participate in continuous professional education.

15. In mental health, 3 professions are being registered as “basic profession” (article 3 Wet BIG):

- Nurses;
- Health care psychologists (*GZ-psycholoog/Gezondheidszorgpsycholoog*), specialised in the treatment of mild to moderate illnesses such as depression and anxiety disorders;
- Psychotherapists (*psychotherapeut*), who work with patients with more severe mental health disorders.

16. In addition, 4 professions are being registered as “specialist profession” (article 14 Wet BIG):

- Psychiatrists are automatically subscribed since they are a “medical specialist”. If the psychiatrist is also a psychotherapist, then he or she has to be registered in two registers within the BIG, one as a “doctor” and one as a ‘psychotherapist’.
- Clinical psychologists (*klinisch psychologen*), specialists in dealing with complex psychopathology that have influence on several domains of functioning.
- Clinical neuropsychologists (*klinisch neuropsycholoog*), specialists in diagnosing, treating and supporting patients with brain injuries.

- Nurse specialists in mental health (*Verpleegkundig Specialisten GGZ*), who treat patients without supervision and have additional competencies in quality improvement, innovation and research (Capaciteitsorgaan, 2013).

17. This register is publicly available for anyone to consult on individual practitioners, to check whether their registration is in order, whether there might be a (temporary) interdiction on their rights to practice, or whether have received a reprimand, fine or other order from the Dutch Health Inspectorate (see section 3.5.).

18. The BOPZ regulates the circumstances involved in involuntary hospitalisation and treatment in psychiatric institutions. The BOPZ states that all of the following conditions must be met before involuntary placement can take place:

- There has to be a significant risk of serious harm to oneself (including severe self-neglect or social breakdown), to others or to society as a whole;
- Which is caused by a psychiatric disorder;
- As assessed by a psychiatrist;
- That there must no alternative other than detainment to avert the danger;
- And that the patient is refusing voluntary hospitalisation.

19. If all of these conditions are met, a judge can decide to have the patient committed. Detainment can be enforced through two procedures: an Acute Involuntary Admission (*Inbewaarstelling – IBS*) or a Court Order (*Rechterlijke Machtiging – RM*).

20. An Acute Involuntary Admission (AIA) is used in case of imminent danger. Anyone can request an AIA, but a psychiatrist has to examine the individual for the aforementioned conditions. If the psychiatrist concludes that an AIA is necessary, a medical report is submitted to the mayor, who then decides whether or not an AIA is issued. Within 24 hours of issuing an AIA, an individual is put into detainment. When an individual is detained, the public prosecutor decides (within one workday of detainment) whether or not further detainment is necessary. If this is deemed necessary, the public officer passes the matter on to the court. The court then passes judgment on the continuation of the compulsory admission within another three workdays (Nuijen, 2010; Kozma and Petri, 2012).

21. A Court Order (CO) is used when a client meets the aforementioned conditions, but when there is no emergency. It can be issued through several channels:

- People “nearest and dearest” to a person judge the person to be a danger to himself or to others because of a mental disorder. They want the person to be admitted, but the client is reluctant, so they can request a CO.
- If third parties wish to request a CO for an individual, they must make a request to the public prosecutor. The public prosecutor has to take any further initiative.
- A person with a mental disorder can request a CO for himself.
- A CO can be issued when a client is already admitted in a psychiatric institution (*e.g.* if the client has been admitted through an AIA).

22. In the CO procedure an independent psychiatrist must present his professional assessment of the client in a medical report, which is then passed on to the public prosecutor. If the public prosecutor agrees that detention is necessary, then he passes the papers to the court. The court makes the final decision on whether or not a CO is necessary. After issuing a CO, the client is detained within two weeks (Informatiepunt Dwang in de Zorg, 2013).

23. Since 1993, the BOPZ obliges every psychiatric hospital to have an independent user advocate and carer advocate. These advocates are employed by an independent trust/foundation and work for free. They are required to respect patient confidentiality.

Patient empowerment legislation

- Wet klachtrecht cliënten zorgsector (WKCZ), Health care Complaints Act
- Wet medezeggenschap cliënten zorginstellingen (WMCZ), Client Representation Act

24. The WKCZ requires every health care organisation, including those providing mental health services, to establish a procedure for complaints. The goal of this piece of legislation is two-fold: first, to offer patients easy access to make a complaint about the care received, and second, to provide professionals with an opportunity to learn from mistakes and thus improve the quality of care. One of the Act's specifications is that organisations must report calamities and sexual abuse to the national Health care Inspectorate (IGZ). The WKCZ is expected to be replaced by the Act on Quality, Complaints and Disputes in Health care (*Wet kwaliteit, klachten en geschillen zorg – Wkkgz*), which is currently before Parliament. This new Act should also replace the aforementioned Quality of Health Facilities Act (Kwz). The new Act aims to improve the quality of health care and the client's position in health care by setting rules to enhance the effective handling of complaints filed about health care suppliers and to enhance the independent handling of disputes between health care suppliers and clients. Depending on the parliamentary debate, it is expected to be in force in early 2014.

25. The WMCZ aims to strengthen the position of consumers by regulating their participation in health care organisations. The Act demands that all health care organisations establish a consumer advisory board and develop internal regulations for its operation. The Act also regulates the board's advisory rights and requirements on providers to keep the board informed.

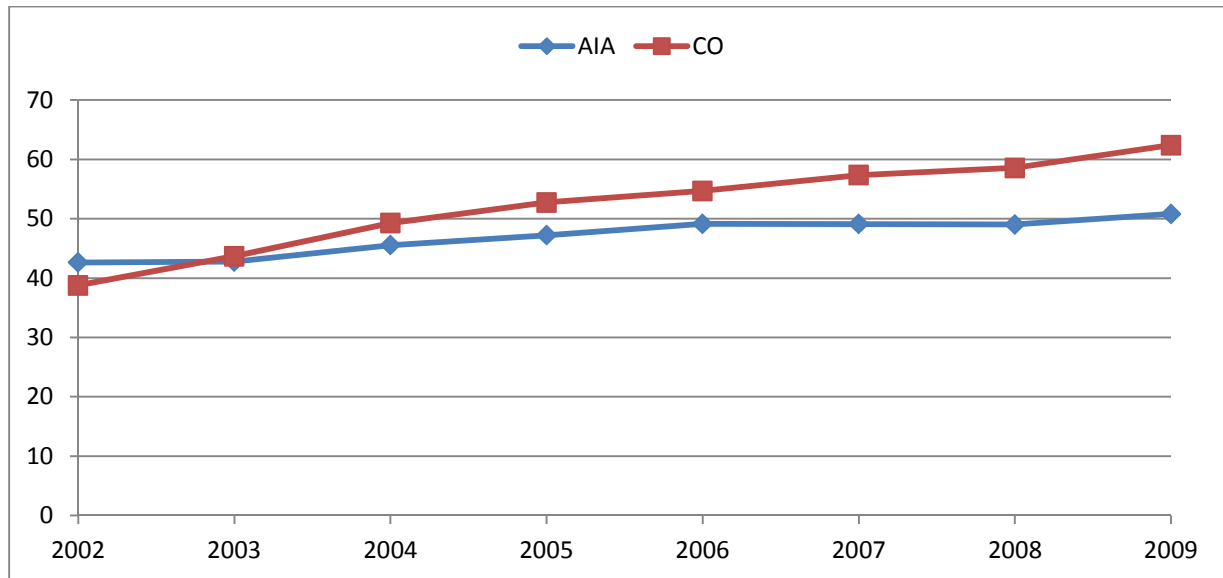
26. For further information on user involvement see section 3.6.

Detainment, restraint and seclusion rates

Detainment rates

27. The number of both AIAs and COs has increased substantially in the past years. AIAs have risen from 6 867 (42.6 per 100 000 citizens) in 2002 to 8 374 (50.8 per 100 000 citizens) in 2009, while the number of COs rose from 6 245 (38.8 per 100 000 citizens) in 2002 to 10 285 (62.4 per 100 000 citizens) in 2009 (Nuijen, 2010). Figure 1 displays the number of involuntary placements from 2002 onward.

Figure 1. AIAs and COs per 100 000 population in the Netherlands – 2002-2009



Source: Data collected from the BOPZ Information System BOPZIS (based on Mulder, Broer et al. (2006), Nuijen (2010) and Zorgatlas).

Restraint and seclusion rates

28. Coercive measures are registered by a national registration system called Argus (for more detailed information on Argus see section 3.5.). In 2006, the government and the Dutch Association of Mental Health and Addiction Care (*GGZ Nederland*) started a programme called Reduction in Coercion and Compulsion (*Terugdringen Dwang en Drang*) – following which there have been marked reductions in the number of hours in seclusion as well as the overall number of seclusions (for further information on the programme and its results see section 3.4). While the average duration of seclusion in the Netherlands (63 hours – Georgieva, 2012) is still significantly higher than in neighbouring countries, it is worth mentioning that in the Netherlands the use of seclusion is preferred above forced medication. Forced medication comprises a large part of the total number of coercive measures in most countries; for example, in Sweden 81% of all coercive measures consist of forced medication (Raboch *et al.*, 2010), while, in the Netherlands, this is roughly between 30%-40% (during 2002-2009) (Nuijen, 2010). Moreover, the relative stability in the use of forced medication during the past years indicates that it is not being used as a substitute for the reduction achieved in the number of seclusions (Nuijen, 2010).

29. As of 15 May 2013, the construction of any new seclusion rooms in Dutch psychiatric institutions is prohibited. In the future, patients may be confined only in a secure room in combination with 24/7 intensive care. This is stated in a new national standard on the physical environment of secured observation areas in psychiatric hospitals (IGZ, 2013).

30. The ultimate coercive measure is physical or mechanical restraint. However, valid and reliable measurements on physical and mechanical restraint have taken place only since 2009, making it difficult to detect trends. It is nonetheless clear that there exists great variety in the frequency of usage between mental health care providers. Some mental health care providers have actually managed to drop the number of physical or mechanical restraints to zero, while others still use physical or mechanical restraint measures on a relatively regular basis (Noorthoorn, 2012).

31. In 2011, GGZ Nederland developed a national guideline for safe and secure physical restraint. This guideline serves to guarantee the proportionality and subsidiarity of the actual intervention and to abolish poor and unsafe practices. GGZ Nederland developed the national guideline for physical restraint with mental health care practitioners and educational organisations that specialise in teaching various methods of physical restraint. The developed guideline was approved as best practice in 2011 by all the member organisations of GGZ Nederland. Consequently, all training institutes must comply with the national standard (GGZ Nederland, 2011a).

2. POPULATION CHARACTERISTICS

2.1. Prevalence of mental ill health across the population

Prevalence of common mental health problems

32. According to the latest national household survey, *i.e.* NEMESIS-2¹ (de Graaf *et al.*, 2010), 44.7% of men and 42.3% of women in the Netherlands have had a mental health problem at some point in their life. The most common disorders are mood, anxiety and substance disorders, self-reported by 1 in 5 people (respectively 20.1%, 19.6% and 19.1%). These are followed by attention deficit or behavioural disorders, which are prevalent in approximately 1 in 10 people (9.2%). Schizophrenia was found in 0.5% of the respondents.

33. Of all respondents, 23% had one Axis I² disorder, 9.7% had two and 10.1% had three or more. Comorbidity was identified in almost half (46.3%) of those with an enduring lifetime Axis I disorder.

34. The most common individual lifetime Axis I disorders were major depressive disorder (18.7%), alcohol abuse (14.3%), social phobia (9.3%) and specific phobia (7.9%). From among the behaviour and attention deficit disorders, conduct disorders in childhood or early adolescence were most prevalent (5.6%), followed by attention deficit-hyperactivity disorder (ADHD) (2.9%). Antisocial personality disorder (the only personality disorder -Axis II³ disorder- measured in this study) was identified in 3% of the respondents. Among mood disorders, major depressive disorders are relatively common, with bipolar disorder and dysthymia relatively rare. Among anxiety disorders specific phobia and social phobia are relatively common.

35. 17.7% of men and 18.4% of women reported that they suffered from a mental disorder over the last 12 months prior to the study. Women are more likely than men to suffer from mood and anxiety disorders. Major depression and simple phobia are relatively more frequent in women. In addition, more women suffer from social phobia and dysthymia than men. Among men, alcohol disorders are the most frequent. Men are also more likely than women to suffer from a drugs disorder (drug abuse and drug dependence).

¹ NEMESIS-2 (the Netherlands Mental Health Survey and Incidence Study-2') (de Graaf *et al.*, 2010) is a psychiatric epidemiological longitudinal study in the general population aged 18 to 64. A multistage, stratified random sampling was employed with a total sample size of 6 646 people. People sampled who did not have sufficient knowledge of the Dutch language to complete the interview were excluded. The response rate was 65.1%. NEMESIS 2 used the "Composite International Diagnostic Interview" (CIDI) 3.0, a tool that allows diagnosis on the basis of DSM-IV (American Psychiatric Association, 1994), which is largely used by psychiatrists and other professionals in the Netherlands. Furthermore, an additional questionnaire was used to address non-clinical issues, including demographics, physical health, vulnerability factors, promoting and impeding factors, function, help-seeking behaviour, sexuality and violence. Participants were interviewed face-to-face twice.

² Axis I disorders include mood, anxiety, substance abuse, ADHD, eating, dissociative and psychotic disorders.

³ Axis II disorders include personality disorders and intellectual disabilities.

36. An important factor associated with mental ill health is a low socioeconomic status. People with lower education, lower household income or without paid employment had a greater chance of all measured 12-month disorders (mood, anxiety, substance disorder and ADHD in adulthood). Other demographic determinants of 12-month disorders were younger age (mood, substance disorder and ADHD in adulthood), not living with a partner (mood, anxiety and substance disorder), non-Western origin (anxiety), not being religious (mood disorder) and a higher degree of urbanisation (anxiety disorder). Ethnicity was rarely associated with the occurrence of a combination of mental disorders (de Graaf *et al.*, 2010). In the youngest age group, *i.e.* 18-24 year-olds, the prevalence of any mental disorder was much higher than in the older age groups, including for women.

37. Table 1 summarises these findings across a number of characteristics, including gender, age, level of education, ethnic background and religious belief.

Prevalence of severe mental illness

38. Serious or severe (and persistent) mental illness is translated into Dutch as *Ernstige Psychische Aandoening* (EPA). Recently, an expert group reached a consensus on the definition of EPA and the number of patients suffering from EPA in the Netherlands (Delespaul and consensusgroup, 2013). This kind of consensus seemed a necessary prerequisite for policy making, innovation and cost predictions for this patient group.

39. The expert group suggested including individuals in the EPA group when the following criteria have been present at any time during their history:

- There is a psychiatric illness that needs care/treatment (symptoms not in remission);
- And comes with severe impairments in social/societal functioning (functions not in remission);
- And with whom the impairment is the cause and the consequence of the psychiatric illness;
- And not of a temporary character (structural or chronic, at least for several years);
- And where coordinated care of professional providers in networks of care is needed in order to realise the treatment plan.

40. Remission can be attained when patients are free from symptomatology and in functional remission for 6 months (Delespaul and consensusgroup, 2013).

41. The analysis of the number of patients in the Netherlands resulted in an estimated 160 000 persons aged 18-65 receiving care for EPA, including both patients within substance abuse care and forensic care (Delespaul and consensusgroup, 2013). When children and youth under 18 years and elderly over 65 years were included, the estimated number of patients in care for EPA was 216 000. Of all EPA patients, 60% were diagnosed with a psychotic disorder, 10% with addiction, and 30% had other diagnoses (Delespaul and consensusgroup, 2013). Sixty percent of patients received outpatient ambulatory treatment, 13% received inpatient treatment and 25% received a combination of both (Van Weeghel, 2010; Delespaul and consensusgroup, 2013). Currently, FACT teams are the main provider groups treating patients with EPA (see section 4 for further information on FACT teams). The population prevalence was estimated at 281 000, so one-third higher than the care prevalence.

Table 1. The relationship between demographic characteristics and mental illness anytime in life

Demographic characteristics	%	Mood disorder	Anxiety disorder	Substance abuse disorder	ADHD or behaviour disorder	any Axis I disorder	Antisocial personality disorder
Gender							
Men	50.3	14.4	15.9	27.7	11.8	43.4	4.3
Women	49.7	25.9	23.4	10.3	6.5	41.9	1.7
Age							
18-24	12.3	15.3	18.9	24.6	15.9	44.9	7.3
25-34	19.6	19.5	18.3	25.9	8.7	46.4	3.5
35-44	24.9	19.8	21.8	17.7	6.2	43.6	2.3
45-54	23.1	24.2	19.6	16.9		42.7	2.2
55-64	20.1	19.3	18.7	13.1		36.5	1.7
Education							
Primary education	7.7	24.5	24.2	24.5	27	47.1	6.9
LBO ⁴ /MAVO ⁵ / VMBO ⁶	22.6	20.1	20.8	18.3	12.2	41.7	3.9
MBO ⁷ , HAVO ⁸ , VWO ⁹	41.7	20.9	19.4	19.7	7.5	44.4	2.3
HBO ¹⁰ , University	28	17.8	17.8	17.1	6.1	39.6	2.3
Ethnic background							
Western	92.8	20.1	19.4	19.4	9.2	43.1	2.9
Non-Westerner	7.2	20.6	22.4	14.4	8.5	36.9	4.7
Religious							
No	61.7	20.6	20.2	21.9	10.9	45.6	3.2
Yes	38.3	19.3	18.7	14.5	5.9	38	2.7

Note: in percentages with 95% confidence interval (95% CI).

Source: de Graaf, R., M. ten Have and S. van Dorsselaer (2010), De psychische gezondheid van de Nederlandse bevolking. Nemesis-2: Opzet en eerste resultaten. [The mental health of the Dutch population. Nemesis-2: design and preliminary results]. Utrecht: Trimbos Instituut. [in Dutch]

Prevalence of mental disorders across children and adolescents

42. Apart from a handful of studies on trends in psychological problems, there is little data available about the prevalence of psychological problems amongst children and youth, and no information at all on differences between subgroups, such as children of immigrants and of non-immigrants. In terms of psychiatric disorders amongst children and youth, no information is available on trends and prevalence rates. The most recent epidemiological population studies were published in the 1980s and 1990s (Verhulst *et al.*, 1985; Jong *et al.*, 1999). A conservative estimate is that 5-6% of all children and adolescents

⁴ Lower vocational education

⁵ Mid-level general continued education

⁶ Preparatory middle-level vocational education

⁷ Intermediate vocational education

⁸ Higher general continued education

⁹ Pre-university secondary education

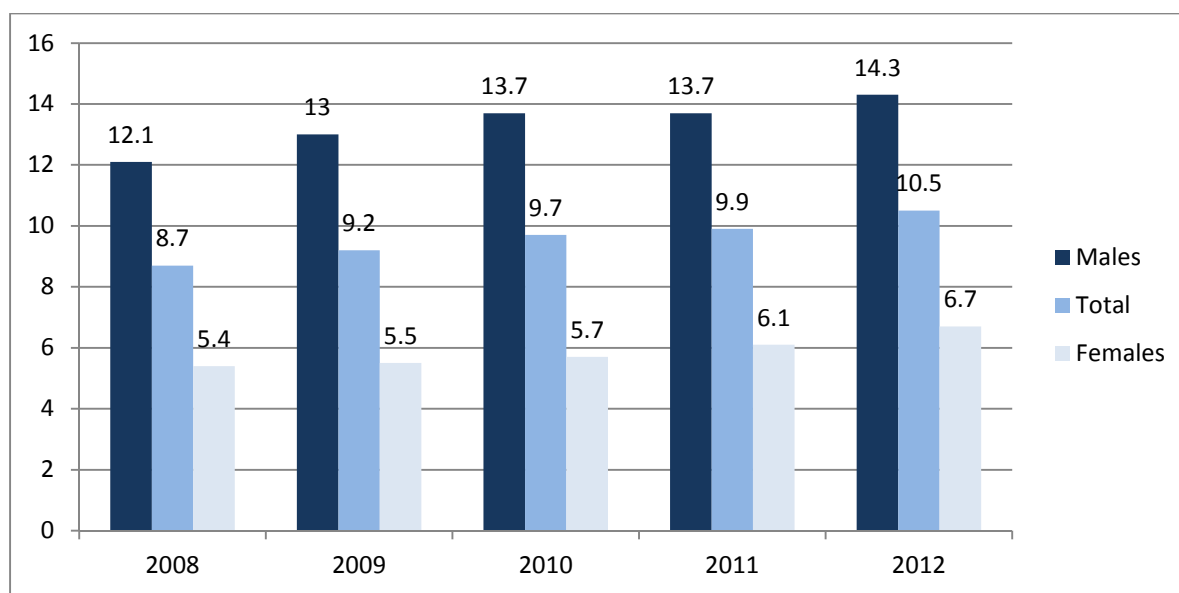
¹⁰ Higher vocational education

experience social dysfunction as a result of a mental disorder and require professional mental health care (Jong *et al.*, 1999).

2.2. Suicide

43. Although the number of suicides in the Netherlands between 2008 and 2010 was still below the average for EU countries (European Commission, 2013), this figure has been increasing in recent years, from 8.7 per 100 000 in 2008 to 10.5 per 100 000 in 2012 (Figure 2). The probability of committing suicide is over two times higher for a man than for a woman.

