Nazorg geeft kopzorg. Een onderzoek met een register oor de geestelijke gezondheidszorg
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SUMMARY

Continuity of care implies that patients receive the care they need at the most appropriate time, regardless of the fact that administratively separate agencies may be involved in its delivery. Although aftercare and its effect of preventing readmission has rarely been studied in the Netherlands, it is often stated that few discharged patients receive such care in a satisfactory manner.

It is difficult to obtain a comprehensive picture of mental health care in the Netherlands, because of the wealth and variety of services, and the discontinuity of their information systems. This study reports on a study of a cohort collected from 1974 to 1978 of 795 discharges of patients aged 15 to 65 years, from a variety of psychiatric inpatient services. The cohort was followed for a period of one year with the help of a psychiatric case register, which covers the 45,000 inhabitants of an urban municipality in the north of the country, and the various mental health services delivering care.

From all discharges, 422 (53%) were followed by some form of aftercare within the first twelve weeks. The social psychiatric service saw 26 percent of this group of patients. Historically, aftercare has been the task of this type of patients were seen at a mental hospital, another patient department of another 21% at an admittance (5%) went to another 21% at an administratively separate agencies may be involved in its delivery. Although aftercare and its effect of preventing readmission has rarely been studied in the Netherlands, it is often stated that few discharged patients receive such care in a satisfactory manner.

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the task of this type of service. But now 23% of the patients were seen at the outpatient department of a mental hospital, another 25% at the psychiatric outpatient department of a general hospital, and yet another 21% at an addiction clinic. The few remaining patients (5%) went to a day hospital or a hostel. In those services most of the patients were seen by social psychiatric nurses (30%), psychiatrists (30%), or social workers (20%); the remainder were seen by psychiatric residents or psychologists.

About twothird (61%) had only one contact, or less than one contact every two weeks during the first twelve weeks. The others were seen at least once every two weeks during this period. Home visits were quite rare (18%), they were made mainly by the social psychiatric service and typically by social psychiatric nurses.

Although aftercare was not particularly frequent, still 9% of patients receiving aftercare visited more than one service, or saw more than one health worker within the same service (12-28% depending on the type of service).

Of 224 patients discharged after a psychosis, 58% received aftercare, mostly from a social psychiatric nurse (52%), and in 44% of cases, with more frequent contacts.

Of 342 patients with psychoneurosis or a personality
disorder 51% had aftercare, more often from a psychiatrist (51%). Of 158 addicted patients 60% received aftercare, very often from a social worker (84%). The social psychiatric service and the outpatient department of the mental hospital see more often people discharged after a psychosis, while the psychiatric outpatient department of the general hospital deals mostly with neurotic cases. By no means all patients receiving aftercare had in fact been referred by the staff of the hospital from which they were discharged. For many patients (67%) it seemed to be a continuation of the outpatient care they had already been receiving before they were admitted.

A comparison of cases receiving aftercare during the first twelve weeks following discharge, with the others without such care, did not reveal many significant predictors of aftercare. Previous outpatient contacts were most predictive of aftercare, whatever the diagnosis of the case. Next came marital state: i.e. married patients received aftercare more often than the non-married. Apparently, aftercare requires extra effort on the part of the services. This is not an established feature in the delivery of care existing in the Netherlands. Although various types of outpatient services have been integrated admittance of in- and outpatient indeed unlikely to occur between the mental hospital and general hospital.

During the past few years we have been allowed to grow in limited aftercare availability. In the first twelve weeks of readmissions during including 56 patients who lacked sufficient psychosis (45%) or with more readily admitted psychosis (30%). The best predictor of previous admission patients which patients entered cases were readmitted for the first time. A detailed analysis of
been integrated administratively, such integration of in- and outpatient services is lacking, and is indeed unlikely to occur in the near future, even between the mental hospital and its own outpatient department.

During the past few years outpatient services have been allowed to grow also because they were supposed to prevent admission, and therefore decrease the utilization of psychiatric beds. This policy includes prevention of readmission by means of intensive aftercare. We have already seen that intensive aftercare is not particularly common, but even the limited aftercare available may reduce readmissions. In the first twelve weeks following discharge 161 patients were readmitted, and 121 later. The rate of readmissions during the first year was 38.2%, excluding 56 patients who moved away, and about whom we lacked sufficient information. Patients with a psychosis (45%) or with an addiction (43%), were more readily admitted than those with a psychoneurosis (30%). The best predictor of readmission was previous admission preceding the admission through which patients entered our cohort; i.e. 50% of those cases were readmitted, but only 29% of those admitted for the first time. A detailed analysis combining the chance of readmis-
sion with diagnosis revealed that more intensive aftercare appeared to delay readmission of psychotic cases who already had a medium or small chance of being readmitted.

The various outpatient services and types of mental health workers had populations of discharged patients with different readmission rates. These appeared to depend not on the pattern of aftercare they delivered but on the characteristics of their population of patients. The social psychiatric service appeared to be more often occupied with patients who were going to be readmitted, during the final four weeks before readmission.

Against the perspective of continuity of care it is interesting to note that one third of readmissions took place in another hospital than that of the previous admission.

In order to promote aftercare we conclude the following:

1. The network of mental health services should be organized with more emphasis on expansion and diversity of aftercare programmes to reach greater numbers of discharged patients.

2. More casuistic studies of aftercare should be undertaken to identify the obstacles to its implementation.

3. Experimental programmes should be started to identify the best predictor of readmission.

Attention should be given to planned changes. A careful assessment in a situation in which contacts and service activities are provided on a voluntary basis, it is possible to record what happens. Some have argued that, since so many charges within a relatively short period are finally followed by aftercare, research with the help of statistical analysis can provide a more meaningful perspective and more reliable results. However, less complex retrospective studies can still provide useful information.
3. Experimental programmes to prevent first admission, should be strongly stimulated, since the best predictor of readmission appears a previous admission. Attention should be given to the evaluation of the planned changes. A case-register is generally considered rather expensive and complicated to run. But in a situation in which registration of patient-contacts and service activities occurs largely on a voluntary basis, it is practically the only means of recording what happens to discharged patients. We argued that, since so many patients have several discharges within a relative short period, only occasionally followed by aftercare, prospective longitudinal research with the help of a case-register offers more perspective and more reliable data than cheaper and less complex retrospective studies.