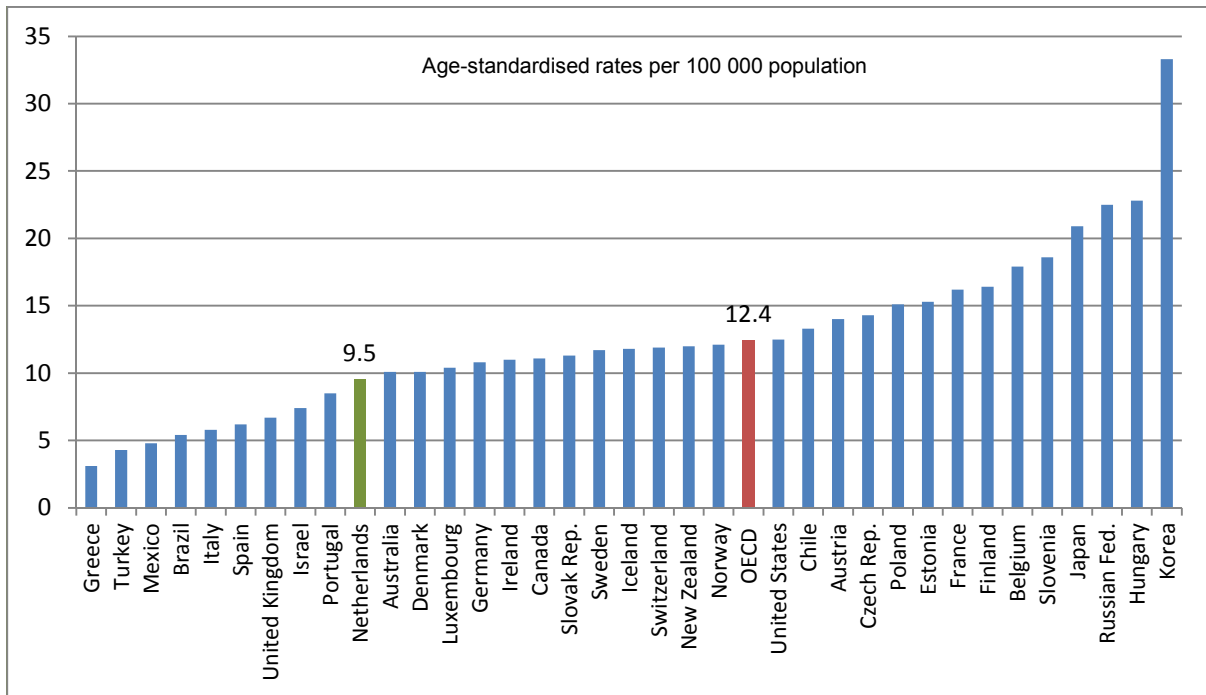
Figure 2. Suicides per 100 000 inhabitants, 2008-2011



Source: Centraal Bureau voor de Statistiek (2013). "Doodsoorzaken; zelfdoding (inwoners)". Den Haag/Heerlen: CBS. Available at: <http://statline.cbs.nl/StatWeb/publication/?DM=SLNL&PA=7022GZA&D1=0,12-16&D2=a&D3=a&D4=58-61&HDR=G1,G2&STB=T,G3&VW=T>. Accessed 7 August 2013.

44. In 2011, the number of suicides per 100 000 population in the Netherlands was well below the OECD average of 9.5 (Figure 3). Suicide rates for men are much lower in the Netherlands compared to the OECD, whilst for women figures are rather similar (Figure 4). OECD data slightly differ from data from national statistics (Centraal Bureau voor de Statistiek, 2013), probably due to the fact that OECD data are standardised.

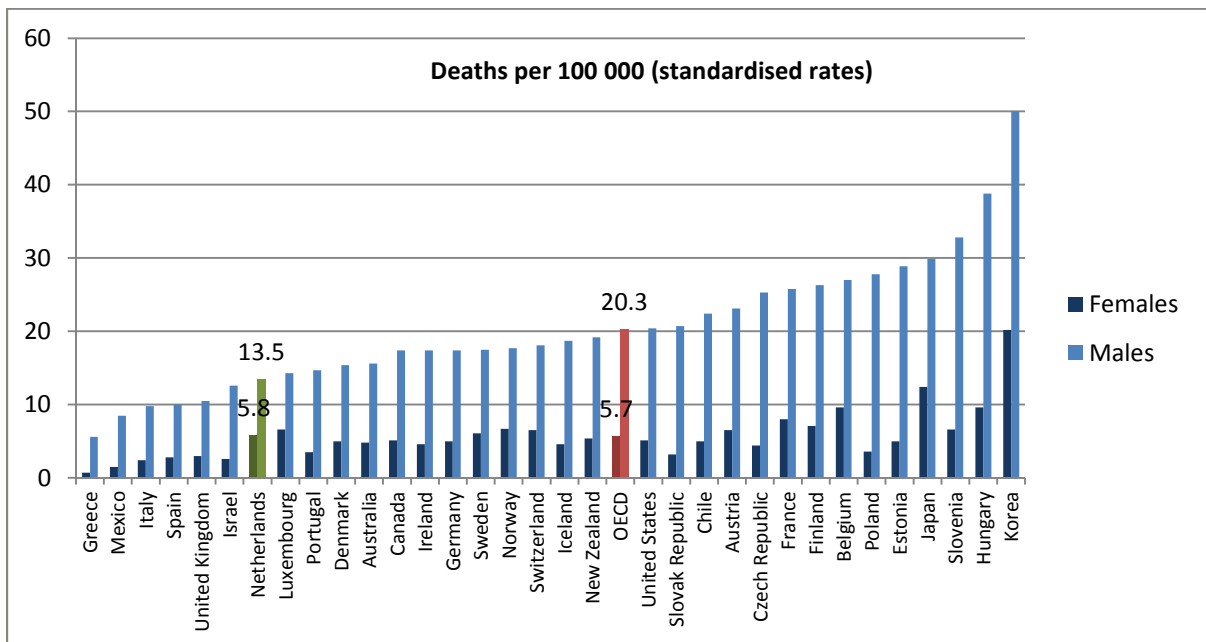
Figure 3. Suicide deaths per 100 000 population (standardised rates) in OECD countries, 2011 (or latest available)



Note: Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing.

Figure 4. Suicide deaths per 100 000 population in OECD countries, by gender, 2011



Note: Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD health database. [Online] Available <http://dotstat.oecd.org/Index.aspx>. Accessed 05 October 2013.

45. The national statistics office, which records suicides on an on-going basis, reported that in 2011 48% of people who committed suicide did so for a mental health problem, 10% did so for other reasons, 9% due to the situation at home, and 6% because of physical health problems, whilst for 27% of cases it was impossible to identify the reason for the act (Bureau voor de Statistiek, 2013).

46. In the Netherlands, around 75% of those who commit suicide have had previous contact with mental health care in their life, 43% of them in the year preceding the suicide (Huisman, 2010). The number of people committing suicide while in mental health care facilities, such as in psychiatric wards of general and university hospitals and sheltered housing facilities, has risen from 539 in 2007 to 677 in 2012 (Ministry of Health, Welfare and Sport, 2013). There is also a registration of people entering emergency rooms because of a suicide attempt (Table 2). From 2007 to 2011, there was no statistically significant rise or fall in the number of attempted suicides in the Netherlands (VeiligheidNL, 2012).

Table 2. Hospital admissions for attempted suicides, and average number of emergency room treatments – 2004-2011

	2004-2008	2005-2009	2006-2010	2007-2011	2011
Average number of hospital admissions for suicide attempts, per year	9 800	9 600	9 400	9 500	10 000
Average number of Emergency Room treatments for suicide attempts, per year	15 000	15 000	15 000	15 000	16 000

Source: VeiligheidNL (2012), *Automutilatie en Suicide*, [Automutilation and Suicide], Available: [http://www.veiligheid.nl/csi/veiligheidnl.nsf/0/C3070C7C2955963AC1257B8D0026F753/\\$file/factsheet%20automutilatie.pdf](http://www.veiligheid.nl/csi/veiligheidnl.nsf/0/C3070C7C2955963AC1257B8D0026F753/$file/factsheet%20automutilatie.pdf). Accessed 06 October 2013

2.3. Other indicators

47. Patients with mental disorders are more likely to be unemployed, have more sick days, and be less productive while at work (OECD, 2012). Consequently mental disorders potentially represent a major cost to society in lost productivity and additional disability benefits.

48. The cost of additional sick days and reduced productivity because of mental disorders has been studied in the Netherlands. Mental disorders are responsible for a total of 12 million additional sick days, or a cost of EUR 2.7 billion, per year. Similar costs due to somatic disorders are EUR 5.3 billion (de Graaf, 2011).

49. There is a gap in the knowledge on the extent of these costs in a situation without mental health care. The magnitude of the economic benefits of mental health care is mostly unknown, *i.e.* it is not clear how high the costs of mental disorders would be to society if they were left untreated (Donohue and Pincus, 2007). Initiatives have been taken to develop an overview of what is known and what can be deduced from existing knowledge. One recent study concluded that the economic benefits of depression treatment in terms of absenteeism and higher productivity alone were EUR 436 million annually (van Geldrop, 2013).

50. Another study in the Netherlands attempted to calculate the costs and benefits of mental health care practice. If health benefits alone are taken into account, the study found a return on investment (ROI) (under very conservative estimates) of EUR 2.59 per euro invested. If societal economic benefits such as improved productivity and a reduction in sick days are included, then another EUR 1.65 is gained, adding up to a total ROI of EUR 4.24 per euro (Lokkerbol, Verhaak et al. 2011). It should be noted, however, that

the study's main goal was to examine the effects of different strategic choices and that many assumptions were made. However, it does give some indication of the tremendous value that mental health care delivers to society, both in health gains and economic benefits.

3. POLICY AND GOVERNANCE

3.1. Governance and organisation of the health system

51. Following the 2006 Health Insurance Act (Zvw), the government is beginning to act as a regulatory and monitoring body, setting the general principles and monitoring whether the rules are being respected. Thus structured, the Dutch health system follows a regulated competition model (Muiser, 2007) composed of three main actors – the health insurers, the providers and the patients – that function in the health insurance market, the health care provision market, and the health purchasing market (Schäfer *et al.*, 2010).

52. Although subscription to a health insurance policy is compulsory for all citizens, patients are free to choose their health insurers as well as their providers. Health insurers have to provide all health care included in the basic health benefit package established by the government. However, not only can insurers compete for patients on price and quality, they can also offer complementary health benefit packages. Although prices and quality standards are set by the government, providers compete for patients by offering better quality services, and they compete for insurers by providing attractive health care arrangements (Schäfer *et al.*, 2010). Social health insurance schemes are further discussed in section 5.1 on Financing.

53. Since the services are mainly provided by the private sector, the role of the Ministry of Health, Welfare and Sport (hereafter MoH) in the Netherlands consists principally in the stewardship of the health system, including the defining of health care and public safety policies, with the aim of improving the population's wellbeing.

54. The MoH is not directly involved in the supervision and the monitoring of the health system, as it has delegated these functions to independent bodies. The Dutch Health Care Authority (NZa) – whose tasks are defined in the Health Care Market Regulation Act (Wmg) – is responsible for overseeing the three aforementioned health care markets in the Netherlands and makes sure that insurers comply with current Dutch legislation. As a main advisory body to the MoH, the Health Care Inspectorate (IGZ) monitors whether the quality of health care provided is in line with national standards, and it plays an important role in regulating the quality of care. The IGZ enforces statutory regulations on public health; investigates complaints and irregularities in health care; and takes any steps deemed necessary and appropriate. Quality indicators provided by providers and institutions are powerful tools for the IGZ. The values of the indicators may give rise to a practice visit or to an investigation to check whether guidelines and procedures are being observed (Groenewegen, Hansen and Ter Bekke, 2007). The Dutch Competition Authority (*Nederlandse Mededingingsautoriteit*, NMa) is in charge of maintaining fair competition by enforcing existing legislation.

55. The MoH is assisted in the decision-making process by advisory bodies, and a consensus is agreed between the government and stakeholder groups. The Health Council (*Gezondheidsraad*) is an independent scientific advisory body whose aim is to provide the government with advice on the field of public health and health care. The Health Council undertakes research studies either at the government's demand or independently. The Council for Public Health and Health Care (*Raad voor de Volksgezondheid en Zorg*, RVZ), established in 1995, also provides the government with strategic advice on welfare policies.

56. The government has delegated responsibilities for domestic home care services to municipalities, which today play a pivotal role in the country's public health sector. Municipalities own or participate in a municipal health service, which is mainly involved in health prevention programmes and acts as the advisory body to the respective municipality. The responsibility for the care of disabled people was first transferred to Municipalities in 1994 through the Services for Disabled People Act (*Wet Voorzieningen Gehandicapten*, WVG), and later integrated into the Social Support Act (Wmo) (2007). The implementation of the Wmo includes the provision of long-term care for disabled or chronically ill people, through home care services, domestic aid, transport facilities and adapted housing. The idea behind the Wmo was that municipalities are in a better position than the national government to assess people's needs.

57. The forensic health service, including the forensic mental health service, is organised and financed by the Ministry of Security and Justice (see section 4.3. on Forensic mental health).

58. The Dutch health system was voted the best health service in Europe in the 2008, 2009 and 2012 Euro Health Consumer Index (EHCI) (Björnberg *et al.*, 2008; Björnberg *et al.*, 2009; Björnberg *et al.*, 2012).

3.2. Governance and organisation of the mental health system

59. Mental health is among the most dispersed group of services in Dutch health care, currently attracting sources from four major schemes: the Health Insurance Act (Zvw), the Exceptional Medical Expenses Act, the Act for Social Support, as well as direct funding through the Ministry of Security and Justice, subsidies and budgetary transfers. This dispersion also results from the triage system. 63% of patients in specialised mental health providers are sent there by referral from a general practitioner, 12% are referred by another mental health care provider, 7% by an acute care hospital, 4% by the police or social care providers, and 10% of patients arrive without any professional referral (Jeurissen *et al.*, 2012). The GP and health care psychologists are the main providers of mental health diagnosis and treatment in primary care, supported by the Practice Support Professional for Mental Health and the social worker. As of 2014, primary mental health care providers can use suitable, and if possible standardised, diagnostic tools to determine the intensity of care required by patients. In accordance with accepted professional guidelines, an intervention programme will be set out based on care intensity, diagnosis and other patient-specific factors. This may include providing an e-health programme, for example, or using a particular health care provider in a consultative role.

60. Over the years this broad funding base has contributed towards a mental health system that, in comparison to other countries, looks at first glance to be highly institutionalised and concentrated in specialised mental health institutions, with fewer services being delivered through general acute care hospitals. Data from the World Health Organization (2011) show that in the Netherlands a large share (82%) of mental health beds are in specialised clinics, suggesting that general acute care hospitals (which also treat other diseases) have a comparatively small role in mental health treatment. The number of psychiatric departments in acute care hospitals declined by 56% between 1998 and 2006 (Leentjens and Sonderen, 2009). The Netherlands has a relative high percentage of ambulatory treatment, but also a relatively high number of psychiatric beds (WHO, 2011). The current focus on integrated mental health care providers is also underlined by the greater number of employees in the sector, compared to other types of care (Jeurissen *et al.*, 2012) (for further information on human resources, see section 4.6). Traditionally, specialised mental health care providers have non-profit status, with only some forensic providers being public institutions. However, in recent years, with the growth in market providers, the number of specialised (for-profit) outpatient mental health providers has increased rapidly.

3.3. Current mental health strategy and recent mental health policy

61. An administrative agreement on the future of the mental health care sector for the period 2013-2014 was approved in 2012 between representatives of health care providers and professional organisations, health care insurers, organisations representing clients and their families and the government. GGZ Nederland, the platform for mental health institutions (Meer GGZ), the National Association of Primary Care Psychologists (*Landelijke Vereniging Eerstelijns Psychologen – LVE*), the Dutch Association of Psychologists (NIP), the Dutch Association of Independent Psychologists and Psychotherapists (NVvP), the Dutch Psychiatric Association (NVvP), the National Association of Organised Primary Care (LVG), the Dutch Association of Health Insurers (*Zorgverzekeraars Nederland*), the umbrella organisation for user and family groups in mental health care (LPGGZ) and the MoH jointly set out a mental health strategy for the years 2013-2014, which was recently extended up till 2017. The major points of the mental health strategy are summarised below:

- Client organisations, health care insurers and health care providers will jointly prepare an anti-stigma campaign to fight discrimination against people with mental health problems. The MoH will co-finance a number of projects aimed at improving labour participation, increasing outpatient provision and reducing or preventing work absenteeism due to mental health problems.
- Health care insurers and providers will organise a system based on GP care, where patients with both mental and physical conditions are properly identified and given the treatment and support they need. Patients whose complaints are not connected with a mental disorder will be referred to other sources of help, such as a social worker. Patients whose complaints exceed the capacity of a GP will be referred to primary or secondary mental health care. Health care insurers will contract primary mental health care providers for treating straightforward, mild to moderate conditions. Secondary mental health care is available for severe, complex problems. The aim of this multi-stage approach is to provide appropriate, effective care.
- Health care insurers and providers plan to cut the current total bed capacity: by the year 2020, the number of beds will have to be reduced by a third compared to the number available in 2008. As a consequence, more importance will be given to mental health outpatient care. Accessible and adequate outpatient care programmes focused on recovery should enable people who are currently institutionalised to move towards social independence.
- Patient organisations will dedicate themselves to the development of a personally-controlled electronic health record system, which will give patients access to information from medical records.
- Mental healthcare professional organisations and patient bodies, in close collaboration with all stakeholders, will establish an ambitious programme for the quality-driven development of treatment guidelines and related instruments such as care pathways, care standards, ROM questionnaires and quality indicators. It will be carried out by the Dutch Psychiatric Association (NVvP), the Dutch Association of Psychologists (NIP) and the umbrella organisation for user and family groups in mental health care (LPGGZ). Care pathways will be developed in close cooperation with healthcare insurers, and patient bodies will be directly involved in setting care standards.
- There is increasing pressure on health providers to be in line with quality standards in a transparent way. Health care providers will provide information about the appropriateness, effectiveness and safety of the care provided, together with feedback on the patient's experience. Primary and secondary mental health care providers will systematically measure patient

satisfaction and their experiences by means of user-friendly instruments. A research programme will get underway in 2012 to develop or identify specific monitoring instruments for psychiatric care in university and general hospitals.

Financing

- Payment for mental health care support for GP practices is made more flexible in 2013.
- In 2014, a uniform payment system will be introduced for primary mental health care, based on a small number of care intensity packages (around three), corresponding to the patient's needs.
- Episode-based payment will be fully introduced for all secondary mental health care providers in 2013, based on existing diagnosis-treatment combinations. The parties will also work on further improving the episode-based system.
- An episode-based payment system that takes account of both care intensity and care outcomes will eventually be introduced for secondary mental health care.

Expenditures

- Health care insurers will align their health care procurement with the annual government budget for curative mental health care, and will make agreements with care providers on rates and ceilings on reimbursement (price and volume agreements). These agreements may be revised if contracted amounts are unexpectedly too high.
- A macro management instrument will be introduced to help care providers control expenditure. It can be used as a last resort if budgets are exceeded in spite of previous agreements. The feasibility of a differentiated macro management instrument (that distinguishes care providers who stay within budget from providers who do not) will be explored shortly. If it turns out that there are practical or legal obstacles to a differentiated macro management instrument, or if it would not be entirely effective in controlling costs, then a generic budget cut will be introduced, whereby health care providers who unexpectedly overshoot their budget will see their funding reduced on a pro rata basis according to their market share.
- The parties agree that the annual rise in costs should be limited in 2013 to 2.5%, excluding annual wage increases and price adjustments, 1.5% in 2014 and 1% annually in 2015, 2016 and 2017.

62. Besides the administrative agreement, the government aims to develop a more targeted approach to the prevention of depression in order to reduce the number of new cases. There are numerous promising interventions that are insufficiently used (Schippers, 2013a; Schippers, 2013b). One of the proposed actions is to focus on a number of specific groups at high risk of depression, for example chronically ill people, women who recently gave birth, or employees involved in stressful jobs. The development of this targeted approach is to take place in cooperation with relevant partners and is part of a National Prevention Programme (Ministry of Health, Welfare and Sport, 2013b).

3.4. Mental health strategic initiatives

National policy on suicides

63. Every year the Minister of Health, Welfare and Sport sends a report to Parliament on suicide rates. In 2008, the government formulated a preliminary target of a 5% reduction of the absolute number of suicides each year, measured over a period of 5 years (Schippers, 2013a). This target is no longer considered feasible, and the government's proposal is now a target of a 1% reduction every year, as measured over a period of 5 years (Schippers, 2013b). This target is more in line with international targets. To reach the new target, the government proposes four measures for the next year: the training of professionals; easily accessible telephone and internet help; cooperation with the railways, and the training of gatekeepers (Schippers, 2013b).

a) The training of professionals

64. In the summer of 2012, the Dutch Psychiatric Association (NVvP), the Dutch Association of Psychologists (NIP) and the Dutch Nurses' Association (V&VN) published the Multidisciplinary Guideline on the Diagnosis and Treatment of Suicidal Behaviour (Van Hemert *et al.*, 2012). This Guideline provides recommendations for physicians, nurses, psychologists and psychotherapists within the general as well as the mental health care system.

65. As suicidal patients often deal with a range of clinicians from different organisations, the collaboration between these clinicians is important. Therefore an additional document on the Quality of Care Collaboration (*Kwaliteitsdocument Ketenzorg bij suïcidaliteit*) (Hermens *et al.*, 2010) has been added to the Guideline.

66. The implementation of guidelines is a time-consuming process, so to accelerate this process the Trimbos Institute – the national institute for mental health and addiction – has drawn up an implementation plan (Trimbos, 2012). Also, the Vrije Universiteit Amsterdam is working on a Randomised Control Trial (RCT) on the implementation of this guideline. The first results of this RCT are available (de Beurs *et al.*, 2013).

b) Easily accessible telephone and internet help

67. Since 2009, the MoH directly finances “113online”, a platform for the prevention of suicide that provides free support – anonymously – for people who are suicidal and their next of kin in pressing situations. 113online has a suicide hotline, a website with information and self-assessments, a moderated forum, online courses and online therapy. In 2011, 75 000 unique persons visited the website, 3 462 adults and 2 016 youth filled in the self-assessments, and 188 people attended the online course. Every day, an average of 143 persons visited the forum. The volunteers and professional therapists of 113online answered 4 965 telephone and 7 849 chat calls, made 2 870 crisis interventions and conducted 902 online therapies (113Online n.d.).

c) Cooperation with the railways

68. In 2010, ProRail¹¹ started a 5-year suicide prevention programme. The company has not only taken physical measures (fences, cameras), but has also arranged billboards with information about (anonymous) hotlines. The 2013 budget is EUR 3.6 million (Schippers, 2013a).

11 ProRail is responsible for the construction, maintenance, management and safety of the Dutch railway network.

d) *The training of gatekeepers*

69. Gatekeepers are persons who may recognise a first signal of suicidal thoughts in other people, e.g. local religious leaders, social workers, teachers and employees in social welfare offices and employees of financial institutions (Schippers, 2013a).

eMental health

70. There are several grand trends in the Dutch health care system. As in most other developed countries, health care costs are a major concern. Furthermore, patients are increasingly being empowered. In light of these trends, e-treatment is seen as a viable option to retain (or even improve) the quality of care, while at the same time minimising costs and increasing patient access to care and empowerment. Apart from this, the Internet is considered to offer users programmes that enhance “mental fitness”, and is thus a powerful tool to prevent mental illness (Trimbos, 2013).

71. Based on these arguments, the Dutch mental health care sector has embraced online care, eHealth or eMental health, as an addition and replacement for off-line care. The first online treatments and supervisory processes started in the late 1990s, with fully online alternatives for regular treatment. A small group of mental health care organisations and the Trimbos Institute initiated this development. Since then, a large series of treatment modules for a range of conditions (depression, anxiety, alcohol, eating disorders, dementia, diabetes and comorbid depression, stress at work and others) have been developed and researched for their treatment effectiveness and cost effectiveness, leading to positive recommendations from the government for large-scale dissemination. In order to provide users with transparent information about their quality, a “self-accreditation” tool is being developed that will help organisations assess the quality of their programme and provide it with a “quality label”.

72. Attention to evidence-based and blended treatment is rising. Currently a trend of mobile eMental health apps is emerging, in which patient treatment can be not only time-independent, but also place-independent.

73. The widespread access to mobile broadband in the Netherlands created the possibility of playing a leading role in the development of effective eMental health. This offers possibilities, but at the same time it poses difficulties, since there is little knowledge about experience from other sources.

74. Between 2007 and 2010, the number of persons receiving online treatment for depression or eating disorders tripled to 181 000 (Trimbos, 2013). In 2010, almost 1.8 million individuals had accessed an online site for help. Although having become a world leader in E-mental health, and with technological developments having reached a stage of maturity, take-up throughout the Netherlands is currently stagnating. There are a number of factors that are presently being considered.

75. First, there is a lack of information on the costs and benefits of eMental health in general. The general consensus is that eMental health will be cost-effective. However, so far scientific studies of the issue do not entirely confirm this expectation. As a result, there is not much willingness to invest on a large scale (Riper *et al.*, 2013).

76. Second, eMental health requires a culture change. Care professionals will have to deal with changing circumstances in which their control and supervision over patients will adapt. If care professionals use eMental health merely in addition to regular care, then efficiency will not improve. It has to be applied as a substitute for (part of) the regular care. A paradigm shift is necessary (Putters *et al.*, 2012).

Covenant between UWV and GGZ Nederland

77. In order for benefit recipients with a certain distance from the labour market and with a (severe) psychiatric illness to retain or attain paid employment, effective support is necessary.

78. A covenant between the mental health care providers (represented by GGZ Nederland) and the Employee Insurance Agency (*Uitvoeringsinstituut Werknemers Verzekeringen*, UWV) was signed in 2012 in order to provide this support. The goal is to develop a working relationship between the UWV and mental health care providers in order to help clients as much as possible with job retention or to promote an optimal reintegration process (GGZ Nederland and UWV, 2012).

79. Key areas for collaboration include: the sharing of knowledge about the function of work as part of effective treatment; increasing the in-depth knowledge about (severe) psychiatric illnesses for UWV professionals; and tailoring efficient treatments that facilitate job retention and effective reintegration.

Covenant between police and GGZ Nederland

80. In 2003, a covenant was signed between mental health care providers (represented by GGZ Nederland) and the police. In the eight years following the covenant, collaboration between the two improved significantly. A new covenant was signed in 2011 (GGZ Nederland and Politie, 2011). The goal was to create more uniformity in the approach to sheltering and assisting people with psychiatric illnesses or substance abuse who come into contact with the police.

81. The covenant provides clear guidelines on protocols and responsibilities in a number of areas:

- The accessibility and availability of mental health care services to the police;
- Temporary deprivation of freedom and temporary deprivation of residence of mentally disturbed persons (containment, where and for how long);
- Transportation of people with mental health problems;
- Help for persons in a non-acute situation;
- The accessibility and availability of public mental health care networks for police and mental health care providers;
- Information exchange;
- What to do with missing persons or unauthorised absence from a mental health care institute;
- Reporting of criminal offences conducted within mental health care providers;
- Education and knowledge-sharing;
- Consultation structure;
- Evaluation of the covenant.

Reduction in coercion and compulsion

82. The project “Reduction of Coercion and Compulsion” (*Terugdringen Dwang en Drang*) was started in 2006 in order to reduce the use of all coercive measures in mental health, with the ambition of reducing seclusions in the Netherlands by 10% annually. The initiative originated with mental health care providers under the guidance of GGZ Nederland.

83. There were a number of priorities based on the development of relevant policies, the education of staff in these policies, and outcome measurement through Argus (see 3.5 for more information on Argus).

84. There have been some marked results since the programme started. The ratio of the number of hours in seclusion in relation to the number of hours admitted decreased by 10.2% in 2011 (compared to 2010) (Noorthoorn, 2012), and the number of unique patients who were secluded – *i.e.* the number of individual patients being secluded in that year – also decreased by 12.2% in 2010 (compared to 2009) and by another 3% in 2011 (compared to 2010) (Noorthoorn, 2012). The average duration of seclusion has also decreased dramatically, from an average of 294 hours (2003) to 63 hours (2009) (Georgieva, 2012) (for further information on detainment, coercion and compulsion see section 1.2.).

Safety houses

85. Safety houses (*veiligheidshuizen*) are a nationwide collaboration between (mental) health care and social care providers, local governments and police departments. These regional co-operative networks come to a multi-agency approach for complex cases in order to reduce severe nuisance and criminality. The network organisation was initiated, and is still funded, by the Ministry of Security and Justice (Ministerie van Veiligheid en Justitie, 2013).

86. Occasionally, cases turn out to be so problematic or complex that regular care trajectories are not sufficient. Safety houses were founded on the insight that co-operation between all relevant stakeholders was necessary to improve the effectiveness of treatment and safeguard the community and individuals. Individual cases are introduced into this network by one of the participants. Each case has to be very problematic or complex and the regular approach and care trajectories are evidently not sufficient (Ministerie van Veiligheid en Justitie, 2013).

3.5. Monitoring and good practice guidelines in the health and mental health services

Information systems and registers

Professions in the Individual Health Care Register

87. The BIG register is a mandatory registration for health care professionals who want to practise the following protected professions in Dutch health care: pharmacist, physician, physiotherapist, health care psychologist, psychotherapist, dentist, midwife, nurse, psychiatrist, nurse specialist, clinical psychologist, and clinical neuropsychologist.

88. Being listed in the BIG register means that:
- a. Professionals may use the legally protected title(s) belonging to the profession;
 - b. Professionals may practise the profession independently;
 - c. Doctors, dentists and midwives may carry out certain reserved procedures independently;
 - d. Professionals are subject to the disciplinary rules of the relevant professional association;
 - e. Professionals can start specialist training in the respective professional field.

89. The public BIG register makes it clear which professions are practised by its registrants. BIG registration means a health care professional may practice the profession for which he or she is registered independently.

90. Under the Professions in Individual Health care act (BIG), the Health Care Inspectorate (IGZ) or a court can impose disciplinary measures on health care professionals. This will have repercussions for the individual's enrolment in the BIG register. It is possible to find out from the register whether this has occurred in the case of a specific individual. The following disciplinary measures and criminal penalties can be imposed under the BIG Act: monetary fine, competency limitation order, reprimand, conditional suspension, suspension, suspension followed by a conditional suspension, limited disqualification, suspension as a provisional measure, cancellation or disqualification of registration after cancellation (Ministry of Health, Welfare and Sport, n.d.).

91. Health professionals (registered or not) who have been convicted of an offence under criminal law can also be prohibited from pursuing their profession by a judgement of a criminal court. In this case, this is an additional penalty imposed by the criminal court. The judgement is not public. However, in case of a BIG registered health professional, his or her cancellation will be included on the public list, as mentioned above.

Mental Health Care Benchmark Foundation

92. GGZ Nederland and the Dutch Association of Health Insurers (*Zorgverzekeraars Nederland*) reached an agreement on transparency in 2010. In this agreement, routine outcome monitoring (ROM) is considered to be an important tool for promoting the quality and transparency of mental health care. Together with the umbrella organisation for user and family groups in mental health care (LPGGZ), the Mental Health Care Benchmark Foundation (*Stichting Benchmark GGZ*, SBG) was founded in 2010.

93. The SBG collects outcome data on seven categories of mental health clients:

- Adults with common mental disorders;
- Adults with severe mental illness;
- Substance abuse in short-term treatment;
- Substance abuse in long-term treatment;
- Children and Adolescents;
- Elderly (psychogeriatric and gerontopsychiatric care);
- Forensic care.

94. The SBG records outcome data in the following domains:

- Reduction of symptoms;
- Functioning in daily life;
- Quality of life;

- Parental stress (children and adolescents);
- Use of substances (substance abuse in short- and long-term treatment);
- Risk (forensic care);
- Support by informal care (psychogeriatric).

95. The SBG started collecting data systematically in 2012. As of 24 February 2013, the SBG has already collected 100 214 flawless individual datasets out of 1 001 344 registered Diagnosis Treatment Combinations (*Diagnose Behandel Combinaties*, DBCs, see section 5.2). After a period of technical implementation, these numbers are now rising rapidly.

96. The Administrative Agreement on the Future of Mental Health (2012) states that mental health care providers on all levels, apart from general practitioners, must provide information on the appropriateness, effectiveness and safety of the care they provide. Primary and secondary mental health care providers will therefore systematically measure the patient's satisfaction and experience by means of user-friendly instruments. They will provide this information to the SBG, which will compile the comparative data. The results can be disclosed to health care providers, health care insurers, patients and patient organisations in order to help patients make informed choices.

97. The nationwide project on routine outcome monitoring in mental health is described further in section 6.1.

The Argus national database

98. Argus is a national database in which data is stored on interventions that limit or restrict the client's freedom of movement, such as seclusion, restraint, forced medication and force-feeding (Boogaarts 2012).

99. The following data have to be registered for each case:

- Form of the intervention;
- Date of the intervention;
- Time the intervention started;
- Time the intervention ended;
- Resistance.

100. Argus was developed out of a public need for information on the nature, size, frequency and duration of coercive measures, and in particular on seclusion. The initial impetus for the development of Argus came in 2004 from six mental health care providers who wanted to improve the quality of their care and needed reliable and valid data in order to measure improvements. GGZ Nederland and the Health Care Inspectorate (IGZ) adopted this initiative soon thereafter (Boogaarts, 2012).

101. Currently, registration is mandatory for all mental health care providers that treat patients under the Compulsory Admissions Act (BOPZ).

Vektis

102. Vektis is a cooperative organisation of all health insurers in the Netherlands that facilitates invoicing processes between health insurers and service providers. Not only does it provide operational standards, but it also collects and analyses data on the cost and quality of health care. It has at its disposal the data on all policyholders and all invoices of health care providers in the Netherlands. Health insurers increasingly use these data to benchmark mental health care providers on variations in treatment and costs (Vektis, 2012).

Outcome and quality indicators

103. The Dutch government introduced regulated competition in large parts of the health care system in 2006. This also applied to a major part of mental health care. Health insurers and mental health care providers had to reach agreements on the price and quality of mental health services, which could not exceed a total of approximately EUR 3.4 billion in cost. To ensure a level playing field, the Dutch government financed the development of a DRG-based financial remuneration system and a performance indicator system for mental health care. Both systems are now in place. Since 2010, mental health care aims to achieve transparency on quality and costs, based on four pillars:

- Outcome measurements;
- Client opinion;
- Patient safety;
- Efficiency.

104. Data on each pillar are collected on the individual (client) level. Combined, they form an integral system for the performance assessment of mental health care providers.

System of performance indicators on outcome, safety and client satisfaction

105. Since 2008, all health service providers in the Netherlands collect relevant data on performance indicators and send these to a national database of the Dutch government. The results of every service provider are published on the internet by the Dutch Public Health Institute (*Rijksinstituut voor Volksgezondheid en Milieu*, RIVM). This arrangement was evaluated for the mental health care system in 2010. The unreliability of the collected data and the poor validity of some indicators limited the value for decision-making on a national and provider level (Stuurgroep Zichtbare Zorg GGZ, 2010). All stakeholders agreed that efforts should be directed at performance indicators that are meaningful, valid and feasible to collect. In 2010, the Dutch Health Inspectorate, health insurers and mental health care providers agreed to reduce the number of performance indicators in mental health care from 28 to 10. These indicators are displayed below (Stuurgroep Zichtbare Zorg GGZ/VZ 2012):

Effectiveness of treatment and support

1. Reduction in the severity of symptoms
 - a. As reported from the perspective of the client (measured by CQ Index, see also below)
 - b. Measured change in severity of problems (Routine Outcome Monitoring)
2. Change in daily functioning of life (Routine Outcome Monitoring)
3. Change in perceived quality of life (Routine Outcome Monitoring)
4. Drop out of treatment against the advice of the professional

5. Availability of a screening procedure for somatic disorders by patients with schizophrenia
6. Timely contact following discharge from a clinic

Safety

7. Medication safety
 - a. Availability of an up-to-date medication list during prescribing of medication
 - b. Information on side effects of medication (measured by CQ Index)
8. Coercion, encompassing restraint, seclusion and forced medication (Argus)
9. Perceived safety of client (measured by CQ Index)

Client satisfaction

10. Client opinion (as measured by the CQ Index with 69 questions)
 - a. On informed consent
 - b. On freedom of choice between professionals and/or treatments
 - c. On fulfilment of wishes in care delivered
 - d. On the evaluation/adjustment of treatment or support
 - e. On the coordination of care
 - f. On housing and living conditions in a clinical setting or sheltered housing
 - g. On approach of clients by professionals

Performance assessment in forensic care

In forensic mental health care, three additional outcome indicators are used:

- Decrease in the risk of re-offending
- Relapse during the period of forensic treatment
- Physical violence during forensic treatment

Routine Outcome Monitoring

Shared vision on outcome monitoring in mental health care

106. GGZ Nederland, the umbrella organisation for user and family groups in mental health care (LPGGZ), the Dutch Association of Psychologists (NIP) and the Dutch Psychiatric Association (NVvP) developed a shared vision on Routine Outcome Monitoring (ROM) in mental health care (Stuurgroep ROM, 2010). In the future, ROM should facilitate:

- Shared decision-making in treatment on the level of clients and professionals;
- Professional reflection on the level of teams, departments and/or providers;
- (Scientific) research on regional and national levels;
- Transparency on the relevance and effectiveness of treatments and guidelines;
- Transparency on the effectiveness of service providers and mental health care organisations at a national level.

107. Creating a transparent, effective and efficient health care system requires a focus on the outcomes of health care. This in turn requires outcomes that are structurally measured at an individual level. The

anonymised data can then be collected and shared at a national level. The nationwide collection of outcome data contributes to reflection and research by professionals, and thus to the quality of care. Additionally, these data offer providers, insurers and government the best possible insight into the effectiveness of mental health care. Health insurers and providers use ROM in their purchasing process (Stuurgroep ROM, 2010).

Nationwide project on Routine Outcome Monitoring in mental health care

108. In 2009, the four abovementioned organisations started a joint project to accomplish their shared vision and set as a high-level goal to “collect sufficient numbers of comparable outcome measurements on a national scale”. Among the results of this project are:

- A national standard for the use of outcome questionnaires for nine major client groups that now cover 80 to 90% of the client population (Stuurgroep ROM, 2010);
- A Trusted Third Party to collect and analyse outcome data and to present reliable benchmarks (see section 3.5.).

109. All mental health providers in the Netherlands have acquired the technical ability to distribute and collect outcome questionnaires digitally. Questionnaires will be part of the electronic patient files. Nearly all providers are now able to securely transmit the outcome data to the Trusted Third Party.

Routine Outcome Monitoring in health care policies

110. The Council for Public Health and Health Care (RVZ) declared the ROM project to be a best practice in the Netherlands in its advice to the Minister of Health “Pay for Performance on Health Outcomes” (Raad voor de Volksgezondheid en Zorg, 2011). In January 2012, the Minister of Health stated that in the near future ROM ought to be the basis of financial compensations for mental health care providers (van Delft and Langelaan, 2012).

Patient safety

111. In 2010, GGZ Nederland and the Dutch Health Inspectorate agreed to align the performance indicators of patient safety to the priorities of the national patient safety programme “Safe care is everyone’s concern” (“*Veilige zorg, ieders zorg*”).

112. For the performance indicator “coercion”, the registration system Argus is used (see section 3.5.).

Consumer Quality Index

113. The Consumer Quality Index (CQ-index) is a standardised method (random survey) used to measure, analyse and present client experiences in health care. Questionnaires have been developed and validated for four specific groups of mental health care clients:

- Outpatient mental health care and addiction care;
- Inpatient mental health care and addiction care;
- Supervised independent living;
- Sheltered housing.

114. The CQ questionnaires overlaps with the patient reported outcome measures. In order to collect more data, the measurement of client experiences will be integrated into Routine Outcome Monitoring systems. As of 2013, the Mental Health Care Benchmark Foundation (SBG) will start to collect and present data on client experiences for outpatient mental health care.

Efficiency of the mental health care services

115. . After a five-year transition period with safety nets, the DRG-based financial system for mental health care became fully functional in January 2013. There are 140 DRGs for treatment and 7 DRGs for use of accommodation, such as clinical and day-care facilities. Each client's invoice from the health provider to the health insurer contains a code with information on the diagnosis (according to DSM IV), the time spent by specific professionals, and the price of the services delivered. More information is presented in section 5.3. The system is constantly being further improved.

Mental health guidelines

116. Although the Netherlands is one of the leading Western countries in the area of developing health care guidelines, traditionally it has had no overarching body to commission guideline development, such as NICE in the United Kingdom. Recently, two bodies were installed to overcome this lack of coordination: the Network for Development of Quality in Mental Health Care (*Netwerk Kwaliteitsontwikkeling GGZ*) and the Quality Institute (*Kwaliteitsinstituut*).

117. The Network has been initiated by the Dutch Psychiatric Association (NVvP) and the Dutch Association of Psychologists (NIP) and the umbrella organisation for user and family groups in mental health care (LPGGZ). Its goal is to continuously improve and develop innovations in the practice of professionals working in mental health care.

118. The Quality Institute is part of the Health Care Insurance Board (*College voor Zorgverzekeringen, CVZ*). The tasks of the Quality Institute are to stimulate continuous improvement in the quality of the entire health care system in the Netherlands and to make sure every citizen can access reliable and comprehensible information about the quality of the care provided. The Institute supports professional and patient organisations to develop and use quality tools, such as standards and guidelines.

119. The development of clinical guidelines in the Netherlands was initiated some twenty years ago by the professional organisations. From the mid-1990s, the MoH grew concerned about the scattered and diverse nature of guideline activities, and encouraged evidence-based development by funding large guideline development programmes. In mental health, this programme was launched in 1999 and headed by the National Steering Group for Multidisciplinary Guideline (NGSG) Development in Mental Health (Franx *et al.*, 2011).

120. Other more recent guideline programmes have been initiated since then, for instance a series of guidelines for the treatment of children in a mental health care or general child care setting. Another guideline on Work and patients with a psychiatric handicap was published in 2012. These were commissioned and funded by the Netherlands Organisation for Health Research and Development (*ZonMw*), in close collaboration with the relevant professional organisations and consumer/carer groups in this area, now united in the Netwerk Kwaliteitsontwikkeling GGZ.

The national multidisciplinary guideline programme in mental health

121. From 1999 until 2009, ten consumer and carer groups and 30 professional organisations were involved in developing multidisciplinary guidelines for a range of conditions and topics (Table 3). The mental health guidelines were developed according to the internationally accepted principles of evidence-

based medicine procedures, promoted in the Netherlands by the Evidence Based Guideline Development platform (EBRO) (Burgers and Van Everdingen 2004; Burgers *et al.*, 2004). The guidelines were all endorsed by the boards of the professional organisations involved in their development, a process that could take up to one year. This procedure of formal endorsement is required to give guidelines legal force under Dutch law, as part of the professional norms and standards for individual clinicians established by the professional organisations.

122. To develop all the guidelines, consumer and carer participation was an integral part of the process, and different formal methods of involvement were applied (Van Veenendaal *et al.*, 2004). In the first edition of the schizophrenia guideline, consumers and carers formed a “topic group”, addressing specific questions concerning the patient perspective, mainly about how to inform and address the patient properly. This group was supported by one of the professionals in the guideline working group, who wrote the patient perspective chapter, the largest chapter of the guideline. In the process of producing the guidelines on depression and anxiety, qualitative research on patient experiences with care was conducted (Eland *et al.*, 2001; Goossensen *et al.*, 2005). To develop the guidelines on personality disorders, a survey amongst consumers and carers was performed with input from the three consumers and carers in the GDG (Trijsburg *et al.*, 2008). The results of these research projects were discussed within the GDGs and resulted either in a separate chapter on the patient perspective or on the integration of the results in the guideline text.

123. After ten years, this guideline programme resulted in the publication of a series of practice guidelines, and a range of other deliverables, such as patient versions, checklists and implementation materials, were produced. Lessons learned in this programme concerned the methodology for developing guidelines, methods of consumer and carer involvement, and the dissemination and implementation of the guidelines. Important future challenges include following a strict and transparent methodology and process management, improving integration of the consumer and professional perspectives, and bridging the gap between guidelines and practice.

124. After the government grant ended, the commissioning and funding of the multidisciplinary guidelines was covered by the Dutch Psychiatric Association (NVvP). In 2011, the NVvP supported the international collaboration on guideline development between the Trimbos Institute and the UK National Collaborating Centre for Mental Health (NCCMH), one of four centres established by the National Institute for Health and Clinical Excellence (NICE) to develop guidance. Since then, the two organisations have shared the review work for two guideline projects, on autism for adults and bipolar disorders, while each country still works towards publishing its own guideline. The Network for development of quality in mental health care will continue working with NICE in future years, and their collaboration will probably expand.

Table 3. Multidisciplinary guidelines on mental health, 2003-2011

Guideline	Year of publication
Anxiety disorders	2003 and 2009
Depressive disorders	2005 and 2009
Schizophrenia	2005 and 2010
ADHD in children	2005
Eating disorders	2006
Personality disorders	2008
Interventions following disasters	2007
Alcohol disorders	2009
Domestic violence	2009
Anxiety disorders in the elderly	2009
Depressive disorders in the elderly	2009
Depressive disorders in children	2009
Somatically unexplained complaints and somatoform disorders	2010
Suicidal behaviour	2011
Heroin addiction	2011
Autism in adults, in collaboration with NICE	2012
ADHD in adults	2013
Bipolar disorders, in collaboration with NICE	2013

Dissemination and implementation

125. The medium used for disseminating the multidiscipline guidelines on mental health was the selling of the guideline books, the dedicated website www.ggzrichtlijnen.nl and the websites of the professional societies, such as the Dutch Psychiatric Association (NVvP) (<http://www.nvvp.net/>). Congresses, publications, and educational programmes were other strategies to raise awareness among clinicians about the guidelines. Implementation programmes directed at changing existing routines towards care according to the guidelines were not part of the guideline programme, but were initiated by either the professional organisations (accreditation, auditing), consumer organisations (spread of consumer versions or other promotion), the mental health providers (integrated care systems and care pathways based on guidelines) and Trimbos Institute.

126. Two important developments in practice have given a push over the last decade to the implementation of guidelines in an indirect way: the introduction of “integrated care systems” and “care pathways”, and the large-scale launch of the Breakthrough Quality Collaboratives - QICs. The first instruments represent organisational translations of guidelines, and also incorporate practice-based descriptions of care, based on the multidisciplinary guidelines. In the Netherlands, around 75% of mental health organisations have developed these instruments for specific populations and reorganised their organisations to a certain extent into a more programme-based approach (Verburg *et al.*, 2008; Hutschemaekers, 2009). The QICs are quality improvement projects that use multifaceted strategies in order to rapidly improve performance and outcomes. QICs have five essential features: (1) a focus on a specific topic, with gaps between best and current practice; (2) clinical experts who provide ideas and support for improvement; (3) the participation of multidisciplinary teams from multiple sites; (4) a model for improvement (setting targets, collecting data and testing changes); and (5) a collaborative process with a series of structured activities within a given time frame (van Splunteren *et al.*, 2003; Hulscher *et al.*, 2009). The Dutch government has sponsored large QIC programmes over the last decade in different settings. Mental health QICs have been organised to implement the guidelines on depression, anxiety disorders, schizophrenia and ADHD. All of them have led to improvements in the quality of care through the implementation of guideline recommendations at the local level (van Splunteren *et al.*, 2011).

127. Despite these national efforts, the use of guideline recommendations by clinicians in daily practice has been limited. In 2008, a survey among 400 psychiatrists, psychotherapists, psychologists, nurses and creative therapists showed that 91% of the respondents knew about the existence of the guidelines (only 73% of GPs), and two-thirds of the respondents indicated they possessed a copy of one or more guidelines. However, only 28% of the respondents indicated that they use them intentionally in daily practice (Sinnema *et al.*, 2009). Implementation is therefore high on the agenda for the future.

128. Guidelines are an important aspect of the basic insurance package. That is, a treatment is covered by this package if the treatment passes judgement from the Health Care Insurance Board (CVZ). The two main criteria used by the Board are 1) “tend to offer”, meaning that the professional organisation itself should define the treatment as something to offer and that the treatment should be offered in a manner that the professional organisation itself deems proper and acceptable (i.e. in line with guidelines, etc.), and 2) in accordance with the latest scientific research and practice, i.e. evidence-based medicine.

Monitoring of good practice guidelines: national developments

129. Two new developments will impact the development and implementation of guidelines on mental health care.

130. The first is the establishment of the new Quality Care Institute (*Zorginstituut Kwaliteit*), which is to be incorporated in the Health Care Insurance Board (CVZ) and which has been recently initiated by the Dutch government to improve the quality of care and the development of quality instruments, especially in settings where these instruments are lacking or are being insufficiently developed by professional organisations. One of the Institute’s activities will be to establish a register of existing standards, guidelines and measurement instruments and to rank these according to a number of criteria. This will help to develop the overview needed to set the future agenda and is expected to provide an incentive for stakeholders to improve their procedures and instruments.

131. A second development is the national quality programme in mental health, as part of the administrative agreement (section 3.3). Within this programme, the Network for Quality Development for Mental Health Care (Netwerk Kwaliteitsontwikkeling GGZ) will be coordinating the development and implementation of new quality instruments. The Network will be steered by the professional organisations for psychiatrists and psychologists and the national mental health platform *Landelijk platform ggz* (LP

GGZ). The Network will work in close collaboration with other stakeholders. The Trimbos Institute will provide methodological and practical support.

3.6. User involvement: consumer associations, carer associations and other NGOs

132. The Netherlands has numerous active mental health consumer and carer organisations. Twenty of these organisations united into the single voice of the National Mental Healthcare Platform (*Landelijk Platform GGZ*, hereafter “the Platform”), a not-for-profit association with sixteen employees. Together, the organisations united in the Platform represent their members, most of whom are consumers of mental health services or their carers. The overall goal of the National Platform is to improve the position of people with mental health problems in collaboration with politicians, policy makers, health care organisations, insurance companies and national associations of professional and provider organisations. The Platform focuses on the following points: improving the mental health care system as a whole (*i.e.* quality, safety, transparency, legal issues, care integration); improving the support systems for consumers and carers (*i.e.* financing self-help, peer-support groups, family involvement and consumer/carers organisations); and promoting appropriate work, payment and education for individuals with mental health conditions.

133. The National Platform aims to improve the quality, efficiency and transparency of mental health care and enhance the participation of patients in their own care process and society. For example, patient participation through shared decision-making, and in guidelines, laws and legislation, as well as the embedding of experienced experts provide more qualitative, efficient, and if necessary specialised care. This helps to prevent relapse and worse outcomes for patients in care. Transparency offers a better insight into the quality and efficiency of health care institutions, which stimulates healthier competition, provides insurance companies with information on the performance of care institutions, and supports patients in choosing their preferred carer or care institution. Participation in care and society is stimulated by several anti-stigma activities, the promotion of self-management, social activation, suitable work and overall employment.

134. In order to carry out this vision, the Platform intensively maintains contact with and obtains input from individual patients, other patient panels, and a wide variety of patient and family organisations who look after the interests of people with specific diagnoses, of their families, and of patients in care in certain regions of the Netherlands.

135. Worth mentioning here are the mandatory patient councils and the – not yet mandatory – family councils within health care institutions, and the patient and family counsellors involved in care. Patient and family councils look after the common interests of patients in the institution. All institutions are required by law to appoint a patient council. Besides the councils, patient and family counsellors operate as supporters, independent and free of charge, for patients or their families in maintaining their rights while the patient is in mental health care. Counsellors can be asked for advice, information and help in case of complaints. They are supported by a national office that provides them education, communication and legal advice.

136. The wishes and preferences of patients are subsequently monitored by the Platform and communicated in different exchanges with the government, policy makers, institutions, insurance companies and other important stakeholders.

137. In recent years, the Platform has been actively involved in a range of policy initiatives. It has, for instance, been cooperating with the government with respect to the development and amendment of laws and legislation concerning the general mental health system, youth and forced treatment. The consumer perspective also played an important role in the development of the first national quality standard for

depression and of mental health guidelines and performance indicators. After the release of the indicators, the Platform developed a performance indicator consumer manual. Related to this role in the development of performance indicators was the development of the Consumer Quality Index, based on the CAHPS, an important tool for insurance companies in the commission of mental health services.

138. The patient movement strives to organise the structural inquiry of patient experiences in mental health care and to imbed this in the national benchmarking process. The Platform plays a considerable role in this process by communicating important issues concerning benchmarks and transparency from the patient's perspective. In order to stimulate care quality and provide transparency, it also rewards care institutions with a quality label for achievements that are important from the patient perspective.

139. Furthermore, the Platform carries out numerous activities in cooperation with patient and family organisations, municipalities, professional and provider organisations and mental health care providers. These are intended to improve mental health care from a patient's perspective, for example by supporting and carrying out the recovery theory, eMental health and self-management, the involvement of the family in care, and by stimulating possibilities for participation in society, stimulating communities and employers to help with combining leisure and work, improving patient participation in patient safety, and reducing forced care, such as the use of isolation units.

4. ORGANISATION AND DELIVERY OF SERVICES

4.1. Adult mental health

Primary care

140. In the Dutch health care system, primary care acts as a gatekeeper for all specialised care, including mental health services. The involvement of family doctors in the provision of mental health care has gradually increased since the 1990s, with the introduction of social workers, nurses and psychologists in primary care. Today, GPs play an important role in the identification, treatment and care of people with mental health problems. Many primary care practices have a mental health nurse who is seconded by the specialist services and who refers patients to a clinical psychologist, but this has not been uniformly implemented across the country. If needed, the nurse may also consult psychiatrists.

141. In the last decade, innovative integrated care models have found their way into primary mental health care. An example of the successful integration of mental health into primary care is the Collaborative Stepped Care model of the Depression Initiative. This model, adapted from the original version developed in the United States, was introduced in the context of a series of randomised controlled trials in Dutch primary care, in general hospitals and in occupational health care settings. The care coordinator, typically a nurse, works closely with the GP, and both arrange consultations with psychiatrists. The treatment plan is done in consultation with the service user, taking into account personal preferences, in view of compliance with treatment. Evaluation studies (Huijbregts *et al.*, 2012; Oosterbaan *et al.*, 2013; Vlasveld *et al.*, 2013) have shown the effectiveness of this model in different settings. The model will be expanded to include anxiety disorders, and is to cover other disorders as well.

142. Another important initiative in primary care is integrated care for mental health and somatic disorders, which is aimed at improving treatment and care for people with co-morbid conditions, such as depression and diabetes. A multidisciplinary guideline for the treatment of diabetic patients with concurrent depression will soon be published by the Netherlands Diabetic Federation (NDF). Also, e-mental health modules for this patient group have been developed.

Secondary and tertiary care

143. Specialist mental health services in the Netherlands (secondary and tertiary care) are provided by 31 regionally integrated service provider organisations that offer care in inpatient and outpatient settings and by a small number of stand-alone community services and mental hospitals. These 31 integrated mental health providers deliver the full spectrum of mental health services.

144. The organisations concentrate about 85% of all mental health services (van Hoof *et al.*, 2011), and they integrate a wide range of services, from ambulatory specialist care, acute inpatient care to community-based services such as Flexible Assertive Community Treatment or FACT teams, sheltered housing, assisted living services, addiction care and forensic care. All mental health service providers are contracted on a competitive basis by insurance companies (see section 5). While most such organisations are concentrated in different regions, the competitive market model entails a diminished role of catchment areas and an increasingly overlapping presence of different service provider organisations in the same regions. In recent years, this has resulted in mergers between different such organisations and a reduction

in the overall number of these organisations nationally. On the other hand, new providers have emerged. In addition to these 31 integrated mental health providers, there are 9 specialist psychiatric children's clinics, 7 psychiatric hospitals, 11 clinics for substance abuse and 20 organisations for sheltered living, along with some 3 000 self-employed psychiatrists, psychologists and psychotherapists as well as a substantial number of new (for-profit) outpatient providers (60 in 2009).

Community-based services

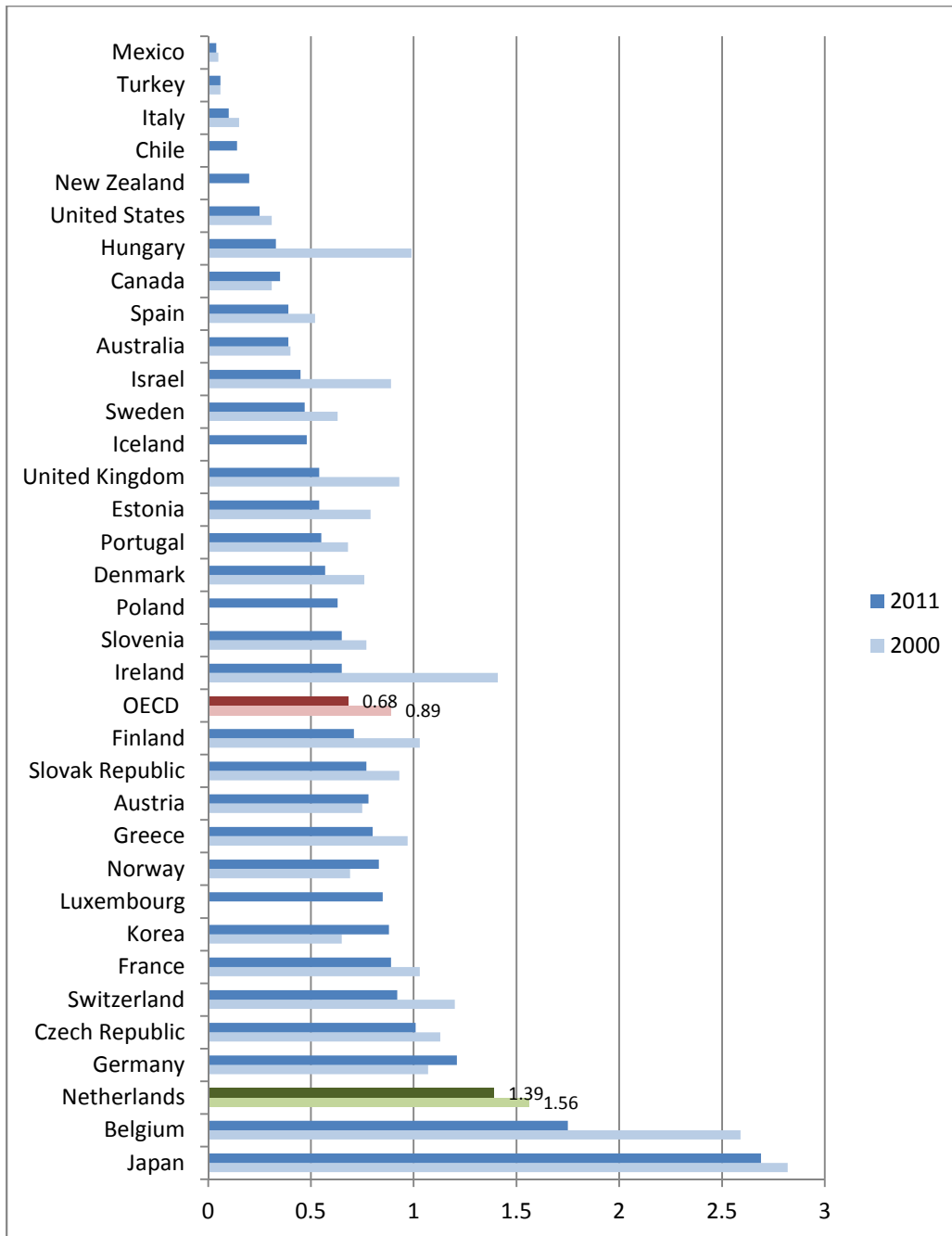
145. Outpatient care is provided in outpatient facilities (1.2 per 100 000 population) and day treatment facilities (260 per 100 000 population) (WHO, 2011). The most prominent organisational model of community services is represented by the FACT teams, although they currently provide care only to 10-15% of all adults with severe and long-term mental health problems (CCAF, 2013). FACT teams provide long-term care for people with severe mental health problems who are not treated in psychiatric hospitals. FACT provides treatment, guidance and practical assistance with daily living, rehabilitation and recovery support, with the aim of ensuring continuity of care, preventing admissions to psychiatric hospitals and stimulating inclusion in society. The teams provide a full spectrum of modern community-based mental health services, such as home treatment, crisis care, assertive outreach, and early intervention. They take an holistic and customised approach to care, providing service users with support as needed, from psychological treatment to work assistance, modulating the intensity and duration of the support services to meet people's needs. These services are provided by multidisciplinary teams that take responsibility for the overall wellbeing of their service users, including during periods of acute inpatient admissions. The FACT teams are decentralised in districts and work closely with other local and neighbourhood organisations. There are currently over 200 FACT teams, but it is expected that this number will rise to 400-500 in the near future (van Veldhuizen and Bahler, 2013).

Inpatient services

146. Inpatient services are provided in: 1) acute inpatient units, mostly small-scale; 2) residential facilities frequently based in former mental hospitals that commonly were located remotely and had large terrains; and 3) other residential facilities (*e.g.* sheltered houses, group homes).

147. The overall number of psychiatric beds in the Netherlands remains among the highest in the OECD (see Figure 5) (1.3 beds per 1 000 population). As in other OECD countries, the number of psychiatric beds decreased significantly over the past decade.

Figure 5. Psychiatric care beds per 1 000 population in OECD countries, 2000-2011



Note: Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD health database. [Online] Available <http://dotstat.oecd.org/Index.aspx>. Accessed 05 October 2013.

148. At the same time, the number of beds/places in residential facilities is also quite high and has been steadily increasing since the 1990s, reaching 78.7 beds per 100 000 population in 2011. Furthermore, inpatient care is also provided in general hospitals, which have 10.5 beds per 100 000 population.

149. Clinical psychiatric beds are beds that accommodate patients with (severe) mental health problems. They include beds in psychiatric departments of general and university hospitals and all beds in

mental health and substance abuse hospitals (see Table 4). These also include beds in the sheltered housing facilities of the Regional Mental Health Organisations for Assisted Independent Living and Sheltered Housing (*Regionale Instellingen voor Begeleid en Beschermd Wonen*). These facilities provide low-intensity care for long-term patients with mental health problems.¹²

Table 4. Types of residential services for people with mental health problems in the Netherlands 2009

Type of service	Total number of beds	Rate per 100 000
Clinical beds (cure) out of which:	21 596	131.0
- Adults and elderly	17 786	107.9
- Children and youth	1 772	10.7
- Addiction care	2 038	12.4
Sheltered housing, mainly group homes (care)	12 978	78.7

Source: Van Hoof F. et al. (2012), *Bedden tellen – afbouw van de intramurale ggz* [Counting the number of beds, phasing out institutional mental health care], *MGv*, jaargang 67 (2012) 6, 298-310. [In Dutch].

Note: The data are for “beds” or “places”. A “bed” is defined as the total number of days that are paid for by public or private insurance, divided by 365 days.

150. The popularity of other residential facilities (e.g. sheltered houses, group homes) is demonstrated by the sharp increase in the places used: from 4 000 places in 1993 to 7 000 in 2004, to approximately 13 000 in 2009 (78.7 per 100 000 inhabitants) (van Hoof *et al.*, 2011). In the long run, many of the group homes with shared facilities will be turned into individual homes (assisted independent living).

Services utilisation

151. In 2010, over 800 000 people (children, adolescents and adults) used specialist mental health services on a yearly basis (5 200 people per 100 000 population) (Table 5). The number of service users has been rising yearly over the last decades, but since 2010 this trend has been changing. Despite the high number of beds/places in inpatient settings, data on the utilisation of mental health specialist services show that 92% of people in contact with specialist services receive care in outpatient settings (GGZ Nederland, 2013a). Of the inpatient services, the most utilised are those provided by mental hospitals, with a yearly admission rate of 372 per 100 000 population.

Table 5. Service utilisation of specialist mental health care providers between 2008 and 2010 (member organisations of GGZ Nederland only)

	2008	2009	2010
Unique patients	804 300	827 500	815 800
Number of treatments:	844 900	884 600	876 000
• Children (0-19)			210 500
• Adolescent (20-24)			65 500
• Adults (25 up)			600 500

Source: GGZ Nederland. (2013a). *GGZ in de Zorgverzekeringswet, tabellen over de jaren 2008-2010: 4-5*. [Mental health care in the Health Insurance Act, tables over the years 2008-2010]. [In Dutch].

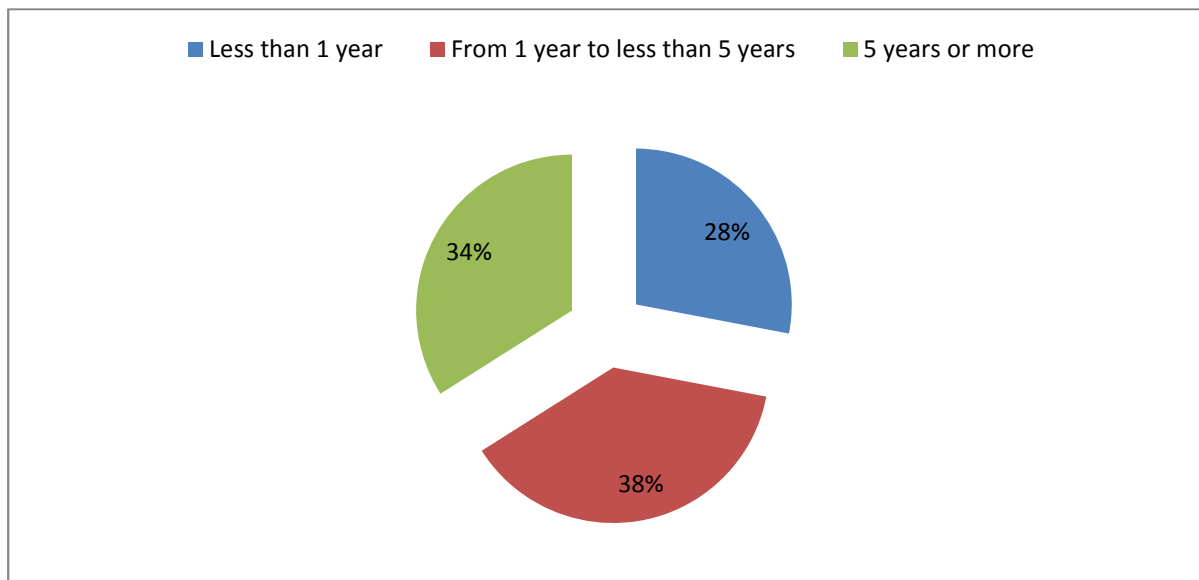
Member organisations of GGZ Nederland treated approximately 95% of all patients in specialist mental health care between 2008 and 2010.

¹²

Such facilities might be included in the social care sector in most other countries. Therefore, international comparison of these data should be done very carefully.

152. It is more difficult to give an approximate calculation for the number of people with severe and enduring mental health problems, due to methodological issues. It is estimated the figure lies between 500 and 1 500 people per 100 000 population (van Hoof *et al.*, 2011). The length of stay varies, among different hospitals, but overall, about 38% stay more than a year, and 34% stay more than 5 years (Figure 6). However, it should be noted that this excludes utilisation of services provided by self-employed providers or by psychiatric wards of general and academic hospitals as well as care provided by institutes for forensic psychiatry and institutes for addiction treatment. In 2009, 78.7 people per 100 000 population stayed in community residential facilities.

Figure 6. Long-term care in mental hospitals (% of persons by length of stay)



Netherlands. Geneva: World Health Organisation; 2011 [7 August 2013]; Available from: http://www.who.int/mental_health/evidence/atlas/profiles/nld_mh_profile.pdf.

Source: World Health Organisation, Department of Mental Health and Substance Abuse. Mental Health Atlas 2011.

153. In an outpatient setting, most contacts are short term, with about 40% of them lasting less than 3 months and 75% lasting less than 1 year. People with severe and enduring mental health problems represent about 25% of the caseload in outpatient settings (WHO, 2011).

Use of mental health services and pharmaceuticals

154. The NEMESIS-2 study (de Graaf *et al.*, 2010, see also section 2.1) reported that about 11.4% of the population (aged 18-64) has used any form of mental health care in the 12 months preceding the survey, and 5.7% has taken medication¹³. About 1.8% of people with some type of mental health problem, alcohol or drug problem reported not using any form of mental health care or taking medication (Table 6).

155. People with a mood disorder were the most frequent users of general health services, mental health care and informal care, and they were most frequently prescribed medication for their symptoms. They were followed by people with an anxiety disorder or ADHD. People with an alcohol or drug use disorder accessed health care services the least, and they were also prescribed medications the least

¹³ The medication ranged from sleeping pills and sedatives, antidepressants and anxiolytics, to anti-psychotics.

frequently. This is mainly due to the overall low use of care by people with alcohol abuse problems. It should be noted that they were asked about their use of health care and prescription medication for mental health problems in general and not for a particular condition. Of people who did not report any Axis I mental illness in the past 12 months, 6.5% were using some kind of care facility for mental health problems and 2.7% were prescribed medication for their psychological symptoms (Table 6).

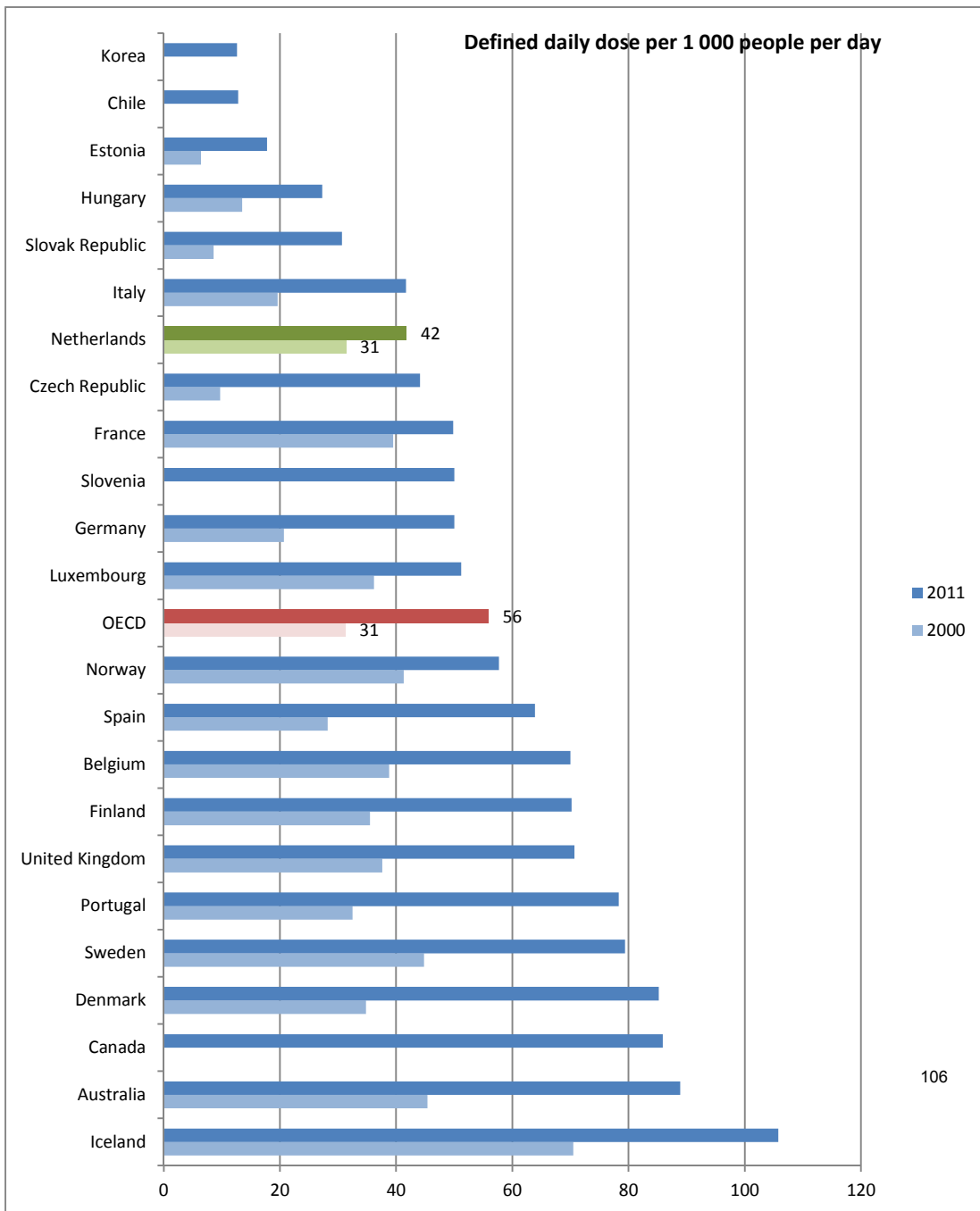
Table 6. Self-reported utilisation of medication and any form of health care because of psychiatric problems, alcohol or drug problems (in the 12 months preceding the survey) by the Dutch population between 18 – 64 years old

	Medication (%)	Any form of mental health care (%)	Unmet need (%)
Mood disorder	36.8	58.7	8.7
Anxiety disorder	20.5	34.8	5.9
Substance abuse	15.3	29.0	5.3
ADHD	24.9	35.2	5.1
Any Axis-1 disorder	19.6	33.8	5.6
No axis-1 disorder	2.7	6.5	1.0
Total population	5.7	11.4	1.8

Source: de Graaf, R., M. ten Have and S. van Dorsselaer (2010), De psychische gezondheid van de Nederlandse bevolking. Nemesi-2: Opzet en eerste resultaten. [The mental health of the Dutch population. Nemesi-2: design and preliminary results]. Utrecht: Trimbos Instituut. [in Dutch]

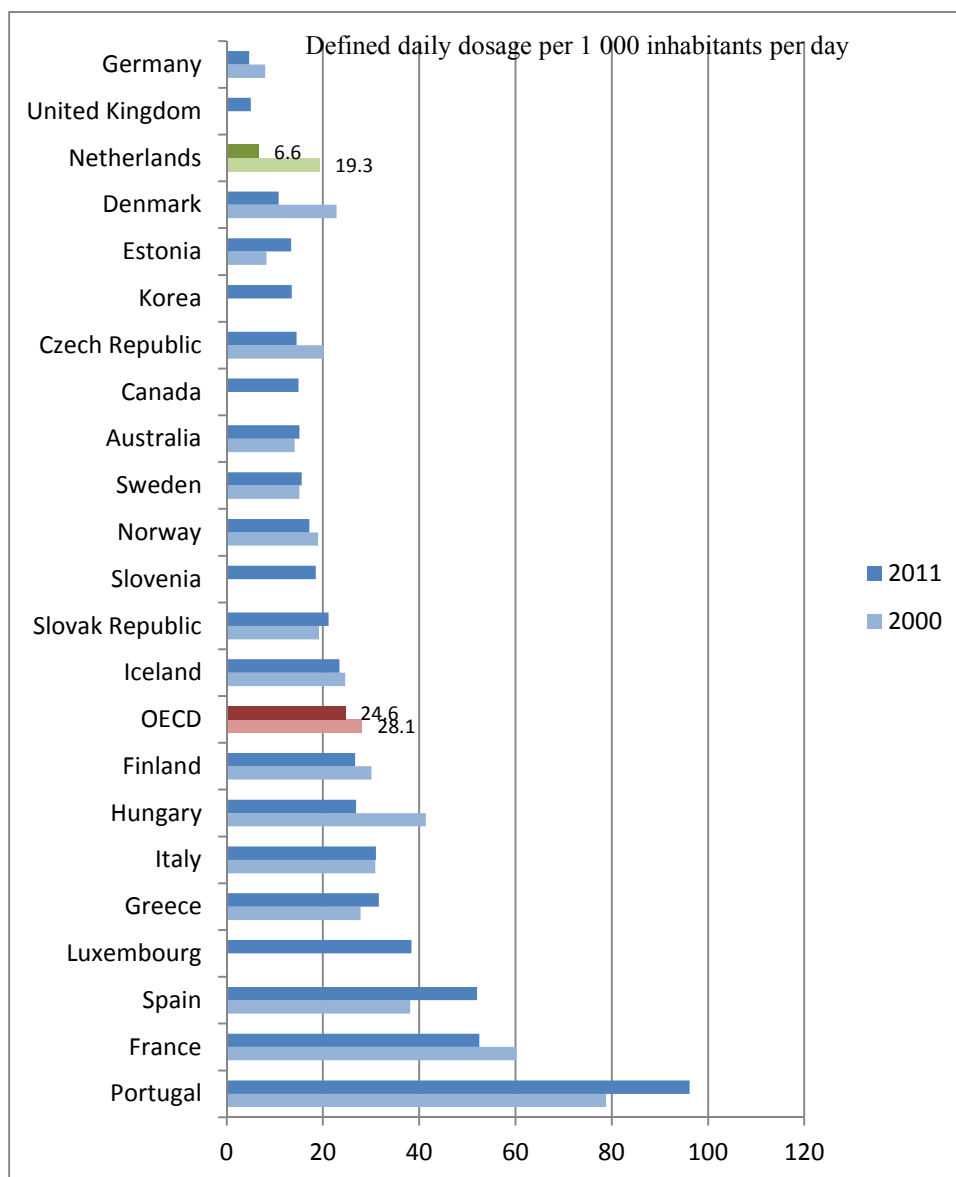
156. In the Netherlands, the consumption of mental health pharmaceuticals in 2011 (antidepressants and anxiolytics) was below the OECD average. In line with other OECD countries, the consumption of antidepressants in the Netherlands has increased significantly over the last decade (see Figure 7), whilst the consumption of anxiolytics has increased over the same period (see Figure 8).

Figure 7. Antidepressant consumption (defined daily dosage per 1 000 inhabitants per day), 2000 and 2009 (or nearest year)



Source: OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing.

Figure 8. Anxiolytics consumption (defined daily dosage per 1 000 inhabitants per day), 2000 and 2011 (or nearest year)



Source: OECD health database. [Online] Available <http://dotstat.oecd.org/Index.aspx>. Accessed 05 October 2013.

4.2. Children and adolescents mental health

157. The MoH is responsible for overall youth policy and most specialised services for families and children in the Netherlands. The 15 provincial authorities and large urban areas and 405 municipalities also have responsibilities regarding youth policy and related services. These local authorities perform their tasks with a great degree of autonomy (Bosscher, 2012).

158. The Dutch youth mental health care system¹⁴ consists of:

- Universal services¹⁵;
- Preventive services;
- Specialised services.

159. Universal services facilitate the normal development of children. Regular schools are an example of universal services. Preventive services refer, for example, to child health care centres. They are aimed at the early detection and treatment of mental health problems and fall under the responsibility of the municipalities. Specialised services, such as provincial Youth Care Agencies, are under the responsibility of both national and provincial governments.

160. There are several reasons why youth mental health care is deemed important in the Netherlands. A significant portion of mental disorders originate in the early stages of life (Kessler, Berglund et al., 2005) and have a significant negative long-term impact. These can be related to premature dropout from school (Kessler and Foster), criminal behaviour (Cocozza and Skowrya 2000), negative long-term employment outcomes (Kawakami, Abdulghani et al., 2012), and high health care utilisation at later ages (Scott and Happell 2011). An emphasis on child and adolescent mental health care is therefore seen as a worthwhile investment in the future (GGZ Nederland, 2011).

161. Providers of child and adolescent mental health care in the Netherlands focus either on clients under age 18 or under age 23, depending on the specific care provider.¹⁶ Youth care also includes the parents of troubled children. In 2010, a total of 182 715 clients (178 177 patients aged 0-23 and 4 538 persons, including parents, who were older than 23) came into contact with this type of care (1 102 clients per 100 000 citizens) (GGZ Nederland, 2013a).

162. Research outcomes on the prevalence of mental disorders in younger people vary. A conservative estimate is that 5-6% of all children and adolescents experience social dysfunction as a result of a mental disorder and require professional mental health care (Jong *et al.*, 1999).

Table 7. Number of clients in child and adolescent mental health care

Age	2008	2009	2010
0 – 5	8 777	9 444	9 715
6 – 11	64 762	70 227	71 118
12 – 17	68 712	73 713	76 754
Subtotal 0 – 17	142 251	153 384	157 587
18 – 23	18 409	19 982	20 590
Total 0 – 23	160 660	173 366	178 177

Source: GGZ Nederland (2013). GGZ in de Zorgverzekeringswet, tabellen over de jaren 2008-2010. [Mental health care in the Health Insurance Act, tables over the years 2008-2010]. [in Dutch]

¹⁴ The terms *Youth (mental) care* and *Child and adolescent mental health care* are used interchangeably throughout this text.

¹⁵ Universal services are interventions meant for the whole population. This could take the form *e.g.* of classroom lessons to strengthen children's mental resilience in general. Prevention mainly focuses on a specific population at risk, *e.g.* children whose parents have (severe) mental disorders. Other examples are interventions for children with minor behavioural problems or children who are bullied.

¹⁶ Throughout this chapter the limit of 23 years old will be applied when necessary.

163. For more about the future development of child and adolescent mental health services, see section 6.2.

Primary and secondary mental health care for children and adolescents

164. Child and adolescent mental health care does not have a leading role in primary care. It is used for consults, for analysis of clients, and to suggest proper interventions.

165. Many municipalities offer primary care for children and adolescents through youth and family centres (*Centra voor Jeugd en Gezin*). Municipalities are also responsible for selective prevention of psychological problems for high-risk groups. Parents and adolescents can also consult a GP or a psychologist in primary care for less complex psychological problems. During the past years, effective treatments have been developed for simple psychological issues, which have been included in basic health insurance package (GGZ Nederland, 2011).

166. Schools play a major role in the prevention and detection of mental disorders. Special Care and Advice Teams (*Zorgadvies Teams, ZATs*) include (but are not limited to) care and education professionals and help detect a variety of problems, including mental health problems. In 2010, over 98% of secondary and vocational schools and 67% of primary schools had access to ZATs (van der Steenhoven and van Veen, 2011).

167. Initiatives have been taken to improve regional cooperation between various stakeholders (such as schools) and share knowledge and best practices (Geudens, 2011) (Box 1).

Box 1. Rivierduinen Mental Health care for Children and Youth

“GGZ Kinderen en Jeugd Rivierduinen” is an institute for the mental health of children and adolescents. Employees of this institution educate teachers in primary and secondary education to pick up signals of psychological problems with their students and to act appropriately. This education is funded by the schools themselves. Furthermore Rivierduinen offers individual consultation for schools that have children with psychosocial problems in their classes. After consent by the client and their caretakers (usually parents), a professional informs mentors, teachers and care coordinators about the behaviour of their students and how to support them. Rivierduinen also hosts classes for students who have parents with mental disorders. This is funded by the municipalities (Brekelmans and Geudens, 2011).

168. Secondary mental health care for children and adolescents is offered at nine categorial institutions that are directed at children and adolescents. Furthermore, there are 32 separate youth departments in institutions that offer mental health care for all ages.

169. Clients in child and adolescent secondary mental health care are referred there through a variety of channels. Most common is referral by a general practitioner (44%), followed by young people coming on their own initiative (21%) and by youth care (15%). Other channels are referral by a hospital (9%), other mental health providers (7%), and social institutions or the police (3%) (GGZ Nederland, 2010).

170. The vast majority (95.9% in 2010) of treatment in child and adolescent mental health care is ambulatory (GGZ Nederland, 2013a). In ambulatory treatment the top three diagnoses are “childhood disorders”¹⁷ (44.1%), disorders associated with substance abuse (19.1%), and other disorders and problems (10.8%) (GGZ Nederland forthcoming).

¹⁷ An umbrella term for a number of disorders. Most common are attention deficit disorders and pervasive developmental disorders.

171. Clients who are not following an ambulatory treatment receive part-time or clinical treatment (GGZ Nederland forthcoming). Of this group, two-thirds (66.1%) have a DRG for disorders associated with substance abuse. Another significant portion (13.7%) have the DRG “disorders in childhood”. The remaining 20% are spread out fairly evenly over the other 17 DRGs (GGZ Nederland, 2013a).

172. The number of available beds for clinical treatment has risen (GGZ Nederland, 2011b), but the growth in the number of occupied beds has been steadily slowing, and the total actually dropped in 2012 (Table 8).

Table 8. Number of occupied clinical beds in youth and adolescent mental health care

	2008	2009	2010	2011	2012
Number of occupied beds	1440	1538	1681	1696	1642

Source: Nederlandse Zorgautoriteit. (2013). Marktscan en beleidsbrief. Geestelijke gezondheidszorg. Weergave van de markt 2008 - 2012. [Market scan and policy letter. Mental health care. Representation of the market 2008 -2012] [in Dutch]

4.3. Forensic mental health care

173. On average there are 12 735 detainees in the Netherlands (2011) (for an overview of previous years, see Centraal Bureau voor de Statistiek, 2013), and there are over 48 000 criminally accused people annually. Research suggests that the vast majority of inmates suffer from one or more mental disorders. Estimates range from 60% (Ministry of Security and Justice, 2013) to 90% (Singleton *et al.*, 1998).

174. Forensic care in the Netherlands can be divided into two broad categories: non-judicial forensic care and judicial forensic care.

175. Non-judicial forensic care is delivered in two situations:

- a) Before a judicial verdict has been delivered, for example, when a client threatens to commit a serious criminal offence, but there has not yet been a judicial verdict, or
- b) The sentence based on the judicial verdict has been served, but treatment continues.

176. Judicial forensic care is delivered once there is a judicial verdict. It consists of mental health care, addiction care and care for intellectually disabled clients, as part of a (conditional) sentence for a criminal offence. It can take the form of either clinical or ambulatory care or be in sheltered housing. It takes place during sentencing or is applied instead of a prison sentence. There are 22 judicial verdicts that lead to forensic care, and there are three main types of judicial forensic care:

- Placement at the disposal of the Government (*Terbeschikkingstelling – TBS*);
- Care as part of a conditional sentence;
- Care in detainment.

Placement at the disposal of the Government (Terbeschikkingstelling – TBS)

177. TBS can be imposed by a court when someone with a mental disorder has committed a severe offence, and is therefore found to be (partially or fully) irresponsible for his/her criminal behaviour. The court can only impose TBS if it is necessary in order to protect the safety of other people, the general public or property.

178. The goal of TBS is threefold: first and foremost, to protect society. Second, to treat the client and facilitate reintegration within society, while reducing the chance of recidivism as much as possible. This is done through a process of increasing levels of liberties and leave-options. And finally, TBS is imposed in order to create a safe environment in which the client can be treated adequately and in which he cannot pose a danger for society during treatment.

179. There are two forms of TBS. The first type involves compulsory confinement. The patient receives mandatory treatment in a closed forensic psychiatric centre and (non-mandatory) treatment is focused on reintegration into society. TBS is evaluated by the court bi-yearly to examine whether or not the client is ready to reintegrate into society. In certain cases, if the offence caused no physical harm or danger to anyone, a judge can impose a capped TBS order with a maximum time of four years. In most cases however, TBS can theoretically be extended indefinitely until the point of safe reintegration is reached. On average a client spends 9.5 years on a TBS order (Dienst Justitiële Inrichtingen, 2009).

The average number of patients with a TBS is shown in Table 9.

Table 9. Total number of TBS patients in the Netherlands

	2007	2008	2009	2010	2011
Average number of TBS patients per year	1 797	1 883	2 008	1 977	1 875
Number of TBS patients per 100 000 citizens	10.99	11.45	12.18	11.93	11.26

Source: Ministry of Security and Justice (2012a), Forensische zorg in getal: 2007-2011 [Forensic care in numbers: 2007-2011]. [in Dutch].

180. Occasionally, patients who are placed under a hospital order are absent without authorisation or try to escape. In 2010, there were 41 cases in which a patient was absent without authorisation (2.07%, based on the total number of TBS patients). In 2011, there were 37 cases (1.97%), indicating a slight downturn. Absence without authorisation means that a patient on a TBS does not abide by the set regulations. For example, he might not report back to the forensic psychiatric centre on time. This is fundamentally different from an escape. In the period 2000-2004, there were on average three escapes per year. However, from 2005 until now there have been only two escapes (one in 2008, one in 2010) (Ministry of Security and Justice, 2012b).

181. The second type of TBS is conditional placement. In this case the court does not impose confinement in a forensic psychiatric, provided that he/she abides by certain conditions. These conditions can vary, but examples are:

- Not using any specified substances (mostly alcohol and/or drugs) for a certain period of time;
- Following a specified treatment;
- Following instructions by a parole officer.

182. If the client does not adhere to the imposed conditions, the court can choose to convert the sentence of conditional TBS into TBS with involuntary placement.

183. Table 10 shows the number of clients who received TBS sentences in recent years.

Table 10. Number of new TBS impositions in the Netherlands

	2007	2008	2009	2010	2011
# of TBS with mandatory treatment	185	126	113	102	100
# of TBS with conditions	55	53	53	37	50

Source: Ministry of Security and Justice (2012a), Forensische zorg in getal: 2007-2011 [Forensic care in numbers: 2007-2011]. [in Dutch].

184. Furthermore, in the vast majority of these cases the offence that was committed contained a component of violence, and this percentage has risen in the past years (Table 11).

Table 11. Violence component in TBS sentences (%)

	2007	2008	2009	2010	2011
% violence component	92%	95%	96%	96%	97%

Source: Ministry of Security and Justice (2012a), Forensische zorg in getal: 2007-2011 [Forensic care in numbers: 2007-2011]. [in Dutch]. Ministerie van Veiligheid en Justitie (2012).

Care as part of a conditional sentence

185. This type of forensic care is applied when a criminal court imposes a conditional sentence. For example, a client suffering from an alcohol addiction may avoid imprisonment on the condition that a certain treatment is followed. Care can be delivered in an ambulatory or clinical setting, or in sheltered housing. If the client does not adhere to the conditions set, then the conditional sentence is imposed after all. The conditional sentence could be anything except a TBS.

Care in detainment

186. An individual who is already in detainment can be diagnosed as requiring mental health care. This can be delivered through special provisions within the penitentiary (Penitentiary Psychiatric Centres (PCC)) or by regular mental health care providers. No court order is needed to initiate treatment.

Organisation of forensic care

187. There are four main parties involved in forensic mental health care:

- Forensic care providers provide the care;
- The Ministry of Security and Justice is responsible for the procurement and payment of forensic care. The Ministry is also the address where forensic care providers send their invoices;
- Institutions that provide the indications and placement;
- Clients who are in need of forensic care.

188. The Ministry of Security and Justice reviews the amount of forensic care required and identifies providers that are able to provide this specialist care. Only contracted providers are allowed to provide this type of care.

189. Forensic mental health care can be provided by regular mental health care providers or by specialised institutions. There are four types of forensic care providers:

- a) Forensic Psychiatric Centres (FPC);
- b) Forensic Psychiatric Clinics (FPK);
- c) General providers of mental health care with a Forensic Psychiatric Department (FPA);
- d) Penitentiary Psychiatric Centres (PPC).

190. The first three are forensic care providers outside a penitentiary (in which the FPC is most secure and the FPA is the most open), and PPCs provide secondary mental health care from within a penitentiary/prison. The number of forensic care providers is shown in Table 12. Further segmentation within the category “Other forensic care providers” is desirable, but not possible.

Table 12. Number of forensic care providers, by provider – 2008-2011

	2008	2009	2010	2011
FPC	12	12	13	13
PPC	-	-	5	5
Institutions that provide ambulatory care within penitentiaries			11	8
Other forensic care providers	55	72	77	87

Source: Nederlandse Zorgautoriteit. (2013). Marktscan en beleidsbrief. Geestelijke gezondheidszorg. Weergave van de markt 2008 - 2012. [Market scan and policy letter. Mental health care. Representation of the market 2008 -2012] [in Dutch]

191. Information on the capacity and utilisation of the number of beds in FPCs is shown in Table 13. The number of beds within other forms of forensic mental health care has also increased in the past years. The objective is to reduce the number of beds in the coming years. In the framework of the master plan by the Custodial Institutions Agency, it has been decided that three FPCs will be closed in the coming years and that the capacity for TBS patients will be reduced from 1 867 in 2013 to 1 339 in 2018 (Dienst Justitiële Inrichtingen, 2013). However, these plans haven’t been approved in the parliament yet.

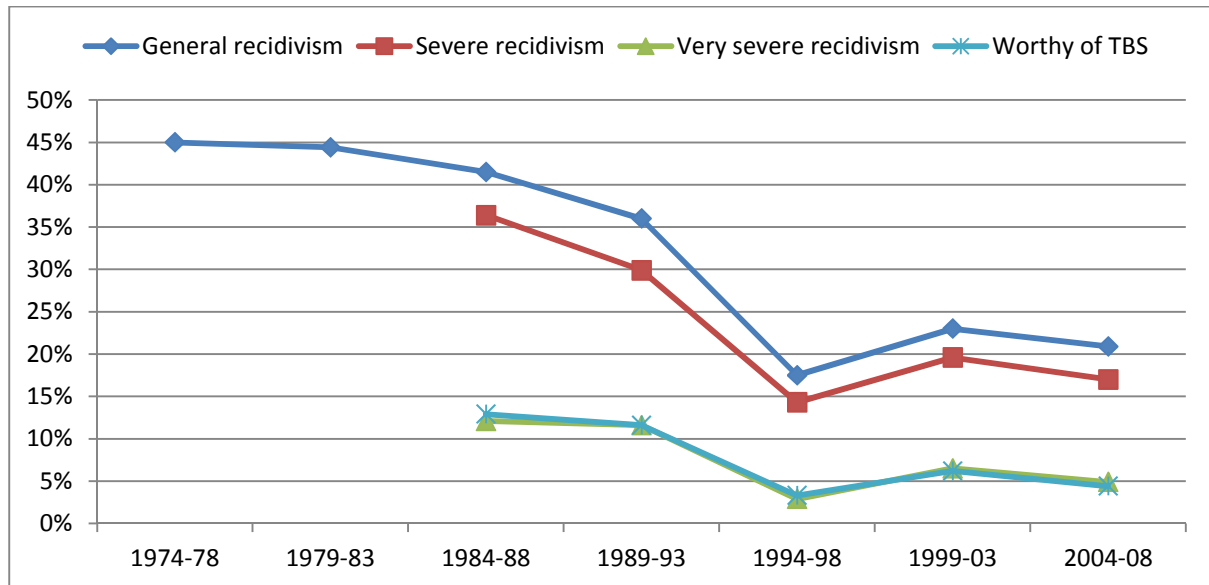
Table 13. Number of forensic mental health beds – 2006-2011

FPCs	2006	2007	2008	2009	2010	2011
Number of beds FPC	1703	1836	1944	2084	2156	2062
Number of occupied beds FPC	1690	1797	1883	2008	1977	1 875
Number of beds (other)	-	-	700	878	974	1004

Source: Ministry of Security and Justice (2012a), Forensische zorg in getal: 2007-2011 [Forensic care in numbers: 2007-2011]. [in Dutch].

192. Quality is measured through nine performance indicators that have been developed specifically for forensic care and which focus on treatment effects and safety.

193. The ultimate goal of official government policy on TBS and other forms of forensic care is to reduce recidivism. The number of recidivists has decreased significantly in recent years (Figure 9). The number of severe, very severe, and TBS-worthy crimes committed by ex-TBS patients has decreased by at least 50% for each group since 1984-1988.

Figure 9. Prevalence of two-year recidivism for cohorts of former TBS clients (for 4 levels)

Source: Wetenschappelijk Onderzoeks en DocumentatieCentrum REPRIS database [Online] Available: <http://www.wodc.nl/onderzoek/cijfers-en-prognoses/Recidive-monitor/Repris/>

194. The number of former TBS clients who, within two years of completing their sentence, have been prosecuted for a crime with a maximum sentence of at least four years has decreased during the past 25 years from 36.4% to 17% (Schönberger and de Kogel).

4.4. Minority and excluded groups

Migrant population

195. The Dutch population counts around 16.8 million inhabitants. In the Netherlands there are approximately 3.5 million immigrants, defined as persons who have at least one parent born outside the country. Almost no representative epidemiological studies have been conducted into the mental health of immigrant groups, and the few that exist have serious limitations. According to the national epidemiological study NEMESIS, which was also hampered by small numbers of immigrant participants, prevalence rates for lifetime depression were somewhat different from those of the non-immigrant population, but not significantly different (De Graaf *et al.*, 2010). The lifetime prevalence rate of depression for non-Western female immigrants was 18.3% and for men 14.3%. Other sources have nonetheless expressed the idea that some ethnic groups might be more vulnerable to certain disorders. For instance, people with a background from Suriname, Netherlands Antilles or Morocco are thought to suffer more often from schizophrenia than non-immigrants, and those from Suriname are at a higher risk for anxiety disorders (Trimbos, 2013). More research is needed to get a better insight into the nature and frequency of mental health problems amongst immigrants.

196. Attention to immigrants and refugees with regard to mental health care started slowly in the Netherlands, with a focus on education and the use of interpreters to bridge language gaps. The underlying idea was that immigration was a temporary phenomenon, and thus did not need long-term investment by mental health organisations. But from the 1980s onwards, following the publication of the Policy on Minorities (*Minderhedennota*), which for the first time abandoned the idea that the presence of immigrants was temporary, the mental health care sector became a leader in the development of care models for patient

groups from other ethnic backgrounds. Projects were initiated, mainly in the urban areas, to adopt immigrants in mainstream care. Ten years later, cultural differences were no longer considered unbridgeable.

197. After 2002, the policies regarding immigrants and integration began to focus on the necessity for immigrants and refugees to adapt to Dutch culture themselves. At the same time, the introduction of market forces in health care led to more patient-centred care. Nowadays, each mental health organisation has implemented policies related to “inter-culturalisation”, very often without a clear vision of what exactly this type of care is supposed to look like. Sometimes confusion arises in debate, when people express their beliefs that “inter-culturalisation” is in conflict with fundamental values such as equality and emancipation. But such discussions are nevertheless considered useful because they can lead to new insights and ideas (Kramer, 2009).

4.5. Drug addiction care

198. Treatment of addiction has a special place in the Dutch mental health care system. It is a specialised combination of mental and somatic health care. The areas of focus are addiction to nicotine, alcohol, drugs, and sedatives and tranquilisers.

199. In 1998, the public held a low opinion of addiction care. Politicians questioned the effectiveness of the system and threatened to halt funding. A group of directors of addiction care institutions responded by designing a programme that focused on three goals (Rutten *et al.*, 2009).

- a) Redesigning addiction care to provide care that is based on protocols and evidence and ordered in a “stepped care” hierarchy;
- b) Developing a system based on the permanent measurement of results;
- c) Creating a support system, for example with initial education and extra training.

200. Through this initiative, the knowledge centre “*Resultaten Scoren*” (translated as “Scoring results”, which refers to the “scoring of drugs” as well as a focus on results) was founded. This centre specialises in addiction care and has had a major role in creating a scientific, evidence-based care approach in the sector during the past decade. The Dutch addiction care sector is held in high regard internationally and is well informed about the prevalence of different addictions and about effective treatments (Rutten *et al.*, 2009).

201. There are currently nine categorical and eight integrated providers for addiction care in the Netherlands. The nine categorical addiction care providers have nearly 5 000 professionals on staff (GGZ Nederland, 2013b). It is not known how many more professionals are employed in the integrated providers that deliver addiction care.

202. In 2012, addiction care had 66 094 clients seeking help (78% male, 22% female), or 395 per 100 000 citizens (416 per 100 000 citizens in 2011). The average number of contacts per client was 30, resulting in a total amount of contacts of nearly two million (Dane 2013).

203. Treatment is mostly ambulatory (76%), but 16% of all clients have a combination of clinical and ambulatory, and 1% have exclusively clinical treatment (Wisselink *et al.*, 2013)

204. A significant share of clients (46.5%) in 2012 had alcohol-related issues. This is followed by addiction to opiates and cannabis (see the list in Table 14). Some of these addictions will be discussed in further detail below.

Table 14. Distribution of patients in addiction care in 2012

Addiction	Percentage
Alcohol	46.5%
Opiates	16.0%
Cannabis	15.4%
Cocaine	11.4%
Gambling	3.4%
Amphetamines	2.2%
GHB	1.1%
Medication	1.1%
Ecstasy	0.2%
Other	2.4%

Source: Wisselink, D., W. Kuijpers A. and Mol (2013). Kerncijfers verslavingszorg 2012. [Key figures addiction care 2012], Houten: Stichting Informatie Voorziening Zorg. [in Dutch]

Opiates

205. The number of opiate users in the Netherlands has declined from an estimated 25 700 – 39 000 in 2002 to 17 300 – 18 100 in 2011 (Cruts and Van Laar 2011). Out of this group, 11 300 persons are enrolled in an addiction care centre or in a regular mental health care provider that also offers addiction care. Almost 10 000 opiate-users are enrolled in a methadone programme (Wisselink, Kuijpers et al. 2012). A smaller group of 700 people is also being treated with heroin. There are 12 institutions in the Netherlands that offer heroin and/or methadone treatment for long-term addicts.

206. A quarter of opium addicts live in social isolation and have multiple interrelated psychological issues (Loth 2009). These sustained substance-dependent patients remain a vulnerable group.

207. Treatment of opiate addiction by medical prescription of heroin has been permitted since 1998. The Central Commission on the Treatment of Heroin Addicts (*Centrale Commissie Behandeling Heroïneverslaafden*, CCBH) has been responsible for coordinating the heroin supply and treatment. Since 1998, treatment has taken place in the context of scientific research. The goal was to provide treatment with heroin as part of a (regular) pharmacotherapeutic regimen. The necessary adjustments in legislation passed parliament in October 2009 (Staatsblad van het Koninkrijk der Nederlanden, 2009). Currently, heroin can be prescribed to a selected group of patients who meet the required indication.

208. The effects of the transition to the medical prescription of heroin have been examined. This study found that clients receiving both methadone and heroin, compared to clients who received just methadone, had higher health benefits, and generated fewer costs for law enforcement and less harm to victims (Dijkgraaf *et al.*, 2005).

209. The new treatment combining methadone and heroin reduced costs to law enforcement by EUR 4 129 per patient per year (pppy), and it reduces the cost of damage to victims by EUR 25 374 pppy. The combined treatment costs an extra EUR 16 222 pppy. Overall then this leads to a reduction in societal costs of almost EUR 13 000 pppy, and furthermore there are also increased health benefits for the patients (Dijkgraaf *et al.*, 2005).

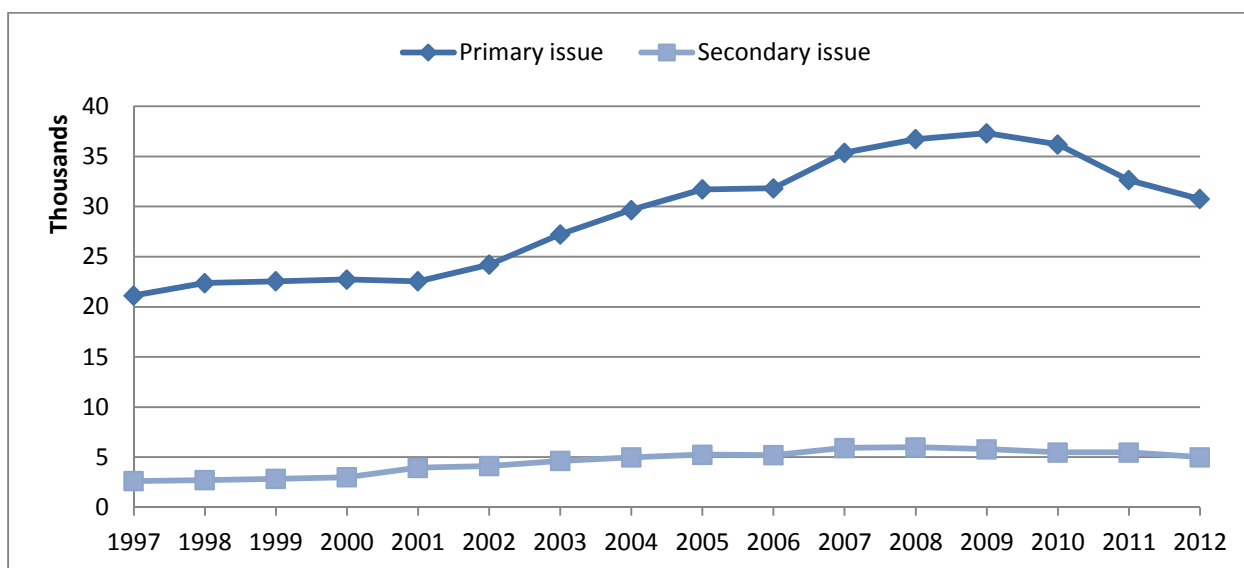
Alcohol

210. The consumption of alcohol is socially accepted in the Netherlands. Of the population as a whole, 84% consumed alcohol in the past year. Alcohol abuse took place among 2.9% to 4.5% of the population

(aged 18 to 65), and alcohol dependence is present in 0.3% to 1.2% (de Graaf *et al.*, 2010). The number of people with alcohol abuse or dependence has decreased since 1997. However, the DSM-IV criteria have become stricter, making it difficult to compare current data to previous figures.

211. In 2012, there were 30 758 (184 per 100 000) clients who registered for addiction care with alcoholism as their primary issue. This number has increased significantly since 1997 (see Figure 10) (Wisselink *et al.*, 2013). About 5 006 clients registered with alcoholism as a secondary issue.

Figure 10. Number of registered patients in addiction care for alcohol – 1997-2012



Source: Wisselink, D., W. Kuijpers, A. and Mol (2013). Kerncijfers verslavingszorg 2012. [Key figures addiction care 2012] Houten: Stichting Informatie Voorziening Zorg. [in Dutch]

212. A troublesome trend is the increase in the number of children and adolescents who suffer from alcohol intoxication. The number of those aged 11 to 17 who were admitted in a hospital for alcohol intoxication and treated by a paediatrician rose from 297 in 2007 to 762 in 2011 (Table 15). This number is an underrepresentation of reality, because not all 11–17 year-olds with alcohol intoxication end up in hospital, and not all 11–17 year-olds in hospital are treated by a paediatrician.

Table 15. Number of 11-17 year-olds treated by a paediatrician in a hospital for alcohol intoxication

	2007	2008	2009	2010	2011
# children with alcohol intoxication	297	337	500	684	762

Source: Van der Lely, N., van Dalen, W., Van Hoof, J., & Rodrigues Pereira, R. (2012). Alcoholintoxicaties bij jongeren in Nederland. Een onderzoek bij kinderafdelingen in Nederlandse ziekenhuizen. Cijfers van 2007, 2008, 2009 en 2010 [Alcohol intoxication with youth in the Netherlands. A study with children's wards in Dutch hospitals] [in Dutch]

213. Information on government policy on drugs and alcohol can be found on <http://www.government.nl/issues/alcohol-and-drugs>.

4.6. Human resources and training

214. In primary mental health care, primary health care psychologists are directly accessible for people with mild mental health problems. These psychologists have a university degree in psychology and two years of specialisation in health psychology. To practice, they need to be registered in the BIG register (see section 1.2 and 3.5.). Some 15 250 health care psychologists were registered in the BIG register in 2013 (CIBG, 2013). Most are self-employed, working in private or group practices.

215. A smaller number of primary health care psychologists are members of the National Association of Primary Care Psychologists (LVE) (Table 16).

Table 16. Number of primary health care psychologists (members LVE) and rate per 100 000 population

Year	Number	Rate per 100 000 population
2006	1 068	6.5
2007	1 065	6.5
2008	1 087	6.6
2009	1 050	6.4
2010	1 016	6.1
2011	901	5.4

Source: M. Veerbeek, A. Knispel and J. Nuijen (2012). GGZ in tabellen 2011. [Mental Health Care - MHC in tables 2011]. Utrecht: Trimbos-instituut [in Dutch]: Page 127.

Secondary and tertiary mental health care

216. Secondary and tertiary mental health care is provided by self-employed psychiatrists and psychotherapists and by psychiatrists, clinical neuropsychologists, clinical psychologists and mental health nurse specialists working in mental health care organisations. Table 17 shows the number of psychiatrists, clinical neuropsychologists, clinical psychologists, and mental health nurses registered in the BIG register, whilst Table 18 shows the registered professionals who are members of the professional associations.

Table 17. Registered mental health care specialists (Article 14 Wet BIG) by profession, 2013

Psychiatrists	3 377
Clinical Neuropsychologists	121
Clinical Psychologists	2 073
Mental health nurse specialists	482

Source: CIBG, 2013 Overzicht zorgverleners per specialisme [Overview health care specialists]. Available online: https://www.bigregister.nl/doc/pdf/OV-062%20Zorgverleners%20per%20specialisme_34664.pdf [In Dutch], Accessed 23 July 2013.

Table 18. Number of self-employed psychotherapists and psychiatrists and rate per 100 000 population

	Self-employed psychiatrists (BIG registered, members of PZG ¹⁸)		Self-employed psychotherapists (members of NVVP)	
	Number	rate per 100 000	Number	rate per 100 000
2004	453	2.8		
2005			1 051	6.5
2006	640	3.4	1 069	5.5
2007	564	3.4		
2008	616	3.8	1 024	6.2
2009	609	3.7	1 113	6.8

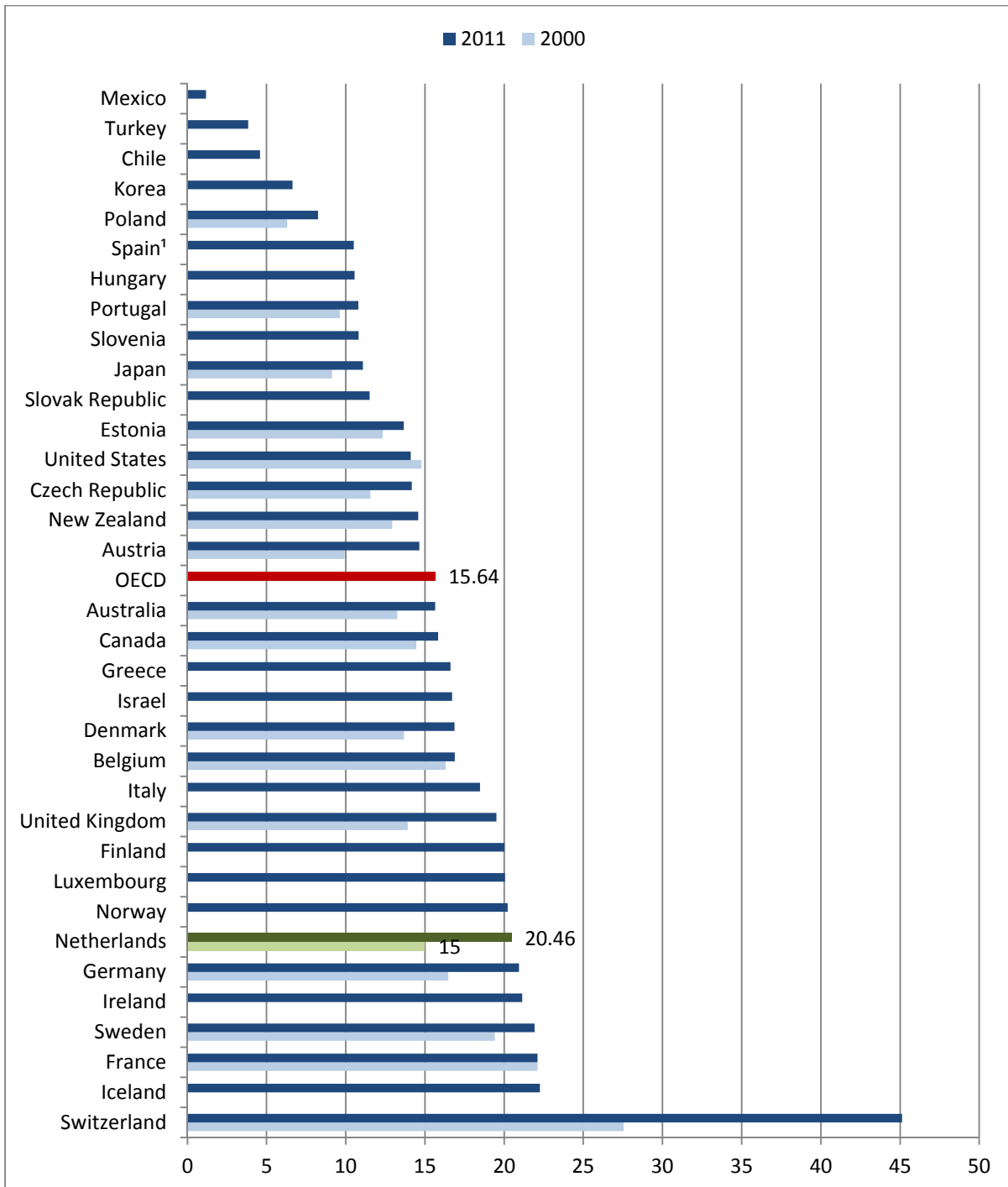
Source: Dijk, S. van, Knispel, A., Nuijen, J.(2011). GGZ in tabellen 2010. [MHC in tables 2010]. Utrecht: Trimbos-instituut [in Dutch]: Page 102 -103.

217. There were approximately 20 psychiatrists per 100 000 population in 2011 in the Netherlands, compared to an OECD average of 15 (Figure 11). Like in the majority of OECD countries, the number of psychiatrists per 100 000 population in the Netherlands has increased over the last decade.

¹⁸

Psychiatrie door Zelfstandig Gevestigden (Psychiatry by self-employed professionals)

Figure 11. Psychiatrists per 100 000 population, 2010-2011



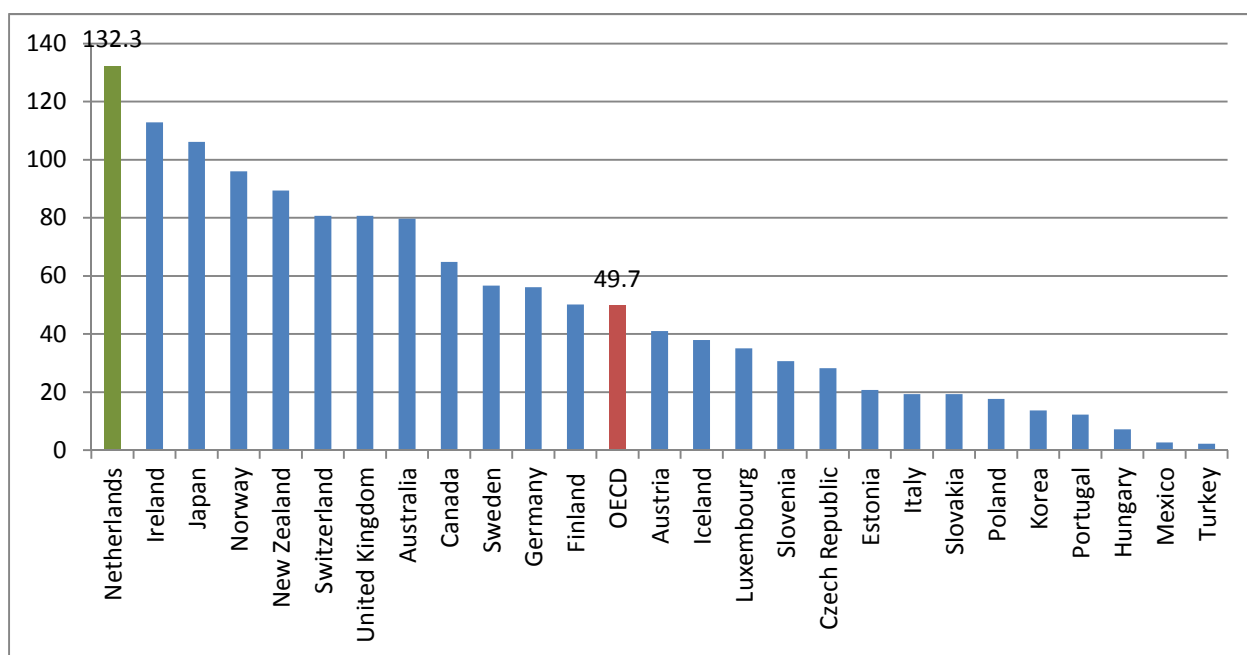
Note: Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD health database. [Online] Available <http://dotstat.oecd.org/Index.aspx>. Accessed 05 October 2013.

218. Mental health nurses play an important role as the largest group in the mental health workforce in the country. The Netherlands has the highest number of mental health nurses per 100 000 across the OECD, with 132.3 mental health nurses per 100 000 population compared to an OECD average of almost 50 (Figure 12). In the Netherlands, mental health nurses also represent about 10% of all the country's

nurses. According to recent estimates, about 60% of mental health nurses have finished an intermediate vocational education programme with a diploma, and the other 40% have a professional bachelor’s degree (Hoger Beroepsonderwijs). The latter group of mental health nurses may continue to follow a 2-year Master’s degree in advanced nursing practice, which qualifies them for registration in the national health care specialist register.

Figure 12. Mental health nurses per 100 000 population, 2011 (or nearest year)



Source: OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing.

219. The overall number of employees (FTE) in mental health increased between 2001 and 2009 by 45%. The number of medical staff rose by 43% (from 5 366 to 7 675), treatment and support staff by 54% (from 7 301 to 11 275), and nurses and carers by 29% (from 18 209 to 23 550). Significant increases were also seen among administrative and support staff, *i.e.* by 81% (from 6 773 to 12 275) (Table 19).

Table 19. People employed (FTE) by mental health care providers by profession, 2001-2009

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Medical staff	5 366	5 553	5 943	6 642	6 277	6 568	6 975	7 400	7 675
Treatment and support	7 301	7 527	8 584	9 360	9 054	9 244	10 325	10 525	11 275
Nurses and carers	18 209	19 184	19 879	19 527	21 316	21 554	20 875	22 025	23 550
Various staff	2 382	2 341	2 422	2 638	4 077	4 371	4 575	4 650	4 425
Hotel staff	3 989	3 993	4 466	4 104	3 788	3 794	3 950	4 375	4 500
Administrative/ support staff	6 773	7 297	8 046	8 729	9 360	10 307	11 825	11 600	12 275
Total	43 989	45 895	49 340	51 000	53 872	55 838	58 525	60 575	63 700

Medical staff: registered physicians (including psychiatrists).

Treatment and support (non-medical): psychologists, educational counsellors, social workers.

Hotel staff: people providing food and drinks, for example.

Administrative and support staff: human resources, finance department.

Source: Dijk, S. van, A. Knispel and J. Nuijen (2011). GGZ in tabellen 2010. [MHC in tables 2010]. Utrecht: Trimbos-instituut [in Dutch]: Page 98.

220. These increases primarily affected integrated institutions, sheltered living and substance abuse services. Table 20 shows that the number of employees working within integrated institutions more than doubled in the period 1998-2008. Likewise, the ranks of employees working in sheltered living and in substance abuse services have also increased significantly. Conversely, employees working in outpatient providers and in hospitals have decreased substantially in the same period. Hospitals include mental health hospitals and general acute care hospitals, and much of the absolute and relative decline pertains to the latter (Jeurissen *et al.*, 2012).

Table 20. Employees (FTE) in mental health (1998 – 2008), excluding for-profits

	1998	2002	2004	2006	2008
Integrated institutions	20 251	31 685	37 217	41 929	45 760
Sheltered living	2 148	2 340	2 664	3 455	5 090
Substance abuse	3 696	3 712	3 643	4 216	4 430
Outpatient providers	3 239	1 645	1 496	1 130	960
Hospitals	13 854	6 510	5 979	5 108	6 360
Total	43 188	45 892	50 999	55 838	62 600

Source: Jeurissen, PPT *et al.* (2012). Beleidsthema's in het hier en nu voor een doelmatige curatieve geestelijke gezondheidszorg in de toekomst [Current policy themes for future efficiency of mental health services], Ministry of Health, Welfare and, Sport, April 2012.

5. MENTAL HEALTH CARE FINANCING AND EXPENDITURE

5.1. Financing of mental health services

221. The financing of health care in the Netherlands is organised on the basis of social health insurance, with a small contribution from general taxation and out-of-pocket payments. All individuals contribute to the health insurance system in three ways. First, income-related contributions are collected centrally and then distributed among health insurers under a risk-adjustment capitation formula. Second, all individuals have the obligation to purchase a health insurance by paying a community-rated nominal premium to the insurer of their choice. Third, there is a fixed deductible for every individual insurance policy. This means that only the health expenditures exceeding the deductible are covered by the insurance policy. The government pays for the premiums of children up to the age of 18 (Eyssen *et al.*, 2010). The health insurance system is divided into three major schemes whose benefit packages are defined by the government: 1) a compulsory health insurance scheme (Social Health Insurance, SHI), 2) a mandatory scheme for exceptional expenses (SHI), and 3) voluntary health insurance scheme (Voluntary Health Insurance, VHI). The 2006 health care reform introduced substantial changes, especially to the functioning of the second and the third scheme in the health insurance system (Muiser, 2007).

222. A compulsory health insurance scheme (SHI) for exceptional medical expenses, including long-term care and high-cost treatment, is regulated in the Exceptional Medical Expenses Act (AWBZ) (Folkertsma *et al.*, 2013). This scheme is designed for people with long-term health problems. A needs assessment by the National Care Assessment Centre (CIZ) is required before care is provided via care offices (*Zorgkantoren*). The AWBZ is a compulsory scheme and is financed through income tax. The fund is managed by the Health Care Insurance Board (CVZ) (Muiser, 2007).

223. A compulsory health insurance scheme (SHI) for basic health insurance is regulated by the Health Insurance Act (Zvw). This scheme covers the entire population and provides essential curative care. Since 2008, this includes the first year of inpatient mental health treatment as well as almost all outpatient mental health. This basic health insurance scheme is financed through patient contributions based on a flat-rate premium – the nominal premium – and through an income-dependent employer contribution. Patients decide to pay the nominal premium to the health insurer of their choice, and the amount paid by the patient is independent of the individual's risk characteristics, hence leaving no room for risk selection (Van de Ven and Schut, 2007). Whilst the nominal premium is community rated and is independent of the individual's risk characteristics, the income-dependent employer contribution is transferred to the Health Insurance Fund through patients' payroll. The Health Insurance Fund allocates the resources thus collected to health insurers, according to a risk-adjustment capitation formula.

224. The basic health insurance package includes both outpatient (ambulatory) mental care and inpatient mental health care. Outpatient care is divided into primary and secondary care. Primary care interventions are short-term interventions by general practitioners, nurse practitioners, and psychologists designed for people suffering from mild mental health problems. It is included in the basic insurance package. There is a substantial amount of mental health indicators in the risk-adjustment capitation formula, especially regarding medication. The actual costs for mental health treatments are quite skewed, more so than acute care: 50% of all acute mental health costs are high-cost treatments costing more than 20 000 euro per case. Nonetheless, it is noteworthy that acute mental health costs only concern 2% of

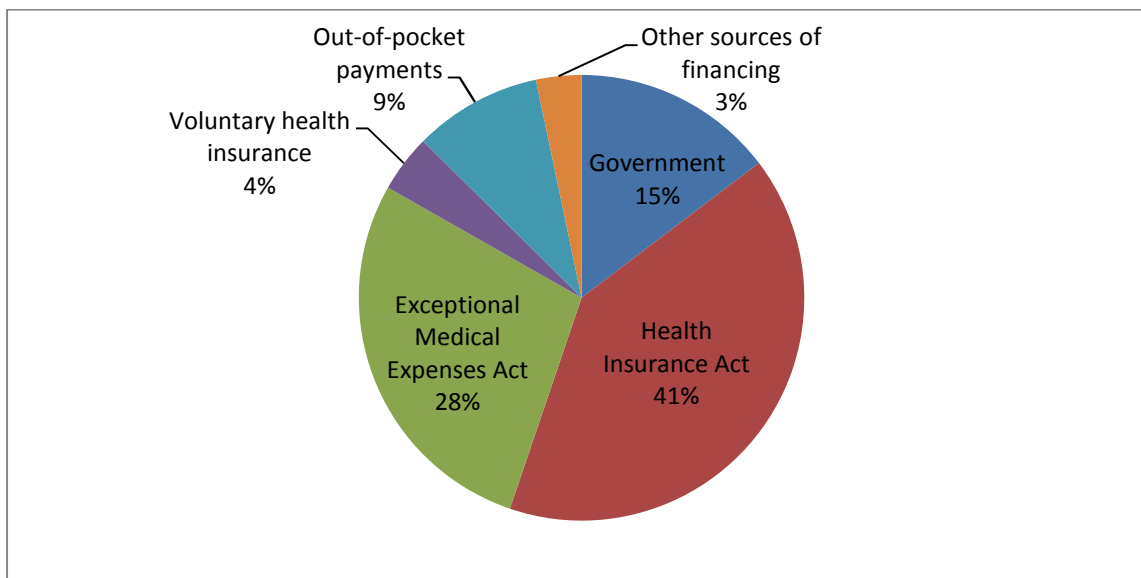
clients. Besides, it is known that inpatient mental health patients generate double the acute care costs of other patients (Jeurissen *et al.*, 2012).

225. A voluntary health insurance (VHI) scheme is designed to cover care that is not covered by the AWBZ and the Zvw. Generally included in the VHI scheme is all health care that is considered less important (Muiser, 2007). Insurers can apply risk selection in this scheme, *i.e.* insurers can adapt the price, the quality and the volume of care to the patient's individual characteristics.

226. Inpatient mental health care is also part of the basic health insurance package. After 365 days, however, inpatient mental care is considered long-term care and the financing responsibilities are thus transferred to the AWBZ (Schäfer *et al.*, 2010). Income-related co-payments are then applicable for people aged above 18.

227. As shown in Figure 13, in 2011 health care providers were mainly financed by the Health Insurance Act (Zvw) (41%); the AWBZ (28%); the government (15% mainly covering forensic care, prevention and social care service provision); out-of-pocket payments (9%); and the voluntary health scheme (4%).

Figure 13. Financing agents and schemes, 2011*



* The figures for 2011 are provisional.

Source: Statistics Netherlands, 2013. [Online] Available <http://www.cbs.nl/en-GB/menu/home/default.htm> Accessed 13 Mar 2013.

5.2. Provider payment mechanisms

Payment mechanisms in primary care

228. After 2006, GPs in the Netherlands have been remunerated through both fee-for-service reimbursements and a capitation formula. The maximum fee that a GP is allowed to ask for a consultation is negotiated between the National Association of General Practitioners (LHV), the Dutch Association of Health Insurers (*Zorgverzekeraars Nederland*) and the MoH. The capitation fee is a flat fee per year, based on the number of registered patients. In order to practice during out-of-hour services, GPs can also choose to participate in a GP out-of-hours cooperative, where they are remunerated through a per hour

compensation. Although enrolment in a GP out-of-hours cooperative is voluntary, approximately 95% of GPs were participating in these in 2009 (Schäfer *et al.*, 2010).

229. As of 2013, GPs have more financial flexibility in organising care for people with mental health complaints. GP practices are able to arrange for the right professionals to help their patients, in keeping with local circumstances. This may include, for example, offering web-based facilities or consultation with psychiatrists, psychotherapists, clinical psychologists and primary care psychologists. This strengthens GPs position to organise and monitor care for people with mental health complaints.

230. In 2014, a uniform payment system is being introduced for primary mental health care, based on four care intensity packages corresponding to patient needs: short, medium, intense or chronic. Each care intensity package is based on five objective criteria:

- a. Psychiatric disorder based on DSM-IV-TR;
- b. Severity of the problems: extent of general symptoms of the psychiatric disorder, extent of impairment of functioning;
- c. Level of risk that comes with the psychiatric disorder (*i.e.* self-neglect, decompensation or suicide);
- d. Complexity: there could be co-morbidity or other factors of influence, but these do not interfere with the treatment of the main psychiatric disorder;
- e. Duration of the complaints.

231. Each package covers the total of activities and care provision for a certain group of patients who fit the patient profile. The Health Care Authority (NZa) does not prescribe the contents of the care packages, instead health care providers and health care insurers are jointly responsible for delivering the care suited to the patient. However, the NZa does set a maximum tariff for each package.

Payment mechanisms in secondary care

232. Since 2005, inpatient and outpatient mental health care has been reimbursed by a DRG-based system known as “Diagnose Behandelend Combinatie” (DBC) or “Diagnostic Treatment Combination”. A DBC identifies the type of care (regular, emergency or chronic), the diagnosis (DSM-IV coding) and the treatment (outpatient or residential; nature of treatment) (Eyssen *et al.*, 2010). Unlike the Diagnosis-Related Group (DRG) system, the DBC system provides a DBC for each diagnosis-treatment combination. As a consequence, flexibility is allowed for co-morbidity cases, in that each patient can be assigned to more than one DBC (Schäfer *et al.*, 2010).

233. Health insurers in the Netherlands are obliged to have an agreement with mental health care providers to ensure the delivery of care. During the procurement process, insurer and provider negotiate on the terms of this contract. A health insurer may pay 110% of the maximum tariff, but typically they start negotiations on 70% of the maximum. Tariffs differ by treatment duration, therapy received and length of stay and are based on actual labour, material and capital costs, which were first collected in 2005. The reimbursement of the DBC is not influenced by the length of stay, nor by the number of diagnosis procedures for a given patient.

234. Longer-term mental health care, after 365 days, is funded under the Exceptional Medical Expenses Act (AWBZ). This care is free to users at the point of access, but an income-related co-payment does exist. In order to be eligible for mental health services provided under AWBZ, a consumer has to pass an objective and independent claim assessment by the National Care Assessment Centre (CIZ) (www.ciz.nl).

235. As explained previously in section 5.2, care under the AWBZ is funded using a payment unit known as care intensity package. The care intensity package describes the amount and type of required care, and each package is assigned a maximum tariff.

236. Each care intensity package incorporates three components: 1) client profile; 2) functioning and weekly client hours (with and without day care); and 3) care setting characteristics.

237. The client profile gives a detailed description of the typical client group, their average scores on a range of “limitation” assessments, the proportion with active or passive psychiatric problems, and the key aims of treatment/support. Average care times are estimated on the basis of contact and non-contact time and include time spent assisting client functioning and providing nursing and personal care. Day care use and therapist use are also specified for each care intensity package. The tariffs are then informed by these estimates.

238. In total 13 different care intensity packages are defined for mental health care delivery under the AWBZ, divided in two ranges:

- B range with 7 packages: continued long stay care is necessary in order to facilitate treatment of the psychiatric disorder;
- C range with 6 packages: continued long stay care with supportive guidance or home-treatment, mostly in sheltered facilities.

5.3. Mental health care expenditure

239. The total preliminary budget allocated to mental health care in 2010 accounted for 6.5% of total health spending (Zorgbalans, 2011).

240. The Gross Healthcare Budgetary Framework (*Budgettaire Kader Zorg*, BKZ) allocated to mental health care – which is the total of expenditures financed by revenues from premium taxes – has almost doubled from 2000 to 2010, from EUR 2.78 billion to EUR 5.09 billion (Folkertsma *et al.*, 2013). Costs for mental health care have risen at almost exactly the same rate as costs for health care in general during this period (Dijk *et al.*, 2011; Hilderink and van’t Land, 2008; Heijnen, 2013). Furthermore, mental health care costs have decreased in 2012. This is opposed to the current general trend in health care, where costs are continuing to rise (CBS Statline, 2013).

241. At the same time, data show that the increase in mental health care expenditure was not driven by an increase in prices, but rather by an increase in volumes, due to a variety of factors, discussed below, and including government policy to reduce waiting lists. This contributed to the diminishing level of under-treatment in mental health. Overall, the volume of mental health care service provision increased much faster than prices during the period 2003-2010, with rising mental health care expenditures as a result. The increase in expenditures in mental health care was not detrimental in that the returns on investments have been shown to be significant in the Netherlands. Research pointed out that each euro invested in mental health can yield EUR 2.59 in health gains (Lokkerbol *et al.*, 2011 – see section 2.3). Nonetheless, as mentioned previously, these results should be taken with caution, as they are based on a series of assumptions and have a large range of uncertainty.

242. One reason for the increase in mental health care expenditures is therefore greater demand for mental health services. It is argued that the demand for mental health services has increased in relation to social changes that have occurred in the Netherlands over the past decade. First, the government played a major role in reducing stigma, hence increasing accessibility to mental health services. Second, the importance given to early identification of mental health problems in primary care reduced the treatment gap, and as a consequence the demand for mental health care increased. On the supply side, the adoption of

health reforms in 2006 introducing competition among health care providers resulted in both a decrease in prices and in the development of new, more expensive treatments, with a parallel increase in demand as a result. This is mainly the result of a combination of few financial risks for insurers and – to a lesser extent – providers in combination with a new volume-enhancing fee-for-time reimbursement scheme since 2008 (see section 5.2.), which is curbed only by some global budgets for the traditional providers with inpatient facilities (Jeurissen *et al.*, 2012, p. 51). Last but not least, over the past 10 years the government has implemented a large variety of health policies to reduce waiting lists, which introduced significant, costly changes in the mental health care sector (Folkertsma *et al.*, 2013).

How mental health strategies might have affected mental health expenditures

243. The modernisation of the Exceptional Medical Expenses Act (AWBZ), adopted in 2002, aimed at, among other things, reducing waiting lists in all health sectors. Reducing these for mental health care was of particular importance, given the significant increase in mental health care demand discussed just above. In order for the AWBZ to be implemented and waiting times to be reduced, the government increased mental health care expenditures by 7.5%, or EUR 240 million (Folkertsma *et al.*, 2013).

244. Since 2005, hospitals have been paid through Diagnosis Treatment Combinations (DBC) (see section 5.2). In 2008, DBCs were also introduced in the mental health sector. DBCs increased expenditures on non-budgeted care providers, without reducing the budget allocated to mental health care. It has been calculated that the cost of introducing DBCs totalled EUR 1.4 billion (Van Diggelen *et al.*, 2012).

245. In 2008 most financing of curative mental health care was transferred from the AWBZ to the Zvw. Curative mental health care includes outpatient curative care and the first year of inpatient curative care. The AWBZ finances all (inpatient and outpatient) non-curative care, as well as the second year of inpatient curative care. According to the Health Care Insurance Board (CVZ), the transfer from AWBZ to Zvm cost EUR 1.1 billion, half of which was due to administrative costs, and the remaining portion to an increase in the volume of mental health care provided.

246. In 2010, care intensity packages (see also section 5.3) were introduced in secondary care. The care intensity package is the description of the intensity of care provided according to patient needs. Care intensity packages are part of AWBZ care, and the budget of health care providers depends on care intensity package. The introduction of care intensity packages increased the administrative burden, and therefore probably mental health care expenditures. However, no data is available quantifying this increase (Folkertsma *et al.*, 2013).

247. The OECD System of Health Accounts (SHA) currently includes country profiles for 13 OECD countries, including the Netherlands. However, the last release of the Netherlands profile dates back to 2001 (Cor van Mosseveld, 2001). For this reason, we did not use data presented in the SHA for the Netherlands, as more recent data was available from other sources.

Out-of-pocket fees in health care services

248. In 2012, out-of-pocket fees in the form of co-payments for secondary mental health care were introduced, in order to diminish the growing expenditures in the mental health care sector, but they were already abolished again in 2013. However, mental health services do fall under the statutory deductible of 350 euros.

249. In 2011, out-of-pocket fees represented only 9% of the total source of mental health care financing (see Chapter 5.1).

6. DISCUSSION, INNOVATIVE PRACTICES AND CONCLUSION

6.1. Discussion and key messages

250. In 2006, the Dutch government introduced regulated competition for health care in which health insurers and service providers are obliged to negotiate on the prices as well as quality of care. This system is likely to work properly only if reliable and comparable information is available on both items. Good information and transparency – available to providers, policy makers, health insurers and patients – on the quality of the services provided and the associated care costs are essential in order to promote healthy competition across providers. In this respect, the Dutch mental health system is regularly evaluated and monitored, and a number of mental health information systems exist, such as the Mental Health Care Benchmark Foundation (SBG) which collects outcome data on groups of patients; Argus, which monitors the use of coercive measures in mental health services; and Vektis, which collects and analyses data on the cost and quality of health care and is increasingly being used by health insurers to benchmark mental health care providers on variations in treatment and costs. These mental health information systems have proved useful to develop a number of indicators on quality, efficiency, patient safety and outcomes for mental health care at the national level. Together this aggregated information is allowing the regular monitoring of the mental health care system and will probably act as drivers of change in the Dutch system, in accordance with recent recommendations of WHO and EU in 2013 (Nas and van Geldrop, 2013).

251. Despite these well-performing mental health information systems, however, information on the prevalence of mental disorders across some population groups is missing in certain cases. For example, the latest surveys measuring the prevalence of mental disorders across children and adolescents are obsolete, and as a consequence not informative to policy-makers. Likewise, data on prevalence in the migrant population is missing. Estimates of the prevalence of mental disorders based on service utilisations are likely to underestimate the real prevalence of mental disorders compared to population-based surveys, and are unlikely to give a reliable idea of the extent of the actual treatment gap for mental disorders. Data on prevalence in specific population groups (*e.g.* children, migrants) could drive policy actions to increase early intervention for mental disorders and address possible treatment gaps in targeted population groups.

252. The role of user groups is relatively strong in the Netherlands compared to other OECD countries. The user groups in the Netherlands are represented by the National Mental Healthcare Platform, which plays a considerable role in the Netherlands in the policy-making process and in communicating about important benchmarking and transparency issues from a patient perspective. The involvement of user groups in government activities might be a considerable driver of future change, especially in a system of regulated competition in which the patient – *i.e.* the consumer – is free to choose the mental health care providers that best provide qualitative mental health care and are able to respond to patients' needs.

253. The Dutch mental health system is in the process of moving towards patient-centred mental health care. In order for this model to develop further, co-operation needs to be enhanced not only within the health care system, *e.g.* between primary and secondary care, but also outside traditional domains, *e.g.* between youth care, social services, employment officers and housing services. Within the context of health care, primary care is of increasing importance for the early detection and treatment of mental health problems, and it is fundamental for referring more severe patients to specialised mental health services. Initiatives to enhance co-ordination between mental health care providers and the police, employment

associations, schools and social care providers are currently in place in the Netherlands (see section 3.4.). Within the context of mental health care, more holistic services exist that aim at tackling the variety of problems associated with having a mental disorder. FACT teams are in this respect a good example of community-based services providing support that ranges from psychological treatment to work assistance, with the aim of facilitating the inclusion of patients in the society. These developments help orient the Dutch mental health system towards long-term strategic objectives, such as detecting and treating mental health disorders in early stages, integrating people with mental health problems in the job market, and facilitating the social inclusion of clients suffering from some type of mental health problem.

254. The Dutch mental health system is at the same time well-performing and very costly. Mental health expenditures are relatively high in the Netherlands compared to other OECD countries, and government spending for mental health services have been increasing until 2011. The rise in costs for mental health services has been driven by an increase in volumes rather than an increase in prices. Government policies to reduce stigma and reduce waiting times for accessing mental health services have resulted in increased access to mental health services, and consequently increased costs for mental health care. The introduction of regulated competition in 2006 might also have been a driver of increased costs. The development of more effective, and more expensive, treatments resulted in an increase in demand for mental health care services, and consequently also increased costs.

255. Moreover, the provision of mental health services in the Netherlands is highly fragmented, including with regard to funding. Mental health care attracts funding from four major sources: the Health Insurance Act (Zvw), the Exceptional Medical Expenses Act, the Act for Social Support as well as direct funding from the Ministry of Security and Justice. The transaction costs associated with such a fragmented and dispersed funding system are substantial. Government policies are currently being undertaken in this respect to bring all specialised mental health services under the Health Insurance Law and reduce transaction costs and inefficiencies. The continuing increases in government costs for mental health care are likely to be unsustainable, especially within the context of the current economic crisis and tight government budgets. Increasing government efforts to focus on prevention rather than on treatment might be a good way for governments to decrease spending on mental health care. Initiatives aimed at developing e-Mental health have good potential to reduce costs and incentivise self-management when possible. Furthermore, there is a general consensus that mental health care has a positive effect on public order and safety, even though there has been insufficient scientific study of this topic. Care providers have publically stated that they expect that budget cuts will lead to less capacity for treatment, which is likely to have wider social consequences. In this respect, focus on self-management and prevention could be a way for governments to obviate the social consequences associated with budget cuts.

6.2. Ongoing mental health agenda – next wave of the agenda

Child and adolescent mental health services

256. A foresight study in 2010 recommended that, in order to increase effectiveness and efficiency, financial responsibility for child and adolescent mental health care should lie with municipalities instead of health insurers. They identified five bottlenecks in the current situation that merited this transition (Werkgroep Toekomstverkenning Jeugdzorg, 2010).

- Imbalance in focus: specialised services are receiving a disproportionate amount of funding compared to universal and preventive services.
- Fragmentation: the great diversity in services, statutory bases, and responsible and funding authorities creates a lack of transparency and makes implementing innovations difficult.

- The prevailing practice of referring clients: clients often need to utilise a variety of services to receive their care.
- Increased use of care: an imbalance in the three services could be one of the reasons for the increase in utilised care (next to earlier detection and societal changes).
- Unmanageability: changes in one type of service influence the other types.

257. There are, however, also arguments against transferring responsibility to the municipalities. These were raised by several stakeholders (GGZ Nederland, 2011b).

- Access to care: will municipalities be able to guarantee everyone access to adequate care? Or will they have to prioritise, and if so, how will they determine those priorities?
- A cut between somatic and mental health care may lead to new coordination problems.
- Will the municipalities (especially the smaller ones) have the necessary knowledge, expertise and funding to handle the new responsibilities?

258. The recommendation for transferring responsibility to the municipalities has been included in the coalition agreement (Rutte and Samsom, 2012). The government plans to execute the transition in 2015. The Youth Act (*Jeugdwet*), in which the above is to be arranged, has passed parliament, and is now awaiting the senate's assent.

Legislation

259. Legislation on mental health is currently undergoing major changes. The Wmo will be expanded to give more responsibility to municipalities for the care of children and for long-term support for adults with severe mental illness. Municipalities have great latitude in implementing the Wmo, which leads to differences between cities. The BOPZ will in the near future be replaced by the *Wet Verplichte geestelijke gezondheidszorg* (Mandatory Mental Health Care Act), currently in parliament. This new act is much more focused on the prevention of forced treatment and aims to make it less invasive if it is required. An important difference with the existing BOPZ is the option to also enforce treatment outside of the organisation, for instance in an outpatient setting. The current concept of the Mandatory Mental Health Care Act also states that the consumer should be able to have a sufficient degree of influence during the whole care process, and that care evaluation should take place. Consumers can also indicate treatment preferences, and there should be options for them to participate in society if possible or to be prepared for this. Carers will also be more involved in decision-making and will be supported by "family support persons" if someone is hospitalised (Informatiepunt dwang in de zorg, 2013).

260. The government aims to send a new act to parliament in 2014, which will set a framework for good governance in health care. The Minister has outlined this new act in a recent letter to parliament (Schippers, 2013b). It should secure: 1) sufficient guarantees for the good functioning of boards of directors and supervisory boards, 2) influence by consumer councils in terms of representation and participation in health care supplier's policy-making, and 3) that the internal governance structure of a new health care supplier meets the aforementioned requirements from the start of health care delivery. The new law will incorporate some elements from the WTZi, and it is expected to fully replace the WMCZ (Ministry of Health, Welfare and Sport, 2013c).

261. Based on the latest coalition agreement, the government is planning a total reform of long-term care (reform of the AWBZ), including long-term mental health care. As discussed above (section 6.2), the

Dutch mental health care system is highly fragmented, generating high transaction costs. Partly as an effort to reduce these transaction costs, the government has decided that per 2015 all long term specialised mental health services predominantly aimed at curing patients, should become part of the the Health Insurance Act (Zvw). Mental health care that is more focused on delivering guidance and enhancing “participation in society” (such as sheltered housing) should become part of the Social Support Act (Wmo). The necessary changes in law are currently in preparation..

Administrative agreement on the future of mental health care 2013-2014

262. In the administrative agreement for organising the mental health system in the near future was laid out., which is currently in the process of being implemented. Its key features are described below (Figure 14).

Figure 14. Organisation of the new model of care and care pathway



263. Building on existing good practices, under the new agreement GPs throughout the country are expected to identify, treat and refer, as needed, to primary and secondary mental health services. The GP’s team is required to include support services provided by assistants, mental health nurses and social workers. In addition, GPs can also consult other health professionals, such as psychiatrists and psychologists, and draw on the support services, which should collaborate closely with primary and secondary mental health care. They are also expected to make active use of e-mental health applications and programmes.

Primary mental health care

264. In addition to GPs, the first specialised services are called primary *mental* health care. This is again an expansion of the current model of care and is expected to decrease referrals to specialist services by 20%. These services can be accessed only through a referral from a GP or other professional, such as an occupational physician, and only when patients are expected to suffer from a DSM condition, accompanied by moderate to low impairment of functioning. This segment of care is intended to deal both with people whose condition is mild to moderate, not complex, and who have a good social network and good prospects of recovery, as well as people whose condition is severe, but stable. It is also expected to provide aftercare and support and prevent relapses.

Secondary and tertiary care

265. This segment of care is addressed to people with severe and enduring mental health problems at high risk of a poor quality of life who require complex forms of treatment and a high degree of specialist knowledge.

266. At this level of care, people with mental health problems can be diagnosed by a clinical psychologist, a psychotherapist or psychiatrist. Treatment and care address the patient’s recovery and

rehabilitation, relapse prevention, self-management and e-health. Regarding the type of setting for the provision of care, the preferred option is outpatient care. This should result in a decrease in inpatient admissions and a shift in care towards community settings, as well as a reduction of the number of available beds. If inpatient admissions cannot be avoided, they should be for only as long as needed, and patients should be transferred to primary mental health care or to the GP, depending on the health situation. This is also known as “balanced care”.

eMental health

267. The government sees great potential in the use of e-health in general, including e-mental health. The main reason for this is that e-health (applications) can support people in incorporating their health problem(s) in their (daily) life and thereby to remain as healthy as possible (self-management). This provides people with a greater ability to remain independent. Following the organisation of the health care system in the Netherlands, health care suppliers and insurers are primarily responsible for embedding e-health and information and communication technologies in the health care process. The government considers that its responsibility is to create the right preconditions for such innovations to take place, for example by eliminating barriers in legislation or in the financing systems. Furthermore, the government is actively involved in the development and use of (international) standards to enhance the interoperability of different e-health applications, and it maps the current use of e-health (applications) in health care through the annual eHealth-monitor.

6.3. Outstanding and innovative initiatives: best practice examples

- Transparency in mental health care – guaranteed through regular monitoring and production of mental health indicators at the national level – as an important part of the governing system.
- The position of clients and family in the system through user involvement.
- Universal health insurance coverage, including a mandatory, broad package of mental health benefits.
- A robust system of primary care, and the presence of a primary mental health team (psychologist, social worker, nurse or Practice Support Professional) treating the bulk of mental health patients.
- The central position and role of the professional organisations, who have taken the lead in mental health reforms, in strong collaboration with other stakeholders.
- The availability and reimbursement of a series of evidence-based e-mental health treatment modules, for different disorders and subgroups.
- The use of FACT teams that take a holistic and customised approach to care, providing service users with support as needed, from psychological treatment to work assistance, with the aim of ensuring continuity of care, preventing admissions to psychiatric hospitals and stimulating inclusion in society.

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GLOSSARY

- **Governance** refers to the exercise of political, economic and administrative authority in the management of a country's affairs at all levels (WHO).
- **Mild** generally refers to relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day-to-day functioning (NICE, 2011).
- **Moderate** refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning (NICE, 2011).
- **Severe** refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities) (NICE, 2011).
- **A user / consumer / patient** is a person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental disorders (WHO, 2011).
- **Family** comprises members of the families of persons with mental disorders who act as carers (WHO, 2011).
- **Mental health policy:** The official statement of a government conveying an organized set of values, principles, objectives and areas for action to improve the mental health of a population (WHO, 2011).
- **Mental health strategy/plan:** A detailed pre-formulated scheme that details the strategies and activities that will be implemented to realize the objectives of the policy. It also specifies other crucial elements such as the budget and timeframe for implementing strategies and activities and specific targets that will be met. The plan also clarifies the roles of different stakeholders involved in the implementation of activities defined within the mental health plan. Mental health programmes are included within the mental health plan category. A mental health programme is a targeted intervention, usually short-term, with a highly focused objective for the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation (WHO, 2011).
- **Mental health legislation:** Mental health legislation may cover a broad array of issues including access to mental health care and other services, quality of mental health care, admission to mental health facilities, consent to treatment, freedom from cruel, inhuman and degrading treatment, freedom from discrimination, the enjoyment of a full range of civil, cultural, economic, political and social rights, and provisions for legal mechanisms to promote and protect human rights (e.g. review bodies to oversee admission and treatment to mental health facilities, monitoring bodies to inspect human rights conditions in facilities and complaints mechanisms) (WHO, 2011).

- **Psychiatrist:** A medical doctor who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution leading to a recognized degree or diploma (WHO, 2011).
- **Nurse:** A health professional who has completed formal training in nursing at a recognized, university-level school for a diploma or degree in nursing (WHO, 2011).
- **Psychologist:** A health professional who has completed formal training in psychology at a recognized, university-level school for a diploma or degree in psychology (WHO, 2011).
- **Social worker:** A health professional who has completed formal training in social work at a recognized, university-level school for a diploma or degree in social work (WHO, 2011).
- **Mental health outpatient facility:** A facility that specifically focuses on the management of mental disorders and related clinical problems on an outpatient basis. These facilities are staffed with health care providers specifically trained in mental health (WHO, 2011).
- **Mental health day treatment facility:** A facility that provides care for users during the day. The facilities are generally available to groups of users at the same time and expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff and / or participate in therapy activities. Attendance typically ranges from a half to one full day (4 – 8 hours), for one or more days of the week (WHO, 2011).
- **Psychiatric ward in a general hospital:** A ward within a general hospital that is reserved for the care of persons with mental disorders (WHO, 2011).
- **Community residential facility:** A non-hospital, community based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions (WHO, 2011).
- **Mental hospital:** A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with severe mental disorders. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably; in some cases only long stay custodial services are offered, in others specialized and short-term services are also available (WHO, 2011).
- **Forensic units:** forensic units care for people with mental disorders who have come into contact with the criminal justice system. They may also be called secure units or special hospitals (WHO, 2008).
- **Community mental health services:** secondary or specialist care (care that cannot be provided by a primary care physician). At its most basic, it may be office-based private care or, more often, outpatient clinic (polyclinic) provision for assessing and treating mental illness by a trained mental health professional (such as a psychiatrist or psychologist). It can also be provided by a multidisciplinary team (community mental health team) comprising psychiatrists, mental health nurses and often psychologists and social workers. They usually provide care for the inhabitants of a clearly defined catchment area (such as a borough or town). Care is provided in a variety of settings (such as clinics, people's homes and day centres). An alternative structure is the

community mental health centre, where several teams run a range of services, one of which is assessment and care outside the hospital (WHO, 2008).

- **Secure psychiatric beds** “Secure mental health services provide accommodation, treatment and support for people with severe mental health problems who pose a risk to the public. Sometimes known as ‘forensic’ mental health services, secure services work predominantly with people who have been imprisoned or admitted” directly to hospital through the 1983 Mental Health Act following a criminal offence. (Centre for Mental Health, 2011)
- **Stigma:** A stigma is a distinguishing mark establishing a demarcation between the stigmatized person and others attributing negative characteristics to this person. The stigma attached to mental illness often leads to social exclusion and discrimination and creates an additional burden for the affected individual (WHO, 2008).
- **Prevention:** Mental disorder prevention focuses on reducing risk factors and enhancing protective factors associated with mental ill health with the aim of reducing the risk, incidence, prevalence and recurrence of mental disorders (WHO, 2008).
- **Primary health care (PHC):** Encompasses any health clinic that offers the first point of entry into the health system. These clinics usually provide initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a higher level of training and resources (WHO, 2011).

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